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A CAT envelope to deliver EMDR (Cognitive Analytic Therapy around Eye Movement Desensitisation and Reprocessing).

Darongkamas, J.[1], Kiely B[2]. and Walker, M. J[3] [4]

Jurai Darongkamas, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Cannock, UK.

Brian Kiely, Independent Practice, Hereford, United Kingdom.

Mark J. Walker, Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, UK.

We thank Derek Farrell for helping convert our initial thoughts down to paper.

Correspondence concerning this article should be addressed to Jurai Darongkamas, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Park House, 12 Park Road, Cannock, Staffordshire, WS111JN United Kingdom.

E-mail: jurai.darongkamas@sssft.nhs.uk

[1] South Staffordshire and Shropshire Healthcare NHS Foundation Trust, U.K. Jurai.darongkamas@sssft.nhs.uk, 001144 7800 977631 and ClinicalPsychologyService.co.uk
[2] Retired Consultant Clinical Psychologist and Psychotherapist in private practice, Hereford, U.K
[3] Birmingham and Solihull Mental Health NHS Foundation Trust, U.K.
[4] We would like to thank Dr Derek Farrell for helping convert our initial thoughts down to paper.

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Abstract

Two psychological therapy approaches are outlined: Cognitive Analytic Therapy (CAT) and Eye Movement Desensitisation and Reprocessing (EMDR). Substantial benefits are to be gained, particularly for patients with complex interpersonal trauma, in combining the two; providing EMDR within the CAT envelope. This synthesis harnesses the benefits of a CAT Reformulation framework of understanding and a proven CAT therapeutic approach generally with the well-established therapeutic efficacy and expediency of EMDR. An overview of each single approach is given followed by the rationale and the main benefits and limitations of the combined approach, with clinical illustrations.

Keywords

Cognitive Analytic Therapy, CAT, Eye Movement Desensitisation and Reprocessing, EMDR, Integration

In the United Kingdom, two relatively well known, efficacious psychological therapy approaches are Cognitive Analytic Therapy (CAT) and Eye Movement Desensitization and Reprocessing (EMDR). In this article, a brief outline of each approach is given before explicating the rationale and proposed major benefits of integrating the two approaches. The integration could take many forms and would be helpful for the range of difficulties people have, ranging from grief with interpersonal coping patterns as sequelae (for example, withdrawal from other loved ones as a form of self-protection) to those with interpersonal difficulties linked to unresolved childhood complex trauma. A hypothetical client with the latter is described here to illustrate the delivery of EMDR within a CAT envelope for such clients.

1 Cognitive Analytic Therapy (CAT)

1.1 Theoretical and conceptual overview

CAT (Ryle, 1979, Ryle & Kerr, 2002) is an integrative psychotherapy originally based on weaving, in a theoretically coherent way, ideas from psychoanalytic approaches, particularly object relations (Ogden 1983) and cognitive therapies (personal construct therapy, Kelly, 1955). Ideas subsequently incorporated included those from developmental psychology, particularly the view of the relationship-seeking infant (Trevarthen, 2001), dialogism (Bakhtin, 1984, 1986) and social learning theory (Vygotsky, 1978).

CAT developed as a response to the perceived need for a collaborative transparent psychotherapy (ie CAT using descriptive observations as opposed to prescribing interpretations often stated as facts.)).

CAT comprises three phases: Reformulation, Recognition and Revision (Ryle & Kerr, 2002). Reformulation is the collaborative process to reach an understanding between therapist and patient of probable causal and maintenance factors linked to a person's difficulties. Most importantly defined are key patterns of relating

(Reciprocal Roles, RRs), and Target Problem Procedures (TPPs/patterns). The latter include emotional self-management procedures and other coping patterns which prevent the patient from making desired changes. In CAT, the word Reformulation emphasizes that it is a re-looking, together, at all aspects including the narrative life story and associated patterns.

TPPs developed in childhood are seen as understandable or necessary ways in which the person copes with difficult positions (roles) that they find themselves in with respect to another (reciprocally). However, some TPPs have become unhelpful in adulthood or have too many costs. CAT holds the idea of seed/core self (McCormick, 2002/12) held back from progressive development due to old, but previously needed, coping mechanisms/patterns and procedures which keep old RR experiences and expectations alive.

There are three subtypes of TPPs: Trap (vicious circle), Dilemma (false dichotomous choices are only seen to be available) and Snag (yes but …, resultant self-

sabotaging effect). Therapist and patient work together to understand how, over time and in different contexts, they could be maintaining or reinforcing difficulties. CAT helps patients to begin recognising these patterns and, when appropriate, experiment with revising them to achieve desired changes including symptom reduction.

The concept of Reciprocal Roles is deceptive at first glance. It appears simplistic, yet coverage is comprehensive. Bespoke words/phrases are elicited from the patient to describe their experience of key childhood relationships, such as abusing-abused, abandoning-left behind, alone. The role position concept encompasses thinking, feeling, action, identity, memories, etc. All these are activated when someone finds themselves in a particular role position. The person also predicts the other's reciprocating role position. "*Patients' interpersonal expectations influence their behavior, which, in turn, elicits predictable responses from others*." (Bennett, Parry & Ryle, 2006/10). This is activated reciprocally between therapist and patient in therapy ("enacted") and can be used to aid therapeutic understanding and address therapeutic breaches.

CAT was the first of the cognitive therapies to state the self as relationally formed. This shift from a then cognitive-centric view is now championed and supported by learning from neurobiology. The conceptualisation, especially of RRs, is in keeping with neurobiological evidence that the neural development of the brain is influenced

directly by interpersonal emotional experience. Thereby, interpersonal interactions are organised and made more predictable (Gerhardt, 2004).

"*Interpersonal neurobiological models of the enduring impact of early attachment trauma on brain development*" have been devised (Schore, 2015, Siegel, 2010). How brain integration occurs is influenced by: attachment history; traumas; emotional experience; plus ongoing relational experiences.

A Reformulation diagram (or map) and letter are key CAT tools used to develop collaboratively both patient's and therapist's understanding and recognition of patterns and RRs. These provide an important framework for change. These tools can be emotionally evocative, particularly the narrative letter, and powerfully containing, particularly the map/diagram (Potter, 2010).

The process of developing and using the tools can consequently strengthen the therapeutic relationship, enabling the person to feel safe enough to explore and begin to address difficulties, including long held roles, beliefs, feelings, memories and coping patterns. It can help address the power differential between therapists and patient. Patients are seen as experts on themselves whereas the therapist brings the tools and ideas of RRs and procedures literally to the table (Potter, 2010).

The CAT framework suggests therapists attend to emotions and readiness for change. This is generally stated rather than protocolised within the Competencies in

CAT measure (Bennett & Parry, 2004[5]); "basic supportive good practice" is rated, including: "…the client's readiness for the stage of the work"; "assimilation of warded-off, problematic states and emotions" with the therapist focusing on the client's emotional experience; and helping the patient explore ways of working through emotions..

Vygotsky's Zone of Proximal Development (ZPD, 1978, p.86)[6] concept is the *"difference between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance…"* that is it, *"defines those functions that have not yet matured but are in the process of maturation"*. Ryle, 1991, summarized Vygotsky's view as the intrapsychological growing from the interpsychological.

In CAT, this is used to consider the patient's readiness and capacity for change. The premise is that what a patient is capable of doing that moment with the structuring support of the therapy and therapist, they will be more able to do relatively more

[5] Bennett, D. & Parry, G. (2004). A measure of psychotherapeutic competence derived from Cognitive Analytic Therapy. Psychotherapy Research, 14, 176–192. Copyright The Australian and New Zealand Association of Psychiatry, Psychology and Law, reprinted by permission of Taylor & Francis Ltd., http://www.tandfonline.com on behalf of The Australian and New Zealand Association of Psychiatry, Psychology and Law.

[6] Vygotsky, L. S. (1978). Mind in society: Development of higher psychological processes. Michael Cole, Vera John-Steiner, Sylvia Scribner, & Ellen Souberman, (eds.) Cambridge, Mass.: Harvard University Press, Copyright 1978 by the President and Fellows of Harvard College.

independently throughout and in the future. The resultant tailoring of the content, pace and process of the therapy by the therapist is not unique to CAT but, holding the ZPD concept in mind helps the aim of achieving true understanding, both emotionally and intellectually.

Within the structure of the therapeutic relationship, the process of Reformulation, recognition and revision is facilitated using the patient's narrative accounts of their activities plus the various 'enactments' of procedures and roles taking place within their relationships and life more generally. The map is a reflective tool to help spot when enactments occur. Thus, the diagram has many uses, including predicting likely painful areas and how emotions will be activated when particular dynamics (RRs) occur within relationships and particular procedures activated which may block progress. When enactments occur within the therapy relationship, these need to be spotted and worked through to avoid damaging the therapeutic alliance. The latter is known to be an important determinant of eventual outcome (Horvath & Symond, 1991; Martin, Gaske & Davis, 2000). It provides an opportunity for relational learning which potentially generalises to other ongoing relationships and may contribute to therapeutic change (Bennett, Parry & Ryle, 2006/10).

1.2 CAT in Practice

CAT developed as a time limited therapy within the National Health Service, U.K (Ryle & Kerr, 2002). It is usually an 8, 16 or 24 (or more) session course of therapy.

A variety of patient groups with a broad range of difficulties have been helped by CAT. It is a treatment of choice for people with Anorexia Nervosa (NICE, 2004), and has been used successfully with people with a diagnosis of Personality Disorder/s (Ryle 1997a, 1997b, Ryle & Golynkina 2000, NICE 2009, Clarke, Thomas & James 2012).

For each course, a particular target problem and up to three associated TPPs become the focus. At the end, a follow-up review appointment, usually after three months, occurs to reassess the situation. As with most time limited therapies, therapy can be quite "busy" and not all work can be completed (Howlett, 2011).

The initial Reformulation sessions are spent understanding the cause and maintenance of a person's difficulties, what prevents them from making desired changes and identifying the RRs and procedures/patterns which have developed.

The middle section of therapy focusses on recognition of the RRs and procedures in everyday life. As recognition improves, revision can begin, using tools available from the therapist's 'toolkit'. Although most of the work uses the emotionally charged "here-and-now" therapeutic relationship, techniques from other schools can be incorporated.

The final section focusses on endings, particularly any RR issues which may be re-stimulated. Endings are a potential stimulus to identify and work on unresolved issues relating to care both in the therapy and more generally in relationships with significant others, past and present (Mann 1972). It is something that the patient is made aware of from the start and the sessions are counted down. Revision may not be consistently achieved during the therapy but is expected to continue subsequently.

The psychoeducational element of CAT, achieved through careful explanation while constructing the CAT tools of the Reformulation diagram and letter with the individual, enables patients to continue using the tools of CAT themselves, long after therapy sessions end. These CAT tools guide and structure enabling subsequent on-going recognition and potential revision of the key ways of relating and the coping patterns.

1.3 CAT and the complex patient

Those offered longer therapies, typically 24 weeks, are usually those with interpersonal difficulties including histories of interpersonal trauma, neglect, with associated strong negative affect (e.g. anger, fear, shame) and markedly negative RRs and procedures. They may have been given a diagnosis of personality disorder, attachment disorder or complex post-traumatic stress disorder.

Due to a fear of re-experiencing earlier relationships, these patients may understandably struggle to establish the trusting relationship necessary to develop a

therapeutic alliance. Consequently, the Reformulation phase of CAT needs to be longer and focus more on establishing patient safety and trust, enabled by identifying RRS and patterns that might be re-enacted within the therapeutic relationship. These could include a longed-for idealised wish, e.g. for rescue, manifest as an RR pair of rescuing to rescued, or a fear of abuse resulting in therapeutic disengagement arising from the RR pair of abusing to abused.

Within CAT, the Multiple Self States Model of borderline personality (MSSM, Ryle 1997a, 1997b) conceptualizes the various ways in which harsh and traumatic experiences, including neglect, influence personality development. Key here is the limited, inflexible range of dissociated RRs and potentially, trauma induced dissociation.

This 'Multiple Self States Model' (Ryle, 1997b, p. 34) outlines three distinct levels of 'disruption' of normal personality development:-

"Level 1: The restriction or distortion of the reciprocal roles repertoire.

Level 2: The incomplete development or disruption of higher order procedures responsible for mobilizing, connecting and sequencing level 1 procedures

Level 3: The incomplete development or disruption of self-reflection"

CAT focusses on increasing the ability to recognise and revise state shifts, including awareness of triggers. This can help the process of integration within the context of the therapeutic relationship. This, combined with CAT's explicit focus on the therapeutic relationship, means it is particularly helpful for those with interpersonal difficulties who will likely have difficulties working collaboratively with a therapist with whom they do not initially have sufficient trust.

In CAT, the working through of the trauma, through talking and feeling, is carried out in a titrated way through constant monitoring of the patient and therapeutic relationship's ZPD in terms of their respective ability to contain the emotions raised.

2 Eye Movement Desensitisation and Reprocessing (EMDR)

2.1 Theoretical and Conceptual Overview

EMDR (Shapiro, 1987) is recommended as a treatment of choice for trauma by NICE (2005) and is increasingly being used for other difficulties (www.emdrassociation.org.uk).

EMDR integrates aspects of various therapy approaches: psychodynamic (etiological events); behaviourism (conditioned responses); cognitive therapy (beliefs); experiential therapies (emotion); hypnotic therapies (imagery work) and systemic understandings (Shapiro 2001).

Adaptive Information Processing (AIP) is the main theoretical model; "*...there is an innate physiological system that is designed to transform disturbing input into an adaptive resolution and a psychologically healthy integration"* (Shapiro, 2001, p.54).

The AIP model proposes that PTSD symptoms result from blocked information processing. Shapiro (2001/7) proposes that trauma disrupts the natural adaptation process due to neurophysiological imbalance. Consequently, the information processing system cannot function to process the disturbing material with the latter being kept apart in its own trauma linked neural network that is dysfunctionally stored.

Various hypotheses for the blocking of the natural information processing system are proposed (Shapiro, 2001): "*Most psychopathologies are assumed to be based on earlier life experiences that are in state-dependent storage*." (Shapiro, 2001, p. 55).

These "small t traumas" and the associated negative affects and sensations may result in dysfunctional storage.

The eight phase protocol used within EMDR, along with the AIP driven case conceptualisation, is proposed to help unblock the natural adaptive information processing system and memory networks to allow transmutations to an adaptive

adult perspective: "*the purpose of … treatment is to facilitate accelerated information processing*" (Shapiro, 2001, p. 89).

EMDR is known for its unique use of Bilateral Stimulation (BLS), usually eye movements (but also auditory and/or kinesthetic). The patient is helped to process a strand of dysfunctionally stored memory and associated belief, by starting with something about that in mind while also focusing on the therapist's hand (light bar or other) moving horizontally back and forth (resulting in patients' rapid eye movements, usually sideways but can be individually adapted). Patients are asked to briefly report what they noticed of what then occurred.

Hypotheses abound concerning the core change agent/s within EMDR including: the integrative elements of other approaches implicit with the model; the unique Bilateral Stimulation (BLS);memory integration akin to that from Rapid Eye Movement (REM) sleep (Jeffries & Davis 2012); increased inter-hemispheric interaction via stimulation of the corpus callossum (Jeffries & Davis 2012) or down regulation of Hypothalamus-Pituitary-Adrenal (HPA) axis facilitating movement and linking of disparate memory networks (Solomon & Shapiro, 2008). The inherent 'dual attention' to BLS and inner experience facilitates 'accelerated reprocessing', Shapiro, 2001.

2.2 EMDR therapy in practice

The EMDR process is used to facilitate adaptive processing of traumatic memories following an eight phase standard protocol as follows:

- History
- Preparation
- Assessment
- Processing
- Installation
- Body Scan
- Closure
- Re-evaluation

A good knowledge of the underpinning theory of the neurobiology of trauma, alongside a good case conceptualisation of the patient's difficulties informed by the AIP, guides all processes and interventions. Such knowledge steers elements including: degree of preparation required, assessment of target and, during processing, any specific interventions required.

EMDR's detailed protocol drills down into actual cognitions, feelings and sensations noted as part of history-taking and later processed for healthier adaptive change. A good therapeutic relationship is assumed as a prerequisite.

During history taking, potential targets for EMDR are identified, alongside rapport building. Assessment includes associated descriptions and ratings of negative and positive beliefs, emotional experience and physical sensations. Like CAT, coping strategies and resources are determined as part of the case conceptualisation.

Patient safety features, resources available (skills and support), and contraindications are explored, e.g. physical health conditions, organic brain injury or active psychosis.

The concept of a “Window of Tolerance” (Ogden, Minton & Pain, 2006, Siegel, 1999) monitors the patient’s affect. Optimal BLS work suggests the patient’s affective and somatic arousal levels should be neither too low nor too high.

Preparation follows: orienting the patient to the model, psycho-education, signposting to relevant literature and, if necessary, affect management strategies (safe place’, Luber, 2009, light stream technique. Shapiro, 2001).

The desensitisation phase involves the patient holding an image, feeling, body sensation and a salient negative cognition in mind whilst receiving BLS
Imaginal exposure, image re-scripting, narrative commentary, dual attention (there-and-then, here-and-now), and free association are carefully used. The therapist is encouraged to keep out of the way of the patient’s own natural adaptive information processing lest their intervention becomes unhelpful interference - by introducing demand characteristics and thus leading or adversely influencing the patient.

The frequent alternation of focus on their interior experience and free association during BLS, along with a return to the here-and-now as they briefly describe their experiences, ultimately facilitates a more coherent and integrated narrative account

of the trauma. The experience becomes integrated with other associated neural networks believed to be responsible for the problem's perpetuation. The latter may be other traumatic experiences and associated fragments of memory and affect. BLS results in the patient accessing more adaptive memories, skills and resources, previously inaccessible.

After processing the disturbing target memory is complete (shown by a significant decrease in subjective units of disturbance), the alternative, more adaptive, positive cognition is installed (Installation phase) with further sets of BLS. This is followed by a 'Body Scan' to address any ongoing somatic disturbances. Therapy then moves on to "Closure" followed by "Re-evaluation".

Throughout all the phases, attention is given to the cognitive, emotional, biological, systemic and relational aspects of the patient, thereby making EMDR a complete and self-contained therapeutic process (Dworkin, 2005, Shapiro, 2007).

There are no expectations as to any prototypical length of therapy.

2.3 EMDR and the complex patient

Novice EMDR therapists often underestimate the amount of therapy required. At the preparation phase, patients need to be able to access positive personal resources and learn some basic emotional regulation skills (Kiessling, 2005, Leeds, 1998,

Leeds & Shapiro, 2000). For dissociative patients, particularly those more distressed, before actively processing traumas, there is a need for stabilisation (Lanius, 2005, O'Shea, 2009). This may involve extensive skills and resource development installation (Leeds 1998).

Additionally, once BLS has begun to actively process trauma, 'cognitive interweaves' are often required (Shapiro, 1995) to enable linking with more adaptive memories and resources and/or update their knowledge.

Non-compliance is recognized within the psychotherapy literature as a significant issue for those with more complex needs. In the extreme it can lead to 42-67% of patients dropping out of treatment prematurely (Bennett, Parry & Ryle, 2006/10).

Within the EMDR literature, for certain populations *"the issues of resistance and noncompliance may be of concern"*. Therapists are cautioned that "*respect for client defences is paramount*". There is a need for the "*clinician to ensure that the appropriate therapeutic relationship, goals, and prioritization of targets have been established. Flexibility and creativity are also critical*" (Shapiro, 2001, p. 312-313).

Commenting on how *"the fears that underlie the lack of compliance may be based on early life experiences"*, Shapiro (2001, p 280) suggests that associated underlying memories are targeted first and a positive template for appropriate future action

installed within a flexible treatment approach; *"noncompliance is viewed as part of the pathology"* (p. 279). These statements perhaps reflect a perception that non-compliance is primarily an intrapersonal issue, not interpersonal.

The importance of the therapeutic relationship is increasingly recognized in EMDR, partly to help address compliance and as a source of therapeutic change.

With approximately 40% of patients, just using BLS within the context of general basic attunement is sufficient. However, for the remainder, more attention to both attunement and therapeutic alliance is needed (Hofmann, 2012). Dealing with and managing ruptures to the relationship (Dworkin, 2005, Dworkin & Errebo, 2010) will help reduce non-compliance and drop out.

Kitchur's "Strategic Developmental Model for EMDR" (2005), proposes that *"the attuned relationship is the necessary context within which therapeutic strategy facilitates developmental healing"* (p. 14).

Twombly, 2005 suggests that key interactions between the patient and therapist can be installed as coping skills in work with more complex clients, such as those with dissociative difficulties, including resolutions of disagreements in the therapy relationship. Twombly, 2005, suggests that EMDR adapted can help decrease negative transferences arising from aspects of the self still stuck in the past.

Such views fit well with the broader psychotherapy literature which has long recognized the importance of the interpersonal experience (Holmes, 1996 cited by Howlett & Guthrie, 2001, p.65) and of the therapy relationship (Kitchur, 2005, Dworkin, 2005, Dworkin & Errebo, 2010).

Reflecting such issues, for complex patients at least, various attempts have been made to adapt EMDR with relational ideas from other approaches, such as attachment theory (Korn, 2009), family systems therapy (Shapiro 2007). However, such integration is embryonic and seemingly not yet, covered in core EMDR training or texts. Shapiro mentions in an appendix on clinical aids only that *"The therapeutic alliance can serve as a resource"* (Shapiro, 2001, p. 436).

Some EMDR writers believe that EMDR can be utilized within the context of a supportive and secure therapeutic relationship without explicating further. However, for some complex patients, the potential for a good- enough therapeutic relationship cannot be assumed to be sufficiently present.

3. Combining the two approaches: A CAT around an EMDR

The main premise here is that CAT offers a useful, complementary intra and interpersonal framework within which to offer EMDR with its primarily intrapersonal focus. This might be particularly the case for patients with more complex, developmental, relationship based trauma where therapeutic engagement may be more problematic and hence need addressing, before EMDR can proceed.

As well as enabling engagement with EMDR, the relational focus offers an important source of personal growth and clinical change. Sometimes, CAT may be useful as a standalone therapy before a course of EMDR or, as proposed here, that such a fusion might be best considered as the delivery of an EMDR therapy within the 'envelope' of a CAT frame of reference.

Norcross & Arkowitz's model (1992) of integration describes four main routes to therapy integration: common factors, therapeutic complementariness, technical eclecticism and theoretical integration. EMDR within a CAT envelope can be seen to follow all these routes, offering the clinician numerous ways of artfully incorporating aspects of this into practice. Elements of technical eclecticism and theoretical integration are mostly apparent here. Technically, BLS can be utilised for both the preparation aspects of the work and the desensitisation/processing phase. The combination of the psychodynamically informed CAT Reformulation and the AIP model allow for some theoretical integration and working at both macro and micro levels.

Both approaches share some conceptual similarities. Both believe in the individual's natural ability to heal and overcome trauma except when the process is blocked - either by self-defeating patterns that are no longer helpful, akin to coping mechanisms and unhelpful self-affirmation procedures, or blocking beliefs, or stuck information processing.

Each model recognises the need to actively reprocess the trauma adaptively. To help achieve this, they each recognize the importance of pacing, tailoring the therapy to the patient's abilities - EMDR's "Window of Tolerance" and CAT's "Zone of Proximal Development" (Vygotsky 1978). As already described, the latter encompasses more elements than the former and could enhance the EMDR therapy process.

With suitable adaptations, the semiotic nature of CAT (Lloyd & Williams, 2003) and the more physical nature of EMDR (Seubert, 2005) enables their use with people who have intellectual difficulties or who have difficulties expressing themselves linguistically.

Another area of compatibility enabling an integrated approach is how both approaches address the acquisition of new skills via 'top down' learning. This is done within the safety, dialogue and boundary of the therapeutic relationship, although CAT makes this, and working directly with it, much more explicit.

Although EMDR generally does not attend to longed-for states particularly, both CAT and the Feeling State Protocol (FSP, Miller 2015; an adaptation of EMDR), recognize the presence of idealized/longed for states (as extensions of normal feelings) which can be changed to more realistic, achievable states accompanied by more appropriate ways to attain them.

3.1 Potential benefits of CAT for EMDR

A general outline is given next of the principles upon which two models might be used collaboratively, illustrated by general clinical examples and also those related to a hypothetical client, Sarah.

CAT and EMDR can be integrated in varying degrees; here a CAT envelope around EMDR is suggested (although the inclusion within a CAT therapy of aspects of EMDR and vice versa is also possible).

3.1.1 The Reformulation process

The need to extend the Formulation or case conceptualisation in EMDR has been noted (de Jongh, ten Broeke, & Meijer, 2010).

The CAT Reformulation process could help to anchor and locate the work of EMDR within a larger context developmentally and in terms of everyday functioning, including relationally. Identifying RRs and TPPs can suggest likely domains wherein negative beliefs may lie for subsequent focusing via BLS. It can also identify potential fear-based blocks to change, e.g. around initially agreed exits and also likely difficulties within the therapeutic relationship.

However, therapists should be mindful of not predicting with total certainty what is likely to come up and why.

The Reformulation phase's provision of a broad and shared understanding of the difficulties experienced would in itself be therapeutic, e.g., due to an increased sense of control or the normalization of the experiences and the patient's subsequent reactions to them, including historically developed ways of dealing with them, i.e., the TPPs.

Co-constructing the map strengthens the therapeutic relationship to help withstand ensuing emotional exploration. It is also part of the healing process, particularly for someone with a history of being neglected and abused, providing the perhaps crucial alternative relational experience of being actively listened to, understood and tested explicitly via the Reformulation process and compassionately responded to.

For the complex patient, constructing a Reformulation diagram with a therapist acts to help contain and stabilize strong emotions, encouraging the development of 'an observing eye' (Denman, 2001) or more distanced, objective perspective. This provides a platform from which a narrative can emerge, facilitated by the relationship; experiences witnessed and compassionately shared.

Tailoring the therapy to the patient's ZPD guides the therapist to consider different aspects of their interventions at all stages, in addition to the more obvious emotional regulation benefits during administering BLS. For example, with patients who have a small window of tolerance, a history of traumatic experiences and multiple self-states, there may be an increase in anxiety/fear when attempting to do things

differently in their life and relationships. 'Front-loading' the work with some affect management strategies and other resources will be useful later when working on 'revision' towards exits. This could be via teaching self-soothing via self-administered BLS, or the use of other installed resources such as helping figures, strengths, spiritual resources available when in other states (Leeds & Shapiro, 2000) or the use of a keyword/trigger for a relaxation response 'safe place' installed previously. This can allow patients to stay in the room and minimize dissociation or state shifts. This will improve the efficacy of any role play or rehearsal strategies.

EMDR may help the person process the trauma relatively quicker than CAT. However, through a shared Reformulation of their ongoing experiences and the link with past developmental experiences, CAT would help to abate feelings of confusion and helplessness when coming across sudden/unexpected strong feelings, memories, etc., during BLS.

In the case of Sarah, she struggled with alcohol misuse and low self-esteem. After several conversations, the therapist and patient agreed that her 2 main RRs were abusing/punishing – abused/punished and rejecting/neglecting – rejected/neglected.

The 3 main TPP/patterns were: compliance (doing what the other wants but then ending up feeling used and abused; fearful avoidance and; Sarah would misuse alcohol as a way of coping with feelings, itself a form of rejection of unwanted feelings.

Later, an idealized RR was also recognized as wanting to achieve a sense of perfect/blissful acceptance and love (even if via accepting abuse). A possible partial CAT map for clinical illustration, Sarah (Figure 1.) is given.

Figure 1: CAT Map for Sarah

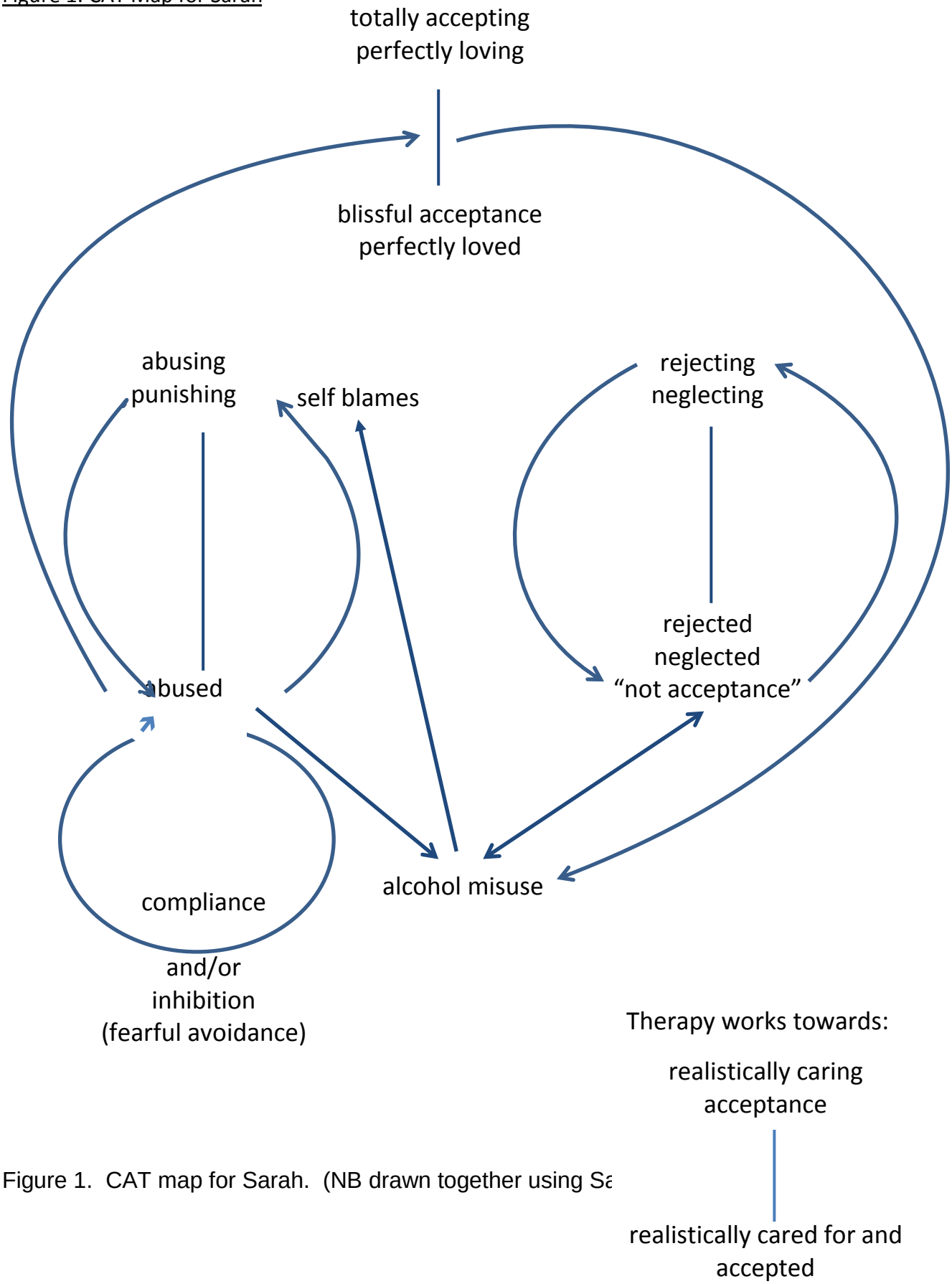


Figure 1. CAT map for Sarah. (NB drawn together using Sa

Guided by her ZPD, RRs and TPPs, resource installation work via EMDR work at an early stage helped. Sarah began to learn to better manage her emotions, including her anxieties about being punished in therapy, e.g. for talking. This enabled her to reduce her use of avoidance and submission TPPs, staying, and more actively taking part, in therapy. Also, later on, it helped her exit from her use of alcohol when distressed.

3.1.2 The active awareness and use of the therapeutic relationship

The patient who has been traumatised relationally in childhood is potentially going to experience a range of roles, e.g., abused, neglected, controlled, contemptible or worthless. There may also be 'escape' RRs based on hoped for fantasies such as being rescued or perfectly in control and safe. CAT conceptualizes the idealized roles/states that the person has to work through, the disappointment of never being able to attain the ideal. EMDR generally does not look at idealized states.

There may also be a variety of TPPs developed to try and avoid experiencing the negative roles, e.g. avoidance of relational intimacy perhaps via rebellious rejection, extreme self-sufficiency, submission, over compensatory care of another or 'excessive' care seeking.

Any therapy, including EMDR, might inadvertently re-stimulate these RRs and TPPs for the patient and the therapist might be encouraged to unhelpfully take up the RR or collude with a TPP.

Such dangers might be reduced by the active discussion of the therapeutic experience from the perspective of RRs and TPPs at suitable points, as and when they occur or during routine check ins. Such experiences will, through dialogue and use of the diagram, explicitly challenge the activated RRs and TPPs. As well as providing useful material for therapy, it can also help reduce the risk of breaches including a consequent dropping out of therapy.

CAT helps the person make meaning a primary aim as well as recognition and revision. This isn't just to forestall breaches, it enables relational relearning. The therapy relationship is the main vehicle for this, particularly necessary when trauma stems from maltreatment by others.

CAT's emphasis on a therapist who is active, empathically caring, compassionate and relatively transparent can help ground the patient emotionally, e.g., feeling safer when feeling overwhelmed during processing. When negative RRs are re-stimulated, this positive experience of the other may serve as disconfirmatory evidence, both implicitly and through dialogue and the use of the map. It also enables the development of an embryonic, new more positive pair of RRs that can generalize to other relationships, a key issue for patients however traumatised.

BLS could be used with revision of TPPs. If traumatised for a long time, unhelpful but hard to relinquish ways of coping may have arisen and require attention, due to the associated costs including the maintenance of trauma symptoms. For example, a patient who deals with interpersonal trauma by social withdrawal fuelled by fear and distrust of others will potentially experience restricted social intimacy, support and fulfillment in a variety of ways, leading to lower self-esteem and low mood. Focusing on the exit of increasing social contact might be considerably enhanced by the inclusion of BLS to help process the fear or depressed cognitive negativity to enable cognitive and behavioural change.

With Sarah, being attuned to her pattern of compliance would alert the integrative therapist to the possibility that this pattern would likely be around when EMDR processing is suggested and, if not discussed and monitored closely, could lead to Sarah feeling possibly abused.

Sarah viewing the therapist as abusive/punishing or rejecting/neglectful is likely to arise. For example, Sarah might re-experience these if the therapist is late for a session or there is a break due to holiday or sickness. This in turn could activate the alcohol use, avoidance or submissive TPPs. Or, rejection may be experienced during BLS when the therapist does not inquire too deeply about the patient's experiences as is common practice during EMDR.

When processing trauma, the negative cognition of feeling a failure, deserving of abuse and neglect can be predicted as likely to arise. The therapist should always

be led by the patient in determining the negative cognition associated with any event, but the patient could be warned beforehand about the possible issues which may surface. This could help the patient realise the strength of feeling likely to arise and to prepare for such, e.g., soliciting support outside the therapy room. Sarah, with key interpersonal dynamics around feeling abused, can be forewarned of re-experiencing those associated feelings when processing; only this time not alone and armed with some emotional management strategies and resources which she may not have had, or had access to, previously; feeling safe will be key.

EMDR processing can help target snags identified (any self-defeating patterns) or blocking beliefs, e.g., I deserve rejection because "I'm not acceptable." Whilst discussing a particular incident of rejection, Sarah was asked to remember the part of the memory, represented by an image, which disturbs her the most. She then identified a negative cognition (self-referencing and currently held when remembering the incident); "I'm not acceptable." The elicited positive cognition of "I am OK" was barely believable (rated 1/7).

She identified the emotion of fear, with a subjective unit of distress (SUD) of 7/10, and a body sensation of a hollow in her chest/solar plexus. BLS allowed active processing of this. BLS work may include cognitive interweaves, e.g., "would you blame your 6 year old niece that people rejected her?" (if Sarah got "stuck" on the issue of self-blame).

BLS enables Sarah to make a shift in her self-perception by 'processing' affect from a specific sample memory, beginning the process of freeing her from the 'freeze or comply' response to abusive others. More work would typically follow this as per the protocol and embedded within the CAT process. It can be seen however, that this emotional and perceptual 'shift' will facilitate further 'recognition' of this RR and associated pattern and lead to 'revision' as she generates and practices those 'exits' in the therapeutic work.

Additionally for Sarah, having a therapist who provides realistic care and acceptance (not idealized perfect acceptance) helps to nurture the positive RRs to balance against long standing negative roles.

3.1.3 Dissociation

Recognizing the limitations of EMDR with patients who dissociate, Lanius (2005) points out that work with dissociative patients has led to the incorporation into the EMDR stabilization phase of techniques from other therapies such as: DBT (Linehan 1993, Lovell, 2005) ego-state (Forgash, 2002), ego-state approaches (Paulson, 1995, Twombly 2000), motivational interviewing (Shapiro, 2009), positive psychology (McKelvey, 2009) and body therapy (Paulsen & Lanius, 2009). Again CAT, both conceptually and procedurally, has much to offer in this area.

Paulsen (1995) suggests that EMDR fails with dissociative patients when the underlying dissociation isn't sufficiently assessed and when the protocol isn't adapted accordingly.

Van der Hart, Nijenhuis and Solomon (2010) suggest linking EMDR with theories concerning complex dissociative disorders including trauma-linked borderline personality disorder. They believe that EMDR can be enhanced clinically by theories conceptualizing the origin of such disorders, such as the theory of structural dissociation of the personality.

In this area, some concepts from CAT have already been taken into EMDR. For example, Paterson, 2008 (cited by Plágaro-Neill, 2011) uses the CAT Self State Sequential Diagram based on ideas from the Multiple Self States Model (MSSM) above. Conceptually, the MSSM enables the therapist and hopefully the patient to understand the role of dissociation within the patient's broader range of experience and functioning, including crucially relationally. This includes how their general experience of life is reflected in and influenced by dissociation. Such understanding can in and of itself aid integration of previously separate states of functioning (including the "healthy island", McCormick, 2012).

Practically, the therapist and patient work together to identify when dissociation is occurring in and out of the room; including the triggers which are embedded within the TPPs. Further, there is incorporation into the broader Reformulation diagram of dissociated states, including any RRs within these and TPPs that feed into and out of

them which serve their maintenance. Subsequently, the use of the diagram as a joint tool along with the ‘observing eye’ enables recognition of the TPPs and identification of which state a patient may be at a given moment including dissociated, along with the presence of other non-dissociated states to enable grounding. This can help manage the dissociation process, whilst enabling the development of new ways of relating to self and others that reduces the need for dissociation.

The combination of this model and approach with EMDR could be very fruitful to enable therapy pacing, incorporation from EMDR (and other models) of stabilization techniques to manage the dissociation experience, revision of TPPs to reduce the risk of dissociation, whilst more generally enabling personality integration.

3.1.4 Endings

The time limited nature of CAT is in part a result of the awareness that endings in therapy can be important points of experience which, if focused on, can yield further growth and change (Mann, 1973). Relational issues which often come to the fore at the end of a therapy include limitations to or inadequacy of care, including not being rescued or cured, rejection, abandonment and control. Actively becoming more aware of and addressing these issues via the goodbye letter and discussion can help reduce the possibility that transferentially based negative affect interferes with post therapy progress. It provides an opportunity for further self and relational learning, e.g., realistic expectations of others and self, increased awareness of feelings and their adaptive containment and expression. CAT considers that such issues are likely to be central for all people, including trauma survivors.

Another function of the ending process made manifest in the goodbye letter is reflecting on the current experience of difficulties in the light of a greater understanding of a person's life more generally, including their RRs and TPPs. This could add a broader context within which to consider the patient's trauma experience whilst looking to their future. Awareness of how RRs and TPPs might habitually re-occur and contribute to re-traumatisation might help reduce the frequency and intensity of such experiences. Reiterating the 'exits' from the TPPs and alternative RRs might consolidate post therapy recovery

Using the CAT tool of the goodbye letters helps the patient (and therapist) to make sense of, and consolidate, what occurred, take leave and say goodbye to each other. Attention is also focused on the possible future re-experiencing of trauma within the broad context of typical RRs and TPPs.

As therapy moves towards its close, patients with RRs linked with, amongst others, abandonment, rejection or inadequate care in other ways, may re-experience the strong associated negative states. If not recognized and addressed within the transference, via dialogue and BLS, facilitated by the use of the diagram and goodbye letter, it is possible the patient might quietly take up their habitual negative RRs or a TPP which could detract from their sustained improvement.

For example, a patient might have the associated TPP of keeping negative feelings or needs hidden for fear of upsetting or overwhelming the powerful other (i.e., in this

instance, the therapist) who is being experienced as rejecting or abandoning, for fear of eliciting an escalation in just this response. Consequently, they might avoid reporting to the therapist any negative affect associated with ending for fear of upsetting them and potentially also being refused future care; the latter a common concern. Instead, they might unknown to themselves and the therapist, take up the RR of abandoning or rejecting the therapy and/or any gains made, fuelled perhaps by a suppressed anger, e.g., thinking the therapy has been useless, or that "I am as bad as I have ever been." Or, they might deny they have any further needs, thereby reducing the need for the other and rejecting themselves in the process, seemingly paradoxically unless viewed in terms of RRs whereby the patient can take up either RR, doing so towards another or themselves.

Alternatively, ending therapy might trigger someone like Sarah to re-experience the role of neglected, feeling consequently anxious. This might encourage her to report an increase in anxiety and trauma symptoms, especially if she is now working on being more expressive as an exit from the avoidance TPP. This could seem excessive when viewed from the perspective of the usual anticipatory anxiety experienced at the end of the therapy. If the historical link with RRs re-stimulated by endings is not recognized by both, the therapy could be extended with a return possibly to reprocessing the index trauma. Instead, it could be an opportunity to do some BLS arising from the therapy relationship, which might start with a float back to other, historical and more significant relationships.

Finally, in terms of the ending process, often in EMDR alone, when patients are better they find it hard to make sense of why and how this was achieved. An explanatory framework of changes in actual patterns of coping and roles (including beliefs) is often helpful. The person then has a feeling of being more in charge of the process now; information is power. For those who have experienced abuse, recent or childhood based, this is an alternative, healthier position to yet again being at the mercy or some external force.

Hence, it can be seen that the full combined therapy may only be needed for certain patients, but elements of CAT can be introduced to EMDR work, and vice versa, either partially or completely to reap the benefits from both approaches.

3.2 Potential benefits of EMDR for CAT

Compared to some therapies including EMDR, CAT emphasizes the relational and developmental processes. It is arguably weaker when considering the structure and change processes of cognitions, behaviours and emotions. Instead, it relies on what's in the integrative therapist's "tool kit." Thus, CAT could learn from EMDR's protocolised affect management strategies, thus enhancing CAT therapists' adherence to structure and ensuring affect management is always considered proactively. Thus, the window of emotional tolerance could enhance the ZPD. EMDR could help patients achieve stabilisation relatively quickly through its various techniques. Brown & Shapiro, 2006, believe that symptom resolution and improved

functioning can be achieved in months, not years, once the patient is suitably stabilised.

For some, accessing beliefs can affect through the dialogue which is core to CAT is insufficient for thorough change and resolution (van Der Kolk, 2002). Rather, many aspects of trauma and emotional distress may be held or experienced in the body and/or stored sub-cortically, not accessible to verbal discourse. In such situations, EMDR with its cognitive, affective and somatic focus can affect change relatively speedily for patients willing to undergo the treatment. This could help alleviate distress associated with RRs and reduce the pressure to use habitual TPPs.

3.3 Potential areas of difficulty or limitation to a combined approach

The first perhaps is determining the degree of integration attempted. There is a continuum possible from using certain aspects of CAT's conceptual understanding (RRs or the MSSM) and methodology (Reformulation diagrams or goodbye letters), 'lifting' these from the CAT approach, across to attempts to fully integrate the models.

This might be determined on a case by case basis, reflecting the patient's main presenting difficulties, their history, level of psychological integration or their level of psychological mindedness, etc. At the extreme, if a previously well-functioning adult suffers an acute, non-relationally based trauma, the need for CAT elements may be

extremely low. The NICE (2005) recommendation for EMDR would clearly apply. In similar vein, a CAT envelope might be less helpful if a patient is very low in psychological-mindedness, nonverbal or avoidant of a relational focus other than perhaps one of being helped by another.

At the other extreme, a patient with childhood complex trauma, potentially with a personality disorder diagnosis may well benefit from a combined approach. Within these extremes are many variations which are more salient now EMDR is becoming increasingly used for people who are not suffering PTSD. Even if the patient is low in psychological-mindedness and desire to explore relational processes, the therapist might still find elements of the CAT reformulatory and relational approach useful to help inform the likely struggles to help the patient engage in therapy.

This individualised determination of how to blend the two models together raises the need for flexibility in assessing when and what to offer and having the skill to do so. This is a higher order skill requiring a good working knowledge of both therapies, requiring in turn a significant investment of time and effort in training and supervision.

Even with enhanced training and supervision, there are considerable technical complexities. It is a challenge to facilitate a relatively more transference based therapy whilst being active and relatively more transparent relationally than a traditional analyst. The technical, highly protocolised nature of EMDR makes this more difficult. It may be confusing for therapist and patient alike when to use BLS to help process emotions and when to sit back and observe the process in the room, discussing what reciprocal pairs or TPPs might be at work and develop a new

understanding of alternatives to these via the therapeutic relationship itself. Or when "stuck" at the difficult parts of therapy, a therapist may lose direction, veering between either therapy, hoping for a "short cut" which could result in loss of focus and confusion for both parties.

Another issue to address is how to marry the differing approach to time frames. CAT is time limited, primarily due to its focus on the ending as a key therapeutic stage. EMDR can be time limited in certain contexts, e.g. medico-legal work, but generally is more flexible. Flexibility is perhaps key to adapt the CAT elements to fit the EMDR's time frame, maybe adding time to enhance the reformulatory and ending stages, if the context permitting. If a fixed time frame is not indicated or possible, these elements of CAT can still be included although the ending stage may be weaker in transferential power.

Overall, supervised therapeutic experience is key to how best to combine the two models on a case by case basis, learning which aspects to emphasise at any point.

4. Conclusion

The CAT and EMDR might be usefully combined or integrated to create a stronger therapy for certain patients. This belief is based on certain conceptual and procedural similarities between the respective therapies, along with how certain

strengths in each model might help compensate for reciprocal weaknesses in the other, theoretically and technically, thereby creating a stronger hybrid. The nature and efficacy of this integration is open to debate, clinical exploration and research.

It is acknowledged that providing EMDR within a CAT framework may be hard to achieve for a variety of reasons, not least of which is the challenge of cross-school dialogue and trainings. Yet by their very nature, both models view themselves as integrative (Ryle, 1979; Shapiro,1995), themselves already recognizing the possible value of evolving by learning from other models, e.g. EMDR from CBT (Herbert, 2010) and psychodynamic (Egli-Bernd, 2011) and CAT from attachment theory (Jellema, 1999/02).

The idea of merging the two therapies in a more systematic way outlined above is simultaneously both challenging and exciting.

References

Bakhtin, M. (1984). *Problems of Dostoevsky's Poetics*. Edited and trans. by Caryl Emerson. Manchester: Manchester University Press.

Bakhtin, M. (1986). *Speech genres and other late essays*. USA: University of Texas.

Bennett, D. & Parry, G. (2004). A measure of psychotherapeutic competence derived from Cognitive Analytic Therapy. *Psychotherapy Research*, 14, 176-192. copyright © The Australian and New Zealand Association of Psychiatry, Psychology and Law, reprinted by permission of Taylor & Francis Ltd, http://www.tandfonline.com on behalf of The Australian and New Zealand Association of Psychiatry, Psychology and Law.

Bennett, D., Parry, G. & Ryle, A. (2006/10). Resolving threats to the therapeutic alliance in cognitive analytic therapy of borderline personality disorders: A task analysis. *Psychology and Psychotherapy, Research and Practice*, 79, 395-418.

Brown, S. & Shapiro F., (2006). EMDR in the Treatment of Borderline Personality Disorder. *Clinical Case Studies*, Vol. 5 No. 5, 403-420. DOI: 10.1177/1534650104271773.

Clarke, S, Thomas, P. & James, K (2013) Cognitive analytic therapy for personality disorder: randomized controlled trial. *The British Journal of Psychiatry*, 202, 129–134. doi: 10.1192/bjp.bp.112.108670

de Jongh, A., ten Broeke, E. & Meijer, S. (2010).Two Method Approach: A Case Conceptualization Model in the Context of EMDR. *Journal of EMDR Practice and Research*, 4, 1, 12-21 DOI: 10.1891/1933-3196.4.1.12

Denman, C. (2001). Cognitive-analytic therapy. *Advances in Psychiatric Treatment*, 7, 243- 256.

Dworkin, M. (2005). EMDR and the relational imperative. New York, NY: Routledge.

Dworkin, M. & Errebo, N. (2010). Rupture and Repair in the EMDR Client/Clinician Relationship: Now Moments and Moments of Meeting. *Journal of EMDR Practice and Research,* 4, 3, 113 – 123. DOI: 10.1891/1933-3196.4.3.113.

Egli-Bernd, H. (2011) EMDR in Dissociative Processes Within the Framework of Personality Disorders: The Impact of Cognitions in the EMDR Process: The "Dialogue Protocol". *Journal of EMDR Practice and Research*, Volume 5, Number 3, 2011 131, Springer. DOI: 10.1891/1933-3196.5.3.131

Forgash, C. (2002) Changing Cognitive Schemas through EMDR and Ego State Therapy. In C. Forgash & M. Copeley (Eds.), *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy*. New York: Springer Publishing Company.

Forgash, C. (2002a). Deepening EMDR treatment effects across the diagnostic spectrum: Integrating EMDR and ego state work [video]. Cited by Lanius, U.F., (2005) EMDR Processing with dissociative clients: Adjunctive use of opioid antagonists. Chapter 4. In Shapiro, R. (ed.) *EMDR Solutions: Pathways to Healing* (pp. 121-146). London: W.W. Norton & Co.

Gerhardt, S (2004). *Why love matters: How affection shapes a baby's brain.* Taylor and Francis, e-library.

Herbert, C. (2010, October). Overcoming roadblocks in trauma. One day workshop at York Stress and Trauma centre, York, United Kingdom.

Hofmann, A. (2012, February). New developments on the application of EMDR. Workshop presented at the Annual Workshop of EMDR Association U.K. and Ireland. London, United Kingdom.

Horvath A. & Symond, D.B. (1991). Relation between working alliance and outcome in psychotherapy. *Journal of Counselling Psychology*, 38, 139-143.

Howlett, S. & Guthrie, E. (2001).Use of farewell letters in the context of brief psychodynamic-interpersonal therapy with irritable bowel syndrome patients. *British Journal of Psychotherapy*, 18, 1, 52-67.

Jeffries, F.W. & Davis, P. (2012) What is the Role of Eye Movements in Eye Movement Desensitization and Reprocessing (EMDR) for Post Traumatic Stress Disorder (PTSD)? Review. *Behavioural and Cognitive Psychotherapy*, doi:10.1017/S1352465812000793 Jellema, A. (1999). Cognitive Analytic Therapy: Developing its theory and practice via attachment theory. *Clinical Psychology and Psychotherapy*, 6, 16-28

Jellema, A. (2002). Dismissing and Preoccupied Insecure Attachment and Procedures in CAT: Some Implications for CAT Practice. *Clinical Psychology and Psychotherapy*, 9, 225-241.

Kelly, G. (1955). *Principles of Personal Construct Psychology*. New York: Norton.

Kiessling, R. (2005). Integrating resource development strategies into your EMDR practice In R. Shapiro (Ed.), *EMDR Solutions: pathways to healing* (pp. 57-87). New York: Norton.

Kitchur, M. (2005). The Strategic Developmental Model for EMDR. Chapter 1. in Shapiro, R. (ed.) *EMDR Solutions: Pathways to Healing* (pp. 8–56). London: W.W. Norton & Co.

Korn, D.L. (2009). EMDR and the Treatment of Complex PTSD: A Review. *Journal of EMDR Practice and Research*, Volume 3, Number 4, 264-278 DOI: 10.1891/1933-3196.3.4.264.

Lanius, U.F. (2005). EMDR processing with dissociative clients: Adjunctive use of Opioid Antagonists. Chapter 4 In Shapiro, R. (ed*.) EMDR Solutions: Pathways to Healing* (pp. 121–146). London: W.W. Norton & Co.

Leeds, A. (1998). Lifting the burden of shame: Using EMDR resource installation to resolve a therapeutic impasse In P. Manfield (Ed.) *Extending EMDR : A casebook of innovative applications* (pp. 256-281), New York: Norton

Leeds A. M. & Shapiro, F. (2000).EMDR and resource installation: Principles and procedures for enhancing current functioning and resolving traumatic experiences In J. Carlson & L. Spery (Eds.) *Brief therapy strategies with individuals and couples* (pp. 469-534). Phoenix, AZ:Zeig/Tucker.

Linehan, M.M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder: Diagnosis and Treatment of Mental Disorders* (Diagnosis & Treatment of Mental Disorders). Guilford.

Lovell, C (2005). Utilizing EMDR and DBT techniques in Trauma and abuse recovery groups, chapter 12 In Shapiro, R. (ed.) *EMDR Solutions: Pathways to Healing.* (pp. 263-282). London: W.W. Norton & Co.

Lloyd, J. & Williams, B. (2003). 'Exploring the Use of Cognitive Analytic Therapy within Services for People with Learning Disabilities and Challenging Behaviour.' *Clinical Psychology and People with Learning Disabilities*, 2, 2, 4-5.

Luber, M. (2009). *EMDR Scripted Protocols: Basics and Special Situations*. Springer Publishing Company. New York.

Mann, J (1973). *Time limited psychotherapy*. Harvard University Press. Cambridge MA.

Martin, D.J., Garske, J.P. & Davis, M.K. (2000). Relation of the Therapeutic Alliance with Outcome and other Variables. A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*, 68, 438-450.

McCormick, E. W. (2012). *Change for the Better: Self Help through Practical Psychotherapy*, 4th edition, Sage, London.

McKelvey, A.M. (2009). EMDR and positive psychology. Chapter 15 In Shapiro, R. (ed.) *EMDR Solutions II: For depression, eating disorders, performance and more (*pp. 242-261). London: W.W. Norton & Co.

Miller, R. (2015, July). The feeling-state addiction protocol: Treatment for behavioural and substance addiction, co-dependence, anger issues, and many other difficult-to-treat behaviours. FSAP workshop for EMDR trained clinicians, London, United Kingdom.

National Institute for Health and Clinical Excellence (NICE, 2004). Clinical Guideline 9. (CG9). *Eating Disorders: NICE guideline*. London: Author.

National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 26. (CG26), (2005). *Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care*. Developed by the National Collaborating Centre for Mental Health, UK.

National Institute for Health and Clinical Excellence (NICE) Clinical Guideline, CG78, (2009). *Borderline personality disorder (BPD): NICE guideline*. Developed by the National Collaborating Centre for Mental Health.UK: The British Psychological Society and the Royal College of Psychiatrists.

Ogden, T.H. (1983). The concept of internal object relations. *International Journal of psychoanalysis,* 64, 227-241

Ogden, P., Minton, K., & Paine, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York, NY: Norton.

O'Shea, K. (2009). EMDR friendly preparation methods for adults and children.

chapter 17 In Shapiro, R. (ed.) *EMDR Solutions II: For depression, eating disorders, performance and more* (pp. 289-312). London: W.W. Norton & Co.

Paulsen, S. (1995), Eye movement desensitization and reprocessing: its cautious use in the dissociative disorders. *Dissociation*, 8, 32-44.

Paulsen, S. & Lanius, U. (2009). Toward an embodied self: integrating EMDR with somatic and ego state interventions. chapter 19 In Shapiro, R. (ed.) *EMDR Solutions II: For depression, eating disorders, performance and more* (pp. 335-388). London: W.W. Norton & Co

Potter, S. (2010) Words with arrows: The benefits of mapping whilst talking, *Reformulation*, 34, 37-45.

Plágaro-Neill, I. (2011, October). *The use of ego state therapy and EMDR to reverse dissociation.* Workshop presented at EMDR Autumn workshops, NE Group, EMDR UK and Europe, Durham, United Kingdom.

Ryle, A. (1979). The focus in brief interpretive psychotherapy: Dilemmas, Traps and Snags as target problems. *British Journal of Psychiatry*, 134, 46-54.

Ryle, A. (1991). *Cognitive-analytic Therapy - Active Participation in Change: New Integration in Brief Psychotherapy.* (Wiley series on psychotherapy & counselling). Chichester, U.K.: Wiley.

Ryle, A. (1997a). The structure and development of borderline personality disorder: A proposed model. *British Journal of Psychiatry, 170,* 82–87. http://dx.doi.org/10.1192/bjp.170.1.82

Ryle, A. (1997b). *Cognitive analytic therapy and borderline personality disorder: The model and the method*. Chichester, United Kingdom: Wiley.

Ryle, A. & Golynkina K. (2000). Effectiveness of time-limited cognitive analytic therapy of borderline personality disorder: Factors associated with outcome *British Journal of Medical Psychology*, 73, 197-210

Ryle, A., & Kerr, I. B. (2002). *Introducing cognitive analytic therapy: Principles and practice.* Chichester, United Kingdom: Wiley. http://dx.doi.org/10.1002/9780470713587

.

Schore, A. (accessed 25th March 2015), http://www.allanschore.com/bio.php

Seubert, A. (2005) EMDR with clients with mental disability Chapter 14 In Shapiro, R. (ed.) *EMDR Solutions: Pathways to Healing*. (pp. 293-311). London: W.W. Norton & Co.

Shapiro, F. (1995/2001). *Eye Movement Desensitisation and Reprocessing: Basic principles, protocols, and procedures* (2nd Edition). New York: Guildford

Shapiro, F. (2007). EMDR, Adaptive Information Processing, and Case Conceptualization. *Journal of EMDR Practice and Research*, 1, 2, 68-87. DOI: 10.1891/1933-3196.1.2.68

Shapiro, R. (2009). Endogenous depression and mood disorders chapter 3 In Shapiro, R. (ed.) *EMDR Solutions II: For depression, eating disorders, performance and more* (pp. 24-48). London: W.W. Norton & Co.

Siegel, D. (1999). *The developing mind*. Guilford: New York.

Siegel, D. (2010). *The Mindful Therapist: A clinician's Guide to Mindsight and Neural Integration.* London. W.W. Norton & Co.

Solomon, R. M. & Shapiro, F. (2008). EMDR and the Adaptive Information Processing Model, Potential Mechanisms of Change. *Journal of EMDR Practice and Research*, 2, 4, 315- 325

Trevarthen, C. (2001). Intrinsic motives for companionship in understanding: Their origin, development and significance for infant mental health. *Infant Mental Health Journal*, 22, 95-131.

Twombly, J. H. (2000), Incorporating EMDR and EMDR adaptations into the treatment of clients with DID. *Journal of trauma and dissociation*, 1, 2, 61-81.

Twombly, J. H. (2005), EMDR for clients with Dissociative Identity Disorder, DDNOS, and Ego States. Chapter 3. In Shapiro, R. (ed.) *EMDR Solutions: Pathways to Healing* (pp. 88–120). London: Norton

Van der Hart, O., Nijenhuis, E.R.S., & Solomon, R. (2010). Dissociation of the Personality in Complex Trauma-Related Disorders and EMDR: Theoretical Considerations. *Journal of EMDR Practice and Research*, 4, 2, 76-92. DOI: 10.1891/1933-3196.4.2.76

van der Kolk, B. A. (1994). The body keeps the score: Memory & the evolving psychobiology of post traumatic stress. Harvard Review of Psychiatry, 1, 253–265. Retrieved from http://www.traumapages.com/a/vanderk4.php

Vygotsky, L. S. (1978). *Mind in society: Development of higher psychological processes.* Michael Cole, Vera John-Steiner, Sylvia Scribner, & Ellen Souberman, (eds.) Cambridge, Mass.: Harvard University Press, Copyright © 1978 by the President and Fellows of Harvard College.