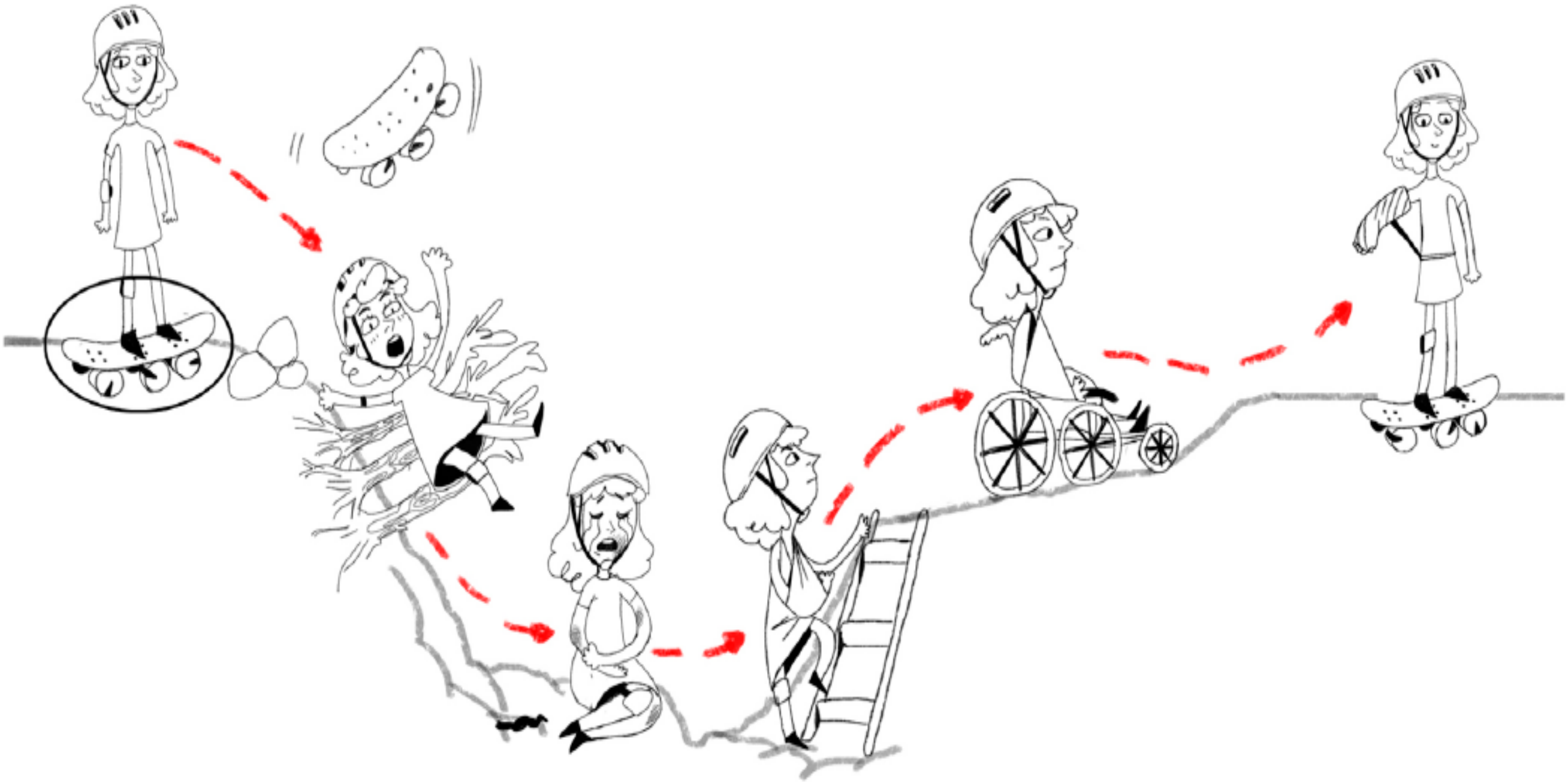
History Taking, Case Conceptualisation and Target Identification. Phase 1 of EMDR Therapy

Dr Tom Flewett.

"The mind is nothing you use," I say. "The mind is just there. It is like the wind. You simply feel its movements"

Haruki Murakami: Hard Boiled Wonderland and the End of the World.



Contents. EMDR Therapy Phase 1

- Purpose of history taking, case conceptualisation and target identification
- Models for history taking
- Process of history taking and case conceptualisation
- Documenting the story as a therapeutic intervention
- Identifying targets for processing

Quiz

How did we conceptualise cases before Shapiro discovered EMDR Therapy?

- What is the difference between?
  - a case conceptualisation,
  - a diagnosis,
  - a mental state examination,

- What are you trying to achieve with a case conceptualisation?
  - Make a diagnosis?
  - Plan treatment?
  - Fill out a form for ACC, DHB, Insurance company?
  - A therapeutic intervention which goes beyond finding targets for treatment?
  - None of the above/ All of the above?

Once upon a time……myths and folk tales
The purpose of taking a history

EMDR Therapy starts from the moment the patient walks in the door

Case Conceptualisation as a therapeutic tool

- A **story** that your patient can understand (in their words) that they haven't heard before
- A story that your patient can listen to and make sense of
- A story that your patient will find meaningful/therapeutic and that has a route towards an ending
- Narrative competence versus narrative incompetence

  Attachment in Therapeutic Practice. 2018. Holmes and Slade. Page20.

Case Conceptualisation as a therapeutic tool

- A story that will resonate inside your patient, often with a profound emotional component, often with discomfort
- A story that may bring relief. “I thought I was going mad”
- A story that is told verbally, has a written component or is presented as pictures. (The Kalahari bushmen do their formulations as dance!)
- A story that can be shared with others

How do we tell stories?

- We need to know the characters and events (just the bare bones) in the story
- We need to know what the characters do and did and why
- Do we need to have an idea about how the story might end?
- Do we need to have lived the story ourselves?
- Some people can't tell stories because it is too upsetting or they can't make sense of what happened

The Clinician as the Story Teller

- “A mirror am I to thee that perceivest me”. Acts of John. AD130
- When your patient can’t reflect, what happens?
- Contingent mirroring in childhood
- i.e The therapist is constantly modelling detached compassion, curiosity and a non-judgemental stance whilst formulating the story and reflecting it back

The Clinician as the Story Teller

- The story needs to be told to the degree that the patient can tolerate/ manage. It may incorporate components that create substantial dissonance. (Goldilocks).

- It's a story of the functioning of the struggling psyche

We've always had stories

- A process for developing a therapeutic relationship
- Sets the foundation for therapy
- A meaningful hypothesis to be tested in the cauldron of treatment
- It should drive the direction and content of treatment
  - Identifies targets and
  - Capacity to engage in processing

Finding the story

- How does the psyche function? How does it manifest?
- Any manifestation of the person's psyche can be used to help you weave the story together
- We are informed by the patient's memories, imagery, emotions, thoughts, somatic experiences, current behaviours, diagnoses, fantasies, dreams, daydreams, etc

Models informing the history taking. 1

Anatomy and Physiology of the Psyche

- For identifying events
  - The lens of AIP.
    - What are the “T” and “t” events and why did the system shut down at the time.
  - Dissociation models

Models informing the history taking. 2

- For assessing capacity for processing
  1. In session: Think resilience, integrative capacity (adaptive information), attachment and dissociation.
     a) Ability to stay in Window of Tolerance (WoT)
     b) Size of Window of Tolerance

  2. Out of session: Routine history taking
     a) Resources for self stabilisation
     b) External resources

- To identify attachment dynamics which will be replicated during processing

Organic, Social, Cultural, Spiritual and Religious Factors

- The clinical presentation of **ALL** psychopathology is **shaped** by these factors.
- Bio-psycho-socio-cultural-religious-spiritual model
- They inform the structure of the story and how it is told
- However, there is only **one** psyche

What goes into history taking?

- What you were born with
- How that was and wasn't nurtured
- What events occurred of importance: good and bad
- What events didn't occur which should have
- Responses to adversity (resilience, hardiness etc)
- How that has created the current picture
- Why the current picture has become entrenched
- Thoughts about a way out of the hole

- But: How do you get all this information?

Process of History Taking

"Tell me your story"

- Symptoms: triggers, events
- Past, Present, Future……but in the order of: present, past, triggers, future
- Cognitions and metacognitions
- Attachment dynamics
- Avoidance defenses

Where do you start?
"Tell me your story"

- Start with the present symptoms and triggers and work backwards?
- Float Backs. Finds the memories and the development of the core schema.
- Find the meaning of the symptoms
- Your skills will evolve with experience
- Anamnesis: The recalling of things past. Keep on thinking about the good and bad events. Not 10 best, 20 worst.

- **Make the links**

What you were born with.

- Genes. Watch out for the person who puts it all down to their genes. Genetic diathesis. Hmmmm
- Temperament. Insights into premorbid personality gives insight into the person/child they were once were before it all went wrong!
- Beware of the person who wants to go back to the Garden of Eden. The restoration of the regressive persona is another form of avoidance

How it was and wasn't nurtured. (WoT and replication in therapy)

- Attachment theory: Emotional regulation, attentional mechanisms –impulse control and mentalization
- How do we assess for neglect. If something didn't happen, there will be no memory of it!
- Look for resilience and integrative capacity

Attachment dynamics 1

We are mostly concerned with the efforts to regulate fear and anxiety which arise from insecure attachments. The type of insecure attachment is less important.

- How does this person try to stay safe?
- How do they regulate closeness?
- Can they regulate affect?
- How robust is their sense of agency?
- Are they inhibited or paralysed by doubt or do they rush blindly into risk without apparent thought?
- Do they minimise their needs for proximity or do they exaggerate them?

Attachment Dynamics 2

- What has led them to defend against closeness or exploration?
- What were the unique qualities of their early relationships, and how did these inform their sense of themselves and their capacity for self-regulation?
- What attachment or relational triggers spark off self-defeating or dysfunctional thoughts, feelings and behaviours?
- What is the downside of the specific strategies they have chosen for staying safe and regulating emotion?
- How are these processes reactivated in the therapeutic relationship?

Responses to the good and the bad

- What are the avoidance behaviours and why?
- What are the soothing behaviours and why? Where does death come in to this picture?
- What are the responses to current stressors and why? Fight/flight/freeze

What's happening now?

- Look for circular patterns of behaviour. Shame and guilt. Avoidance and idealisation to protect from "trauma"
- Look for the primary and secondary negative core schema and find where they came from. (Internal working models of Attachment Theory)
- Why depression? Why anxiety? Why phobia etc?
- What do the primary negative core schema protect the patient from? (Hint: a cognition is a verbalisation of an affect)

Don’t forget the Disorders of Secrecy

- OCD
- Eating Disorders
- Dissociation
- Addiction
- Psychosis

- Mostly driven by shame or a desire to control the world or a view of the world as threatening.

When to use Psychometrics

- Screening
- Measuring change
- To check the background in simple PTSD “I had a perfect childhood”
- To learn how to assess for different disorders.

- DES, IES, ACE, SDQ, DDIS, MID

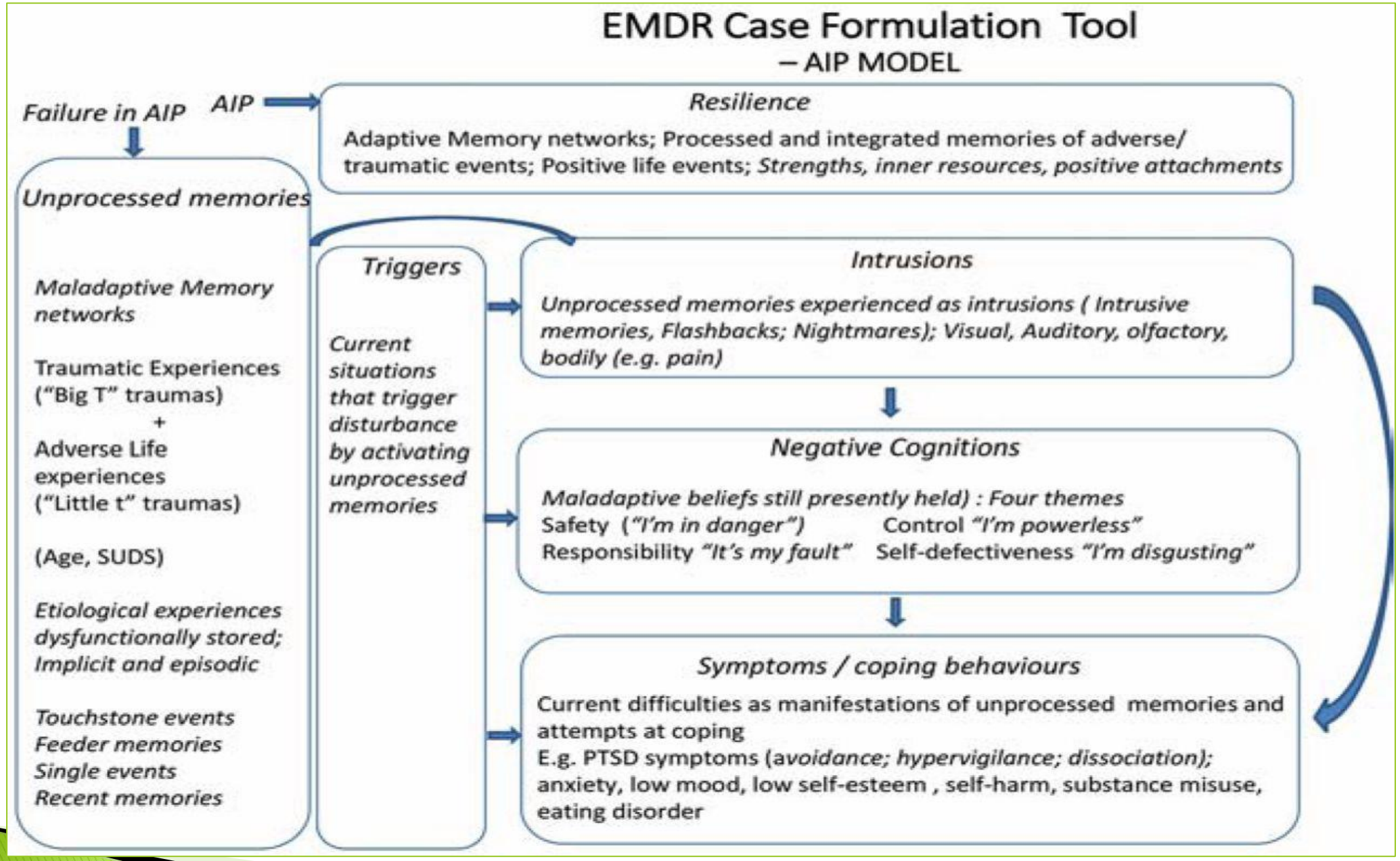
- Mood and anxiety measures.

Synthesising the data

- Do you understand the story?
- How many stories have you heard?
- Spirituality/ religion /culture / social mores
- Can you weave the story together and then tell the story in a meaningful way that Goldilocks would understand?

Putting it all together

- Linkages of past to present with thoughts of the future.
- Make sense of everything and tie it all in together. The events, emotions, thoughts and somatic experiences all need to be accounted for.
- Don’t forget: it’s a hypothesis only, to be tested in the cauldron of treatment.



Ines Santos. EMDR Case Formulation Tool
Journal of EMDR Practice and Research, Volume 13, Number 3, 2019

The four PPPPs

- Predisposing
- Precipitating
- Perpetuating
- Protective

- Useful as a template but can be limiting and too generic

Identifying targets for processing

- Memories (including flashforwards), parts of memories or memory networks
- Intrusions and Nightmares
- Cognitions or metacognitions. Think generalisation thoughts
- Emotions
- Behaviours
- Somatic sensations

- Where do you start?

Identifying Targets

- Phobias (Fear and/or avoidance) of going there. You can make these a target
- The **story** will tell you both where to start and which **portal** may be used.
- EMDR, EMDr (focussed) or EMD or even fractionated processing?
- Using the story as the target. (Story telling protocol – Joan Lovett)

Consider drawing a Matrix if several themes are present

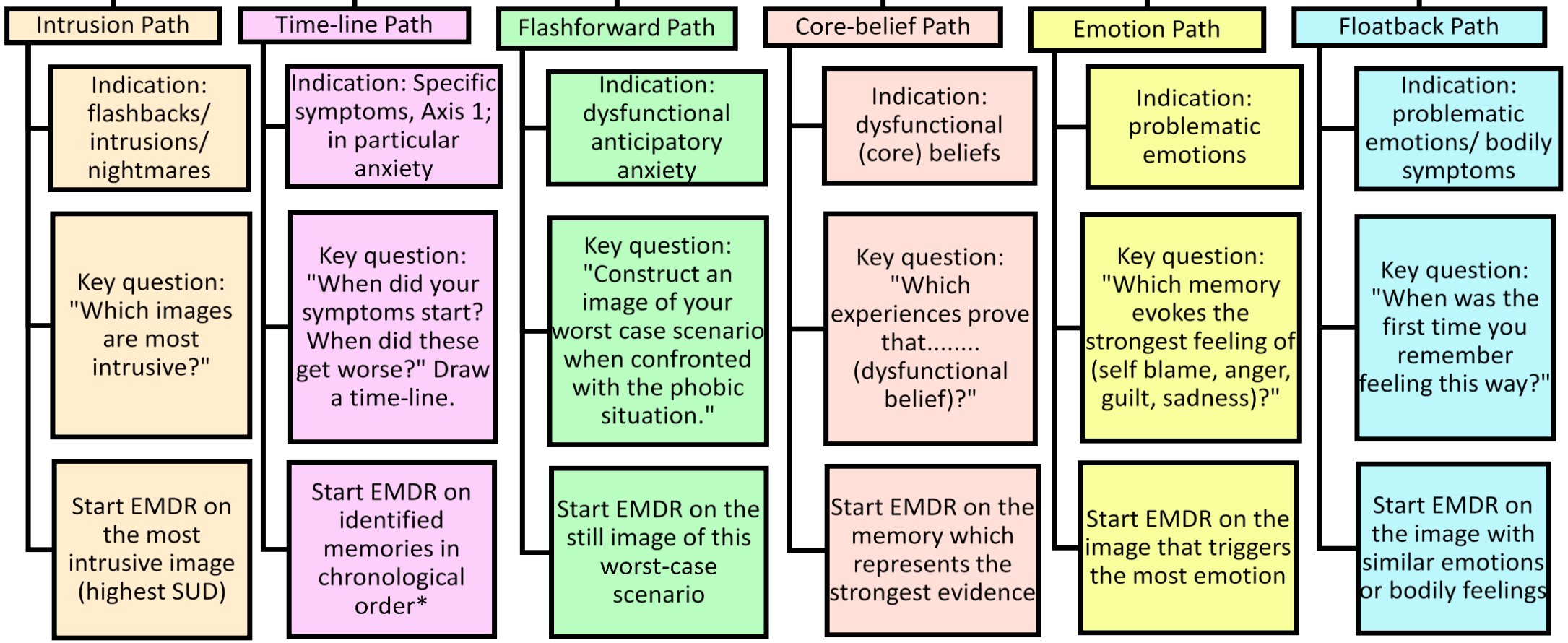
	I'm a failure	Anxiety	Anger	Needle phobia
Past	Rejecting events from the past ------- ------- ------- -------			First episode --------- ---------- Worst episode ---------- ---------- Most recent episode
Present	Recent Triggers			Needing COVID- 19 vaccination
Future	Managing future situations effectively			

EMDR Case Conceptualisation Flowchart

1. Psychological symptoms and reasons for referral
2. Understanding of the psychological symptoms from an AIP perspective
3. Treatment planning.

Indication for EMDR? If yes, which path?

Source: Dutch EMDR Trainers 2017. Adapted for NZ April 2019 by Tom Flewett



* Optionally, start with another dominant memory representation or with flashforward.

Thank you

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