COVID-19, MENTAL CONDITIONS & EMDR DISSOCIATIVE DISORDERS

Dolores MOSQUERA, Clinical Psychologist & EMDR Europe Trainer

Dissociative Disorders (DD) present challenges for trauma therapists for different reasons. Some patients need a longer stabilization phase to be ready to face their unresolved traumatic memories, not just processing, even talking or become aware of them. Many patients with DD present with amnesia of the past and in some also for experiences in the present. Phase 2 includes helping patients relate to the different dissociative parts in a more adaptive way. Many patients have a lot of difficulties functioning in daily life due to the intrusions from other dissociative parts or other trauma-related memories.

IMPACT OF COVID-19

Many patients still live with the perpetrators from their childhood or with other people who behave in an abusive manner. They may have fewer resources and support than usual. The Pandemic and its lock-down (forbidden to leave the house) can exacerbate symptoms and many already existing triggers due to the feelings of being locked up, not having a way out or feeling a lack of control and uncertainty.
Since many patients are getting triggered, the tendency is to go back to old unhealthy patterns of functioning (not taking care of self, staying in bed, not eating healthy, resorting to self-harming behaviors, alcohol abuse or drugs).

CONSIDERATIONS IN EMDR therapy

If doing telehealth: Seeing your patient online may feel very different for both therapist and patient. Therefore, it is important to be aware of your own reactions, as well as the reactions of patients.

- Ensure the camera is well adjusted (from chest up, no windows behind, good light)
- Make sure your patient knows that you might get disconnected and what to do if that happens. If you are working from home and don't have access to a business number, your patient should know how to reach you.
- Make sure you have a specific safety plan for patients, since you are not in the room with them.
- Explore grounding tools adapted to the new setting.
- Please follow telehealth recommendations for your country.

Privacy: Be aware that it may be difficult for the patient to find sufficient privacy at home during sessions (i.e., if they live with untrustworthy people or there are children home at the moment).

Boundaries: Make sure you maintain time boundaries of sessions just as usual. There is only so much the patient can integrate and going over time is not going to make things better. Being predictable and structured is a good setting for patients that are often functioning in chaos. Some patients may need only 30-minute sessions because on-line sessions are different and may be tiring.

Validate feelings and do Psychoeducation: It is key to allow time for the patient to share what this experience is like for them and allow for time to adjust. Therapists can share that it feels different and normalize their reactions to this modality of therapy and the times of the pandemic. Psychoeducation about triggers and the relationship to their history can help patients feel a bit more understanding and in control.

Safety plan for critical patients: Have a safety plan in place for patients who are likely to need it:

- What will happen if the patient becomes dysregulated during a remote session?
- Who is the patient's emergency contact? Have that phone number nearby.
- Where should the patient go in case of emergency, and what transportation is needed? Emergency services such as police and ambulances can be busy in some locations due to Covid.

Create a healthy routine for the patient: A good way to avoid abandonment of basic care habits is to work on a routine, for example set a time to get up, have breakfast, etc..

Assess support system: Help patients identify people that they can reach out to if they need support, and the ones they should avoid (because instead of helping, they make things worse).

Assess and create remote support networks: Online meetings with other people such as friends, family members that are not toxic or triggering can be a way to feel more connected and supported.

Triggers: There are specific issues to keep in mind regarding predictable and unavoidable triggers:

- Eliminating triggers (e.g., putting a photo away).
- Avoiding triggers (e.g., not reading or watching the news excessively; not reading about abuse).
- Anticipating triggers – imaginal rehearsal.
- Recognizing options (e.g., "I can find something healthy to occupy my mind right now.").
- Distinguishing the past from the present.
- Attending to dissociative parts stuck in trauma-time – compassionate containment and orientation. Have a part functioning in daily life help the part stuck in trauma-time for example.

Identify alternative targets: The pandemic causes ongoing psychological stress but patients may have difficulties identifying how this situation is activating old triggers. Therapists should remain curious about the impact of Covid on the patient´s life and functioning. If the patient can tolerate trauma work, possible targets for EMDR processing could include hearing about risks related to Covid for the first time, reactions associated with guilty (not taking it seriously, possibility endangering others, …).

Consider a focus on the present-day: If the patient is very hyper-aroused and reliving traumas, a present-day focus might be needed, focusing on the patient´s current anxiety or sense of overwhelm or lack of control.

Aim for resilience whilst the situation continues to be uncertain: Imagining feeling better in the future can be a challenge for patients who are getting triggered with thoughts such as "it´s never going to be safe", "just when I think things can be better, something horrible happens", "there is no way out". Resources for difficulties can be identified and installed with slow BLS.

Listen to their concerns and give them choices. Since many traumatized patients are getting triggered by the lack of choices and lack of control, we want them to feel empowered and capable. A good way to work towards this goal is to explore their concerns, help them identify them, and express them openly. Then explore choices and options that the patients might not be able to access on their own.

Temporarily limit working with parts and trauma processing: When patients need maximum energy to deal with external crisis such as the pandemic, working with parts should be limited to inner cooperation at managing the crisis. Intensive work with parts should be slowed and even stopped for many individuals for a temporary amount of time. Some parts stuck in trauma-time might need help using the safe place for containment.

Desensitize triggers and trauma-related phobias. If the patient can tolerate the work with parts, we can continue with the work we were doing before the pandemic once we address current triggering situations and revise/adapt the safety plan. Desensitizing trauma-related phobias or limiting triggers can be a good way to stabilize patients. The target would be the rejection or fear/phobia of one part towards another part, conceptualizing this as dysfunctional information that is getting in the way. Ultra-short sets of BLS (5-7 movements) can be used to desensitize the phobia.

Titration. Some patients with dissociative disorders can tolerate the work with traumatic memories. If this is the case, clinicians might want to limit associations when doing telehealth using EMD or EMDR strategies. Another tool is to titrate traumatic memory work by reducing the number of elements that we are working with; instead of gathering all the elements that Phase 3 incorporates: Image, Cognitions, Emotions and Body sensation take one or two such as a photogram and sensation (Gonzalez & Mosquera, 2012; Mosquera, 2019). It might be important to remember that many patients with dissociative disorder are extremely phobic of inner experiences, so limiting awareness of body sensations when they have difficulties tolerating them is a good recommendation.