

The processing body - integrating
EMDR and Body Psychotherapy

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Abstract:

The paper presents a model for integrating EMDR with Body Psychotherapy principles and techniques. The model will be illustrated by clinical material from work with a patient who suffers from complex PTSD as a result of a recent traumatic event which evoked her early developmental trauma.

Based on a shared understanding of the body as the carrier of trauma and its symptoms, Body psychotherapy and EMDR offer different and complementary ways of utilising the body during the processing phase of the work. Drawing also on recent neuro-biological research, the paper will explore some of the similarities and differences of the two approaches. It also offers insight into the work of some of the leading experts in the field of Body Psychotherapy and their approaches to trauma work.

This paper introduces a model which was developed in the context of work with patients at the Maudsley Hospital in London and at the Oxford Stress and Trauma Centre. The model, as the title suggests, integrates EMDR and Body Psychotherapy. The theoretical exploration will be supported by clinical material, describing a significant phase of therapeutic work with a client who suffers from PTSD as a result of complex trauma.

A brief overview of Body Psychotherapy and its relevance to trauma work

Body Psychotherapy as a tradition reaches back to the 1930's and has been *the* pioneering psychological approach that has – from the beginning and throughout the eight decades of its development – proposed and applied an explicitly holistic bodymind meta-psychology. It is beyond the scope of this paper to give details of its complex theories and methodology, originating largely in the work of Reich (1934). Body Psychotherapy has always been rooted in a bodymind explication of those aspects of Freud's theories that were based on trauma as the core etiology of psychological disturbance, and has therefore a long-standing and sophisticated grasp of the bodymind phenomenology of trauma, especially of early and developmental trauma. A comprehensive developmental formulation of the traumatic origins of the whole spectrum of psychological pathology can be found in Johnson (1994), whose life work integrates traditional Reichian 'character structure' theory (Reich 1934) with a wide range of other developmental theories, including Kleinian, object relations, ego and self psychological perspectives.

Key aspects of Body Psychotherapy relevant to this paper are its theory of the functional identity of body and mind (now being confirmed by modern neuroscience, see Damasio 1996, 2004, Ledoux 1999), its notion of embodied defences (including splitting and dissociation), its concept of vegetative processes and impulses underlying affective and cognitive dynamics and – as I shall illustrate in some detail – its idea of the vaso-motoric cycle of expression (Reich 1983, Boyesen 1980) as an essential avenue for the working-through and resolution of traumatic memory.

Body-orientation during all eight phases of the EMDR protocol

This paper proposes that EMDR is an integrative *body*-based therapeutic method, which utilises the body in various ways in *all* eight phases of its protocol. In developing the EMDR protocol, Francine Shapiro (2002) recognised the body as an important holder of trauma memory and therefore as a main agent in the processing of traumatic memory. From its underlying assumption that the “emotions are indeed bodily events” (Mollon 2005 p.3) to the explicit use of bilateral stimulation, the client’s body plays a central role in the therapeutic process that EMDR aims to facilitate.

When the traumatised client first enters the room, her perception of the therapist is largely based on her “orienting reflex - the brain’s immediate reaction to a new sensory stimulus” (Dworkin 2005 p.14) and on the client’s ‘appraisal’ – a process by which specific areas of the brain “assign meaning to the new stimulus” (Dworkin *ibid*).

As the therapist works towards establishing the necessary safety of the therapeutic relationship that will allow the client to trust her through the more challenging phases of the process, the therapist mostly relies on “right-brain-to-right-brain communication”, as the neuropsychologist Allan Schore calls it (Schore, 2003 p.215). Similar to the attunement in the mother-infant bond, the sense of safety and containment in the therapeutic relationship is based on attunement and resonance (Dworkin *ibid*) between client and therapist, both accessed and felt as an emotional and visceral experience.

During the preparation phase, when the work is focused specifically toward creating ‘the safe place’, the therapist anchors the image that emerges in its ‘felt sense’: sensations, smell, sound, temperature, texture, and asks the client to notice where that sense of safety is felt in the body. Similar principles pertain during the resource installation procedure of the preparation phase.

During the assessment phase, establishing the SUDs (Subjective Units of Disturbance) is usually followed by the question: “Where do you feel it in your body?”

In the desensitisation phase the therapist uses the client's non-verbal signals, e.g. breathing, skin colour and energetic presence, to assess whether the client is working within their capacity to modulate arousal, also known as 'window of tolerance' (Ogden 2006 p.26). The installation phase is followed again by a body scan which aims to anchor the positive cognition in body sensations.

At the end of the session the therapist offers the client some relaxation exercises designed to reduce the level of arousal in the body and then tests the client's readiness to leave the session and the ability to return to performing functional daily tasks (like driving, working etc) by conducting another body scan.

In summary, implicit and explicit attention to the client's body constitutes a significant aspect of each of the eight phases of the EMDR protocol.

The therapist's own body

Moreover, it could be argued that in significant ways the EMDR therapist relies on the use of *her own body* to enable her to perceive, monitor and regulate the system of the therapeutic relationship. Latest neuroscientific research shows that, like the mother, the therapist functions as an "affect-regulatory object" (Schore 2001), helping the client to achieve states of auto-regulation through the inter-active regulation which her attuned presence provides. Inter-active regulation is a spontaneous, pre-reflexive phenomenon that occurs via mutual unconscious communication between the therapist's and the client's right-brain hemispheres. These unconscious processes involve the therapist's tone of voice, quality of eye contact, appropriate matching and modulating of facial expressions, and especially the moment-by-moment timing of responses and interventions. In their complex entirety, it is these subliminal processes which convey to the client that the therapist is 'with' them. Whilst these processes are conceptualised as mediated and organised by the right hemisphere, it is understood implicitly that all right-hemisphere functions rely on intricate interconnection with the body, indeed can only occur through a constant flow of information from the body (Damasio 2004). Interactive right-brain-to-right-brain regulation is only one of the many ways in which the therapist's body plays a

significant, containing role in the healing process, be it consciously or unconsciously.

It could also be argued that many therapists use the spontaneous reactions of their body when monitoring the client's arousal level during the desensitisation phase of the EMDR protocol. Although therapists are trained to ask the client *verbally* about their feelings and sensations during this phase, they still rely on their own perceptions to assess the validity of the client's report in response to the question. In order to attune to the client's state and to gauge whether the work can safely be continued or whether the client's system is too overwhelmed, therapists implicitly depend on their own physical sensations to inform their assessment.

If the therapist's body sends alarming signals of distress (for example: if she feels frozen, nauseous, dizzy or unable to breathe), the therapist might look carefully for equivalent physical signals from the client's body. It could be that the client is not currently in distress and that the therapist is experiencing some of her own un-processed material that has been activated and provoked by the client's trauma. On the other hand it is equally conceivable that the client's system is resorting to its habitual coping mechanism of numbing, cutting off or dissociating, so that the client is reporting feeling "just fine", but actually under the misleading lid of para-sympathetic 'calmness' his sympathetic nervous system is hyper-aroused.

The therapist's capacity to tune into *her own* body's involuntary responses is a prerequisite for her being able to also tune into the client's energetic state. As modern neuroscience has shown, a subliminal and automatic process of resonance occurs via mirror neurons (Gallese 2001) by which one person's internal state gets communicated and represented in another person's body. Many therapists are unaware of this subtle body-resonance, which has been proposed as the main cause of the condition known as 'compassion fatigue' (Figley 1995, 2002, Rothschild 2006). However, these subtle and spontaneous processes - mediated subliminally in the right brain - do not have to remain entirely unconscious. Whether or not a therapist can become aware of them, in themselves or others, depends largely on the degree of connection with their own body, their own subjective sense of embodiment. When attended to with awareness, pre-verbal and pre-reflexive

communication and attunement can become a robust foundation for an embodied working alliance in any therapeutic relationship.

So far, the role of the body has been discussed as relevant in traditional EMDR treatment. Whilst there are significant body-based aspects to EMDR theory and practice, this paper proposes that EMDR as an integrative approach, and specifically the EMDR protocol, has as yet remained uninfluenced by the large body of holistic therapeutic theory and practice available in the Body Psychotherapy tradition (Totton 2003). Specifically, it will address the ways in which Body Psychotherapy goes further in involving the body in the processing of traumatic experience and ‘body memory’ by working with the so-called ‘interrupted impulse’.

The rest of the paper will, therefore, address the possible integration of principles derived from Body Psychotherapy into EMDR practice. This integration is based on the author’s training in Body Psychotherapy in the 1990’s, her second training in Integrative Psychotherapy 10 years later, and her training as an EMDR practitioner in 2002 - 2004.

Case study

The initial session

The client came to therapy after a 5 years period of intrusive suicidal thoughts, severe headaches, nightmares, insomnia and uncontrollable outbursts of rage. The client had lost her eldest daughter Lucy in a car accident 6 years earlier when the child was 4 years old. She had a son who was now 8 years old, and a daughter from her ongoing second marriage, now 10 months old. Pale and looking anxious, the client told the therapist that she “felt nothing” when talking about her dead daughter and that she had not been able to cry or mourn her since the accident. With great shame and self-loathing the client revealed that she had tried to kill herself a few months after Lucy’s death and felt that she was a “horrible person” as that attempt meant abandoning her son, who was then only 2 years old. Her own father had died a year after the accident and since then her symptoms had intensified.

Being with the client in the room during the first assessment session was not an easy experience for the therapist. The therapist's body was tense and rigid - she felt frozen with fear and at the same time boiling with rage, it was hard for her to concentrate and think straight: her somatic countertransference was overwhelming, giving her a strong indication of the client's state. The therapist regulated herself by using her own sense of 'safe place' and resources. This initial reaction made more sense to the therapist as the work progressed and she learned more about the client's up-bringing.

The client's background

The youngest of seven siblings, the client grew up with an alcoholic abusive father who terrorised the family with his outbursts of anger and aggression. Although he never hit her, she witnessed him being physically abusive towards her brothers and her mother.

The client spent her childhood being petrified of her father's unpredictable behaviour, and used to run to her room and hide in bed whenever she heard him coming back home. Her mother was often away from home, working night shifts, leaving the younger children at the mercy of their father. The client was an anxious, shy child, who was not able to concentrate at school and felt, as she put it "stupid and different from other children". Hearing constantly from her father that she was "the apple of his eyes", "his youngest and sweetest daughter", she was confused by her conflicting emotions towards him and felt bad about her feelings of fear and rage. This confusion intensified after he inappropriately reached out and grabbed her one night when they were alone in the house. The client stopped him and he apologised, half-blaming her for his sexual attempt. The client was 8 years old at the time. She remembered hiding that night in her bed, numbing herself out by holding her breath as long as she could until "her head was full of fog". The client never told anybody about that incident, and although she felt angry with her mother for leaving her alone with her unreliable father, she blamed herself for what had happened. Unconsciously, she also blamed herself for her father's drinking and outbursts of aggression, thinking that if she was, in her words "a better daughter, a good pupil, a normal girl, he would not

be so angry”.

The client grew up, left school when she was 15 and since then had worked as an auxiliary nurse. She had a series of unsuccessful relationships until she married her first husband and gave birth to her daughter and later to her son. Although her husband was not supportive and was often absent and detached, she considered herself lucky to have a family of her own. She was, therefore, shocked to discover one day that he was having an affair with his secretary. “My whole world crashed”, the client said, “I didn’t know how to deal with it. I felt the fog was filling my head up again”.

The next day, as she fetched her daughter from nursery, she met a close friend on the way home and was telling her about the affair. Being overwhelmed by the shock of her sudden discovery, she did not notice that her little daughter was leaving her hand and the next thing she heard was the sound of a car breaking hard. When she looked behind her she saw the child lying on the road. She died instantly, as the car had hit her head.

Initial stages of the process

A description of all stages of the therapeutic process is beyond the scope of this paper, therefore the focus will be on a pivotal session that will serve to illustrate the integrative model. Suffice to say that the first 5 sessions were dedicated to working through the first 2 phases of the protocol and about 5 more sessions were spent processing the client’s early childhood memories. The client was able to feel and express some of her rage towards both her parents. Her perception of herself as responsible for her father’s attempted sexual advance had shifted after a successful use of cognitive interweave. However, her core belief that she is a bad person proved to be very resistant to any cognitive challenges. The author has written elsewhere (3) about the need of the abused child to cling on to her sense of badness because by becoming ‘bad’ she can keep the objects of her attachment ‘good’. It was, therefore, anticipated that the work with this central negative self-image would be an ongoing integral part of this client’s process.

However, the client’s symptoms had become less debilitating at this stage: she was sleeping better, had

less headaches, was able to cry sometimes when remembering her daughter, and generally looked more alive and present in the sessions. Her body was signalling that she had now more resources and was somewhat less numb, and the therapist perceived that the client was ready to begin processing the traumatic loss of her child.

A pivotal stage in the process

Session 11 was spent with client and therapist talking about the accident and identifying some of the possible targets that could be processed. In the next session (Session 12) the client appeared anxious and told the therapist that she had had a vivid dream just earlier that morning. That was rather unusual, as the client never remembered her dreams and had not brought any dreams to the sessions before. The therapist sensed that a new channel of unconscious communication had opened up and carefully listened for its message.

The client dreamt that she and her baby daughter, Ruth, (from her second marriage) were swimming at sea when suddenly a great storm broke and the waves grew higher and higher, sweeping her daughter away from her. As she was struggling to keep her head above the water she was screaming: "I want my baby, let me get to my baby!"

The client woke up in great distress, feeling nauseous and panicky. As she recalled the dream in the session, her heart was pounding and she felt agitated and tense. She noted that it was the first time since the accident that she had woken up after a nightmare and remembered the content of the dream, with the feelings provoked by it still present in her body. Usually she would wake up anxious and confused, and soon after would feel numb and suicidal.

The therapist asked the client to repeat the sentence: "I want my baby, let me get to my baby" a few times. For the first time in the course of therapy, the client was crying openly, feeling deep pain in her chest. Staying focused on the physical sensations enabled the client to get in touch with a memory that had not been available to her until then. The client saw herself standing in the mortuary, behind a glass wall, looking at her dead daughter lying on the table. That was shortly after they had arrived at the hospital and the child's body was

taken away. The client wanted to go and hold her daughter in her arms but was not allowed to do so. She was on her own, as her sister, who accompanied her to the hospital, was not able to bear the agony of looking at the dead child and chose to wait outside.

The therapist asked the client if she could recall how she felt at that difficult moment. The client said: “I did not feel anything, I was numb, I did not understand why Lucy was lying there and why I could not go and hold her. *I thought it was because I am such a bad mother* that they do not want me to go near her.”

That was an important moment in the process. It became clear how the dissociation had happened, how it was impossible for the client to take in the reality of her daughter’s sudden and shocking death. Moreover, the negative cognition of the present trauma echoed the early developmental trauma and its consequences: the pattern of self-blame, of feeling responsible for anything bad that happens to her or around her, the unbearable guilt, shame and helpless rage that turns against the self.

The client having decided to choose that highly charged image as the target, the next session (Session 13) began by implementing phase 3 of the protocol, the assessment phase. The target was the image of the client standing behind a glass window in the mortuary, looking at her daughter’s body, not being able to go and hold her in her arms. The negative cognition was: “I am a bad mother.” The positive cognition was: “I did the best I could.”

The VOC (Validity Of Cognition) was 2. The emotions were: confusion and fear. The SUDS (Subjective Units of Disturbance) were 7 and the body sensations were: emptiness in her belly, charge in her hands, slight trembling in the whole body and twitchiness in her right leg.

After a few sets of eye movements the client felt shaky and was twitching all over. Her thoughts were: “Oh, my poor baby”, and as processing continued the tension in her leg grew stronger, the client felt nauseous and developed a headache. The therapist invited the client to stand up and follow the movement in her leg. The client stood up hesitantly, but soon the strong charge in her right leg took over and she was kicking and

stamping. She reported feeling afraid and tense. The therapist encouraged her to follow the movements of kicking and stamping, saying to her: "Let your leg do what it wants to do, just follow the movement in your leg."

After some time, the movement subsided and Sarah felt weak and tired. She was not twitching anymore, nor did she feel sick or scared. She was saying: "I can not believe this is happening, I can not believe my baby is dead."

There were no feeling of sadness or fear, the SUDS were down to 3, and it was time to end the session with a guided imagery of the safe place. The therapist was aware that - although something significant had happened in that session - the processing phase had only just begun. Therefore, the therapist was not surprised when the client arrived back the following week (Session 14), looking pale and anxious. The client reported that she had had a difficult week, had felt agitated, suicidal and unable to sleep and had suffered strong headaches.

The therapist invited the client to process the same image again. This time the SUDS went up to 8. The therapist was not surprised, as she had a clear notion that an impulse had been triggered in the previous session that needed to be fully expressed.

As the processing began, the client felt nauseous, her breathing grew heavy and her head was slightly dizzy. These symptoms indicated that some charge was building up in her system. After two more sets of eye movements the client reported feeling very angry whilst seeing herself standing behind the glass wall at the mortuary. The therapist noticed that the client's right hand was forming a fist and encouraged her to experiment with some movements that might arise from that hand. Processing with eye movements was stopped at that point and the client was hesitantly moving her fist back and forth. Her breathing grew heavier and the movements became stronger and more defined. The client then said that she could clearly see the glass wall in front of her and that she felt very angry. She wanted to hit the wall with her fist and break it. The therapist encouraged the client to follow the impulse in her body and held a pillow in front of her. The client then lashed

out and hit the pillow, first with her fist and then with both hands, whilst screaming: “I want my baby! Let me go to my baby!”

As the movement grew stronger the client began to cry, tears of anger and frustration were running down her face as she was stamping her legs and demanding access to her dead child. The therapist held the client in her arms and the client cried and shook for some time. The client then felt the anger rising up again. The therapist invited the client at that point to process again with eye movements.

Right at the first set the client had an image of herself throwing a tantrum at the mortuary, kicking and screaming, this time all of her body was involved. As the image grew stronger, the therapist stopped the eye movements and invited the client to kick the sofa in the consulting room and to hit it with her fists. The client did not need the therapist to repeat her invitation twice, the movement was *already* expressing itself and the therapist’s words just enabled the client to express it openly and safely. The therapist watched with awe as this mother was fighting like a lioness to get to her wounded cub, surrendering at last to a basic, primal life instinct that had been buried and suppressed in her system for so many years. The therapist could feel the client’s power and strength, which had not been apparent until then. Together with the recognition of the client’s vitality, the therapist could feel arising in her own chest an enormous piercing pain of loss and grief - the pain the client would have to endure in days to come, the pain her system was not able to cope with without having first access to her power, to her life-affirming rage.

The client was now exhausted, and needed to rest. The therapist supported the client’s body as they sat together on the sofa, and the client said: “I did not know I was so angry. I am often angry with my husband, sometimes with my children, and always, always with myself. I did not know that when my daughter died I was so angry, I thought I could not feel a thing that day or ever since.”

The therapist said: “Perhaps it was not so safe for you to feel your anger that day, as you were on your own at the mortuary. Perhaps it was never safe for you to feel this kind of rage, as there was never a safe way to

express it, even before your daughter died, so it became a habit to keep it inside and take it out on your self.”

The client was quiet. The therapist could sense that she was taking in this new way of understanding herself. The client then said: “My father was always angry when he was drunk, I was scared of him all my life. I do not want to be an angry person, but I am very angry that my baby has died.”

It is beyond the scope of this paper to describe how the work with that important theme developed or indeed to describe the following stages of the process. Suffice to say that the client is still engaged in therapy, processing her early childhood traumas. The main aim of the therapeutic journey at this stage is to support and enable the client in building a strong enough container in her self that will tolerate the deep mourning for her dead daughter and, indeed, her own traumatised inner child.

Discussion

The following discussion will focus on the various methods that were used during the pivotal session as well as their underlying rationale, as a way towards understanding the integration of several approaches into a coherent model.

In session 13, via the use of EMDR as described above, the client got in touch with what in Body Psychotherapy is known as the ‘interrupted impulse’. One of the basic concepts in Body Psychotherapy is the ‘vaso-motoric cycle’. This is the cycle of stimulus – charge - discharge – equilibrium, with each stage involving organismic, emotional, imaginal and mental aspects of the psychological process. Every day of a person’s life can be conceptualised as comprising a multitude of cycles, initiated by responses to internal or external stimuli at every level of being - specifically at every level of the complex system which is the bodymind.

During a traumatic event, when the stimuli can be powerful enough to actually threaten survival, the charge that accumulates in the system is much higher than in response to day-to-day stimuli. This level of energy cannot be discharged as long as the amygdala (which is part of the limbic system) perceives the threat as ongoing and therefore continues to stimulate the Autonomic Nervous System (ANS) into reaction. As the ANS

responds by activating more physiological and biochemical mechanisms to deal with the perceived threat, the charge in the body intensifies beyond endurance. At this point, the process of dissociation kicks in, disconnecting the hyper-aroused energy from the person's awareness and thus preventing the dangerous 'fullness' of the experience in the moment.

So begins a self-perpetuating cycle in which the ANS is only able to recognise that the threat has passed when the accumulated energy is discharged, but no discharge can happen as long as the ANS is locked in this freezing response. The only way out of the cycle is to activate the Sympathetic Nervous System (SNS) impulse which is stuck in the fight-flight response, but has been blocked under the frozen 'lid' of the Parasympathetic Nervous System (PrNS). This is called the 'interrupted impulse'.

In its healthy form, this SNS impulse is usually spontaneous, arising in the body during the 'charge' phase of the cycle. It aims towards an expressive action in response to stimuli, so bringing about the completion of the cycle.

When, for any reason, expression of this impulse is stopped or interrupted, the cycle cannot move towards completion. The impulse, however, does not disappear, as the energy in the blocked cycle is constantly motivated towards completion. Rather, the interrupted impulse manifests in a range of usually unconscious somatic reactions, e.g. small movements or sounds, shifts in the breathing pattern or changes in the direction of the eyes. In Sarah's case it took the shape of her right hand forming a fist and the twitchiness she felt in her legs. If this interrupted impulse is not followed and encouraged towards full expression, the energy blocked within it usually creates somatic disturbances.

EMDR and Body Psychotherapy suggest different ways of conceptualising both the phenomenology and the techniques for processing the sensorimotor manifestations of trauma. It is specifically their contradictory and complementary therapeutic responses when confronted with an 'interrupted impulse', which provides a rationale for integrating EMDR and Body Psychotherapy (Heitzler 2009).

EMDR has been shown to effectively facilitate processing of traumatic memories and their transformation from an overwhelming highly charged 'here & now' experience towards a low-arousal past experience stored appropriately in the memory system. However, it can be argued that comprehensive treatment needs to facilitate completion of the cycle of expression and release all residues of the blocked action through a physical expression.

In his book "Waking the Tiger" Peter Levine (1997 p. 159) explains why discharging the extraordinary level of energy that has built up in the survivor is necessary. Levine developed a method of work called Somatic Experiencing, in which he invites the client to follow the interrupted impulse and to access the 'fight-flight' response blocked in their body.

Van der Kolk (2002 p. 62) similarly suggested that "performing actions that would have overcome one's sense of helplessness at the time of the experience that became traumatic, and expressing the sensations associated with the memory of trauma, effectively helps people overcome their traumas."

Pat Ogden (2006) has developed the Sensorimotor approach to trauma which aims to "address the incomplete defensive response, which, when completed, fosters a sense of mastery and 'triumph', that then facilitates the execution of more adaptive mental actions and the formation of autobiographical memory." She continues: "The physical actions that 'want to happen' are discovered through awareness of the body. These actions, when executed, mitigate feelings of helplessness and shame and give rise to moments of joy, confidence and satisfaction. ... The traumatic memory becomes associated with empowering actions and their corresponding emotions and cognitions."

This is very similar to the concept of 'positive cognition' and its installation in EMDR work, the only difference being that the positive cognition in this case is a positive *action*, arrived at *through* the body and carrying with it the power of the blocked, primal spontaneous impulse towards survival and healing.

In her recent article "The complex subjectivity of the body", Roz Carroll (2008) explores the role of

movements in psychological process and argues that “the motor system is the background to our ongoing sense of self in the world, organising fundamental aspects of our thinking, feeling, subjectivity.” She stresses that “deeply entrenched habits of being, relating and organising experience will persist until shifts in the motor organisation occur.”

In inviting the client to follow the movements and sounds that already spontaneously existed in her system, the therapist’s intention was to facilitate a completion of the interrupted cycle. Moreover, the therapist saw the movement arising in the client’s body as a necessary agent in the process of change: the repression of the client’s rage towards her abusive father and her absent mother was transformed into full expression of healthy aggression. A life-long pattern of passivity and self-harm was - at that moment - reorganised into an active, outgoing relational expression. It is in these moments of expression that the seeds of a new self-image are firmly planted and the client’s new experience of herself and her power were established.

As Van der Kolk (1996 p. 436.) puts it: “Talking about the trauma is rarely if ever enough; trauma survivors need to take *some action* that symbolises triumph over helplessness and despair.”

In integrating Body Psychotherapy with EMDR, the bilateral stimulation was partly used for the purpose of “pressing the accelerator pedal for the free-associative function” (Mollon 2005). When the client is re-experiencing the most highly charged moments of the trauma, the embodied experience of the interrupted impulse and its release through movement, voice and action allows an integrated, embodied and positive experience of completion and active triumph. That experience contributes to a healthier sense of self.

EMDR is then used again to install the positive image of the client in his power and to allow a full integration of the process to be restored in the brain.

Added to that, of course, is the relational aspect of the work, which, although not explored here explicitly, was an integral part of the process, and largely informed the therapist’s thinking and presence.

It takes more than one or two sessions to change a pattern established for many years. The client is now

bravely exploring new dimensions and possibilities of her inner and outer world and at times struggles with old demons. The therapist continues her work with the client, using this integrative model, feeling excited and privileged to be a witness to this life-enhancing process of a new Self emerging.

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