Using Stories in EMDR

A Guide to the Storytelling (Narrative) Approach in EMDR Therapy

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Formerly known as HAP UK and Ireland, Trauma Aid UK (TAUK) is a charity supporting traumatised communities globally.

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Joan Lovett

Joan Lovett MD is a Behavioural Paediatrician in Berkeley, California. She graduated from Wellesley College and University of California San Francisco School of Medicine. She completed paediatric internship and residency at Montreal Children's Hospital, after which she was a Robert Wood Johnson Clinical Scholar at Stanford University. She is a fellow of the America Academy of Pediatrics.

Dr Lovett is an EMDRIA Approved Consultant. She has given presentations and trainings about childhood trauma and EMDR therapy in the US, Canada, Central America, Europe and Asia. She is the author of two books:

- *Small Wonders: Healing Childhood Trauma with EMDR*
- *Trauma-Attachment Tangle. Modifying EMDR to help children to resolve trauma and develop loving relationships*

Joan's particular contribution to EMDR therapy is in founding and developing the use of storytelling in the practice of EMDR therapy with children which is described in both her books. We are indebted to Joan for this wonderful approach which has transformed the work that we do with children.

Joan retired in 2018 but, prior to this, she had a major input into earlier drafts of this book, for which we are most appreciative.

We wish Joan all the best for her well-earned retirement and this book is dedicated to her.

Our own Stories: Author Biographies

Robin Logie

Robin has always loved stories and fondly remembers having Winnie The Pooh read to him as a child. He trained to be a Clinical Psychologist and then worked with both adults and children in the NHS and then in private practice. In 1997, a long time ago now, he first learned how to do EMDR therapy. He used it more and more in his work and became an EMDR Consultant and then a Trainer. He was President of the EMDR Association UK & Ireland for three years and has published articles about EMDR therapy, especially the Flashforwards procedure. He has used the storytelling approach with lots of children, especially those who have been adopted.

Robin is married to another psychologist and they had two daughters. One very sad thing that happened to Robin was that his elder daughter, Becci, died in a bus crash in 2008. He still feels sad about this but some EMDR therapy helped him to understand his feelings much better. When he is not doing EMDR therapy, Robin enjoys travelling to new places, going for walks, singing in a choir and playing the trumpet.

Mark Bowers

Since leaving school Mark has worked with children and young people in a wide range of settings. This journey involved work for the catholic church, nursing, and residential care work for local authority looked after children. Listening to the stories of the children and young people that he met spurred him on to seek qualifications so he could work in mental health.

Mark qualified as a Clinical Psychologist in 2000 and since then has worked for the NHS in child and adolescent mental health services. He initially trained in EMDR therapy in 2004 alongside some training in Dyadic Developmental Psychotherapy. He went on

to complete further EMDR child training and gained accreditation in 2013. He started to use stories in EMDR therapy to help Looked After children who struggled with the Standard Protocol and has noted positive results. His interest in how other people used stories in their EMDR work and asking questions of colleagues led to many conversations and a desire to clarify the process.

Alexandra Dent

As a child, Alexandra found it difficult to read stories. She didn't realise at the time that she was dyslexic and instead believed she wasn't good enough and wasn't very clever. However, she had a big heart and has always been an enthusiastic and determined person with lots of energy. She followed her heart and went to University, firstly to study Physiology and then pursued a career in Clinical Psychology. Having a strong drive to connect with children, she worked in a Child and Adolescent Mental Health Service in the National Health Service (NHS) for 11 years, during which time she trained in EMDR therapy and Dyadic Developmental Psychotherapy.

She then left the NHS to work in independent practice with people across the age span. She is a Child & Adolescent and Adult EMDR Consultant and an EMDR Training Facilitator. Her passion for EMDR therapy is so strong that she joined the EMDR Child & Adolescent committee in 2016 and became the Chair in 2017, which means she is actively involved both in UK and Europe.

Her other interests include Mindfulness and Spirituality and Alexandra runs workshops on how these can be incorporated within EMDR therapy. She also set up a Special Interest Group in EMDR and Spirituality in 2019 and wrote a book on using Spirituality in Psychotherapy which was published in 2019. Alexandra has learned to believe that if you follow your heart, you can learn to believe that you are good enough and can achieve whatever you want regardless of life's challenges.

Jo Elliott

Jo qualified as a Clinical Psychologist in 2007. Since then she has worked with children, with and without learning disabilities, and their families, firstly in the NHS and then in private practice. As a child, Jo always really enjoyed telling stories to her family especially when on long walks in the hills. She later became fascinated with the stories of some of the people she worked with whose perception of themselves and the world had been changed through their reading of novels and how these novels had impacted positively on the decisions they had made in life. Following this, she became interested in how a person's own narrative could impact on their lives.

Jo trained in EMDR therapy in 2013. She found the storytelling approach helped many of the families she was working with to move forward when other interventions had not been effective, and now uses this approach frequently in her work. When not working, Jo still enjoys telling stories to her two children especially whilst out exploring the countryside.

Mike O'Connor

Mike is an EMDR Europe Accredited Consultant and Training Facilitator whose core profession is Educational Psychology. His initial training in EMDR therapy took place in 1996 under the HAP Programme following the mass shootings in Dunblane Primary School. Later the same year he completed EMDR Child Training with Bob Tinker and Sandra Wilson. He was accredited as an EMDR Consultant in 2001 and as an accredited Child & Adolescent Consultant in 2017.

He has worked in a variety of posts in the voluntary and local government sector since 1974. During his career he has been involved in developing specialist services for children and families affected by loss and trauma. His former posts include Principal Psychologist for Clackmannanshire Council, Director & C.E.O. of the Notre Dame Centre, Glasgow and Consultant Psychologist in a residential school for Looked After children. Currently, he works in an Educational Psychology Service where he is a member of an Intensive Therapy Service providing EMDR therapy to children and young people. Mike has been using the EMDR storytelling approach with children of different ages for many years.

Mike was the Chair of the Child & Adolescent Section of the EMDR Association UK & Ireland from 2008 until 2015, and in that capacity, was a member of the Board of the EMDR Association. He has continued to serve on the Board since 2015 and in March 2020 he will become the President of the EMDR Association.

Ali Russell

Ali trained initially as an Educational Psychologist and worked in a number of local authority settings, specialising in working with pre-school children and families. In 1996 she became a member of the dedicated team set up to work with the children and families affected by the shootings at Dunblane Primary School and went on to work for over a decade in a number of community-based projects offering therapeutic help to those affected by loss, trauma and abuse.

Ali started her generic and Child and Adolescent training in EMDR therapy in 1996, completing it in 1998. In 2001 she was accredited as an EMDR Europe Consultant and accredited as a Child and Adolescent Consultant in 2017. Working almost exclusively with very young children during the past 30 years, she has found storytelling invaluable.

She retired from full time working in 2013 but continues to act as a Consultant Psychologist in the area of fostering and adoption.

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Foreword

Although Joan Lovett's two books both refer to the storytelling (narrative) approach in EMDR therapy in some detail, there has, thus far, been no definitive publication to describe EMDR storytelling with the level of guidance necessary to utilise this approach effectively. This small volume is therefore an attempt to fill this gap.

We are six EMDR therapists (including four Consultants and a Trainer) in the UK with extensive experience of working with children and using the storytelling approach in EMDR. Some of us have also presented workshops on this topic at study days and conferences organised by the UK & Ireland EMDR Child & Adolescent Committee.

In earlier drafts of this book we were liaising with Joan Lovett, prior to her retirement, to produce a paper for publication and we are indebted to Joan for her involvement with this project. But as the paper has expanded in its scope it seemed more appropriate to publish it as a book.

The book starts by putting the storytelling approach into some context, describing how creating narratives is important in normal psychological functioning, how trauma disrupts the narrative and how storytelling has generally been utilised in psychological therapy. We then introduce the incorporation of storytelling into EMDR therapy before describing in detail the procedure for using it and outlining for which individuals it may be useful. We then describe several case studies including the full script of the stories that were created. The book finishes with a list of Frequently Asked Questions.

It should be emphasised that, like EMDR therapy itself, the storytelling approach in EMDR therapy is constantly evolving. Joan Lovett, herself, told us that she had modified the method, and we have continued with this fine tuning ourselves, as we continue to explore our use of this approach with our clients.

It should be noted that this book is aimed at an audience of readers who are already trained EMDR therapists. It is therefore assumed that readers are familiar with the Standard Protocol for EMDR.

It would also be recommended that those readers who work with Children and Adolescents also attend the Part 1 and Part 2 Child and Adolescent EMDR Trainings. In addition, readers should be aware that this is an advanced therapeutic technique which should only be utilised by experienced practitioners, especially if they are working with complex clients. It is advised that all therapists should receive regular supervision from an EMDR Consultant who is familiar with the storytelling approach.

The storytelling approach is not just relevant for children and adolescents. It has been used successfully with adults of all ages including those who have a learning disability as well as mute or very shy individuals. We know of a 74-year-old selectively mute client who started talking again after a session utilising the storytelling approach.

We hope that you find this book useful and we look forward to receiving feedback from our readers.

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The Narrative in Psychological Functioning

> "Telling the story is important; without stories, memory becomes frozen; and without memory you cannot imagine how things can be different." (Van der Kolk, 2014, p. 219.)

To appreciate the importance of the narrative or storytelling in psychological therapy it is important, first, to understand how narrative is related to adaptive psychological functioning, and what happens to people's own narratives when they have experienced psychological trauma.

The Role of Storytelling in Adaptive Psychological Functioning

Research on child development indicates that children are already starting to create stories about events in their own lives before the age of three (Howe & Courage, 1997; Nelson & Fivush, 2004). These narratives help the child to make sense of the world and are a fundamental building block for the child in becoming psychologically integrated (Siegel, 2015). By the age of five, children are able to generate their own narratives and know that stories are expected to have a definite beginning, middle and end. The ending is expected to provide a resolution to the plot complications that developed over the course of the story (McAdams, 2001).

Storytelling may incorporate into the explicit autobiographical memory other implicit memories of events that are no longer consciously recalled:

> "Our dreams and stories may contain implicit aspects of our lives even without our awareness of their origins in the past. In fact, storytelling may be a primary way in which we can linguistically communicate to others - as well as to ourselves – the sometimes hidden contents of our implicitly remembered minds. Stories make available perspectives on the emotional themes

> of our implicit memory that may otherwise be consciously unavailable to us as remnants of prior experiences" (Siegel, 2015, p. 373).

Dan McAdams' "life story model of identity" asserts that individuals provide unity and purpose in their lives through the construction of internalised and evolving narratives about themselves (McAdams, 2001). He states that "identity itself takes the form of a story, complete with settings, scenes, character, plot and theme." (p. 101). Stories help individuals to organise their ability to act on their desires and beliefs in order to accomplish their goals.

Developing a coherent, positive "model of identity" is more likely to occur when individuals develop secure attachments. Siegel (2001) describes five elements which are necessary in order to foster a secure attachment. These are collaboration, reflective dialogue, repair, coherent narratives and emotional communication. He states that coherent narratives are necessary in order for the child to connect parts of their lives. "The connection of the past, present, and future is one of the central processes of the mind in the creation of the autobiographical form of self-awareness" (Siegel, 2001, p.79.). Siegel states that in order to achieve integration of functioning, individuals need to have an internal connection to the past, to live fully and mindfully in the present and prepare for the future in a way which is informed by the past and the present. Clearly, being able to create a narrative regarding one's life is necessary in order to achieve this coherence. He goes on to say that:

> "adults can teach children about the world of the self and of others by joining with them in the co-construction of stories about life events. These stories focus on activities as well as the mental life of the characters. In so doing, the adult is both collaborating in the construction of reality for the child, as well as giving her the very tools she needs to make sense of the internal and external worlds in which we all live." (Siegel, 2001, p.79.)

Siegel also describes the way in which the creation of stories assists in integrating right hemisphere-stored images and emotionally laden experiences with left hemisphere-stored linear organization. When securely attached, the child will co-construct stories with their caregiver through resonance between the child's and adult's corresponding hemispheres.

Trauma Disrupts the Narrative

In their cognitive model of Posttraumatic Stress Disorder (PTSD), Ehlers & Clark suggest that, in PTSD, the "trauma memory is poorly elaborated and inadequately integrated into its context in time, place, subsequent and previous information and other previous information and autobiographical memories" (Ehlers & Clark, 2000, p. 325). As a result, they propose that the event becomes difficult to intentionally recall because the semantic route to retrieval has not been developed. Instead the trauma memory is left with a "here and now" quality with no context in time and absence of links to subsequent information (e.g. "I did not die"). This results in a constant perception of current threat and a tendency for symptoms to be easily triggered by physically similar cues.

The Adaptive Information Processing (AIP) model, which underpins EMDR therapy (Shapiro, 2018), posits that traumatic experiences cause an imbalance in the nervous system. This imbalance compromises the ability of the information-processing system to function. As a result, traumatic memories remain as implicit memories (i.e. unconscious and unintentional) and remain unprocessed in a 'raw' disturbed state (including images, sounds, affect, physical sensations). The short-term memory system causes the experience to be perceived as 'frozen in time', as if it has only just happened. The experience remains stored in the right hemisphere. In order to process the traumatic memory, a shift must happen to store it as an explicit narrative memory based in the left hemisphere (Van der Kolk, McFarlane, & Weisaeth, 2012).

Solomon & Shapiro (2008) describe the process of "alignment of memory fragments" (p. 319). Events that have not been processed may be stored as memory fragments (Van der Kolk & Fisler, 1995) with the process of EMDR therapy enabling the client to make sense of their experience and facilitate storage in narrative memory.

> "When people receive sensory input, they generally automatically synthesize this incoming information into narrative form, without conscious awareness of the processes that translate sensory impressions into a personal story. Our research shows that traumatic experiences initially are imprinted as sensations or feeling states that are not immediately transcribed into personal narratives, in contrast with the way

> people seem to process ordinary information. This failure of information processing on a symbolic level, in which it is categorized and integrated with other experiences, is at the very core of the pathology of PTSD…" (Van der Kolk & Fisler, 1995, p. 13.)

The AIP model also relates to understanding and processing traumatic events in relation to the "three prongs" of past, present and future (Shapiro, 2018). Part of this involves understanding what is occurring in the present as it relates to the past and the implications that this will have for the future. To achieve this, the individual needs to develop a coherent narrative of their life, and how past events have affected the way in which they understand the present, and what they anticipate for the future.

Therapies that use a Storytelling Approach

In order to place the use of storytelling in EMDR therapy into context, it is instructive to compare it with other therapeutic approaches that make use of storytelling or narratives.

Narrative Therapy (White & Epston, 1990)
Narrative therapy aims to help people to identify the values, skills and knowledge they have to live these values, so that they can effectively confront the problems that they face. The therapist works to help the person co-author a new narrative about themselves by investigating the history of those qualities. Narrative therapy advocates a social justice approach to therapeutic conversations, seeking to challenge dominant discourses that it claims shape people's lives in destructive ways.

Life Story Work (Aust, 1981)
Life Story Work is a social work process which is designed to recognize the child's past, present, and future. The work usually includes the use of a "life story book" in order to give a visual aid and reminder of important events or feelings.

Life Story Therapy (Rose, 2012)
Life Story Therapy or Therapeutic Life Story Work is a therapeutic approach as compared with Life Story Work. It aims to assist children who have significant problems in misinterpreting what has been happening in their life. It is designed to assist them in exploring, questioning and understanding past events in their lives in order to connect, integrate and develop a healthy identity for now and in the future. Whilst the therapist provides the structure, the child is actively involved in the process of mapping out their life story through pictures and words on paper as well as other sensory modalities. The therapist aids the child to integrate the story into the way in which they understand themselves.

Narrative Exposure Therapy (Schauer, Schauer, Neuner, & Elbert, 2011)

In this form of cognitive behavioural therapy, the therapist assists the client to construct a detailed chronological account of their own history. An important aspect of the therapy is the transformation of the fragmented traumatic experiences into a coherent narrative. The therapist ascertains the current emotional, physiological, cognitive, and behavioural reactions. The client is encouraged to relive these emotions while reporting the events. The traumatic event is focused upon until a habituation of the emotional reactions presented and reported by the client takes place. At the last session, the client receives a written report of their biography. A specific version of this therapy, KIDNET, has been developed for children and adolescents (Schauer, Neuner, & Elbert, 2017).

Related to the above approaches is the work of Golding (2014). Golding's approach, and her preparation of a selection of themed stories for working with traumatised children provides a helpful resource for others working with this client group in the context of therapy or Life Story Work.

The Development of Incorporating Storytelling into EMDR Therapy

Eye Movement Desensitization and Reprocessing (EMDR) therapy was developed in 1987 by Francine Shapiro for the treatment of traumatic memories (Shapiro, 2018). EMDR therapy has since grown from a desensitisation technique into an integrated psychotherapeutic treatment approach (Solomon & Shapiro, 2008). This therapy is underpinned by the Adaptive Information Processing (AIP) model which theorises that psychological disorders arise from unprocessed information that is dysfunctionally stored in the brain (Shapiro, 2018).

Storytelling in EMDR therapy has some similarities with the approaches already described, in that it focusses on the stories or narratives that are created regarding people's lives. The aim is to help the individual to make connections between different events in their lives and how events have affected the way in which they now see themselves and feel about their place in the world.

However, it differs from these approaches in that it is based on the AIP model. This model is built upon the idea that the experience of certain events in the individual's life remain unprocessed. These memories continue to be 'frozen' in time and continue to affect the individual in ways that are no longer relevant to their current environment. Through a combination of storytelling and bilateral stimulation (BLS) the individual starts to reprocess these memories by making sense of how they fit into their own life story. A coherent narrative is created for the individual for whom the parts of the story were previously unconnected fragments.

Storytelling was first incorporated into EMDR therapy by Joan Lovett and described in her book, *Small Wonders* (Lovett, 1999). She describes how she was challenged to develop another way of using EMDR therapy when working with a 20-month-old Vietnamese boy who spoke no English but was psychologically affected by a road traffic accident (RTA). She had the parents tell him the story of the accident whilst she used tapping as a form of BLS. The story was brief and simple:

> "Riding in the car. Everybody happy. Big boom! Everybody scared and crying! Go to hospital. Everybody fine. Everybody go home. Go to sleep"
> (Lovett, 1999, p. 38.).

She reported that after only one session his symptoms cleared completely. This led Lovett to experiment with this approach with other children. Her book includes an appendix with guidelines for using storytelling in EMDR therapy.

The use of storytelling is also described in Lovett's later book entitled *Trauma-Attachment Tangle* (Lovett, 2014). In this book she provides more detail about how a 'healing narrative' can be constructed. She also revises some of her advice about how the storytelling approach should be used. For example, in her first book she states that the parents would write the story themselves. However, the second book describes a case in which the story written by the parents was not child centred and told the story from the parents' own perspective. Since then she has always written the story together with the parents to ensure that the story is child centred.

Since Lovett first described the EMDR storytelling approach, other writers have mentioned its use in their work (e.g. Wesselmann, Schweitzer, & Armstrong, 2014). The first case studies of the EMDR storytelling approach to be published in a peer reviewed journal were in relation to working with both adults and children with a learning disability. These studies have reported effective results in treating Posttraumatic Stress Disorder in such clients using the storytelling approach (Mevissen, Lievegoed, & De Jongh, 2011; Mevissen, Lievegoed, Seubert, & De Jongh, 2012). A more recent case study described the successful use of this approach in a five-year-old child with complex problems related to early attachment related trauma (Rathore, 2018).

The EMDR Storytelling Procedure

Over time, the storytelling approach has evolved with the shared experience of therapists who have utilised this approach. Whilst there have been variations between practising therapists, the following description is an attempt at describing the generally accepted current 'state of the art', as agreed by the authors (all experienced in this approach) in relation to the application of the EMDR storytelling approach.

It is important to note that the procedure described here should be utilised only by Child and Adolescent mental health professionals who have been fully trained on an accredited EMDR therapy training. They should also have completed an accredited Child and Adolescent training, unless they are only using the approach with adults.

In the following description, "parents" should be understood to refer also to single parents or caregivers.

History Taking and Preparation (Phases 1 and 2)

The storytelling approach should only be used once the therapist has obtained a thorough history, has developed a case conceptualisation and has used whatever preparation strategies might be required. In other words, the process starts after Phases 1 and 2 have been completed. This will have included some resource installation in which BLS will have been used, so that the child is already familiar with this prior to subsequently using it together with the story during EMDR processing. The first part of the storytelling procedure equates with Phase 3 of the Standard Protocol (Shapiro, 2018).

In some circumstances, it will be advisable for the History Taking to be carried out without the child present if, for example, the child is too young or if there is early attachment trauma or other events of which the child has no explicit memory. Relevant information about the trauma and a thorough background history should be obtained, as well as identifying whether a storytelling approach might be appropriate (Lovett, 2014). In addition, it is important to assess whether the parents have been traumatised. If so, the therapist may choose to do some initial work with the parents, refer them for therapy, or use the creation of the narrative as an

opportunity to help the parents to resolve their own trauma related to their child's traumatic experience.

If the child has attachment-related problems, they may not be ready to start with any form of EMDR therapy, and a great deal of preparatory work may be required in order to build the necessary resources to process their traumatic experiences. Sometimes a separate therapeutic approach may be necessary by way of preparation, such as Dyadic Developmental Psychotherapy (Hughes, 2017) or Theraplay (Booth & Jernberg, 2009). At this point, the child will be more stable, less dissociative and more receptive to the story.

Creating the Story (Phase 3)

In most cases the therapist meets the parents or caregivers without the child being present. (However, if the young person is old enough this may be completed with them.) The therapist explains the AIP model to the parents, how this applies to their child's problems and how the storytelling approach can help their child to process the trauma. The therapist asks the parents for a detailed description of the trauma and other traumatic experiences that may be related. The therapist also ascertains the child's current symptoms that are related to the trauma and any positive changes that may have occurred since. The therapist and parents then speculate as to what the child's Negative Cognition (NC) might be in relation to the trauma (for example, "I'm not safe"). The Positive Cognition (PC) is then discussed with the parents which will include some education about how it needs to correspond to the NC. The therapist assesses the parents' degree of trauma resolution and learns about the belief systems that they want to transmit to their child (for example, beliefs about death, or ways to assess and respond to situations perceived as "unfair", or how to make amends, or when to extend forgiveness). The therapist also ascertains the child's strengths, resources, imaginative powers and activities that they enjoy.

The therapist and parents will then write the story together. This itself can be helpful to the parent in assisting them in understanding their child's problem and their approach to it. Some parents however, because of their own limitations, may be unable to collaborate in this way, in which case the therapist will write the story themselves. The next step is for the therapist to type a draft of the story and, usually, this will be emailed or posted to the

parents for their comments. The parents may then suggest adjustments to the story. Sometimes the parents will be concerned about re-traumatising the child or disclosing information that is new to the child. In this situation a further meeting with the parents may be necessary to discuss this in order to help them understand about EMDR therapy and the AIP model and how EMDR therapy works to reprocess unresolved traumas. Sometimes it may also be appropriate to share the story with the child's school (with the parents' consent) and ask them to provide feedback about any positive or negative changes which can then be incorporated into the story.

Structure of the Story

> "A good story 'rings true'. Even if some of the details of the story are omitted … the pain and confusion caused by the experience should be acknowledged.
>
> A good story has a beginning, a middle section, and an ending. The story starts with a setting of safety and describes strengths and resources. The middle section relays one or two significant events, including some sensory information accompanying the events that can be useful targets in EMDR processing. The story ends in a way that offers the possibility of trauma resolution, personal empowerment, and trusting relationships…
>
> [Where appropriate and required] the story includes cognitive interweaves and educational interweaves, information that serves to fill the gaps in the child's understanding. Cognitive interweaves can provide information about safety, responsibility, or choices that the child couldn't have known at the time of the traumatic event. They could elicit the adult perspective or encourage the [client] to imagine giving his/her younger self what he/she needed at the time of the trauma. A good story provides positive cognitions, which are beliefs about the self that are true, useful, and self-enhancing.
>
> The story differentiates between 'then' and 'now'. 'Then' the child was truly in danger. 'Then' the child was powerless and helpless. 'Now' the emergency is over. 'Now' the child can begin to trust others to take care of him/her and can continue to learn to care for himself/herself." (Lovett, 2014, p 171- 172.) [Words in parentheses are our additions]

Before describing how to write a story, we need to stress that, beyond the general description outlined above, there should be no hard and fast rules about what should be included in the story. Most importantly, the story must be written in a form which will be most therapeutic for the child and, in different situations, differing types of stories will be necessary. The following description is the default protocol for writing a therapeutic story, but the section below (entitled "Modifications to the Basic

Storytelling Procedure") will outline situations in which this default protocol will need to be modified.

- The story should be of similar length to a bedtime story for the particular child. The story should be written in simple child centred language appropriate to the child's developmental age. For children with attachment disorders and relational trauma, the story needs to relate to their emotional age rather than their chronological age.

- The story should also take account of the child's age:
  - at the time of the trauma (e.g. whether pre-verbal or verbal)
  - at the time of the therapy

- The story should be about another child and the child's own name should not be included. Neither should it include the actual names of family members, friend or pets. Usually no name is provided, and the story is, for example, about "a boy". This enables the child to distance themselves from the story and empathise with the child in the story rather than identify with them. The EMDR principle of having "one foot in the present and one foot in the past" (Knipe, 2008) is thus achieved. After hearing the story, some children will claim the story as their own and, if they do so, that is fine.

- Like all children's stories, it should have a 'beginning', 'middle' and 'end'. The 'beginning' describes a situation of safety and stability in the child's life. The 'middle' describes a distressing event that is hard to understand. The 'end' suggests a resolution and positive ending.

- The story will usually contain the elements of an EMDR therapy session including the worst moment of the traumatic event, the NC and PC.

- The 'beginning' needs to establish and nurture the child's pre-existing attachments and resources and may include information about the loving family in which they lived, what they enjoyed doing, what they were good at and so on. For a child with a secure attachment and a recent single-event trauma, the beginning would describe the child's life directly before the trauma occurred. However, for a child with early attachment-based trauma, the therapist needs to be creative with statements such as "he was born lovable", "strong" or "healthy". Alternatively, the story can actually start in the

present and describe the child's current attachment and security.

- The middle of the story needs to start by showing that the child is, in important ways, just like everyone else. It offers the essential PC that the child is good and lovable at heart. It normalises that everyone has experiences that are difficult and hard to understand. For example, "like everyone else in the world, this boy had some things in his life that were wonderful and some things in his life that were hard to understand. One wonderful thing was that he was born good and lovable. One hard thing to understand was what happened when he was x years old." The 'middle' then describes the trauma and what the child may have experienced (using all five senses if appropriate) and accompanying cognitions. It describes the effects of the trauma on the child and how the symptoms and NC relate to trauma. It should address the confusion the child will feel about what occurred and sometimes the issues of blame for what happened, for example, "because he was only a baby, he didn't understand why …"

- The story will connect the current symptoms to the trauma and what are current triggers for these symptoms.

- The story should address resolutions for the overwhelming, incomprehensible emotions, cognitions and feelings created by the trauma. These will be in the form of interweaves. There can also be words from the parents or other important people in the child's life. For example, "His mother says, 'I love you forever and will always do my best to protect you and to teach you what you need to know.' "

- The 'end' describes how the child is now safe from the trauma and is not responsible for what happened. It indicates what PC the child will have and predicts a future reduction in symptoms.

- It is often useful to include a Future Template which acknowledges what the child hopes for in the future. It gives guidelines for how the child will cope with similar events in the future and how they will feel good about themselves. For example, "Now when something changes, like when he goes to a new school, he can expect that he will make friends and learn new things."

Telling the Story (Phases 4 to 8)

Once the story has been agreed between the therapist and parents, a further meeting occurs with the child. In most cases the parents will be present whilst the therapy takes place but there may be circumstances where this is inappropriate, for example, with adolescents when the parents themselves are still traumatised by the event and it has not been appropriate or possible to do some prior individual work with the parents. However, it should be acknowledged that often the parent will also benefit from being involved in the EMDR storytelling process and, in a sense, the parent and child may both be processing the trauma together.

The child then hears the story being read to them all the way through whilst receiving BLS. The way in which this is carried out will need to depend on the age (both chronological and developmental) of the child and a great deal of flexibility and creativity may be required before discovering how best to do this. Sometimes the child can be asked to choose a toy to follow in order to assist with eye movements. With young children or those who have delayed emotional development, the use of tapping, especially by the parent, is likely to be the preferred method. With the small child, being seated on their parent's lap provides the additional feeling of being safe, supported and contained whilst listening to the story. Sometimes the parents will do the tapping whilst the therapist reads the story but there may be circumstances in which these roles would be reversed, and the child's own preferences should always be acknowledged.

It is advisable to read the whole story in its entirety before interrupting and discussing the story. This is because the story needs to be perceived by the child as a complete entity before focussing on specific moments during the story. The therapist should tell the child that the story will have a "good ending" before starting the story.

The first reading of the story is done by the therapist whilst BLS is simultaneously being provided, usually by the parent or caregiver.

Once the story has been read through completely the child is asked what they thought about the story, whether they liked it and whether they feel anything needs changing. For example, the child may be asked:

- which bits they like best
- how the story makes them feel
- if they want to change or add anything to the story
- which bits they thought the child in the story would have found more difficult

Sometimes the child will be happy with the story and will not want it changing at all (even though the story will be read again to the child – see below). Other times the child may want to change some parts or add to the story. If this is the case, the therapist will then read the whole story again. At this stage the BLS will be omitted because the story is being worked on and the child needs to concentrate on what they want to change. This time, the therapist will pause after each paragraph, or at a significant point within a paragraph, and ask the child such things as:

- how they feel or how the child in the story might feel
- where the child might have those feelings in their body
- "this made the child feel (pause)" and allow the child to fill in the gap (if necessary, the therapist can suggest a word)
- "when the child felt scared and that they were not safe, where do you think they might have felt this in their body?"
- to draw a picture of that part of the story
- what they think the child in the story thought, felt, wondered, needed, wanted
- whether they think the cognitions and feelings are the rights ones or if the child might have had different ones
- is there anything they think the child might have needed that they didn't have at the time
- how the child would have felt after getting what they needed

The therapist will respond to the child's feedback by making changes to the story and checking with the child that they are happy about these changes ("Does that seem to fit better now?").

The therapist may also offer comments or educational interweaves, followed by BLS, for example:

- "let's help the child in the story feel better. Let's let him know it's not his fault the accident happened"
- "let's help him get over the sad feeling"
- "let's imagine that his mum was right there to give him milk when he was hungry"

Even if the child has suggested no changes after the first reading of the story, the therapist is advised to re-read the story, stopping after each paragraph in order to elicit the child's comments with the questions described above. BLS should be omitted during this process so the child can concentrate on thinking about what they might wish to change.

After having made all the changes that the child wishes to make, the amended story is read again to the child coupled with BLS. Again, at the end of the story it is important to check with the child whether they are happy with the new version or whether they feel anything else needs changing or including. This process is continued until the child is completely happy with the final version.

As in the Standard Protocol, the procedure will depend on whether the processing appears to be complete or not. If the child appears to have fully processed the trauma, the therapist can ask the child about their Future Template i.e. how they wish things to happen in the future in relation to their trauma and this can be added to the story. Also, the child will often want to 'own' the story in some way. Sometimes the child will ask if they can take a copy of the story away with them and older children may want to read it to themselves. If the processing is incomplete, the therapist asks the child to imagine putting away the story until the next visit, for example, using a container exercise or some other form of resourcing tool.

At the end of each session, depending on the age of the child, the therapist can provide the child with the opportunity to draw or to play. The therapist would have available whatever is relevant to the trauma, for example, a dog or a car in addition to enough people or dolls. Young children often re-enact parts of the story and the therapist can use BLS where possible and use some of the information to update the story. Sometimes the therapist can also

use cognitive restructuring at this point, for example, “let’s let him know that it’s not his fault. He is good and lovable.”

Finally, the session will need to be ‘closed’, for example, with some directed non-trauma play or instructions to close or put away the story until the next session.

As with the Standard Protocol, the subsequent session would start with Phase 8, a review of the previous week, whether any further processing has occurred and whether there has been any symptomatic change. If appropriate, the therapist can ask the parents and school to send a message about any changes in the child (either improvement or deterioration) prior to each session so that alterations to the story can be incorporated prior to the next reading. If it appears to be beneficial, the storytelling process will be repeated in the same way. Sometimes a modified version of the story will be used, depending on the child’s feedback or emotional response to the first reading of the story.

Modifications to the Basic Storytelling Procedure

There are various situations in which the basic storytelling approach, as described above, might need to be modified:

Emotions and cognitions
In the experience of the Joan Lovett, the inclusion of emotions and negative cognitions in the story may be too triggering, especially in more complex cases, and the child may stop listening to the story as it becomes too upsetting. In such instances it may be worth considering initially leaving the emotions out of the story. However, the therapist always has the option of asking the child at the end of the story "how do you imagine the child in the story felt?" or "how do you feel when you remember?" If the child is in agreement, the child's response can be added to the story and read again. Similarly, Joan Lovett also finds that the inclusion of the NC may also be problematic for some children. She will ask, "what's the thought you have about yourself when you remember what happened?" or "what does that seem to say about you?"

Stories about the child's whole life
The story needs to include information about the child's life that is relevant to the trauma and its resolution. With a recent trauma that is not attachment related, it will therefore not be necessary for the story to encompass the child's whole life. However, for early attachment related trauma, for example when the child has been adopted, the whole life story is relevant in order for the child to understand what has happened to them. In such cases the story will start from the beginning of the child's life and include all the relevant life events, especially the point at which the child had their first opportunity to develop an attachment when no such attachment or only a disorganised attachment previously existed. However, for some children this may be too much for them to process initially and the story may need to be kept very simple at first with further 'chapters' being added at a later stage, as described below.

Separate chapters
If the child has experienced multiple traumas at different times in their life or has a long history of abuse, it may not be possible to incorporate all the relevant information into a single story which can be read in one sitting. Alternatively, the traumatic memory may have several components, for example, an RTA followed by surgery and then chronic pain. In these situations, the story may need to include separate, relatively self-contained chapters which

cover each of the major traumatic events. Sometimes the initial story needs to be brief, emphasising the child's current safety. As the child is able to tolerate remembering more, additional chapters can be added (Lovett, 2014).

Incorporating the story into child's play
Some children may not be able to tolerate the formality of sitting and having a story read to them or may have difficulty concentrating on a story. "The story does not have to be read aloud, but rather may be used informally, with parts of it woven into the child's play. Some children may like to have toy figures act out the story so that they can visualise what happened." (Lovett, 2014, p. 172.)

Enacting the story
Similar to the process described above, some children may find it helpful to act out the story as it is being told to them. This will help them to process the story. However, some creativity will be required in terms of providing BLS during the enactment or BLS will have to be provided subsequent to the enactment.

Writing one's own story
For older children the process of writing their own story may be therapeutic in its own right. The child can write the story jointly with the therapist who will prompt in each section for cognition, emotion and bodily sensation.

Reverting to the Standard Protocol for 'hot spots'
Even after several readings of the story, some clients may continue to experience significant levels of distress regarding certain aspects of their story. In this case it can be useful to read the story and also check Subjective Units of Disturbance (SUD) ratings as the story progresses. If SUD ratings are low (e.g. 1-3) but not at zero, the therapist can re-read the paragraph, then ask the child what he/she is noticing. A few sets of BLS can then be used as per the Standard Protocol until SUD ratings of zero are reported. The therapist can then continue to read the story. However, at times when SUD ratings are higher, the 'hot spots' may need to be separately processed during further sessions using the Standard Protocol. It is usually advisable to then include at least one reading of the whole story after all the 'hot spots' have been fully processed.

Generally speaking, it should be acknowledged that, when working with young children, or those with early attachment-based trauma or developmental disorders, a great amount of creativity is always

required. The therapist must always 'think on their feet' and often find creative and novel solutions for the blocks that occur in therapy. The above list should therefore not be regarded as an exhaustive one and it is important for therapists to share with each other the ideas that they have developed in working with such children.

Who Benefits from the Storytelling Procedure?

In answering this question, we must first consider why we would use the storytelling approach rather than the standard EMDR protocol. As a general rule in EMDR therapy, with both adults and children, it is agreed that the Standard Protocol should be utilised wherever possible and that any modification to the Standard Protocol should occur only if the Standard Protocol is not practically possible or is not effective for some reason (Shapiro, 2018). Therefore, the following list of criteria first specifies why this particular client group is unlikely to benefit from use of the Standard Protocol or needs a coherent narrative in addition to the Standard Protocol.

Very young children (under-fives) unable to produce an NC or PC

The youngest children that we see for therapy will be unable to respond in a meaningful way to the Assessment Phase in the Standard Protocol. Although we can still utilise the Standard Protocol and leave out or simplify aspects of the Assessment Phase, the advantage of using the storytelling approach is that it can include NCs and PCs for children who would be unable to produce such cognitions themselves due to their developmental age.

Children with early pre-verbal trauma, especially attachment trauma

Older children may be quite capable of responding to the Assessment Phase. However, some of these children will have early traumas that they cannot access either because they occurred in infancy and the child has no explicit memory of them or because they have amnesia for the trauma due to dissociation. For these children the storytelling approach can be particularly effective as it provides the missing parts of the child's life story which might help them, for example, to understand why they respond to current triggers in the way that they do.

Children who are prone to dissociate

These children are often unable to benefit from EMDR therapy using the Standard Protocol. Using the storytelling approach helps to gently introduce the background history in a way that is manageable. It engenders engagement and helps the child to be more 'present', in order to work on complex traumas.

Individuals with a learning disability and/or communication problems

Owing to limitations in their cognitive development, some individuals may be unable to utilise the Standard Protocol. Both adults and children with communication problems, whether due to a learning disability or other reasons, can benefit from the storytelling approach. As has been mentioned above, case studies have been published with regard to the successful use of the storytelling approach in treating PTSD in both adults and children with a learning disability (Mevissen et al., 2011; Mevissen et al., 2012).

Mute, unresponsive or very shy individuals

For a variety of reasons, some clients may be unwilling or unable to speak to the therapist and, for this reason the Standard Protocol cannot be utilised. For example, the first author (RL) was asked to see a five-year-old boy who had become anxious, clingy and difficult since an RTA. His parents were very negative about the prospect that he could be helped because "he won't talk to you." Apart from a big yawn and making popping noises, the boy never communicated anything during processing, but the parents subsequently reported an almost complete resolution of his post-accident symptoms.

Case Examples

The following cases describe work done by the authors. The intention is to illustrate the application of the storytelling technique to a variety of clinical presentations. (All names have been changed.)

John: Four-year-old with single event trauma

John was a 4¾-year-old boy who lived with his parents and 8-year-old brother. He was referred to AD by an insurance company following an RTA the previous year, with concerns that he had been suffering from psychological trauma following the accident. After the accident John had bad dreams, regularly leading to his wetting the bed. He was very anxious in the car, hypervigilant, easily upset or angered and would often say to his mother, "mummy I don't want you to die".

John was born prematurely at 35 weeks gestation following a planned C-section. The week before John's birth, his mother had been diagnosed with a rare neurological syndrome that affects the nerves at the end of her spinal cord and symptoms include severe pain and sometimes paralysis. When John was born, he had jaundice and sepsis resulting in his admission to a neo-natal unit for a few days and then a special baby unit for a week. John was diagnosed with laryngomalacia which results in floppy airways. During his first few years of life he had ENT difficulties and had his tonsils and adenoids removed and grommets fitted when he was two years old.

John attended a nursery from 11 months of age and no significant issues were reported. At the time of his referral, John was in the first year of school. At school he demonstrated some difficulties with transition and he was energetic, fidgety and struggled to concentrate.

John's mother initially had post-natal depression. Some of her neurological symptoms improved following an operation when John was a baby but unfortunately the RTA caused her physical symptoms to recur including experiencing constant pain. At the time of the impact of the accident her legs were numb, and she had to be removed from the car by the fire brigade. John witnessed this and he was scared his mother was going to die.

The first session was with John's mother alone as AD had already considered the possibility of using a storytelling approach with EMDR therapy based upon previous referral information. At this appointment a full history was taken as well as a detailed description of the RTA. The EMDR storytelling approach was explained to the mother. At this stage it was also possible to ascertain the mother's ability to contain and provide a safe environment for her son if this therapy was going to be used. Despite all her difficulties, the mother appeared to have processed the RTA herself and presented as a strong, capable person who could focus on her child's issues.

At the second session, AD met the mother again and together they wrote the story. The process of writing the story, including all aspects of the EMDR protocol, was explained to the mother as well as creating a positive beginning and a positive future ending whilst focusing on the trauma in the middle. The mother was emailed the story to check she was happy with the contents.

On the third session, John attended with his mother. He engaged well and brought his favourite teddy. This teddy was used as a positive resource using BLS and John responded well to this and was very happy. John was asked whether he wanted to hear a special story and he was keen to listen. He sat happily on his own chair with his mother at the side, as his mother was physically unable to have him on her lap. He was keen to use buzzers as a form of BLS.

AD told John the following story whilst the buzzers were on:

Once upon a time there was a lovely boy who was born into a very happy family. He had brown hair and blue eyes and he lived with his mum, dad and brother.

As with all children, some things in life were lucky and some things were unlucky. For this boy, what was lucky was that he learnt how to swim really well, he was great at gymnastics, he had lots of friends, he was very funny and he was much loved.

One day something happened that was not so lucky. His family were driving to the seaside for the day and everyone was very happy and excited. There were lots of cars on the road which made the car journey very slow. Suddenly without warning a van crashed into their car from behind. The boy bumped his head against the window. Everyone was very shocked. The boy and his brother started crying as they were frightened in their tummies. The boy

didn't feel safe. The boy's dad said he would ring the Police to get help and he got out of the car, but the driver of the van went to his dad and started shouting at him. This confused the boy. Now the boy was even more scared in his tummy!

The boy's mum could tell that her children were scared so she tried to tell them that everything was going to be OK. Soon the Police and two ambulances arrived, and they got the boys out of the car with the help of their dad.

The boys were taken into the ambulance with their dad and were looked after to make sure they were all OK. The boy was still worried about his mum who was stuck in the car as he was scared that she was hurt.

The fire brigade arrived so that they could safely help the boy's mum out of the car. The boy and his brother went into the fire engine and the nice fireman gave them a drink and a snack.

The boy saw his mum being taken out of the car – the fireman had to smash some of the glass and remove the top of the car. The fireman did a fantastic job and the boy's mum was lifted to safety.

The boy's mum was taken to hospital just to make sure she was OK. The boy, his brother and dad went in a police car to the hospital too. A bit of the boy was excited when he was in the Police car and a bit of him was still scared about his mum.

The boy's granddad came and picked the boys up from the hospital. They were all hungry, so they had a lovely picnic on the grass outside. The food was yummy, and they had lots of fun. The boy's granddad then took the boys back to his house until the evening and then took the boys back home where their mum and dad were safely waiting for them. They had pizza for supper and the boy was happy that his family were all safe and well.

For a while, the boy was really scared about getting into a car again as he was worried they would have another car crash and someone might get hurt. The boy was scared when his dad drove or if he heard any car noises. He would sometimes have bad dreams at night time which reminded him of the accident.

Over time the boy learnt that he could be safe in a car as nothing bad happened to him or his family. His dad was a really good driver and the accident was not his dad's fault. The boy learned to trust his dad and mum when they were driving, and he learnt to feel safe

in any car. He stopped worrying about any noises that reminded him of the crash as he knew he was safe now. He stopped having the bad dreams. The boy was really pleased and proud of himself for getting stronger and learning to trust his parents. He learned that he could go to the seaside again as he would be safe in the car. He could feel his heart beating fast with happiness at what he had achieved. Well done.

John listened really well to the story and at the end he said he loved it and would not change anything. John spontaneously commented on how he noticed his eyes had moved from side to side as the story was read to him, even though eye movements were not used by AD as part of the bilateral stimulation. He was keen to hear it again and the process was repeated. At the end of the session, John was encouraged to use his teddy to reinforce the earlier resourcing.

At the following session, the mother reported that John was making very good progress. He was not showing any anxiety in the car, he was sleeping well and was calmer in himself. His mother also reported that she was benefiting considerably herself from the storytelling approach because it was helping her to think about how she communicated to her children using the AIP model. John's great-grandfather had died during the week and the mother had used a storytelling approach to help her children process the death, including when they visited the hospital. A reduction in John's symptoms was also evident on the Preschool Anxiety Scale (parent form) (Spence & Rapee, 1999) from pre to post therapy.

No further sessions were arranged owing to the progress made.

Sarah: Five-year-old selective mute child with single event trauma

Sarah was a 5-year-old girl who lived with her parents and siblings and some members of the extended family. She was referred to AD by an insurance company following an RTA over three years previously with concerns that she had been suffering from psychological trauma following the accident. After the accident, Sarah became selectively mute, only speaking to close members of the family. Sarah struggled to sleep for the first year after the accident, regularly waking up during the night and, at the time of the assessment with AD, she was still having regular bed wetting incidents. Sarah had also been anxious about being in the car, but this had improved with time.

Sarah's early developmental and family history was unremarkable. She attended a nursery from 2 years old (following the accident) and the main issue reported was her selective mutism. She was in the first year of school (Reception) when she was referred to AD.

The first session was with Sarah and her mother and at this appointment a full history was taken. Sarah engaged well in a playful way but did not speak at all in the session. The EMDR storytelling approach was explained to the mother and, at the second session, AD met with the mother and together they wrote the story. The process of writing the story, including all aspects of the EMDR protocol, was explained to the mother as well as creating a positive beginning and a positive future ending whilst focusing on the trauma in the middle. The mother was assessed to be a safe and containing attachment figure in Sarah's life who would be able to engage well with the storytelling procedure and who did not present as having any unresolved issues or traumas. The mother was emailed the story to check she was happy with the contents.

On the third session, Sarah attended with her mother. She brought her favourite toy which was a cuddly elephant. This elephant was used as a positive resource using BLS and Sarah responded well to this and was very happy. Sarah was asked whether she wanted to hear a special story and she was keen to listen. She sat happily on her own chair with her mother at the side, and she was keen to use buzzers as a form of BLS.

AD told Sarah the following story whilst the buzzers were on:

A story about a girl that stopped speaking for a while

Once upon a time there was a beautiful girl who was born to her wonderful parents. The girl had an older brother and her family all lived very happily together with her grandmother, uncle and cousin. The girl felt very safe with her family. She was very chatty and had lots of friends and loved playing with them all.

One nice day, when the girl was nearly 2 years old, her parents took her on a trip to spend the day at a lovely lake. The girl sat in the back of the car and was singing songs and talking happily to her parents.

Suddenly, a car appeared from nowhere and crashed into the right-hand side of the front of the car that the girl and her parents were in. This was a huge shock for everyone, and they all thought they were in danger. There was a huge noise as the cars crashed and smoke was coming from the cars. The car stopped. Everyone was very scared, and the girl had butterflies in her tummy. Her parents got out of the car and the girl's daddy opened her door and took her out of the car.

The girl and her parents had to wait a long time for the Police to turn up. Some nice people stopped to make sure everyone was OK. The girl was very shocked by what had happened, she felt a pain in her throat and struggled to find any words to say.

The Police arrived, followed by an ambulance and they checked to make sure no one was badly injured. The Police said that everyone was OK. The cars were taken away to be fixed. The Police took the girl and her parents to McDonalds so that they could have a drink. The butterflies were still in the girl's tummy, making her feel sick inside.

Some family friends came to pick the girl and her parents up from MacDonalds. The girl was still really shocked and didn't talk because she was still very scared. Their friends took them straight back to the girl's house and she was so tired that she went straight to bed.

The girl continued to be scared by the car crash. She was <u>so</u> scared that she stopped talking to anyone except her family. As the girl grew older, she struggled to talk to strangers or anyone she didn't

know really well. She went to nursery but didn't talk to any of the grown-ups or children there.

The girl had a baby brother who was born when she was nearly 3 years old. She liked having a baby brother and wanted to play with him and help mummy feed him. This made her feel excited all over her body.

When she was 4 years old, the girl and her family moved house and her grandmother and uncle also came to live with them. The house was very full! The girl loved talking to everyone at home.

The girl started school in Reception but still found it very hard to speak to anyone at school. It was as if the words were stuck in her throat. She started to become a little bit brave and after some time she managed to say a few words to her teacher as she felt safe to do so. The teacher was so proud of her for being brave.

The girl was growing up really well. She then moved into Year 1 at school. She learnt that it was safe at school and she became braver and braver. The girl learnt that it was OK to talk to the teachers and other children as nothing bad would happen. She didn't have any more butterflies in her tummy. Soon she began talking a few words at a time. Everyone was very pleased with her and they loved hearing her talk and all the wonderful things she had to say. Later on, the girl learnt that it was fun to talk and join in with the other children. She made lots of friends and felt very happy and safe and loved to laugh and sing too!

Everyone was very proud of the girl. Well done!

Sarah listened really well to the story and at the end she told her mum that she liked the story and would not change anything. She did not want to hear the story again. AD therefore helped Sarah connect to her positive resource, the elephant, in a playful manner and during this time Sarah started to giggle quite a bit. This was the first time that Sarah had made any sound in the sessions! Given that Sarah was happy with the story, AD asked whether she would like to take it home. At the end of the session, Sarah and her mother were given the story to take away so that her mother could read it to her whenever she wanted and Sarah agreed to this idea.

Three weeks later the mother attended with Sarah for a follow up session. Sarah was very energetic from the start and made some small noises of excitement whilst playing with AD. AD heard from

the mother how Sarah had started talking to her peer group in the playground and being much more interactive in general. Sarah was still quite shy in lessons but was gradually building up her confidence. Her bedwetting had stopped completely and there were no other issues reported. Within 10 minutes of this session, Sarah was counting numbers out loud when playing hide and seek with AD and spoke quite naturally.

A reduction in symptoms were evident on the Problem Rating Scale (parent form) by Ricky Greenwald (1996). Pre therapy, Sarah's mother scored the selective mutism as being the biggest worry (8/10 where 10 represents the worst it can be) and bedwetting was the other concern (6/10). Post therapy, the selective mutism was scored as 3/10 and bedwetting as 1-2/10. On the Parent Report of Post-traumatic Symptoms (PROPS; Greenwald et al 2002), the pre therapy score was 39 which reduced to 19 post therapy.

No further sessions were arranged owing to the progress made.

Ben: Eight-year-old with low self-esteem and separation anxiety following his parents' separation

Ben was an 8-year-old boy whose parents separated when he was 6 years old. Ben spent equal amounts of time living with each parent who now had an amicable relationship.

Ben was referred to JE owing to his parents' concerns about his difficulties separating from them. He was unable to play in his bedroom without their being in the room with him and he would follow them around the house. At night, he became upset if he was left to fall asleep in his bedroom on his own and his parents had developed different strategies to manage this. His mother would remain in the bedroom until he was asleep, and his father would leave him to cry, intermittently reassuring him that he was "fine" until he fell asleep.

Ben's parents were also concerned about Ben's perception of himself as he would frequently make negative comments relating to his abilities and appearance. His teachers had reported that he was reluctant to try new challenges and that he was passive in group situations.

Ben's parents reported that, prior to their relationship deteriorating and their separation, Ben had been a content and confident child and was able to separate easily from them.

The first session was with Ben's mother who provided a detailed account of the difficulties and a full developmental history. Ben's mother reported that Ben had initially developed a secure attachment and that there were no concerns prior to the deterioration in her and her husband's relationship. She and her husband had worked hard in an attempt to minimise the impact of their separation on Ben, but she was concerned that this was the main cause of his difficulties. It was agreed that a storytelling approach would be helpful along with resource building and support to increase Ben's tolerance of his distress.

At the second session, JE met with Ben and his mother. During the session, Ben was asked about the emotions he experienced when he was in a room on his own and when he was in bed at night. He was also asked about the thoughts he had about himself at these times. Visual aids were used to help Ben to identify these

negative cognitions. Ben reported that when he was on his own, he felt scared and that he had thoughts that he was not lovable. He stated that, if he were not lovable, his parents might leave him and then he would not be safe.

During this session, Ben was also provided with psychoeducation relating to anxiety, and resources were discussed. These included visualising a 'safe place' and breathing techniques, which Ben practised through the week.

During the third session, JE and Ben's mother developed the story which was then emailed to Ben's father, inviting him to make suggestions for amendments. Once the final version was agreed, a fourth session was arranged which was again with Ben and his mother.

During the fourth session, Ben reported having found his 'safe place' helpful in 'reassuring' his scared feeling. The following story was read to him, excluding the parts in brackets, which were added during the fifth session:

This is a story about a brave boy. It has a good ending.

There was once a boy who lived some of the time with his mummy and his two cats and some of the time with his daddy. The boy really liked playing with Lego and being creative. He was like a fish in water and felt so proud in his chest when he swam 500 metres without stopping. The boy felt relaxed and safe when he cuddled up on the sofa with his mummy and she stroked his hair.

Just like most people in this world, the boy had some things in his life that were lucky and some things that were difficult and hard to understand.

One lucky thing was that, when he was born, he was a good and lovable baby. His mummy, daddy and all his family loved him very much and enjoyed watching him grow and develop. The baby felt very happy and safe in such a loving family, and they would call him The Giggler, because he giggled so much.

A difficult thing was that when the baby grew into a little boy, the mummy and daddy started to have problems of their own and, because of this, they would sometimes argue. These arguments would make the boy feel scared and confused and he sometimes even thought that he might have done something wrong.

Because of the problems, mummy and daddy stopped spending as much time together. This was confusing for the little boy and because he was only little and was not able to understand that it was because of his mummy and daddy's problems, he started to think that he might not be lovable.

The trouble was that whilst the mummy and daddy still loved the boy very much, they had stopped loving each other. But they were able to make good decisions and decided that it would be better for everyone if they lived in separate houses.

The mummy and daddy then moved to separate houses. While it was good that the arguments had stopped, the boy wondered why his mummy and daddy were no longer together, and he felt sad and confused and thought that he might have done something wrong and that he might be not be lovable. The boy started to worry that his mummy or daddy might leave him too and then he would not be safe, and be on his own.

The boy started to spend some time with his mummy and some time with his daddy. This was often good, and he enjoyed having fun with both of them. But he started to get a tingly scared feeling in his tummy when either of them went out of the room away from him because he thought that he could not trust them to stay with him because he might not be lovable.

The little boy's mummy and daddy did not understand why he was getting upset when they left him in a room on his own. Whilst they both wanted the boy to feel happy, they had different ideas of how to help him, which was confusing for the little boy. Sometimes, when he was scared and left on his own, he would feel that he wasn't safe.

The boy is bigger now and he is starting to realise that his mummy and daddy live in separate houses because of their own problems and that their arguments were nothing to do with him. He is starting to understand that he is a good and lovable boy and that his mummy and daddy both love him very much and will always make sure he is safe and will never leave him in a house on his own. He is starting to understand that, when they do things differently, they do this because they are trying to work out what he needs, because they love him very much and want him to be happy.

Knowing this is making the boy feel much braver and he is starting to feel safer when he is in a room on his own, knowing that his parents both love him and will keep him safe. (He now knows that,

if he needs to, he can think about his enchanted forest, squish Big Teddy and do his tummy breathing to help to reassure his scared feeling that he is OK.) He is starting to be able to fall asleep without his mummy or daddy in his room, and is feeling very proud of himself for this.

(The boy then grew even older and he still enjoyed spending time with both his mummy and his daddy and he felt that they loved him very much. The boy felt happy and safe and enjoyed having time on his own. And he knew that if his scared feeling ever got confused again he had the skills to help it to understand that he was OK.)

Ben concentrated well throughout the reading of the story and at the end he stated that he liked the story and that it was good for the boy that his parents loved him so much. He stated that it was difficult for the boy that his parents had argued.

During the fifth session, the story was read to Ben again and was then read at a slower pace a second time with Ben being given the opportunity to change the negative thoughts and emotions and to add the sensations that the boy in the story may have experienced. Ben engaged well with this and stated that the boy had experiences just like his. When asked by JE, he agreed that his name should replace "the boy". He also requested for his new resources to be added the story and he wrote the Future Template final paragraph with JE.

During the sixth session, Ben and his mother reported that Ben had been managing much more easily at both his mother's home and his father's home. This was later confirmed by Ben's father. Ben reported that his scared feeling was nearly gone and that he was able to stay in his room on his own and fall asleep without his mother in his room. He stated that he no longer cried at his dad's house and that he felt confident that he could "reassure" the scared feeling if it got confused. Ben's mother also reported that Ben had been less critical of himself and less reluctant to try activities that were challenging for him.

Ben was given a copy of his story to keep. No further sessions were arranged.

Rebecca: Ten-year-old with severe early attachment related trauma

Rebecca was a 10-year-old girl who lived with her foster-carers and younger sister. She and her sibling were removed from the care of their birth mother when Rebecca was 7 years and 3 months. Both children had lived with the same foster-carers from the time they were removed from the care of their mother. The foster placement was regarded as a successful and stable placement by Rebecca's Social Worker, and the long-term plan was for both children to be placed with their carers on a permanent basis.

Her early history was one of severe neglect, emotional, physical and sexual abuse, documented from the first few weeks of her life and until her removal aged 7. Child Protection records revealed that, as an infant, she had been neglected by both her parents and exposed to frequent domestic violence. When she was 3 years old her father died of a heart defect. From this point onwards the neglect and emotional abuse intensified as her mother introduced a number of male partners into the family, who, together with her mother, are believed to have physically and sexually abused her.

At the time of her referral for therapy Rebecca had occasional supervised contact with her mother and aunt, which she found distressing; she had settled well into her foster placement, wanted to live there permanently and wished all contact with her birth family to end. Rebecca was aware that her mother wished to maintain contact and that she was not in agreement with the plan for Rebecca to remain in foster care.

Rebecca was referred to MO'C for EMDR therapy by her Social Worker because of concerns about her emotional wellbeing. Specific concerns raised by her Social Worker and by her foster-carers included:

- Nightmares
- Sleepwalking
- Soiling
- Acute distress following contact with her biological mother and other relatives

She was 9½ when therapy began. She would only agree to attend for therapy if meetings were held away from the town where she had been neglected and abused for fear that she might encounter her mother or others who had abused her. Her foster-mother brought her to therapy sessions. For the first 5-6 meetings, her

foster-mother remained present throughout the entire session, and then gradually withdrew from a part of the session as Rebecca became more confident about meeting the therapist on her own.

From the very beginning of therapy Rebecca made two things very clear:

1. She was not going to talk about or listen to anything to do with her past life
2. She was interested in the therapy but needed time to decide whether or not she would trust the therapist

However, she was willing to admit to her nightmares and sleepwalking, though sceptical that the therapist could help with these. Her approach to the sessions was to employ a range of avoidance strategies, which included hiding behind furniture; communicating via written messages (held up as she hid behind furniture); eating lots of food (provided by the Centre where we met); singing and dancing. All these were performed with good grace and humour – and with the overriding message that she needed to take control of the therapy time. She was very interested in listening to the therapist talking with her foster-carer about what was happening in the sessions. Often this would prompt her to write messages for the therapist to read. Between the sessions, she had begun to write letters to her Social Worker documenting specific memories of assault and abuse (over 60 letters) and, later, wrote that she wanted the therapist to see these letters. But she remained adamant that she was not willing to talk about these memories in the sessions.

By session 10, Rebecca was able to tell her foster-carer that she trusted the therapist. This became evident in the therapy sessions when she spent less time employing her avoidance strategies and clearly had less need to be in control of the sessions. She began to regress in sessions and became playful rather than avoidant. She even allowed the therapist to use EMDR to successfully deal with her nightmares. Another change during this time was that a decision had been made that all forms of contact with her birth family would be ended and reviewed after a year.

A major development was the beginning of formal proceedings to secure the foster placement on a permanent basis. Rebecca and her sister were not actively involved in this process in that they did not have to attend meetings to discuss this. However, Rebecca was aware that this process was underway. (Being asked to give your views on your future on a Review Form was all it took to trigger feelings of insecurity.) It unsettled her greatly because it

precipitated her worst fear, that she would be returned to the care of her mother.

Around this time, she began to imagine that her mother and "bad men" came into her bedroom at night, terrifying her. She refused to sleep in her bedroom. From then onwards, for a period of 9 months, she slept in the hall outside her bedroom. (As a foster-carer you cannot have a foster child sleep in your bedroom no matter how distressed they might be.)

By about the 20th therapy session, she began to become avoidant again and refused to acknowledge her distress. At the very outset of the therapist's contact with Rebecca, the foster-carer and the therapist had discussed the use of an EMDR story and how it might be used. It now seemed appropriate to consider this, not least because it was very evident that, even though she was happy in her foster family, she trusted the therapist and was functioning well in almost all areas of her life, she could not bear connecting with her memories of past abuse and neglect.

However, she was very interested in the idea of a 'story' about her experiences and became very engaged in the delivery of the process of the 'storytelling'. The actual story was written mainly by the therapist (who had access to the 34-page 'chronology' of Social Work records documenting concerns from 0-7 years) with help from the foster-carers. The original version of the story is included below.

The Story
A story about a girl who wanted to be happy

Chapter 1: A Hard Life
This story is about a girl who lived with her foster mum, her foster dad, her younger sister and her foster brother. The most important thing for this girl was her wish to be able to stay with her foster family for as long as she wanted to.

Just like everyone else in the world this girl had some things in her life that were lucky and some things that were difficult. One lucky thing was that when she was born she was a healthy and very lovable baby who deserved to be loved and cared for.

An unlucky thing for this girl was that when she was born her mother and father had lots of problems in their life and they argued a lot - which was very scary for the baby girl. But the worst thing was that her mother and father didn't know how to look after

children properly. So, as this baby grew up, she wasn't given all the cuddles she needed to help her feel safe and loved; she wasn't always kept clean and warm, and often she wasn't fed properly. Even having proper sleep was difficult for this baby because of the arguing between her mother and father, and the noise that strangers made when they came to the house where the baby girl lived.

So, as she was growing up, the baby girl often felt alone; she was tired; she felt frightened and unloved. And because she was just a baby she couldn't tell anyone how she felt. She had to keep all these hard feelings to herself and they made her head sore and gave her pains in her tummy. But it was not her fault. She was just a baby who needed the things that all babies need – to be kept safe, warm, clean and fed.

Every now and again things got a little better when her gran and her aunt looked after her. But this didn't happen very often. The baby girl began to think that there was no one she could trust.

When she was about three years old things got worse for her. She got a baby sister and she started worrying about her. The man who was her father died. She didn't know what to feel when this happened because he didn't look after her much, but she wondered if there would be less shouting and arguing. But this didn't happen. Instead, the shouting got worse and it was her mother who began shouting at her and hitting her even more. And the arguing was even worse now because strangers came to the house and hurt each other and hurt her mother. They even broke the windows and the doors. The little girl was very scared and so confused that her head was sore with all her worries. And she still had pains in her tummy and in her head - and she began to have bad dreams.

When she was old enough, the little girl went to nursery school. She liked the nursery because the grown-ups were kind to her. She wanted to go there all the time, but couldn't because her mother was sleeping a lot or forgot to take her. After a while, the little girl started school in Primary 1. More strangers started to come to the house. They were men, and the little girl began to be afraid of them. Sometimes they hurt her and sometimes her mother helped them to do bad things. The little girl wanted to tell the grown-ups in school, but her mother told her she was not allowed to tell anyone about the bad things that were happening at home. The little girl decided that she would not tell anyone because she was very frightened of her mother and the bad men who hurt her. But the little girl could not keep all her worries to herself, so she began to be angry at home and in school. Sometimes when she was very hungry, she had to

take money from her mother's purse to get food for herself and her sister. When she was angry in school her teachers began to think that this girl was very unhappy, and they told other grown-ups, called Social Workers, about how unhappy she was. The Social Workers spoke to the little girl, but she was frightened to tell them about the bad things that were happening at home and about the men who came to the house. The Social Workers spoke to her mother and her mother did not tell them the truth.

The girl began to think that she would never have a happy life, and she worried about her sister, who also seemed very unhappy. Then, when she was seven, a wonderful thing happened. More grown-ups told the Social Workers that the girl and her sister were still not being looked after properly and that there were lots of arguments happening in their house. When the Social Workers went to the house it was not clean; there was no good, healthy food for the children to eat; the girls' mother was drinking a lot and taking drugs. She forgot to take the girls to school and to take them to the doctor when they were ill – and there were men coming to the house that were not supposed to be there.

The Social Workers realised that the girl and her sister needed to live with another family who knew how to love and care for children properly. This is when the girl's life changed for the better. She and her sister went to live with foster parents. Things seemed strange at first and the girl wondered if her life would really be any better. She wondered if she could trust her foster parents, but she was willing to give them a chance.

The girl was seven years old when she went to live with her foster-carers. It was very different. Her foster-carers were kind to her and her sister. They didn't shout at her or tell her that she was bad. She even had her own bedroom to sleep in and nice food to eat. After a while her foster-carers thought it would be a good idea for the girl to move to a school nearby. The girl thought that this was a great idea because it meant that she didn't have to go anywhere near to her mother's house, and this helped her feel safe. She began to think, "maybe I can have a normal life now and be like other girls".

Chapter 2: Life Gets Better

The longer she lived with her foster-carers, the more the girl realised that they really did know how to take care of children. Having clean clothes, good food and her own bedroom felt good. But the most important thing for the girl was that she began to feel safe. She had never felt safe when she lived with her mother. And because she

felt safe, she began to enjoy her life. She made new friends, her schoolwork improved and she felt happy.

But there was one thing that still made the girl worry – a lot! Her Social Workers said that she still had to have contact with her family. Although she didn't really want to see them again, the girl agreed. So, she met with her mother again, and her aunt and her Gran. This happened a few times. Sometimes, the girl thought, "Will I be sent back to live with my mother again?" This made her feel scared and unhappy. Her foster-carers noticed that, after these family visits, the girl seemed upset; she had nightmares and she began to sleepwalk. They began to think that these family visits were not helping the girl at all. When they spoke to the girl about this, they realised that the girl was really afraid that she would be sent back to live with her mother, when what she really wanted was to stay with her foster- carers. The girl began to feel that she would never be happy again.

Her foster-carers realised that the girl was feeling very sad and unhappy and they wondered what they could do to help. They spoke to Social Workers and other grown-ups who wanted to help children have a happy life. One day, the girl received some very good news from her foster-carers. They told her that she did not have to have any contact with her family. The girl felt very happy to know that grown-ups were listening to her. Now she felt confident enough to tell them what she really wanted, which was to stay with her foster-carers for as long as she wanted.

Rebecca agreed to listen to the story. Her foster-mother was present, but Rebecca chose to sit opposite her on the floor in front of the coffee table (with pen and paper ready!). The therapist read the story. As the story was read to her she listened, wrote things down, gave strong eye contact to her foster-carer, wrote more things down and re-engaged eye contact with her foster-carer. After ending the story, the therapist asked Rebecca some questions about the story, including "Is the story like any girl that you know?". Rebecca picked up the paper she had been writing on and showed it to the therapist. It read:

"Yup!

True story like duh!!!
Can I make a story?
Thanks
Seriously
I am so interested (totally)
This is……annoying
But interested
What the…."

Then Rebecca asked to have the story and a highlighter pen. She then went through the text and began to highlight individual words. This was not a random process as it turned out. She was systematically highlighting words which resonated with her; words which had special significance and meaning. On one page she highlighted the word "**Safe**" and wrote

"Big Key Word"

At the very end of the story she also wrote –

"Happily ever after
THE END"

That evening, Rebecca asked for the story to be read to her by her foster-father whilst being cuddled by her foster-mother. After listening to it, she asked if she could add "The girl will be getting permanence so she can stay with her foster-carers forever!"

Three nights later, after an absence of nine months, she returned to her own bedroom to sleep. She has not asked for the story again, but she has been able to return to her bedroom each night to sleep.

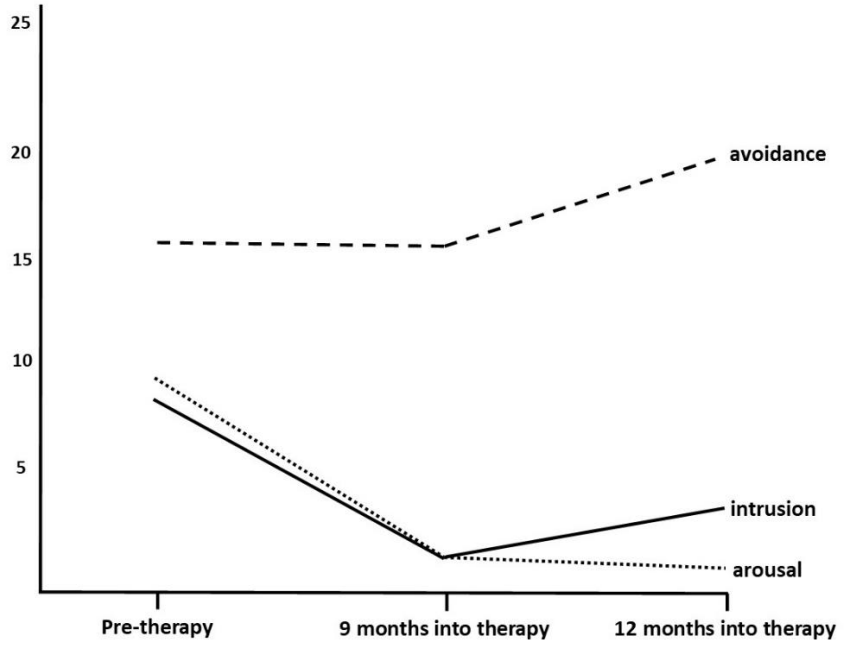
The therapy is ongoing although contact is less frequent. What has become evident during therapy, to date, is that Rebecca does not yet feel safe and secure enough to directly address her past trauma. There may be many reasons for this. With such complex cases, there is rarely a simple or straightforward answer. Feelings of shame, associated with experiences of abuse, can be a powerful barrier to disclosure. Rebecca might well be worried that, if she discloses further information about her abuse, her foster-carers will reject her and that she will be returned to the care of her mother.

At this stage in her life, it seems that Rebecca's priority is to do all she can to make sure that she can stay with her foster-carers for as long as she wants to. For her, achieving this may well be more important than dealing with her past, because, in her understanding, it will provide her with a sense of physical, emotional and psychological safety.

From a therapeutic perspective there is much more work to be done and EMDR therapy has the potential to help Rebecca to fully address past trauma. The therapy to date, including the use of the EMDR storytelling approach, has helped her to feel 'safer' but not safe.

The scores on the Children's Revised Impact of Events Scale (CRIES-13) (Smith, Perrin, Dyregrov, & Yule, 2003) seem to support this. Rebecca was very reluctant to complete any formal measures during therapy. However, she did complete the CRIES, pre-therapy and on two other occasions over a period of a year. The graph below summarises her scores over these three time periods.

CRIES-13 scores



As is clear from the CRIES scores over the three time periods the Avoidance score has changed little and actually increased after nine months. In contrast, the scores on Intrusion reduced over time as did the scores on Arousal. The authors of the CRIES-13 recommend that for screening purposes only the results of the Intrusion and Avoidance scales should be used. They also advise that if the sum of the scores on these two scales is 17 or more, then the probability is very high that that child will obtain a diagnosis of PTSD.

At this time, making a formal diagnosis is not a priority. Rebecca has made her priorities clear. Sadly, the fact is that there is a lengthy legal process to go through before any decision will be made about her future long-term care.

Millie: Adolescent with lack of confidence and confusion about adoption

Millie was a 17-year-old girl who lived with her adoptive parents and younger brother. She had recently left school and was attending college. Millie was emotionally younger than her chronological years and looked and dressed like a younger girl.

Her biological parents separated when she was a baby. Her mother suffered from severe depression and alcohol problems, and Millie was neglected and often left with unsuitable babysitters, whilst her mother was at the pub. Her mother had another baby son by a different man, and Millie grew up feeling responsible for both her mother and baby brother. She was taken into care with foster-carers at the age of seven and adopted at the age of nine.

Millie was referred to RL by a post-adoption Social Worker for psychological therapy, funded by a government sponsored Adoption Support Fund. She was struggling with her identity. Millie had recently become distressed in college and had cried a lot, saying that she wanted to know why she had been adopted and why she had to leave her birth mother behind. Millie was coming to the end of her first academic year in college and this coincided with her being over-emotional.

Millie was extremely withdrawn, hid her face, and spoke very little in the first session. Her parents hoped that therapy would enable Millie to become more independent, outgoing and confident. Millie herself hoped that the therapy would help her to get rid of "bad memories" regarding her early life. She was unable to describe her early traumas and was reluctant to speak to the therapist about anything.

Although Millie's cognitive abilities were in the normal range and she had no language problems, her intense shyness rendered it impossible to use the Standard Protocol. In addition, some of her trauma may have been implicit and pre-verbal, and her attachment-related complex trauma meant that she needed to understand the 'big picture' in terms of her life. For this reason, a decision was made to use the storytelling approach in working with Millie.

One session of preparation work was carried out, installing a 'safe place' (Shapiro, 2018) and resources related to her current 'go to' person (her adoptive mother) and a feeling of self-worth. She was

reluctant to use eye movements, perhaps because of the necessary proximity of the therapist, and opted for shoulder tapping. Being too large to sit on her mother's lap, she arranged to sit beside her mother whilst her mother reached over and tapped her on the shoulders.

The next meeting was with Millie's adoptive parents only, in order to construct the following story:

One day a little healthy baby girl was born in a hospital. She went home to live with her mum and dad who both loved her very much. She had a big sister too. She also had an aunty who lived close by and enjoyed being with the new baby. She also saw her grandmother and lots of cousins who all loved her very much. She had an older brother and sister, but they didn't live with her mum and dad anymore.

Sometimes her mum would feel very sad and she found that she would feel better if she drank alcohol. But she drank too much and fell out with the baby's dad who left the home. This made her mum drink even more. When she was drunk, she couldn't look after the baby properly and would forget to give her proper meals and would leave her in dirty clothes, which would make her smelly. She was only a baby, so she didn't understand what was going on. But she didn't feel safe and secure like a baby should, and it meant she was feeling scared most of the time. She thought, "I'm not safe".

After a while her mum found another man and they had a baby together, so now the girl had a little brother as well as her big sister. As she grew up to be a girl, she learned that her mum didn't know what was going on most of the time, because she was usually drunk. So the girl started to make sure that she and her brother and sister got what they needed, and she would even have to look after her mum, sometimes, too. She started to feel responsible for everyone in the family, and if things went wrong, she would think, "bad things are my fault".

When she started going to school, the teachers noticed that the little girl didn't know how to keep herself clean, and they were worried that her mum might not be looking after her properly. They tried really hard to help her mum, but she kept drinking too much and things did not get any better. Sometimes her mum would go to the pub and leave her with babysitters, who were also drinking and using drugs. The house was dirty and full of rubbish and there were no toys or books, or anything that children need to keep them happy and interested.

When the Social Workers saw all of this, they decided that the children weren't safe staying with their mother. So, one day, when the girl was seven, the Social Workers came to the girl's house when her mum was out. They took her and her little brother to live with a foster family where they would be safe and would have regular meals and stay clean. The little girl felt guilty about this, because she thought it was her job to look after her mum and her little brother. She felt like she had let her mum down, because she had grown up feeling responsible for everyone.

The girl enjoyed living with her foster carers who lived on a farm where there was a big playroom, cats and dogs and other children. She was meant to carry on meeting her mum, but her mum kept forgetting to come to the meetings and she only saw her once.

When she was nine, the Social Workers found a 'forever family' for the girl and her brother, and they went to live with their new parents who they called "mum and dad" straight away. The girl still felt she was not safe and she got lots of comfort from getting a hug from her new mum and dad. She liked to be praised by them. She started to feel some stability and routine in her life. She enjoyed having her own room, and she liked holidays with her mum and dad. She went to Rhodes, where they had a swimming pool, and she enjoyed camping in Wales. She enjoyed having her little brother with her, even though he could be annoying at times, just like all little brothers are. She also carried on seeing her big sister, who eventually had two children of her own, which meant that the girl was an aunty now!

The girl was safe now because she had a new mum and dad who could care for her and make sure she had everything she needed and could give her a cuddle whenever she wanted one. But she still didn't feel safe, and that old feeling was still there. Little by little, she began to realise that she was safe, and she could carry around that safe feeling inside her and wouldn't need to always go to her mum or dad to feel safe.

The girl also didn't need to worry about anyone else or feel responsible for them. But she still worried about her birth mother and felt guilty that she had left her when she was seven. After a while, she realised that it wasn't her decision to leave her mother – it was the Social Workers' decision. She also learned that she should never have felt responsible for her mother because adults are meant to look after children and children shouldn't have to look after adults. That's not their job. She realised that her birth mother had a lot of problems

of her own, but that the girl couldn't help her. It was up to other adults to help her mother if they could and not the girl, or any of her brothers or sisters. When she realised that, she felt happier and could start to believe, "I'm responsible for myself and no-one else."

Once she started to feel safe and not so responsible, the girl started to grow up very fast. She began to feel more confident and, like other teenagers, she didn't rely on her parents so much. She started to make friends and to go out on her own. Her mum and dad were always there for her when she needed them. They were like a 'safe base' she could go back to when she needed to discuss things that were worrying her. But most of the time she felt OK to enjoy life, go to college and be with her friends. She grew into a confident young woman, who got a job and eventually got married. Maybe she even had some children of her own.

At the next session the story was read to Millie by the therapist whilst her mother provided BLS. Millie became very upset during the first reading, holding her head in her hands. At the second reading, one paragraph at a time, Millie was able to describe the feelings evoked by the story and these feelings were processed. At the third reading she was less upset, gave the therapist more eye contact and appeared more 'present' in the room.

During the next session, Millie's mother informed the therapist that her daughter had said she felt happier after the last session, particularly mentioning her relief that she did not need to feel responsible anymore. The story was read again together with BLS in order to consolidate the progress already made. Her mother was still concerned with Millie's lack of confidence and Millie identified the NC that relates to this: "There's something wrong with me." A 'floatback' on this NC took Millie to a memory, aged seven, when she was removed from her mother's care by the Police. She also expressed anger with Social Services for having removed her from her mother's care at that time.

At the following session Millie was able to engage more with the therapy, to the extent that it was possible to utilise the Standard Protocol to process the memory identified at the previous session. She expressed anger towards the Police, and also towards her mother for being neglectful. The therapist helped 17-year-old Millie to speak to her younger 7-year-old self to help her understand why she needed to be taken into care. At the end of the session she was still producing a SUD rating of 5 even though she said she was no longer distressed by the memory.

At the next session the SUD rating had reduced, and a 'complete session' was achieved using the Standard Protocol. It was agreed that there was no need for any further processing. Her mother reported that Millie was generally calmer and no longer preoccupied by the past. There was some discussion as to whether any more therapeutic work could be used to help Millie to socialise more but, at this stage she was very reluctant to work on this. It was therefore agreed to finish therapy.

Subsequent contact with her Social Worker revealed that Millie had made a dramatic improvement during her therapy and had subsequently started to socialise much more.

Given that the Standard Protocol was subsequently utilised successfully, one needs to ask whether the storytelling approach was actually necessary in this case. It is unlikely that the Standard Protocol would have been initially effective, given Millie's lack of communication and acute shyness. In addition, it is likely that she would not have got the 'big picture' regarding her life, without the assistance of the storytelling approach.

Frequently asked questions

1. Q: Who should write the story?

A: Many therapists prefer to write the story themselves in collaboration with the parent/carer. However, with older children, there is more possibility of collaborating with the them. The therapist needs to be flexible when working with adolescents and the decision will depend on the situation and therapeutic relationship.

It is important that the story records what happened from the child's and not the parent/carer's point of view.

2. Q: How long should the story be? What language should be used?

A: The language content and length of the story should consider the child's age/developmental stage. It is helpful to use simple rather than complex phrases/sentences and to consider what vocabulary the child would use and be familiar with.

The therapist should always check the story with the parent/carer before the session where the story is read to the child in case, for example, it includes words that the child may not be familiar with.

3. Q: Should the therapist include all trauma targets in the story at the same time?

A: When a child has experienced a number of traumatic events, the therapist may judge that to include all the events in the story might overwhelm the child.

One way around this is for the story to have several chapters to help break it down into manageable bite-sized pieces. The first chapter may be a very brief overview of the story. Then the following chapters, if required, can target more specific areas, always using case conceptualisation to guide this. This will also depend on the child's age.

4 Q: Should I take SUD ratings?

A: Just as with the Standard Protocol it is very helpful to obtain SUD ratings before and after reading a story. With smaller children this can always be done using a child friendly and age appropriate visual rating scale.

Where several traumas are being covered within a single story it can be much harder to obtain individual SUD for the separate traumas. In such cases, an alternative is to use questionnaires in the assessment phase and post therapy when re-evaluating the storytelling approach. This may be a more effective way of assessing change and can include parent/carer evaluation.

5 Q: Who should read the atory?

A: With small children, the therapist will often read the story whilst the child is sitting on the adult's lap, facing the therapist. That way the therapist can closely monitor how the child is reacting and may decide if the story needs to be shortened in this session, stopped altogether, or if it should be repeated. If this option is chosen, it is important that preparation has been done with the parent/carer, so that they know how to cope or respond during the story. However, even some smaller children may prefer to sit on their own chair.

In most situations, the therapist reads the story the first time.

6 Q: When in the process of reading the story should the therapist use BLS?

A: BLS should be used whilst the story is being read to the child and should stop as soon as the end of the story has been reached. However, BLS should be omitted when the story is being read in sections in order to help the child to decide which parts of the story they may wish to change.

7 Q: Should we use eye movements (EMs) or alternatives?

A: As a general rule of thumb, children below the age of five do not find it easy to cross the midline and can find it hard to do EMs. For that reason, tapping is often used with younger children.

As described above, often it works best when the child sits on their parent/carer's lap and the parent/carer taps the child on their shoulders, hands or knees. In some instances, the child may prefer to do a butterfly hug.

It is also difficult for the therapist to read the story and do EMs at the same time. In addition, using headphones may conflict with hearing the story as both involve auditory input. So, if tapping is not used, the therapist may opt to use buzzers. Generally, it is suggested that the therapist checks with the child what they prefer.

8 Q: How many times should the therapist read the story in each session in total?

A: The answer will vary depending on the particular child. The therapist needs to monitor closely the child's reactions and tailor how often to read the story in the session.

It is important to always ask the child what they thought of the story and if there is anything they would like to change. Also ask the child whether they want to hear the story again. If they are happy with it, or if they have made changes, then ask them if they want to hear the new version.

9 Q: What if the child resists the telling of the story?

A: When a child is not yet ready to deal with the content of the story, they may be resistant to having the story read or refuse to listen once it has been started. The child may need more time and preparation. The child should be aware of the stop signal. It is important that they feel in control at all times.

10 Q: Should I video the storytelling sessions?

A: With carer and child's permission it may be appropriate to video sessions. Often, this can give the therapist a later opportunity to look closely at the child's responses.

11 Q: Should the story or any videos go home with the child?

A: Stories and videos may go home with the child once the therapist is confident that the trauma contained in it has been processed, and where the therapist is confident that the parent/carer will handle this appropriately. In this situation the story may be reinforced by the parent reading it to the child at home.

Final words

The EMDR storytelling procedure can be regarded as another important development in the use of storytelling as a therapeutic approach. In addition, individuals for whom the EMDR Standard Protocol is likely to be ineffective could be helped by use of the storytelling procedure. Such individuals will include very young children, those with early attachment trauma, those with learning disability and communication difficulties and those who are extremely withdrawn and have difficulty in communicating.

One criticism of the storytelling approach is that it loses an important aspect of the Standard Protocol, namely the 'free association' that occurs in EMDR therapy, enabling the client to go naturally where they need to go in terms of memories, cognitions and emotions. Although the client is invited to interact with the story, and to provide their own interpretations, and describe their own feelings in relation to the story, the storytelling approach is much more prescriptive and directive than the Standard Protocol. Something of the flexibility and adaptability of the Standard Protocol is therefore lost as a result.

Firstly, however, it is the authors' experience that children, especially young children, often spontaneously correct our errors if the story is not quite right! It can also be argued that, if the Standard Protocol is impossible to utilise for a particular client, then the storytelling approach will be the next best thing. In addition, some individuals are not able to come to adaptive resolution without a narrative to help them to understand and organise the traumatic experience and its sequelae, even if they were able to utilise the Standard Protocol to desensitise and reprocess specific aspects of the traumatic experience. In any event, if lack of flexibility has prevented an individual from being able to fully process their traumatic memories, SUD ratings can be used to identify where they have become 'stuck', and these 'hotspots' can be worked with using the Standard Protocol, as detailed earlier.

Whilst the storytelling approach is now widely used by EMDR therapists, particularly those who work with children, there has been very little published empirical research regarding the use of this procedure. Other than a few case studies (Mevissen et al., 2011; Mevissen et al., 2012; Rathore, 2018), there have been no

published randomised controlled trials (RCTs) regarding the EMDR storytelling procedure.

One important research question to answer is whether BLS is critical to the effectiveness of this approach. Given that other therapeutic storytelling approaches exist which do not utilise BLS, and it is known that storytelling can be inherently therapeutic, research needs to be carried out to compare storytelling with or without BLS. A further research question would be to establish which components are essential, for example, emotions, NCs, PCs, interweaves and so on.

Research also needs to be carried out on the value of participating in story writing and storytelling for parents. A parent, whose child has been traumatised, often feels guilty or helpless, reducing the effectiveness of their parenting. Also, in the Assessment Phase, many parents cannot formulate a true Positive Cognition for their child. For example, when asked what they would like their child to believe about themselves when they remember the accident, the parent many respond "I'd like him to not get so upset when we have to go in the car" instead of, "it's safe for him to relax in the car. He can trust that we do our best to keep him safe and if an accident happens, lots of people will help." It is possible that a parent's trauma of being unable to protect their child from a traumatic experience can be resolved by their participation in providing a narrative.

Anecdotal evidence from many EMDR therapists suggest that this approach is extremely effective and can produce often dramatic results. The authors therefore suggest that further research is carried out in order to provide empirical data to support this approach.

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