EMDR now

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EMDR in the treatment of low-weight anorexia nervosa

Mel Temple reports encouraging results from her work with anorexic patients with very low BMIs

Preliminary findings suggest that EMDR may be effective in assisting anorexic patients with ultra-low body-mass indices (BMI) to manage core symptoms of eating disorders and achieve some respite from anorexia nervosa.

As Consultant Psychiatrist to a Tertiary Eating Disorder (ED) Service, most of the referrals I receive are for patients with Anorexia Nervosa (AN), many of whom present with low and ultra-low weight (where BMI <14 and as low as 10). There is little research evidence that any therapy modality is effective for this very low-weight subgroup due to the slowing of brain cognitive and executive functioning, physical ill health and so on. The on-going multi-centre study comparing a range of approaches including E-CBT, IPT and E-MI / supportive relational therapy has so far found little effect over and above that for the treatment-as-usual group (preliminary findings were presented at the Yorkshire Centre for Eating Disorders Conference on Updates of Psychological Therapies /Approaches in Eating Disorders, held in Leeds in September 2010).

AN patients often have a history of trauma and may have associated co-morbidities with Axis II disorders, in particular personality disorder types that are emotionally unstable. Psychological therapies for EDs currently focus on managing ED symptoms and (maintenance) behaviours. Whilst they may identify causative factors, such approaches do not necessarily address them. This can often leave patients unable to engage in (or complete) the ED work to recovery, or lead to repeated relapses.

Given the dearth of research on the use of EMDR in AN, I wished to investigate whether adding EMDR to standard ED therapy might promote a fuller recovery. However, I was aware that since conscious cognitive processing does not occur normally at BMI <15 (and certainly <14) there would be no way

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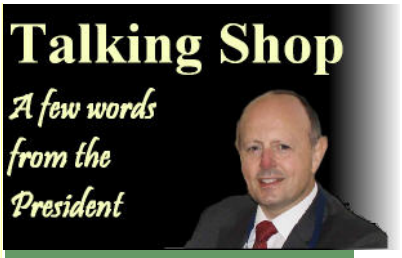
New EMDR and deafness Special Interest Group

A new group focusing on the use of EMDR with D/deaf clients is inviting practitioners with relevant experience to become members. The group aims to collect data on EMDR work with D/deaf and eventually write about and present its findings.

A small number of clinicians working in National Deaf CAMHS and adult services are trained in EMDR have already begun to deliver EMDR through British Sign Language. The delayed languages skills that accompany deafness have so far presented a challenge for CBT practitioners working with deaf clients. EMDR offers a promising alternative.

The idea for the new special interest group emerged at the 8th European Congress on Mental health and Deafness, held in Cambridge in



The start of a new year presents us with opportunities to change old habits and commence new activities. I would encourage you to promote EMDR in your local area, to trained professionals, those considering training, and potential users of our services.

Promoting EMDR requires a full understanding of Francine Shapiro's Adaptive Information Processing Model and an ability to explain it to others in a way they can appreciate that trauma is more than PTSD. A working knowledge of the neurobiology of trauma is helpful and, to this end, the keynote address at our 2011 conference will assist you.

It has been suggested to me that some practitioners see EMDR as something they can bring out occasionally, perhaps when their usual therapy has proved unsuccessful with a particular client. EMDR is an integrative psychotherapy which starts when our client enters the room. It continues on from taking a detailed history, giving education and ensuring client stability before we activate the traumatic memory and add in the bilateral stimulation. We all should be looking to when we can introduce our clients to the power of processing trauma with EMDR.

of knowing whether the information processing integral to EMDR could occur at such low BMIs.

In agreement with their primary ED worker and with full informed consent, I selected three AN inpatients with low body weight (BMI 10.4, 12.8 and 14). All had had their ED for at least 10 years and shown little response to previous interventions. Each had a history of trauma. Two had comorbid diagnosis of PTSD and one had Emotionally Unstable Personality Disorder (PD).

All were surprisingly successful at installing a peaceful place and resource figures. This preparation phase was intensely positive for all three patients, resulting in dramatic "mental quietening" from the internal "noise" of the AN. Two patients described it as the only escape they had had for 10 years.

Trauma processing proved more difficult as the intrusiveness of AN thinking and compulsions limited patients' ability to focus on the trauma work. However, encouraged by the positive response in the preparation phase and linking to the pain protocol, we sought to help patients develop a representative image for their symptoms which would enable them to separate the ED from themselves. We could then apply the concept of "mastery" or change over the ED via processing with BLS. All three brought in resource figures, achieved change within the imagery related to their AN and developed some sense of being able to take control. Clinically, this translated to better engagement in ward-based ED plans around diet and activity. Patients continued to use the imagery work prior to and after meals to tackle exercise compulsions and other unhelpful thoughts and behaviours. As a result, the two patients with PTSD could begin processing past traumas and the third could start processing the negative life experiences that underpinned the maintaining beliefs.

Dramatic improvement

The two non-PD patients showed dramatic improvement after trauma processing; there was marked recovery from AN symptoms, thinking, compulsions and body dysmorphism and complete resolution of PTSD symptoms. The third, more complex PD patient, continues to experience excellent symptom reduction with EMDR and we are adding DBT-based work to complement and support the ongoing trauma/AN work. Notably, we found that two-handed cognitive interweave approaches within processing based on traditional CBT rationalisation for body dsymorphic symptoms produced a perceptional shift within single sessions and reduced the distress arising from increased dysmorphism as a result of weight gain. Such approaches are not usually feasible in patients with BMI <16 and the increased dysmorphism often stalls recovery at stages of weight gain.

Information processing at ultra-low BMIs

These findings are encouraging. Information processing systems would appear to still function at ultra-low BMIs, including processing of interweaves and material not normally accessible via standard CBT approaches. EMDR appears to be useful for processing trauma and negative experiences underlying AN presentations. Moreover, it can help patients to manage ED symptoms, including body dysmorphism, to achieve some respite.

We plan to open a regional 15-bed inpatient unit for ED at the West Park Hospital, Darlington, in April 2011. EMDR is to be a core element alongside e-CBT/ Dialectical Behavioural Therapy/Mindfulness. Staff will be trained to practitioner level. Our aim is to work with more patients of this type in order to develop a model that will permit outcome testing.

I'd welcome views and questions on the use of EMDR in this difficult client group and am keen to collaborate on a model that can be formally assessed.

Dr Melanie Temple is an Accredited EMDR/IPT Practitioner and Consultant Psychiatristat Tees Esk Wear Valleys NHS Mental Contact her on 01624 601801 or via melanie.temple@tewv.nhs.uk

Following screening for dissociation, which should be done with *all* clients, there may be a need for significant preparatory work; for the more debilitated clients that only means remaining longer in the Preparation Phase (Phase 2). The therapeutic skills you have gained from other therapies work well *within* the EMDR model. So long as you return to target to reprocess material in undistorted form and follow the protocol you will do your clients a service.

To members already promoting EMDR, thank you. For others, please do heed what I am saying. The anti-EMDR lobby would revel in EMDR becoming marginalised and being seen as ineffectual.

On a different note, the Association has now become a company limited by guarantee and awaits the granting of charitable status. We have a new-look website which allows searches to be made for Accredited Practitioners and Consultants rather than scanning a regional list. Our conference in Bristol on 25-26 March is on course and we look forward to a good turn out of members. You will be pleased to note that we will be hosting the EMDR Europe 2014 conference in Edinburgh. Our delegation to EMDR Europe put forward an excellent presentation and secured the nomination – I think they should have been asked to present to FIFA to secure England as the venue for the world cup!

Our colleague, John Spector, has come to the end of an era. John introduced EMDR Institute trainings to the UK and Ireland in the mid 1990s and this resulted in hundreds of therapists being trained in EMDR over the years. Although John now plans to spend more time in Devon his expertise is still available as he continues to do therapeutic work and consultancy. We owe John a debt of gratitude for initiating the recognition and training of EMDR here.

This is my last column. Our President Elect, Robin Logie, takes over as President at the 2011 conference in March. I will be available to support him and Council in my new role as Past President and Trustee of the charity. I would like to wish you well for 2011 and thank you for support and continued membership of our Association. Kindest regards,

Michael

Dr Michael C Paterson OBE is President of the EMDR Association UK & Ireland

What influences the onset of PTSD?

John Campbell-Beattie and David Mulhall consider the effects of normalising trauma

Consider two cases. In the first, a member of the special forces experiences hand-to-hand fighting and, in the same tour of duty, witnesses enemy combatants being mown down by machine-gun fire. He experiences no PTSD. Decades after leaving the forces, a heavy object narrowly misses him as it falls from a building. For the first time, he develops PTSD.

In the second case, a woman driving in overtaking lane of a motorway is undertaken by a car that cuts in front of her. In attempting to avoid an accident she swerves to the right, hits the central reservation and crosses all three lanes of the busy motorway without incident. She hits the hard shoulder before coming to a halt, facing oncoming traffic in the left-hand lane. She immediately develops PTSD. Why does the ex-Royal Marine develop PTSD symptoms after a comparatively minor incident, years after experiencing extraordinarily traumatic events in combat, whereas the woman driver develops PTSD almost immediately?

There is a view that some people are more likely to develop PTSD than others. Another view proposes a cumulative effect; once a certain critical level of repeated trauma is reached, PTSD develops. We propose an alternative hypothesis: PTSD symptoms emerge when the limits of a person's normal coping mechanisms are exceeded. The delay of PTSD in the ex-Marine can be explained by a process of normalisation. Two factors contribute to normalisation: suppression of trauma and emotional support through trauma. In order to survive in such extreme environments, service personnel learn to suppress the horrors they experience. They become inured to trauma, often relieving stress through black humour. In routine trauma, the support of comrades is critical.

This culture of suppression and support is common to all military services and civilian services such as the police, fire and ambulance services. (There are examples from civilian life where brutality can become normalised and violence become a way of life.) Suppressed trauma can be subliminal for many years and may present no problems at all. However, if the person is re-exposed, at times even to slight trauma, the suppressed trauma can be re-awakened and assume a ferocious form that may destroy quality of life.

Support of comrades

In the first case, the Marine had the support of his comrades and the horrors of war had become normalised. In some sense he learned to accept unspeakable horrors and to suppress them. In the second case, the woman had no support system in place and the accident was unique. Such events had in no sense been normalised. In the ex-Marine's case it took a second trauma to rejuvenate old, suppressed traumas and it is this that instigated PTSD. In the second case the event was unique and affected a wholly unprepared person who immediately developed PTSD.

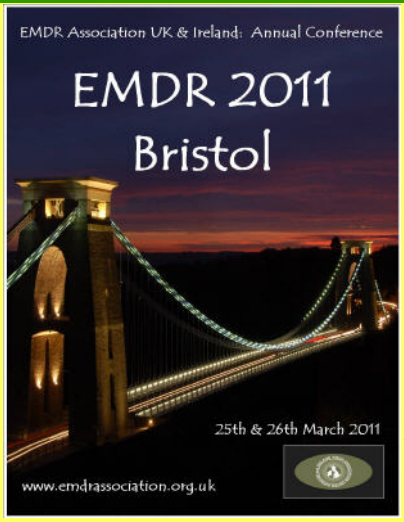
John Campbell-Beattie is an Accredited EMDR Consultant. David Mulhall is a Chartered Clinical & Neuro Psychologist and Fellow of the British Psychological Society. They live and work in Plymouth.

Annual Conference to highlight EMDR research

Bristol's historic and vibrant quayside is the location for the 2011 EMDR Association UK & Ireland Annual Conference and, like the city, it promises to be a blend of both the old and the new. The 'old' relates to parts of the programme format that participants always report as valuable and enjoyable; a full-day pre-conference workshop, sessions on EMDR Europe Accreditation, an Expert Panel of EMDR Trainers and Consultants, a distinct EMDR child and adolescent pathway, the annual EMDR UK & Ireland AGM, copious amounts of good company and an EMDR-HAP fundraising Social Event (dinner at the UK's first 'eco' restaurant).

New for this conference is a distinct, double symposium that allows the Association to grandstand doctoral-level EMDR research carried out by members. The continued development of EMDR relies on sound research and it is important to recognise the contribution that Association members are pioneering. Research areas include:

- The subjective experiences of children following EMDR for PTSD following a single incident trauma - Dr Ruth Armstrong
- Which, how and why memory networks combine: a plasticity of meaning (PoM) extension to adaptive information processing (AIP) - David Blore
- Patterns of reduction of distress in clinical conditions using EMDR - Dr Brigitte Bodill
- Integrating EMDR into clinical practice - Dr Tim Dunne



- A phenomenological study of anxiety following trauma during competitive cycling: implications for the EMDR protocol - Peter Hudson

Professor Onno van der Hart, an international expert from the Netherlands, will present on *Dissociation following Chronic Traumatisation*. He is to explore ways in which the EMDR standard protocol needs modification for chronically traumatised populations.

This year's *Francine Shapiro Lecture* (on the Saturday) will be delivered by our current President, Dr Michael Paterson OBE. He is to present a comprehensive up-date of the present neurobiological understanding of EMDR.

See you in Bristol. Don't miss the early bird rate!

Leaves of experience

Derek Farrell recognises a good investment in Integrating EMDR into your Practice *by Liz Royle & Catherine Kerr, Springer, 2010, £38*

This book is a much welcomed addition to the EMDR literature not just because of its well written content and clever format but because the whole style of the delivery screams that its authors have been there, done that, seen the movie and continue to live the experience of being EMDR clinicians and supervisors.

The thing I most liked is that the client is never far away from any of the points the authors address with each of the client examples being clear and helpful. This helps to integrate theory and practice and demonstrates to the reader that therapy is not just about doing something, but being absolutely clear about the reasons for your actions.

My abiding memory of this book is 'Fail to Plan – Plan to Fail'. This is representative of the underlying philosophy of the book. As a trainer and supervisor, I found many tables and helpful materials that lend themselves to the teaching and learning experience. The identification of common pitfalls throughout is a helpful device that I'm sure readers will appreciate.

The book carries strong tones of Cognitive Behavioural Therapy (CBT), which might polarise some readers, but worked well for me. On a distinctly negative note is the cost. However, this is a criticism of the Springer Publishing Company which seems to charge premium rates for most of its EMDR catalogue. That said, this is an excellent book which I will be advising all my trainees and supervisees to purchase. I am confident that you will find it really helpful.

Dr Farrell is a Chartered Psychologist and Lecturer in Mental Health at the University of Birmingham. He is an EMDR Europe Accredited Trainer, President of EMDR Europe HAP and Co-Chair of EMDR Europe Practice Sub-Committee

November 2010. During an EMDR presentation by Dr Sylvia Glenn (National Deaf CAMHS) and Dr Kevin Baker (National Deaf Adult Mental Health), participants were excited to discover a number of practitioners who have significant experience working with deaf children and adults.

A small virtual network was established during the conference for deaf and hearing practitioners working with deaf clients across the UK, Europe (Norway and Sweden) and the US. Members hope to keep in touch via an internet group site and a plan to form a UK supervision group.

The group would like to hear from EMDR practitioners interested in using EMDR with deaf clients. You can join the internet group at www.emdr-deaf.groupsite.com or email us.

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Regional news

CENT. SCOTLAND <arussell@clacks.gov.uk>

The Central Scotland Section was formally constituted as a Geographic Section in 2003. Its origins are in the EMDR Support Group which met at the Notre Dame Centre, Glasgow, from 1999; this remained the venue until 2008. In 2009, it relocated to Alloa. The Section has primarily focused on EMDR with children and adolescents, but provides a range of training and supervision opportunities. The founders of the Section, EMDR Europe Accredited Consultants Mike O'Connor, Alison Russell, Helen Myers, Pam Grandison and David Murray, are still actively involved. Mike is the current Chair and Alison is Secretary/Treasurer.

In response to dwindling attendance during the past year the Committee sought feedback from members which showed strong support for continuing the Section and a desire for further training opportunities in a different format. The outcome is a series of four free half-day workshops open to those using EMDR with Children and Adolescents and those with an interest in EMDR. All workshops are presented by EMDR Europe Accredited Practitioners and Consultants who give their time free of charge. The programme for the year 2010-2011 is listed below.

More than 25 people attended the October Workshop from all around Scotland and from Wales. Feedback from evaluations was very positive and encourages us to believe that this format is meeting the needs of members using EMDR with children and adolescents. Anyone interested in attending the Workshops scheduled for 2011 please email cpreston@clacks.gov.uk

29 Oct 2010 13.30-16.00	EMDR with Children and Adolescents. Resource Installation."Best Foot Forward" and other resources.
28 Jan 2011 13.30-16.00	EMDR with Children and Adolescents: Current Research Mike O'Connor (overview of recent publications).Pam Grandison (presentation of Doctoral research)
18 Mar 2011 13.30-16.00	EMDR Master class - Case-focussed discussion Panel of Europe Accredited EMDR UK and Ireland, Child and Adolescent Consultants.
24 Jun 2011 13.30-16.00	Working with Children and Adolescents: EMDR and Grief. Helen Myers and David Murray.

NORTH WEST <info@fokkina.co.uk>

South Manchester

Fellow EMDR practitioners sought for a new daytime peer supervision group to be held initially in Chorlton, South Manchester – venues may interchange to accommodate members. If you are interested please contact

Have your say!

Contributions from Association members of articles, letters, book reviews, conference and training write ups are always welcome. We hope to run a question and answer column, so please send any questions about EMDR theory or practice to me; looking forward to hearing from you. **Omar Sattaur** **Contact:**