Treating dissociative disorders with EMDR Therapy

Confidentiality of Videos

- Videos cannot be video or audio recorded.
- The videos are distorted. If a participant happens to know a client, it is important to remember that the information is confidential and cannot be discussed. You may consider refraining from watching the video if you were to recognize the person.
- Client information is confidential, and must not be discussed outside of this workshop or in any media, not even in professional forums. In the case of wanting to discuss what has been learned, any relevant clinical information that may identify the client should be omitted.

Based on the book

- An extended AIP model
- High order mental functions
- Self care patterns
- Dissociative language
- Co-consciousness and integration
- Dissociative phobias
- Blockages
- Defenses and motivation
- Trauma processing
- Relational issues
- The meeting place procedure

With the collaboration of Andrew M. Leeds, Jim Knipe, Roger Solomon, Natalia Seijo, Sandra Boix & Janina Fisher
Treating dissociative disorders with EMDR Therapy

Main aspects

- A progressive approach to traumatic issues
- Self-care work
- Working from the Adult Self
- Processing phobias
- Meeting place procedure
- Working with blockages
- The Tip of the Finger Strategy

In the progressive approach:

EMDR is seen as a psychotherapeutic approach, not just a technique for trauma work

EMDR is an integrative therapy; other models for complex trauma, dissociation and personality disorders may help us in case conceptualization

Phase-Oriented Model

- Symptom reduction and stabilization
- Treatment of traumatic memories
- Personality integration and rehabilitation

Amersfoort 2017
As Shapiro states (Luber & Shapiro, 2009):

- “When we are dealing with the most debilitated patients, it is most important for us to incorporate the wisdom of other fields. The more we learn from other disciplines, the more efficient and effective we can become. In order for EMDR to be used as a psychotherapeutic approach applicable to the full range of psychopathologic situations, its theoretical model needs to integrate developmental neuropsychology with the effect of cumulative traumatic experiences”
A spiral
(Courtois, 1996)

- Early phases of treatment will be revisited periodically as learning experiences in more advanced phases allow deeper work regarding previous issues.

To work with this kind of complexity we need two relevant resources:

1. The AIP model: our GPS

Amersfoort 2017
2. The Standard Protocol: The trunk of the tree

In Francine Shapiro’s words:

- “It is better to provide practitioners with a conceptual framework or model to serve as a guide to their clinical practice than merely to give them an inflexible step-by-step procedure for implementing EMDR”


From the all/nothing perspective to the Progressive Approach
Treating dissociative disorders with EMDR Therapy

The all/nothing perspective

- Trauma processing is understood as a discrete intervention that happens in a specific session.
- Bilateral stimulation (BLS) is only used to install positive elements.
- The use of BLS for "desensitization" or "reprocessing" is used only on traumatic memories.

Side effects of the all/nothing perspective

- Excessively delay of trauma processing (the client is never stable enough to meet criteria for it).
- To start processing a traumatic memory (even a recent event) may be overwhelming for the client.

Side effects of the all/nothing perspective

- The main problems with the "all/nothing" perspective:
  1. EMDR is underused, applying it only in highly functioning clients, or after many years of other therapeutic interventions.
  2. Retraumatization when clients lack Adaptive Information or resources to regulate after the sessions.
The Progressive Approach

- Processing of dysfunctional elements is introduced from the very early stages of therapy.
- BLS is dynamically applied, using procedures characterized by a gradual approach to the traumatic contents.

The AIP model in severe traumatization

The AIP model – when things flow naturally

- One of the basic principles of EMDR therapy is helping the patient to reproduce natural adaptive information processing which has become blocked or impaired as a consequence of adverse and traumatic life experiences (Shapiro, 2001, p. 32).
- When reprocessing a memory for a single traumatic experience in a person with a reasonably healthy previous life history, dysfunctionally stored information will generally link spontaneously with adaptive information contained in other memory networks.
- This is what we expect with standard EMDR procedures, but this natural process of spontaneous adaptive linking can be severely impaired in dissociative disorders.
The AIP model – when things get stuck

- The linking with adaptive information might not happen spontaneously because defensive barriers between dissociative parts can be strong, the capacity for dual attention is limited, or there is a lack of adaptive information.
- One of the key aspects we must be aware of is the need to establish means of communicating with these emotional parts of the personality.
- Without specific interventions to establish communication, we will not have access to all the DSI and we (therapist and client) are likely to encounter many difficulties during and after reprocessing.

The AIP model in severe traumatization

- The AIP model is extending to explain issues related to the effects of chronic, early neglect and traumatization (Gonzalez, Mosquera, Leeds, Knipe & Solomon, 2012).
- Case conceptualization in complex trauma:
  - It is very useful to incorporate elements from the Theory of Structural Dissociation of the Personality (Van der Hart, Steele & Nijenhuis, 2006; Van der Hart, Groenendijk, Gonzalez, Mosquera & Solomon, 2013) and from the Attachment Theory (Bowlby, 1973, 1980; Main, 1996, 1999)

The AIP model in complex traumatization

DSI is more than memories

- The familiar term “dysfunctionally stored memories” will be used in this presentation to refer specifically to the memory of traumatic (exteroceptive) events (including implicit and explicit elements).
- A broader term, “dysfunctionally stored information” will be used to include both autobiographical memories as well as those dysfunctional elements that are generated in the client’s intrapsychic experience.
- A number of EMDR protocols already implicitly address DSI in a larger context other than the autobiographical memories of traditional EMDR “targets”. Examples include work on:
  - Defenses
  - Affect tolerance
  - Dissociative phobias
  - Dysfunctional positive affect
DSI

- Exteroceptively generated DSI (E-DSI). Dysfunctionally stored information resulting from an exteroceptive (environmental) element (a traumatic event).

- Interoceptively generated DSI (I-DSI). Inner experiences that provoke intense and unbearable emotional activation and block the functioning of the AIP system: for example, the interaction among the different parts of the personality.

Structural Dissociation of the Personality

Van der Hart, Nijenhuis, & Steele, 2006

A definition of Personality

- Inspired by Allport (1931) and Janet (1907), Van der Hart, Nijenhuis, and Steele (2006) define personality as:
  - The dynamic organization of those biopsychosocial systems within the individual that determine his or her characteristic mental and behavioral actions.
  - The concept of healthy personality includes the idea of integration and in that integration neurobiological, psychological, and social elements are related in a coherent, flexible, and adaptive way.
  - Pathology is defined by the lack of integration between these subsystems, which can operate erratically, be unmodulated, or in internal conflict. The various reactions and emotional states of complex trauma clients, relate to this situation.
Structural Dissociation of the Personality

- The term dissociative disorder is related to a **diagnostic label** that is characterized by different symptomatic presentations.
- Structural dissociation of the personality describes a **mechanism** by which trauma generates psychopathology.

Defense and daily life

- Daily life activities are incompatible with defense.
  - An animal is eating, and suddenly hears a noise. His feeding behavior stops, the alert system is activated, and the animal is now focused on identifying a potential threat. After the noise is identified and labeled as harmless, the alert disappears, and the animal keeps eating its food.
  - When a traumatizing event occurs, the action system of defense is strongly and recurrently activated, and the personality reorganizes itself in alternating and competing subsystems (Myers, 1940).

Defense and daily life

<table>
<thead>
<tr>
<th>Emotional Part: fixated in traumatic memories and defensive action systems</th>
<th>Apparently Normal Part: focused in daily life and trauma avoidance</th>
</tr>
</thead>
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Avoidance of trauma

Defensive action systems are the foundation of EPs
- Fight
- Flight
- Freeze
- Submit
- Attach

Dissociative Phobias
Dissociative Phobias

- The term “phobia” is frequently used just in anxiety disorders and is understood as directly related with external elements (animals, social situations, etc.).
- Janet (1904) described phobic reactions directed toward internal experiences such as thoughts, feelings, fantasies, etc.
- Chronically traumatized individuals are often extraordinarily fearful of internal mental contents as well external cues which trigger traumatic experiences (Steele, Van der Hart, and Nijenhuis, 2005).

The maintenance of dissociation

- Dissociation and lack of integration start during early traumatizing events
- But is predominantly maintained by a series of phobias that characterize trauma survivors and by a lack of social support (Van der Hart, Nijenhuis, & Steele, 2006)

Dissociative Phobias

- The core dissociative phobia is the phobia of traumatic memories (Janet, 1904).
- But there are other phobias that can interfere in different Phases of EMDR Therapy.
Dissociative Phobias

The concept of dissociative phobias is very relevant in EMDR therapy. If we try to re-process core trauma, without realizing the presence of these "protective layers", we will probably encounter diverse problems. These layers should be carefully removed (and eventually reprocessed) in a step by step procedure, approaching the extreme pain that the patient is feeling in a gradual, safe and careful way.

In the progressive approach

- In early stages the therapeutic relationship is the most challenging issue, because relationships in general are extremely difficult for people who grew up in severely traumatizing and neglecting environments.
- The phobias to attachment are manifested in many ways but in therapy they will be mainly focused in the figure of the therapist.

In the progressive approach

- The client may be phobic toward many necessary procedures in psychotherapy
- They may avoid thinking, feeling, noticing their bodies
- This is related to the phobia of trauma-derived mental actions and it is usually more evident in early stages of therapy.
In the progressive approach

- When we approach the internal system of parts, some degree of conflict between these parts is often present.

EMDR

Why are those concepts relevant for EMDR therapy?

A standard (?) EMDR session

- The client says: “I need to work with trauma, I can’t stand feeling like this anymore”
- She becomes emotionally hyper-activated from phase 3.
- In phase 4 the client cries, holds her legs and cannot say what is happening
- “Go with that” says the therapist. He thinks: “The client is having an abreaction, and I must not stop it”
- The client is apparently more and more disturbed. Her face is tense, her fists are strongly closed. She can’t speak
An standard (?) EMDR session

- Suddenly the client improves. She says “I am fine.”
- The therapist thinks: “The abreaction has successfully ended, we can go on.”
- He asks the client, and the client says: “I can continue a little bit more.”
- Desensitization process continues and suddenly the client feels intensely tired. She is unable to continue the reprocessing.
- The therapist feels uncomfortable and doesn’t understand what is happening. “Am I doing something wrong?”

What happens inside

- Daily life part: “I need to work with trauma”
- Sudden the client improves she says: “I am fine”
- Daily life part: “I am fine” “there is no problem”
- Desensitization process continues and suddenly the client feels intensely tired. She is unable to continue the reprocessing.
- Daily life part: “I can follow a little bit more”
- The client is more disturbed. Her face is tense, her fists are strongly closed. She can’t speak
- Working through the Adult Self
The Adult Self

- We propose to work with dissociative clients through the Adult Self.
- The adult self (the observer, reflective self) relating with compassion and acceptance for the experiencing self.

The Adult Self

- The Adult Self is an emergent set of self-capacities, which are not yet developed in any part of the personality.
- It is the representation of the integrated, healthy, well-functioning self.
- The future integrated Adult Self (Korn and Leeds, 2002).

Promoting the Adult Self: A seed

- We proceed from the implicit understanding that the future self is already present, as a seed.
- We are confident in the client’s possibilities of improving.
The Adult Self: Empowering the patient

- **We do not talk directly to the parts**, but instead we show the Adult Self how to talk and communicate with the parts.
- We help the Adult Self learn how to understand what they need, how they feel and how to take care of them.

The Adult Self: fostering capacities for Self-care

- Through consistently working with the Adult Self, we model a new way for clients to look at themselves.
- We foster their capacities to understand their needs, and to develop empathy and true communication with dissociative parts.

By working through the Adult Self:

- We are enhancing **metacognitive** processes and **integrative** capacities
- Increasing **self-reflection**
- Developing healthy **self-care** patterns
- **Empowering** the patient and promoting his **autonomy**
Lack of integration and the internal conflict

Dissociative disorders and complex trauma
Lack of integration

- More internal conflict
- More dissociative phobias
- Internal conflict
- Dissociative Phobias

During the first sessions we will need to remember:

- The management of severely traumatized clients is not just about learning procedures.
- These procedures (and how we teach them) need to keep in mind specific characteristics of early traumatization.
Traumatized clients usually have several dilemmas:

- Some parts might want to “tell” and get help.
- Other parts don’t want to tell (for different reasons, some might be afraid, others think they “have to keep the secret”…).
- Protector parts can be experienced by the client as intrusions (somatic symptoms, etc.).
- The evaluation and interventions can activate different parts.
- And the client can be aware (or not) of these reactions.

Exploring the internal system

Exploring the internal system. Tools

- Drawings
- Free associations, help with indications
- Figures, playmobil, puppets, etc.
- The meeting place procedure

All of these tools help:
- Externalizing the conflict
- Creating some distance which is helpful when dissociative phobias are very strong
Exploring the internal system

- Videos, examples

The meeting place

The Meeting Place Procedure
Gonzalez, Mosquera & Solomon, 2012

- The Meeting Place procedure evolved from earlier procedures:
  - The Dissociative Table technique (Fraser, 1991, 1993)
  - The Conference Room (Paulsen, 1995, 2009)
  - Internal Group Therapy (Caul, 1984)
  - The hallucinated room (Watkins, 1984)
The meeting place procedure in other approaches

- Usually when the meeting place procedure is proposed, the patient or “host” is placed inside as another “part”.
- In these other approaches, a specific part can play a mediator role.

The meeting place procedure in the Progressive Approach

- In our procedure the patient is not placed inside the meeting room, it becomes a mediator to communicate with other parts.
- In our approach it is the Adult Self, which will implement all actions regarding the internal system, borrowing and finally integrating different aspects from other parts.

Meeting place and useful questions

- Adapted to the characteristics of the client
- Norms of no aggression
- Screen if needed
Meeting place. Useful questions (through the Adult Self)

- What do you see?
- How does this part feel?
  - How do you think this part feels?
- What does this part need?
  - What do you think this part needs?
- What is this part’s function?
- How can this part help?
- How can we help this part?
- Does this part know that the danger is over and that you are safe now?

Important to help the Adult Self to:

- Understand
- Change defensive attitude for curiosity and observation
- Function from a caring position
- Understand the needs of each part / voice
- Understand how they tried and are trying to help
- Develop reflexive thinking
- Improve communication
- Promote empathy, collaboration and cooperation
Reprocessing Dissociative Phobias
(Gonzalez & Mosquera, 2012)

- The target will be the dysfunctional emotion (fear, rage, shame, disgust) and the somatic sensation that one part experiences towards another.
- Careful with “somatic sensation”. It can be too much in the more severe cases.
- After doing the short set of BLS, we check how the system responds to this (any part/s involved in the procedure and any other parts that might be affected by it).

Video examples

The Tip of the Finger Strategy
Gonzalez & Mosquera, 2012
Gonzalez, Mosquera & Fisher, 2012
Tip of the Finger Technique  
Gonzalez & Mosquera, 2012

- Intentionally targets information related to the traumatic content.
- The term “tip of the finger strategy” (TFS) comes from the hand metaphor used to explain the processing of a traumatic memory.
- In the standard protocol, we start with the memory itself and follow the different associative chains (the fingers), returning periodically to the original memory (the palm of the hand).
- In TFS, the target is not the traumatic memory, but a small part of a disturbing sensation or emotion that may be considered a peripheral consequence of the memory.

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Tip of the Finger Technique  
Gonzalez & Mosquera, 2012

- In EMDR’s standard protocol, when working with single traumatic events, we choose as the initial starting point the worst part of the first or worst memory.
- An inverted strategy may be implemented with severely traumatized people.
- When using the metaphor of the hand in processing memories with EMDR, we should start with the “tip of the pinky finger” (a peripheral element), rather than the “palm of the hand” (memory), in order to progressively approach the core traumatic events.

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Tip of the Finger Technique  
Gonzalez & Mosquera, 2012

- We utilize an “outside in” perspective, beginning at the periphery (e.g., emotion) and slowly approaching the central aspects (e.g., core memories).
- Metaphorically, this would be like peeling the layers of an onion, little by little.
Peripheral somatic sensations or emotions are, ultimately, the consequences of dysfunctional stored memories, so we will first work with these peripheral elements. The processing of these peripheral elements in combination with other procedures, such as the meeting room or parts work, is an effective and useful intervention for the first phase of trauma therapy (stabilization and safety).

This is a basic concept in a progressive approach. Our goal is to progress towards a thorough processing of the traumatic experience. However, when this experience is extremely overwhelming, we need to approach those memories in small steps, starting with the most tolerable interventions and processing small quantities.

The mechanism on which both this procedure and the standard protocol are based is exactly the same. We are activating the brain’s innate processing system, which has been blocked by the traumatic experience. To untangle both a simple knot and a ball of tangled wool, we use similar movements: the first step to untangle a ball of wool will be to start with a small, peripheral and more accessible knot.
Processing Periferal Traumatic Elements: “Tip of the Finger” Technique

Gonzalez & Mosquera, 2012

In this procedure, we will be starting here.

Tip of the Finger Technique
Gonzalez & Mosquera, 2012

1. Psychoeducation
2. Explain to the dissociative part how this procedure may help
3. Explain the potential benefits to the Adult Self
4. Explain the specific procedure
5. Select the target
6. Desensitization
7. Check the effect on the dissociative part
8. Check the effect on the adult self
9. Closure / Stabilization
10. Re-evaluation

If new memories or emotions come up, we can talk about it a bit, but our goal is not to get into issues of the past.
Thank you for your attention and time!