Dissociation of the Personality and the EMDR Treatment of Chronic Traumatization: Day 2

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EMDR International Association
Natick, MA, April 22, 2017

Round 1: Avoiding Overwhelm during EMDR Processing with CPTSD

- *"The risk inherent with the use of EMDR with chronically traumatized individuals is that it **often reactivates too much traumatic memory too quickly.**"* (THS, 2006, p. 327) [emphasis added]

Complex Posttraumatic & Dissociative Disorders

Includes many trauma-based disorders: Complex PTSD (CPTSD), DDNOS, DID, many anxiety disorders, most phobias, most somatization disorders, etc.

- Focus on CPTSD & DDNOS

Overwhelm during EMDR Processing with CPTSD & DDNOS

- "Overwhelm"/"over-accessing" - processing that is too intense for the client, exceeds "zone of tolerance"
- Accompanied by loss of dual focus of awareness:
  - "Vehement emotion"; processing stops.

- Overwhelm may:

- Re-traumatize
- Reinforce primary phobia of traumatic memories
- Disrupt the therapeutic relationship
- Induce fear of EMDR

What CPTSD characteristics call for what adaptations to standard EMDR?

- EMDR - original focus of PTSD; then applied to other disorders/problems; adaptations made for differences that made a difference! (e.g. phobias, recent trauma)

- What about CPTSD is different & is posing problems for EMDR clinicians?

- Compare clinical presentations & structures of: adult onset 'simple' PTSD with CPTSD.

PTSD: Presentation & Structure

Bi-phasic numbing, constriction, & avoidance, punctuated by repetitive intrusions, in chronic physiological hyperarousal

(Repetitive intrusions - Involuntary compulsive tendencies to repeat/re-exp. an aspect of trauma)

- Cognitive
- Affective
- Behavioral re-enactments
- Somatosensory/motor re-experiencing

Complex PTSD (CPTSD)

Repeated trauma, esp. childhood &/or interpersonal
- Clinical Presentation: **Classic PTSD** + the triad of:

1. **Dissociation**
2. **Somatization**
3. **Affect dysregulation**

*Four factors highly interrelated.
(Van der Kolk et al., 1996, DSM-IV multi-site CPTSD research)

Subsequent work has identified somatization & affect dysregulation as dissociative symptoms. (somatoform dissociative symptoms & intrusions of affect from trauma-derived dissociative parts)

Complex PTSD: Associated Features

1. *absence of ability to self-regulate*
2. *multiplicity of Sxs*
3. *heightened levels of distress*
4. *greater co-morbidity*
5. *distorted & delayed personality development*
6. loss of stimulus discrimination
7. inability to cognitively integrate experience
8. greater damage to the self-system

Highly traumatized individuals may suffer from various combinations of Sxs over time.

CPTSD Characteristics that Pose Problems for EMDR Clinicians

1. Many symptoms (typically w/co-morbidity) - *"When can I start using EMDR?" &*
2. Many potential targets to process -"*Where do I start?"*
3. Complexity - moving parts, that interact Gawande's (2009) "complex" situations.
4. **Compromised mental level** - involved in overwhelm *(Round 1)*
5. **Pervasive dissociation** *(Rounds 2,3,&4)*

"Mental Level" in CPTSD

- "Mental level" - how able an individual is to take in information, & respond adaptively. Mental level involves two factors:
- "Mental **energy"** - (includes physical energy)
- "Mental **efficiency"** - ability to use & focus available mental energy adaptively (THS, 2006)
- But: many survivors have low levels of both.
- Little mental energy - often exhausted, depressed &/or physically ill &
- Low mental efficiency - lowered ability to efficiently focus & use available mental energy.

Mental Efficiency & Trauma Work

- Mental efficiency includes integrative capacity, i.e., being able to reach a high enough mental level to integrate experiences, including in trauma processing.
- Many survivors have low levels of mental efficiency **regardless** of how much mental energy is available.
- Low mental efficiency can contribute to overwhelm, including "vehement emotion"

Mental Efficiency & Overwhelm

- *"Vehement emotions involve an excess of mental & physical energy, & insufficient mental efficiency to use these energies, leading to disorganized behaviors…*
- *different from intense emotions that may accompany & guide adaptive action (Janet, 1928b). Vehement emotions can emerge when our action systems are tested beyond our limits of functioning*." (THS, p. 188)
- Overwhelm during BLS processing - a form of vehement emotion
- With CPTSD & DDNOS, overwhelm usually → dissociation

Mental Level Can be Compromised in a Number of Ways

1. Repeated traumatization
2. Especially if onset during childhood
3. Neglect - development of few personal resources (e.g. tolerate affect, self-regulate, etc.)

- (In AIP terms - few adaptive networks to readily convert NCs →PCs & into which changed memories can be integrated.)

4. Few healthy restorative skills & habits to maintain whatever mental level has developed
5. Presence of activated dissociative parts
6. Operating a dissociative system - it's expensive!
7. Phobias of Structural Dissociation of Personality
8. Problems & demands of having CPTSD & secondary elabs.

What Stands in the Way of Standard Processing?

1. Many individuals enter treatment with **compromised** mental levels (i.e., integrative capacity).

2. Standard EMDR processing imposes **relatively high demands** on the integrative capacities of clients.

Overwhelm in EMDR Processing

- A client's ability to process disturbing memories, esp. using EMDR, is heavily dependent on their mental level or integrative capacity.

- But, the demands of standard processing may exceed the "integrative capacity" of the client (or part), leading to overwhelm (& in CPTSD or DDNOS to dissociation).

- Overwhelm is a risk when the demands of standard processing **exceed** the integrative capacities of the client (or the part), at that time.

Other Major Factor Leading to Overwhelm in EMDR Processing

Demands of processing

- Other major factor in overwhelm is the high level of demands made by standard processing EMDR protocol on the integrative capacities of clients.

- Standard processing imposes such high demands on client's integrative capacities for two reasons.

1. Associative nature of brain's information processing systems

Memory storage & EMDR's AIP model:

- Brain's information processing is associative in nature:

"…memories are stored in associative memory networks."

"…new experiences link into these networks."

"… [similar] new experiences are stored as memories in the dysfunctional network."

Storage of traumatic material - think of underground interconnected tree roots

2. Associative Nature of EMDR Processing

Standard EMDR processing = "associative processing"

- BLS set, "GWT", follows channels of associations.

- **Benefits** of standard processing:

A. pulls in different elements of a traumatic memory, so all are desensitized; (e.g., body)

B. "pulls up" un-recognized elements of target memory contributes to resolution

C. pulls in other memories associated w/target memory; useful, e.g. another bullying event, or not useful, e.g., feeder memory or affect bridging; expression of the underground tree root system.

- ("Mike" - "It brings in everything else.")

Desensitiz. & Cognitive Re-Structuring

Both necessary for full resolution of a tr. memory.

- Desensitization decreases level of disturbance &/or physiological activation in which other elements of the dysfunctionally stored memory are embedded.
  - necessary to be able to integrate the memory into adaptive networks. Also assists synthesis.)
- Cognitive Re-structuring - (NC→PC/RPC) occurs when SUD is very low (or ecol. valid);
  - dismantles distorted belief about the self (i.e. NC). If allowed to remain, NC acts as a dysfunctional template - influencing perceptions, emotions & behaviors.

Why give up all benefits of associative processing? … Only if we have to.

Overwhelm - when low mental efficiency meets high integrative demands of associative processing.

Standard EMDR challenges low integrative capacity:

1. **High emotional intensity** in processing - *"A major criterion for the suitability of clients for EMDR is their ability to deal with **the high levels of disturbance** potentially precipitated by the processing of dysfunctional information*." (Shapiro, 2001).

2. Second source of high demand - the **sheer number of other related memories** pulled in by associative processing. Integrative capacities of some clients - insufficient to process so many memories at once.

Adapting Procedures for CPTSD & DDs

- Avoid overwhelm by closing the gap between insufficient mental efficiency & the high demands of standard EMDR processing.

1. Raise client's mental level

2. Reduce the demands in processing with BLS to more closely match the client's (or part's) integrative efficiency at that time.

Preparation - Repeated requests for consent to proceed

Request consent before beginning, or changing, EMDR procedures & continue to do so at intervals during procedures.

- *"We decided that this week, we'd start processing that memory from 8 yo. Is that still okay with you (*or *with everyone) to go ahead with that today?*
- *"Is it okay to do a couple more sets?"*
- *"Would you please ask that 11 yo part, is it okay to do a couple more sets or does it feel it needs to stop now?"*

To Restore Dual Focus During Processing

- To restore shaky dual focus of awareness, ask questions about it.
  - *"And let me ask you, do you remember where you are now (or right now)?*
  - *"Do you still have one foot here with me now?"*
- Get a response & establish eye contact. Continue with questions & responses until dual focus restored.

Reducing Demands of BLS Processing to Match Client's Integrative Capacity

- To make fewer demands on client's integrative capacity, reduce the **intensity, speed**, &/or **range** of processing.

- Slow things down, give client more time, reduce intensity – protect client from too many memories too fast.

- Allows some processing to take place - task is more do-able.
- Beneficial spiral.

Adaptations that Lower Processing Demands to Match Integrative Capacity

Used in response to client's (or part's) mental level at that time.

A. BLS adaptations - easiest

B. "Restricted" or "focused" processing protocols - most powerful

C. Target choices to avoid overwhelm

D. Increased use of cognitive interweaves

E. Fractionating

A. BLS Adaptations- shorter & slower

- E.C. Hurley: # of EMS in a set "*most of [his] clients meet classification as CPTSD with dissociative exhibitions.*" "*Complex trauma requires flexibility….I have learned to adjust the BLS*" "*Being client-centered, [BLS] is based on the client's response; …I adjust my provision of BLS (number & speed) in accordance with the client's level of [dissociative responses].*" "*wide variation in what people can tolerate;*"
- He begins BLS at about 12-20 reps "*with slow/moderate speed & increase the reps & speed as the client demonstrates the ability to be present*." (online posting)

BLS Adaptations - Audio &/or Tappers

Less intense than EMs, gradual, gentle; less likely to provoke defensive resistance by parts;

1. Discuss rationale; obtain consent. Review "Stop" & "Keep Going" signals.
2. Client settings re speed & volume – W/CPTSD, usually moderate, [their current activation level]
3. No BLS during: Assessment, when checking in or obtaining ratings (e.g. SUDs, VoC)
4. Desensitization – 45-100 secs. each set; clients (& parts) differ in sensitivity to set length
5. Shorter sets for CIs, & installing positive material.

[6. With dissociative clients, avoid using only audio; include tappers]

B. Restricted Processing (RP) Adaptations

- Three protocols that restrict range of processing in similar ways: EMD, 4-Step EMDr, & R-TEP (Recent Traumatic Episode Protocol).
- All keep processing close to the target memory.
  - Don't "allow" processing to follow associative channels,
  - Repeatedly return client to target memory after BLS sets.
- RP reduces/prevents the "recruitment" of other memories that are similar-in-some-way to the target memory; isolates the target memory.
- Reduces the total "load" or amount of material the information processing system must process & integrate into adaptive networks, and slows it down.

Benefits of Restricted Processing (RP)

- Powerful way to reduce demands of processing to match the integrative capacities or mental levels of individuals with CPTSD or DDNOS.
- Reduces risk of overwhelm.
- Is more "do-able", better tolerated. (Think about eating a PBJ!)
- Facilitates NC→PC when several related memories feed into, and sustain, that NC (i.e., when an NC is trapped in an interlaced root system & cannot convert to a PC)

Underground Interconnected Tree Roots

Restricted Processing: Original EMD

- Eye Movement Desensitization (EMD) - Original processing protocol developed & tested by Francine Shapiro (1989) in the 1980s; before 1991 name change.
- Very restricted, narrow-focus processing protocol, designed to desensitize a single event or part of an event
- Re-introduced EMD in 2004 for crises, emergencies, ERs, combat, veterans, EMTs, firefighters.
- Important procedure - being re-introduced into basic Parts 1 & 2 EMDR trainings this year
- *[My thanks to Francine Shapiro, Deany Laliotis & the EMDR Institute & Trauma Recovery/HAP for providing me with their EMD materials in time to use them today.]*

Restricted Processing Protocols: EMD

Designed primarily for desensitization -

1. For symptom reduction of memory or intrusive part of memory while limiting spontaneous associations to earlier events.
2. For selected clients who can easily get emotionally overwhelmed & dysregulated & appear to be outside their window of tolerance
3 To be used in circumscribed situations to reduce arousal & increase client stability

- Can also be used for recent crisis &/or ongoing events

[Limitations: Usually does not obtain cognitive restructuring (i.e., NC →to PC), so template remains in the neural network….. May not clear disturbance from body.]

Restricted Processing Protocols: EMD

Differs from standard (associative) EMDR in 4 ways.

1. Does not allow pursuit of associative chains
2. Returns the client to the target after each set
3. Asks about the intrusive image & the NC, to obtain the SUDs level *after each BLS set*, &
4. Uses shorter BLS sets.

High level of intervention: strictly narrows range of associations; restores present day orientation by checking SUDs after sets.

EMD Procedure

[Follow along in your handout "EMD Worksheet" if you'd like.]

Usual Client History & Client Preparation (including Safe Calm Place),

- Identify memory or intrusive image [EMD Worksheet, p.1, under "Purpose"]
- Assessment of experience, as usual. [EMD Worksheet, pp.1-2]
- Desensitization - (EMS, tactile, or tones). Short sets e.g., 12-15 eye movements per set. [Desensitization begins on p. 2 of Worksheet.]

EMD Desensitization

EMD Desensitization: [Begin as usual]

1. *"I'd like you to bring up that picture, those negative words* (repeat NC), *& follow my fingers*." (12-15 repetitions or shorter…)
2. After each set: "Let it go. Take a deep breath." (Pause) "What are you noticing now?"
3. Return to Target [image & NC take a SUD]. *"When you bring up that picture of ___& those negative words, on a scale of 0 to 10, where 0 is no disturbance & 10 is the highest disturbance you can imagine, how disturbing does it feel to you now?"* [GWT]

EMD Desensitization - continued

4. Continue with additional (short) sets of BLS until the disturbance is as low as the client can go, or is ecologically valid under the current circumstances. [With EMD, often the SUD level will not go to zero.]

After each set, ask for feedback *["What are you noticing now?*"];

Return client to target image & NC to obtain client's SUD level now. Provide next set.

(Note: If other associations arise, use a containment strategy & return to target. Shorten subsequent sets.)

EMD Procedure - continued

5. Once the SUD has stopped decreasing, move to Installation. [as usual]

[Note: Do Not Do A Body Scan; instead go directly to Closure.]

- Closure
- Re-Evaluation

- (Wording for the above phases on pages 2-3 of EMD Worksheet)

Clinical Illustration of EMD: Very recent crisis

- Man came out of basement immediately after major tornado in Joplin, MO;
- Very disoriented (no landmarks left with which to orient himself) & high level of disturbance
- But he needs to be able to function in the aftermath of this event and his experience
- EMD used to desensitize the experience as much as possible at that time, so he can continue to function
- At a later date, he could seek treatment to fully desensitize & cognitively re-structure the sequelae of that event

Benefits of Restricted Processing

1. Desensitization by all RPs; Cognitive Restructuring by some
2. Increases stability by desensitizing a memory (or part of)
3. Reduces trauma burden, raising mental level.
4. Adds to the number of adaptive networks. (Doubled effect)
5. Provides experience that processing works; hope.
6. Begins decrease of phobia of SDP: traumatic memory
7. Contributes to benign spirals in treatment & person's life
8. Used earlier in treatment than associative processing
9. Bridge to later comprehensive EMDR processing
10. For "on-going", unavoidable traumatic events; help individuals meet those challenges less encumbered - E. Shapiro & B. Laub; Francine Shapiro avoid or reduce cumulative traumatization

Double Benefit of Clearing a Dysfunctional Memory - reduces negative networks while increasing adaptive networks

Second RP Protocol -"4-Step EMDr"

- moderately restricted, allows processing to follow most channels within target memory.
- restricts processing range - returns to memory after sets
- moderate length BLS sets;
- asks for SUD after each set, increases client's orientation to the present
- more nearly matches integrative capacities of CPTSD or DDNOS clients than associative processing;

4-Step EMDr RP: Benefits & Limitations

Benefits:

- Very similar to EMDR; adaptations only for Desensitization phase (& to finish Desensitization, if necessary in Re-Eval.)
- Keeps processing moving in forward direction
- Obtains both desensitization & cognitive restructuring of entire memory
- Avoids overwhelm
- *(Can follow along in your handout if you'd like.)*

Limitations:

- Clears smaller area of dysfunctionally-stored material around target memory
- Often means more targets need to be resolved to obtain the same results.
- No research on this protocol yet.

4-Step EMDr Procedure

- Begin as usual: Client History; Client Preparation; choose target; Assessment of memory (as usual)

- Desensitization: EMs, audio w/tactile BLS, or tapping, depending on client.

- Sets: intermediate in length, i.e., usually 15-25 EMS, moderate speed; audio & tappers, about 30-120 seconds, depends on client response to set length.
- (processing with an EP, shorter & slower sets, e.g., 12-20 EMs (20-80 seconds for audio/tappers), again depending on mental level of that part. Interventions are designed to keep the processing within the target memory. Associations within the target can be followed if no overwhelm develops.

4-Step EMDr - Desensitization

1. Provide moderately short BLS set (e.g., 15-25 EMS)
2. Ask what client is noticing/what has come up **now**.
3. Obtain client's SUD level **now**.
4. Return client to target & ask what they're noticing **now**. Say *"GWT"*

- Repeat 4-step sequence until SUD=0 (or ecol. valid).

- Processing with 4-Step EMDr over time→
  Target >

4-Step EMDr Desensitization, with *script*

1. Provide moderate length set of BLS,
2. Ask what client is noticing now/what has come up. *"Un-hunh, & what's coming up **now**?"* Or *"What are you noticing **now**?",* etc.
3. Obtain client's SUD level: *"On a scale of 0 to 10, how disturbing does it feel to you **now**?"*
4. Return client to target, ask what they're noticing now: *"Un-hunh, and please go back to that memory, & what do you notice **now**"*. *"GWT"*

- Repeat 4-step sequence until SUD=0 (or ecol. valid) for two BLS sets. Then do Installation of PC (as usual).

If Associations Occur during 4-Step EMDr

If processing associates **to** different memory, client becomes overwhelmed, or makes generalizing statements, shorten sets & remember to use all 4 steps of the sequence.

Examples of processing associating to a different memory

- Near drowning: "I don't like skiing either, too out of control." & "Another time I got shoved into a pool & couldn't touch the bottom there too."
- Assault & rapes: "I hate hospitals, like when I got my tonsils out." & "Every time I think they'll see me in the courtroom I panic."
- If problems continue, slow down, use very short sets, use dual focus of awareness, give client a breather, go to EMD.

4-Step EMDr Procedure - continued

- Once the SUD=0 (or ecol. valid) for two BLS sets, just proceed through the usual phases.
- Installation of PC (or RPC)
- Body Scan
- Closure
- Re-Evaluation - If SUD level not down to a zero (usually because it wasn't a 0 at the end of the previous session), resume with 4-Step EMDr.

Clin. Illust. - Moving from EMDR to EMDr

Near drowning in a river & rescue when 7 years old.

Client problems re standard processing:

1. avoided disturbance;
2. made generalizing statements, then overwhelmed;
3. associated to other incidents, not moving forward;
4. SUDs did not decrease to 0 (or ecol. validity), because other memories loaded in;
5. No NC→PC;
6. avoided realization.

- With consent, changed the processing to the 4-Step EMDr for the following week.

Clin. Illust. - Moving to 4-Step EMDr

- 4-Step EMDr processing: 1. shorter sets, 2. asked what came up, 3. checked SUD level **now**, 4. returned client to memory to see what came up **now**, & only then said "GWT"; repeated the sequence: Processing moved forward to experiences towards end of being rescued.

- "*I wanted him to put me down, not carry me like a baby*."
- "*I was so cold, shivering, & nobody noticed*."
- parents didn't ask what happened, no one talked with her about it,
- *"I didn't want to go back into the river."*

Clin. Illust., cont. - EMDR → EMDr

- She began to wonder why parents hadn't kept their eyes on her – *"They knew I couldn't swim."* [!]
- SUDs down to ecological validity (SUD=1)
- Processing moved to adaptive networks; held parents appropriately responsible for their non-protectiveness; [realization - difficult for her]
- Client's NC →RPC.

Usual Installation; Body Scan; Closure.

Following week & Re-Evaluation - memory still resolved (SUD=1, VoC=7, clear Body Scan)

Other Clinical Uses for 4-Step EMDr

1. "Merry-Go-Round" - circular dilemma
2. NC not changing
3. Wandering processing in which recruited memories don't link up with target memory
4. "Closing the deal" with obsessional, intellectual, &/or generalizing clients

Recent Traumatic Episode Protocol R-TEP

- Elan Shapiro (2009) & Brurit Laub (2010) - Used to desensitize & cognitively restructure several recent, related events that occurred over an interval of time;
- Based on F. Shapiro's EMD work & Recent Events Protocol, "… other specific procedures & additional measures for containment & safety." (E. Shapiro & B. Laub, 2015).
- Recent episodes are not yet consolidated, so stored as fragments. Need to process individual elements.

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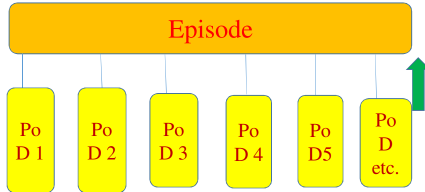
R-TEP Basic Structure

R-TEP begins with "Client Narrative" of the **episode**: client tells story of episode, from beginning "up to today"; continuous mod. to slow BLS-tapping or audio.

- No Assessment beforehand. Client Narrative may take more than 1 session. Close sessions with Safe Place. Accomplishes some desensitization
- When story has been told "up to today", client is asked to search the episode (w/continuous, slow BLS) & identify 1st piece of disturbance that comes up - usually a disturbing fragment (i.e., Point of Disturbance - PoD);
- R-TEP then processes that one fragment only.

Structure of R-TEP for an Episode

- (In R-TEP., traumatic fragments are called Points of Disturbance (PoDs).



R-TEP Processing with Each Fragment

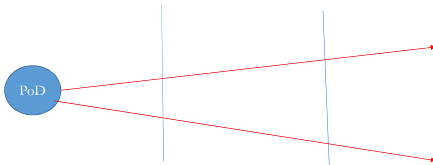
Usual Assessment. Desensitize fragment, using:

- EMD at first, i.e., allow associations only to the fragment. When EMD stalls, processing moves to
- EMDr - wider focus, associations to the episode. When EMDr stalls, processing moves to
- EMDR, assoc. processing, broad focus; PoD Desensitization: SUD may not go to 0; do Install. for PoD PC , Closure & Re- Eval., No Body Scan.
- Repeat for next identified PoD; same procedures for each until no more PoD found. Then R-TEP returns to episode level & processes episode as a whole using EMDR. Body Scan is now included.

R-TEP Processing Strategy: Expanding associations: EMD > EMDr > EMDR

- For each PoD: EMD > EMDr > EMDR:

EMD ……>	EMDr …>	EMDR
(narrow focus - assocs. to PoD)	(wider focus- (assocs. to episode)	(broad focus- assocs. to life)



Why R-TEP Is So Useful

- Client Narrative (w/continuous BLS) – desensitization: reduction in distress, chaos, & increase in coherence of memory; increased ability to observe; reduction in fear of memory [phobia of traumatic material - SDP]
- Successfully limits associative chains:
  - Restricts processing – fractionates episode;
  - Uses restricted processing initially with PoDs
- Structured protocol within which to resolve complex trauma in an organized & safe way

Caution!

- Restricted processing allows us to use some forms of EMDR processing with clients who can't use standard processing protocols &/or procedures, or to use processing earlier in treatment.
- But, they are not designed to be used instead of stabilization & Client Preparation procedures.

Round 2: Managing Dissociative "Vanishing Acts" during EMDR

- Understanding & managing **dissociative barriers** to therapeutic progress - crucial to success or failure of many trauma therapies.
- Dissociative "vanishing" of traumatic material - any phase of EMDR therapy, but especially processing
- Limited progress until existence of dissociative impediments identified
- Focus now - how to recognize & manage dissociative interferences in therapy, especially during processing

Pierre Janet

- Credited as 1st to write ~ connection of trauma to dissociative Sxs (aka "hysteria" in those times);
1st to write about ~ OCD, & bulimia;
1st formulated & wrote about "phase-oriented" treatment for trauma; coined terms the "subconscious" & "automatisms" for those behaviors that are so overlearned, we do them "automatically".

Dissociation - the 800 Pound Gorilla!

- Dissociation interferes with progress in all therapy approaches, esp. those treating trauma.
- EMDR approach: "*By far, the greatest number of reported difficulties and stories of clinical problems & potential harm through the improper use of EMDR have involved clients with dissociative disorders.*
- *On the other hand, trained clinicians report that the proper application of EMDR greatly accelerates & eases treatment of this population ….*" (Shapiro, 1995, p. 303; 2001, p. 308).

Dissociative Problems during EMDR Processing

Literature review found that dissociation caused EMDR more problems than any other clinical process (Gelinas, 2003).

What this can look like:

1. Looping – (Shapiro, 2001)
2. Treatment failures (Paulsen, 1995)
3. Penetration of dissociative barriers, w/flooding & destabilization (EMDR Dissociative Disorders Task Force, in Shapiro, 1995, 2001)
4. Abrupt exposure of undiagnosed dissociative parts (Paulsen, 1995; Shapiro, 2001)
5. Traumatic material (or elements of a memory) remains inaccessible to processing (Gelinas, 2003)

Problems Caused by Dissociation for EMDR- looks like processing fine, but:

6. SUDs does not decrease much, or goes back up between Desensitization & Re-Evaluation
7. NC does not shift to a more adaptive PC
8. Presence of persisting Blocking Beliefs
9. Autonomous parts explicitly block progress
10. Inability to establish the therapy [phobias of SDP]
11. Refusal of EMDR treatment altogether (Shapiro, 1995, 2001)
12. Avoidance of EMDR, after earlier good results
13. Inability to identify any disturbing memories
14. Unusual symptoms that do not resolve

Types of Dissociative Interference

- Positive dissociative symptoms - intrusions of **something that shouldn't be there**, i.e., intrusions of traumatic material, e.g., autonomous part intruding into ANP, or EMDR
- Negative dissociative symptoms - refers to **loss of something that should be there**; e.g., disturbance during processing with BLS; less noticeable, last longer than positive dissociative intrusions
- Phobias of Structural Dissociation of Personality - **fear & avoidance of own traumatic memories & internal experiencing**; maintain dissociation
- Especially likely in EMDR processing phases

Dissociation May Not Be Easily Identified

- Use of the term has been confusing

-Symptoms not immediately obvious, may be intentionally hidden, or be unknown to the ANP

- Change over time; "Protean" quality (J. Herman)

- Many EMDR clinicians are untrained in dissociative disorders; some may not believe that dissociative conditions exist.

- Omissions more difficult to spot than commissions.

- But, spotting them is easier in EMDR - standardized processing formats, baseline measures, criteria for a resolved target memory (i.e., SUD=0 or ecol. valid)

To Process Traumatic Material

Heart of processing traumatic material calls for the client to:

1. **Access** the traumatic memory, i.e., remember
2. **Contain & tolerate** the memory, i.e., engage with the memory, maintain a connection with it, be conscious of it
3. **Metabolize & integrate** the traumatic memory - noticing, thinking & feeling it (emotionally & physically); making connections (insight) about it; & integrating the newly processed, changed memory & insights into the rest of the memory system, sense of self, & life.

Essential Concept: Dissociation & Denial of Access to Traumatic Material

Dissociation powerfully disrupts processing because it **can deny or prevent access** to traumatic material.

- If some elements of a traumatic memory are made inaccessible by dissociation, they're not available to EMDR processing & so will remain in the memory system unchanged.
- For EMDR to process traumatic material, EMDR procedures need to have access to traumatic material.
- George Abbott: "**No Access = No Process**."

During EMDR, Avoid Triggering Dissociation Whenever Possible

- Use adaptations from Round 1 with individuals who tend to dissociate:
- Shorter & slower sets
- Adapt BLS modality
- Restricted processing protocols
- Also - inoculate client against dismay, unhappiness about beginning to feel, or know -

Working Directly with Dissociation

Fundamental Therapeutic Stance Re Dissociation

"I have no desire to try & take away your capacity to dissociate. There may be times when you will want to be able to use dissociation. My job is to help you bring your considerable abilities to dissociate under your conscious and voluntary control."

- Couldn't take it away if we wanted to.
- Can be useful at times, i.e. if invoked rather than afflicted
- Benefits: foundation for working with dissociation; eases client (& parts') fears, avoids control struggles, helps to enlist EP (& ANP) cooperation

Example - Using Therapeutic Stance re Dissociation in Sessions

- If client dissociates in sessions; we can ask: "*Is this under your conscious & voluntary control?"*
- If client responds "*No*". …Therapist can say - sounds like they're not in good control; we can help them regain it.
- If client responds "*Yes*": …Inquire about why they are doing that now, or at least allowing it to go on?
- **Awareness of immediate experience** is a central mediator of therapeutic change, that is, experiencing more, rather than learning facts (knowing more). Good idea to decrease ambient dissociation during sessions.

General Method to Manage Dissociative Impediments to Processing*

1. **Recognize** dissociation is happening.
2. **Stop** what we're trying to do, **turn** our attention to the dissociative symptom & **ask** about it.
3. **Intervene** to reduce or eliminate dissociat. interfer.

- Basically, clinician needs to notice something's going on that shouldn't be (or the reverse), turn to deal with it right away, ask about the problem, & intervene to manage underlying issue so the dissociative interference no longer impedes work.

"Vanishing Acts" during Processing

- During EMDR processing, negative dissociative interference frequently takes the form of either:
- "**buffering**"- attenuating client's experience of the memory (or some aspect of it, e.g., disturbance)

Or

- "**sequestration**" of some aspects of a traumatic memory by a rudimentary dissociative part

Method to Manage Dissociative Buffering during Processing

1. **Recognize** that buffering is happening
2. **Stop** what we're (unsuccessfully) doing, immediately **turn** our attention to dissociative buffering & **ask** about it.
3. **Intervene** further, to reduce or eliminate the dissociative buffering so the processing can continue.

Step 1: **Recognize** Dissociative Buffering

Markers: If client says: things are getting foggy, graying out, far away, they're seeing it (or therapist) through wrong end of a telescope, feel wrapped in cotton wool, don't feel any disturbance, don't feel anything, feel numb - probably dissociative buffering

Unusually for EMDR, we wouldn't say "Go With That"!

- We wouldn't just keep going - because processing isn't happening. Whatever is buffered by dissociation is no longer accessible to process.
- Instead, ask about whatever it is that we've noticed.

Step 2: **Stop, Turn & Ask** about Buffering

2. Stop what we're doing, immediately turn our attention to the buffering, & ask about it.

- "*From the wrong end of a telescope? And when did that start?*"
- "*Getting foggy? Would you please describe that a little bit for me?...Un hunh - & why do you think that's happening?*"
- *"Like wrapped in cotton-wool? What might you think about that?* Or

"What do you already know about why that might be happening?"

Step 3: **Intervene** Directly with Buffering

To return client from buffering & resume processing:

1. George Abbott's "Back Up" technique*
2. Ask what percent is client in the here-and-now with therapist. Work with "Conscious & Voluntary Control" stance regarding dissociation.
3. Ask client to re-ground or to come back. Restore eye contact (use gestures if necessary), & re-ground client.
4. Knipe's Back of the Head intervention

(To resume processing, use somewhat slower &/or shorter sets, or go to headset w/tappers if that would work better.)

* [in handout &/or downloadable]

Timing and Dissociative Buffering

When (how early in treatment, &/or EMDR) dissociative buffering occurs - gives us information. Can show up earlier than Desensitization.

- During **Assessment** of a memory: suggests more pervasive use of dissociation, & stronger phobias of SDP, poor affect tolerance, & lower mental level
- During **Client Preparation**: buffering during Safe Calm Place; probably not simple buffering; likely activation of autonomous dissociative part causing the buffering, because of 1 or more phobias of SDP

Sequestration of Memory Elements during Processing

- Sometimes an fairly rudimentary EP will hold, or hold off, some element of a traumatic memory.
- This makes it inaccessible to the EMDR processing.
- This type of interference can also be fairly subtle, so recognizing it is part of the challenge.

To Manage Dissociative **Sequestration** of Memory Elements in Processing

Same basic procedure

1. **Recognize** dissociative interference, e.g., EMDR not resolving memory in one way or another.
2. **Stop** what we're (unsuccessfully) doing, **turn** our attention to the interference, & **ask** about it.

   See if a dissociative part is involved. Begin work with a client's dissociation as soon becomes apparent
3. **Intervene** with the part to begin enlisting it in the treatment & manage its concern or objection so processing can resume & resolve the memory.

Step 1. Recognize Interference by Rudimentary Part during Processing

Sometimes EMDR processing is hindered by the activation of **a rudimentary EP** that is unknown to the client. At other times, client as ANP knows they have a part, but doesn't disclose this.

Markers to help recognize sequestering:

During processing, client is suddenly distracted or feels no disturbance; difficulty finding words; sudden numbness; looping; SUD is stuck; some elements of the memory don't change, e.g., SUD, or VI, or body sensation, etc.; NC doesn't convert to a PC

Step 2: Stop What We're Doing, Turn, & Ask About the (Stuck Processing)

Step 2: Stop what we're trying to do, **turn** to problem, & **as**k about the lack of change or movement.

Then ask about the possibility a part is involved, (using language client can tolerate).

"Can I ask - what is your understanding, or best guess, about why "X" doesn't seem to be changing/(is a little stuck)?"

*"Can I ask you, might you have some reservations (*or *concerns) about continuing to process this memory?"*

"Might you be of two minds about processing this memory?"

"Can I ask, might there be a part of you (of your mind) that's confused (or unhappy) right now about our processing this memory?"

Step 3: Intervene with the Rudimentary EP & Manage Its Objections

Once the involvement of a rudimentary part has been identified:

Step 3. **Intervene** with it to manage its concern or objection, so processing can resume & fully resolve the memory.

- Lightly identify the existence of dissociative part to the ANP (& to the EPs).
  - E.g., *"Un-huh, looks like there may be a little "split-off" aspect there that's somehow involved with this memory?"*

Step 3: Establish Communication with a Rudimentary EP Through Client as ANP

Establish communication among ANP, EP, & therapist: Usually - "through" the client as ANP

Ask ANP to please get into contact or connect up with the EP (e.g. *"that little aspect"* or *"that young part")*

- Then ask if (ANP) would convey questions from (therapist) to that part & its responses back

- Benefits: 1. EP may be very rudimentary, &/or developmentally too young, so difficult for it to "come out"; 2. increases co-consciousness between ANP & EP; 3. reduces the phobias of SDP that ANPs & EPs very frequently have about each other.

Scripts for Working with Rudimentary EP Thru ANP re its Concern

"Would you please ask that part of yourself what it's concern is about our processing that old memory?"

"Would you please ask that part of yourself why it's (still) there [at the site of the trauma]?

"Would you please ask that 6 yo why the pix is still the same?"

"Would you ask that part if it knows that it's part of you?

"Would you please ask that young part of yourself, how old it feels itself to be?" … Does it know how old you are?" "Yes." Uhunh, & how old does it think you are now?"…" Would you please tell it how old you are now?" (ANP does so.) *Oh!"*

"Would you please ask that 8 year old aspect of yourself if it knows that…how it feels about…if it might be concerned about..

Step 3: Intervene with Rudimentary EP & Manage Its Objections

Once EPs concerns or objections are identified, focus on those to resolve or soften them, so the EP allows EMDR procedures to now process those held-out elements. For example:

Does it know why we're doing EMDR?

Is it worried about something, that X isn't changing?

Is it fearful it will disappear?

Does it not know the event is over?

Is it afraid to lose an important attachment relationship?

Explore, name, ask about, address, etc.

Clin. Illustr. - Work with **unknown** EP Interference in Processing

- **Floatback** for "I'm out of control." Earliest memory: 4 yo, "*woke up from nap, called for mother who didn't come, walked around house, couldn't find her, woke up sister, "told her we were alone in house, didn't know what to do, panicked, both hysterical, she came in really angry*,";
- VI: standing at back door window - alone, trapped, didn't know what to do…..NC: Out of control. PC: Can get control. VoC= 1-2…..Affect: tense, anxious; SUDs = 7; Body: breathing shallow, shoulders tight almost tingling

Steps 1& 2: Recognizing & Asking

- Desensitization: distracted, thinking of other things; *"feel I'm not in control"*; associates to teen memory - not in control; mother reacted with anger there too. Client realizes her feelings were appropriate, mother always reacted to pt.'s feelings w/anger. End session *"Never occurred to me that my reaction was appropriate."*
- Re-Eval. "almost no disturbance"; SUDs = 2, trouble connecting with memory; I ask her to tell me about it – "*almost nothing – I can still see the little girl at the window; she's looking out the window*". [No change in VI. Why "she" re that image of herself?]
- Step 2. Could you ask her why she's still there? *She's waiting to see her mother come back*."

Step 3: Working with EP's Concern

- CI: Does she know its over? *"I know it's over."* [ANP speaks "for" EP; remind her to ask EP for its response & convey to me.] And would you ask **her**, does she know it's over? "*No. Says she has to be there to see when mother comes back."* [pretty stuck; I try again]
- Would you please ask her how old she is? *"Says she's 4."* Does she know she's a part of you? *"Knows she's going to grow up into me."* Does she know that incident is over & she can leave the window & come be with you? *"She's asking if mother is in the house; if yes, she's okay, doesn't want to be alone in house."*
- CI. Could you please tell her that that's a pretty normal feeling for a little kid?) *"Oh."* (reinforce w/short sets).

Step 3: Working with EP's Concern

- Now EP can hear mother came back, years ago; I ask if she'd like to stay there or be with ANP? Comes w/ANP.
- EP agrees to look through ANP's eyes & process old disturbance: SUDs=0, VoC=7, & clear BS. Goes to rest in a safe place; debrief with ANP: surprised at having a part. ANP has SUDs=0, VoC=7, clear BS.
- Re-Eval. (ANP first) - old memory is still resolved;
- I ask to check with EP; ANP says EP told she was tired of old memory & "wanted to stay with" ANP, so merged with ANP; is now integrated into the overall personality
- ANP remains skeptical about EMDR. [sigh…] She is however willing to do EMDR for next target in the target sequence for "I'm out of control."

Round 3: Managing Hijacking by Dissociative Parts during EMDR

- This is about intrusions!
- "Hijacking" - dissociative part disrupts or prevents therapeutic work
- Either openly or by internal influence
- These intrusions into the ANP (or other EPs) by autonomous parts are "positive" dissociative symptoms, i.e., the presence of something that shouldn't be there.
- Any of us ever been nervous about evoking a challenging dissociative part?!
- These situations can be managed.

Autonomous Dissociative Parts

- Autonomy ….degree to which a given part functions outside conscious control of the patient, experiences itself as more separate, & can act alone. … (paraphrased from Steele, Boon & Van der Hart, 2017, p. 206)

*"A particular dissociative part must always be understood in the context of the person as a whole ….it is a subsystem…. important to grasp the functions of a given part within the whole person. As Janet (1945) noted, dissociative parts represent certain non-realizations. (*Steele, B & VdH, p. 208)

*"**Core Concept**: The therapist must understand the reasons why the patient continues to have dissociative parts - that is, continues to have profound non-realization. These reasons are the targets of treatment & include the phobia of inner experience, & of traumatic memories."* (p. 207)

How to Work with Dissociative Parts
(Van der Hart slide)- borrowed here - important

- Think in terms of how a part fits into a whole system
- Think about why parts experience the need to remain separate: those reasons are entrees for therapeutic interventions
- Always try to include "all parts" in sessions
- Do not treat parts as people, but rather as aspects of one person
- Do not ignore parts and hope they will go away
- Accept the patient's experience of separateness without agreeing yourself
- Find ways to move past fascination and fear
- Always emphasize internal empathy, cooperation, and negotiation

Therapeutic Stance about Parts

- Therapeutic intention is not to eliminate (erase, empty, exile) any part - reassure it that we understand each part is important.
- They would block such attempts anyway.
- Parts have functions; doesn't make; their functions & concerns are foci for intervention.
- In fact, we want them to be part of the therapy; welcome their listening; want them to take in information & learn, catch up.

Therapeutic Stance - Accountability

- Conversations about parts & accountability: Every part is responsible for its actions, & the client holds overall responsibility for his/her actions.
- Safety first: suicidal (&/or internal homicidal) thoughts, risky behaviors, self-harming, violence - need to be shared with the therapist by EPs &/or ANPs as soon as they are able.
- Go directly to the parts responsible for these, (through ANP) to ask about it, explore, defuse if possible.

Techniques for Working with Intrusive Parts -1

- Establish communication as soon as a part is noticed, don't wait! Working with a part, even a little, confirms its existence.
- (Increase presentification; reduce EP isolation & rigidity)
- Establish a therapeutic alliance, recruit cooperation
- Allude to therapeutic expectations: we want parts to listen during sessions (a few exceptions), & begin to "catch up" with things
- Encourage EPs to take in info. from the present, to begin to change how they enact their jobs, help them develop, **in ways that are right for them**

Techniques for Working with Intrusive Parts -2

Help client as ANP & EPs gradually understand dissociation: language they can accept, explain what **their** dissociation looks like (i.e. identify their dissociative symptoms. Ask & talk with EP about what functions it feels it's performing & why.

- Stick close to their symptoms; don't get too theoretical. What is it we need to explain to them? What dissociative symptoms do they have?
- Usually work first with ANP(s), then with EP(s)
- Explain about some parts being a little stuck "back there" in trauma time.

Techniques for Working with Intrusive Parts - 3

- "Multi-laterality" - every part has some vested interest in the system. Recognize that, explicitly.
- Many parts listen in during sessions. So speak about, & to, all parts with respect; never disparage any part, even if we must disagree or set some limits with one or more parts.
- Avoid being pulled in to play favorites! Be even-handed, fair, respectful, & polite.
- Don't forget about some parts. Check in with all parts even if we have to focus on one or two parts for a while.

Protect the Therapeutic Relationship - 4

- Recovering from chronic traumatization can be done only within a benign therapeutic relationship.
- Need to attend to this relationship, with all parts!
- Not working with one center of consciousness but several
- Different parts are likely to have different issues, concerns, mental levels, & responses to us.
- Check in with all parts regularly, esp. if we think a part is upset with us.

Techniques for Working with Intrusive Parts -5

- Avoid ANP speaking "for" the EP, i.e., when an ANP tells us what they think the EP must be feeling, thinking etc.
- Ask "*Is that what that part is saying*?" Or "*Would you please ask that 8 yo aspect ___?"*

Benefits to working with EPs through the ANP:

1) increases co-consciousness between ANP & EP;
2) interacting directly with an EP (through ANP) begins to change it;
3) reduces EP isolation & some stuck-in-the-past aspects
4) gradually reduces the phobia (of SDP) each part has for the other

Method To Manage Intrusive Dissociative Parts during Processing

Yes! Same basic procedure, adapted for autonomous parts:

1. Recognize that a part is interfering with processing

2. Communicate with the part; ask who & why it's interfering. What is its **objection**? (It's identity may or may not be obvious.)

3. Begin work with the EP's **underlying concern**, to manage it well enough that therapeutic progress, including EMDR, can resume.

Step 1. Recognizing Interference by a Part during EMDR Phases

Obvious markers – a part emerges & blocks continued processing, e.g., "*It's against the rules*."; client's processing is "taken over" by another part; a part disrupts Safe/Calm Pl. or clamors to be heard

Subtle markers of internal influence - client is suddenly distracted; speech stops or client has difficulty finding words; thought withdrawal &/or thought-blocking; sudden numbness; looks stricken & is silent; long latency of speech; small body movements, e.g., shakes head, looks away, hands clenched; signs client is in pain……….Client suddenly stops talking, looks distracted: what would you do?

Recognition: Examples of Autonomous EP Interference in EMDR Phases

- Safe/Calm Place: e.g. *"something" wants it* (horrible tar-like substance) *to seep into the good place*;
- Safe/Calm Place, client's closed eyes flickered twice, couldn't do Safe Place; didn't volunteer but when I asked about eyelid flickering, she blithely said *"Oh, that's my little girl, she won't allow things like that!"*
- Assessment: DID client: *"It's against the rules to talk about this."*
- Desensitization: {see further slide}
- Installation: "*You don't know what he's done. He doesn't deserve it*."

Step 2 - Communicate with Part

Communicate with the interfering part. Ask who it is & what it's objection is.

"Who seems to object to your _______?
" Who's not happy about processing & is stopping it?"
"We've started to go round & round; who's involved with this?

"Might you have an objection about his doing EMDR for this old memory? What would that be?"

Step 3 - Begin Working with the EP's Underlying Concern

When the interfering part is identified, or identifies itself, ask what it is concerned about.

What's the underlying fear, concern, or phobia of SDP?

Intervene directly with the activated EP (thru ANP) about that concern. These often involve:

- Blocking Beliefs about itself or ANP;
- concerns about its continued existence
- its understanding of its role & reluctance or fear to give it up

Step 3: Intervene with the EP About Its Concern

"I'm wondering why that part is now involving itself in your processing. Would you please ask it?"

"Would you please ask him what he might be concerned about in our processing that memory?"

"She seems to be stopping your processing. Please ask her what her worry seems to be?"

Clin. Illust: Known but undisclosed EP

50+ yo man, Target – at 16 yo, finding his mother's body; she had taken her own life; persistent looping, with belching, eye rolls around the 17th pass in each set;. (I didn't know what was going on.)

- **Finally**, I stop what I'm doing & ask "Is there some part of you that has concerns about letting yourself feel what's coming up?" He smiles at me & says "*Well, we're not alone anymore!*" I ask about this. He has a 16 yo EP - known about, but didn't disclose.
- EP afraid to feel; BB: "can't handle it"; CIs about adult resources (vs. then), & EP processes to, SUDs→1 (ecol. validity), VoC=7, clear Body Scan.

Techniques for Working with Intrusive Parts - 6

- Consider setting up a meeting place e.g., Conference Room within which to work with parts;
- Based on George Fraser's (1991; 2003) original Dissociative Table Technique (DTT)
- Meeting place - outdoors or indoors; a place of safety
- Fraser - the DTT was not a therapy itself, but rather an adjunctive strategy … to assist the therapist in his or her preferred therapeutic approach

Working with Intrusive Parts - CR, cont.

Fraser's Dissociative Table Technique - designed to:

1. Allow clients to recognize [parts] of their personality
2. Provide a structure in which to help parts negotiate conflicts
3. Facilitate internal communication among parts, & esp. support therapist engaging parts in negotiations leading to eventual resolution of the dissociative fragmentation
4. Be useful in managing the various [parts] "which may actively take exclusive control or merely influence from within."

Working with Intrusive Parts - CR, cont.

Fraser - necessity of working with parts

Brand et al. (2016) - large prospective treatment study - Treatment of Patients with Dissociative Disorders (TOP DD)(2013) – found that when dissociative parts were included in treatment:

- "over 30 months, patients showed decreases in dissociative, posttraumatic, & depressive symptomatology, … decreases in hospitalizations, self-harm, drug use & physical pain. Clinicians reported that patient functioning increased significantly over time, as did their social, volunteer, & academic involvement." (2016, pp. 264-265)

Working with Intrusive Parts - CR, cont.

Clinicians have added other uses:

Mapping the internal structure; ….heightening co-consciousness….; obtaining informed consent from different parts for treatment interventions;…. finding & resolving resistances of some parts, e.g., "protector" parts; …. & providing a safe containing structure within which to use techniques for processing memories, e.g., EMDR* & guided synthesis & realization; stabilization*

Gradual name change from Dissociative Table Technique (DTT) to the Conference Room (CR).

Preparation for Use of Conference Room

- Establish CR after diagnostic work, including co-morbid conditions & initial stabilization, is completed
- Educate & prepare client about CR, after obtaining consent to do so
- Fraser's reminders still apply:
- Presume that most parts are listening in to sessions, even if no contact has been attempted by therapist;
- Work may be stressful for therapist: guard personal boundaries, don't become over-involved in the therapy & obtain consultation when stressed;
- Be familiar with phase-oriented treatment for trauma
- Reassure parts that their elimination is not intended
- CR works at deep level, so be scrupulous re principles!

Setting up the Conference Room

Ask client to **choose** a place that's safe, where they & parts of their personality can meet. Many like Conference Room; if not, can choose another place.

Ask them to **describe** it & include elements useful for them (ANP & EPs). Often image of a table with chairs is welcome; encourage oval shape.

Clarify the **intent** of the meeting place: a safe place where parts can speak & become acquainted with other parts & therapist, make their problems & needs known & have them addressed; ….negotiate disagreements with other parts & learn to work together in a way that's beneficial to all.

Conference Room Set Up, cont.

- I include 2 Safety Rules: 1. **No part can harm** another part (including ANP), themselves, or therapist; can disagree but not "go after", or harm anyone.
- 2. Near end of session & it's time for parts to "tuck (or "pack") back in" to ANP & leave the CR, I give them a chance to say or ask something before doing so, but then they need to tuck or pack back in to ANP & **leave the CR promptly.**
- Otherwise they, or the ANP, can be vulnerable to distraction, preoccupation, premature exposure to the world; also that hijacks this way of working, & if that happens, we won't be able to use it.
- No one can come to the Conference Room without agreeing to & abiding by these 2 essential Safety Rules.

Clin. Illustr. - Using CR for Stabilization

- Woman, 60s, anxiety→DDNOS

Clin. Illustr.- CR for Stabilization, cont.

Clin. Illustr. - CR for Stabilization, cont.

Clin. Illustr. - CR for Stabilization, cont.

Clin. Illustr. - CR for Stabilization, cont.

Clin. Illustr. - CR for Stabilization, cont.

Closing CR - with Inter-session Stability

Close & debrief - Abbott's "Con. Rm. Checklist" - to provide good inter-session stability by using sound containment at end of sessions.

- Before closing the CR: Acknowledge efforts made in the session's work, credit gains any parts have made, etc.
- Ask, "Is there anything to be stated or asked before all parts tuck back-in to the body, comfortably & securely?"
  - (If yes), "Is there anything else that needs to be stated or asked?... EPs tuck [or "pack"] back into body.
- Closure & Reorientation to the Therapy Office
  - Ask client as ANP to "please close the conference room now, (turn off the lights to save energy), lock the door & come back into the office with me. Let me know when you are back."

Closing CR - Method for Inter-session Stability

- Check for parts that have remained activated following Closure: Ask client, as ANP, to report on how they feel (something like a 'body scan').
- If there is any slight disturbance in sensation, emotion, or perception, inform the client that it appears that one or more parts have remained active, & that they will be vulnerable in the world if the patient leaves the office in this condition.
- Ask client (as ANP) to re-open the CR, turn on the lights, & search for the parts or parts that have remained active, & to let you know what they find.
- (When client reports discovering a part of personality anywhere in the CR) ask "What needs to be stated or asked before you can tuck back in to the body comfortably & securely?

Closing the CR Method for Inter-session Stability

- (Following response by the part, provide empathic response, [write down any response], then say "Thank you, please tuck back-in, comfortably & securely."
- Re-Closure & Reorientation to the therapy office
- Repeat the debriefing, check for parts that have remained activated following Closure: Ask client, as ANP, to report on how they feel (again, something like a 'body scan'). If any disturbance, again ask client to go back into CR, etc., until all parts are sufficiently tucked or packed back in that ANP feels no disturbance upon leaving the CR.

Step 1: Autonomous EP Interference with Client in Session- Clin. Illustr.

Steps 2 & 3: EP Interference with a Client

- Two sessions later, I ask if "that part" is still around. "*Yes*." It's hard to tell because I don't even know if it's been around for a long time or not. Can I ask, has it been around for a long time by now? "*Yes.*" Can you remember a time before it was around? "*No*." "So it's been around for over 30 yrs.!"
- Would you mind asking it - Has it had any help in doing its jobs, or has it had to do all that by itself? "*No help*."
- I express empathy for it, e.g.: "That's been a really long time, handling whatever it's had to handle, alone." No response. Would it be alright to ask it, does it remember what happened that made it necessary for it to start doing its jobs? "*Says remembers some of it*." Sounds like there was a lot back then. I'm sorry to hear that it's had to shoulder all that alone for such a long time. Would it let me help in some way? "*No one can help, that's why I'm here*." Oh, I see.

Step 3: Working with Autonomous Dissociative Parts

- Frequent, measured empathy, over time, [he] gradually softens & develops, e.g. allows himself to have a small fountain in his cell; allows primary ANP, 9 yo EP, & Little Ones to desensitize some old memories, as long as I recognize that he's not supposed to be doing this so he isn't really.
- A set of perpetrator imitating parts,[MMs], also responded to graded empathy - chairs in their back hallway; eventually agreed to have their own Safe Place, but far away (the Alps), in a cold stone cabin. After 2 yrs of interactions, they allowed themselves to come to their own adjunct to the Conference Room, where they could listen though not speak.
- Genuine, but graded empathy is essential with such EPs, & for working with the phobias of SDP.

Round 4: Overcoming the Phobias of Structural Dissociation of the Personality during EMDR Phases

- *"When my need exceeds my fear, I make progress."* ["K"]

"*The ANP takes mental flight from the traumatic memory & the associated EP because experiencing the memory is inherently aversive*." (THS, 2006, p. 198)

Phobias of Structural Dissociation of the Personality during EMDR Phases

- Phobias of SDP - comprehensive, pervasive & powerful set of dissociative impediments to all trauma treatments
- Especially for EMDR; ironically, because of the EMDR approach's strengths
- Can impede progress in any EMDR phase, & are especially likely to so during the processing phases.
- Can be expressed as either positive or negative dissociative processes, or both!
- Arguably the most important set of dissociative impediments.

Phobias of Structural Dissociation

Key for working with the CPT&DDs & the dissociation-based avoidance of feeling, knowing & processing.

- Phase I - phobias of:
  - A. Attachment/ attachment loss with the therapist
  - B. Trauma- mental contents – (inhibition of thoughts & of affect, thoughts, wishes, feelings, needs, fantasies, dissociative parts of the personality)
  - C. Dissociative parts – the EPs
- Phase II - phobia of:
  - Traumatic memories [especially disturbance/emotions] (In many ways, the core phobia of structural dissociation.)
- Phase III - phobia of:
  - Normal life (including change, risk-taking, intimacy)
- Phobias reinforce structural dissociation.

Phobias of SDP Appear in All Phases

- May appear anywhere in treatment, though certain phobias tend to be more frequent in certain phases.
- For example, the primary phobia of SDP (i.e., phobia of traumatic material) may become an issue in:
- Phase I - client repeatedly cancels sessions &/or drops out of treatment "for no reason"
- Phase II - client: procrastinates & avoids target selection; distracts to avoid doing Desensitization, despite earlier successful resolution of target memories, noticeable increase in mental level, & decrease in symptoms; jokes relentlessly to derail desensitization
- Phase III - clients fear & avoid change, moving into normal life, &/or giving up their dissociative way of life

Phobias of SDP Interfering with EMDR

- The phobias of SDP are frequently involved when traumatized individuals avoid seeking treatment, including or especially EMDR.
- For example, in a discussion of non-compliance re keeping a log between sessions, Shapiro (2001) observed:
- "*Ironically, except for the* ***client's refusal to engage in the treatment itself****, the log is the major source of noncompliance in EMDR treatment*, …." (p. 280). [my emphasis]

In Research

Kelly & Benbadis (2007) – intractable psychogenic non-epileptic seizures; hospital study; EMDR, cogn.- behave. & supportive TX:

- 14 patients initially expressed willingness to consider therapy, then
- 6 declined all psychological treatment,
- 2 stopped after the initial consultation, &
- 2 more discontinued Tx after two or three sessions. Of the 4 remaining pts.,
- 1 refused EMDR altogether.
- Of the 3 pts who did EMDR, 2 became seizure free after 6 & 7 sessions, & remained so for more than 12-18 months at follow-up. One continued with what the authors felt were dissociative seizures; had strong secondary gain issues.

Clin. Ex. - Multiple Phobias of SDP - "treatment resistant depression"

See presentation slide.

Working with Phobias of SDP

- Simply **knowing about** the existence of the phobias of SDP changes how we perceive situations & can respond in sessions or on the phone before first appointments, etc.
- Recognize that the client is experiencing one of the phobias & identify this gently to the client, in language they can tolerate, (e.g., perhaps wonder to the client if they are experiencing a concern about _______?).
- Contextualize some level of such concerns: "many people"
- Phobias of SDP rarely disappear quickly; instead they tend to decrease a little at a time, & not always in ways we might predict. (So, EPs may show decreased fear & avoidance of their traumatic material, with increased willingness to do EMDR processing, once they've seen other EPs successfully process their material, & survive as parts.)

Work with Phobias of SDP

- Clients generally do not spontaneously bring up their phobias – they don't want to talk about them.
- Clinical examples I discuss today reflect, some therapeutic progress - these clients had developed some ability to tolerate working with their phobias
- Once a phobia of SDP becomes conscious to the client, it begins to change as does the client's relationship to it. They (ANPs & EPs) are not quite as vulnerable to it.
- They may not be able to make it go away, but being conscious about them means clients don't get blindsided & confused by them; experience is becoming more understandable, & workable

Intervening with the Phobias of SDP

- Talk with whichever part(s) holds the phobia a little at a time about structural dissociation:
  - subsystems for physical survival, with examples from their experiences
  - different physiologies underlying EP(s) & ANP
  - phobias of SDP – what they are, using their own examples
- Context the phobia, so it makes sense: use Qs: "*Did you know that…?*"
- EMDR clinicians can use slow (audio & tactile) continuous BLS while talking about client's phobias (once client has done a Safe/Calming Place or analogue).
- Help client increase affect tolerance

Overcoming phobias of SDP: patience, & many small steps; avoid forcing the part to "dig in its heels" about their avoidances, but be gently persistent.

Method to Work with Phobias of SDP

1. **Recognize** that a phobia of SDP is operating
2. **Stop** what we're doing, **turn** to **ask** about the phobia; find out **what part** of the personality holds the phobia.
3. **Intervene directly** with that part's phobic concern.

   (Step 3 is comprised of a 3-step sequence - It's good to have a Plan B {& even a Plan C!}. See next slide.)

(This is an integrated method for working with the phobias of SDP because it uses BLS where & how appropriate.

However, please remember: **Any** form of BLS should be used only by clinicians with **formal training** in EMDR.)

Method for Phobias of SDP: Step 3 Sequence

Step 3: Hierarchy of direct interventions: Start with the simplest. Work with EP or ANP holding phobia.

A. Have client identify the fear/concern, **name it** & provide BLS for it. (It's like "naming Voldemort".)

B. Find the origins of the phobia, i.e., Touchstone, & provide 4-Step EMDr for Touchstone & see if that softens the phobia. If not:

C. Establish target sequence for the phobia using a Floatback; process the target sequence using usual sequence (first, worst, chronological); usually dismantles one line of experiences that created & has maintained a phobia of SDP.

Step 1: Recognizing that a phobia of SDP is Interfering in EMDR

Avoidance can be obvious or pretty subtle.

- **Right out there**: *"I don't want to work with what happened, I just want to know what did happen." "Well I got sick so you couldn't do processing!" "I hate that stuff. I've worked 30 years to avoid it."*
- **More subtle**: cancelled appointments; procrastination; complaints of illness or being very stressed, introduction of yet another crisis; disclosure of previously withheld important information; onset of "helplessness", joking, getting "lost" on the highway & missing the exit, etc.

Step 1: Recognizing Phobia of attachment & attach. loss w/therapist: Clin. Ill.; DID

- Autonomous parts block dialogue, prevent ANP from speaking. I throw up my hands, acknowledge I'm helpless too, & ask if anything **they** want to say; some responses to this, with looooong latency of speech. I don't know what they'd like to talk about, but I'm willing to listen.)
- *"They don't know how to talk, never have. It's their job – to be alone.* (How'd that happen?) *"IDK, it's the job, to make sure people don't get close enough to hurt me."* (I repeat a phrase.) *"Or not so close, that way I get warning. Like a big mean dog that might bite you, you stay away from it, you keep it 100 ft. away & you watch it, because if it's really close to you, you're bit before you know it. It's all about having a head start."* [Repetitive nightmares about this.] *I get away."* (Yes.)*"That's why I have to watch you so closely. I can't help it. It's about having a head start away from you."*

Step 1: Recognizing Phobia of Dissociative Parts

- 32 yo woman with DID - "*I hate them. It's humiliating to have them; they mean that some of that* [nightmares & memories] *must be true. They're stupid."*
- 68 yo woman with severe DDNOS - about an important EP that holds "The Insanity": *"I hate her & I used to beat the crap out of her internally whenever she showed up, but I'm learning I can't do that, because over time, she gets pissed off & stronger somehow, & if I drop my guard, she comes out & then there's hell to pay!"*

Step 1: Recognizing Phobia of Traumatic Material

- DID patient – triggered in her DBT group, during the Distress Tolerance module:
- "*the group started to talk about radical acceptance & about facing all the things you know are true but don't want to say are true, face what you don't want to have to, didn't want to walk out & have them feel bad, so started to dissociate, counted colors for about 15 minutes, til the break, then I hid in another room*"

Step 2

Step 2. **Stop, turn** to the phobic behavior, & **ask** about it, including what part of the personality holds the phobia.

Inquire about who's holding that concern or objection, or who has the most concerns about _____?

What might they be concerned about if they processed (or felt their feelings, or remembered more about that memory, etc.)?

Step 3: Intervene with the Phobia

Step 3, think of "KISS" - "Keep It Simple Sam". Do simplest intervention first; step up to next level of intervention if needed, after obtaining consent **for each step**. If intervention successfully overcomes the phobia, go to the work that the phobia had avoided.

If not, ask for consent to go to the next step.

Intervention sequence: **3A** - Provide some BLS sets for phobia; **3B** - Find Touchstone that established phobia & reprocess it using a formal protocol; **3C -** use a Floatback to establish target sequence, & reprocess in usual order: first, worst, and chronological.

Clin. Illustr: Work with Phobia of Emotions in EMDR: Steps 1, 2, & 3A

Step 1. Recognize phobia : **no** affect during EMDR

Step 2. Stop, ask who holds the phobia & what the concern is: having emotions - 16 yo ANP

Step 3. Client names phobia: "If I start to cry, I'll never stop."

This is a Blocking Belief - **a common form of phobia of SDP**.

3A. Provide BLS to dismantle or soften phobia of emotions

"As you look at that fear - if you started to cry you might never stop, what would that look like?" *"I don't know."* Would you ask that part of yourself that question & follow my fingers?

I'd really cry & my nose'd run; nose runs when I cry; I hate crying; crying is stupid; crying makes me really tired; crying is for babies; if I started to cry I'd get over it all right; if I cried, I'd get tired & fall asleep; no one can keep crying, that's stupid; I wouldn't keep crying; I can stop it you know….

Working with Phobia of Traumatic Memories

Steps 1, 2, & 3 A,B: 55 you man, treatment for work failures

Step 1. Recognize a phobia. Client's <u>agitated</u> about EMDR.

Step 2. Stop, ask about who & central concern. "*I just don't want to.* Q *When I think about it, I feel like I used to." (*Phobia held by EP with vehement emotion). "Do you have concerns about what could happen if we worked with those experiences?" "*If I open all that up, I'll be back at square one."*

<u>Step 3</u>. Client agrees to BLS sets for current fear [<u>not</u> work situation] Not useful, we go to next step. **3B**: find origins of the phobia - Touchstone. "You're concerned that if you work with that stuff, all the work you've put in to your life will go down the drain? And where did you learn that?" "*The last time I was in therapy*," [!] Reprocessed Touchstone. Phobia of processing & the dangers of working with adverse experiences resolved enough; we used EMDR for his presenting problem.

Finding & Desensitizing Touchstone of a Phobia of Feelings: **Steps 1, 2,3ABC**

- 26 yo man, out of college, life stalled 3 yrs. Refuses EMDR. He names the fear associated with this refusal - "having feelings is dangerous; you can get hurt"; young EP. **Step 3A**: BLS sets don't help, so I go to next step - find the Touchstone.
- **3B**:"You're concerned that feeling your feelings during EMDR, could be dangerous. *"Oh yeah!"* What taught you that? "*Are you kidding?! In my family you never talked about your feelings."* Q "*Because if you did, they'd know you'd had a feeling & go after you for it."* "And what taught you you'd better not <u>have</u> feelings*?" "Oh, uh, well, we lived on a busy road. One day a dog got hit by a car; it was really hurt & I started to cry. My father saw me & said "What are you crying about, I'll give you something to cry about." & beat the crap out of me*." "Oh, how old were you?", "8". **3C** Reprocessed Touchstone & target sequence. His phobia resolved & then we successfully used EMDR for college & life targets.

"Conservation of (Structural) Dissociation"

- 58 yo woman: DID; ADD
- See presentation slides.

Conservation of (Structural) Dissociation

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