



ASSESSMENT AND CASE CONCEPTUALISATION: BEYOND THE BASICS

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ADAPTIVE INFORMATION PROCESSING MODEL IN EMDR

Shapiro developed the Adaptive Information Processing (AIP) model as the underlying explanatory model of EMDR. EMDR is based, therefore, on a distinct information processing model which incorporates specific principles and treatment procedures. The AIP model guides history taking, case conceptualization, treatment planning, intervention, and predicts treatment outcome. (See Appendix A of the EMDRIA Curriculum for information about antecedent information processing models. www.emdria.org)

Basic hypotheses concepts of AIP:

1. The neurobiological information processing system is intrinsic, physical, and adaptive
2. This system is geared to integrate internal and external experiences
3. Memories are stored in associative memory networks and are the basis of perception, attitude and behaviour.
4. Experiences are translated into physically stored memories
5. Stored memory experiences are contributors to pathology and to health
6. Trauma causes a disruption of normal adaptive information processing which results in unprocessed information being dysfunctionally held in memory networks.
7. Trauma can include DSM IV Criterion A events and/or the experience of neglect or abuse that undermines an individual's sense of self-worth, safety, ability to assume appropriate responsibility for self or other, or limits one's sense of control or choices
8. New experiences link into previously stored memories which are the basis of interpretations, feelings, and behaviours
9. If experiences are accompanied by high levels of disturbance, they may be stored in the implicit/nondeclarative memory system. These memory networks contain the perspectives, affects, and sensations of the disturbing event and are stored in a way that does not allow them to connect with adaptive information networks
10. When similar experiences occur (internally or externally), they link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise
11. This expanding network reinforces the previous experiences
12. Adaptive (positive) information, resources, and memories are also stored in memory networks
13. Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks and a transformation of all aspects of the memory.
14. Nonadaptive perceptions, affects, and sensations are discarded
15. As processing occurs, there is a posited shift from implicit/nondeclarative memory to explicit/declarative memory and from episodic to semantic memory systems (Stickgold, 2002)
16. Processing of the memory causes an adaptive shift in all components of the memory, including sense of time and age, symptoms, reactive behaviours, and sense of self

Clinical Implications: The AIP guides case conceptualization, treatment planning, intervention, and predicts treatment outcome

1. Clinical complaints that are not organically based or are caused by insufficient information are viewed as stemming from maladaptively stored and unprocessed information which has been unable to link with more adaptive information.
2. Earlier memories which are maladaptively stored increase vulnerability to pathology including anxiety, depression, PTSD, and physical symptoms of stress and may interfere with healthy development of an individual's sense of self-worth, safety, ability to assume appropriate responsibility for self or other, or limits one's sense of control or choices
3. The information processing system and stored associative memories are a primary focus of treatment

4. Procedures are geared to access and process dysfunctional memories and incorporate adaptive information
5. The intrinsic information processing system and the client's own associative memory networks are the most effective and efficient means to achieve optimal clinical effects (*most of the time. GT*)
6. Targeted memories must be accessed as currently stored so the appropriate associative connections are made throughout the relevant networks
7. Unimpeded (*by the therapist*), processing allows the full range of associations to be made throughout the targeted memory and the larger integrated networks (*most of the time. GT*)
8. Interventions to assist blocked processing should mimic spontaneous processing
9. All interventions are viewed as distortions and potentially close some associated pathways. (*but appropriate interweaves will open adaptive pathways. GT*)
10. Following any intervention (See 9) the target needs to be re-accessed and fully processed in undistorted form
11. Processing shifts all elements of a memory to shift to adaptive resolution

QUESTIONS:

What is meant by "information"?

What is meant by "processing".

What characteristics that differentiate between "unprocessed" and "processed" information?

NEURO-NETWORKS OR SCHEMA

Only Shapiro uses the term neuro-networks, everyone one else calls them schema.

A definition (Taylor, 2015-2017): A schema is:

- a network of associated memories, thoughts, beliefs, emotions and body sensations
- substantially formed in the developmental years, and persisting into adult life.
- These networks determine how an individual perceives and interprets life events, and
- significantly drive the individual's emotional and behavioural responses to these events.
- Schemas can be adaptive or maladaptive.
- Maladaptive schemas give rise to patterns of responding that are inflexible, rigid and self-defeating.

Note: The self-referenced cognitions reflecting a schema are often known as Core Beliefs.

CORE EMOTIONAL NEEDS (AFTER YOUNG)

Secure attachment to others; includes safety, stability, and nurturance.

Autonomy, competence, and a sense of identity.

Freedom to express valid needs and emotions.

Spontaneity and play.

Realistic Limits and self-control

MEMORY MAPPING QUESTIONS

The questions in the AAIP, ACE and various questionnaires can uncover clinically relevant history that points to the development of schema (networks of associated memories, thoughts, beliefs, emotions and body sensations). If at any stage you identify history that may be etiologically linked to the client's present difficulties, then you would explore that issue more thoroughly, looking for examples, what the child felt and learnt from the experience, and importantly, what is the legacy of that learning in the life of the person now. **Key point:** Any emotionally significant event will have **Content, Meaning and Affect**. From any of these elements you can link to other significant events, and in so doing quickly build a memory map that leads to an understanding of the connections between a person's history, critical learning events, core beliefs, and coping strategies. Typical follow-on questions could include.

Tell me more about that. (client could give you content, affect or meaning. You can build a map from any element.)

CONTENT QUESTIONS

Have there been other times something like this happened?

When, Where, Who, What questions.

Can you think of some early experiences that go with that?

What is the earliest event you can remember that had something in common with this? (Collect a range of events across the developmental year.)

Did this sort of thing happen often?

AFFECT QUESTIONS

What was that like for you?

What was it like for you then, when those things happened?

How did you feel back then? (Looking for emotional responses at the time.)

And now, when you think about it, what is that like?

When you think of those experiences now, what feelings go with those memories? (Looking for evidence of resolution. Is this still a Hot Memory?)

Are there some emotions that show up too often, or too strongly, or last too long?

What emotions are difficult for you to cope with?

MEANING QUESTIONS

When that happened, what did you think about the event?

How did you think about yourself back then?

How did that sort of thing affect the way you thought about yourself back then?

How did those sorts of experiences affect the way you think about yourself (or with others, or with the world) NOW ?

Do you have thoughts about yourself NOW that are a legacy of those events?

(Looking for presently held schematic level beliefs.)

BEHAVIOUR QUESTIONS

Behaviour patterns are not part of schema, but are shaped by schema. Identifying these is important, as changing schema-driven behaviour is essential for lasting change.

**How have those experiences shaped the way you live your life now?
Are there activities now that you find yourself doing, or avoiding doing, or over-
doing because of what you learned then? Looking for schema driven behaviour
patterns.)**

THERAPY GOALS

These are useful focusing questions to ask early on in the first session with a client. **“I’d like to better understand what you are seeking in coming to see me today. How will you know this therapist is working for you? Try to complete the following sentence for me: I know this therapy is working when ...”**. You can then explore this in more detail. If you use ACT, you could link this to the client’s values.

COGNITIVE QUESTIONS

These questions explore cognitive goals, adaptive beliefs the client is working towards.

When we have finished our work together, how will you be thinking be different about yourself compared to now?

What would you like to be able to think about yourself now?

What sorts of thoughts about yourself would help you live your life better? (These will link to new patterns of behaviour. See below.)

BEHAVIOUR QUESTIONS

If you could let go of the impact of those past experiences, how would you like to be doing differently?

What things would you be more easily able to do or start doing that is difficult for you now?

What sort of things would you like to do less of or stop doing altogether that you find difficult to stop doing now? (Behavioural goals for future work. Identify behaviour change targets for the client’s future. Link to values (from ACT).

EMOTION QUESTIONS

When we have finished our work, how will the emotional side of your life be different?

What emotions would you be having less of, less often or less strongly?

What emotions would you be having more of, or more often, or more strongly?

What emotional changes would let you know you are making progress?

Once desensitisation (Phase 4) is complete with a SUDs = 0 or 1, we introduce a more adaptive perspective in the form of the Positive Belief (PB), modified if necessary at the beginning of Phase 5.

Because the Positive Belief has a VoC greater than one, it follows that the client has information in their memory networks that links to the PB. During the History Taking or Preparation Phases it can be very useful to expand on the network of associations around the Positive Belief by asking for recent experiences that fitted that belief, earlier experiences that fitted that belief, felt emotions and body sensations associated with accessing those memories, and pairing these with a Very Short (4 – 6 cycles) set of SLOW eye movements, as in Resource Development.

Useful questions include

Can you think of a recent experience where that idea fits?

What was that like for you? When you think of that experience now, what do you feel? Where do you notice this in your body? (Evoking positive emotions assists recall of other positive experiences.)

Can you think of an earlier experience with this same idea fits? (Meaning bridge.)

Have there been other times when things like this have happened? (Content bridge)

Do an Affect Bridge / Floatback to earlier experiences, or ask

Can you recall an earlier experience where you had this same feeling? (Affect bridge)

When new experiences are identified, have the client focus on their emotions and body sensations.

When you focus on that experience now, what do you feel? Where do you notice this in your body?

The aim of this strategy is to create a broader range of positive experiences and emotions associated with the Positive Belief. When you introduce the Positive Belief at the beginning of the Integration phase, you bring not only the Positive Belief, but a richer network of useful associations.

You may find that Stacking the Deck in the Assessment phase or Target Memory phase in of itself stimulates natural Adaptive Information Processing for the client.

Although this variation has not yet been tested empirically, it is consistent with Shapiro's Adaptive Information Processing model and other models of memory networks. Clinically, it does appear to be a useful strategy, particularly for schema related issues.

ASSESSING PRIMARY ATTACHMENT

Many clients have a history reflecting attachment problems. These questions, taken from the Adult Attachment Interview Protocol by Mary B Main, may be useful in assessing the impact of this. If you have not used the interview protocol before, see the resources library for detailed notes that accompany the interview questions.

1. Could you start by helping me get orientated to your early family situation, and where you lived and so on? If you could tell me where you were born, whether you moved around much, what your family did at various times for a living?
2. I'd like you to try to describe your relationship with your parents as a young child if you could start from as far back as she can remember?
3. Now I'd like to ask you to choose five adjectives or words that reflect your relationship with your mother starting as far back as you can remember in early childhood – as early as you can go, say, age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think for a minute (*It is useful to ask for the adjectives first, before asking why the client chose them.*) Then follow with “I'd like to ask you why you chose them.”
4. Repeat questions 3, regarding the father. Note as for Q.3
5. Now I wonder if you could tell me, to which parent did you feel the closest, and why? Why isn't this feeling with the other parent?
6. When you were upset as a child, what would you do?
7. What is the first time you remember being separated from your parents?
8. Did you ever feel rejected as a young child? Of course, looking back on it now, you may realise it wasn't really rejection, but what I'm trying to ask about here is whether you remember ever felt like being rejected in childhood.
9. Where your parents ever threatening with you in any way – maybe for discipline, or even jokingly?
10. In general, do you think your overall experiences with your parents have affected your adult personality. Are there any aspects to your early experiences that you feel were a set-back in your development? Is there anything about your earlier experience that you think may have held your development back, or have a negative effect on the way you turned out. (*This is a good cover-all question, which often reveals more to investigate.*)
11. Why do you think your parents behaved as they did during your childhood? (*It is helpful if clients understand why their parents were the way they were, so it's always worth asking.*)
12. Were there any other adults to whom you were close, like parents, as a child?
13. Did you experience the loss of a parent or other close loved one while you were a young child – for example, a sibling, or close family member? Did you lose other important people during your childhood?

14. Other than any difficult experiences you've already described, have you had any other experiences which you should regard as potentially traumatic, any experience which was overwhelming and terrifying.
15. Were there many changes in your relationship with your parents after childhood, between your childhood and adult years?
16. Now I'd like to ask you, what is your relationship with your parents (or remaining parent) like for you now as an adult? Here I'm asking about your current relationship with your parents.
17. Is there any particular thing which you feel you learned above all from your own childhood experiences? I'm thinking here of something you feel you might have gained from the kind of childhood you had.

These are the sort of questions that can uncover clinically relevant history that points to the development of networks of associated memories, thoughts, beliefs, emotions and body sensations (i.e. schema). If at any stage you "strike gold" then you would explore that issue more thoroughly, looking for examples, what the child felt and learnt from the experience, and importantly, what is the legacy of that learning in the life of the person now.

Use the Memory Map questions to explore further.

SUGGESTED EXERCISE

With a trusted colleague, compete a full AAIP on each other. Map off your responses. It will be probably be quite revealing.

ADVERSE CHILDHOOD EXPERIENCES (ACE) QUESTIONS

Search **Adverse Childhood Experiences** for a wealth of information on this huge study. A summary of this large body of work can be found at www.canarratives.org and additional resources can be found at www.canarratives.org/resources/. The official ACE questions are set out below, but as an initial screening you may want to consider the scripted alternative, set out in **bold**.

Shame based reactions can see people denying ACEs. You can use the **(bracketed)** words below as a checklist, asking for no more than an initial nod or shake of the head. Respond to disclosure with obvious support. When ready, explore more fully, using memory mapping questions.

I want to run through a few issues now that I ask everyone about. These are not easy issues. We don't have to talk in detail about anything right now, can you just give me a nod for yes or a shake for no. OK?

While you were growing up, during your first 18 years of life did you experience :

1. Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you or act in a way that made you afraid that you might be physically hurt? **(verbal abuse, put downs, humiliation, verbal threats.)**
2. Did a parent or other adult in the household often push, grab, slap, or throw something at you or ever hit you so hard that you had marks or were injured? **(Physical abuse.)**
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way Or try to or actually have oral, anal, or vaginal sex with you? **(Unwanted sexual approaches or sexual abuse in any form.)**
4. Did you often feel that no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other? **(Lack emotional support, love, empathy, protection.)**
5. Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? **(Poverty, neglect.)**
6. Were your parents ever separated or divorced? **(Parent split up.)**
7. Was your mother or stepmother often pushed, grabbed, slapped, or had something thrown at her? Or sometimes or often kicked, bitten, hit with a fist, or hit with something hard or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife? **(Witness domestic violence.)**
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? **(Live with a person affected by drugs or alcohol.)**
9. Was a household member depressed or mentally ill or did a household member attempt suicide? **(Live with a person who had mental health problems.)**
10. Did a household member go to prison? **(Live with a person who had spent time in prison.)**

ASSESSING TRAUMA AND POST-TRAUMA OUTCOMES

First step: is the client in imminent danger, or at risk of harming others?

Second step: Psychological stability. If the client is overwhelmed or cognitively disorganised, stabilisation interventions (reassurance, psychological first aid, reduction in environmental stressors) should be provided before more detailed assessment.

Third step: Assessing trauma exposure. The nature of the trauma: when, where, who, what, severity, duration, frequency, level of life threat. This generally precedes assessing the effects of exposure to trauma, but in some cases this may need to be addressed first, e.g. acute assault or accident.

Note: In assessing trauma consider

- The level of trust, safety and rapport the person has with you.
- Explore the reason the person is presenting at this time.
- Be open to exploring details of sexual abuse and violence. Under-reporting of trauma is common, if you don't ask you probably won't be told.
- Use behavioural definitions. E.g. "Did anyone ever do something sexual to you that you didn't want, or make you do something sexual to them?" Respond to disclosure with obvious support.
- Disclosure of trauma may bring up intense emotions, including shame, embarrassment, guilt and anger. Support and validation is crucial.
- Some relevant information may not be disclosed or may be denied until such time as the client feels safe with you. Repeat assessments as necessary.
-

Be ready for Activation responses, where there is the sudden emergence of post-traumatic emotions, memories or thoughts in response to a triggering question or comment. With recent trauma a moderate level of activation is a good sign that the client is not highly avoidant or dissociative. With older trauma, activation points to the need for resolution work.

Be ready for Avoidant responses, including an emotional numbing, dissociative disengagement, thought suppression, denial, alcohol or drug use prior to the session. Consider these issues during preparation for trauma therapy.

A thorough trauma assessment addresses many (if not all) of the following:

- PTSD symptoms (intrusions, avoidance, hyperarousal).
- Dissociative responses, including Depersonalisation / derealisation, "spacing out", amnesia, identity confusion.
- Substance abuse.
- Somatic disturbance.
- Perceptual disturbance.
- Trauma related cognitive disturbance.
- Tension reduction activities.
- Transient post-traumatic psychotic reactions.
- Culture-specific trauma responses when assessing individuals from other cultures.

IMAGERY ASSESSMENT

Start and end with Calm / Peaceful Place.

Begin early in session.

Explore positive resources. Being happy, succeeding, being loved, mastery, belonging, being in charge, at peace, etc.

Then selectively move to negative experiences. Tailor these to the client, but could include being talked about, being trapped, being hurt, being aggressive, being laughed at, not coping, being helpless, being promiscuous, hurting others, losing control, being followed, failing, lonely, mistrustful, etc.

Ask about any persisting or disturbing images that interfere with daily functioning.
Ask about nightmares.

Affect Bridge from recent to earlier events.

Imagery linked to somatic symptoms.

EXERCISE FROM YOUNG ET AL. (2003)

ASSESSING TEMPERAMENT

Labile	Nonreactive
Dysthymic	Optimistic
Anxious	Calm
Obsessive	Distractible
Passive	Aggressive
Irritable	Cheerful
Introverted	Extroverted

No formal clinical measures of temperament that I know of. Ask questions such as

What do your family members say you are like as a child?

Are you generally a high-energy or a low-energy person?

What is your general outlook on life?

Are you generally optimistic or pessimistic? (There is a measure of Explanatory Style [Seligman])

how do you usually feel when you are alone?

Do you worry a lot?

Where on the scale of introverted to extroverted would people say you were? We would you say you were?

The more consistent and long-term the feelings are, in the earlier they begin, the more likely is that they are contributed to by the person's innate temperament rather than a response to life's events?

QUESTIONNAIRES

Young Schema Inventory
Use & scoring

Young Parenting Inventory

Avoidance & Compensation inventories

Early Adaptive Schema Inventory (EASI, Lockwood & Young) Not available from Internet

Family Experiences in Childhood (FECS, Gonzalez, Mosquera & Leeds, 2010)

Psychotherapy Assessment Checklist (PAC)

Any of these instruments generate leads that may be followed up with Mapping questions.

General Considerations

EMDR is not a cure all. Client problems may be remedied by education, problem solving, stress management techniques, and skills training etc. A full history is required, as you would do in order to formulate a person's presentation and problems, before planning an intervention.

Single incident PTSD problems can be treated by targeting the traumatic memory, but a good history is still required. In more complex presentations, including multiple trauma (e.g. abusive or neglected childhood origins), current and past events will require reprocessing, as will the integration of more adaptive responses.

A useful detailed framework for a comprehensive assessment is given by Lazarus, A. & Lazarus, C. (1991) Multi Modal Life History Inventory, Research Press.

Following the collection of general information about the client, the assessment follows the seven modalities of behaviour, affect, physical sensation, imagery, cognition, interpersonal relations and biological factors.

The following summary provides basic guidelines for the assessment necessary to use EMDR. See pages 91 - 108 of Shapiro's (2001) book for a detailed example, with commentary.

Description of Presenting Problems

Client describes the nature of their main problems and the degree of severity, and impact on their current life.

Dysfunctional behaviours, emotions, beliefs

duration of problems **"How long have you had these problems?"**

factors which make things better/worse

repeating patterns

clusters of similar events – different memories, with same associated Core Belief.

the earliest example

the worst example as recalled now

additional past occurrences **"What are your worst memories?"**

are there present factors which mitigate against change

what is the desired state. How will the client know that therapy has been successful?

what will be the effects of successful therapy- for the client, and the client's systems?

General Information including

Family history of psychological therapy and problems.

Father's personality and attitude toward client, past and present.

Mother's personality and attitude toward client, past and present.

Family history of emotional or mental disorder, including suicide.

Methods of discipline or punishment.

Ability to confide in parents.

Was client loved and respected by parents.

Childhood/adolescence problems : deaths, medical problems, school , religious issues, drug / alcohol use, physical / sexual / emotional abuse.

Work, present and past. Reasons for leaving.

Previous therapy, and outcome. Client's expectations of therapy and the therapist.

BASIC IB: Modality Analysis of Current Problems – (Arnold Lazarus).

Behaviours:

What would you like to start doing, or do more of.

What would you like to stop doing or do less of.

Magic Wand questions.

Check for problems of excessive consumption (food, alcohol, cigarettes, drugs)

Check for overwork, impulsive reactions, avoidance, suicidal attempts, sleep disturbance, behaviours associated with aggression or depression.

Affect (Feelings)

Check for presence of negative emotions (too many, too often, too strong, for too long).

Check for blocked emotions.

Ask "What are your 10 worst fears?"

Free association techniques may be used to elicit early memories associated with particular emotions.

Check for positive emotions, and the activities that generate these.

Explore memories, imagery, or skills that the client can use to evoke a sense of calm or relaxation. These can be used in the construction of a Safe Place, or other resourceful state.

Somatic Sensations

Check for physical symptoms, particularly those unexplained by medical opinion. Especially headaches, abdominal pain, bowel, fatigue, nausea, flushes, blackouts, excessive sweating, and other symptoms of excessive autonomic arousal.

You also need to screen for Dissociative Disorder, using the DES. This is supplied as part of your EMDR training .

Imagery

Have the client relax, close their eyes, and report the image that comes to mind at the first mention of each idea.

"I picture myself [Be selective, but the following are often useful] -- being happy, being hurt, not coping, succeeding, losing control, being aggressive, being helpless, being in charge, hurting others, failing, being trapped, being laughed at, etc.

These images often provide valuable information about target memories or the origins of dysfunctional beliefs. Start off with positive images (e.g. succeeding, displaying independence, being courageous, etc.) before moving on to negative images (e.g. being hurt, failing, etc.). Select your probes, being guided by the information concerning the presenting problem, and your history to date.

For example, with presentations of anxiety probe for issues related to over-concerns about performance, approval/acceptance and predictability / control / safety. For depression, probes for issues related to loss, "not good enough", and caught in the "worth = work &

achievements” trap. Enquire after each probe. Watch closely for non-verbal responses. It is important to finish with a further set of positive images related to positive resources and recovery.

Check for flashbacks associated with unpleasant sexual images, unpleasant childhood images, or images related to previous trauma.

Check for persistent or disturbing images that interfere with daily functioning, and nightmares.

Ask client to describe their image of a completely Safe Place.

Cognitions

Explore for themes and cognitions related to abandonment, mistrust, abuse, emotional deprivation, defectiveness, social isolation, dependence, vulnerability to danger, enmeshment, failure, entitlement, insufficient self control / self discipline, subjugation, self-sacrifice, approval seeking, unrelenting standards of performance, taking excessive risks, inhibiting emotional expression.

Imagery may be used to derive target memories for use in EMDR.

Free association techniques may be useful, using the technique described above in the section on Imagery.

The Schema Questionnaire (Young, 1990) may be used to identify dysfunctional schema (Core Beliefs). An exploration of the origins of these schema, and how they play out currently in the client’s life may provide useful information for targeting with EMDR.

Interpersonal Relationships

Friendships - Easily made? Maintained? Common patterns?

If the client is in a committed relationship; what they most like and least like about their partner.

Issues which impair satisfaction.

Check for communication styles, how problems are solved, how conflict is managed, any problems related to children or extended family, sexual relationship.

Biological Factors

Current health concerns and treatments. Get permission to contact GP if self-referred.

Medications and their effects

Present diet

Physical exercise – what, how often.

Physical handicap.

For women, hormonal factors.

Depersonalisation and derealisation.

He/she does not feel like him/herself (e.g., smaller or larger)

His/her surroundings do not look the same.

Look in mirror and see something other than usual reflection.

Floating above or alongside self.

Life as dream-like.

Memory lapses

Example: How one got to the store; finding unfamiliar items in the house; or missing narrative history of life. However, this may be due to substance abuse, illness, depression, or dementia.

A highly organised DID system can fill in blanks.

Somatic symptoms

Headaches intractable to over the counter remedies.

Illnesses that physicians cannot account for may be somatic memories.

Sleep disorders

Frequent nightmares or night terrors.

Sleepwalking usually associated with DD.

Flashbacks

Recent traumatic events, childhood events, multiple, serial PTSD ->MPD.

Therapy history

Clients with many different diagnoses over the years.

Multiple psychiatric hospitalisations with varying diagnosis.

Internal conversations (Voice Hearing)

Frequently hearing voices in head, not externally (as in schizophrenia)

Feelings that come out of the blue without any way to explain them.

Given the possible under-reporting of dissociative disorders, and the risk to the client if therapy proceeds without their identification, it is considered mandatory that a screening for dissociative disorders be undertaken prior to doing EMDR therapy.

DES ITEMS REFLECTING PATHOLOGICAL DISSOCIATION.

3. Some people have the experience of finding themselves in a place and having no idea how they got there.
5. Some people have the experience of finding new things among their belongings that they do not remember buying.
7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person.

8. Some people are told that they sometimes do not recognise friends or family members.
12. Some people have the experience of feeling that other people, objects, and the world around them are not real.
13. Some people have the experience of feeling that their body does not seem to belong to them.
22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were 2 different people.
27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things they are doing.

TOP TEN LISTS

Name : _____ Date : _____

List the Top Ten BEST events in your life. You don't need a lot of detail, just enough to locate that event in time and place. These could involve people who were special to you in some way, particular achievements, acts of initiative or independence, etc.

Age	When, Where, Who, What	Main emotion.	What it meant to me.

Complete this list first, before starting the second list, on the next page.

In your view, how did these experiences contribute to you becoming the person you are now?

COLLABORATIVE CASE CONCEPTUALISATION

- The client presents: problems, symptoms, positive resources.
- There is a relevant history: attachment, trauma, unmet childhood needs.
- This history results in the development of Core Beliefs.
- The client develops coping strategies which emerge when schema is triggered. Behavioural strategies tend to be rigid, inflexible and self-defeating. These strategies also include cognitive and emotional patterns.
- These patterns are played out in the therapy relationship.
- The therapist may also use a variety of questionnaires.

Drawing data from all these sources, the Therapist and the Client together develop a Collaborative Case Conceptualisation. This gives the client a deep understanding of why they are the way they are.

The therapist and client develop goals for the therapy.

The therapist and the client then identify the obstacles and issues to be addressed in therapy, and how will these will tackled.

Sit alongside the client. Start with a blank A3 piece of paper. Set out the above headings. Present pieces of data, ask the client questions like “does that seem right for you?”, “do these things go together?”

When the client sees the connection, at the data to the piece of paper, drawing an arrow between them. After three or four links have been drawn, hand the paper to the client and continue fleshing out the formulation.

RESOURCES

Andrew Leeds : <http://andrewleeds.net/resources/free-downloads/>

PAC forms <http://www.affectphobiatherapy.com/forms/>

Ad de Jongh <http://psycho-trauma.nl/praktische-info/downloadpaginas/emdr-with-fears-and-phobias/>

In particular see <http://psycho-trauma.nl/wp-content/uploads/2015/08/Two-Method-Approach-De-Jongh-et-al.-2010.pdf>

Trauma – for an overview of trauma measures see <http://www.ptsd.va.gov/PTSD/professional/assessment/overview/index.asp>

JOURNAL OF EMDR PRACTICE AND RESEARCH

Apart from the latest 4 issues (12 months) all papers in the journal are available as full-text PDFs. To access the latest issues, a subscription to the journal is available for members of EMDR Australia, for \$20. Normally a subscription is US\$160. <http://www.ingentaconnect.com/content/springer/emdr>

FRANCINE SHAPIRO LIBRARY

This library is maintained by EMDRIA. It contains every published article and EMDR conference presentations, and can be searched for specific topics. <http://www.emdria.org/?page=45>

EMDR RELATED RESEARCH

EMDRIA maintains a page on their website summarising research. <http://www.emdria.org/?page=EMDRResearch>

EMDR RESEARCH FOUNDATION

Find out what research is currently in progress. The EMDR Early Intervention Toolkit is available as a free download and contains several recent event protocols and trauma measures including IES-R, IES-R(Children), CAPS, PCL5. You can subscribe to their regular newsletter. <http://www.emdrresearchfoundation.org/>

TRAUMA PAGES

David Baldwin's award winning trauma site has papers and links to all aspects of trauma, and covers everything from client handouts to the neuroscience of trauma. www.trauma-pages.com