

EMDR THERAPY QUARTERLY

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The world of therapy according to COVID-19

Online experts share their experience in the fight against COVID-19

Welcome to this special edition of ETQ born out of the desire to urgently address the needs of our existing clients once it became evident that we would all have to adapt to the

reality of having our personal and professional life being completely transformed. As it began to sink in that our usual way of connecting with our clients and providing EMDR therapy would no longer be possible, suddenly the prospect of providing therapy 'remotely' was no longer an academic question or the topic of casual conversation between therapists. It warranted serious and urgent consideration.

Fortunately, we have among our members a cohort of therapists who have considerable experience of providing EMDR therapy remotely. Thanks to them and their willingness to share their experience and skills we have been able to put together this special edition of the Journal. The collection of papers is very much concerned with the practicalities of working remotely with clients, highlighting the importance of preparation; practical tips for dealing with the unexpected; necessary adaptations, and welcome reassurance that client and therapist quickly adapt

to the new medium.

There can be no question that in these extraordinary times our clients, especially those most vulnerable, still need to be supported. Furthermore, there can be no question that the demand for mental health services will only increase significantly in the immediate and longer term as the aftermath of the pandemic unfolds.

At present there is very little published research on the provision of therapy remotely. However, there is a growing body of anecdotal evidence for its effectiveness. This is an opportunity, born out of necessity, to add to this body of evidence and in time to address the research questions that must surely follow.

Many commentators speak of a 'new normal' for society yet to come. Will we, as EMDR therapists, choose to transform our usual ways of working from now onwards or will remote working be a temporary 'life-line'? Time will tell.

Mike O'Connor, President, EMDR UK



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EMDR Therapy Quarterly

EMDR Therapy Quarterly (ETQ) is the official publication of EMDR UK. 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 editor's discretion. We welcome inquiries.

Editorial Policy

The Journal is published for members of EMDR UK (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. 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

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Adapting to a fast-changing world

NEWS

Margo Brock van der Zanden reflects on how COVID19 is changing our lives and the adaptations it is forcing us to make of our sense of self and agency

From one day to the next our world is rapidly changing. Initially, it seemed a distant thing, something that was bad but something that was happening somewhere else. It was worrying, as is all human suffering across the globe but, as yet, not close enough to our everyday lives to impact on our personal space and our brains' sense of threat. As with all fearful events, we heard of those affected responding in different ways but we saw many slipping easily into denial – avoiding, minimising – insisting they were fit and healthy and everything would be OK.

Since the threat is invisible and not something we can locate in order to run away from, it left us waiting for those in the know, and whose way of life was already changing, to inform us. They left us with worry, with sincerity, with a sense of alertness, with messages from Italian health professionals reminding us of how bad this actually is, with an (alarmist) press, and with us scrambling around for facts. Our brains recognised it: here is a threat, and our fight/flight response was activated. In an attempt to do what we do best, I observed all my EMDR colleagues busily trying to regroup and connect with their patients. Reading the many comments about continuing to work with our patients online I had to share my concerns because the entire context of our world had changed.

Our sense of personal space has changed. Social isolation necessarily means being alone for some people, or spending more time at home with those we live with (which can be good, or not so good). Our sense of physical safety has changed. Will we become ill and, if so, will we survive the infection? Our access to resources has changed. Some people are on furlough, others have lost their jobs, supermarket shelves are emptying. Our support systems are significantly strained. Our gyms, clubs, restaurants, pubs, and the many other places we formerly met to socialise are now closed and holidays seem like a distant memory. Members of our family and social circle may be at risk because of vulnerability to infection or proximity to sources of infection.

Listening to the messages from those working in the affected areas in the rest of Europe, and a bit ahead of us, it is clear that this will get a lot worse. We can expect a shortage of beds and equipment. Choices will be made about who will be treated and who will be asked to stay isolated at home. We can predict tragic experiences for some. Mothers who might die alone at home; others who might be turned away from hospitals in favour of treating those with a better chance of recovery. Loss and bereavement will become commonplace. (These predictions are based on events happening

in other countries at the time of writing.)

All of this makes me wonder; is this the time to continue working on past trauma, or do we help to prepare ourselves and our clients for survival? Do we discuss the pervasive grip of anxiety as our exposure to uncomfortable and terrible events increase, as we grudgingly admit that death has never be so present in our minds? Normalising these emotions and reflections seems to me to be the first step towards building hope, social strength and resilience.

All this makes me wonder about those on the front-line. Those who are supporting patients in their current traumas while perhaps experiencing their own traumas at home. I spoke to some working in Holland today; they are traumatised, exhausted ...but carrying on, numbing themselves to survive the physical, psychological and spiritual demands that COVID-19 has forced upon them. Their brains, like ours, are now midway between an acute and chronic stress response, yet having to make decisions and problem-solve, the very thing our brains struggle with. There is no time to process.

The current crisis isolates us. Research on those isolating in the SARS pandemic found PTSD and depression commonplace. We have all probably noticed a sense of powerlessness and helplessness in the

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face of impending losses and bereavement. Our usual ways of self-soothing are severely constrained - giving each other hugs and kisses is now dangerous. Visiting loved ones, especially if they are ill or dying, is now impossible. We are left questioning our own endurance, even as we wonder how they are faring.

The precious present

However, life – albeit a radically changed one – goes on, and I realise that what I continue to have is now. Now is the time to remind my mother of how much I love her. Now is the time to make it obvious to my sisters, brother, my family and friends of what they mean to me and to let them know that I am here. Now is the time to be generous with my time, with my partner and my daughter in an intense, loving, laughing, sharing, sorting out, rebuilding and appreciating kind of way. This way only seems to become obvious when we are reminded that we might lose each other. This way is how we acknowledge the precious gift that is the present. It allows us to prioritise what is really important.

We need to adapt to working with our traumatised patients in this new world context and supporting ourselves and our colleagues, using the amazing wealth of knowledge and support in our community to get us through. We need to be connected in our efforts to adjust to what we spend our lives running away from, our transience, or mortality. Addressing what can only be seen as a reminder

that we are all humans, susceptible to one single virus and vulnerable to the consequences of infection. And in the EMDR community particularly, I hear a healthy resolve to 'be there' for our patients and colleagues. (Thank you for being such a generous and amazing force for healing and learning). For me, this adaptation to my work means open exploration of these implications with my supervisees and patients in an idiosyncratic way. For me, it means stepping back from processing and to continue working online, building resources, desensitising via EMD, teaching my clients how to ground themselves, create a safe place, and so on. EMDR is every bit as powerful when the focus is on the here and now.

Current resources are different and need adapting. And current events and issues will impact on past traumas. A brain flooded with cortisol and unable to remain in the window of tolerance will not have an active, processing hippocampal function, hence processing as before might be off the table. A client in the middle of processing may perhaps be helped to protect some of the material that has arisen, with the aim of revisiting this when the brain is once more in a position to engage in processing the past. But perhaps we need to change the emphasis to resourcing the present instead.

Jessica Woolliscroft on JISC-Mail noticed how the onslaught of new information had resulted in a freeze/dissociate response for some people. She admitted that she personally

found the speed and volume of new information coming at her from all sources overwhelming. She has been reminding her clients and supervisees that, when a person is in a crisis situation, it is hard to take in new learning and a lot of us will freeze or regress, going back to what we know and feel comfortable with. She has been encouraging people to pause, breathe and think about zone zero first of all; that is, to think about our personal resources and family situation.

Resourcing

Here are some suggestions for surviving the present crisis (apart from staying at home, washing regularly with soap for at least 20 seconds, abiding by the two-metre social distancing regulation, keeping each other safe, and looking after your immune system).

- Plan a routine
- Stay connected
- Exercise daily
- Limit news checking
- Doctors are asking us to discuss health and dying with our loved ones, we could support our patients in doing the same.
- Engage in hobbies

This could for all of us be the most difficult and yet most deeply connected time in our human lives. Keep well, stay connected and stay safe.

Margo Brock van der Zanden is an EMDR Consultant and Clinical Lead for the Let's Talk Wellbeing IAPT service in Nottingham. She is a supervisor and has been active as the secretary of the EMDR depression SIG since 2014. Since writing this she has experienced first-hand how important connection in the present is, having had to part with her mother who lives in a different country.

Useful online resources

Dr Bruce Perry provides basic information on the Neurosequential Model in this 40-minute video. He then outlines how the uncertainty associated with COVID19 impacts on us. He goes on to explain how we can act as leaders in this time of uncertainty by taking control of what we can.

Specifically, he suggests that families keep a familiar routine and structure, have a family meal together and insert intentional exercise into the day (throughout the day). He makes suggestions for maintaining relational regulation during this time when we are practising social (better described as physical) discipline in order to keep our emotional connections.

<https://www.neurosequential.com/covid-19-resources>

NCABM Videos

The following are videos posted by National Institute for the Clinical Application of Behavioural Medicine (NCABM) featuring advice from Christine Padesky and Ron Siegel and their shared their techniques for finding relief from anxiety during these difficult times. Bessel van der Kolk talks about how to respond to help get our brains back in sync.

<http://tiny.cc/c2t9mz>

<http://tiny.cc/s4t9mz>

<http://tiny.cc/o6t9mz>

<http://tiny.cc/p8t9mz>

<http://tiny.cc/cdu9mz>

<http://tiny.cc/wau9mz>

Support for dealing with death and dying

<http://tiny.cc/2gu9mz>

<http://tiny.cc/5iu9mz>

<https://www.interfaith.org.uk/news/faith-communities-and-coronavirus>

General resources

The following are sites that offer general support to build resources during physical self-isolation.



Take a virtual tour of the pyramids

Chatterpack, a voluntary special-educational needs and disabilities hub, has put together a [varied list of resources](#) to keep boredom and loneliness at bay.

<https://chatterpack.net/blogs/blog/list-of-online-resources-for-anyone-who-is-isolated-at-home>

Virtual museum tours

These museums offer free online tours

<http://tiny.cc/fru9mz>

<https://www.familydaystriedandtested.com/free-virtual-tours-of-world-museums-educational-sites-galleries-for-children/>

Free audio stories for children

<http://tiny.cc/utu9mz>

Live primary school lessons

<http://tiny.cc/6vu9mz>

Digital dance

<http://tiny.cc/txu9mz>

[Free until 1 May]

Free online yoga classes for children

www.clanyogis.com/timetable

Happiness course

Yale University's class on how to lead a happier life is now available free online:

<http://tiny.cc/d4u9mz>

Free daily meditation

<https://free.healthjourneys.com/>

Pandemic prompts international support for virtual EMDR with children

Susan Darker-Smith outlines the objectives and achievements so far of the newly formed Global Child EMDR Alliance

On Friday 12 March, out of the blue, Ana Gomez phoned me. Her opening words were, “We have to do something...” She was, of course, talking about the coronavirus. Moments later, we had a plan. Ana contacted every child EMDR expert she knew and I emailed every EMDR European Child & Adolescent Trainer that I knew. Two days later, on Zoom – the Global Child EMDR Alliance was established. An alliance of 25 child EMDR clinicians, trainers and experts from around the world are now sharing, consolidating and translating EMDR child resources for free use and creating free webinars to help support clinicians as they adapt to virtual working with children.

The aims of the Global Child EMDR Alliance are simple: in order for our global society to survive this pandemic and to flourish where tragedy and trauma impacts on people, we have to rise above individual egotistical aims in order to stand together and support one another. In this way, our understanding of the nuances, cultures and societies we are from and the skill sets we bring can be shared for the benefit of all.

Within a week of its formation the Global Child EMDR Alliance had created four new children’s stories ranging from managing grief and loss to coping with self-isolation, anxiety and the fears that children have

around the impact of the Coronavirus. We had collated dozens of EMDR resources from around the world.

By week two, these stories and resources were being translated into 15 different languages.

By week three, we had produced three free webinars covering EMDR virtual working and tele-health with adults and children - which went out live and were recorded. These recordings are available freely to EMDR clinicians.

The Global Child EMDR Alliance is currently in its fourth week of existence. Over 80,000 lives have been lost to the coronavirus worldwide, but we are determined to do all we can to maintain children’s mental health. The following is what it has come up with so far:

A [Facebook page](https://m.facebook.com/pages/category/Mental-Health-Service/Global-Child-EMDR-Alliance-110539197240016/) for the Alliance which has access to stories and songs that are freely available to download in a multitude of languages. - <https://m.facebook.com/pages/category/Mental-Health-Service/Global-Child-EMDR-Alliance-110539197240016/>

We are currently building a website – a hub – for the distribution of these free resources. Children, parents, families and EMDR clinicians will be able to download resources in a multitude of languages from this central hub - <http://www.globalchildemdralliance.com/>

The Adolescent task force has created an [Instagram account](#)

enabling teens to connect to one another <https://www.instagram.com/globalchildemdralliancectr/>

Three songs and one audio-book have been professionally recorded to help explain the coronavirus to children through music and dance (a child’s more natural mechanism of communication), which are available on the *Facebook* page.

The Clinician task force is currently developing demonstrations of online work with children which will be recorded as webinars to guide clinicians responding to the demand for online therapy. The demands on the delivery of therapy is likely to impact on services across the world for many months to come.

The creativity, respect and love we have for one another underpins the work of the Global Child EMDR Alliance. Alliance members offer their time and skills freely – in order to make a difference in the world. As Ana says, “by working together, we can change the world, one child at a time”.

Susan Darker-Smith is an EMDR Accredited Child & Adolescent Trainer and Consultant. She is the UK representative for the Global Child EMDR Alliance and sits on the Child taskforce and the Clinician taskforce. She is also a Trustee for the Trauma Response Network UK.

COVID-19: changing how we work today – and in the future?

Mark Brayne, former BBC and Reuters Foreign Correspondent, has covered some of the biggest stories of the 20th Century, from Tiananmen Square in China to German reunification at the end of the Cold War. But nothing, he claims, even begins to compare with the impact of coronavirus. Mark generously shares his experience and tips gleaned from a decade of providing online EMDR therapy, and makes a bold claim for the future of EMDR



Webcam ready, Mark Brayne

The end of the Cold War brought profound change to Europe; remember the GDR? Czechoslovakia? The Soviet Union? Maastricht and the morphing of EEC into EU?. But if the fall of the Berlin Wall marked a gigantic geopolitical watershed, I would argue that Covid19 has already been, in an even shorter time span, bigger in terms of impact on our own therapy profession than any event in history, including Jung's fracture with Freud in 1912 and even, yes, Shapiro's 1987 walk in the park.

As colleagues reading this will already know, social distancing and the lockdown in their homes of a good half of humanity has meant that each one of us, whatever our ethical reservations or technical fears has, almost overnight, found ourselves having either to start working online or quitting altogether.

I have been working as an online EMDR therapist for a good decade, so it's been rather rewarding to experience how

rapidly our EMDR UK community has now risen to the challenge. There have been some terrific discussions on JISCMail and elsewhere, with superb and immediate best-practice guidance from colleagues such as Naomi Fisher and Alexandra Dent.

The UK Association's new President Mike O'Connor asked me to write this article in March, at the height of what most readers will recall as intense and urgent online discussion about how best to deliver EMDR remotely, about the security of platforms such as Zoom in particular, and for example, whether it's OK to start remote work with a client one has never met in person.

It's a testament to how effective this discussion has been that in completing this article now, just a fortnight later, the arguments are largely settled, and pretty much everyone reading this will have already had extensive experience of doing remote EMDR for real.

You'll be making mistakes of course - at least I hope you will as that's how we learn, stumbling as you get into gear. But I trust that most of you are discovering already that this is not just second-best therapy, but in its own way an extraordinarily effective and powerful way of using EMDR with even very complex clients.

Necessity has indeed once again been the mother of invention, or, as Shakespeare put it in *As You Like It*, "Sweet are the uses of adversity".

So, what can this article usefully add to what you will already know about EMDR online (and if you haven't already, please read the full Association guidance document, which covers all the essential bases of how to do this work.)

Sharing just some experiences that have helped me work this way, I'd first encourage colleagues to relax, to trust your existing skills and to know that EMDR at a distance is fundamentally no different from

▶ working with a client in-person, except perhaps that it can be, at least in my experience, even more effective.

For a start, note that the difference is not between online and face-to-face, but between in-person and online. I find that working online is even more intimately face-to-face than when we sit in a room, opposite or to one side of our client.

Preparation

A key difference, obviously, is that you're sitting at home as therapist in your own space. The client, too, is likely also to be at home or, I sometimes find, in the often therapeutically supportive privacy of their car.

It's important therefore before you get going that you explicitly coach your client to prepare for their sessions. Ask them to take time beforehand, and not for example just rush in from feeding the kids, and then afterwards to tune into the session and out again. Both therapist and client need to occupy a spot in the house not just with good internet (and both have sufficiently high-spec computers) but one that will remain quiet, private, and undisturbed for the duration of the call.

And don't forget, just as you would if meeting in person, to make sure that your client has tissues at hand, and a glass of water.

Resourcing

Your clients online need to be



It may take some practice to perfect the use of the green backdrop

explicitly well-resourced, not just with a Special or Safe Place in Phase Two, but also (as I encourage my supervisees and trainees to do as a matter of course with every client) with imaginary support figures that bring qualities of nurture, protection and wisdom to the work.

But otherwise, do EMDR as you already best know how, without compromise or fear.

Session structure

It's even more important when working online to keep a focus on session structure, so you can wrap up each meeting with installation, or tapping in, of a positive outcome, even if the SUDs on a target are still high (you can gently tap in a drop from a 9 to a 5 – “good work!”). Especially online, NEVER leave a child ego state which might have been activated in the work still stranded in the past. Either get both child and adult parts safe in their special place, or encourage your adult client to know that, as their much younger self has always been with them, day-in, day-out, from the beginning, they are in effect taking that child home with them today, so please keep him/her safe.

Technology

Which raises the big question, how to do BLS online, and in-

deed, what technology is best for remote EMDR.

For my part I've found the online platform Zoom to be brilliant for this work, more

straightforward than (and at least as safe/confidential as) other apps such as Skype or VSee, or Google Hangouts, WhatsApp and the rest. But if only for your own peace of mind, and to be able to make the case effectively with your client for the platform you prefer, do explore for your-selves. For one thing, Zoom allows both parties in a conversation to speak over each other at the same time, which other programs often interrupt.

Unless you don't mind your clients looking up your nostrils, position your camera at eye level, if necessary placing your laptop on a pile of books. If you can, use a full-size monitor that's separate from your laptop, with a USB webcam clipped on top. Make sure the lighting is good, and that there's no light source directly behind you, either window or lamp.

Check your outgoing picture (it shouldn't show much of either ceiling or floor) and ask yourself whether, as a client, it would be acceptable to see your therapist like this.

Backgrounds matter, so make sure that yours is appropriately neutral and business-like. I use a “green screen” (available from Amazon), hung behind me in my home office; this allows me to upload to Zoom an appro-

▶ appropriate picture against which clients can see me (for me, this backdrop is a picture of my own living room bookcase).

BLS

When working remotely, the BLS that makes EMDR distinctive is of course a challenge. There's a lot of technical innovation under way at the moment, and new kit for remote EMDR is coming on the market almost daily. But even without that, a simple butterfly hug (thumbs interlocked, fingertips tapping just below the collarbone on each side) works extremely well.

With clients who can handle the tech, I encourage them to wear ear buds connected to the *BSDR Player* app (or similar) on their smartphone. The player generates bilateral audio clicks or buzzes. Clients ideally wear a larger microphone-enabled headset over the ear buds to allow us to continue communication during BLS.

This set up allows clients to start and stop the BLS themselves, on instruction from the therapist. I find it

works best for them to close their eyes when processing (which holds true for when I work in with clients in the same physical space).

Dissociation and abreaction

Colleagues often ask about how to deal with dissociation and abreactions. In my own experience, I have never found these an unmanageable problem, and have indeed often had clients emoting as intensely online (sometimes more so) as they do in-person (remember the tissues).

Use all your usual skills to manage how a client might do their processing, though of course do take care, as you would in-person, with someone who severely dissociates or who might be at risk of self-harm. With these clients, you can agree before you start that they may need to have someone in their social support network available, and perhaps even present in another room, in case the client loses psychological contact or is too distressed to continue processing.

There is so much more that

could be written – and surely more than enough for a book. Much has already been shared on the many webinars run these past weeks by Naomi Fisher on behalf of the Association, and by myself with the Yorkshire regional group, with Dr Jamie Marich in the US and with the Australian EMDR Association. Several of these webinars are still available online, and I am sure that, at warp speed, we will all continue to learn.

In conclusion, I've enjoyed these past weeks recalling an email conversation between myself, the editor of this Journal, Omar Sattaur, and former EMDR Association President and Senior Lecturer on the Worcester University EMDR MSc course, Derek Farrell.

It was July 2017, and with Derek highly sceptical about the ethics and safety of doing EMDR online, I proposed an article for the journal, then called *EMDRNow*, framed as a debate between us on the motion that it was high time that the EMDR community embraced online EMDR therapy. Unfortunately, the arguments for and against never made it to print.

Today, I would go even further to say that, however the present crisis unfolds, EMDR online will rapidly become the prevailing method for practising this therapy worldwide.

Advertise in *EMDR Therapy Quarterly*

EMDR Therapy Quarterly (ETQ) is distributed to the 3000-plus members of EMDR UK. With the inclusion of original research articles, case studies and articles of clinical interest, we hope *ETQ* will attract readers outside of the Association too.

ETQ invites ads for book sales; EMDR equipment for BLS; courses and workshops relating to EMDR and conferences on mental health. Advertises for events organised by the Association (including Regional Groups, Sections or Special Interest Group Events) and Trauma Aid UK are free of charge.

The new format allows for half

page and one page advertisements as well as the established quarter-page advertisements. Deadlines for advertisements are as follows: Winter: 15 November; Spring: 15 March; Summer: 15 June; Autumn: 15 September. Submit as .png, .jpeg, .pdf files.

As before, non-profit making CPD events that are under the aegis of the Association are free of charge.

For pricing details contact: editor@emdrassociation.org.uk

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Mark Brayne is an EMDR Europe Accredited Consultant. With their company EMDR Focus, Mark and his EMDR Consultant partner, Jutta Brayne, have been running advanced workshops in integrative EMDR for Attachment-related disorders internationally and now online.

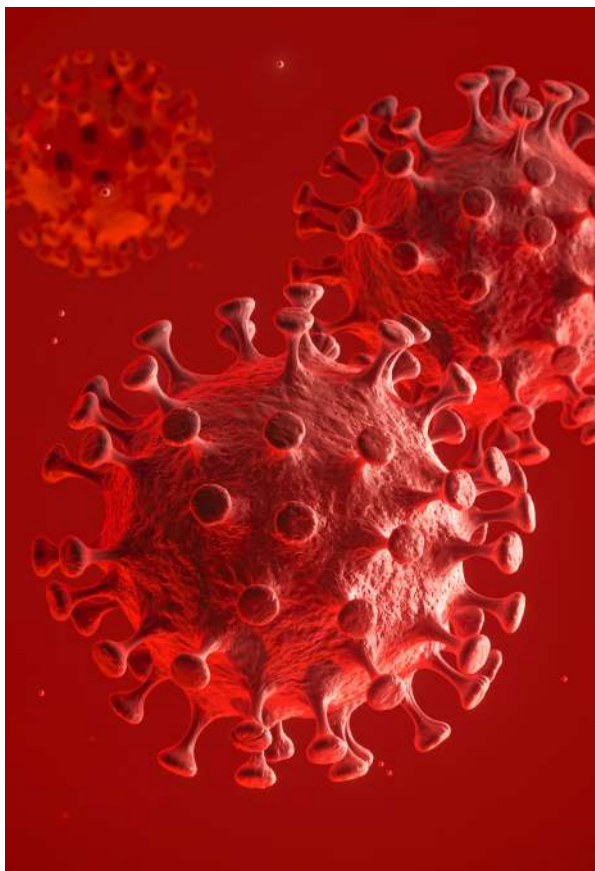
Ten tips for using EMDR online

In this practice-based article, Naomi Fisher summarises what she has learned from her experience of online EMDR. It is not intended as official guidelines, which EMDR UK has already circulated to members. Readers should use their clinical judgement to make any decisions and seek clinical supervision where necessary

I never thought it was possible to do EMDR online. As a clinical psychologist and EMDR Consultant who has been using EMDR since 2005, I occasionally did other sorts of therapy online if I had to, but EMDR? No. It seemed safer to keep that for my clinic room.

Then I moved to France. Suddenly I was not able to set up a practice or get a job, because here I had no core profession; my title did not automatically transfer. As I looked around for alternatives, working online – with people outside France – was an obvious choice. But I was still wary about using EMDR online.

As I started to build up my online practice, I couldn't help trying out some EMDR preparation techniques. EMDR is the basis of my therapeutic practice, it forms the core of what I do. I use CBT and ACT as well but, without EMDR, I felt like there was a huge hole in my approach. So I started with some resource installation, installing a safe space, and tried out preparation techniques such as the Flash Technique (FT), CIPOS and Loving Eyes. In order to do this, of course I had to work out how to best use BLS online. As I did so, I become more confident and started offering full EMDR processing to people



who I felt confident could manage this.

It worked. Just like it does in the room. In fact, in some ways it felt even more attuned. I felt deeply in touch with my clients, thousands of miles away. We created a little therapeutic bubble, in virtual space. I've been using EMDR online for nearly two years now, and this is what I've learnt.

1. Expect technological problems in the first session

I see the first session in online therapy as a chance to sort out issues and create the space. I don't send out lots of guidelines in advance, I just ask clients to find a quiet, uninter-

rupted space with a good internet connection and to make sure that someone else is looking after the children (if this applies). I use the first session to talk about how we can create a therapeutic space together and form an online therapeutic relationship. I always have a phone number for people and if there's a problem with logging on, I ring them. Sometimes I talk them through installing Zoom, sometimes we have to continue talking on the phone.

Check out what device they are using. One of the advantages of Zoom is that clients can use it on smartphones, tablets and computers. This does mean, however, that they may be on their phone on the sofa, making it difficult to do any sort of BLS. The device they are using needs to be handsfree in some way; they may need to prop it up against a cushion or book.

Check with them that their battery will not run out halfway through.

2. You may not be able to create a safe space for processing

If clients can be overheard by other people, if they are in the house with people who are abusive to them, if they can't find someone to care for their young children – then you can't

do trauma processing. Use your judgement. I find that if I keep the first session open, without too many advance requirements, clients are more likely to be honest with me about their family environment and what's possible. If you send an exacting list of things that they've got to get it right in advance, then you may find they don't feel able to tell you that actually they live in a studio flat with their children and the only private space would be the bathroom.

3. You can't effectively use your fingers for eye movements over the computer

They blur. It's hard to follow. You can't see their eyes well and you don't know what size of screen they are on.

I use three different types of BLS online. My preferred method is tapping together. I tap so that the client can see my hands, on a cushion, and they follow my tapping. They can tap on a cushion, on the table or on their knees. I learnt this technique from Philip Manfield who trained me on the Flash Technique (FT) and I like it because we are doing the BLS together; I can control the speed, when we start and stop and there is no other technology to go wrong. Clients say they like how it feels, and the processing works.

If tapping together doesn't work for some reason, I sometimes ask them to use butterfly tapping. I might also switch to this if processing is blocked. As a back up, I ask them to download an EMDR app to their phones. *Sleep Restore* is a free

app by Mark Grant. They put through their own headphones, and they start and stop it using an agreed visual signal. Any headphones will work as long as there is sound in both ears.

Other colleagues use EMDR apps on their computer. I haven't done this because I haven't needed to and I like to keep it simple.

4. Leave space for the transition

If you're changing from shared physical space to online, don't expect the transition to be seamless. You're in a new space together, use the first session to talk about how that feels and to work out how it will work. If you're already into trauma processing, you may need to back out and go back to the preparation phase for a while. People may also feel angry or scared about the reasons why you're moving online. Make space for that discussion.

5. Make life easy for yourself, set up your whole clinic on one platform I don't offer clients a choice of platform

I used to do this and it became very stressful, trying to remember who used *Skype*, who used *Zoom* and who preferred *FaceTime* or *WhatsApp*. Sometimes I would be on *Zoom* whilst they were waiting on *WhatsApp*.

Now, I use *Zoom* for everything. I schedule the whole day in advance and send out invitations the night before or early in the morning. Clients click on the link and there we are. We both have to do something in order to get into that meeting, so we are both consenting to be there.

6. I dissuade clients from closing their eyes

The one thing you really can't do online is physical grounding. You can't throw a cushion to your client, you can't easily move around the room, and you can't wave essential oils under their nose. You can't touch them.

This means that if they dissociate, you have fewer tools than usual for bringing them back. I deal with this in two ways. I encourage them not to close their eyes. You only have two senses through which to communicate online, hearing and sight. If they close their eyes, you're down to hearing solely.

Clients say that they can get into the memory more easily with their eyes shut, to which I say that, in EMDR, we need to keep one foot in the present and one foot in the past and that keeping their eyes open will help keep part of them with me at the same time as going into the memory. This applies most to those clients for whom dissociation is a distinct possibility; more straightforward cases do sometimes close their eyes.

The other thing I do is enlist a 'co-therapist' if there is a supportive person in the house who I can talk to about dissociation and grounding techniques. This person needs to be in the house but not in the session. You need to be able to contact them, perhaps by text or phone. This way, if your client is dissociating and you can't bring them back, you call in your co-therapist. You can then guide them through using physical grounding techniques.

7. The unexpected will happen

Working online is different to being in a clinic room. It's more like a home visit. You are in the client's home and you see snippets of their real life. If you take this into your stride, your clients will do so too. Sometimes, urgent deliveries arrive and I find it's better to let them go and answer the door. Otherwise I can see how they become preoccupied with wondering if the postal worker will come back, or if they'll have to rearrange delivery. Particularly now, it's easier just to let them leave the session to attend to the interruption. I have had children interrupting – again, ask your client to try to make sure this doesn't happen, but if it does, take it into your stride. Pause, give your client time to take the child out and settle them, and then pick up where you left off. Letting them deal with it causes fewer problems than if you and they try to ignore it.

8. Check who else is in the room

I've found that people interpret 'a quiet uninterrupted space' in all sorts of ways. Sometimes I've found myself in a corner of someone's living room with the TV on and children watching it. Dogs wander in and out.

You need to problem solve with them how they might find a private space where they will not be overheard and this might require some creativity right now when everyone is home.

In particular, ask who else is there with them. I once heard a laugh during a session. I asked

who it was and my client said that her sister was sitting on the other side of the computer, out of my line of vision. Now, I ask all clients to tell me who is in the room at the start of each session and sometimes to move their device around to show me what the rest of the room looks like.

9. You can always say no

Your clinical judgement is important. Don't feel you have to offer EMDR online to anyone who asks. Do your usual full assessment and, if you feel uncomfortable or unsure, don't do it. Start slowly with the preparation phase and use that as a way to test out how they respond. I'd start with using CIPOS, the FT or 'tip of the finger' processing before I used full EMDR. This way, you get an idea of how they will manage thinking about the trauma.

Only progress to trauma processing when you and they are confident. If it feels unsafe, back out and do more preparation. If you want to record the sessions for your own records, it's very easy to do so using Zoom. Obviously, they have to give consent and they will know that you are recording because Zoom tells them so. I don't think it's easier for clients to record us without our knowledge online than in person. They could always be carrying a phone in their pockets with the 'record' function running. If you want a record of the sessions, record them yourselves.

10. Working online can remove barriers to participation

Clients will be anxious about

this transition. So you need to be confident that this is a good alternative, not a second-best, stop gap. The reason I don't send out lots of guidelines in advance is that I don't want to give the impression this will be difficult for them, or that they can get it wrong. Use the first session to work out your way forward together.

Working online gives us a new flexibility. I sometimes offer much shorter sessions online. I'm working with an autistic teenager at the moment who prefers 15-minute sessions. Online, this is easy to arrange.

Working online also means that people can be more at ease since they are in their homes. We can work with people who aren't able to leave their homes. For children and young people it's possible to have parents around but not directly in the session, if that is what is helpful.

Online EMDR therapy isn't a poor substitute for the clinic room. It's something slightly different, with its own advantages and pitfalls. For many clients it's a choice between no EMDR at all, or EMDR online, rather than between EMDR online and EMDR in the clinic room. It takes most therapists out of their comfort zone, but if we can face that anxiety, the potential benefits to our clients are great. The challenge is ours.

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Online EMDR - Up Close

How does an online EMDR session differ from an in-person session? Naomi Fisher recounts in detail a recent online EMDR session and analyses the differences.

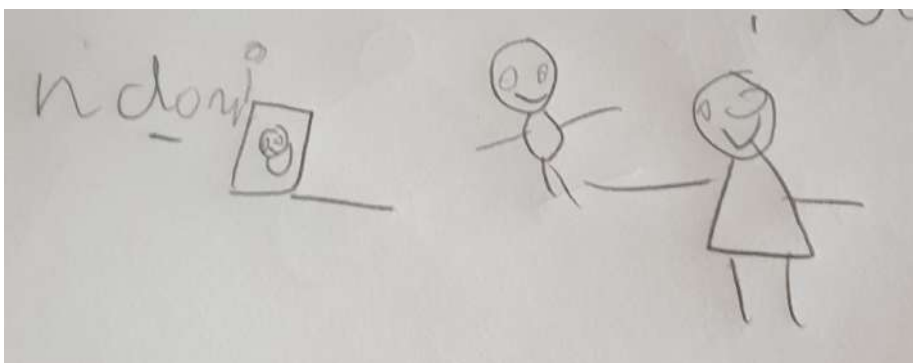
If you've only done EMDR in-person, the online version can be hard to imagine. I hope this article of a recent online session I had will give you an idea of what working online might be like.

Sally approached me for online EMDR following a traumatic incident last year. She had been in a car accident and her legs had been trapped whilst she waited for emergency services. After the car accident she had been in hospital for over a week. She had made a full recovery but was left with flashbacks and nightmares.

Soon after she contacted me, the COVID-19 crisis hit. Sally was confined in a small house with her partner, older child and baby. They were both working and were passing the children between them when they had to take video calls.

She was initially unsure about online work but agreed to give it a try. In her first session, her WiFi cut out and we ended up talking on the phone. This worked well for history-taking and we were able to establish a rapport. After this, she was happy to try working online.

In the first two sessions I explained the AIP and how trauma affects the brain, and how EMDR can help. She was very keen to do trauma processing as she was experiencing intrusive thoughts, flashbacks and problems with sleep. She was also getting angry and frustrated with her partner as they were at such close quarters.



This 7-year old client and his mum are happy to have therapy with Naomi (in the box, far left, and helpfully labelled 'Naomi')

Whilst everything in this report happened, in order to protect client confidentiality all identifying details have been changed and experiences from several different clients have been used to create this session report

There were some advantages to the timing since she had her partner at home and he could help to care for the baby while she had her therapy session.

In the second session, we found a safe space – a beach near where she used to live. She reported no history of dissociation and no early childhood trauma. I used tapping together and butterfly tapping with her. Immediately, she found that the tapping with her hands provoked very intense feelings. She got in touch with the feelings of peace and calm in her body and said she really liked the tapping as it made her feel very grounded.

In the following session, we started the desensitisation phase. When she connected to the session she was at the end of her small garden, but I couldn't hear her due to road noise and intermittent WiFi problems. She had to move inside where, she explained, she

felt more exposed as her husband and baby were downstairs. She decided that this was private enough for her, though, and she wanted to continue.

The target she chose was the moment in hospital when she realised that she was badly injured and could not move her legs. The doctors and nurses did not seem to realise that anything was wrong and told her that she would soon be up and walking. She did not know why she was unable to walk.

She identified several negative cognitions, including 'I am not safe', and 'I am a failure' but said that the most powerful was 'I am broken'. Her preferred cognition was 'I am okay as I am'. Her SUDs were 9 and she felt her fear in her midsection and throat.

We began with using tapping together and she said that the movement felt like the opposite of paralysis. I asked her if she'd like to switch to tapping with her legs, since it was her legs that she had been unable to move during the trauma and she liked that idea. From then on, I moved my hands and she moved her legs in time with

me, tapping her feet on the floor. She commented that the movement felt really at odds with the memory, and that this meant she was experiencing the memory in a different way.

She described a feeling of light and said that she was starting to feel different. Previously, she had experienced only fear and anxiety but now she was experiencing a wider range of emotions. She spontaneously closed her eyes whilst processing - then her headphones stopped working.

No stop signal

I was unable to give her a stop signal, as she continued to tap her feet. I watched her closely and she appeared to be processing well, deeply into the emotions. After a while, she opened her eyes and said that she felt it in her stomach. I gently asked her to try to keep her eyes open as the headphones had stopped working and then we continued. Luckily for me, her headphones must have righted themselves because, whilst processing, she closed her eyes automatically again. She described herself feeling that the tapping of her feet was trying to pull her away from the terror, but the terror went very deep and she was clinging onto it.

The next time we stopped, she said that she felt the scared feeling was necessary for her survival. She said she had noticed other people's feelings around her and everyone had been so afraid and worried. She said she felt stuck in the negativity of that whole period.

At this point I used a cognitive interweave and asked her what

she needed. She said a good friend (who we had previously installed as a resource) would be helpful and we brought her in. Immediately, the terror in her stomach dropped away. She said she felt more hope and positivity and that her feet had changed from feeling leaden to feeling bouncy. She said that, in her head, she imagined speaking out. She would say 'There's nothing wrong with me. I deserve to be heard'. I asked her to say those words as she tapped her feet. She stood up and said them as she moved around the room.

At this point we started to be able to hear the babbles of her daughter who was in the room, underneath her. We both listened to the baby's noises. The baby sounded happy and active. She said that being in the memory felt very different now. She could no longer contact the feeling in her stomach, and she felt that her mind was no longer dwelling in fear.

We returned to target and she said that the memory no longer activated the feeling in her stomach. She rated her SUDs at 4 so we closed down as an incomplete session as we were coming to the end of our time. She was able to bring herself back to her safe space.

Reflecting afterwards, she said that she had needed to hold onto her fear in the hospital because no one had been taking her injury seriously. They had all been treating her as if she should bounce back to normal. For a week she had been saying that there was something wrong, but they had told her that she was fine and

would soon be out of bed.

Bringing in her friend allowed her to let go of the fear because her friend listened to her and so could help her be heard. Doing the EMDR helped her to put that fear in the past and to feel that, right now, she was safe. She could accept that what had happened to her wasn't a personal failure.

We agreed that we would come back to that memory in the next session. My feeling was that the SUDs were not fully down because there were several other connected memories of that time which remained unresolved. There were more channels to go down. The memory also connected to some earlier experiences of not being listened to or taken seriously, which might have been feeder memories.

Differences online

Working online with her made a few differences to the session. I would not have used tapping together if she had been in my clinic room, and yet using her feet to tap became an important part of the processing. It kept her in the present; in the past she had been unable to move her legs. In her first session we had had to use the phone when the internet cut out, and so we had had the experience of talking without images, although for processing the video conferencing worked well. That first history taking session was more powerful than I had anticipated, somehow only having voice meant we connected differently and formed a strong rapport right from the start. It also reassured her that even if the internet

went down we would still be able to communicate and she would not be left in the lurch. I was glad to be able to see her in the later sessions however, when her internet connection was good enough for us to use Zoom.

We had had to decide whether the space indoors was 'good enough' even though she would have preferred to be in her garden; a process of balancing out all the different parts that went to make up our therapeutic space. And with her, I was reminded of why I ask dissociative clients not to close their eyes. I did lose contact with her briefly when her headphones cut out; whereas this was fine for her and she came to a natural end, it might not have been fine for someone else. She experienced the shift in her feet, as they changed from leaden to bouncing.

There was something very special about the happy sounds of her daughter in the flat. The sounds kept her in the present whilst she was remembering the past. In this way, working in the environment of her flat gave us advantages as well as challenges to overcome. In conclusion, working online offered us the chance to do effective EMDR, something that would otherwise have been impossible due to the restrictions of lockdown.

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Virtual EMDR therapy with children and adolescents

Susan Darker-Smith considers the specifics of working online with teenagers and younger children

Children around the world are asking: 'when can I see Gramma or Grandpa again?' The simple truth? We just don't know. What we do know is that, for children, COVID-19 has the potential to be one of the greatest Adverse Childhood Experiences in our time. And the impact could last for a generation.

We are all driven by personal experiences: for me, it was working with a 6- and 9-year-old from the Manchester Arena Bombing. The family were physically unharmed following the attack and they decided to attend the Ariana Grande One Voice benefit concert. During the concert, the children became agitated and asked their parents 'Can we leave now... before the bomb goes off?'.

They taught me that anticipatory anxiety is a huge factor for many following an incident of mass trauma (such as COVID-19) and mass terrorism. And with this piece of information, we now realise that many recovering from psychological trauma may be as traumatised by the 'what ifs' as they are by what actually happened.

We are also seeing children struggling with survival guilt from the loss of older relatives, fears that they may be responsible for the illness and/or death of relatives and we are seeing children left orphaned. The rate of domestic violence is increasing and, for children with

attachment wounding forced to self-isolate with the perpetrators of that wounding, the hopelessness and despair may feel endless.

These are all issues which would classify as Adverse Childhood Experiences (ACEs) and it is likely that the majority of our child population is experiencing ACEs in direct response to the COVID-19 Pandemic. ACEs can lead to physical health difficulties (such as heart disease, cancer and addictions) in addition to longer-term mental health issues in adulthood. Thus, it is vital that we start responding to child mental health issues now in order to prevent and protect the longer term impact of mental health difficulties influencing the physical and psychological health of our next generation.

Daunting

Yet, for many of us, the issue of adapting our work with children to a virtual format is daunting, at best. The fears of unfamiliar technology and whether it will work are common themes for many of us. And it appears, if only for a moment, we forget how much of our world has already transformed into a virtual one.

For the majority of teenagers, the world is online. Homework is set via online apps and teenagers use social media such as *Tinder, WhatsApp, Snapchat,*

► *Instagram and Facebook to communicate.*

For teenagers, the move to a virtual platform is seemingly effortless. This is their natural method of communication and for many, the risk of ending up in a waiting room next to a peer

wounds.

In this context, the only difference is the method of alternate bilateral stimulation (ABLS) we utilise – as eye movements tend to be challenging to deliver online, not least because movement is blurred and, if clients

Use of the butterfly hug (or variants of it, such as the ‘gorilla’ where the child clenches their hands like a gorilla and performs a light version of King Kong’s chest-beating) also affords the therapist the opportunity to mirror the client’s



For the majority of teenagers, the world is online and the move to a virtual platform is seemingly effortless

from school is mitigated. The use of online communication appears familiar, reassuring and instils a sense of authority and expertise, which is helpful in building resources for young people. There are emojis offering a more acceptable way of communicating emotions on many virtual platforms (*Microsoft Teams* and *Zoom* both offer these), there are shared white boards for drawing and the chat bar is always a good option – although if you are, like me – try to resist the urge to correct grammar!

Managing risk

Risk may also be managed more effectively online for teens where they are in a supportive family environment and are surrounded by those who care about them. However, this may be the reverse for unsupportive environments where parents may have unwittingly contributed to attachment

are using mobile phones, the sweep of eye movements will be minimal and possibly less effective.

Butterfly hug

Much more effective for virtual therapy is the use of the [butterfly hug](#). Clients report that it feels containing to place one hand over the heart and the other on the opposite side of the chest.

When using EMDR with children (and, I would suggest, more fragile adult clients) the butterfly hug enables us to ensure visually that the client is actually doing alternate bilateral stimulation – rather than simply tapping their legs or the table simultaneously. This is an important factor – as so many of our clients, when asked to tap, are more likely to tap both hands at the same time – meaning that alternate bilateral stimulation is not actually taking place.

bilateral movements to increase attunement in a virtual session.

In therapy, regardless of whether it is in-person or online, attunement is an important aspect of the client’s potential to improve with their chosen therapist. And it’s one that causes a great deal of concern about working with children online.

Attunement

We know from research that therapeutic alliance and attunement are vital in helping clients recover from psychological trauma. How else can they trust their pain and distress can be held and healed by another? It may be easy for us to assume that if we are using virtual platforms to deliver therapy, attunement may be lost. Or worse, we may, as therapists, be replaced by online ‘bots’ who can deliver the same intervention just as effectively. Yet,

▶ despite efforts in 2014 by the US Military to create a virtual therapist called 'Ellie' who was programmed to read emotional changes in vocal patterns and body language, [the US Army had to admit defeat](#). Robots simply cannot replace human therapists – even in a largely virtual world and even when therapists have no other option but to deliver therapy online. We are capable, even in a virtual world, to attune to our clients. A robot, no matter how cleverly they are programmed, simply cannot.

By doing what we can to create a safe and containing virtual environment for the child and using alternate bilateral stimulation which the therapist can mirror, we can move towards attunement, even in a virtual world. And with teens, this works.

Younger children

I agree that it can be difficult to engage younger children in a virtual world. There is a tangible loss of creativity and connection. And my preference in all honesty with children under the age of nine would be to always deliver EMDR in person. However, in the current circumstances this is not possible. And I would argue that virtual therapy (given the context) is better than no therapy at all. For young children – I would always suggest starting with a game that you can play together and share online as a form of building attunement and creating a sense of shared engagement.

The use of the virtual white board (available on many platforms) and 'scribbling out' the

drawing of the 'sad, bad or mad' feelings can be one of the easiest ways to deliver virtual EMDR to a child under the age of nine. They naturally will track the virtual pen movements – the function of drawing the traumatic image is seen as grounding (Dagmar Eckers, 2010 observed this in the child modification of Jim Knipe's CIPOS) and we can check by their movements for ABLS.

ABLS

When it comes to ABLS, I would suggest that as therapists, we place the child's needs central to the clinical decisions we make. Some children will prefer the butterfly hug, others the gorilla and others to draw. When the child is made the effective agent of change in therapy, they feel motivated and engaged in the process, thus conveying ownership in the therapeutic journey, regardless of the age of our client.

For the very youngest of children, using the parent as a co-therapist can be hugely helpful – but this depends on the relationship between parent and child. The Storytelling method can still be used effectively via a virtual platform and indeed, I have recently used this with a five-year-old child utilising puppets on my side of the screen to help 'tell the story' – and it worked.

What I would suggest – above all else – is that we don't lose our capacity for creativity, humour and engagement out of the anxiety associated with having to use virtual platforms during the pandemic. For this is what makes us able to meet a child in their own natural lan-

guage of play and creativity. Is delivering EMDR online as effective as face to face therapy? My view is that it is. It is not always comfortable and children, like each of us, are unique and differ in their responsiveness to online therapy. Is it better than not being able to offer anything to a child and their family that are struggling during this pandemic? In my view, definitely.

Susan Darker-Smith is an EMDR Accredited Child & Adolescent Trainer and Consultant. She is the UK representative for the Global Child EMDR Alliance and sits on the Child taskforce and the Clinician taskforce. She is also a Trustee for the Trauma Response Network UK.

We welcome your words

Have you seen, witnessed, read, developed something in the EMDR field that would be of interest to others? We know that you are curious, creative and reflective. If you wish to share your discoveries, experiences, views, comments or thoughts related to reflective practice, we would like to hear from you.

Write to:
editor@emdrassociation.org.uk

Utilising EMDR Therapy with Generalised Anxiety Disorder including anxieties related to COVID-19 – A brief case study

Introduction

For many of our clients, COVID-19 has led to an exacerbation in symptoms or caused a setback when previously they might have been managing well post-discharge. Many supervisees have asked me whether EMDR has much to offer when the coronavirus pandemic, the changes to our lifestyle that it imposes and the anxiety that this causes are ongoing. A client whom I had previously helped to manage his generalised anxiety disorder (GAD) got back in touch for a 'booster session' following a setback related to the pandemic and the results of the ensuing treatment would suggest that EMDR has much to offer.

Earlier treatment

We first started working together in October 2019, when he had presented with many of the classic symptoms of GAD including restlessness, a recurrent sense of dread, feeling constantly 'on edge' and difficulty concentrating. Like many people with GAD, he also had some OCD symptoms alongside this, including some rituals.

We had worked together for 10, 60-minute sessions over three months. We first utilised CBT competency framework for GAD based on the Dugas/Ladouceur/ Freeston model (available at: <http://tiny.cc/ttwbnz>).

This CBT for GAD therapeutic work included an assessment, formulation and then cognitive

by Matthew Wesson

and behavioural strategies to increase his tolerance of uncertainty. This worked well over the first six sessions and led to reduction in symptoms.

However, like many GAD clients I have worked with, his progress then started to slow. At this point I switched to EMDR Therapy to 'supercharge' his recovery, whilst asking him to continue with the CBT strategies as between-session work.

In the seventh session we prepared for EMDR processing in the usual manner with safe place, but I also used the Flash technique (Manfield *et al.*, 2017) to demonstrate how EMDR processing is very different to CBT and this had the desired effect of reducing the distress of one of his core past memories. In the following session we processed a childhood memory of his anxieties with the standard protocol (Shapiro, 2018). This was a memory of being driven to secondary school, feeling very distressed because he wanted to stay at home. This cleared in a single session and, when we met again the following week, he reported a marked reduction in his anxieties and an increased ability to integrate the CBT strategies we had covered previously. Clearing this memory had seemed to generalise across to other similar targets, so after a re-evaluation we decided to concentrate on his future fears. We used the Flashforwards procedure (Logie

& De Jongh, 2014) to target a catastrophic fear of a car crash involving all his family. This is similar to the Cognitive Exposure element of the CBT for GAD model; however, I have always found it quicker and easier to utilise the Flashforwards in addressing relevant core future fears. This protocol completely cleared the future target in one session, with the progress from this being maintained at the next session. Session 10 was then a therapy wrap up including a future template on handling uncertainty and a CBT relapse management plan. We met six weeks later for our first 'booster session'. The client was doing well and had achieved his therapy goals with the psychometric scores all in normal levels. We spent our time revising some of the CBT strategies to help maintain his progress.

Resurgence of symptoms

A few weeks into the Covid-19 crisis he got back in touch requesting another 'booster' session. This session had to be delivered online due to social isolation restrictions. The client had noticed an increase in his anxieties, although this was much less than he had expected considering the level of uncertainty that the virus was causing him. However, he had significant fears about how long he could cope with the lockdown, because this meant being away from much of his support network. As these fears were future based and

An example of a client-therapist contract for online work

The contract displayed on the right is an example of the contract for online work that I use with clients. It is published here as a guide to be adapted as you see fit. I make no claims as to its legal status and it is the responsibility of individual therapists to check this for themselves. I accept no liability for its use but offer it as a model for others to adapt to suit their purposes.

Alexandra Dent

Dr Alexandra Dent is a Registered and Chartered Clinical Psychologist, EMDR Europe Accredited Consultant/Clinical Supervisor and Training Facilitator and EMDR Europe Accredited Child and Adolescent Consultant/Clinical Supervisor. She chairs the EMDR Child and Adolescent committee.

I would like to provide you with some practical information to help you understand what to expect with online sessions and also provide some tips to make sure the process runs smoothly. It might feel scary or uncertain to have some sessions online but they can be as effective as meeting face to face, so long as you follow the sensible tips below. My goal is to create a safe and contained space to work with you. However, I am unable to personally guarantee the complete 100% security of any online platform so please do your own research and decide which you would prefer to use. If there are some material/documents that we need to use for the sessions (e.g. when I am going through psychoeducation and mindfulness), I will make sure that I have emailed this through to you before the session.

Services we can use:

1. Zoom

This is free for you to download from: www.zoom.us

A video on how to use Zoom is here : <https://support.zoom.us/hc/en-us/articles/201362193-Joining-a-Meeting>

If we are using zoom I will send you an email before the session which contains a meeting number. Please make sure I have the correct email before the session. When you open Zoom, it will ask you to enter the meeting number

so that you can join me. Please do NOT join the meeting until the agreed time.

2. Skype

An alternative is skype which is also easy to use: www.skype.com

My skype address is .

Please make sure you have connected with me before the session so that when the time arrives, we can start on time.

3. WhatsApp

Another alternative is using Whats App. Please make sure that I have your correct number in advance of the session. www.whatsapp.com

TIPS

Please make sure that:

1. You have your computer or mobile set up with Zoom, Skype or WhatsApp before the session commences. This includes having your microphone and video turned on.
2. Your computer or mobile is positioned at a sensible height so that I can clearly see your face and that the camera is at eye level. If several people will be participating, please make sure that I can see everyone clearly.
3. It is very easy to hear background noises e.g. animals and washing machines and kettles etc. so please make sure you are in a quiet location.
4. You will not be disturbed for the

p20

considering our previous interventions, we decided to once again utilise the Flashforward procedure.

The catastrophic image was that he was in great distress, alone and isolated. The negative cognition was 'I cannot cope', the positive 'I can cope' with a validity of cognition of 2, the primary emotion was fear with a SUD of 9-10 and nervousness in his chest and arms. We were able to clear this target quickly through Phases 3 to 6, without the need for any unblocking strategies. We even had time to install a Future Template of what an 'adaptive day' would look like

during the lockdown.

Conclusions

It has now been several weeks since this session, so the client may get back in touch, but he certainly felt calmer to face the challenges ahead following our last session.

Since COVID-19 became a pandemic, many supervisees have asked me how to utilise EMDR therapy when it could be argued that client's anxieties are completely justified. For me utilising Flashforwards was one way to help with this client. I am sure the EMDR community will come up with many other creative strategies to util-

ise EMDR therapy in helping people through this challenging time.

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duration of the session and that the door to the room you are sitting in is closed.

5. If you are using your computer, you have your mobile out of reach and with the sound muted so that it is not a distraction.
6. You do not have your back to a window or light – this can make it very hard for me to see you clearly.
7. That there is adequate lighting in the room you are in.
8. You have a box of tissues and a glass of water nearby.
9. Your computer, iPad or mobile is charged sufficiently before we speak.
10. You have not been drinking alcohol or taking drugs before any sessions where they may still be in your body.
11. You do NOT record the sessions. I will not be recording any of our sessions UNLESS I have prior consent from you and this has been mutually discussed and agreed and a consent form has been signed by you.
12. You join the meeting at the agreed time.

Sometimes people use headphones during online sessions. Using headphones can create a more intimate and powerful connection. If we plan to do some EMDR then using headphones is also desirable (if we are going to use auditory bilateral stimulation) - I will explain more about this in the EMDR session.

As with face to face sessions, the confidentiality agreement we signed together still applies. In addition, my terms and conditions that you signed at the beginning of working with me are still applicable.

By signing this, I confirm that I have understand the information above and have had any concerns explained to me. I agree that I will NOT record any part of the session or let anyone else listen in to the session (via phone or any other device or means) without prior agreement with (name of therapist). I understand that (name of therapist) cannot be responsible or liable for the online security or breach of security of any of the online platforms I choose to use for sessions.

Client's Name..... Date.....

(or parental or carer's name if client is not Fraser competent)

Client's Signature...Date.....

(or parental or carer's name if client is not Fraser competent)



The Sea Shell

By Susan Darker-Smith
From an idea inspired by Ana Gomez
Illustrated by Jo Henry

The EMDR Child Global Alliance
'healing one child at a time'

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Reviewed by Omar Sattaur

This beautifully illustrated book is intended to help children cope with loss. It was inspired, the author says, by an idea of the renowned child therapist, Ana Gomez. It is written in response to the millions of children worldwide currently struggling with bereavement or simply unable to see their loved ones because of the restrictions on movement during the pandemic. It uses

the idea of how holding a seashell to your ear can give you the sound of the sea even though you might be very far from the sea. In the same way our loved ones can 'hear' us if we think of them with love - a kind of loving meditation which helps the child to feel connected. A simple grounding technique is incorporated, using the breath and visualisation of the loved one.



♥ Breathe in for 4
beats of your heart.

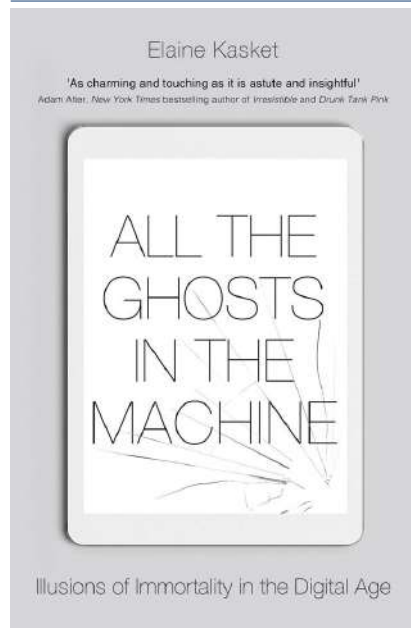
♥ Hold for long
enough to think
'I love you.'

♥ Breathe out for 4
beats of your heart.

All the Ghosts in the Machine: Illusions of Immortality in the Digital Age by Elaine Kasket

Robinson, London

ISBN: 978-1-47214-189-7



Reviewed by Omar Sattaur

One of the many things I learned in this informative and very readable book is that I am a digital immigrant. That is, I grew up keeping address books, writing letters and spending many happy hours reading books and browsing my parents' photo albums (pxx). As a journalist I kept a large contacts book, with the numbers of experts and quotable sources and when the fLOFAX made its appearance I was pleased with myself for keeping up with the times and organising my life with its help.

Unlike a digital native, I had not considered my 'digital footprint' – all the stuff about me and the people I know that now resides online. Kasket's book set out to consider "death in the digital age" but as the author notes, it ended up focusing more on how we man-

age the considerable challenges of how we live now and which will accompany the people that may end up managing our digital legacy (p239).

And there are many challenges. Kasket has been studying this complicated and intriguing subject for many years; she has interviewed people who have fallen foul of the legal and administrative jungle that has grown up around our digital legacies and the stories are often painful, but unforgettable. An early example she gives is of Hollie Gazzard, a young woman stabbed to death by a former boyfriend when she told him that the relationship was over.

Hollie, like many digital natives, lived her life in full public view on social media. And her family, as is common today, did part of their grieving online, by visiting her *Facebook* page. The only problem was that it was covered in images of Hollie with the man who murdered her and, at that time, there were no conventions about what happens to a *Facebook* page when the creator of the page has passed away (p69).

Kasket charts the learning that has taken place since, the question of ownership of online assets (for example photographs), ethical questions (for example, the rights of children whose parents indulge in sharenting -posting pictures and conversations with their children online), the establishment of organisations such as the Digital Legacy Association and development of legal expertise on digital legacies.

Helpfully, but somewhat per-

turbingly, it asks the reader what they have done about their digital assets and what they want to happen to them when they die. I admit, I have given it no thought at all. Remembering when my own parents died, probate and the settling of their modest financial assets and physical belongings were onerous enough.

We now have so much more to deal with online. Ask yourself: have you made a will? Have you decided on a legacy contact? Who will take care of your online accounts and who has access to your passwords etc?

Take heart. The book ends with "A Decalogue for your Digital Dust" – a ten-point list to consider before you shuffle off this mortal coil (p242).

Omar Sattaur is a Counsellor at the University of Manchester Counselling and Mental Health Service. He has a private therapy practice in Cheltenham and edits EMDR Therapy Quarterly



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Friday 12 June & Saturday 13 June 2020

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BOOKING FORM

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Free Resources for COVID-19 & Online Work

Dear Colleagues

There are now dedicated pages on the EMDR Association website for Online EMDR Therapy & COVID-19, including information for therapists and clients. Look for a large blue banner on the homepage, with links.

Therapist resources include hyperlinks to access useful information including the five webinars on the subject of online work.

<https://emdrassociation.org.uk/>

Please pass this information on to non-members and other EMDR therapists. If you have other information that you think the Association should publicise please forward it on to me (as long as there is appropriate permission to share publicly).

Many thanks and take care everyone

Matthew Wesson
EMDR Europe Accredited Senior Trainer
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Noticing the Effects of Narcissism: Working with Clients Ending Abusive Relationships

Tom Tomaszewski

EMDR Practitioner in private practice in Central London.

Contact: tom@t-practice.com



Echo and Narcissus, 1903, by John William Waterhouse. It illustrates the poem Echo and Narcissus from Ovid's Metamorphoses

Introduction

I have tried here to summarise some sustained work with women ending abusive relationships. In recent years my practice has been drawn to various ways of thinking about narcissism. This includes varieties of pathological narcissism, as Kohut (1966, 1971), Miller (1979) and Kernberg (1985) have described them, and thinking about healthy narcissism along the lines traced by Federn (1952). Federn's thoughts relating to 'ego feeling', the basis of his 'ego psychology', have influenced mine.

I shall discuss how the EMDR with these clients drew me to a particular form of history-taking rooted in psychoanalytic practice, and how the work that followed seemed to move through three recognisable phases:

- i. exploring the formation of a personality prone to entering an abusive relationship with a pathological narcissist.
- ii. recognising and engaging with the present-day dissociative or repressive patterns that isolate an individual and which may relate to a distorted sense of reality and how these are induced in unhealthy narcissistic relationships. These patterns can emerge in the rela-

tionship between the therapist and the client.
iii. working through a conflictual stage which almost inevitably arises once the client has experienced the narcissistic gains that result in greater autonomy and agency. That is, once clients have been reintroduced to the qualities a narcissist might covet but which they, themselves, became separated from, are unable to acknowledge in themselves, and which leave them with what is generally referred to as 'low self-esteem'.

EMDR is about keeping things moving. Traumatic memories are reprocessed, negative beliefs are revisited and lives are re-started after becoming stuck. The paper is about how EMDR uniquely addresses the transfixing effects of pathological narcissism where people get stuck in abusive relationships. It explores how EMDR releases healthy narcissism, the good 'ego feeling' (Federn, 1952) that allows a life to be invented with a sense of possibility.

Taking a History

Taking a history can reinforce unhelpful narratives. These might be anything from the idealised 'you and me against the world' stories that shore

► up abusive relationships to phenomena such as screen memories (Freud, 1899): the kinds of exceptionally vivid childhood recollection of innocuous or banal occurrences that condense real emotional experience and fantasised events. Screen memories are constructions not to be taken literally.

Shapiro observed that clusters of memories can be addressed in one instance of EMDR (2001, p76). There is usually a benefit from finding what seems to be the earliest instance of a trauma, but I find the conception of trauma as progressing linearly, and originating singularly to be problematic. Memory chains are often unpredictable and volatile. Working with people who present with pronounced attachment difficulties, people who might be described as having 'complex PTSD', asks us to avoid limiting accounts of their histories.

Creating an ongoing history, or histories, through 'free association' (Freud, 1912) brings to consciousness surprising, unexpected, and incongruous thoughts. Competing histories may emerge, each relating to different forms of thinking¹. This is a less cognitive approach; one open to the unknown and close to the spirit of EMDR processing during which a therapist tries to follow the memory chains and not to obstruct the client. In some ways, free association is similar to 'floatback' (Young, Zangwill & Behary, 2002). The two approaches differ in the way that, once material has been activated in free association, the client is not 'encouraged to think of similar events' (p. 196). Floatback carries implicit narrative-oriented, messages. On the surface, it would appear that a client is left to make connections relating freely to the phenomena they are experiencing after activation – and in many cases floatback leads to an antecedent traumatic memory that can be processed.

However, floatback remains more consciously directive: a client is encouraged to follow a direction (into the past) and a possibly incongruous sensation (floating), and to connect to a place (somewhere in the past). A lot will depend on how the client and therapist interpret the idea of 'similarity'. The value of an approach such as free association is that it can lead to connections that are anything but free, but

which, because of their inescapable nature, have been repressed or dissociated from. Trauma is sometimes unthinkable.

A recent example of this kind of work occurred when a client approached me in relation to a traumatic incident when he was called to give evidence at a tribunal. The experience had been devastating. A range of physical symptoms had arisen after the event including sickness, dizziness and headaches. The client had felt intensely paranoid to the point where he imagined and regularly dreamed that he would somehow die because of his testimony. Once activated in relation to the tribunal something felt strange. The client recorded SUDS of 7-8 and was able to talk about the tribunal only with difficulty, but it felt to me as if something was getting in the way of him talking about the tribunal – a rather different state of affairs from the experience being 'too much' to consider. There was also a deep mistrust of me. Not of me, personally, the client insisted, but of me as a professional. That part of the situation seemed connected to something other than the tribunal. The client had no complaints about professional misconduct in relation to that event.

I tried floatback, as I sometimes do, but without any luck. When I instead drew a vertical line with 'o' at the bottom and his age at the top, and asked him to tell me about what else had happened to him he was astonished to find himself remembering an incident in his twenties when he almost died from a burst appendix. The combination of physical symptoms associated with that event, and fear and outrage at the professional negligence which had almost resulted in his death, were things he said that he had not thought about since they had happened. They felt, he told me, almost identical to how he was feeling after the tribunal.

Literary criticism can help therapists here. Wood (2014) writes about 'following without following' as key to reading of all kinds. She thinks about how one might read anacoluthia: sentences or verbal constructions, poetic or conversational, that lack the usual grammatical continuity. If we want to approach the unknown we need a way of proceeding that does not rely on what is already 'readable' to therapists or to

¹Thinking at a different age, for example, or thinking that incorporates unconscious fantasy, or material told to the client by a third party.

▶patients themselves. We need to open our ears to that which has been cut off from, whether by dissociation, repression or some other disconnecting phenomenon.

It is a commonplace of psychoanalysis that we do not know ourselves. I have observed that one persistent effect of pathological narcissism is to render people close to the narcissist somehow unreadable to themselves. Pathological narcissism can disrupt or deform the personalities of others, leaving them with a diminished or patchy sense of self. They are less able to experience some of their most positive attributes. They become stuck, their lives fixed by their diminished sense of themselves. It is a kind of trance state, into which they are seduced or otherwise overwhelmed by the narcissist who has no intention to support their flourishing.

(i) The Diminished Personality

“I’m no good”, Roshni said.

“What do you mean?”

She shouted at me as if I were deaf: “I had a narcissistic mother. OK? I have done the research. And I think I am a piece of shit. OK?” She told me she had no specific traumatic memories. “It was the whole thing.”

Roshni, a drummer, was obsessed with her boyfriend, lead singer of another band. She told me how she did everything for her own band. She organised the gigs, got them to practices and had even found them their manager. As she spoke she regularly checked her mobile phone and asked me whether I thought her boyfriend was cheating on her. After she’d taken her phone out for the seventh time, read whatever messages had arrived, then packed it away in her bag I asked her: “What makes you think he’ll cheat on you?”

“Why wouldn’t he?”

I try to see clients in intensive blocks, often daily, initially for seven sessions before reviewing the work. Generally the less material stability there seems to be in the client’s life (as distinct from any emotional instability) the less frequently I work. Despite Roshni’s practical organisational abilities, it was difficult to find much material stability in her day-to-day existence. She had no fixed address or stable social group that she felt she belonged to apart from

her band. I agreed to see her the following week at the same time and for five weeks afterwards following the same pattern.

In our next session she looked exhausted and cried from the moment she walked into the room. “I’m so sick”, she said. “I’m so sick I can’t leave him alone. He’s so angry with me.”

At the first meeting I usually try to obtain only the most basic historical details from a client. In addition to what I have already mentioned, I knew that Roshni, who was born in and spent her earliest years in India, had no history of epilepsy or any other condition, was taking no medication, had grown up in England after her German mother and Indian father divorced, and had two sisters. Her boyfriend liked her to remain ‘on-call’, would sometimes ‘let’ her sleep over, and would often disappear for days without saying where he was going. Roshni didn’t like any of this, but told me she was fine putting up with it because in the end the other women didn’t mean anything to him.

But did she like that?

“Of course not”, she told me. “But that’s life.”

Roshni was typical of many people I see: someone with obsessive-compulsive behaviours, addictions and unwanted dependencies, but to begin with no memories that she regarded as traumatic. For a therapy session to remain open to free association it needs to be founded on a sense of free movement. This means ‘following without following’, approaching the work, as Bion (1967) described it, without memory, desire or understanding, and trying not to think too hard about what’s going on while remaining receptive to what is happening in the room. Targets for EMDR are formed from associations. I might, for example, point to what is happening in a session (it may feel either too heavy or too light, in terms of affect). It’s from these slight discordances or digressions, seemingly off the point, or from an associative connection with the past that a potential target emerges.

I reflected back to Roshni: “Your band’s doing better than ever, but you don’t seem interested. You moved away from talking about it as soon as you can. You want to talk about your boyfriend not your band. Not about you and him, but about what he’s doing. We end up not talking about you”.

► “Yes, that’s right.” She looked at me as if I were an idiot.

“If you let your mind go wherever it wants, where does it go?”

“I don’t know.” She looked pinched and distant.

“Maybe when you say that you mean that you don’t feel able to let it go anywhere?”

She was silent. “It doesn’t go anywhere.”

“Roshni, what’s happening?”

“I am really ill. I am useless. I am a piece of shit. It’s like that bitch, it was always about her. Everything was for her, nothing is for me.”

I noted the negative cognitions as they flowed.

“What are you thinking about?”

“I had a box in my bedroom where I kept my toys, because if I left them out she would take them.”

“She’d take your toys?”

“Yes.” EMDR processing began with the image of the toys and the cognition ‘nothing is for me’.

“My back, it really hurts.” She started to stiffen.

We processed the sensation of her back hurting and a feeling of an awful presence in front of her and above her, to her right. We agreed that these represented her mother standing in front of her, shouting while Roshni closed her eyes, and the sense of someone always watching her from behind, never taking their eye off her.

With the former memory the target became the sound of her mother shouting, with the latter the target was the sense of being watched. We used an iPhone to record Roshni saying what her mother had said and played that during the Alternate Bilateral Stimulation (ABLS, I usually work face-to-face) to recreate her being shouted at. We used a cushion to suggest the weight on her back. These things helped to activate the memory.

As we processed, we used negative cognitions that corresponded to her interpretations of herself as a result of what her mother had shouted at her (for example, ‘I am a piece of shit’), to feelings of pain and to the feeling elicited from her mother’s verbal assault. Memory chains emerged that released the following biographical information after the SUDs reached zero. Roshni had learned to play drums in London only after qualifying as an accountant there, because completing an accountancy degree “was what my mother wanted me to do”. When she

was 10, she had joined a English school. The head teacher had told her she would need to join at a stage with students younger than her because her English was not perfect. She asked whether she could try to learn more English before the school year started, and then start with people her own age. The head teacher agreed and Roshni managed this difficult thing. Then she had to cope with her mother’s reaction in private – at Roshni ‘showing off’. In public, in contrast, her mother paraded Roshni like a trophy.

When Roshni showed interest in music her mother hired teachers Roshni didn’t like. They liked the kind of music her mother did and tried to force Roshni to play that way. She achieved a very high standard but “with no love for it. I hated it as much as I hated my bitch mother”.

Each of these memories helped us to understand how Roshni had become estranged from herself, from her musical and intellectual talent; from her ability to stand out. The idea of her band becoming successful was triggering extreme fear of her losing it. She felt this fear as pain, and so she was doing all she could to have nothing to do with it: the pain it caused, her band and its success. It was rather as if something she possessed might explode. Psychically, dissociatively, she found a way of forcing a distance. Roshni became ‘unreadable’ to herself.

The sessions allowed a better, closer reading of Roshni’s life to emerge. It was a reading that could contain things that on the surface didn’t make sense. Like obtaining an accountancy degree and becoming a drummer. Seen this way, life resembles a poem, something that can sometimes only be appreciated by being accepted just as it is. Those words, that order. Apparent incoherence can lend itself to a greater sense.

We processed the negative affect relating to each of Roshni’s memories, and the negative beliefs which included ‘I am stuck’, ‘I can’t do anything’, ‘I am so ill’. Each of these beliefs related to a form of stubborn passive resistance she tried to deploy as a child.

‘Nothing is for me’ became ‘I can try. It might be good.’

There have been similar patterns of disconnection in every case I have worked with in-

▶ involving narcissistic abuse.

Another client, Alison, a cardiologist, had worked with me for several months in ordinary psychotherapy. We tried EMDR several times without any great success. She disliked it, finding it frightening and intrusive, but without easily being able to say so. I'd noticed her very subtle discomfort, masked by a determined enthusiasm. Instead we proceeded to explore what this meant about my approach, her response to it, and what it meant for us to continue working together. When her marriage became an issue we tried EMDR again. This time she felt much more confident about being in command of the process.

"I don't want him to touch me", she said. She and her husband had been married for 30 years. "He puts his arm around me and I smell poppers. He says it's normal but I hate it. When we have sex I think I could be anyone to him."

She seemed to flinch from me as she said this. I mentioned a session when she'd felt almost unable to look at me because, unusually, I'd been wearing a tie. "Do you remember that?" I asked her. "You told me then there were some men you couldn't stand to be near?" There was a feeling she had shared which had struck me: being unable to feel comfortable in the presence of some men. "That feeling", I said, "can you feel it now?"

She nodded. I was working intuitively, trying to stay in touch with something about her discomfort around men. "Where does it take you?", I asked. "What do you see?" Again, I was following her, ready to find a target image, a sound. Somewhere to work from. Something in her past to link to.

"It's like the way my father puts his arm around my mother. I saw him do it the other day. She hates it. And with G- it's like - I just don't want to be touched at all. He doesn't see me."

"Where do you go now, with that thought?" I needed to see if we had reached the end of something.

We hadn't. She shrank back in her chair. "I feel sick. I feel really young. I'm eight years old."

"What do you see?" I asked her.

"It's a photo of when I was about eight and I

look really, well, I look really mad. It's awful."

This became our target image.

"What do you feel?"

"I feel so angry. I feel really hot. In my chest."

We had emotions and sensations activated. All of the associative work concerns activation. Following like this helps bring memories to life. There is an element of surprise that promotes anxiety during the session. I am not the one searching or connecting. Once the target image or other focus (sound, touch, taste) is activated, a trauma can be processed in perhaps ten minutes with clients where conventional, Standard Protocol EMDR appears to have failed. I often use techniques like the ones Ad de Jongh and Suzy Matthijssen have developed, tasking the client to hold onto a memory while I try to disrupt it using ABLS and anything else I can think of.

"What does it make you worry about, what do you fear?"

"I'll go mad without G-. I'll get dragged back to being that little girl again."

"Does that feel true?"

"Nobody else will want me." I could see from the look on her face that this might be an effective negative cognition, but she didn't seem to have arrived at the most intense thought yet. "I feel so scared. That's what they told me - that I was really bad and that nobody else would want me."

I suggested: "You looked mad then because of what was happening to you. Your parents told you that nobody else would want you."

"... don't want to be in this body." She was furious.

"If nobody wants you, that includes you. You didn't want to be there." I had conflated two negative cognitions, nobody will want me, and I don't want to be in this body.

"That's right. That's right. I wanted to be anywhere else." She sobbed, full of rage, as we proceeded with rapid ABLS about 10cm from her face².

"They wanted to keep it a secret [her abuse]. Nobody else would want me. They didn't want anybody else to know. I wasn't safe there."

Later, as she was about to leave the session, she

²The principles of working memory taxation (WMT), for instance this kind of very close-up working, have recently been outlined at events such as 'EMDR 2.0' presented by Ad de Jongh and Suzy Matthijssen in Manchester, UK, on 7 March 2020.

▶ said to me: “He slept with those other women and he broke the rules. Whatever he says about me, he can’t do that to me. If you’re married you agree not to do that.” She looked firm. Rock solid. Serious. It was the first time I had heard her assert herself like that and I heard in what she said a rebuttal of the thought forced onto her when she was a child, that nobody else would want her – that whoever wanted her could do what they wished. She could stand her ground now.

(ii) Distortion: Recognising and Engaging with the effects of Present-day Dissociative or Repressive Patterns

Each of the scenarios described so far, and the material targeted with EMDR, suggest how the scene was set for the individuals involved to develop an attachment to a narcissist. Recent attachment theory, (Janoff-Bulman, 1985; Lyons-Ruth and Block 1998; Ullman and Brothers, 1988; Terr, 1991), has taught us a lot about attachment deficit.

Good EMDR lets us observe the client’s childhood experiences as they have become transferred and preserved in adulthood. Earlier experiences reappear through events, structural formations or individuals, who in some way evoke a childhood state and repeat the pattern of abusive ‘love’ and ‘care’ that first led the subject to recognise herself as attached.

‘Transference’ (Freud, 1920) will be familiar to any psychoanalytic psychotherapist, in whose modality it is regarded as an important part of the work. The narcissistic relationships described in this paper, where an individual managed to tap into something about that woman from her past, cultivating a sometimes profound attachment, have echoes in what goes on in a consulting room. The ‘hook’ of a narcissist is the technique of the analytic psychotherapist: to become attuned to what Harry Stack Sullivan referred to as ‘parataxic distortion’ (1953). Like Wood, he is using literary terminology. Parataxis is a rhetorical technique in which sentences follow on without conjunctions, without the ‘ands’, ‘buts’ or ‘ifs’, that coordinate or subordinate the clauses or phrases in relation to each other. Sullivan describes the effect as: *when, beside the interpersonal situation as*

defined within the awareness of the speaker, there is a concomitant interpersonal situation quite different as to its principle integrating tendencies, of which the speaker is more or less completely unaware (p. 92)

Some relationships contain an element of fantasy based on a previous relationship. In Roshni’s case she was still seeking a ‘mother’, someone to bond to in a particular, dependent way, after distancing herself from the one she was born to. Her wish for a ‘mother’ was confined, unfortunately, by the one she was born to – an awful but indelible attachment experience, a wish for a mother destined to be repeated until Roshni noticed her blindness to it. As Freud tells us, when writing of a patient’s blindness to her ‘wish’: “The content of the wish had appeared first of all in the patient’s consciousness without any memories of the surrounding circumstances which would have assigned it to a past time” (1895). Roshni actively desired the man onto whom she projected her experience of a mother. It is the trance state I mentioned at the start of this paper. A life destined to repeat experiences determined by a diminished sense of self.

A situation like this cannot be approached as if the client needs to be educated away from their partner, or rescued from a ‘bad’ man. The client needs to recognise what is happening for herself, unbidden, and begin to realise fully who she is. Recognition is crucial: the client’s recognition, not the therapist’s. The therapist’s reiterations of the dynamics are liable to repeat the problem. Working ‘blind to therapist’, a protocol I often use, allows the client to notice aspects of a previous relationship which they have been unable to see. In EMDR a client can become aware of transference material without it even having to be interpreted.

Dissolving the state is largely dependent on being able to recognise that it is recurring. As a reader, the therapist needs to have an awareness of what is happening and at the same time an ability to ‘go with’ the sentence: the client’s processing. To be both in and out of the transference. Apparently innocuous, often kindly acts such as reducing fees, changing session times, getting drawn into giving unnecessary advice

▶ and commenting on someone's appearance or behaviour might be evoked by transference. They might reinforce the client's sense of helplessness or exaggerate the power differential in the relationship. It is, for example, usually within the therapist's power to renegotiate a fee, but not the client's. Being drawn into 'rescuing' someone can repeat the part previously played out by the narcissist, who in their turn was to some degree playing out a part 'written' for them during the subject's early life.

EMDR is interesting in that it offers a certain resistance to some aspects of transference. In particular it does not privilege speech and the therapeutic relationship in order to elicit change³. Speech occurs, of course, but in the main part the client is directed towards noticing herself. She focuses on herself, on Federn's 'ego feeling', that is the feeling of herself. In EMDR the movement of processing defines the ego-feeling as always ongoing, rather than essentially 'fixed', which seems characteristic of pathological narcissism. She cultivates a healthy form of narcissism which supersedes the felt sense of negative cognitions with the feeling of positive ones.

Recognising the intensity of these transference moments, ones in which a demand is placed on the therapist, and then acting in a way that questions what is going on in a manner that the client may not be used to, can prove very helpful for dissolving the transference. This may draw a client out of their distorted experience.

Interventions of this kind need to be in some way surprising, if not disturbing. They have to cause a particular kind of emotional and intellectual upheaval in which the world is presented as it has not been before. This is similar to Strachey's (1934) conception of a 'mutative interpretation'. The therapist's thoughts are received without consciousness contracting. Similar to the most effective cognitive interweaves, they provoke new thinking and new feeling.

A client, Kate, had made good progress. However, with this kind of work there usually arrives a tipping point at which insights gained in one session seem to dissolve by the time the next session arrives. If they are mentioned at all they feel, according to the clients, or as I hear the client describe it, incongruous. The thought is no longer felt to be true. The distortion persists. Defences have reformed against the perceived version of life as a product of the diminished personality and the impossible world outside.

In one session Kate spent a good deal of time talking about herself. She spoke about her partner's aggressive comments concerning her looks and weight with contempt and anger. However, at the next session, as we returned to check the SUDs on work from the previous session, Kate seemed to lose confidence. Her feeling of being not good enough felt true once more.

"It's my stupid idea of myself again", she said.

"My low self-esteem."

"I don't agree", I told her. "Low self-esteem doesn't exist."

She looked at me as if I was mad. "What?" she said, utterly confused. She blinked. "What did you say?"

"Your gifts, you've hidden them somehow. Cut off from them."

She shook her head: "I don't get it. I don't understand."

I could see that her breathing had sped up, I drew her attention to it and in the session she started to breathe like she'd learned, slowly, from her diaphragm.

We sat together in silence and then she suddenly relaxed. She remarked: "Yes".

With Alison, a similar moment had occurred in the session following her realisation about her husband's infidelities. When we met after a week she immediately said to me: "I think I may be getting things out of proportion".

"What things?", I asked.

"Well maybe I've only got myself to blame for

³Work, for example, at the Psychotrauma Expertise Center (PSYTREC) in the Netherlands suggests that successful EMDR can occur when client and therapist barely know each other. Perhaps the idea of an organisational or institutional attachment (or transference) is important here. People who are used to working in places like addiction treatment facilities or any well-integrated clinic are likely to know what I mean by this. Possibly it also brings into focus how much of a therapist's work is not directly involved in EMDR treatment, but in relation to a person who will have or has had EMDR. I regularly refer clients to other therapists once someone has had EMDR with me; and although there is inevitably an intimate connection between my psychotherapy and my EMDR work I am aware that when I offer EMDR it can be an intervention among other processes, rather like a cutaway shot in cinema.

the way he behaves.”
 “And nobody else will want you?”, I asked.
 “Exactly.” Her eyes dulled as she said this.
 “What was that?”, I asked, drawing attention to her, looking into her eyes.
 “What?”
 “Your eyes grew dull. You looked sad. You still do.”
 “Because ...”, She turned away. “It’s too big. It’s too much.”
 “You don’t want to look at it, do you?” *It* remained unnamed, as it needed to. I had no idea what she meant by ‘it’.
 I asked her to try and hold onto the feeling she had while I processed it with ABLS. I asked her: “Do you really think it’s your fault?”
 She shouted: “No of course I don’t. I could have been with someone else all these fucking years, I can see that, I just can’t stand thinking about it.” Then she relaxed.

She seemed *there*, in the same way that Kate had suddenly relaxed. On both occasions there had been an invitation for me to play a part in the drama being acted out, confirming the way that things had been and taking both women back to the ‘trance state’ of the relationship with the narcissist. Simply opposing that flight into unreality as if one is trying to cast a bad idea out does not, however, seem enough. A battle of wills is likely to ensue and in my experience that never ends well. With EMDR we need to be careful not to see abreaction as cathartic, like an exorcism. What seems to be effective is what de Heusch writes of as *adorcism* (1962), in which the ‘bad idea’ is somehow accommodated. The ‘bad idea’ needs to remain in place, but felt as ‘bad’, an undesirable ego-feeling, so that it can be moved on from.

On occasion the trance state dissolves of its own accord. It is the client’s less distorted perception of themselves, their consciousness released from the hypnotic state, which seems to countersign its dissolution.

At the beginning of a session Roshni had reported a phone conversation with her mother. “So she called me up out of the blue and asked if I knew what next Sunday is. I told her it was the beginning of Lent, but why was she asking me? She said to me: don’t forget what day it is, and you need to go to church. Then she was gone.

She rang off. And I was so angry. I was furious, because in the past that would have got me calling her back, feeling bad, like I had done something wrong, like I did when she made me go to church and told me how bad I was. You know, she had asked me for some money the week before and I know she gets a lot of money from my brother. So I said to her that I wasn’t able to. That’s why she was ringing, and all she wanted to do was get me to ring back, to go crawling back to her. How many times have I done that? How many times? But I saw it when she called me. It was like she was triggering me. That’s how it works, getting me back trapped in her own sick little world.”

(iii) The Conflictual Stage

For clients working through the issues raised here there is usually a period where narcissistic gains lead to conflict. Feeling better about oneself and being able to talk about things that have been unspeakable is one thing. Confronting an abuser or others you may have instinctively deferred to, is another. In some cases, a relationship ends and there’s no need for further contact between those involved. In most cases, however, especially marriages, and ones which involve children, the client needs to make decisions that will have material effects long into the future. Maintenance and access agreements, for instance.

Looking at triggers, such as the one Roshni identified, and working through reactions and projected reactions is an opportunity for using EMDR fluently, perhaps insistently. Integrating EMDR in ways that include looking at the effects of changed posture, breathing and qualities of speech (drawing for example, on aspects of Sensorimotor Psychotherapy (Fisher, Ogden, 2015), Somatic Experiencing (Levine, 1997) and Focusing (Gendlin, 1996) is very helpful. These techniques can spark associations from sensations, abstract feelings, and apparently meaningless images or haunting phrases.

Alison told me about a mediation session with her husband, and her fear that she might ‘close down’, and so lose track of what was happening. ‘I’ve just started to begin to believe that he was wrong.’ She wished she could curl up in a ball on the floor and forget about it all.

► In a previous session she'd spoken about her business plans. Her husband had frequently criticised her attitude to money. He had been the person who had worked and been paid for it; she had devoted herself to bringing up their children as part of a fairly well thought-through arrangement between two open-minded people; or this is what she had thought. Talking about money had in the past always been a trigger for Alison. There had been very little of it around when she was a child. Family arguments usually involved centred on money and her father's business had frequently been in trouble. My experience of Alison was that was very careful with money: she knew how to spend it and enjoy herself when a lot of it was around but she also knew how to save it. She kept track of the finances for her husband's business. She was despairing that after divorce there would be less money but, as she put it, "If I was that obsessed with money I wouldn't be going through with this."

I drew attention to her 'business mind'. She stopped crying, as if she had been jolted out of thoughts about something. Her voice dropped a couple of tones and she seemed to speak from lower in her body, closer to where we had identified her 'imaginary centre' (a Focusing technique). Her gaze was intense and alert. She looked powerful and in control. We spoke about the financial arrangements for her divorce for some time. She was angry but capable of thinking while she was angry.

"What do you think will happen", I asked, "that will stop you being like this?"

"Like what?"

"Like this". I described how I had been experiencing her for the last few minutes.

"I know I can be like this", she said. "I just don't know if I can be like this while he is sitting in front of me. I get it. I can see what's wrong. But it just feels too much. It hurts."

"So if you take your mind to the moment that hurts what do you see?"

"I see his face and he looks so fucking furious, and like he is going to take me apart. And he's all rigid like he's like one big dick." She began to falter in her speech. "I just don't know if I can do it." Her voice was higher and thinner. A memory was activated. Her head leaned to the other side

of her body, to her left. She crossed her legs.

"How much does it hurt?"

"It's a six or seven." She knew when I asked a question like that I was referring to SUDs.

"Where do you feel it?", I asked.

She put her hand to her throat, then her chest and then to her heart.

We processed the image of her husband's face, and the feeling, and the sensations, and I asked her how true it felt that she couldn't do it. Her head tilted to the other side of her body and she spoke from lower down again, more confidently once more. At this point I did not interrupt her process, although there may well have been a memory acting as a feeder here. My approach often involves sustaining a process to see what arises.

"I can do it. But not if I do it like that."

"How do you mean?"

"Like when I was crying, when I saw him like I did."

"And when you look at him now what do you see?"

"He's just a little boy and he can't get what he wants and who knows why but that scared him to death. It's like his life depends on getting what he wants and he will do anything to get it and that's why it's so scary. But he's only an insecure man, ashamed of what he's done and unable to see he's got a problem. He doesn't want a divorce, but he didn't want to go to school when he was little either. He stayed at home and then cheated in his tests."

We later processed a positive cognition: 'I can leave him'.

Another client, Claire, referred to me by her solicitor specifically for support during her divorce, spoke to me about how difficult she found it to give herself time during mediation sessions.

"When he looks at me and raises his eyebrows, I just find myself opening my mouth and saying what's there." We processed the feelings that arose in relation to that look (which resembled a 'look' her violent father used to give her when he demanded an explanation for why she was not doing what he told her). We also processed the moments before, which she identified as actually more important.

"Just before, it's as if he's reaching critical mass

▶ and the look's a full stop. It gets more and more tense." Paying attention to precisely the language she had used we explored how her own body tensed as his did, as it had done with her father. The tension she felt was in her as much as in him.

Alison was in couple's therapy while she was working with me. Her female therapist had summed the session up by describing her husband's wants and needs, and then Lorna's. Lorna was shocked and did something she described she would never have been able to do in the past: she told the therapist that this didn't feel right. Why was she drawing an equivalence between her husband's secret sexual behaviour with her feeling unlovable and unloving? The therapist made an attempt to justify what she said, qualifying that she hadn't meant to say these were the same kinds of thing.

In her session with me Alison was able to describe how the session had felt abusive, as if something was being repeated from her childhood where people turned the other way (teachers at the school where she was abused, and her mother). She had noticed how excited her husband became describing the kind of sex he wanted, and how 'gaslit' she felt when she heard what the therapist had to say, and its justification.

Alison was taking responsibility, overcoming her fear of entering into conflict, and speaking out when she felt something wrong was happening. She was not scared of being abandoned. In the past she had remained silent when similar incidents had occurred, blamed herself, and lived in fear, rationalising the situation as how things inevitably needed to be given the undesirable person she felt she was.

Conclusions

People leaving abusive, narcissistic relationships are liable to find the immediate aftermath of that situation fraught with the effects of abuse. This paper limits itself to experiences working with heterosexual women leaving narcissistic men. But experiences in other situations, ones in which issues of race, sexuality and other forms of difference have needed to be considered, suggest that this approach can have a broad application, especially in relation to ob-

serving the conflictual stage of the work when a person might in some ways be most vulnerable. It is during this time that their future security is usually decided.

Often a person who needs to leave an abusive relationship has been financially dependent on their partner, and they might leave the relationship with dependents. Mediation and court appearances are weighted against these individuals because of ignorance, denial or adversarial thinking in the legal and therapeutic professions relating to the compromising effect of pathological narcissism. Those crucial legal and therapeutic situations are also places where a husband can continue to dominate proceedings as he may have done in the marriage or relationship.

Looking at triggers then, exploring moments of crisis in adversarial situations at the end of a relationship are particularly important and can, in fact, be treated as isolated EMDR targets if time available for work is limited. Hopefully I have given a clear idea of how such exploration can occur without creating unhelpful fixed and fixing narratives. Healthy narcissism is about keeping things moving.

It is also essential to recognise that the kind of client mentioned here is liable to present with symptoms compatible with a description of 'complex PTSD'. Work with these individuals is often resistant to EMDR unless a particular approach is found that is compatible with the client's defences. In carrying out the work it has been helpful to keep in mind the 'working memory' theory of EMDR. Some people have a capacity to accommodate ABLS, tapping, whatever, and to hold in mind the traumatic memory without it being disrupted. Giving such a person more to consider in the form of different kinds of stimulation, increasing their anxiety, can lead to the memory being processed.

Whether or not working memory theory has a basis in agreed scientific truth it seems, as a way of thinking, to promote very good results. I believe in the theory not necessarily as 'science' but as a very good way of conceptualising what works in EMDR processing. Freud's 'repression', after all, didn't involve people with guns.

The form of history-taking I have described here, the philosophy of 'following without fol-

lowing', paying attention to the body, and introducing transference interpretations as interweaves that make nonsense of a nonsensical situation all seem highly compatible with the ethos of 'EMDR 2'.

The idea of the trance state as I have presented it, an expansion of Borch-Jacobsen's collected thoughts about psychoanalysis and hypnosis (1992), has its foundations more in anthropology (Lévi Strauss, 1963; Luhrmann, 2012) than in psychology. Van Binsbergen (1991) writes with force about the relationship between seduction, shamanism and therapy. Psychoanalytic practice makes use of what it calls 'the transference' just as hypnotherapy does of hypnotic states. EMDR is not hypnosis but it may be useful to discuss whether EMDR, hypnosis, psychoanalysis and any other thing we call 'therapy' works on the basis of a certain kind of 'trance state'. Within this conception of the therapeutic relationship it would also be interesting to explore how a therapist's interventions related to perceptions of time, timing, rhythm, intensity and attunement to affect might be as important as interventions founded in cognition.

I have tried to describe a conception of how abusive relationships are formed and perpetuated, even despite good advice from outside observers. This description suggests a way of working that sets aside a certain 'explanatory' approach in favour of attunement to repetitive patterns of being: study of presence. EMDR, which privileges noticing and understanding rather than knowing-through-thinking seems ideally suited to this. It is a good and effective way of 'following without following'.

For several years Tom was clinical manager at the Charter clinic in London. He has extensive experience as an individual and group psychotherapist, working with clients who have dependency issues. Originally trained psychoanalytically he is interested in many different forms of thinking and practice

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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 EMDR UK. 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:

- 
- 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.

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

5.3 Financial Support

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

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