EMDR UK & IRELAND

EMDR *now*

Jul 2014 Vol.6 No.3

The newsletter of the EMDR Association of the United Kingdom & Ireland

EMDR EUROPE **Edinburgh 2014 Conference Highlights Inside!**

A powerful tool for tackling addiction

Jacky Smith was impressed by Robert Miller's workshop on the Feeling State Addiction Theory of Behavioural and Substance Addictions which was held in London in April

The Feeling-State Theory of Behavioural and Substance Addictions postulates that addiction (both to behaviours and substances) are created when positive feelings become rigidly linked with specific objects or behaviours. This linkage between feeling and behaviour is called a Feeling State and is composed of the memory of sensation, emotions, thoughts and behaviour of that event. The addiction is the result of the urges to behave in a set way whenever a corresponding Feeling State is triggered, or when a desire for that Feeling State arises.

The two days consisted of a comprehensive training covering the theory and practice of the Feeling State Protocol. We were provided with a training manual detailing the theory that underpins the approach, case examples, the Feeling State Protocol, the course slides and another protocol that Robert has developed called the Pain Release Protocol. The latter is aimed at releasing both emotional and physical pain.

Miller showed recordings of himself delivering the Feeling State Protocol with two clients who were trying to quit smoking. We were also given an opportunity on both afternoons to form triads in which we could practise receiving, delivering and observing this technique. Our group of three, and many others found this a very powerful experience.

Miller also led the class through the practice of the Pain Release Protocol which, again, I and many others found powerful and unlike previous pain release techniques I had come across.

During the training, Miller discussed the many potential applications of this new EMDR protocol, which included addictions to drugs, alcohol, food, smoking, pornography, sex, gambling and shopping. He also reported good results with treating, anger, eating disorders, co-dependence, chronic depression, sexual abuse and fantasies. Miller said he believes the main difference between his approach and other therapeutic approaches is that other approaches leave the feeling state intact, and therefore the potential for relapse remains high. Also, he does not focus his treatment on the urges, cravings or triggers but on the root cause of the addiction which is the Feeling State that was created at the origin of the addiction.

Contd. p2

"It's an honour to have been selected" said Maeve Crowley, the new President of the EMDR Association, UK & Ireland, when I met her in Edinburgh and asked her about her vision for the Association. With a lifelong clinical interest in trauma, training in EMDR was only a matter of time even though, she said, "I was somewhat skeptical that this strange therapy could be effective". But like so many EMDR practitioners, when she decided to begin training in EMDR in 2001 and it came to the practicum, Maeve was quickly convinced of its value: "I was so surprised", she said, "I couldn't wait to check out its full clinical potential". Maeve is an EMDR Consultant, Supervisor and Facilitator. She has been working in the NHS since 1990, is a Consultant Clinical Psychologist and Clinical Lead for Complex Trauma

Miller also taught us the difference between a behavioural addiction and a substance addiction. He said that a substance such as cocaine can create a feeling state of its own. In the case of substance addictions abstinence was desired whereas, in the case of a behavioural addiction, a person could resume normal use of the presenting behaviour (such a person could shop, eat, or have sex normally again without re-triggering the addiction/compulsion).

Miller has generously put his Protocol for the Feeling State Theory and the Pain Release Technique on his website for free download, but I can't emphasise enough the importance of attending a full training which in my view was simply excellent, to really grasp the full understanding of the theory and application of this new and exciting EMDR protocol. www.fsaprotocol.com

Miller currently works as a psychologist at the Naval Hospital Camp Pendleton in the US working with Marines and Navy personnel who suffer from combat PTSD as well as running a private practice. He received his PhD in 2005 during which he developed the fundamentals of the Feeling-State Addiction Protocol which has since been published in the *Journal of Traumatology* in 2010.

Jacky Smith MSc is an EMDR Europe Accredited EMDR Consultant

for Sussex Partnership NHS Trust. Since then, she has done everything she can to promote EMDR in her work with the NHS, her private practice in Hove, Sussex and with just about everyone that she meets.

For the past two years, Maeve has chaired the EMDR Accreditation Committee. Her priorities as President are to:

- Focus on governance to embed consistently high standards of practice;
- Do all she can to make members feel they have an important part to play in the Association;
- Encourage more research into EMDR so that its effectiveness becomes more obvious to the public;
- Support the Humanitarian Assistance Programme.

When she is not being a Psychologist and unflagging EMDR promoter, mother and partner, Maeve enjoys music, theatre, film and reading.

Omar Sattaur

Share your thoughts and practice!

The EMDR UK & Ireland Workshop and the EMDR Europe Conference in Edinburgh last month was an inspiring event. The energy, commitment, enthusiasm and curiosity of the EMDR community is always infectious. One thing that always surprises me is the creativity of this community. I hope you have noticed John Spector's new column which focuses on this very aspect - your creativity - and sharing that with your colleagues.

EMDR*Now* is published four times a year and is always on the lookout for good material to publish. I hope that you will enjoy this issue - thanks to all those who contributed articles - and consider not only sending material for John's column but also sending your case studies, regional news, questions about EMDR, views about the Association and so on. Tell us about the books you'd recommend (or avoid!), workshops you've attended, research you've done or are thinking of doing. Write to the Editor at o.sattaur@gmail.com. I'd be delighted to hear from you. Copy deadlines are: Winter: 1 October; Spring: 1 March; Summer: 1 June and Autumn: 1 September.

Advertisement

This space could be all yours!

EMDR *Now* reaches all members of EMDR Association UK & Ireland. We aim to publish four quarterly issues per year and consider advertisements relating to: book sales; EMDR equipment for BLS; courses and workshops relating to EMDR and conferences on mental health. Adverts for events organised by EMDR Association (including Regional Groups, Sections or Special Interest Group Events) and HAP UK & Ireland are free of charge. All other adverts are charged at the following rates (subject to increase): one-quarter page at £100 and one-eighth page at £50. Deadlines for adverts are: Winter: 1 November; Spring: 15 February; Summer: 15 May; Autumn: 15 August. Write to o.sattaur@gmail.com

Twenty-five impressive years!

John Campbell-Beattie on Francine Shapiro's Keynote address

All Conference Photos by Robert Pereira Hind & Scott Wilkins. www.robertpereirahind.com

Francine Shapiro received a spontaneous standing ovation from the one-thousand-strong delegation. Charting the milestones of the past 25 years, she placed great store on the dedication of every therapist in helping people to reclaim their lives, reminding us that our efforts amounted to tens of thousands of successful outcomes. Shapiro emphasized the importance of the Eye Movement (EM) component as it effects working memory and the orienting response to relax and mimic the processes of REM sleep; even though we still do not understand the brain workings in between the beginning and end of therapy, we do know that processing of episodic memory leads to enlightenment. Rapid (saccadic) eye movement is superior to slow movements. Taps and tones came in as secondary forms of stimulation.

She contrasted psychodynamic psychotherapy, CBT and EMDR. EMDR therapy processes physiologically stored memories and patients are treated by helping them to access and process memories, triggers and future templates. The WHO specifies only two recommended therapies for PTSD: trauma focused CBT (TF CBT) and EMDR and the WHO 2013 definition can be used to inform patients.

Shapiro went on to include negative life experiences that have been shown to correlate to presenting problems and are not necessarily traumatic in nature. The message was: don't just think trauma for history taking, embrace all negative life events. EMDR uniquely allows second-day treatment thereby providing focused and rapid treatment and earlier relief.

Shapiro called for and encouraged research to continue and be initiated in areas where EMDR is successful e.g. EMDR with US soldiers and service personnel helps to reduce the 25 suicides per day among this group in the US. EMDR with somatic and anxiety disorders works, but needs to be shown to work via research that validates EMDR therapy. In some countries, this can help to allow insurance funding for sufferers.

Finally, Shapiro referred to extinction reconsolidation; the new thinking is that prolonged exposure leads not to extinction but to a new competing memory whereas EMDR short exposure enables reconsolidation of the original memory, that is, the memory is transformed. When one considers EMDR through institutions like HAP across the world from trauma to domestic violence, abuse in many forms and bullying, depression, bipolar and so on, what other therapy has such a pedigree? Motivational on so many different levels I'm glad I didn't miss this speech.

John Campbell-Beattie PhD is an Accredited EMDR Consultant. He lives and works in Plymouth, Devon, UK. Contact:

Francine Shapiro received a standing ovation in Edinburgh

Flashforward: the best development in EMDR since Francine's famous walk in the park

Sanja Oakley reports on Ad de Jongh's Keynote address on EMDR for Fears and Phobias: Effective Application and New Developments

Although Logie and De Jongh (2014) are not the first writers to formulate the flashforward concept (a negative intrusive image about a catastrophic event that may happen in the future), their article puts it firmly in the limelight. This keynote goes a few steps further to securing it a center-stage position on the EMDR protocol stage.

In a particularly entertaining presentation, Ad de Jongh—whose penchant for the dramatic inspired him to show the audience images of a doctor injecting an eye, passengers about to die in a highly arousing plane crash scene, and a birth from an angle only those with medical degrees normally see—promises that we will become much more effective *and* efficient in treating phobias using the flashforward procedure.

Ad de Jongh kept the audience on its toes

Take a choking or vomiting phobia, for example. CBT exposure treatment may take more than 30 sessions and still leave the client troubled by the original problem. Targeting the catastrophic image with EMDR, in contrast, can solve the client's problem in 30 minutes, De Jongh tells us. Miraculously, the eye movements eliminate the core of the anxiety by wiping out the dreaded catastrophe.

To try this at home, do the following:

1. Help the client identify the flashforward: This form of words may be helpful*: "If you think about the worst thing that could happen, what would it look like?"*
2. Proceed with the standard protocol
3. Don't be surprised if you complete the exercise quickly (30 minutes)

De Jongh stops at nothing to keep his audience on its toes. He even manages to give us an example of a flashforward by sharing, what he stresses is, a scientifically supported fact about spider phobia. The most feared event for women with this phobia is the spider crawling up their private parts. Target that, he advises.

To learn more about the flashforward procedure, check out: Logie, R. & De Jongh, A. (2014). The "Flashforward procedure": Confronting the catastrophe. *Journal of EMDR Practice & Research,* Vol 8, No 1, pp25-32.

Sanja Oakley is an EMDR Europe accredited consultant and a UKCP registered psychotherapist, practicing EMDR in London face to face and worldwide via Skype.

The miracle that is EMDR

By Zoe Oakley

EMDR helped Sally Dowler to recall happy memories of Milly

EMDR is a miracle treatment. In her keynote address, Sally Dowler tells the story of how she waited for this miracle to rescue her from 11 years of pain following her daughter's murder.

I am not new to EMDR. My therapist mum has tapped on me many times—bilateral stimulation has cured my fears of roller coasters, school presentations and tweenage social scenes—so I know that EMDR works, but I was astonished that anything could provide relief to a woman suffering such a tragedy as Sally Dowler's. Sally described how rapidly and dramatically EMDR can rebuild someone's life by offering closure to the past.

Losing a child must be the most devastating thing that can happen to a parent. The worst part, Sally said, was the loss of happy memories of her daughter. Since her daughter's disappearance in 2002, Sally had been unable to recall them. Neither drugs, nor CBT, nor an excessive exercise regime were able to bring down Sally's adrenalin levels and allow her to recall blissful images of her daughters Milly and Gemima teasing their mum about the outfit she dared to wear on their first day of school. Within a week of EMDR, however, Sally told us, she could imagine a cheerful scene of Milly, and say a proper goodbye to her. Now Sally could cry the comforting sort of tears that allow her to reminisce – the tears of grief.

As I left the auditorium, I heard two therapists remark how touching Sally's story was. The next thing they said, however, was that they see clients experience such liberating scenes on a daily basis. I think EMDR therapists get used to the magic (and so do their children).

Zoe Oakley is to study Social Policy with Government at the London School of Economics in September (but may well change her study path to reflect her increasing interest in becoming an EMDR therapist).

Positive psychology and post-traumatic growth: have we discovered the true potential of EMDR?

Maggie Allison is impressed by the range of speakers

Having had a few days to reflect on my first EMDR Europe Conference, I think my only gripe would be that it wasn't possible to attend every symposium. If I were to attempt to sum it up in one word I think it would have to be 'eclectic'. Speakers ranged from those in search of scientific rigour, to those who were generously willing to share their own personal experiences.

David Blore asked, what is the antonym of trauma?

Nowhere was this more the case than in the EMDR and Positive Psychology Research Symposium, chaired by Michelle Depre. The Symposium was opened up by David Blore, with a discussion on the phenomenon of Post Traumatic Growth. This highlighted the importance of research and the need to provide evidence based practice (and practice-based evidence); Ann-Marie McKelvey then went on to speak about the benefits of Loving Kindness Meditation; Claudia Herbert then considered the therapist factors in her own work with Positive Growth in Complex Trauma; and finally Candida Condor described her personal experience of positive growth following EMDR treatment.

David Blore posed the question, "What is the antonym to trauma?" There is no word for the opposite of trauma. Is it simply an absence of symptoms, or is it something more? Here the phenomenon of Post Traumatic Growth makes its presence felt. And following on from this, have we yet discovered the full potential of EMDR? We were asked to give a show of hands if we had ever noted that our client was demonstrating post traumatic growth. In looking round the room, I may have missed somebody, but I couldn't see anybody who had not raised their hand. Post Traumatic Growth is an aspect of treatment that most of us seem to be familiar with. Perhaps now is the time to really explore how far we can take this.

This was followed by Ann-Marie McKelvey, who is a Buddhist chaplain as well as a psychotherapist. McKelvey pointed out that therapists can often be caught up in focusing on pathologies, seeing not the whole person, but more of a collection of symptoms. DSM-5 diagnoses are often an important part of our work because treatment recommendations as well as payment by healthcare providers can be determined by DSM classifications. McKelvey gave some useful teaching on how we can all benefit from building on our own resources, truly, deeply listening and learning to be grounded in the physical body. She also reported on research from "The Three Treasures Practice and Study" which utilises EMDR, Positive Psychology and Loving Kindness Meditation.

Then there was a presentation from Claudia Herbert on the work that she does with complex trauma and the therapist factors that facilitate Post Traumatic Growth. The point was made that a lot is dependent on the skill and experience of the therapist to be able to engage the client and to contain their trauma. Less experienced therapists might be overwhelmed and feel out of their depth. Herbert went on to highlight the importance of adding to the evidence based research on EMDR. Sometimes it can feel like EMDR is fighting to maintain its place as a therapy. It is, however no bad thing to be challenged and this is an opportunity for us to expand the focus of EMDR beyond symptom reduction.

Candida Condor ended the symposium with a description of her own

Where to next for the SIG?

The Special Interest Group (SIG) was originally intended to serve as an online forum for exchanging ideas and was launched online at www.linkedin.com on 9th October 2011. It has since outgrown its EMDR UK and Ireland base, and is currently the fourth largest EMDR group online with over 950 members across more than 40 countries. So much for the good news. Unfortunately the forum is not well used, with very few ideas shared and has recently been the concerted targeted for advertising. I proposed a new 'spotlight' focus and that members be 'spotlighters', that is, responsible for certain defined areas.

The following are the 'spotlight areas' chosen by the SIG as worthy of attention:

- **Spotlight on Positive Psychology research – (AMMcK, CH, DB, MA)**
- **Spotlight on Post Traumatic Growth following EMDR – (multi-centre)**
- **PTG post EMDR, linked to the clinician – (PS-LC)**
- **Spotlight on resource development and Maslow's 'full psychological height' – (CH)**
- **Spotlight on making Phase 5 work harder – (DB)**
- **Spotlight on a genuine evidence-based practice approach in UK IAPTS: a short measure of positive change - (DB)**

The traumatised elderly: a neglected client group

Omar Sattaur felt privileged to hear of Tomris Grissard's work with the elderly

With so many TV and radio programmes marking the centenary of WW1, not to mention the many current conflicts, the cost of war has been very much in the public consciousness. Fitting then that Tomris Grissard turned her attention to living survivors of the WW2, a largely neglected, group, she says, but one that could benefit greatly from EMDR.

Tomris Grissard says the elderly have much adaptive ability

Grissard has decided to work in Care Homes in Germany with clients between the ages of 70 and 90. Even though their needs are great, she said, they rarely seek therapy. Yet a quarter or more suffer psychological problems, one in 10 have a diagnosis of depression and 25-40 per cent are on medication.

In a moving and inspiring presentation, Grissard presented videos of her work in a pilot project at a Care Home. One such case concerned a blind patient who was convinced that she was responsible for the death of her friend, so much so that she told staff she no longer wished to live. She had entered a deep depression and was beset by looping thoughts of nagging guilt. This client had witnessed her closest friend slipping and falling on the stairs. Her friend had been hospitalised and died a couple of days later. The client, however, was only told of her friend's death two days after she had 'disappeared'.

Guiding the patient in float back it emerged that, 40 years ago, when she was a child, her mother had disappeared. Two days later the police had arrived to tell her that her mother had died. Her friend's death had triggered this early traumatic memory and gave rise to her depression. Following EMDR treatment the patient came out of her depression and has resumed normal functioning.

Many of Grissard's patients have begun to experience the reactivation of wartime trauma. An 80-year old woman who had been symptom-free for decades began to experience increasing anxiety about five years ago. Grissard discovered that her distress had its roots in an unresolved trauma which the woman had experienced at the age of 12, at the end of WW2. The patient had no happy memories of her childhood; instead her past was blighted by distressing intrusions concerning the arrival of Russian soldiers to her birth-family's house. She remembered seeing her sister covered in blood. In a chilling account caught on video during processing, she said "the door opens, Russians come in. I have to save my mother". Grissard asks, "What are you doing next" and the patient replies "I am holding my mother in my arms, there is blood all over her". Grissard replies, "it was a hard time. You did a good job as a child". The patient visibly relaxes, telling Grissard, I feel better. Three sessions later she is able to look back at her life without anxiety.

Watching Grissard work with these elderly women reminded me again of how far off the mark are those who criticise EMDR for being technique-focused, overly directive and non-relational. No one watching this work could have maintained such views. There was so much empathy and tenderness as Grissard held the patients' hands in hers during BLS (musical excerpts through headphones). Grissard combines EMDR with Life Review Intervention in her work with these patients whom, she says, already have much adaptive ability. Watching her work it was easy to see why she found the work "worthwhile, interesting, satisfying and surprising".

Omar Sattaur is an Accredited EMDR Practitioner and Counsellor with the University of Manchester Counselling Service. He edits EMDR*Now*

Derek Farrell hopes to form a new EMDR Special Interest Group - EMDR with Older Populations. Anyone interested should email Derek directly:d.farrell@worc.ac.uk

personal journey towards becoming an EMDR therapist, through trauma to personal growth. Her talk was punctuated with a slide show of some of the most gorgeous images from the places she has lived in the US. Condor's message was clear, however, and pertinent to the work we all do. She spoke of the importance of the client's resources. Find out what resources the client already has, she advised, and consolidate these.

Dr Maggie Allison is a Chartered Counselling Psychologist and Accredited EMDR Practitioner working in independent practice in the North East of England.

- **Spotlight on EMDR and Compassion Focussed Therapy (CFT) – (JV)**
- **Spotlight on 'Good Mother and Father Messages' – (CC)**
- **Google 'circle group' (invitation only group) – (MB) (The Linkedin group to act as a 'reservoir' for invitations to the Google group**

The new committee was also elected as follows: Chairperson, David Blore, UK (DB); Secretary, Lillian Moore, UK (LM); Treasurer, vacant - to be filled in due course.

Committee members: Ann Marie McKelvey, USA (AMMcK); Candida Condor, USA (CC); Claudia Herbert, UK & Germany (CH); Maggie Allison, UK (MA); Penny Smith-Lee Chong, UK (PS-LC).

Associate members: Michelle Depre, France (MD); John Varley, UK (JV); Mark Brayne, UK (MB)

David Blore

EMDR reported successful in treating fibromyalgia

Melvin Claridge was professionally, and personally, intrigued to hear about a successful outcome in this chronic condition

Fibromyalgia Association UK describes fibromyalgia as "a chronic condition of widespread pain and profound fatigue. The pain tends to be felt as diffuse aching or burning, often described as head to toe. It may be worse at some times than at others. It may also change location, usually becoming more severe in parts of the body that are used the most." When I was diagnosed with fibromyalgia, I was told that there was no cure and that it is a syndrome with many complicated components, not fully understood by the medical community. I was also told that it wouldn't kill me, that many people cope with the symptoms and that the best that I could hope for was management of the condition through pain medication, diet, exercise, physiotherapy, acupuncture, massages, or whatever I could find that worked for me. It was a pleasant surprise therefore to find this conference session, based on research by Emre Konuk, Zat Zeynep and Tuba Akyuz at the DBE Institute for Behavioral Studies in Istanbul. The presentation was introduced by Konuk, and delivered by Zeynep, the clinician who provided EMDR therapy in the research project, under Konuk's supervision.

The idea to conduct the research came about when a client treated for panic attacks with EMDR reported that her chronic pain had disappeared. The team's literature research discovered only one study on EMDR for fibromyalgia, Gerhardt, *et al.* (2013).

It is widely accepted now that there is a link between traumatic events and psychological illness; however the link with physical illness is still open for debate. The Adverse Childhood Experiences (ACE) Study is now showing evidence that traumatic childhood events and cancer, liver disease, heart disease and other illnesses are "related in a causative way". Other research that the team looked into indicated that adverse childhood events may be a causative factor in the development of fibromyalgia.

The team designed a protocol and conducted a single-case design research, which was followed up three months after treatment ended. The basics of the protocol were explained (see Box, left).

Zeynep showed a recorded case presentation of her EMDR sessions with the research subject. She followed the protocol and began with a memory that the client felt was linked to her pain. Anger and frustrations around not being able to say "no" or "stop" to others, came up. It wasn't clear how many sessions the client had, as there was an unfortunate technical issue with the video and it had to be stopped before the end.

Zeynep made a great recovery from the glitch and talked through the final client session, where the client reported that her body relaxed and she felt no pain at all, after she accepted that she could say "no" to others. In the three- month follow-up, she reported that she had been pain-free and that she was able to do things that she was physically unable to do prior to EMDR treatment, that she was able to stand up for herself, and trust her judgment.

This was an intriguing and exciting presentation indicating that EMDR had been effective in the treatment of fibromyalgia in this case. It would have been useful to have had an indication of the numbers on the various scales prior to, after EMDR and at the three-month follow-up, together with information on how the EMDR sessions affected other symptoms. Apparently, research with another seven clients has produced similar results.

I am now eager to try this protocol out myself to see how it will affect my condition. Perhaps I should put myself forward as a research subject, as much more research is needed in the treatment of fibromyalgia and other physical chronic conditions with EMDR.

Melvin Claridge MA, is a Psychotherapist and Trauma Therapist working towards EMDR Practitioner Accreditation. He has a private practice in London.
www.claridgepsychotherapy.co.uk

The Protocol

Phase 1
- The fibromyalgia must be diagnosed by a physician.
- Take a history of fibromyalgia symptoms and other history.
- Set treatment goals regarding pain, relationship with pain and how it affects relations with others.
- Develop resources.
- Then look at first remembered and worst traumas relating to fibromyalgia.
- Investigate traumas before fibromyalgia symptoms started (and after, if there are any).
- Look at triggers.
- Set future template goal.

Phase 2
- Introduce scales.
- Have the client complete the Fibromyalgia Impact Questionnaire (FIQ) and the following questionnaires: Visual Analog Scale (VAS), Pittsburgh Sleep Quality Index (PSQI), Beck Depression Inventory, Adverse Childhood Experiences Questionnaire (ACE), Symptom Assessment-45 (SA-45), State-Trait Anger Scale (STAS) and Posttraumatic Diagnostic Scale (PDS).
- Install resources.

Phases 3-8

Choose the target and use the standard protocol, working through first remembered and worst traumas relating to fibromyalgia and then other traumas.

What to listen out for as clients tell their stories

Sandi Richman presented an overview of the use of EMDR in treating attachment disorder. Omar Sattaur reports

Research shows that EMDR can help in attachment repair and so improve emotional stability and present-day relationships. Sandi Richman's presentation emphasised the value to EMDR therapists of understanding adult attachment styles and their development from childhood experiences of attachment.

People's attachment styles influence how they make sense of their experiences of relationship, and this understanding shapes all future relationships into adulthood. Richman explained how the influence does not stop with the individual but can be passed down to the next generation. There is a clear relationship between child and adult attachment styles. Intriguingly, the characteristics of the various attachment styles are clearly heard in the way that a person relates his or her life story.

A child who had a secure attachment experience will develop into an adult capable of forming secure adult attachments. The resulting adult narrative is coherent; the person, having been able to make sense of the behaviour of caregivers, is also able to be emotionally close to others, is not worried about being alone and is able to repair ruptures in relationship. A child who formed an avoidant attachment style will develop into an adult with a dismissing adult narrative. When this type of client tells their life story it is likely to reflect a defensive emotional independence: 'I like being on my own. It is very important for me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me'. Correspondingly, early ambivalent attachment styles give rise to an adult preoccupied narrative, the adult client finding it difficult to become close to others and feeling undervalued and let down by others. The disorganised infant attachment style results in adults who describe marked state shifts from loving to chaotic and aggressive.

These styles will influence how clients respond to the various phases of EMDR therapy; the main characteristics are summarised in the table below. Listening

	Secure	Dismissing	Preoccupied	Disorganised
History taking	*Communicate truthfully, succinctly, relevantly. Remain connected with therapist.*	*Have trouble being truthful, coherent and collaborative. Over succinct and may contradict themselves. Don't need others. Often present because partner thinks they have a problem. Uncomfortable talking about (what they perceive as) the irrelevant past.*	*Truthful but rarely succinct. Can easily become emotional and overwhelmed. Narrative mixes past and recent. State shifts between adult and child. Therapist feels emotionally swamped.*	*Disjointed narrative. Can become silent for two minutes then resume on a different topic. Can give great detail about loss. Can feel inappropriately responsible for losses. Can switch between emotional availability to zombie-like presentation. Therapist feels fragmented, hard to get a clear picture.*
Preparation	*Often resilient enough but can easily engage with resource installation and target identification.*	*Reject safe place and RDI. Block anything good coming from therapist .Cannot self-soothe. Either devaluing, idealising or controlling of RDI work. Hard to identify targets as clients 'don't remember' trauma.*	*Can work with safe place and RDI but often choose SP with someone else looking after them. Can become overwhelmed with sadness in SP. Present and past may become entangled in target selection.*	*Need lengthy preparation. Can dissociate in RDI. If one ego state relaxes other, sabotaging or frightened, parts may be in conflict. Find it hard to select targets and their relevance varies between ego states.*
Assessment	*Easily able to collaboratively identify the elements of the disturbing event.*	*Thwart attempts to find a PC. NC never quite good enough. Can become a power struggle when identifying elements of Assessment Phase and basic protocol. Body sensation completely dismissed. Therapist can end up feeling beleaguered.*	*Find it hard to settle on one NC and PC. NC can spark distressing feeling state, re-associating client to traumatic event and activating dissociative defences. Identifying NC may be experienced as therapist abandoning client.*	*Identifying baseline information can trigger dissociation. Can enter trance or become terrified. Elements for one target may be irrelevant to other ego states.*
Processing	*Can process with thought, feeling and sensation, making adaptive links. Interweaves often unnecessary `*	*Struggle to enter a mindful state. Often answer 'nothing' in response to questions aimed at eliciting feedback between saccades. Need to be told what they are supposed to do. SUDS do not decrease as so little emotion accessed.*	*Need constant reassurance and have chronically incomplete sessions. Move from one distressing memory to the next with little adaptive linking. May exhibit high emotion as a way of eliciting care from therapist. Endless processing with little resolution.*	*Processing is disorganised! Primary, secondary and tertiary dissociation to be expected. Therapist works hard to keep client connected to present safety. Expect dissociation, projective identification and counter transference.*

Table showing the adult attachment style and its influence in the various phases of EMDR treatment

The Dialogue Protocol: encouraging the adult to talk to the traumatised child

Working successfully with complex trauma inevitably involves understanding attachment deficits. Hanna Egli, who was trained as a psychodynamic therapist before training in EMDR brought an interesting perspective to some particular challenges posed by clients who in their birth families have had traumatic attachment experiences. She began with a simple observation about the difficulty such clients have with identifying a positive cognition. Judging by the murmurs of assent and nodding heads in the audience, she was not alone in recognising this difficulty. Then she asked a question which, for me at least, illuminated this murky area of difficulty: When as therapists we ask the client for a positive cognition, whom are we asking, the traumatised child ego state or the adult ego state (hopefully present and sitting in front of us)?

It is often the case that there is little or no 'dialogue' between the ego states and the therapist's job is to create one. Implicit in the client's negative cognition there is often evidence of the client's internal working model of the self in relation to an important other – such as the primary caregiver. For example, the NCs "I am bad" or "I am a burden" are clearly relational (bad in comparison to whose expectations? A burden to whom?). Jim Knipe's 'Loving Eyes' protocol helps to do just this, but Egli thinks that a better result can be achieved if this dialogue is initiated in the Assessment Phase (Phase 3) rather than waiting until the desensitisation phase. Egli proposes her EMDR Dialogue Protocol which asks the present (undissociated) adult to address the child ego state in the 2nd person singular: "You are/have....." This, she says brings forward the healing process.

The therapist must prepare the ground for this dialogue to begin, providing sufficient psychoeducation (sometimes one sentence will do) so that the client can recognise the different parts or ego states (traumatised child and defended adult). This is quite easily achieved since the client will often shift states when asked to identify the NC. Quite often the question speaks to a partially dissociated part and the therapist is able to see that the client is visibly less present and emotionally engaged. Requests to provide a PC can often be met with visible distress: "I don't know. I can't do that". At this point the therapist can briefly explain, bringing the client to an understanding of what has just occurred in terms of the partially dissociated parts. This should also facilitate the start of a dialogue between the traumatised and partially dissociated child part and the functioning, present-day adult part. This may be something along the lines of, "let's say there are two parts of you, the child part that is affected by this negative image, and the adult that you are today. What would that adult part say to the young child that was so….(hurtful, abusive…etc)". The client is instructed to make this statement beginning with the words "you are..." or "you can…" , for example "you are strong, you have done your best". Once the VOC is obtained, the therapist asks the adult to remain present but passive and the dialogue continues with the child part as subject. The presence of the adult part, Egli suggests, facilitates the integration of the functional, present-day networks with the traumatic memory network.

You can read more about this intriguing Dialogue Protocol in 'EMDR in Dissociative Processes Within the Framework of Personality Disorders: The Impact of Cognitions in the EMDR Process: The "Dialogue Protocol", *Journal of EMDR Practice and Research*, 2011, Vol 5, No 3, pp131-139.

Omar Sattaur

out for these styles can enrich a therapy, helping you to be aware of particular challenges a client may face and alerting you, for example, to the level of stabilisation and resource building that may be required. Richman then summarised some cases studies from recent research which strongly confirm that EMDR is much more than an evidence-based trauma therapy, bringing about not just state changes but trait changes.

The rejected self at centre-stage of eating disorders

The biggest obstacle to recovery faced by people with eating disorders is rejection of the self. According to Natalia Seijo, eating disorders are often the result of dissatisfaction with the body, a disparity between the perceived self and an ideal self. Seijo said it has its roots in early negative messages from caregivers (particularly mothers) about body image. This criticised self eventually becomes a 'rejected' self – an abhorred embodiment of everything the person rejects later in life and which thereafter serves as a comparator. Standing in front of the mirror the patient compares their present self with this hated, rejected self.

Seijo has developed a structured approach to working with people with eating disorders which comprises five stages or phases. In the first, she

Picture highlights of the 15th European Conference

Isabel Fernandez receives the David Servan-Schreiber award for outstanding contribution to EMDR from Udi Oren, President of EMDR Europe. Patron of EMDR UK & Ireland Terry Waite (left) received a standing ovation after describing his enforced capture and incarceration.

The urge for power and control

John Campbell-Beattie on treating the perpetrators of domestic violence

Julie Stowasser focused on the situation in the US but unfortunately domestic violence is familiar across the globe. Suicide and homicide in such settings are under-reported as domestic violence (DV) is not considered contributory. Predominantly men perpetrate DV simply because they can! It is not caused by alcohol addiction or compulsion - power and control are the driving forces. DV is a pattern of behaviours that is intended to control through coercion. Perpetrators find inventive ways to exact abuse. Treatment cannot begin until DV is clear for 12 months. Calm, clear and connected is the desired state for anyone beginning the programme. Questioning participants is important e.g. Do you know the ongoing effects of your actions? Is violence still current? Is there fear? Is there sobriety? Are you concerned for your children? Is there hope of being reunited? Always ask the man why he is coming for therapy because, if participants don't want to address their violence, there is little point in their continuing.

Therapists have to address their own traumas, too. Have they been the subject of sexual abuse in child or adulthood, neglect, other interpersonal victimisations including marital or couples discord?

It is important to prepare clients for change, which may require them finding 20 things they can do round the clock. Non-violent conflict-resolution skills future castings are used - similar to future template but are more like a 'grappling hook' used to get them closer to their goal. There are 168 hours in the week; we have them for just one of those hours, so safety-first issues are a high priority. The most dangerous time is when he thinks she is leaving, has left or when she is pregnant. The best safety is no access at all.

gathers information about the present and rejected self. She then offers psychoeducation on self-image and self-esteem. Stage three involves working with the patient's defences of rejection, shame and worry. Next comes resource building and finally, the negative cognitions pertaining to the rejected self, conceptualised as beliefs that block the acceptance of the real self, are processed in the usual way.

Interestingly Seijo adapts Jim Knipe's 'Loving eyes' protocol to help these patients accept the rejected self. She says she can tell when the processing is progressing normally because the defences of rejection, shame and worry transform into sadness for this neglected part. You can find out more about this creative and interesting approach by writing to Natalia at: seijonatalia@gmail.com

Omar Sattaur

Picture highlights of the social event and participants' impressions of the 15th European Conference

The haggis was ceremonially piped in....

***Paola Pomponi writes*:** I am flying back home after three exciting and active days in Edinburgh. I am a novice in the realm of EMDR conferences - this was my first one – but, for sure, it will not be my last. In fact I am already wondering whether I can begin booking for Milan in 2015.

One of the first things that I filed away in my brain during the opening keynote of the conference was that it would be good to try to take home just three inspirational thoughts out of the huge quantity of information offered by seminars and lectures. Pondering those words now I move my eyes rapidly, from the top right corner of seat A, two rows ahead of me, to the top left corner of seat D, attempting to identify some image, feeling or body sensation that will guide me toward the three things that I want to bring home with me.

The first image immediately connects with the Sally Dowler's account, her vivid description of years of battling through her pain following the loss of her beautiful daughter. I was moved beyond tears, honoured and stunned to listen to and look at this incredible woman and I am proud to recognise in her an ambassador for EMDR's achievements in helping people in distress.

From a professional point of view I can single out Julie Stowasser's presentation "An Introduction to the Treatment of Domestic Violence Perpetrators". With vibrant style, Julie described domestic violence as a widespread reality that creates suffering, wrecks homes, causes trauma in children and leaves a legacy of violence that could be carried on from one generation to the next. Although a definition of violence may vary from one cultural context to another, it can usually be expressed physically, verbally or not verbally,

...and, having been lauded in traditional poetic manner (see over), was enjoyed by all present

More photo highlights and impressions

Anna-Konstantina Richter writes:
When Janet from Kent told me that colleagues from the UK usually have no more than 12 sessions with their health service clients I was deeply impressed, and sorry. I often complain that in Germany, a CBT therapist can apply for a maximum of 80 sessions paid for by State Health Insurances (with private insurance agencies, it differs), and 80 sessions are not much when treating someone who has, for example, a multiple personality disorder. But I realised that I was probably complaining too much - I hold my colleagues from UK (and their clients) in high regard.

Richard Mitchell made the traditional, Burns' Address to a haggis.....

I was impressed by colleagues who work with refugees. I felt comfortable with colleagues from different cultures and enjoyed the diversity of their behaviour. I am both Greek and German and although Germany is the third highest immigration country in the world (and needs immigration because of the ageing population), I suspect that Germany has a blind spot when it comes to certain matters of migration. My clients are not only Germans but from Morocco, Russia, Poland, Turkey, have different religions, and I am happy when I can discuss cultural and religious differences of clients with a few immigrant colleagues from Turkey and Romania.

Therefore, I was fascinated when I listened to Ann-Marie McKelvey's and Candida Condor's lectures (both from the US) about EMDR and Positive Psychology; I was deeply touched by the way they opened up and showed how human vulnerabilty can be treated with (self-)respect whereas David Blore (UK) amusingly demonstrated at the same symposium how to deal with someone who tells you that you don't know what you're talking about! (I salute British humour).

In Germany, I often feel a strong importance of hierarchy (as psychologist Harry C. Triandis would say, it's a country of vertical individualism), therefore I appreciated very much Francine Shapiro thanking EMDR therapists for their everyday work. I think she was right to focus

...and there was much merrymaking

psychologically, actively or passively by exerting control, threat or interference with the normal running of one's life. It is most often intentional, and its aim is power and control over another person. There is usually a continuum of violence that may start with just a non-verbal gesture and escalate, in the most acute cases, to homicide or suicide. We can identify a cycle within which Domestic Violence is exerted, which has three distinct phases: Escalation, Explosion and Apology.

Treating cases of Domestic Violence may involve working with individuals, couples or families. In any case, interventions can be complex and drawn out. EMDR therapy includes risk assessment and support for the victims involved as well as rehabilitation for the perpetrator. Not an easy task at all, and one that will require a maintained effort and preparation on the part of the therapist, the object being to restore a safe and healthy environment and a building up of non-violent resolution skills and behavioral change. I found the presentation rich with practical information that is very relevant for my practice.

I need some more BLS to find my third image. I see a connection with two specific moments during the last afternoon. They refer to the presentation by Marshal Wilensky, "When the safe/calm place does not work" and the final Keynote talk by Ad de Jongh about EMDR for phobias. Beyond the technicalities, research results and adaptations to the protocol, what I am taking home, thanks to both speakers, is a sense of the great passion and love that they have somehow 'infected' me with. If we love the work we do, we will do it well, we will live well, and help our clients to live well.

This is such a simple thought, but it fills me with an awareness that, having spent three days in the company of excellent minds and incredible people, being 'infected' in this way is a real blessing.

Paola Pomponi is a UKCP Accredited, Bilingual (English-Italian) Existential Psychotherapist, EMDR practitioner, Psychosexual and Relationship Therapist and Mediator. She runs a private practice in Central London. www.ppomponi.com

on every delegate who was there: I think it's a great thing to experience healing, a revolution, and every therapist multiplies that experience. This is a huge thing and we all help to achieve it.

There was more merrymaking....

that was really fun. The art of teaching, thank you for that.

Long before the conference started I knew that Andre Monteiro from Brazil prepared his lecture on Trans-generational Transmission of Family Values and Cognitions. He has inspired me to work more with genograms - it does really make sense to do this in Germany where so many clients, their parents and grandparents experienced trauma.

As I am doing more therapy than research at the moment, I love and need inspiration and information from researchers. I still smile when I remember Ad de Jongh's lecture on EMDR for fears and phobias. Not only was it very interesting to hear when EMDR produces better results than CBT – it was really great how he teased the audience by triggering fears and phobias with photographs and films (spiders! plane crashes!) –

I want to close with my start in Edinburgh: the pre-conference workshop by Michael Paterson. I want to thank him for the important information on ego state therapy and how to use BLS while being in contact with clients' different ego states and also for his very friendly and humorous way in showing what a client experiences with fighting ego states.

Thank you, Edinburgh, Scotland, UK and the world, for this congeniality! I wish to bottle these precious moments as I am back in Germany again ...

Anna-Konstantina Richter is a Psychotherapist practising in Friedberg, Germany http://www.richter-psychologie.de

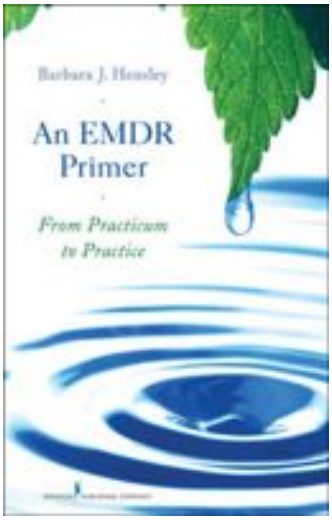
Organising Committee members and friends got into the spirit (and dress) of things.

...and even more dancing

oks books

A robust complement to Shapiro's seminal text

An EMDR Primer: From Practicum to Practice
Barbara Hensley
New York: Springer, 2009
Hardback £47.50
Reviewed by Jen Popkin



An EMDR Primer serves both as a mentoring tool for trainee EMDR therapists and as a text for updating those therapists who might have qualified some years ago and who have not used EMDR as much as they could. It would also be a useful reminder to Consultants of the level that novice EMDR therapists need to be working at.

Hensley adheres closely to the accreditation criteria, cross referring frequently to Shapiro's seminal book of 2001 (2nd edition) and offers clear guidance on how to fulfil the requirements for Practitioner status.

There is particular emphasis on the Preparation Phase, touchstone events, float back and dissociation. The text works through the protocols in a straightforward way. The author gives several tables outlining the main points for the various phases within the protocols for example, Table 2.5, p51, suggests elements pertinent to EMDR when taking the client's history in Phase 1. Chapter 3's *Stepping Stones to Adaptive Resolution* helpfully deconstructs the

meaning of the Adaptive Information Processing model that underpins the EMDR process; the author also does this pictorially to reinforce meaning. Chapter 5 offers a thorough exposition of blocked processing, although unfortunately the references to Gilson & Kaplan, 2000, and Dworkin, 2003 are not mentioned in the bibliography.

Hensley has kept things simple by limiting the types of presenting issues to those typically covered in weekends 1 and 2 of the trainings (p133), presumably the equivalent of Parts One and Two. The author offers succinct criteria for Negative and Positive Cognitions – the bugbear of many new EMDR therapists! Table 3.4, p98, gives clear pointers to aid us in identifying ecological validity and other aspects of these two important concepts.

Flow charts, tables and diagrams, combined with several transcripts of composite clients' issues all serve to underpin the procedures that need to be in place in order to satisfy the Practitioner criteria. Hensley focuses on what she considers to be the neglected prong of the three-stage model, the future template; like the past and present 'prongs', it must be addressed, she says, if the client is to process fully.

There are a few channels of negative experience that I need to clear regarding this book! Although it is not the fault of the author, the editing is disappointing, with incorrect indexing and a lack of clear page references to Shapiro's text.

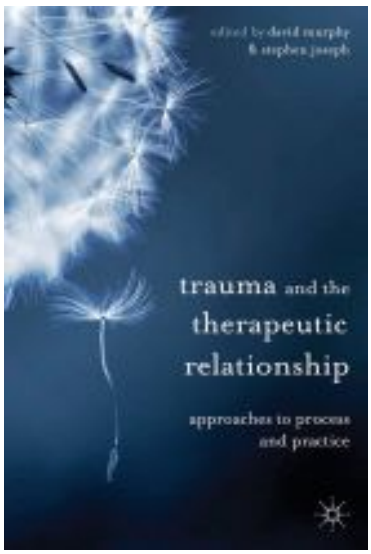
However, overall, I highly recommend this book as a clear introductory text that teases out the salient points made in *Eye Movement Desensitization Reprocessing: basic protocols, principles and procedures*. Hensley does not replace Shapiro's writing, rather she offers a robust complementary companion volume to her work.

Jen Popkin is a BACP Snr Accred.and Registered Counselling Therapist, practising in E. Sussex.

It's all in the relationship!

Trauma and the therapeutic relationship: approaches to process and practice

Ed. David Murphy & Stephen Joseph
Palgrave Macmillan, 2013,
Paperback £21.99
Reviewed by Omar Sattaur



Murphy and Joseph have compiled a diversity of approaches to working with traumatised clients, bound together by an appreciation of the importance of the therapeutic relationship to successful outcomes. The chapters are authored by experienced researchers and practitioners representing a range of therapeutic approaches who examine the role of the relationship from their perspectives. The result is in an illuminating and stimulating read.

Janice Krupnick's chapter exploring the significance of trauma history to the therapeutic alliance was very helpful (Chapter 3, p25). Insecure attachment styles feature in many trauma histories and intensify certain therapeutic challenges: containing emotion; earning trust; repairing ruptures in relationship and building connections.

In Chapter 5 (p58) Julian Ford explores affect regulation and mentalization, stressing the importance of the therapist's ability to regulate their own emotion in facilitating the client's move towards independent emotional regulation.

Reading these experts on relationship, one readily appreciates the second theme of this collection; that good relationships promote personal growth and development. Post-traumatic growth is given its fair share of space and we are reminded more than once that it is old wine in new bottles (p2, p97, p109). This raised a perennial question for me: in our drive to explain good therapy with greater precision, must we condemn or diminish other approaches or points of view? I refer for example to the editors' assertion regarding trauma-focused cognitive behaviour therapy and eye movement desensitization and reprocessing (EMDR) as having "… at their base a common core assumption that reduction of symptoms is the sole goal of therapy" (p50). As a therapist routinely using EMDR in working with traumatised clients I know this to be a narrow and inaccurate view of (at least) EMDR. This useful book on an important subject is let down by such occasional slips. And rekindling a tired argument about relationship versus method unsettles the firm premise underpinning the book – that relationship is valued by good therapists across the board. If therapy is conducted by numbers, blame the therapist rather than the therapy.

Guidelines for reviewers

1. *Please make your review no longer than 450 words.*
2. *Please include the ISBN, price, author and publisher details at the start of the review and your preferred credit at the end, eg Fred Bloggs is a clinical psychologist practising in Bristol.*
3. *Please note that all published reviews may be edited.*
4. *Publication is at the Editor's discretion.*

Please try to address the following points in your review

1. *What is the book saying, overall? Try to give an overview of the content*
2. *Is the book essential reading?*
3. *Are there similar works and, if so, how does this book compare?*
4. *What are its strengths and any weaknesses?*
5. *How useful is it for practitioners and why?*
6. *What readership is the book aimed at and appropriate for?*

All for one, not one for all

Soraia Crystal attended Michael Paterson's workshop on Ego-state therapy and has begun converting her colleagues

The 15th EMDR European Conference started for me with Michael Paterson's EMDR and Ego-state therapy workshop. I work in the UK and anyone working in public mental health services here (Adult or Child services) would be familiar with so-called untreatable, complex cases that have been haunting the system for many years, puzzling mental health practitioners as to why such patients have not responded or improved as a result of their particular therapeutic approach. The lack of change is often attributed to the familiar Freudian concept of 'clients' own resistance to change'.

Michael gave us an overview of such challenging presentations. They are characterised by the absence of the basic provision during childhood of safety, predictability, love, nurturing protection and validation. This neglect often results in abandonment and physical or sexual abuse, leading to severe PTSD; dissociation; and/or unexplained somatic sensations, self-harming and OCD.

Michael Paterson: calm and containing

We learned about the importance of identifying clinical signs of dissociative disorder including: memory lapses, depersonalisation and derealisation, flashbacks; intrusive thoughts, Schneiderian symptoms (Kluft 1997, 1990) including voices inside or outside the head and somatic symptoms such as headaches that don't respond to medication; sleep walking and depression (often with suicidal attempts). We were presented with a good overview of the validated measures available both for adults and child/young people and relevant web references.

Reinforcing the message from practitioner training, Michael cautioned use of EMDR in treating complex and dissociative clients. He expanded on ideas for stabilisation and resource building as well as on the importance of preparation for bilateral stimulation (BLS) with this client group; reminding us of the risk of de-compensating those clients if we fail to prepare them adequately. We reviewed ideas of self soothing techniques such as light stream, guided imagery, spinal technique and meditation and of resource building such as the extended safe/special place i.e. of using symbolic figures that represent the attribute that the client wants to connect with (calm, courage, strength); the idea of using an aura of colour representing that state e.g. calm and letting that aura embrace you using slow short sets of BLS (eye movement) as well as reminding us to ask frequently for feedback.

Further, we learnt about primary, secondary and tertiary types of dissociation and the various theoretical models since Pierre Janet's work. Ego state therapy, originally a hypnotic technique created by Watkins & Watkins (1997), forms an essential part of the preparation for Phase 4 of EMDR. Its aim is to allow the client to function adaptively; to access ego states in a secure way and to invite the various parts into a dialogue such that integration is effected. Michael finds that BLS helps during ego state therapy.

Michael's calm and containing presentation style made this challenging subject appear manageable. The video material allowed us to see ego-state therapy in practice creating a real sense of understanding of how theory is put into practice. Michael reminded us to be creative about connecting ego states through using for example, imagery of a phone or video link to find out what each

Making EMDR your own

Jen Popkin reports on Liz Royle's and Cath Kerr's workshop addressing the challenges to integration

Walking along Princes Street to the jaunty tune of *The Proclaimers'* '500 Miles' set the pace for an energetic, practical and stimulating day at Liz Royle's and Catherine Kerr's workshop. The presenters' rationale for facilitating this event was: 'Research suggests that many newly trained EMDR therapists feels deskilled, disempowered and unsupported following their basic training and struggle to transform the theory into their own particular practice'.

As there were more than 50 delegates attending the workshop, it was clear that Royle and Kerr have touched a chord with many therapists who really want to offer the best service to their clients, incorporating EMDR. Having read their excellent book (*Integrating EMDR into your Practice,* Springer, 2010), I found the day really reinforced its content. From the beginning, I was encouraged by the brief DVD of a therapist new to EMDR discussing their experiences, followed by partnering up with someone to share our thoughts and feelings about

Don't urge clients to run before they can walk!

Joany Spierings' stabilisation programme is a recipe for successful EMDR. Omar Sattaur reports

Attending Joany Spierings' workshop brought to mind a client with whom I had worked, shortly after completing my training. I thought I had done everything by the book, yet had to admit that processing never seemed to get off the ground. I wondered why, what was stopping our progress? Okay, I was still somewhat sheepish about my interweaves, but (believe me) some were quite good and most were adequate. Why the stuckness? The answer was straightforward, my supervisor pointed out, I had not paid sufficient attention to the preparation phase. Listening to Spierings explaining clearly the critical importance of emotional stabilisation I recalled that her teaching informed much of my supervisor's helpful recommendations.

Joany Spierings gave a road map for stabilisation

In this engaging, funny and inspiring workshop, I realised that I have only been touching the surface of the work of emotional stabilisation. The client I was remembering had been sexually assaulted. Every time we mentioned the targets, she would do all she could to block out the memory, to escape from it and she would cut off from her emotion. She simply did not feel safe enough to connect with her traumatic memory and I was too inexperienced to understand this. Spierings reminded us that for successful EMDR we have to help the client to work within a window of tolerance in which she is optimally aroused – too little and there is no processing, too much arousal and the client is in fight/flight/freeze mode. Sometimes this window of tolerance is non-existent or very narrow; our first job is to help our clients to ease it open a little more.

Spierings then proceeded to map out a structured approach to stabilisation in preparation for the next two parts of EMDR therapy, trauma confrontation and consolidation. The stabilisation work, she said, can be structured in such a way that therapist and client work towards passing three tests: the daily life test, the milk stool test and the nutshell test.

The daily life test is just what it says. How is the client dealing with day-to-day things like eating, sleeping, exercising, working, relating to friends and family

part needs or inviting parts to join forces to make things better for the client. In this process, we were reminded not to 'kill ego states', even the more critical or malevolent parts could be invited around the table in a dialogue where Socratic questioning could be used - a process that Michael called "rolling with resistance".

The questions and answers section was also very exciting, giving participants an opportunity to express doubts as well as hear more examples of applying theory into practice. This workshop inspired me to delve deeply into all the other related workshops throughout the two days of the conference. A week from the workshop and I have already contaminated a few colleagues and supervisees with my enthusiasm towards committing to work together across the Trust with the aim of developing some guidance in our work with complex trauma and dissociative clients. It has also encouraged me to help our managers to understand the need to invest in further training for all mental health practitioners in the screening and treatment of dissociative clients.

Soraia Crystal is an EMDR European Accredited Consultant

the integrative process. This first exercise was the foundation of the activities for the rest of the day. It normalised the learning experience, reminding us of the 'conscious incompetence' phase in the cycle of learning, when it can feel as if we tyros have to throw away our previous therapeutic approaches whilst struggling to embed the protocols of EMDR. It was very reassuring for me to have my uncertainties acknowledged by two very experienced practitioners.

Common dilemmas such as helping clients to formulate positive cognitions that make sense once the negative cognition has been identified, an exploration of terminology and definitions drawn up by ourselves, how to make greater use of the DES with dissociative clients, and revisiting Phases One and Two of EMDR – all made the day enjoyable and productive.

Both presenters modelled a very respectful and, at times playful interaction, both between themselves and with the group. They created a safe place for discussion, rich in content, where we could flag up problems we might have with integrating EMDR; lots of mini-peer-supervision here!

What then did I take from the day? Two things: first, that the process of EMDR allows for, indeed it welcomes the therapist's experience in other disciplines and that the latter can be the foundations upon which to build EMDR. Secondly, a practical tip; when a client is giving positive feedback concerning the interim period between sessions, a short round of bilateral stimulation to enhance their positive steps can work wonders. Something I had never thought of before but I will certainly use with my clients in future!

An urge-reduction protocol for treating addictions and dysfunctional behaviours

John Henry on the differences between EMDR and DeTUR

'AJ' has a very relaxed way of presenting. I came away from the workshop with a clearer idea of how I would use the DeTUR protocol. I had used DeTUR in the past, trying to follow the instructions that I had downloaded from the internet, but having seen the live demonstrations and video material I now have a much better idea of how it works.

AJ summarised the differences between EMDR and DeTUR as follows: EMDR is a complete psychotherapy with its eight phases and three prongs (Past, Present and Future) and its targeting of traumatic memories. DeTUR, in contrast is a specialised Phase 2 intervention. It works with the present and the future. Whereas EMDR has limited interweaves, DeTUR employs many overt interweaves, targeting triggers and urges. And whereas EMDR makes use of SUDs and VOCs and focuses on the experience of the trauma, DeTUR focuses on behaviour and uses Level of Urge (LOU) in place of SUD and Positive State/Goal instead of VOC. Both are client centred.

AJ defined addiction as any substance or behaviour that prevents an individual from coping and functioning in life. DeTUR is not a stand-alone treatment and does not require the client to be abstinent for treatment to be successful. Client readiness is an important element so full and careful history taking is essential. Support in the form of crisis management, 12-step programmes and training for life skills, amongst other things, are also important adjuncts to successful treatment. As with any therapy the client's desire and commitment to the future goals are essential.

It seems useful to conceptualise addiction as a (faulty) response to anxiety reduction rather than as an inherited faulty gene or predisposition. So when there is a known trauma, EMDR is applied to reduce the disturbance experienced by the person being treated before dealing with urge reduction. However when there is no known traumatic memory, the behaviour can be modified using DeTUR.

Those of you who wish to discover more on this topic a Google search of 'aj popky detur' will yield a useful download. There is also a chapter in EMDR Solutions; pathways to Healing edited by Robin Shapiro published by Norton ISBN3-393-70467-x

John Henry is a UKCP Registered Psychotherapist, EMDR Consultant, Facilitator and Practitioner

members and pets? What do they have to say about medication, addictions, self care, their daily or weekly rhythm, work and study, money, spirituality?

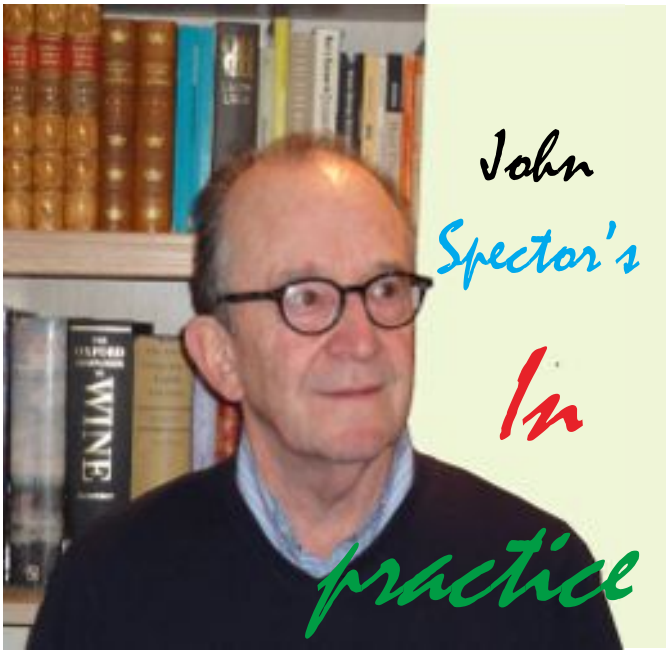
Next comes the 'milk stool test', so called because of the stability of the design of a three-legged milking stool. If one leg is weak, the structure collapses. Spierings' three 'legs of the milking stool' are: affect regulation, inner connectedness or attachment and self compassion. All three, she says, develop from early interactions with caregivers. The therapeutic relationship, she reminded us, provides the client with a second chance to repair attachment deficits, so therapist attitudes and manner are critically important.

In affect regulation, we need to help our clients to tolerate intense feelings of sadness, fear and anger and if they cannot, it is our job to help our clients learn how to manage these feelings. If you are anything like me, at this point you will begin looking for special, or extraordinary, solutions or techniques. But Spierings reminds us that we are always building on what clients already have – a solution focused approach to the problem. So what are clients already doing that helps them to self soothe? This can be anything from taking a hot scented bath to ringing a friend when emotions are running high. When they are almost absent, it could mean working with the client to explore what they learned as children about being sad, afraid and angry. Encourage them to make lists and praise their efforts.

Similarly, we should remind our clients of those people in their lives who inspire confidence and strength, to whom they feel connected, loved. Learning self compassion is often the most difficult for clients who present with complex trauma. A simple scaling exercise can often help us to assess how much work needs to be done; at one end of the scale, I have no right to exist because I am worthless; at the other end of the scale, I am okay as I am, warts and all. Discovering the client's inner commentary and helping the client to challenge negative commentary is important. Jim Knipe's observation of such clients believing as children (and adults) that it is easier or safer to be a bad child with good parents than a good child with bad parents can be useful here.

The nutshell test is the final rehearsal before reprocessing. Can the client tell you of their major life events and what happened to them without going into detail and while remaining present?

There is too much to cover here – I can only recommend that if you have not already done so, do attend one of her workshops.



John Spector invites readers to submit examples of interesting and creative clinical uses of EMDR. If you would like to share your work, write to Omar Sattaur, Editor of EMDR*Now at o.sattaur@gmail.com*

Case 1: submitted by Dr Joanne Weston, Chartered Clinical Psychologist

Jack was a 15- year old GCSE student who was referred for therapy just over a year after a road traffic accident. He had been involved in a minor shunt and consequently developed moderate travel anxiety. Two weeks after the accident he also developed a tic disorder which presented in the form of shaking his head. This was very noticeable and significantly impacted on his self confidence. His family also found it "abnormal" and pressured on him to "try harder to stop doing it".

My initial formulation was that Jack's trauma from the car accident was presenting in the form of a tic disorder, but between his assessment and first session of therapy, the travel anxiety diminished and the tic disorder got worse. Jack had a number of stresses in his life as he was an A grade student and had a lot of pressure placed on him to do well in his forthcoming exams. It materialised that Jack also had a few months of having a tic disorder about seven years previously but this had resolved spontaneously and was not so severe.

I decided to use Grant's Pain Protocol (2009) over the course of nine sessions. Jack's negative cognition was "I am not in control", his PC was "I am in control".

Jack slowly developed a very detailed picture of an Elastic Band machine in his neck, which he said was "causing" the problem. He described it as a two-forked machine; each fork had two prongs at the end holding elastic bands-one fork for the up and down nodding motion and one for the side to side shaking motion. He said that a wheel wound them up and caused the bands to get tighter until they snapped and caused his head to jerk. He said that the elastic bands would change colour-red (hot), blue (cool), and black (embarrass-ment). He said it was a silent machine and ran on "Jack energy", mainly happiness, anger or stress as these were the times when his tic disorder was at its worst. During processing the machine would get bigger and smaller and rise and fall in his neck. New elastic bands would replace snapped old ones had snapped, re-starting the process.

We carried out processing on the machine for a number of sessions, during which we came to know how it functioned really well. A significant step forward was asking Jack, "what would make the machine stop working?" Jack first decided he needed to try to saw off the prongs of the machine, then used a laser gun on them, leaving tiny stubs remaining. This had limited effect as the pesky elastic bands hung stubbornly on to the stubs. So, Jack decided he needed to freeze the machine and hit it with a very large hammer. At this point, the machine shattered into small pieces and disappeared into a black hole in his neck.

Following the 'destruction of the machine', Jack had a two-week break. I was not sure if this progress would be sustained or need further processing. However when Jack returned he said that the machine had not come back at all. He reported a notable decrease in his tics and their severity, and his positive cognition was installed quickly. Jack was also continuing to do stress reduction techniques and the safe place exercise on a regular basis. He said he felt happier in himself, more confident, and that the tic was not a focal point in his life anymore.

Joanne's clinical report on this creative use of EMDR with a presentation of tics is timely as there is currently only one published study in this area so far (Kim 2009).

As often with this kind of case there is a strong psychological element to the presentation of tics and one's first assumption that the tics might be a physiological problem triggered by the RTA is modified by the information that Jack had had a previous episode of tics not apparently triggered by physical trauma. The fact that he was also under considerable stress then adds to our sense that psychological factors are prevalent here.

Joanne used Grant's Pain Protocol which turned out to be a good choice but it is interesting to speculate on how things would have turned out had she used the illness/somatic protocol (Luber, 2009) for which there would have been good justification.

This client Jack has a highly developed sense of imagery which undoubtedly helped in the resolution of his problem. Perhaps a different approach might be needed for clients who find visualisation harder.

As Joanne indicates, the key question that lead to resolution in this case was "what would make the machine stop working?" This creative kind of interweave led to adaptive image manipulation and resolution.

It is difficult to know whether EMDR was the sole tool of resolution in this case as Joanne mentions that she had got Jack to use stress reduction techniques on a regular basis and these may have contributed, however it is clear that EMDR was a very significant factor in the resolution of this problem and it gives us all encouragement to think of EMDR in presentations such as tics or Tourettes where stress and other psychological factors may be prevalent.

References:

Kim D (2009). A single case study of EMDR with tourettes disorder aggravated by stress at work. *Mental Health Research,* Vol 28,pp14-20

Luber, M. (2009).Ch 23 Illness & Somatic Disorder Protocol, in *EMDR Scripted Protocols,* Springer.