The Journal of the EMDR Association UK & Ireland
Winter 2020 Vol 2 No 1

EMDR THERAPY QUARTERLY

3MDR: EMDR and Virtual Reality Exposure Therapy for treatment-resistant PTSD

EMDR Association UK & Ireland
PO Box 3356
Swindon SN2 9EE
info@emdrassociation.org.uk

https://emdr-europe.org/
Eva Muenker-Kramer, EMDR Europe Association Secretary
secretary@emdr-europe.org
Valentina Martini, EMDR Europe Executive Assistant
valentinamartini@emdritalia.it

Plugging the research gap

Whilst researchers continue the quest for a mechanism to explain how EMDR achieves reprocessing other research/ practitioners continue to innovate. In this edition of ETQ two therapists write about their experience of using Phil Manfield's Flash technique (FT) with remarkable success. FT is not EMDR, and the publication of these clinical experiences should not be taken as an endorsement by the Association. Yet there are similarities with EMDR and seemingly with the efficacy of FT in reducing the distress associated with traumatic memories.

In an earlier incarnation of this publication, around this time last year (http://tiny.cc/kxs7iz) Manfield responded to some of the puzzling aspects of the FT posed by Derek Farrell. For example, how does it sit with the AIP model? Is it more to do with 'dosed exposure' and is reprocessing also taking place? Manfield's reply was as comprehensive as possible at the time and many aspects cannot yet be fully explained. Briefly, it does seem that reprocessing in addition to desensitisation of traumatic material does take place during FT but possibly by a different means. For those interested in this subject I recommend revisiting Manfield's response to the questions that Farrell posed as to what FT is and how it works.

Adding to the theme of innovation is an article on early trials of 3MDR - a combination of EMDR and Virtual Reality Exposure Therapy for treatment-resistant veterans with PTSD. It makes fascinating reading and, of course, raising yet more research questions.

I suspect it will be a few years before these questions are sufficiently resolved to publish confidently a theory explaining the mechanism for EMDR, FT and 3MDR. Meanwhile practitioners are using all three with good results. Again, research is of paramount importance. Any takers?

Omar Sattaur

EMDR Therapy Quarterly

EMDR Therapy Quarterly (ETQ) is the official publication of the EMDR Association UK & Ireland. It offers coverage of Association news, regional, national and European EMDR conferences and articles on the clinical practice and research of EMDR.

Full guidelines for authors of original practice and research articles are given on the inside back cover.

News articles covering presentations at EMDR research or clinical practice meetings and conferences are welcomed. These may be submitted to editor@emdrassociation.org.uk Please note that all articles are subject to editing and publication at the editors' discretion. We welcome inquiries.

Editorial Policy

The Journal is published for members of the EMDR Association UK & Ireland (EMDR Association), to promote research and innovative practice among its members, to provide a resource and forum for contributions from the membership and to promote knowledge and understanding of EMDR Therapy more widely in the therapeutic community. The contents are provided for general information purposes and do not constitute professional advice of any nature. Whilst every effort is made to ensure the content is accurate and true, on occasion there may be mistakes and readers are advised not to rely on its contents. The EMDR Association and the Editor accept no responsibility or liability for any loss which may arise from reliance on the information contained in ETQ.

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EMDR community bids adieu to Francine

NEWS

John Spector gave the first eulogy at Francine Shapiro's memorial service in January 2020. He describes the gathering at St Ethelburga's in London to mark the occasion

An important milestone in EMDR history was marked by a beautiful and moving Memorial Service for Francine Shapiro that was held in the early evening of 25 January at St Ethelburga's Centre for Reconciliation and Peace in the City of London. The event was organized by our inestimable Derek Farrell and conducted with great thought and sensitivity by Robert Miller, Archdeacon of Derry and (confusingly for many of us there) the identical twin brother of Dr Paul Miller, also present, and well known to the EMDR community for his work with psychosis.

Francine would have approved of the venue. St Ethelburga's is a medieval church that was rebuilt full of old character after it was bombed by the IRA in April 1993. It is an oasis of peace in the City, surrounded by towering office blocks and busy streets. Dedicated to peace and reconciliation for all faiths, it engenders an instant tranquility as you enter. To the rear there is a glorious planted courtyard with a central fountain. One of wall plaques from donors read: "Yesterdays foe is todays friend". When we arrived, Marian Tobin was just completing some wonderful flower arrangements of scented lilies, narcissi, and freesia and, as members of our EMDR community gathered, we were able to reflect, relax, and take in the extraordinarily calming ambience of St Ethelburga's.

A photograph of Francine and the apt lines from William Blake adorned the cover of the service booklet: "For the eye altering alters all". The booklet also contained written tributes from Robbie Dunton, Francine's close friend and administrator of the EMDR Institute, and Joany Spierings from the Netherlands. As we waited for the event to begin, all were reflecting in a few moments of silence on our individual memories of Francine and the huge significance for our EMDR community of her passing.

> For the eye altering alters all
>
> - from The mental traveller, by William Blake

After a brief welcome from Lorraine Knibbs, President of the Association, Robert Miller led us through the haunting Psalm 139 which poetically addresses our problems with life and death. Then followed the first eulogy which I gave, addressing Francine's passing from both a personal and a British point of view (see p4).

Following each eulogy *Sistina*, a quartet of singers, performed for us. They began with Hubert Parry's *Crossing the Bar*. This piece, as with all the pieces they sang, resonated and echoed through the Centre, amplified by the amazing acoustics, and moved us all.

The second eulogy was delivered by Dr Udi Oren, past President of EMDR Europe and EMDR International Trainer. Udi made us smile as he talked of Francine's nickname in some quarters as "Big Moma". He reminded us of how determined and driven she was, and how she expected her colleagues to have the same drive – and if you didn't "you needed some EMDR to see what was blocking you!" But most of all, he talked of her being a carer and creating a family in the EMDR community.

The third eulogy was read by Dr Marilyn Luber, the American Psychologist who was by Francine's side from the beginning and who helped train many of us to become EMDR Institute Trainers. Marilyn is known to the wider community through her books on EMDR Protocols. We owed a special debt of gratitude to Marilyn for coming from the US for this event as it was the second eulogy she had given that week – her mother had died earlier that week. Marilyn recalled that Francine had known her mother and had often visited her mother's art shop in Philadelphia. She took us through the history of how Francine discovered and developed EMDR.

Robert Miller designed the last two sections of the service to acknowledge Francine's Jewish heritage, first with a reading of *Meditations before Kaddish* by Merrit Malloy, and closing with a symbolic *Mitzvah* (good deed) of those present writing some brief words about Francine on a sticky-note to go on a wall, echoing the Jewish tradition of leaving a stone on the grave of a departed loved one.

The final eulogy was given by Dr Paul Miller, the psychiatrist

John Spector's Eulogy for Francine Shapiro (1948-2019)

Firstly, a thank you to dear Derek for organising this event – so meaningful in so many ways.

As I look around our assembly today I see so many colleagues and friends who have shared the EMDR journey with me, some of you from the very beginning.

As with many others, Francine profoundly changed the course of my life. She had an indefinable presence about her, a mixture of a fierce intellect and a deep compassion, that could not fail but to leave an impression on all who came across her. I realise that she continues in unconscious ways to influence me even now. For instance I was thinking earlier on why I had chosen to dress today in the untypically formal way that I have, and what came into my mind was the the theory of old memory networks stimulating present behaviours, which was so central to Francine's AIP model. We would often illustrate how old learning influences present decisions with old advertising slogans - "Have a break, have a ..." and "Beans means ...", and of course everyone knew the responses of "Kit Kat" or "Heinz". Then I thought of Francine's early Institute Trainers' manuals in which male Trainers and Facilitators were instructed always to wear a suit, shirt and tie when presenting. As you can see my memory network, triggered by Francine, determined what I wore today.

Francine gave all us clinicians here in the UK a gift, and it started like this. In 1990 when I was Head of Clinical Psychology at Watford General Hospital, my wife Karen, also a Clinical Psychologist, showed me a paper she had come across by one Francine Shapiro – Francine's seminal paper introducing EMD, as it then was, as a promising treatment for PTSD. I filed it away in the "interesting but bizarre" supension file only to come back to it a year later when I read a paper by Wolpe and Abrams - (that's Joseph Wolpe of Behavioual fame), who had tried the EMD treatment on PTSD clients with surprisingly successful results and they reminded us that PTSD had up to this point been considered a "Hard-to-treat diagnosis". Encouraged by their endorsement of the treatment I and my colleague, Dr Mark Huthwaite, a psychiatrist I was colloborating with, started to use the procedure as described by Francine with PTSD clients. We wrote up one of these clients who had PTSD from a RTA and that became the 1st publication in the British literature on EMD as a treatment for PTSD in the *British Journal of Psychiatry* in 1993. This chance discovery then set off a chain of events that led to where we are today with EMDR in the UK.

Firstly, Francine, eagle-eyed as ever, picked up our publication and invited me to go to the USA to train with her which I did in 1993,and formed together with Arne Hoffman and Franz Ebbner from Germany and Ad de Jongh from the Netherlands the 1st European clinicians to train in EMD. Secondly, I started a PTSD Clinic at WGH using EMD as the main treatment. Thirdly, a small group of British clinicians including Richard Mitchell and Sandi Richman and myself began meeting firstly at my home, and then at The Priory Hospital, Southgate in London, forming a core group of clinicians interested in EMD to develop the method in the UK. And fourthly, Francine asked me to sponsor EMD Institute Trainings in the UK; the first was in 1994 in Kensington. From that moment on we started riding an unstoppable wave. Our European group expanded rapidly and we began meeting

brother of Robert, and known to us through his talks and wisdom on psychosis, medication effects, and active engagement in JISCMAIL. Paul talked from the Irish perspective and told us how he had gone sceptically into EMDR when he attended the first HAP Training in Northern Ireland but that Training had started his EMDR journey. He talked of EMDR healing people, and working with victims of The Troubles and how it developed in Northern Ireland leading to The Crest Guidelines supporting EMDR. He told us about a patient he had worked with and who told Paul that EMDR and Paul's work had given him life.

The service ended and we were treated to wine and canapes. We had plenty of time to catch up with others and to reflect with each other on the astonishing ride we had all been on and the extraordinary life we had witnessed in Francine Shapiro. This felt like an essential completion of a stage in the EMDR story, the only regret being that, owing to problems with the website of the organisers of the event, many of those who had wished to attend were unable to do so.

John Spector is a Consultant Clinical Psychologist, EMDR Trainer and EMDR Consultant

regularly, leading to the formation in the late 1990s of what was to become EMDR Europe. And a core group of us across Europe were trained by Francine and Marilyn Luber to become EMDR Institute facilitators teaching in the practicums of Trainings.

These times were for most of us the most exciting of our professional lives – we really felt like pioneers. Francine instilled in us a conviction as to the vital importance and rightness of the work we were doing – a conviction borne not only from the amazing results our clinicians were getting but from a deep humanitarian drive conveyed by Francine about the healing power of EMDR and our duty to deliver that. She inculcated in us a sense of "giving back" through what we had learnt, and this ethos developed through the Humanitarian Assistance Programme treating pro bono victims of crises around the world. But Francine was not just a gifted evangelical. She recognized early on the importance of evidence-based practice if EMDR was to be accepted in the face of sustained attack, particularly by the dominant CBT group at the time. Francine was eternally insistent on us carrying out the research on EMDR because she knew that without the evidence base we would not succeed. She was always there in the background and in our minds driving us on - and we did succeed. In the first decade of this century EMDR was adopted widely by national and international guidelines as a frontline treatment for PTSD, inluding of course here in the UK by our own NICE guidelines.

I have often pondered on what it was about Francine that so powerfully and positively influenced so many of us. Many people make important discoveries, but mostly those discoveries fall by the wayside. What was Francine's secret? Here I rely on what I have learnt about her from others as well as my own observations. Let me start with my own observations. Although she had what could at times feel like an intimidating intellect and determination, she aslo had a playful side and a sometimes wicked sense of humour. I remember our early European training days with her with such fondness not only because of the learning from her around EMDR and Trauma, but because of the fun we would have when we would all relax and let our hair down at some lovely restaurant in Amsterdam or London and she would engage with us all with banter and jokes. Many years later she asked me what I was up to in my life. Somewhat sheepishly (because I was concerned she might think I was disengaging from our work) I told her I was working less and engaging with grandchildren and tennis and going to the countryside more. "Oh", she said smiling broadly, "so you are getting a life?" "Yes", I said, with huge relief! I always felt a need to bask in the warm glow of her affirmation.

Where did her drive and compassion come from? I believe some events in her life were seminal. She was born in New York and had two sisters and a brother. Her sister Debra died at age nine when Francine was 17. This loss resulted in Francine searching for new meaning and purpose in her life. Her interest first turned to literature which she became passionate about and taught. She also became interested in what she had read about Behaviour Therapy, and wrote "The idea of a focussed predictable cause and effect approach to human psychology seemed fully compatible with the concepts of literary character and plot development" and "I had fascinating discussions with my English Professors on the interaction between the rich multifaceted texts I was reading and the physiological cause and effect implications of behavioural formulations". A second formative event was her contracting cancer and its origins and cures absorbed her. She was particularly intrigued by the connection between disease and distress. She left New York to make a journey of discovery which led to her enrolling on a PhD programme in Clinical Psychology in San Diego California. She became an intuitive and rational psychologist with a keen eye for the observation of human behaviour and character. The integration of evaluation and intuition became an organising principle through which Francine channeled her choices and built EMDR after its discovery on her famous walk in the park.

When asked what she would say to the EMDR community, Francine responded; "Research is not just about proving to others. It is a way to guide each one of us to establish the best practices. It is about staying on the right road. We are all responsible for the world we live in. Worldwide, clinicians are forging bonds that transcend countries and ideologies. Bonds that can help heal the trauma and pain that leads to ongoing violence and suffering. To make a difference that affects generations to come - don't leave it to anyone else. We all have a part in it".

Thank you Francine for your life, and the gift you have given us.

NEWS

President elect reflects on his EMDR journey

Mike O'Connor takes up the position of President of the EMDR Association in March. Here he tells us about his professional background and his involvement with the Association over many years

The prospect of taking up the post of President in March has caused me to reflect on how and when I became involved in the Association and the broader EMDR community. The 'when' is easy. It was 1996. I was an Educational Psychologist working in a local government area known as Central Regional Council, based in Stirling. At the time I was a member of the Critical Incident Team for the Council. One day, out of the blue, I received a telephone call from my office manager instructing me to report to a school immediately where I would be met by a Police Officer who would brief me. The school was Dunblane Primary. When I arrived, I encountered a throng of very anxious and distressed parents and a cordon of policeman. A Police Inspector briefed me and I learned, for the first time that, an hour earlier, a gunman had killed a teacher and a large number of very young children in the school. Others had been wounded. Together with a colleague, Alison Russell, I spent the remainder of the day in the school with the parents and relatives of the children who had been killed or wounded.

Frankly, both of us, faced by such horror, felt completely deskilled and wondered what we could possibly do to help.

At the time neither of us had heard of EMDR. Within a matter of weeks this was to change. A small team of mental health professionals assigned to the local community in Dunblane was invited to take part in EMDR training organised by the EMDR Institute Humanitarian Assistance Programme (HAP). Along with several of these colleagues I was seconded to work in the community of Dunblane. In my case I worked there for the next three and a half years during which time I completed my EMDR training, including EMDR Child training; developed my EMDR skills; and engaged with the EMDR community around the UK and beyond. Those years explain the 'how' I became involved.

The tragic shooting in Dunblane in 1996 was the impetus for Mike O'Connor to train in EMDR

Further training, consultation and supervision experiences had led to opportunities to meet other EMDR therapists some of whom had formed the fledgling EMDR Association. More significantly, I had experienced the 'power of EMDR' and saw first-hand how it could transform the lives of traumatised people. Along the way, I became a member of the Association.

No trauma novice

Not that the experience of working in Dunblane was my first experience of working with trauma. I have worked in a variety of posts in the voluntary and local government sectors since 1974. During this time I have been involved in developing specialist services for children and families affected by loss and trauma and prior to Dunblane, I had worked as a teacher for children with emotional and behavioural difficulties and spent thirteen years working for a charity in an independent Adolescent Unit.

My former posts include Principal Psychologist for Clackmannanshire Council, Director and C.E.O. of the Notre Dame Centre, Glasgow and Consultant Psychologist in a residential school for Looked After children. Currently, I work in an Educational Psychology Service where I lead an Intensive Therapy Service providing EMDR to children and young people. In parallel to this I have been a member of the Association since 1996; became an accredited EMDR Consultant in 2001 and an accredited Child & Adolescent Consultant in 2017. From 2008 until 2015 I chaired the EMDR UK & Ireland Child & Adoles-

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cent Section and in that capacity was a member of the EMDR UK & Ireland Board. I have continued to serve on the Board since 2015 and currently, along with others, I represent the Association in EMDR Europe. I am currently a member of the EMDR Europe Practice Committee and the EMDR Europe Board.

Commitment

So, as I contemplate taking up the post of President, after two years as President Elect and many more years on the Board, I can't claim that I have been thrown in at the deep end. Being part of the Board and associated committees has allowed me to see first-hand the commitment of the many who form the EMDR community, including individual members, previous Presidents, Trustees, administrative staff and Regional Groups. This commitment has enabled the Association to develop from a very small base to one where our membership now approaches four thousand and has brought EMDR Therapy to the attention of the public and professional mental health community.

One of the challenges we face as an Association as we grow in size and influence is to strengthen our governance structure. This is an issue I hope to address together with the Board over the next two years. As we all know, there is still much to be done to raise further the profile of EMDR and its application to a wide range of mental health concerns. No doubt there will be many other issues and challenges that will arise for the Association over the next few years but, hopefully, not too many!

CPD events increasing available year on year

NEWS

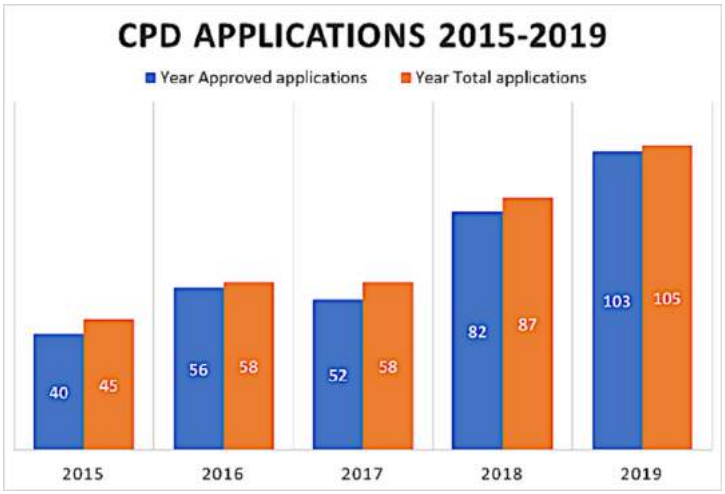

Fig1: CPD applications have increased steadily from 2015-2018

A recent audit of CPD applications has shown that local CPD events are increasingly available across the country. Regional Groups and non-profit groups are putting on significantly more CPD events compared to 2015 when figures began to be recorded. Applications received for 2019 are up by 20 percent compared to 2018 (see Figure 1). The figures suggest an upward trend, since the number of applications received in 2018 was 50 percent higher than in 2017.

The largest increase was seen in the Northeast region where the number of events in 2019 almost tripled (14) compared to the number of events staged there in 2018. Child-specific training events also more than doubled from five in 2018 to 11 in 2019.

If your Regional Group or organisation is thinking of staging a CPD event, check out the guidance and criteria for awarding CPD points, and the application form to apply, from the Association website.

Jane Ware

Dr Jane Ware is the CPD Representative on the Accreditation Committee

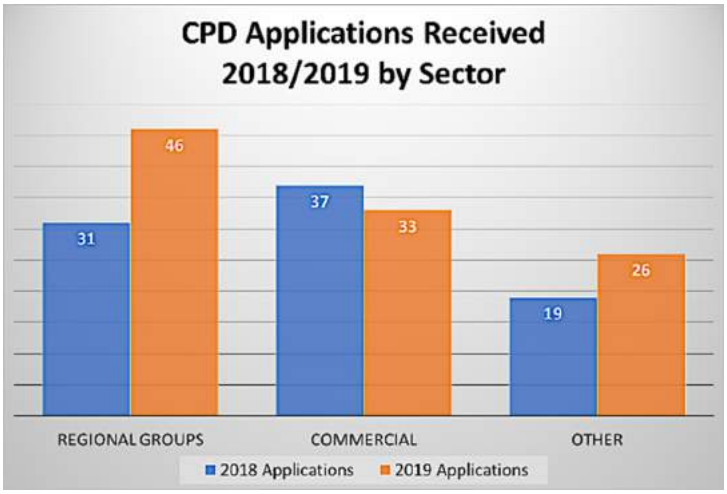

Fig 2: Applications from Regional Groups have increased by almost 50 percent

NEWS

More than 100 EMDR therapists now trained in Egypt

The hard work of many clinicians and the dedication of Cairo University's psychiatry department and Trauma Aid UK has resulted in the establishment of EMDR Therapy in Egypt. Osama Refaat and Matthew Wesson chart the story so far

Matt Wesson training the latest cohort of therapists in Egypt

There are now more than 100 clinicians trained in EMDR therapy in Egypt. This significant milestone could not have been reached without a particular interest in psychotherapy practice and training within the psychiatry department of Cairo University that stretches back to the 1970s. A group of professors including Drs Shahin, Gawad, and Rakhawy pioneered a move towards psychotherapy which is firmly established today.

Dr Yehia Rakhawy has an evolutionary perspective in psychiatry and has conducted weekly Gestalt group therapy at the department for almost 50 years and still does so, even though he is now in his 80s. In 1972, he developed the first psychotherapeutic milieu in Egypt; a groundbreaking move away from the medical model of psychiatric management predominant in Egypt at that time. Currently there is a special unit in the department of psychiatry that carries out the training of psychiatrists and psychologists on wide variety of psychotherapy modalities with regular individual and group supervisions. In 2014-2015 this extended to EMDR therapy when a few psychiatrists from Egypt received their basic training in EMDR via Trauma Aid UK (TAUK, formerly known as HAP) in Istanbul and in Turkey in 2014 and 2015. These doctors were so enthusiastic about the potential of EMDR they set to work on how they could open more opportunities for therapists from Egypt and nearby countries to attend the accredited training in EMDR in Egypt.

Through the hard work of many clinicians, the Psychiatry Department at Cairo University, in collaboration with TAUK, has managed to deliver several EMDR training courses in Egypt to psychiatrists, psychologists and social workers. The three parts were delivered in 2018 by Matthew Wesson (EMDR Europe Senior Trainer, UK) and Dr Khalid Sultan (EMDR Consultant and Consultant Psychiatrist, UK) to 21 clinicians from the region. The training was sponsored by TAUK including the provision of volunteer EMDR consultants / supervisors from the UK via *Skype* and *Zoom*.

Demand from psychotherapists to be trained in this modality continued to increase after this so TAUK responded with a second round of training which was completed in 2019 and attended by another 36 delegates. The main trainer was Caroline Van Diest (EMDR Accredited Trainer, UK) with facilitation by Dr Khalid Sultan, Dr Hamodi Kayal (Consultant & Clinical Psychologist, UK) and Dr Walid Abdul Hamid (EMDR Consultant and Consultant Psychiatrist, UK). The training also included five therapists from Libya and Sudan.

EMDR therapists based in Cairo formed a monthly peer supervision group in September 2019. Their two-hour meetings take place in Cairo University's psychiatry hospital and supports therapists in their clinical practice with EMDR. Most continue to gain online supervision and support from

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EMDR Consultants in the UK via TAUK arrangement. In December 2019 Dr. Khalid Sultan returned again to Cairo to deliver two days of EMDR supervision followed by a two-day refresher training on treating pain and complex trauma using EMDR therapy.

Participants of the second round of training in 2019

The third training in EMDR in Cairo for Part 1 was completed in January 2020 and attended by 34 trainees, including participants from Algeria and Jordan. Matthew Wesson once again led the training with expert facilitation by Dr Walid Abdul Hamid, Hamodi Kayal and Dr Matthew Wilcockson (EMDR Consultant and CBT therapist, UK). The week of this training, interestingly, coincided with the opening of an independent institute for training and research in psychotherapy under the name of Rakhawy Institute. Parts 2 and 3 are planned for August this year and will include a revision for those clinicians that have already completed their training. It is hoped that this will be delivered at the new Rakhawy Institute. We are preparing for the Child Level 1 EMDR training in Cairo in March delivered by Joanne Morris-Smith, (EMDR Child Trainer).

Trauma Aid UK thanks everyone involved in pulling this all together including the in-country team at Cairo University, the trainers and facilitators who all give their time for free, as do all the Consultants that support the delegates during and post training from the UK. This initiative is part of the TAUK Middle East programme, which began in 2013. Since then, six full trainings (in addition to those in Egypt) have been delivered in Turkey, Jordan and Tunisia and more than 130 clinicians have been trained.

TAUK continues to support them, offering supervision and CPD events so that they can develop and work towards accreditation. TAUK aims to build capacity in the region so that each country establishes its own EMDR Association and a regional EMDR Arabic Association. The needs are huge given the years of conflict that has traumatized millions of people in the region and continues to do so.

TAUK is a charity managed by volunteer Trustees and led by its President, Sian Morgan. TAUK is funded largely by the EMDR Community through Regional Groups, EMDR Association UK & Ireland and our membership. If you don't already support this charity through a £15 donation once a year, please consider doing so. Although the membership of EMDR UK Association is 3,000, TAUK membership is roughly 300 members. TAUK is making a real impact on trauma and trauma training across the world. https://www.traumaaiduk.org

Professor Osama Refaat is an Older Adult Psychiatrist at Cairo University and leads the organization of EMDR training / supervision in Egypt. Matthew Wesson is an EMDR Europe Accredited Senior Trainer with The EMDR Academy

Some observations on the use of the Flash Technique

Peter Eldridge attended Philip Manfield's first UK training workshop on the use of his Flash Technique in September 2018. Since then he has used it almost exclusively with dozens of clients. Here he generously shares what he has learned from the experience

The overwhelming advantages of Flash Technique (FT) are, first that it avoids very nearly all the re-traumatisation often prevalent in Phase 4 and, second allows trauma processing to proceed much more swiftly. These notes are not intended to help a reader unfamiliar with Flash to learn how to do it. I strongly recommend attending a Philip Manfield workshop first (I am told he also offers online tuition in the technique on his own web site). I don't regard Flash as 'another protocol'. It provides an alternative way to work through the standard EMDR protocol, obviating the need for Phase 3, replacing Phase 4, and making a small change to Phase 5.

Phase 1

This remains History Taking. I use the Memory Timeline as it incorporates SUDs (at the time of the events), Emotions (as remembered) and known Beliefs (NC or PC). (See p6 for a worked example and p9 for a blank that you can copy on A3 paper. NB. The Timeline to complete must be printed on A3 paper, the example can be on A4.) But, I add a request that my client thinks back to a very happy memory in their life, a positive engaging focus - something they'd enjoy thinking about any time I ask them to. Unlike Safe Place selection, this does not have to be from their adult years. Note that Philip Manfield uses the term 'positive engaging focus' which can be other than a happy memory, for example, listening to a much loved piece of music. I'd be happy to play a client's choice via Spotify on my mobile if required but have not yet needed to as all my clients have come up with an excellent happy memory.

Phase 2

Target Selection is agreed with the client: preferably in ascending time sequence. Sometimes a client is keen to process a later event first, which I'll agree to do unless I can identify an earlier event with similar characteristics of content, emotions and/or beliefs (i.e. a potential Touchstone Event).

Once we've agreed on the event to be addressed, I ask the client not to think further about it but, instead, to concentrate fully on their preferred (earlier discovered) happy memory, Note that the client can have a happy memory from their childhood if they wish, however, at any age of memory, it is critically important that others involved in that memory should have no connection with the Target Event we are about to work on. If necessary I'll ask for a second happy memory.

Phase 3

I don't need to do the Standard Protocol Assessment of Phase 3. It is possible that several of the questions normally asked in assessment will have appeared on their Memory Timeline. But I only need to know their present SUDs level, so I ask for this in a 'roundabout' way, at the start of Phase 4, using the following convolutedly conditional question:

"I don't want you to think about the target event we've identified to work on with Flash. I want you to think wholly about your Happy Memory. However, hypothetically, if I were to ask you to think about the Target Event (which I shall not do), how upsetting or disturbing, on a scale from '0 = not at all to 10 = the worst you could imagine' do you think you might find it, were I to do so, which I shall not?" Whatever number they give me is the starting SUDs.

Phase 4

This phase is replaced by Philip Manfield's approach. My FT is wholly focused on engaging the 'conscious' part of the brain on the 'enjoyably happy memory' we previously identified in Phase 1. The other, often seemingly comic, actions and responses are designed fully to occupy the rest of the client's 'conscious brain' with perceptions, motor actions and unpatterned stimuli requiring physical responses. Then the 'unconscious brain' can get on with the desensitisation process (much as it does when we fail to remember something or someone, give up trying, then find the correct answer comes into our head a few minutes later).

I believe that the FT process occupies the client's left cortical hemisphere so completely that what Manfield refers to as 'other neural processes' are then free to do the Phase 4 desensitisation AIP, faster and with little or no re-traumatisation.

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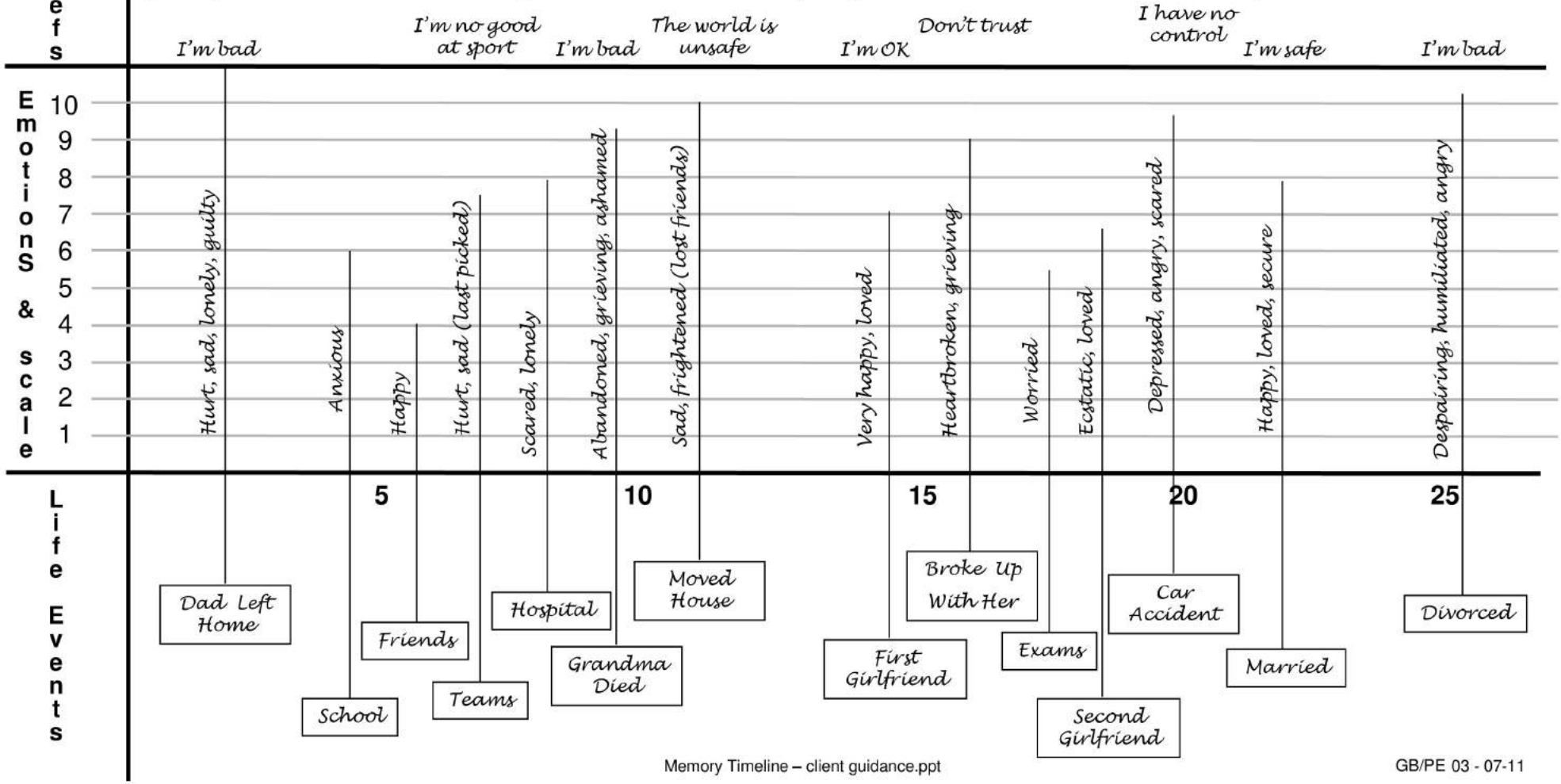
Memory Timeline - Example

The varied range of life's experiences over the years includes significant interactions with other people; some of which were positive and some negative.

These experiences have helped formulate our beliefs, value systems, patterns of behaviour and even our personalities. As we recall the most important events of our life's history we are able to understand the part they have played in our development.

Using your large Memory Timeline sheet, record your major life events in the lower section – including both positive and negative events – with a line up to the timeline. Then mark the emotions that resulted from those events in the middle section. Take some time to consider the strength of those emotions and record them by extending your event line upwards to the appropriate level (where 1 indicates weak emotion and 10 the strongest emotion you can imagine). Then write the emotion(s) you were feeling along the middle section line.

In the top section make a note of the limiting or negative belief, or the empowering or positive belief, you formed about yourself at that time. At some points you may also become aware of decisions (then conscious or unconscious) that you arrived at as a result of those encounters, and can record them as well.



Memory Timeline – client guidance.ppt

GB/PE 03 - 07-11

When Philip Manfield taught me the FT he did not specify where these 'other neurons' were, but I am happy to deduce that they must be among the billions of neurons in the right cortical hemisphere! I know of no supporting research to validate my hypothesis (fMRI, etc.) but that's how I explain it to my clients and it makes enough 'common sense' to them that they engage, and the process works!

Flash!

It is important that I call 'Flash!' at completely random intervals (it takes focus), while keeping a steady rhythm of tapping my own knees for them to synchronise an equivalent tapping of theirs. I lift my arm to shoulder level and flip my hand back towards my shoulder to keep the timing (I lift each hand in turn and drop it back to my knee in approximately two seconds per hand). You may realise that asking a client to tap their knees alternately in synchrony with me is a way in which I am effectively administering BLS to them!

After a set of Flash activity, I'll ask the client momentarily to stop thinking about their happy memory and take a peek, briefly, at the actual Target Event, letting me know if the way they perceive it has changed and if the level of upset or disturbance has moved on their 0 to 10 scale? They may report a change in perception (e.g. "It seems further away" or "It seems hazier or blurred") and may volunteer a thought (e.g. "it's less upsetting" or "it's not so bad"). They invariably report a current SUDs number. In the majority of cases it will have lowered.

In some cases, it stays the same. It may even, rarely, rise if they think of other events connected with the target event. In this case, or if the SUD value stays the same more than twice, I'll check with them whether they're able to keep full and constant focus on their happy memory and whether thoughts or perceptions of the Target Event or related events are intruding. I note their reported value and ask them to return to their happy memory, giving them a moment to get there before starting the next set of Flash (saying, "Let's resume. Please join in when you are ready", and starting my own knee-tapping cadence).

At first, nearly all clients struggle with the knee tapping and 'Flash-stimulated' blinking three times. It is harder than patting your head with one hand while rubbing your tummy with the other! But I encourage them, remind them that focus on their happy memory is their highest priority, and that it doesn't matter too much if they momentarily lose the knee-tapping timing, or blink twice or four times instead of three – as long as they are trying to do each of these things.

Pacing

When I first used the FT I noticed that SUDs movement downwards happens more slowly at high SUDs and quite quickly once low SUDs are reached. So I learned to do a longer Flash set early on. This minimised the number of times I'd need to stop and ask the client to review the Target Event, and thus minimised any potential re-traumatisation.

In fact, I learned to add a moment's pause in the middle of longer sets. "And, pause, but stay resolutely in your happy memory. This is just a moment's respite so you can relax your arm and shoulder muscles, and you can take a couple of deep breaths – but keep the happy memory!" Then I restart as above. When SUDS are down to three or less, I dispense with the pause.

Once the client has reported SUD at zero, I check that they still have the memory of the event, and that it no longer upsets them at all. Then we proceed directly to Phase 5. Without worrying about whatever negative cognitions they may have had before I simply ask, "Now that we have done that, what do you believe about yourself?" Invariably they reply with a well-formed Positive Cognition, which I ask them to rate on the VOC scale. I then install the PC as usual. I ask them to bring up the target, as it no longer upsets them, repeat their new PC in their heads, and watch my fingers - keeping their heads still. I just reach my hand towards their position across from me and sweep my raised fingers left and right in a broad arc. Recently I bought an LED on an extensible pointer, on Amazon, to save reaching so far forwards and sideways.

Once they are at VOC=7, I ask them to do a Body Scan, as is usual in Phase 6. For each reported body sensation, I ask them to bring up the target, as it no longer upsets them, repeat their new PC in their heads and, while watching my LED - keeping their heads still, give all their remaining mental attention to the area reported. So Phase 6 is the same as in the Standard Protocol.

Other observations

In Phase 4, when the "uncon-

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scious brain" is engaged in this way, not only is desensitisation un-troubling for the client, but processing proceeds at least twice as fast. In one session one client processed four targets to resolution in 58 minutes!

I have used the FT 'Blind to Therapist' on targets which are shameful or hard to assess, and with clients for whom "Standard Protocol EMDR" would otherwise have caused (and has caused in the past) hyperarousal and/or dissociation. I don't need to know any details at all of a traumatic target. Nor do I need to know the happy memory the client is asked to keep in mind instead of the traumatic target, although many clients enjoy that so much, they tell me anyway.

I have also used the FT with a client whose dissociative childhood Emotional Part (EP) had thwarted our EMDR work for some time. The FT works just as powerfully with dissociative clients. I recently helped a client to process an originating trauma that caused a dissociative EP's formation from SUD =10 to SUD=2 in one session. My hypothesis that the right cortical hemisphere takes over AIP processing when the left is otherwise engaged may indicate that the limbic system is used to originating dissociation when the left hemisphere is attempting to process trauma. When the left hemisphere is thinking of a happy memory the limbic system does not need to go into survival mode, so perhaps the right hemisphere addresses the target without the limbic system becoming aroused?

Client experience

Rarely, the FT is not a preferred option for a client. One client tried it, and fully resolved an adverse event with it, but then felt discomforted by that, as she "didn't know how that happened – the change was as if by magic!" So she asked to go back to the Standard Protocol, as the more emotionally painful journey helped her to see how the change came about.

Another of my clients is a drummer in a band. He is so adept at doing many physical and attention tasks simultaneously that he could still think about the negative memory! (Perhaps a church organist might, too?) As the drummer had previously worked with me on several targets with Standard Protocol EMDR he had learned that processing targets more slowly and with greater emotional pain had given him a firm sense of hard-earned progress and, he said, "a significant catharsis". Subsequently, after much thought, he felt he should 'give Flash another go', and we've used it ever since.

In one of his recent sessions, SUDs were not decreasing. He admitted that he's so used to doing and thinking many things at once that some thoughts upon the real target were still getting through. I realised I needed to occupy his left cortex even more, so must increase the load on it. So, with his agreement, I stopped saying, "Flash" and said instead, in a random way, any number from 1 to 4. He was then required to blink that number of times! It worked very well. The client then suggested that I throw in some larger numbers, like 5 and 7. So then I picked at random from 1, 2, 3, 5 and 7 (all prime numbers, taking more concentration). This worked better, processing being faster. I enjoyed benefitting from such a Working Alliance.

Relationship

Last, but not least, clients may see your requests that they wave their arms about to tap their knees with you, and blink (very quickly, just using their eyelids, not screwing their eyes up tight) when you say randomly spaced 'Flash!' instructions and try to keep a happy memory in mind as 'all too much'. My experience is that they will do it, on trust, but only if you have already established a trusted therapeutic relationship with them. Once they have processed one target with the FT, their other targets process with increasing familiarity and speed.

My greatest learning has always come from trying things and my confidence in my use of the FT and my ever-growing admiration for its power soon followed its practice. I am, of course, still learning!

I hope these notes prove useful to those of my colleagues who decide to learn it, too.

Peter Eldridge is a Psychotherapist, Supervisor and EMDR Practitioner at Objective Reach Counselling Services & 3 Counties Counselling Service

We welcome your words

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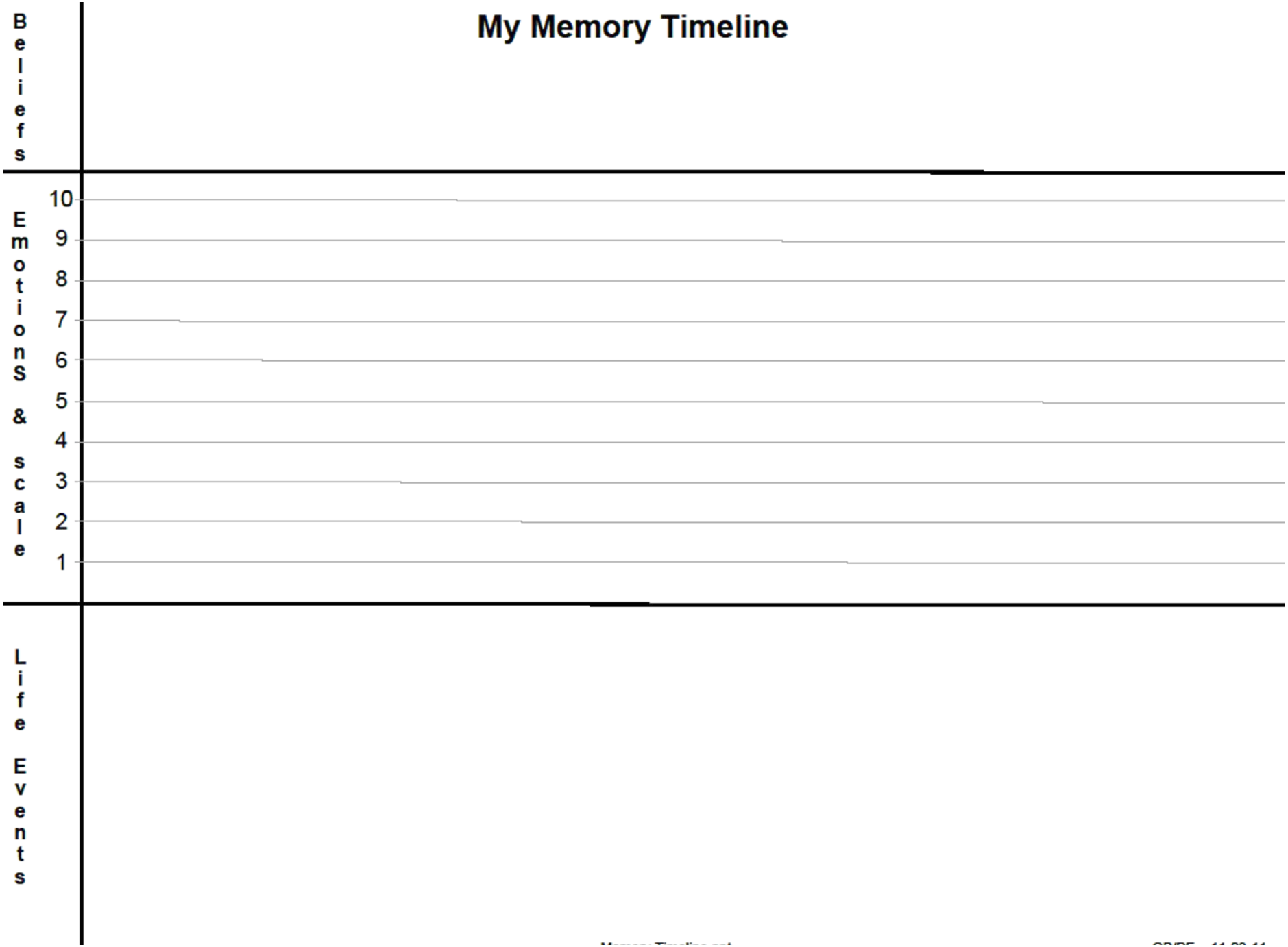
My Memory Timeline
Beliefs
Emotions & scale
10
9
8
7
6
5
4
3
2
1
Life Events

A tale of three sessions: the art of the possible

Justin Havens briefly outlines the use of the Flash Technique and EMDR in a recent case

The following case study demonstrates that it is possible to make therapeutic progress in very few sessions, even with clients with significant trauma and high levels of emotional dysregulation using EMDR and associated approaches.

Background

A male client in his thirties presented with emotional dysregulation, paranoia and relationship issues stemming from two significant periods of childhood sexual abuse from ages of four to 11, following adoption at an early age. The client reported poor sleep and a variety of nightmares including being chased through woods by a gang of men and then being raped. The nightmares caused significant distress even though the experiences in the dream had not occurred in real life. Nonetheless the client woke up every night sweating and unable to resume sleep.

Having tried other approaches over the years with little impact, this client was ready and motivated to participate. He also had limited funds and wanted to get the most out of the sessions. We had established a good rapport and agreed nominally on seeing what could be achieved in three 60-minute sessions.

Session 1

This focused on a basic history, taking care not to permit the client to go into any details of the abuse he suffered. I taught him the calm place and the Dream Completion Technique to resolve his nightmares. I used the five-minute animated video to teach the technique, and then we discussed what the client wanted to put into his dreams to help them 'complete'. It was important to reassure the client from the outset that we wouldn't be talking about his trauma and that he wouldn't have to recount what happened. Tackling the nightmares first was also a way of stabilising him, starting the process of healing from the inside out, and building his confidence in the therapeutic process. The client took the ideas on board and had indeed tried to experiment with lucid dreaming before, but without success. Importantly, he accepted the idea that the dreams were his and that he could add dream content.

Although he had a variety of nightmares, we focused only on the most recent one and what he wanted to have happen next. He came up with two ideas: a tree falling on the 'bad guys' and squashing them, or blasting off into space on a rocket. I asked which felt stronger, and he went with the rocket idea. I then asked him to think about it before going to sleep with the thought 'this is what I want to happen in my dream'.

Session 2

Feedback on sleep was positive – although he was still waking up, he was much less distressed, couldn't remember the dreams and generally felt better in the morning. I decided then to introduce the Flash Technique (FT) to reduce the disturbance of his traumatic abuse. My rationale was that the trauma was still likely to be extremely disturbing and the FT offers an opportunity to start reducing disturbance levels without focusing heavily on the trauma.

There were two significant perpetrators, and these were the targets selected. I did not ask for SUDs but did emphasise that the perpetrators were far away. However, even talking in the most roundabout way about the trauma seemed to engender some dissociation (apparent from the client's fa-

cial expressions). I used a spiky ball to play catch to ground him and bring him back to the room, which worked well. This client had a good 'positive engaging focus' from his experience of playing rugby as a teenager. He proceeded to do the 'triple blinks' as instructed whilst we talked about his most memorable rugby game. He reported some change (memory more distant) after the first set. However, I could see that he was still easily being 'sucked' into the trauma when checking in with the memory (and still not asking for SUDs). A few more ball catches were required.

After two more sets and more distancing, I checked the SUDs which had reduced to 8 – It was now much safer to ask the client to rate his distress. Each perpetrator was labelled, and then we did a further set before stopping. He was able to say the name of the abuser at the end without dissociating. Had standard EMDR been used instead of the FT, I don't think the client would have been able to tolerate it, and he would certainly have dissociated. Processing would therefore have to be taken very slowly, additional tools such as CIPOS would be required, and it would be hard work for client and therapist alike.

Session 3

The client had talked about his abuser with his girlfriend in between sessions without getting triggered; he said this was significant. Both main targets were still SUDs 8 at the start of session. I briefly installed some resources which included nurturer, protector and wise figures and then explained the EMDR process, instructing him that if he felt he was dropping more than 50 percent into the trauma, we should stop and play catch with the spiky ball. I then set up the first target using Parnell's modified EMDR protocol , emphasising that he didn't need to describe the image (see *Attachment Focused EMDR*, 2013, p180, Norton). By using the shorter assessment, I reduced the time the client was in the traumatic memory, whilst also making sure the memory was activated.

I just asked him to think of the worst image from the abuse with perpetrator 1 (which took place over a few years), how it made him feel, where in the body it was and the Negative Cognition ('I'm a victim'). I used a retractable wand to facilitate eye movements. (I find the wand indispensable - no sore arm and no ships in the night). I was amazed that after the first set, the image had disappeared. I facilitated a few more sets until there were no remaining feelings and body sensations, and the PC ('I've dropped it') was installed, followed by a body scan.

I then needed to let this work sink in as the client was surprised about what had just taken place. We talked about it for about 10 minutes, and with 15 minutes to go, I asked client if he wanted to deal with the second perpetrator, who had abused him multiple times over a number of years until the age of 11. He was up for it and, this time, the emotion was rage. After a few sets this drained from his body, along with the image, leaving him feeling calm and free. We installed this feeling and followed it up with a body scan. The client was very happy.

Discussion

Both my client and I were amazed at how fast the processing was. I believe this was due in part to the client's readiness for therapy, high motivation and a good rapport with me. However I also believe that the sessions comprised a blend of approaches - the FT, the Dream Completion Technique and EMDR - used in a coherent and effective way. The process of resolving nightmares, using the FT to reduce trauma intensity and stabilise and finally EMDR to adaptively process the trauma seemed to flow one to another and work very well together. It was almost as if this work had 'tuned' the mind's innate trauma processing system, as it appeared to be much faster and more effective than standard EMDR trauma processing.

Not every client is like this of course, but I was amazed at the ease and safety of tackling such a client. Of course, further follow up is required. But I hope this brief case study is helpful and demonstrates what is possible when the conditions are favourable.

For more about the FT or Dream Completion Technique, please contact Justin at: mail@justinhavens.com

Dr Justin Havens is an EMDR Consultant and Supervisor with a private practice in Cheltenham

Sharing my mistakes: Lessons learned using EMDR tools for addiction recovery

Annabel McGoldrick reviews what she has learned from working with addiction

My first therapy job, after beginning basic EMDR training in 2007, was in an addiction treatment centre in Australia called South Pacific Private, which used a trauma-based approach to support clients in their recovery. I found EMDR a great extension to my tool kit and a really good fit for my private work. I began experimenting at an early stage with some of the well-known protocols including DeTUR, the urge reduction protocol (Popky, 2005), Jim Knipe's tools for treating addictive disorders with Adaptive Information Processing (AIP) Methods (2015); Laurel Parnell's Attachment Focussed EMDR (2013) and later her Rewiring the Addicted Brain (2018) and Robert Miller's Feeling State Addiction Protocol (FSAP). I have found something useful in all of them, but I tend to use the FSAP most frequently to reduce the euphoria and buzz that goes with addiction. I have made quite a few mistakes as well as breakthroughs, which I'll share in this article.

What do we mean by addiction?

According to Brewer (2019), addiction is the 'continued use despite adverse consequences'. This is the simple definition given in his useful psycho-education video about everyday addictions, which I often send to clients. However, I prefer the definition I offered family members in my role as family therapist at the hospital: 'actions or behaviours that are beyond the control of the conscious mind that have life threatening consequences' (South Pacific Private, 2009). To me this is what makes addiction an ideal target for EMDR, both in the trauma that often causes it and the unconscious drivers that maintain it. It's estimated that globally 35 million people suffer from drug use disorders (Grisel, 2019) so, as EMDR therapists I think it's really important to understand how to help clients recover.

Twelve keys

Attending a talk by Robert Miller in November 2018, I realised that I'd been wrongly implementing his FSAP. It was apparent that he had made a number of changes to the protocol since I'd first learned it. So, let me outline some key learning points that helped me to understand how to use this protocol more effectively and how to link with other EMDR tools to bring relief to clients struggling to overcome the debilitating symptoms of addiction.

In summary the FSAP (see Figure 1) requires that we make the Feeling State (FS) our first target. According to Miller, "addictions are created when a desired feeling and behaviour become fixated together". This "fixation" of feeling, which Miller now calls an Assured Survival Feeling (ASF), is "linked with specific objects or behaviours to form a state dependent memory" (Miller, 2017, p. 10). Note that there may be many ASFs. The Positive Feeling State (PFS) measures the strength of the association between the ASF and the substance or behaviour on a scale of 0-10. The FSAP uses the AIP model to integrate isolated neural networks of emotions and physical sensations that were created during a positive event using a behaviour or substance . Some readers may notice similarities with Jim Knipe's Level of Positive Affect (LOPA) – a potentially controversial matter that is outside the remit of this article. The focus here is on what I've learned in applying Robert Miller's FSAP. This includes both my interpretation of certain nuances in the protocol and learning from the mistakes I have made in my experience of working with it. I have called this my 12 Keys to working with addiction.

Key 1: Target selection

Targets are selected following Phases 1 and 2 of the Standard Protocol (SP) but the latter must include explaining to clients how fixated memories cause behavioural and substance addictions and that such addictions can also serve to avoid painful memories and feelings. In Phase 3 (Assessment) the therapist helps the client to identify the FS. The FS is what the client feels at the most intense moment of their drug 'high' or addictive behaviour. I sometimes invite the client to run a movie in their head, from the planning through to the consumption (or behaviour), then ask them to press pause and to focus on the most intense moment.

Some people may find it easier to think about the FS as an Addiction Memory (originally

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The Feeling State Addiction Protocol (Robert Miller Manual, 2017)

Phase 1: History and Evaluation

1. Obtain history, frequency and context of the addictive behaviour.
2. Evaluate the person for having adequate coping skills to manage negative feelings if the person is no longer using substances to cope. If the person is too fragile for releasing the addictive behaviours process the pain, terror, and traumas until s/he is capable of coping without the addictive behaviour.

Phase 2: Preparation

3. Prepare the person for doing the standard EMDR protocol – explanation of EMDR safe place, container, etc.
4. Explain the FSAP including the Feeling State Theory and how fixated memories cause behavioural and substance addictions.
5. Explain how addictive behaviour can also be used to avoid memories and feelings.

Phase 3: Processing the FS

6. Identify the specific aspect of the addictive behaviours that has the most intensity associated with it. if the addiction is to a stimulant drug, then the rush/ euphoria memories are usually process first. However, if some other memory is more intense – process that first. The starting memory may be the first time or the most recent – whichever is most potent.
7. Identify the specific self-referential positive feeling (ASF) linked with the addictive behaviour.
8. If the ASF is a drug-induced Sensation-FS of rush or euphoria, release the Euphoric Sensation Release Protocol (ESRP). Then continue to step 9. If the ASF is not a drug-induced Sensation-FS, go to step 9 without ESRP.
9. Measure the intensity of the link between the feeling and the behaviours using the PFS (0-10) scale. The PFS always measures the intensity of this link. (e.g. When you imagine yourself smoking with your buddies, how intensely do you feel that you belong?)
10. Locate and identify any physical sensations created by the positive feelings.
11. Have the client combine 1) visualising performing the addictive behaviours 2) intensely experiencing the positive feeling and 3) feeling the physical sensations.
12. Perform BLS until the PFS level drops to 0 or 1.
13. Scan the body for any sensation. Perform BLS until there is no sensation related to the FS.
14. Process the hyper-need for the desired feeling. Obtain a SUDS level of the feeling as a general feeling not connected with the behaviours. (Can you feel your general desire to belong? Feel important? Etc?)
15. Perform BLS until the SUDS = 0 or 1.
16. Reevaluate the FS. Perform BLS until PFS = 0 or 1. (when you think of the original memory, on 0-to-1 scale, how intense is it now?)
17. Give homework to facilitate evaluation of the progress of therapy and to elicit any other feelings related to the addictive behaviour.
18. In the next session, reevaluated the addictive behaviours for the feeling-state identified in the last session. If that FS is still active, continue processing. If the FS has been eliminated, evaluate for other FS or avoidance dynamics, as appropriate.
19. Steps 5-18 performed again, as necessary.

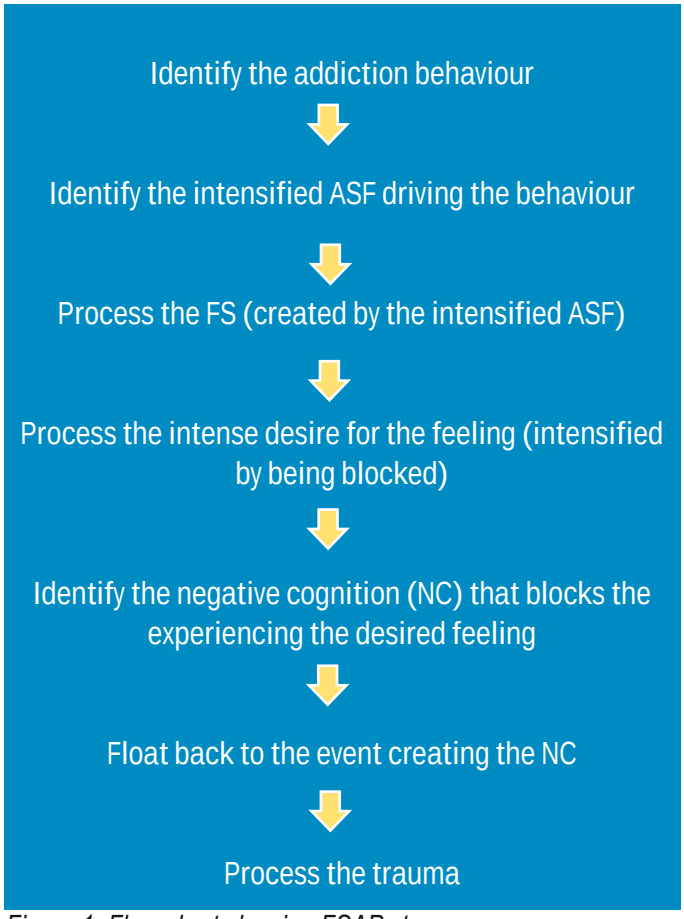

Figure 1: Flow chart showing FSAP steps

Phase 4: Process the NC underlying the FS

20. Identify the NC underlying the feeling. (What's the negative belief you have about yourself that makes you feel you can't belong? Can't connect? Aren't important? Etc?).
21. Use the float-back method to identify an event related to that feeling. If no event is identified, target the NC. (Can you remember an event that made you feel that way?)
22. Process with the standard EMDR protocol.
23. Install a future template related to the PC of the trauma processing.

Phase 5: Process the NC caused by the FS

24. Determine the negative belief that was created as a result of the addictive behaviour and have the client choose a positive belief.
25. Use the standard EMDR protocol to process the negative beliefs and install the positive beliefs.

Phase 6: Process the memories and images that may cause anxiety about relapsing

26. Identify the image or memories related to expectations or anxiety about relapsing.
27. Process the identified image or memories with the standard EMDR protocol.

defined by Boening, 2001 in Knipe, 2015, p. 102) and contributed to by Hase and colleagues (2008) who described it as "a non-conscious, implicit memory with craving for a substance as its conscious manifestation". Hase's contribution is very important in that it points out that much of what drives addictive behaviours is non-conscious. Most addictive states of mind have an aspect that is automatic and therefore not under direct conscious control (Knipe 2015, p. 102), The Feeling State, then, comprises the most intense positive feeling and the embedded ASF,

Safety: safe, secure & in control
Relational: bonding, connected, important, special, powerful, strong, invincible, acknowledged, "I exist", "cared for", whole.
Winning: "the man", "big man on campus", feminine, masculine, smart, winner, approval, reward, "I can have what I want."
Sensation / alive: excitement, danger, aliveness, euphoria, alive.

Figure 2: Categories of ASFs Embedded in the Feeling States

including the associated cognitions, emotions and physical sensations.

Key 2: Assured Survival Feeling

The ASF is the positive feeling that is embedded in FS. It drives the compulsive behaviour and is usually unconscious; it is a feeling that's underneath the FS. It is crucial to understand the difference between the FS and the ASF. My mistake in the past was merely to identify the most positive feeling, but this may simply be the result of meeting the ASF's needs, cravings or urges.

Let's imagine, for example, a client who may be feeling unsafe or that they don't belong. They may not be in touch with these feelings and therefore unable to articulate them clearly. Let's say they discover that, by eating chocolate, those feelings temporarily disappear and are replaced by a feeling of calm and relaxation, which they then report as the most intense feeling. It is all too easy – as I have found in the past – to misidentify the feeling of calm and relaxation as the FS and potentially pointing to a 'false' target. In this example, the target should instead be the feeling of safety or of belonging, which the client temporarily enjoys via eating chocolate (i.e. the feelings of calmness and relaxation are additional but not drivers of the addiction). In this example, then, the ASF is the feeling of safety or belonging that is experienced at the peak of the addiction behaviour.

It is the ASF, the positive feeling the client is seeking, that I find particularly useful in Miller's protocol. With this understanding it is easier to see why addictions persist even though trauma memories may have been fully processed.

Miller recognises four categories of ASF: Safety, Relational, Winning and Sensation – alive (see Figure 2). I find these useful in helping clients to tease out the ASF. Miller explains that only people with some developmental deficit in their early life will have the urge to artificially create such feelings. This is consistent with many theories of addiction as an attachment-based disorder. 'The wondrous power of a drug is to offer the addict protection from pain while at the same time enabling her to engage the world with excitement and meaning (Mate 2018, p. 39). In other words, people with a secure attachment do not tend to develop addictions. For a victim of bullying who consequently feels like an outsider, the craving for cigarettes is not about the nicotine but about membership of the group that smokes behind the bike sheds.

Key 3: Link between behaviour and ASF

We're not just asking the client to measure how positive the feeling is, but how strong the link is between behaviour and ASF e.g. 'When you imagine yourself smoking with your buddies, how intensely do you feel that you belong? (Miller 2017, p.68)' Or I might ask 'When you imagine yourself smoking with your friends, how much is that linked with that sense that you belong?" An easy mistake to make is to focus on the strength of the positive feeling rather than the strength of the link between the addiction behaviour and the ASF.

Key 4: No free association

In Phase 4, we desensitize the memory by inviting the client to imagine replaying this most intense moment whist focussing on the positive feeling (ASF) and the body sensation. We then add bilateral stimulation (BLS), eye-movements, audio or tactile, and between saccades ask for feedback on the PFS; i.e. the strength of the link between behaviour and ASF. We can ask: 'is the link increasing or decreasing?' until the PFS drops to 0 or 1. Note that, unlike in standard EMDR, we are seeking only to desens-

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itise the PFS; we don't want the client to free associate. That comes later when we're targeting the trauma underlying the dissociation. Again, this was a mistake I'd made in my early use of the FSAP which led to long and messy forays into irrelevant channels.

Key 5: The FS can be both a pleasure-seeking and a trauma-avoidance strategy

In his manual, Miller makes it clear that the FS is about seeking pleasure not avoiding pain or trauma. Personally I don't think it is that simple. The way I see it is that there is usually both avoidance of pain and seeking of pleasure. "It originates in a human being's desperate attempt to solve a problem: the problem of emotional pain, of overwhelming stress, of lost connection, of loss of control, of a deep discomfort with the self. In short, it is a forlorn attempt to solve the problem of human pain (Mate, 2018 p. xix)."

Miller advocates that if the person is avoiding a feeling, the therapist should first work to identify and process the memory generating the guilt. For example, he writes, in the case of a gambler avoiding feelings of guilt, "the therapist should use the SP to clear the memory generating the guilt. But in working with a gambler seeking a feeling of winning the therapist should use the FSAP" (Miller 2017, p. 4).

I see the FS more like a lid, a form of dissociation that sits on top of the trauma, removing the pain and the memories. If we correctly identify and process the FS target, it can shift very fast and the client's natural bodily responses to excessive food or alcohol will return, e.g. nausea. As mentioned earlier, only clients with a developmental deficit get this positive 'hit/high' from unhealthy behaviours. So it is the ASF they are compulsively seeking; e.g. a sex addiction is never about the sex but the feeling of adoration or safety. I tell my clients that I want them to have the positive feelings of safety, aliveness, belonging or winning as a matter of course and not by harming themselves through addiction.

In my experience of using the FSAP, I hadn't fully understood the relationship between the FS and the trauma and why we needed to process both. As Knipe says, "addictions often function as defences and incorporate both the avoidance affect (i.e. positive feelings of escape or relief from troubling feelings) and the positive affect of defensive idealisation (i.e. unrealistic overvaluation of an image, concept, action, or part of self)" (Knipe, 2015, p. 101).

A report issued by the National Center for Post-Traumatic Stress Disorder and The Department of Veterans Affairs showed a strong correlation between trauma and addiction in adults: An estimated 25-75 percent of people who survive abuse and/or a violent trauma develop issues related to substance abuse (Parnell, 2018, np)

Key 6: Process past traumas to complete the process

Miller proposes a few extra steps that are helpful before going directly to the trauma. He recommends that we:

a. Process the hyper-need for the desired positive feeling (ASF) e.g. belonging, safety, connection. Ask the client to 'feel the need for the feeling X (state the feeling) as intensely as you can. On a scale of 0-10 how intense is it? Where do you feel it in your body?' Do BLS until the number is 0 or 1 (Miller 2017, p. 57). I believe this step to be very similar to Popky's measure of Level of Urge for the substance or behaviour used in the DeTUR protocol that focuses on desensitising the triggers.
b. Miller then recommends identifying the negative cognition (NC) that underlies the feeling. (What negative belief do you have about yourself that makes you feel you can't belong? Can't connect? Aren't important? etc?).
c. Ask: What emotion & body location goes with that NC?
d. Go back to earliest touchstone memory. I find Laurel Parnell's Bridging technique to be the most simple and effective wording for this. First ask your client for an emotion and body location as they think of that NC then say: 'Trace it back in time. Let whatever comes up come up without censoring it (Parnell, 2017, p. 177)'. Parnell recommends not to ask for a memory 'to keep the clients out of their heads, and their thinking, instead make this a right-brain experience (p. 175) I haven't had a client yet who has been unable to recall an early life incident. If you draw a blank, try again or add BLS before attempting a second or third bridge.
e. Process the touchstone memory with the Standard or Modified protocol (Parnell 2013, p. 183) to SUDS of 0 or 1; install PC until there is a VoC of 7 and a clear body scan, thus completing Phases 4-7 of the SP.
f. Create a Future Template of

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achieving the desired positive feeling (ASF) e.g. feeling of belonging or connectedness by doing something other than the addiction behaviour (this will generate an alternative image to work with). I believe this is very similar to Popky's Positive Treatment Goal during the preparation phase of DeTUR. Here he recommends inviting the client to think of an imaginary day in the future where they are free from the need to smoke, drink, use pornography etc.

g. Have the client imagine feeling that desired positive feeling (ASF) e.g. feeling of belonging or safety as part of themselves. E.g. Where do you feel that ASF in your body? Add BLS. This is very similar to Popky's Positive State which, again, forms part of the preparation phase of DeTUR.

h. Check the PFS, the link between the addictive behaviour and the ASF e.g. feeling of belonging or connection. If it is greater than zero, add BLS until it is reduced to zero.

i. Many people find being caught in an addictive cycle shaming and disempowering. This can generate NCs such as: 'I am out of control' or 'I'm a failure' which will also need to be reprocessed. 'Determine the negative belief that was created as a result of the addictive behaviour and have the client choose a positive belief (Miller, 2017, p. 69)'. Process using the SP and install PCs like 'I am in control' or 'I can succeed' to a VoC of 7.

j. Identify the image or memories related to expectations or anxiety about relapsing. "Process the identified image or memories with the Standard EMDR protocol (Miller, 2017, p. 69)."

Key 7: Several FSs

It is common for there to be several feeling states each related to one of the four ASF categories (see Figure 2). Often these are generated by different stages of the addictive process, from fantasizing and planning the drinking or eating binge; buying the alcohol or chocolate; pouring the booze or unwrapping the chocolate; through the first sip or bite of chocolate. Each of these steps could have its own FS that all need to be processed separately. Addiction is held in place by a complex of set of threads that all have to be unpicked. Jim Knipe has a helpful picture in his *EMDR Toolbox* of two interlocking hands with the "clenched fingers symbolizing the many separate factors (dysfunctional channels of information) that maintain the tight hold of an addictive disorder" (Knipe, 2015, p. 114) these include: ways to dissociate, avoidance of disturbing memories, a way to feel good, addicted family and friends, how long the person has been addicted, unexpected triggers.

Key 8: If at first you don't succeed, try, try again

The FS target selection can be tricky and working with any addiction is complex. Using trial and error in a spirit of curiosity, experimentation and exploration is very important. Loosening the grip of the separate interlocking factors of addiction takes time, diligence, patience, commitment and acceptance from both client and therapist.

Key 9: 12-step programmes

Robert Miller believes that 12-Step Programmes are unnecessary partly because the FSAP does not require abstinence and many clients can enjoy non problematic use of alcohol, sugar, gambling etc. after clearing the FSs. The goal of the FSAP he says is "not to quit but to no longer want to do the addictive behaviour" (Miller, 2017, p. 12).

However, others like myself, Knipe, Popky and Parnell believe it's not a 'one size fits all' and that 12-Step programmes can be helpful. Some people benefit from the support network they offer and I have found that they can make a huge difference to a client's capacity to achieve abstinence or non-problem use. The primary objection many have is that 12-Step Programmes are religious; members talk about God, although this is intended as a God of your understanding.

In addition to the original Alcoholics Anonymous, fellowships for other addictions using the same 12-step structure and philosophy have been established. They exist for addiction to food, pornography, sex, love, debt, work and so on. Co-dependents Anonymous helps those in relationships with addicts and Adult Children of Alcoholics Anonymous helps those parented by addicts or dysfunctional parents.

Key 10: Psychoeducation about addiction

It's often helpful for clients with addiction issues to understand where they are on the spectrum of addiction (see Figure 2), which is about frequency of use and consequences experienced.

- Abstinence means they don't

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use e.g. alcohol at all;
- Non-problem use means they use alcohol like a beverage so may not even finish one glass.
- Problem use means there are consequences to drinking, the client may open a bottle then not be able to stop until they've drunk the whole bottle, thus having a mild hangover the next day.
- Abuse means they may drink between one and four bottles of wine when they take a sip, thus experiencing a very severe hangover and even the next day off work perhaps once a month.
- Dependency means they must have a drink every day or experience seizures and withdrawal.

Stages of recovery are also classified:

1. Pre-contemplation is a state of total denial: 'what do you mean? I don't have a drinking problem, leave me alone';
2. Contemplation: 'I might have a problem';
3. Preparation for recovery and abstinence, removing alcohol from the house, attending a 12-Step Programme, Therapy for trauma and Feeling States;
4. Action to get clean;
5. Maintenance of healthy living. (Stages of Change Model, accessed 2019.)

I found Pia Mellody's Codependency model useful in understanding the ego states of addicted clients (See Figure 3). The Wounded Child (WC) is the part of self who responds to the childhood trauma by: having low self-esteem; no boundaries; distorts reality by filtering feelings and events to protect their vulnerability; overdependency on others; behaving immaturely, chaotically and impulsively.

The WC is directly contrasted with the Adapted Adult Child (AAC). The AAC responds to the childhood trauma by having high self-esteem, feeling better than others and putting up walls rather than boundaries so that nothing gets in and nothing gets out. The AAC distorts reality by filtering feelings and events as a way of protecting vulnerability; being anti-dependent on others and manifesting super maturity, often by being extremely controlling.

The Functional Adult (FA) is right in between the polarised ego states of the WC and AAC. This healthy version of self has healed their childhood trauma so feels equal to others; has healthy boundaries to protect and contain the self. The FA can accept reality and accept life on life's terms; is interdependent and is appropriately mature or carefree and flexible according to the circumstances.

The Codependency Model bears some similarity to Richard Schwartz's Internal Family System (IFS) model with the Manager, Fire-fighter, Exiles and healthy Self in the middle. I find both models can be useful in helping clients to understand and separate their emotional parts and defences as well as giving them a map of health and wellbeing.

Mandy Seligari in her book Proactive Parenting (2019) offers a useful list of the Core Characteristics of addiction and codependency. If you're new to the field of addiction recovery I recommend you read her book or watch her TedX Talk (Seligari, 2017). The book is an excellent tool for clients to understand themselves and other family members, particularly children.

Nature of the child	Core Issues	Primary Symptoms	Secondary Symptoms	Relational Problems	The Functional Adult
	Childhood Trauma → *causes* Immaturity → *both drive* Unmanageability → *all 3 create* Problems with intimacy Wounded child ↔ Adapted child				
Valuable	Self esteem	Less than ↔ Better than	Chemical addictions Process addictions Eating disorders Money disorders Depression Anxiety disorders Rage issues Intimacy issues Control issues Spirituality issues Physical illness	Problems with intimacy Enmeshment Avoidance issues Dishonesty Problems with interdependence Love addiction Love avoidance	Esteem for his/herself from within
Vulnerable	Boundaries	Too vulnerable ↔ Invulnerable			Is able to protect and contain both his/herself
Imperfect	Reality	Bad/rebellious ↔ good/perfect			Accepts imperfection in self and others
Dependent	Dependency	Too dependent ↔ anti dependent			Is aware of, and appropriately meets, needs of self and others
Spontaneous & Open	Moderation	Out of control ↔ controlling			Is able to be spontaneous, open and moderate

Figure 3: An overview of developmental immaturity *© Pia Mellody*

Key 11: EMDR Resources

In the preparation phase, with all my clients, I always install Laurel Parnell's external nurturing, protective and wise figures (Parnell, 2013). I find this to be vital when working with any com-

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plex trauma of which addiction is an outcome.

It's also really important to reinforce the clients' personal store of positive feelings as ways of surviving without that addictive behaviour. I ask the client to find create an image of a day in the future when they are free from their addictive behaviours. What would be good about that? Perhaps clients wanting to overcome an alcohol addiction can see themselves at a party drinking only soft drinks, feeling clear-headed and confident. Or someone with morbid obesity can imagine themselves six stone lighter, with their family or playing football with a child and feeling strong, confident and free. Once they've got a good sense of that goal, strengthen it with BLS. As mentioned earlier this is part of Popky's DeTUR Method (2005).

I like to help clients identify certain positive feelings they want to feel more often, such as confidence, courage, hope, strength, groundedness, safety. One way of doing this is with Arne Hoffman's Absorption method where the client recalls memories of having such feelings. I like to embellish this by drawing a picture of a gingerbread person and asking the client to assign a colour and body location to the feeling then add BLS. Next, I ask the client to draw that colour and body location on the gingerbread person. Many clients photograph the picture to use at home themselves on a difficult day, looking at the photograph and giving themselves the butterfly hug.

Parnell, in Rewiring the Addictive Brain: An EMDR-Based Treatment Model for Overcoming Addictive Disorders,

An example of of how I have used Miller's FSAP

Janet (not her real name) was 39 years old, a mother of two children with special needs. We had already had about 12 sessions during which we worked on trauma that had resulted from the domestic violence she had experienced. Her next goal was to stop binge eating cakes and chocolate. At times, Janet said she would miss meals so that she could eat a family bar of chocolate, a cake or bag of Maltesers alone.

Janet recalled a recent binge of chocolate and located the most intense moment as being when she tasted the chocolate in her mouth. That's when she would experience a 'fizz' in her stomach, she said: "it's a treat, a reward for getting through the hard stuff", she said. In other words, the ASF for Janet was to do with Miller's 'winning' ASF category and to do with status [Keys 1&2]. The first PFS measure, for the link between eating the chocolate and sense of winning was eight (PFS = 8) (Key 3). I added BLS (using audio & tactile buzzers) and after several sets of BLS, the PFS reduced to zero (PFS = 0).

Then I asked her to think about the first time she binged on chocolate [Key 4]. She recalled being seven years old and stealing chocolate from the kitchen cupboard and eating it whilst doing her homework. Again, the most intense moment was the first morsel of chocolate entering her mouth to give the buzz of taste, with the linked ASF of reward, and winning. The PFS this time was seven (PFS = 7). I added BLS and after several sets of BLS the PFS reduced rapidly to zero (PFS = 0).

Next, I asked her to think of the worst binge she'd had. She recalled having a break from the children, she had planned the binge to be at a time when she would be away from home, alone, and free to eat a huge amount. Again, the most intense moment was the chocolate entering her mouth, to give the buzz of taste with the linked ASF of reward and winning. The PFS was eight (PFS = 8). I added BLS and after several sets of BLS the PFS reduced to zero (PFS = 0) and she said, 'yuck, it's too much'.

We then followed Miller's further FSAP steps. I instructed her, "now I want you to feel the need for the feeling of reward as intensely as you can. On a scale of 0 to 10 how intense is it? Where do you feel it in your body? [Key 6] Provide BLS until the intensity of need drops zero. She said that the need for reward was intense and that she felt it most in her solar plexus. After a couple of sets, this rapidly shifted to zero. Next, I indentified the NC underlying the feeling (Key 6 contd.). I asked her, "what negative belief do you have about yourself that makes you feel that you can't have what you need (in terms of that feeling). She said, "I don't deserve it". She identified the sensations related to that feeling as "exhaustion".

Then I did a Parnellian Bridge: inviting her to trace "the exhaustion and the sense that you don't deserve it, back in time as far as you can go without censoring". After a short pause I asked what had come up, where she was, and how old she was then. She said she was five years old and her Gran was feeding her two younger

has a long list of resources that can be tapped in, including memories of times of gratitude and inspiration; a circle of love; ideal mother and father; dream recovery team; resources for parts (ego states) to have their own safe place, with carers and to store these images inside the body (Parnell, 2018, np).

Key 12: Consequences

Parnell recommends installing with BLS a negative future image as well as a positive goal image. I have tried this a few times when faltering with the FSAP. I ask the client, "so what would happen in five years' time if you carried on eating like this, how big will you be, where will you be living, what job will you have? Imagine

brothers but there was no food for her because, in Gran's words, "boys are more important than girls". Her NC was "I don't deserve it". She felt sad in her stomach. As we were short of time I didn't take a SUDs rating. In a few sets of BLS the sadness had gone. And Janet said: "I always thought there was something wrong with me, but this is ridiculous. This is wrong, boys are equal to girls". Her adult self wanted to share this insight with her child self. We then installed a PC of 'I am good and deserve it'. Her VoC rose to 7 and her body scan was clear.

Miller's next step is to develop a future template in which the needed positive feeling (ASF) is obtained and internalised without doing the addictive behaviour. I asked her "what could you do in the future to get that feeling of reward?" She replied, "I can have a drink of water or some nice perfume (she makes her own perfume)". that...", and add BLS. I have then done a two-handed interweave: one future in one hand (e.g. the goal image, the positive future) and the image of the negative future in the other. The therapist commences eye movements or tapping, or the client can alternate opening and closing hands (just notice). If there is distress in one or both of the choices, it is cleared with the SP. Both hands are then rechecked (Shapiro, 2005, p 161.)

One of my clients saw himself 10 stone heavier, sat in a chair, depressed, having lost his wife, child and job. He cried when BLS was added. His goal image was five stone lighter, at a party socialising, happy, then playing football with his son. He smiled and felt happy when BLS was added. He put the negative image in his left hand, the positive image in his right, and after several rounds of BLS felt more motivated to achieve his goal and avoid his negative future. Jim Knipe suggests inviting the client to give a percentage on their Level of Motivation to quit (Knipe, 2015, p. 110). In this case the client felt 70 percent motivated. I'm planning to measure this again in future sessions.

Pam Virdi in her book, *Trauma informed approaches to eating disorders* suggests inviting the client to write two letters, one to their friend the eating disorder and the other to their foe, or the enemy the eating disorder. Again this can be turned into a two hand interweave to add BLS, as described above.

Dr Annabel McGoldrick is EMDR Consultant based in Oxford UK and Sydney Australia, she's a member of both EMDR Association UK & Ireland and EMDR Association Australia

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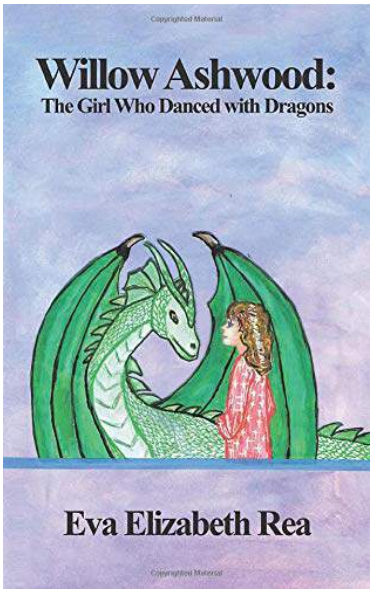
A story that inspires the courage to heal

BOOK REVIEW

Willow Ashwood : The Girl Who Danced With Dragons
by Eva Elizabeth Rea

Dragon's House, 2019
ISBN-13: 978-1999370701



Reviewed by Rita McGrath

This remarkable short novel tells the story of a lonely teenager who is struggling with the traumatic experiences of living with an emotionally abusive mother and witnessing parental discord and paternal violence. It could be helpful for adolescents who may be struggling with similar difficulties but have reservations about seeking therapeutic help. It could also be beneficial for adults who are addressing childhood abuse in their therapy.

The editor describes the book in the following way:

"Willow Ashwood is sad because her parents fight at home, but play happy families in front of other people. Running, love of dogs and belief in the extraordinary, help Willow when she is sad. This gripping psychological fantasy novel will help teenagers and grown - ups to talk openly about their mental health and achieve their goals. Let Willow show you the way."

The author, Eva Rea, is a psychologist and EMDR Consultant who works both privately and in the NHS with children, adolescents and adults. In her unusual novel, she explores themes frequently experienced by teenagers and adults who may have reservations about embarking on therapy. For instance, why would they benefit from talking about private family matters to a complete stranger? And if they've been let down in the past, why would they be willing to trust someone new? Why would they choose to open up old wounds and risk having more flashbacks or nightmares than they already have?

Willow's colourful and fantastical journey brings her into contact with other young people also struggling with their feelings and difficult memories. Willow makes friends with these young people and, in this way, Rea gently encourages her readers to realize that they are not alone. Like Willow, they learn that when they can risk sharing some of their personal trauma with others, the healing can begin. Rea indirectly reflects on the common assumption of adolescents, namely that they are the cause of the problem. It is their fault if life is bad, so they deserve no better! This may be what abusive adults have told them, and it sticks.

Animals, especially caring and protective dogs and dragons, feature prominently in this story. This may appeal to young people who think that adults can never fully understand them. However, this book doesn't shy away from the reality that some animals and people are not to be trusted. Readers understand that teenagers might need help in developing their own intuition about whom to trust. This process takes time; through making mistakes and showing their vulnerability they gain the necessary experience that can guide them in the future. A wise adult, perhaps a therapist, can guide them towards a growing self-awareness.

This is not a preachy story but one that gradually pulls the reader into a different world and offers new insights including:

- It often helps to share thoughts and feelings about difficult experiences with a therapist, knowing that they will listen without judging;
- It's natural to have mixed feelings about therapy, and it's good to talk about those too;
- It's not uncommon to have family problems which affect how we feel about ourselves;
- Sometimes such feelings can be so overwhelming that it's natural to want to dissociate from them;
- Therapy can help us to understand ourselves better and improve self-esteem;
- We can develop adaptive ways of managing unhappiness, e.g. running, creativity, caring for animals;
- Nightmares and flashbacks may be the body's way of helping us to recognize that we need to deal with traumatic memories.

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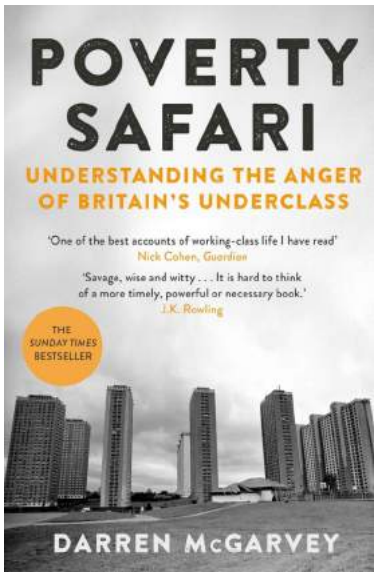
BOOK REVIEW

A lesson in hypervigilance for therapists

Poverty Safari: Understanding the Anger of Britain's Underclass by Darren McGarvey

Picador, 2018
ISBN-13: 978-1529006346



Reviewed by Russell Wharton

As a trauma therapist, how do you view hypervigilance? Do you measure it as a symptom of PTSD? Something to be scored and reduced on an outcome measure? In his arresting account, Darren McGarvey talks in lived rather than clinical terms. Reading his book has forced me to think again and to re-evaluate my understanding of hypervigilance.

McGarvey (aka *Lockey* the Scottish rapper) explains his formative experience of growing up in Pollok, Glasgow. McGarvey's landscape is one of pervasive, discriminating and indiscriminating violence. Rather than a survival mechanism, tolerated in brief exceptional circumstances, hypervigilance is the "default setting". McGarvey's text has caused me to reflect on the impact of hypervigilance; not just on individuals and families, but entire communities. The link between PTSD and violent crime is not new. The London Community Foundation highlighted this in a report by Tania Skae:

"They ('young people') will likely demonstrate hyper-vigilance - a constant state of alert where they see potential dangers everywhere and are looking to protect themselves. They may carry a weapon."

Community initiatives such as Project 507 (http://www.project507.co.uk) are doing fantastic work in this area, recognising the importance of delivering, "compassionate initiatives".

McGarvey gets down to the details of what it feels like to be continually hypervigilant. He describes an inability to be in the present moment, a persistent reading of facial expressions or tone of voice as a means of estimating and negotiating the ongoing threat of violence. A paradoxical sense of trying to avoid aggression yet just wanting it over with, in all its horrible inevitability. If your client feels like this most of the time, how do you begin to develop resilience and resources collaboratively? Whether the hypervigilance is for violence, shame or humiliation?

What if your client's experiences have taught them that you, the therapist, probably don't like them? What if they

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Rea employs fantasy to emphasize that people can use their creativity and imagination to help themselves and others to overcome difficulties. She encourages them to hold on to their amazing sense of kindness and compassion for one another as the way to find self-healing. Compassion essentially entails the gradual recognition that parents may have also experienced trauma and that this could hinder their ability to develop strong, secure attachments to their children. This insight regarding the cascading impact of trans-generational trauma could then lead to the development of more positive family relationships.

The novel could be helpful to therapists in emphasizing that, although their clients may have loving parents, clients can learn to manage their emotional difficulties themselves. For other clients who may have grown up in a culture in which domestic violence was the norm, the novel shows how this too can be challenged. The book will also help to banish the stigma associated with domestic violence and related mental health problems. It could help teenagers in care, as well as adults with unhappy childhoods to appreciate that, although they cannot change their past, they can change themselves and move on to lead emotionally fulfilling lives.

This delightful book will be helpful for those working with adolescents and adults who have experienced attachment trauma, childhood abuse or neglect. These people may well be feeling highly anxious about the therapeutic journey ahead of them; this book can give them the courage to continue.

Rita McGrath is an EMDR Europe Accredited Consultant and Supervisor and a Systemic Psychotherapist and Supervisor

see you as a kind of ambassador for a middle-class enemy? Consider the client whose children have been removed and for whom therapy is part of a legal recommendation. Consider clients who have had only bad experiences with the professional class.

So, what might the implications be for EMDR? A recent client of mine described 'the safe place' as, "somewhat indulgent". For the client whose default emotional setting is hypervigilance, resource installation must seem not indulgent, but unattainable. I'm not even sure switching the word 'safe' to 'calm' really makes all that much difference with many cases.

In my view, EMDR is a straightforward process but complexity arrives in its application to the individual. Poverty Safari helped me understand how hypervigilance is part of this. In complex trauma where hypervigilance is on-line in session, it is something we need to consider and include in any formulation. Behaviour that we may interpret as difficult might not signify a reluctance to engage, but a reluctance to be put in harm's way.

Targeting and reprocessing memories can be both rewarding and fascinating for therapists. Often there is a keenness to get to this phase of EMDR. By understanding hypervigilance and how this experience is lived highlights the parity of Preparation as a phase of EMDR. In my basic training, Richard Mitchell made the statement, "it's all EMDR" in reference to the 8-phase protocol. If it's all EMDR then perhaps resourcing transcends the installation of positive experiences and figures. Perhaps before even history taking and planning, we need to take account of the hypervigilance in front of us. Philip Manfield's superb Flash Technique might well have a place in this; a means of reducing disturbance with minimal activation and personal exposure.

I felt compelled to share my experience of Poverty Safari as I believe it can enhance understanding for therapists working with PTSD. I would recommend to anyone working with trauma that they read this text which, in my view, deserves its many accolades. I even suggest to some clients that they read this book as I think McGarvey describes hypervigilance better than many academics. For those new to EMDR, there often seems an impulse to get on with it - which memory to target and in which order, deciding whether a safe place is right or not. Perhaps our first target should be what is going on in the room right now.

Russell Wharton is an EMDR consultant, CBT therapist and supervisor in full time private practice in Norwich. He work with adults, children and adolescents.

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The Special Interest Group for EMDR and Eating Disorders will be starting via a virtual platform on Wednesdays on the following dates :

Wednesday 5 February (6.30 pm - 8 pm) For the first half an hour : Pam Virdi will be speaking about addressing some of the biggest challenges in engaging young people in eating disorder treatment

Wednesday 11 March (6.30 pm - 8 pm)

For the first half an hour : Susan Darker-Smith will be speaking about formulation and wounding messages in eating disorders

Wednesday 22 April (6.30 pm - 8 pm) For the first half an hour : Pam Virdi will be speaking about parts work in eating disorders

Presentations in the first half hour by nominated speakers will be followed by a shared group discussion of clinical issues related to eating disorders.

Please feel free to join us! Attendance at the group is free and the only thing we ask is that you respect the confidentiality of cases raised and discussed within this group.

The web address to join the group is:
https://www.gotomeet.me/cttc

If you require a code to access the meeting via www.gotomeeting.com the code is: 485-704-509

If you need assistance in joining the meeting - please look on the gotomeeting website for assistance or, if needed, please feel free to email us at : info@childtraumatherapycentre.com in advance of the meeting.

We will additionally be meeting up face to face at the EMDR UK & Ireland Conference in Cardiff at lunchtime - if you will be there, please look out for us!

We look forward to meeting with you, sharing ideas and helping our children, young people and adults with eating disorders!

Pam Virdi & Susan Darker-Smith
(EMDR Consultant & Specialist in Eating Disorders)
(EMDR Consultant and Child & Adolescent EMDR Accredited Trainer)

Modular motion-assisted memory desensitisation and reconsolidation (3MDR) for treatment-resistant post-traumatic stress disorder

Victoria Williams[1], Kali Barawi[2] & Neil Kitchiner[3]

[1] Lead Therapist, Veterans' NHS Wales, Swansea Bay University Health Board

[2] Division of Psychological Medicine and Clinical Neurosciences, Cardiff University School of Medicine, UK

[3] Director & Consultant Clinical Lead, Directorate of Psychology and Psychological Therapies, Cardiff & Vale University Health Board, UK

Contact: victoria.williams4@wales.nhs.uk

3MDR gives participants the virtual experience of walking into, and back out of, their trauma

Introduction

The majority of those who leave the UK armed forces do well after they have been discharged. There is evidence to suggest, however, that a minority who leave military service, particularly after experiencing combat, can develop ongoing difficulties including common mental health disorders and substance-use disorders (Goodwin *et al.* 2015). It is estimated that 6-17 percent of veterans go on to develop PTSD (Stevelink *et al.*, 2018).

Furthermore, some veterans struggle in their transition to civilian and family life and require additional support from statutory and third-sector agencies (Ahern *et al.*, 2015). The evidence suggests that veterans benefit less from psychotherapy than non-military PTSD populations (Watts *et al.*, 2013) (See Figure 1). Interestingly, in December 2018, NICE updated its guidelines on PTSD and suggested that individuals with combat PTSD should not be offered EMDR due to lack of evidence for its effectiveness (NICE, 2018). A recent systematic review and meta-analysis recommends individual TF-CBT as the first-line psychological treatment and that urgent trials of EMDR for PTSD in active duty and ex-serving personnel be conducted. The authors concluded that new psychological treatments were needed for this population (Kitchiner & Lewis, 2019).

Virtual Reality Therapy

Virtual Reality (VR) as a potential treatment addition for mental health disorders was introduced more than a decade ago in the treatment of various anxiety disorders. In phobias, VR has been used as an aid to graded exposure of feared

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stimuli, e.g. spiders (Powers, 2015). These early studies contributed to the development of VR for the treatment of many anxiety disorders and other mental health conditions including PTSD (Van Gelderen, Nijdam & Vermetten, 2018). In recent years, there has been an expansion of Virtual Reality Exposure Therapy (VRET) for PTSD, where participants are exposed to their traumatic event, with the aim of reducing avoidance while both activating and processing the traumatic memory (Rizzo *et al.*, 2009).

3MDR

Modular motion-assisted memory desensitisation and reconsolidation (3MDR) is a novel therapy for treatment-resistant PTSD based on eye movement desensitisation and reprocessing (EMDR) and virtual reality exposure therapy. In 3MDR, the participant is invited to walk on a treadmill whilst interacting with a series of self-selected images that represent their traumatic experiences. The participants may choose to work through one or more events during each session. These are displayed on a large virtual-reality screen. The exposure is heightened by introducing a piece of music which evokes memories of their traumatic event. The 3MDR rationale is that exposure aided by virtual reality and enhanced with walking, music and high-affect images eliminates cognitive avoidance during exposure and leads to the memory being reconsolidated into long term memory.

3MDR therapy is delivered weekly, over nine weeks. This includes two weeks for preparation including picture selection and psychoeducation, six weeks of 3MDR and one concluding session. Below is a description of the process.

Participants are fitted with a BioHarness as they step onto a treadmill. The harness is connected to ropes secured to the ceiling to protect against falling. During the warm-up period, they are given the opportunity to get used to the treadmill. At this point, the virtual scene is a blue-coloured landscape to induce calmness.

During the session, self-selected music is played over a high-quality surround sound system. This is designed to take participants back to the time they were affected by their traumatic experiences. Once the music ends, the scene transitions to a red landscape in which the participant sees a road leading to a container-like building. On arrival at the entrance of the building, the doors open onto a high-tech looking corridor. At the end of the first corridor is another door. As the participant goes through this second door, the first of seven pictures is revealed in the distance. Once the picture has filled the screen, the scene stops moving and the participant is asked to describe the details in the picture. They are then asked to discuss any feelings and physical sensations, which are then written on the screen in front of them along with any associated memories as they continue to walk towards the image.

When they have stopped reporting memories or feelings, a red ball begins to move from left to right across the screen. The participant is then asked to follow the ball with their eyes for 30 seconds and call out a random number which appears on the ball with each saccade. After these bilateral eye movements, the picture fades, the road reappears and the procedure is repeated with a new target picture.

After the seventh cycle, the scene returns to blue for a cool-down phase; music previously selected by the participant for bringing them back to the present is played. The treadmill then slows to a stop so the participant can dismount and discuss any new insights that may have come up. It is important to note that, as with any therapy, the participants are reminded before the sessions that they can, at any point, stop the process.

The distinction between 3MDR and traditional trauma-focused techniques is that, in 3MDR, participants learn how to move through their avoidance by walking back into their trauma memory and out again. As is hypothesised in EMDR therapy, the mechanism in 3MDR is thought to centre on taxing the working memory, which is believed to result in memory reconsolidation. This hypothesis proposes that engaging the client in physical and mental tasks uses up so much of the working memory's capacity, there is little left for attending to traumatic memories. The net effect is to make traumatic memories less vivid when trying to recall them, and less vividity means less associated affect. (See: http://tiny.cc/vwwliz)

Method

A randomised control trial led by Professor Jonathan Bisson of Cardiff University in collaboration with Veterans' NHS Wales service completed the first RCT of 3MDR in the UK, funded by the Forces in Mind Trust. Six experienced therapists, all with previous experience in working with the military and all fully trained

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EMDR practitioners, were invited to deliver the therapy.

In total, 42 military veterans were selected to participate in this trial as they continued to experience service-related PTSD following treatment with trauma-focused psychological therapy and were deemed treatment-resistant. Given the high rate of co-morbidity in PTSD, individuals with co-morbidity were included only if PTSD was considered the primary diagnosis and other inclusion/exclusion criteria were met. Participants completed a baseline assessment and were then randomised to receive 3MDR immediately or after a delay of 14 weeks, with follow-up assessments occurring at 12 and 26 weeks following randomisation.

Members of the 3MDR Team (from left to right): Ben Hannigan, Clare Crole-Rees, Victoria Williams, Neil Kitchener, Marieke Van Gelderen and William Watkins

The results so far

Retention rates were 83% (35 participants) at 12 weeks and 86% (36 participants) at 26 weeks. Using 'intention to treat' analysis (http://tiny.cc/v9wliz), the severity of PTSD symptoms was, statistically and clinically, significantly better for the immediate treatment group than for the delayed treatment group at the 12-week follow-up point (mean 17.7 CAPS-5 score reduction versus 6.8). The delayed treatment group also responded well to 3MDR and the immediate treatment group maintained their improvement at 26-week follow-up. Not all participants improved following 3MDR and some reported increased symptoms. The effect size of 0.63 represents a moderate treatment effect despite it being tested in veterans with treatment-resistant PTSD.

The study also examined the experiences and views of both the therapists and veterans using qualitative data analysis. The purpose was to learn about participants' acceptance of the therapy and its feasibility. Eleven of the veterans who had completed the trial were interviewed using a semi-structured interview in order to evaluate 3MDR from the veterans' perspective. Several stated that they would recommend 3MDR to others in a similar situation. However, some added caveats. For example, some thought the process was difficult and participants should be warned not to expect miracle cures. Overall the interview data found 3MDR therapy to be a complex, powerful, psychological intervention. Those who participated in the therapy said it was more than just the time spent on the treadmill but rather the whole process, including the selection of images and music. Others spoke of the importance of support outside of the sessions.

Discussion

The results from the Cardiff and a recently completed RCT in the Netherlands (Van Gelderen, 2019 in-press) demonstrate that 3MDR therapy has the potential to help some veterans with treatment-resistant PTSD in an acceptable and feasible manner. However, it might not be the right therapy for everyone. For example, the therapy requires commitment over several weeks and external factors such as other life responsibilities and demands can compromise this level of commitment. In addition, participants may feel that reducing avoidance, the very symptom that was keeping them functioning, may have left them overwhelmed by the traumatic memories they were once able to distance themselves from. Further exploration of these and other factors will feed into continuing research.

It was also noted that part of veterans' commitment to the therapy was based on the importance of wanting to help others in the future. The extent to which this might hold true for non-military populations is unknown. There are ongoing 3MDR trials taking place in the Canada, Netherlands and United States.

Conclusions

- Evidence is emerging that 3MDR is effective for treatment-resistant PTSD among military veterans;
- The likely effect size is moderate, despite 3MDR being tested in veterans with treatment-resistant PTSD;
- 3MDR did not help all participants and some reported increased symptoms;
- Further research is now required to research its true effectiveness and optimal delivery.

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For more information on the 3MDR, please see YouTube clips below:

https://www.youtube.com/watch?v=joCklRoP1RI

https://www.youtube.com/watch?v=IUnWe7tfgSQ

https://www.youtube.com/watch?v=bOAbDv-Ai6o

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EMDR Therapy Quarterly
Guidelines for authors

EMDR Therapy Quarterly is intended as a practical journal combining scientific rigour, carefully selected practice updates and evaluations and innovative and novel research. The following guidelines aim to elicit useful practical applications in a structured and exacting scientific style.

1. Editorial Statement

EMDR Therapy Quarterly is peer-reviewed and aims to disseminate and promote effective research and practice. Its intended audience is practitioners, and, with this in mind, the journal publishes articles covering both clinical and professional themes. Papers describing empirical research will be considered in line with those that are practice-focused. The journal will ensure the publication of theoretical research of exacting standards together with articles accurately detailing clinical and professional matters.

2. Scope

Articles will be welcomed from those involved in the practice and/or research of EMDR. All articles must include 3 – 5 learning objectives that are achieved through reading the paper. A summary must be included at the end of the article detailing principal points and suggestions for further reading. This is consistent with the aim of the journal in providing professional development and supporting practitioners in delivering therapeutic treatment.

Articles should contain only original material that has received all required ethical approval and is not published, or under consideration for publication, in any other domain.

2.1 Practice Articles

The development of EMDR has relied on empirical research. Articles will be published that explore EMDR practices and their research base, as well as innovative practices and their outcomes. This may include the application of EMDR in new treatment areas, in novel service models or in particular clinical settings. Information regarding both successful and unsuccessful practices are valuable in the development of EMDR and are equally welcomed.

2.2 Case Studies

Case studies are sought which contribute to the development of EMDR theory and/or practice. Sufficient detail must be included for other practitioners to replicate successful treatments. The suggested structure for case study articles is as follows:

a. Abstract
b. Learning objectives
c. Introduction
d. Presenting problem
e. Course of therapy
f. Outcomes
g. Discussion
h. Summary and further reading
i. Required Statements
j. References

2.3 Original Research

Research evidence forms the basis of EMDR practice and development. Original research will be welcomed, including the investigation and evaluation of therapeutic processes and techniques and application in new treatment fields. Such investigations must be scientifically rigorous and should include the standardised outcome measures of the EMDR Association UK & Ireland. Research articles should be sufficiently brief to enable assimilation and discussion of the study's implications. Consideration will be given to quantitative, qualitative and any other approaches providing an appropriate investigation of the research question. A similar structure to that of the case studies papers could be beneficial, such as:

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a. Abstract
b. Learning objectives
c. Introduction
d. Research question
e. Methodology
f. Results
g. Discussion
h. Summary and further reading
i. Required Statements
j. References

3. Preparation of Manuscripts

Articles should be 5,000 words or fewer on submission (excluding references, tables and figures). Formatting of text should not go beyond using bold or italics to distinguish between main title, headings and sub-headings. All submissions should be addressed to: editor@emdrassociation.org.uk

3.1 Structure

1. Title Page: highlights major issues
2. Main manuscript:
   a. Abstract
   b. Learning objectives
   c. Introduction
   d. Presenting problem/Research Question
   e. Course of therapy/Methodology
   f. Outcomes/Results
   g. Discussion
   h. Summary and further reading
   i. Required Statements
   j. References

3.2 References

APA referencing style should be followed throughout the document. http://www.apastyle.org/

3.3 Tables, Figures and Graphics

These should be submitted as separate files but have their intended position clearly marked in the manuscript.

4. Ethical Standards

EMDR Therapy Quarterly is committed to investigating any suspected cases of misconduct. All manuscripts are screened for plagiarism. Reviewers are asked to disclose any conflicts of interest when assigned a manuscript and, where necessary, other reviewers will be sought to maintain a thorough peer review.

5. Required Statements

The following three sections must be included after the references section:

5.1 Ethical Statements

All articles should include a statement declaring that the authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the American Psychological Association http://www.apa.org/ethics/code/. Authors should also confirm if ethical approval was needed and provide the relevant reference number. If no ethical approval was needed, the authors should state why.

5.2 Conflict of Interest

All known professional, financial and personal relationships with a potential to the bias the work must be declared.

5.3 Financial Support

Sources of financial support, including grant numbers, must be provided for all authors.

6. Proofs and Copyright

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