Incorporating Eye Movement Desensitisation and Reprocessing (EMDR) into Cognitive Analytic Therapy - Reaching Reciprocal Roles that other therapies cannot reach

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Introduction

This paper has been developed following my presentation of a case of complex trauma treated with combined CAT and EMDR at the ACAT conference in London in 2015, and a workshop presented with Tracy Wade (an EMDR consultant and CAT therapist) at the most recent ACAT conference in Exeter in 2016. I have been trained in EMDR for around 5 years now and initially saw it as a way of treating those patients who had Post Traumatic Stress Disorder presentations. However, using it has gradually changed my understanding of reciprocal roles and I now offer it to almost every patient that I see for CAT. I will introduce EMDR, discuss how and when I use it within CAT and then describe a case report.

PTSD is defined as a syndrome following a terrifying, life threatening traumatic event which the person has been unable to process. The person is left with repeated experiences of "re-living" the memory of the event as flashbacks and nightmares, as well as being hyper vigilant and easily startled. They also develop a tendency to avoid anything which would remind them of the event, and so trigger a flashback. Normal processing of traumatic experiences seems to involve the memory being "date stamped", integrated with the person's other experiences and knowledge of the world, and filed in long term autobiographical memory. When traumatic experiences are not processed, the memory fragments of the event are stored in a kind of trauma memory network which is not "date stamped" as in the past and is not integrated with other knowledge about the world. If something in the present triggers the memory network, then the person experiences the event in the present as if the trauma is "happening again". This includes emotions, bodily sensations and cognitions which occurred at the time of the trauma, and have not been processed and integrated with other positive memories developed since the event. Thus, someone who thought "I am going to die" at the time of a critical event will continue to think "I am going to die" when the memories are triggered, even though it is clearly no longer a valid reaction to current triggers. For further detailed description of this theory, watch a webinar on Youtube by Francine Shapiro, who first described EMDR (Shapiro 2014).

I don't know about you, but a combination of thoughts, emotions and bodily reactions from past traumatic events, which can be triggered by similar events in the present, and lead to the person feeling, and reacting, as if "it is happening again" sounds pretty much like a reciprocal role enactment to me? This description, and the idea that the traumatic events have not been "date stamped" as being over and in the past, definitely seems to strike a chord with patients - it seems to make sense to them and is helpful in encouraging them to be a bit more compassionate towards their "primitive brain" which just cannot help reacting this way. Some patients are dismissive of what I describe as traumas in their early life, for example being bullied at school. I think it is important to remind them that, since humans are social animals and need to be part of a tribe to survive, being rejected by your tribe, or your family, feels like a life or death problem to the primitive part of the brain. It is also really helpful to work with the detail of some of these memories using EMDR. It becomes clearer to both me and the patient just how traumatic they were, and how they link to the problematic reciprocal roles.

My early experiences of using EMDR

The NICE guidance for psychological treatment of PTSD recommends either trauma focussed CBT or EMDR (NICE 2005). Since many of the patients I work with in liaison psychiatry have PTSD like reactions to traumatic accidents, painful illnesses and frightening medical interventions, I wanted to be able to offer an evidence based treatment for those patients where it seemed appropriate. EMDR training involves

an initial three day introduction, an intermediate day after having practised on a few easy cases with a single trauma (rather than chronic, complex traumatic experiences throughout childhood) and then a further three day training to focus on more complicated presentations. There is also a growing evidence base for the use of EMDR in complicated bereavement, phobias, chronic pain, addictions and other disorders. EMDR trainers and supervisors differ in how open they are to combining EMDR with other therapeutic options, but all agree that the starting point of the work has to be a good, trusting therapeutic relationship and a thorough assessment of the patient's lifetime "trauma landscape" so that you both know what you getting into. The process of CAT reformulation is a great way of doing this early assessment work, and also of building a good therapeutic relationship.

I started to offer EMDR in the middle of CAT for those with clear trauma related problems. The patients and I were amazed at the powerful reactions to what seems like a "crazy technique that can't possibly help". The patients didn't even seem to have to believe that the technique might help in order for it to be effective - some of them have been very sceptical - they just need to be prepared to give it a go, and presumably to trust that I believe in it. As my confidence grew, and with further training and supervision from an EMDR consultant, the results have continued to astound me.

What the Treatment involves

For sceptics the technique does sound bizarre, the patient is encouraged to think about a traumatic memory and describe the worst bit of the memory. The EMDR 8 phase protocol then takes you through various steps to explore the trauma memory network. This includes asking the patient what negative thought or belief about the self goes with that memory (the negative cognition) - this is nearly always the same as the belief associated with the person's most painful past experiences, the "core pain" of CAT. Typical negative cognitions are "It's my fault" , "I am damaged", "I am helpless" etc. The patient is then encouraged to think about what they would like to believe about themselves when that memory comes to mind (the positive cognition), and to rate how true this feels as they think about the memory. They are then asked to rate how upsetting the memory is on a scale of 0 to 10 (Subjective units of distress), and to describe the emotions and physical sensations that come up as they think about it now.

At this point, with the trauma memory network activated, the patient may already be quite upset and the therapist begins bilateral stimulation. This may be side to side eye movements, alternating taps on the back of the patient's hands, or an electronic device which makes alternating sounds or vibrations. Bilateral stimulation continues for a short period of time until the patient seems more relaxed, or something changes. The bilateral stimulation is then paused and they are then encouraged to simply report "what comes up for you now". This may be a change in the memory, a new thought or feeling or sensation, or even a completely new memory. What they report becomes the start of the next cycle as they are asked to "go with that" and further bilateral stimulation is undertaken.

Gradually over time, the memory becomes less distressing and new, healthier memories and associations emerge. It is as if the negative memory network is being integrated with more positive information that the patient knows about themselves and about the world, as if it is being updated. At the same time, the traumatic memory seems to move more firmly into the past and patients may say something like "well it was a long time ago" or "at least it is not happening now". From time to time, the therapist checks back in with the original target memory and asks for a new SUDS rating as to how much going back to that memory bothers the patient now. Work should continue until the SUDS is zero, or as near as possible if it is the kind of trauma which will never be a zero. Sometimes a session may be incomplete, where the SUDS is still fairly high at the end and the session has to be closed down safely, perhaps using an imaginary container to put the upsetting thoughts and feelings in until next time. Patients are warned that the processing which has been started may continue over the next few days and they should just make a note of anything new which comes to mind.

What is remarkable is how fluid and changeable people's memories are. Although we all know this in theory, it is amazing to see people's reactions and descriptions of their memories change before your eyes.

Preparation and positive resources

Before starting the trauma work, people need to be able to self soothe in between sessions when difficult memories come up. Many patients may already have positive, healthy ways of coping, but if their only coping strategy is self harm or alcohol, you don't want to be triggering further distress. Before starting the trauma work, slow bilateral stimulation is used to install positive resources that the patient can use to soothe themselves. The most common ones are a "safe or special, calm place" and a memory of a quality that will be needed for the trauma work, such as showing courage or determination. Laurel Parnell has written a whole book about tapping in positive resources (Parnell 2008) and I now routinely tap in her idea of an EMDR team which

includes a "wise figure", a "protective figure" and a "compassionate figure". These can be real people, fictional characters or even animals - as long as thinking about them evokes the feeling of wisdom etc. As the patient thinks about them, slow bilateral stimulation is carried out. As well as providing positive resources, this also gives the patient a gentle introduction to EMDR so they know what the work is going to be like in future sessions.

These resources are also helpful as a therapist if you need to close down a session safely at the end, or as "interweaves" during the processing. Using interweaves is a more advanced technique to encourage processing when the patient seems to be stuck in a negative loop. The therapist asks a question which triggers the patient's own resources if these are not coming through spontaneously. For example, a patient working on memories of childhood sexual abuse might be stuck on "why didn't I tell someone". As EMDR continues they may spontaneously start saying "I couldn't have told, they threatened to kill me if I told" but if someone is stuck repeatedly saying "why didn't I tell someone", the therapist might ask "what would your wise figure say about that?". Having installed these positive teams for EMDR, they can also be used as resources for the CAT work. For example, a recent patient had a team of three strong women installed for her EMDR work on childhood abuse. When she broke up with her boyfriend and started to feel too old at 30 to ever find a permanent partner, she would consult her "team" in her imagination. These three feminists would immediately help her see that this was a ridiculous way to think.

EMDR as a therapy does not have a clear process for building up a positive therapeutic relationship before the trauma work, and I think the CAT process of reformulation and development of a diagram adds a huge amount to the later EMDR work. When I have decided to skip that part, for example with a private patient who would not be able to pay for a full 16 sessions and who came specifically for EMDR, I have regretted it. With this patient, a problem arose in the therapeutic relationship which I needed to address but had no way of doing so, as our CAT ? diagram was so basic.

When is EMDR helpful in CAT?

Having started using EMDR for patients with clear features suggestive of PTSD, I started to reformulate my ideas of traumatic events and to start recognising them everywhere! EMDR therapists are quick to say that "small t" traumas can be as important as "big T" traumas and are well worth working on. Listening to patients' histories through a "trauma lens" gives a different perspective on reciprocal role enactments. These are not just understandable because they are repetitions of internalised relationship roles - it is possible to give, what I think, is a much more convincing explanation of, for example, why raised voices is unbearable and you have to avoid conflict and please people at all costs. The raised voices are a trigger to memories of being physically abused as a child and to your primitive mind it is as if things are about to "kick off" exactly as they did then. The need to properly process those old memories becomes more convincing and EMDR can be suggested as a way of working on that. I often introduce the idea of using EMDR in the first few sessions and put it in the reformulation letter as a possible suggested way of working later in the therapy. I have started to think of three ways of changing problematic reciprocal roles:

1) Top down, by thinking differently about myself and others, I can consciously try and react differently.

2) Side to side through a different experience in the therapeutic relationship, a new, healthier reciprocal role is experienced and internalised.

3) Bottom up, using EMDR to change the memories which created the reciprocal roles in the first place. This seems to be like cutting off their blood supply, they wither and die without too much conscious, deliberate need for change.

This last point, that EMDR can work without the need for conscious efforts at change, or without the patient doing anything outside the sessions, is one of the reasons why I tend to try it when I am stuck. This can be presented as trying something different from talking "since talking doesn't seem to be getting us very far". The EMDR technique of tracing back can be helpful here in terms of trying to find a trauma target to work on. The patient is encouraged to notice the feeling or belief that they have which is the main problem (the target problem in the CAT). They are encouraged to focus on a recent example of it and notice what feelings come up, how their body reacts and what the negative cognition is that goes with that memory. Then they are asked to close their eyes and trace back through their life, without censoring anything, as far back as they can go to see where they land. This early memory may not seem like a very significant one at first, but if you work on it with EMDR, it usually turns out to be important.

The fact that most of the time the therapist is just accepting of whatever comes up for the patient after the bilateral stimulation, can also be helpful for patients who need to "do it all themselves" and feel ashamed or embarrassed about needing help or not knowing what is going on for them. In a EMDR session, nearly all the ideas and the more positive suggestions and insights are coming from the patient's own mind. Often the

therapist is just saying things like "aha, go with that". This total acceptance, rather than the more usual exploration and challenging of unhelpful beliefs, puts you both into a very different therapeutic reciprocal role, which can work better for some patients.

Having seen how transformative this kind of "bottom up" way of changing reciprocal roles can be, I feel that I want to offer it to everyone who has had early traumas as it seems to make the other, more deliberate ways of changing so much easier to do. If it doesn't work you haven't lost anything, and you will probably have discovered some new insights about how the patient's mind works. I tend to suggest trying three sessions to see if it is helpful. If it is, then those sessions count as part of your therapy contract, if it doesn't work for them then I may not count those sessions and we will go back to the CAT. In my experience, approximately half of my patients respond to EMDR like a textbook and are themselves amazed by it (this proportion has increased as I have got more experienced in using it), approximately a quarter have some kind of benefit and things seem to get unstuck, even if not a typical EMDR response, and around a quarter do not respond at all.

Adverse Effects

EMDR sessions are a bit like a roller coaster, often with intense emotions expressed and sometimes new memories, or new details arising. Generally patients find this helpful, even though the details may be upsetting, they feel it is better to remember and to know what really happened, it makes more sense of why they have been so affected by the experiences. I have had only two patients (out of around 50) who did not want to continue after the first trauma session because it was so upsetting and both were at the start of my using EMDR so I was not so skilled at target selection and keeping patients in their "window of tolerance". If a session has been left incomplete, so the SUDS at the end is still quite high, then patients can have quite a difficult week between sessions so it is important to warn people about this and help them plan how to manage. Those patients who tend to dissociate are difficult to work with and further training and experience is needed to manage this.

Complex Trauma

Where CAT and EMDR combined may have a particular value is in the emerging diagnostic category of complex PTSD or Complex Trauma. These are patients who have had repeated traumatic experiences through childhood and who have a personality which has been shaped by the trauma and their reactions to it. It has been acknowledged that the standard PTSD guidelines of CBT or EMDR may not be adequate for this group of patients who are likely to need longer term work, or work on building trusting relationships, but there are currently no clear guidelines as to what does work for this group. The research has not yet been done as the diagnostic category itself is new. A more detailed exploration of the theoretical benefits of combining CAT and EMDR is provided in a recent paper by Jurai Darongkaras et al (Darongkaras, 2016). Looking back through the routine CORE scores collected from the last 5 patients that I think would meet the criteria for a complex trauma diagnosis, whom I have treated with this combination of CAT around EMDR, only one showed no change in CORE score. The average CORE scores of all those 5 patients at the start of therapy was 21.52 and at the end was 12.58 and these were all given 16 sessions of therapy in total. Below I describe a case where the combination seemed to be helpful in treating complex trauma, and the patient has also written a brief reflection of his treatment for inclusion in this paper.

Case example

First of all, I would like to thank "Nick" for allowing me to present his story and for writing his own reflections. I have changed his name and several of the minor details to make it more anonymous, but the story itself, and his past experiences are unchanged.

Nick is a 55 year old man, married with 4 grown up children, who was referred to our service by the clinical psychologist from the pain clinic. In a bicycle accident 7 years previously, he had broken his right ankle and developed chronic regional pain syndrome. This is a condition which is still poorly understood but seems to result from traumatic nerve damage, leading to severe neuropathic pain and a strong desire not to use the affected limb because of the pain. Gradually, the part of the brain controlling that limb starts to "switch off" creating a vicious circle of more immobility and increased sensitivity to pain. During this period of severe pain and insomnia, Nick started to remember fragments of a horrific episode of sexual assault in his childhood and was diagnosed with PTSD.

He had been seen by our local mental health service and treated with three years of trauma - focussed Cognitive Behaviour Therapy. This had helped him remember the incident so that he had a narrative to tell, and helped him to be able to talk about his traumatic childhood experiences without dissociating. His flashbacks and nightmares were less frequent, but the therapy had not really changed the way he felt about himself and his experiences emotionally or the way he functioned. This therapy did not come to a planned end, but the therapist himself went off sick and Nick was left in limbo. Further assessment led to a change in diagnosis to Borderline Personality Disorder and he was offered a six session

Fig. 1 Diagram

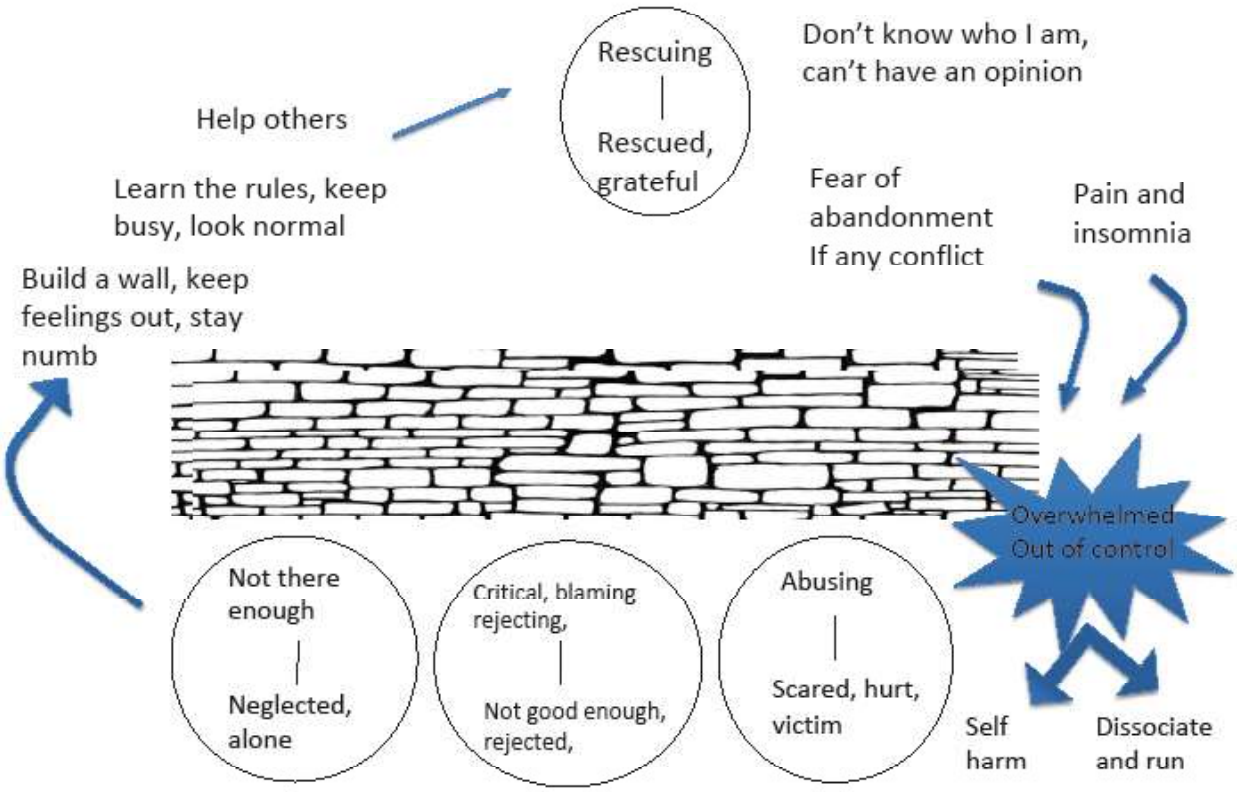
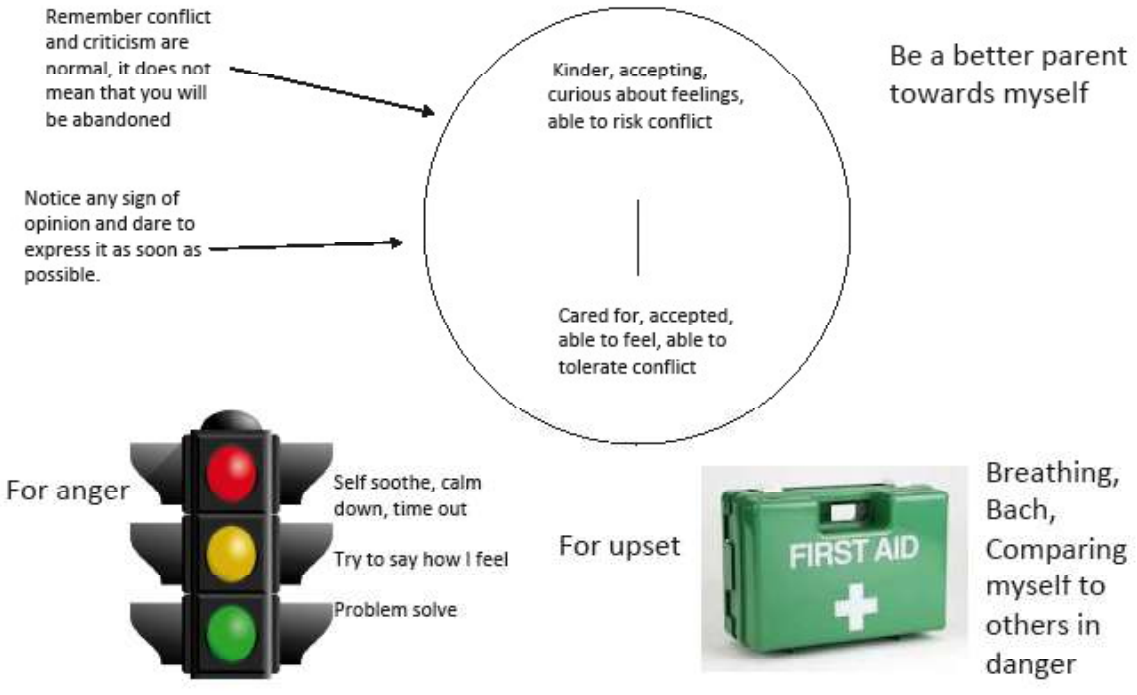


Fig. 2 Exits to the cycle, finding another way to relate to others and to myself



psycho-educational programme to come to terms with this diagnosis and understand it more fully. He did not find this useful and was not offered any further therapy at that point. The local personality disorder service were not willing to see him. We agreed to try 24 sessions of CAT with EMDR.

Nick had taken part in the group pain management programme organised by the pain clinic and had found it somewhat helpful, but continued to feel very low, irritable and frequently suicidal. The psychologist felt that CAT could be helpful to him. At assessment, Nick brought a list written by his wife (at his request, as he found it difficult to verbalise his problems) describing the "problems with Nick", these included:

It is like living with a recalcitrant toddler

We never know where he is, he never has his phone on

Foul moods and bad language

Irrational outbursts

Lack of personal hygiene, total inability to dress as anything other than a tramp

Obsessed with breeding chickens

Our first few sessions felt rather strange. Nick was keen to tell me all about his traumatic experiences but it was done in a rush with no time to stop and think about them, it felt as if he wanted me to know what I was letting myself in for at the start. However, once he had told me all of that, he seemed not to have much else to say, as if he could not imagine that I would be interested in anything else about him, such as other aspects of his childhood, his career or his current family functioning. I felt this might be partly because that had been the focus of the CBT, but it also seemed hard for him to hold on to the more positive aspects of himself, as if he was just one big problem to be solved.

His history was indeed complicated. He had grown up in a family with little affection from either parent, and much criticism from his demanding father. He wondered if his mother had Asperger's syndrome as she showed so little emotion and was very odd, two of his own children had been diagnosed with Aspergers and Nick wondered if he might also have it. He had had few friends at school but had been good at science and good at singing so had done well academically in a cathedral school. He had spent his school holidays with a grandmother on the Dorset coast and had been groomed by a man who lived near his grandmother. This man was a paedophile who would encourage Nick to dress in female clothes, as the man did himself, and then would sexually abuse him, starting at around 7 years of age. Although he had sometimes been hurt during these experiences, Nick remembered this man as the "only person who really loved me" and described the abuse as "making love" which I found rather disturbing. He talked about it as though it had been a kind of equal, adult relationship. The memory of this abuse had been with him vaguely all his life, but a much more traumatic experience, with the same abuser, only came back to him after breaking his ankle. This was a horrific experience of being tied up, raped and strangled at the age of 11 years old. He had believed that he was going to be killed and was actually left for dead, covered in blood, on a cliff top near a beach. Amazingly, he managed to escape, clean himself up in the sea and return to his grandmother's house as if nothing had happened. He did not disclose it to anyone and never saw his abuser again, later hearing that the abuser had been sent to prison for "interfering with boys". This was not even the first experience of sexual abuse, as he had previously been raped by a hospital worker when in hospital for treatment of an anal polyp.

Having heard all this, and knowing that he had already had three years of trauma focussed CBT without getting very much better, I did feel a bit overwhelmed and not sure how far we could get, but was determined to give CAT and EMDR a try, as was Nick.

When I asked Nick how he had coped with the experiences, he described building "a wall" to block off the memories and feelings in order to appear normal. I had an image of him building the wall and then having to balance precariously on top of it throughout his life with great effort. He had a successful career as a scientist, but felt that this was partly because he had had two very supportive bosses. He had a strong religious faith and support from his church, he loved his children very much, and also his chickens! It sounded as if every now and then he had fallen off the wall, for example having urges to dress in women's clothes, nightmares and dissociative episodes, but had never really understood why or made sense of it. He was very ashamed and guilty about this. He had met his wife at university and they had fallen in love at first sight. They still seemed to have a strong relationship, despite all the recent problems, but I was a bit concerned that Nick described learning "how to be normal" from his wife Gill, and thereafter agreeing with everything she felt and wanted. He said "if she is happy, then I am happy" and seemed to have no sense of his own feelings, desires or wishes. I encouraged him to start keeping a diary of his feelings and he found this impossible. However, he did bring some images, as Gill had reminded him that when he looked at paintings he could get quite emotional. He had grouped the images into some which were labelled "numb, uncertain, lost – are these feelings?" and others which were labelled " rage, confusion and despair – are these valid feelings

and what do they mean?" . These two groups of feelings seemed to represent being on the wall "normal but cut off from feelings" and falling off the wall "overwhelmed with fear, anger and despair" - this state leading to self - harm or sometimes to dissociative episodes. These episodes took the form of Nick running off for long periods of time, to be found later in a confused state and were alarming for him and his family. They often seemed to be triggered by conflict. He felt intensely self critical and guilty if he upset anyone in the family, but this meant that he avoided ever bringing up anything which may cause a problem. In the long run, this caused greater problems as he would suddenly present a "solution" to a problem that no-one knew existed. It seemed that he was drawn to rescue others and solve their problems but unable to take basic care of himself. It felt a bit as if he was saying that Gill had rescued him and therefore he had to be grateful. I felt as if I was being pressured to rescue him. This meant that there was little room for disagreement, negotiation or discussion about differences of opinion. We started to draw out a diagram together and agreed that there was work to do in helping him to understand, and label, his emotions. (Figure 1).

The Reformulation letter which I wrote led to some conflict with his wife. Nick had agreed with my comments that he had always tried to please Gill and had never really developed, or expressed his own feelings or opinions, and I did not realise that Gill knew nothing of this pattern. He had shared the letter with her and was puzzled by her angry reaction - saying "she was always happy before, why should she be upset just because I was trying to please her all the time?". Nick requested a joint session as he felt that his relationship was at risk. The joint session seemed to go OK and both agreed that the therapy should continue as they could not stay as they were at the moment.

Nick's family was incredibly important to him, but he seemed to be realising that he needed to find himself in order to survive. Although this was one of the patterns that we focussed on, he also wanted to be able to manage his anger better. For this we used the idea of an anger 'traffic light system". When the anger is red hot, it is best to just have some time out, when it is amber and has cooled a bit, it is helpful to try to describe what made you angry and why. Lastly, when it is green, you can try to problem solve how to manage those situations if they happen again in the future. One of the conflict situations for Nick and Gill was food shopping. They liked to do this together, but any disagreement now would lead to Nick dissociating and running off. On one occasion, he had a letter in his hand ready to post and he was able to say "I'm just going to post this and come back", which he did. For the first time, he was developing a "window of tolerance" in which he could feel angry but not be overwhelmed, and could think how to deal with it. He was also starting to be a better parent towards himself and take more responsibility for managing his emotions. We developed a healthier part of the diagram (see figure 2).

We started EMDR at session 10. He did well on the positive resourcing, thinking of his safe place as being at home at his desk, listening to Bach. His EMDR team consisted of Einstein and an old boss as wise figures, Gill as a protective figure and a hug from his daughter as a compassionate resource. We started with a snapshot memory near the end of his ordeal by the beach as the first target. This meant that surviving and being safe was relatively easy to get in touch with as the ordeal was already over, he just had to get home. Nick processed extremely well, almost according to the EMDR manual, he has a very strong visual imagination and often found that the traumatic images would spontaneously change to exclude the abuser or make him seem further away. As the sessions continues, we gradually moved backwards in time to the earlier aspects of the trauma. Eventually, we processed the memory of the earlier abuse, which was mainly in the form of painful physical memories. Gradually, the flashbacks and nightmares faded and the dissociative episodes became much less frequent. In total, 10 of our 24 sessions were EMDR sessions.

Ending was painful for Nick. Although he felt a bit better, it was fragile recovery and Nick experienced a return of his suicidal thoughts towards the end of our individual work, when Gill became physically ill with flu and was not available emotionally to support him. His GP contacted me urgently but I was not able to see him for a few days and he felt that was a good thing, as it made him try and find some strategies for himself rather than me coming up with them. This linked with our work on being kinder to himself and being his own parent. We wrote out the strategies he had used as an emergency First Aid Kit and this seemed to give him the confidence to face the ending. At the end of therapy, he seemed more able to be realistic about his busy family life and the fact that he was not the cause of all the problems at home. He was more able to see his experiences of sexual abuse as abnormal and "not love". He no longer had flashbacks or nightmares. His CORE score at this point had reduced from 27.9 (raw total score 95) at the start of therapy to 19.1 (raw total score 67) at the end.

I facilitate a post-CAT group for patients who have chronic physical health problems, medically unexplained symptoms or chronic pain, and are likely to struggle to continue the CAT work on their own. People bring the pattern that they have been working on in individual therapy that they would like to continue working on while in the group. Nick attended the group for 15 months

and did very well, despite ongoing physical health problems. His CORE score at the end of the group was 4.4 (raw total score 15) which is below the cut off for psychiatric caseness of 10.

Nick's own Reflections

I am a gentle man, or so I like to think, a plant biologist, because I like flowers. I don't find people easy to understand - some would place me on the autistic spectrum, perhaps they are right - whatever else, I was the brightest and most obsessive plant biologist I knew……I am also extraordinarily lucky, having survived an attempt to kill me by one of the people who sexually abused me as a child. Until I smashed up my ankle some years ago, and acquired chronic regional pain disorder, I had no recollection of this abuse, but the exhaustion that followed degraded the box into which I had put it all, and out it flooded. At last, it was possible to understand a lifetime of nightmares, flashbacks and occasional rages and dissociative fugues. I had PTSD.

At first I thought that this would be easily fixed. However, over the next few years it became clear that this was not the case. Talking therapy (CBT) helped me to process much of what had happened, but left a terrifying burden of incomprehensible emotion thrashing about in my poor old mind. Frustration built up and by the time I met Dr Jenaway, I was so confused and hurt and sad and angry that I had been diagnosed, rightly or wrongly, with borderline personality disorder.

Dr Jenaway told me that CAT with EMDR might help me. She was right, it did. The CAT side of the work helped me to realise that I have emotions like other people and to begin to be able to recognise what they are and what they mean. It has given me a toolkit of ways of looking at life that are helping me to make sense of what has happened to me and to be able to better regulate my emotions and behaviour. The EMDR was tough (probably for both patient and therapist). I was pretty sceptical, but something extraordinary happened as we did it. Thinking about some of the most horrible experiences, in sensible bite sized chunks, whilst being tapped on alternate knees (since initially I could not concentrate with my eyes open), somehow allowed the terror, powerlessness and pain associated with those events, not to drain away, but rather to migrate to a place where I could look at them if I wanted to, but no longer had to re-experience them every time I thought of the events.

After we had finished individual CAT and EMDR, I joined a therapy group for people with similar pain issues. This has continued to build on the foundational toolkit from CAT, as well as helping me to see that my emotional and physical pain are a normal human response to extraordinary events. All in all, life was on the verge of being intolerable before this therapy, and now, for the first time in years, I feel optimistic and look forward to the future. Thank you……..

Summary

I think that CAT combined with EMDR can be a really useful therapeutic option for patients presenting with complex trauma. It combines a specific evidence based therapy for trauma with an evidence based therapy for personality disorder and they seem to work well together in my experience. The CAT provides a comprehensive assessment process and the development of a therapeutic alliance, with the capacity to explore any problems in this if they arise. It is also a useful focus to return to at the end of the trauma work to try and integrate the new insights into a plan for the future and what the person still needs to work on. I have now treated over 50 patients with this kind of combination and have found it a really useful way of working. The rough average number of EMDR sessions per CAT patient has been around 5 sessions.

I have also found that having an option to work within CAT using a technique which is less verbal, less cognitive and "left hemisphere" adds something extra and makes changes in reciprocal roles easier.

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Further Opportunities to Learn about the ideas described in this paper

Tracy Wade and I are planning a CPD day on combining EMDR with CAT in the spring of 2017, booking will be through the ACAT website.

A special interest group for those CAT therapists interested in working with trauma and using techniques such as EMDR is in the early stages of development. If you are interested in joining, then please contact sjysmudge.young@gmail.com

Coming soon (check the website for more information)
CAT & EMDR - Alison Jenaway and Tracy Wade, 20 March 2017, London
www.acat.me.uk/event/895/