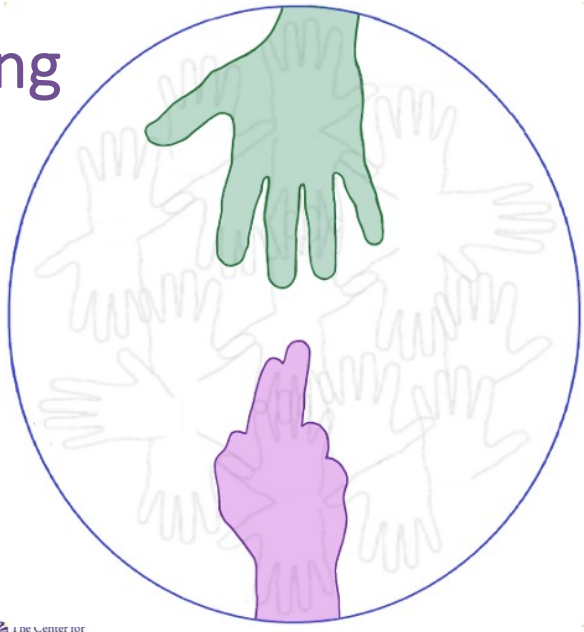
EMDR Therapy Training

Module IV:

Children & Adolescents and Advanced Treatment Considerations

Friday, June 2, 2023 –
Saturday, June 3, 2023



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Welcome to Module IV

Where we are, and where we're going…

- Four Learning Modules
  - ✓Module I (3 days, virtual)
  - ✓Module II (3 days, hybrid virtual/in-person)
  - ✓Module III (3 days, hybrid virtual/in-person)
  - *Module IV (2 days, virtual)*
- Group Consultation (2 hours each, virtual)
  - ✓1 session post-Module I
  - ✓2 sessions post-Module II
  - ✓2 sessions post-Module III
  - *1 session post-Module IV*

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Remember

- All questions are good questions
- Be kind to your mind and body
- It's healthy to make mis-takes
- Enjoy your learning process
- If it's old, be patient with *us*
- If it's new, be patient with *yourself*
- Breathe deeply, and stretch often
- Breaks are built into the schedule to cue you to give your mind and body the space they need throughout the training
- Reach out to training staff via chat, email, or privately in person if you need additional support

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Today's Schedule: Module IV, Day 1

9:30am – 10:00am	Review of Modules I-III
10:00am – 11:00am	EMDR Therapy with Younger Children and Adolescents
11:00am – 11:15am	*Brief Break*
11:15am – 12:45pm	Advanced Considerations I (Phases II-III)
12:45pm – 1:45pm	*Meal Break*
1:45pm – 3:15pm	Advanced Considerations II (Phases V-VIII)
3:15pm – 3:30pm	*Brief Break*
3:30pm – 4:00pm	Q&A and Day 1 Wrap-Up

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Review of Modules I-III

The three stages of complex trauma treatment

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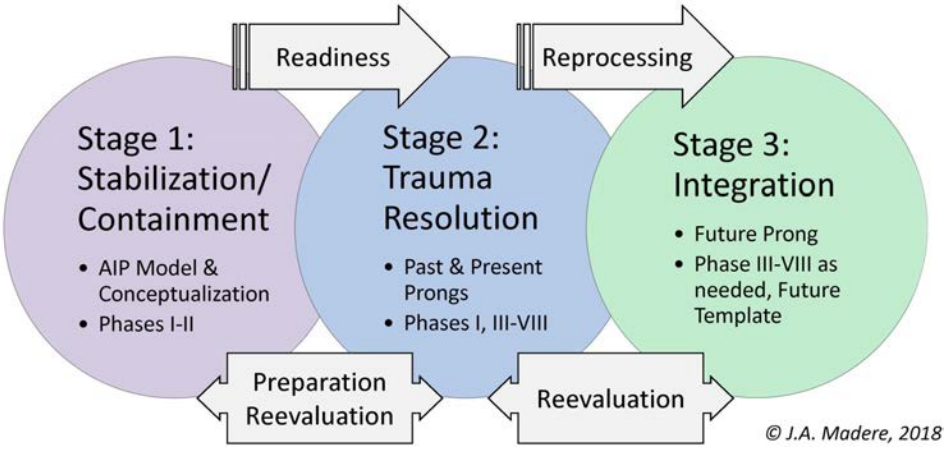
Scope of Treatment

3 Stages + 3 Prongs + 8 Phases



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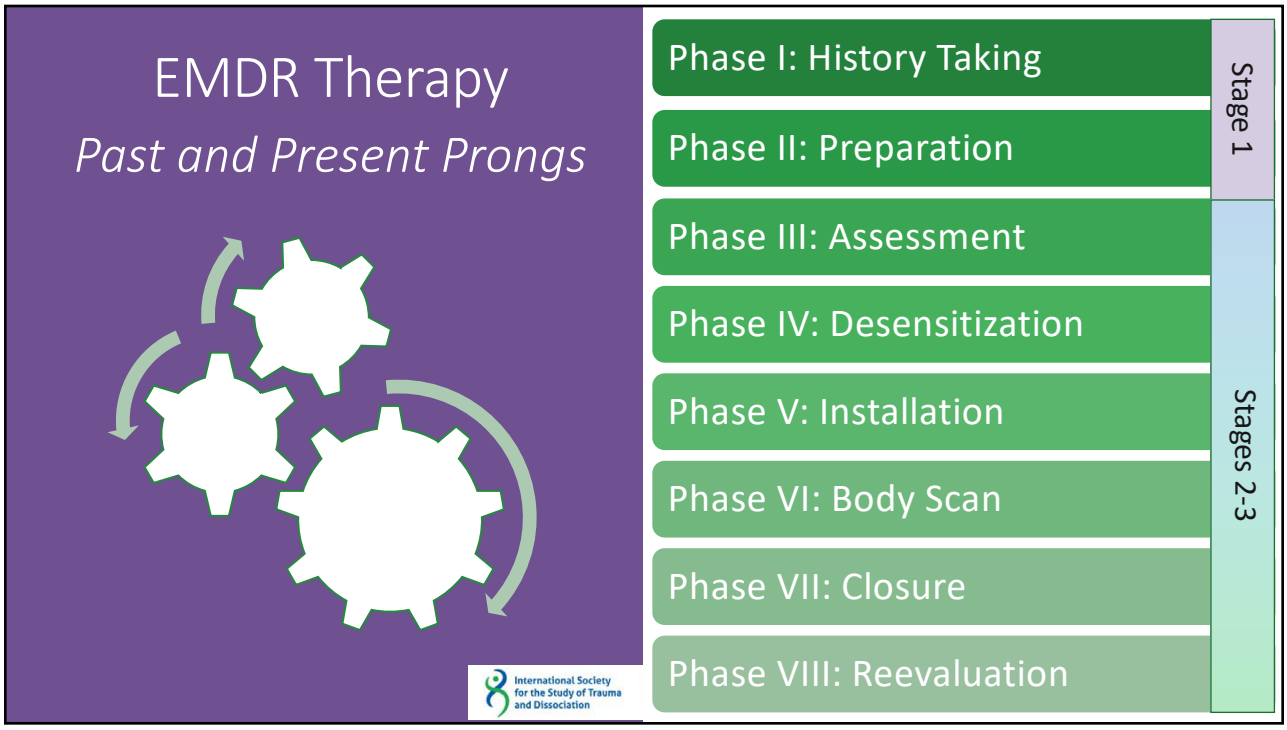

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Phase I: History Taking and Diagnostic Evaluation

- Bio/psycho/social/spiritual intake with AIP glasses on

  Assessing readiness for trauma accessing:
  - ✓ Diagnostic evaluation + screening or assessment for dissociation
  - ✓ Practicing containment, state shifting, and closure strategies
  - ✓ Assessing ability to sustain dual awareness

  Green lights or red flags?

- Determining readiness and appropriateness for EMDR therapy
- Identifying focus of EMDR treatment plan

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Phase II: Preparation

- Educating the client
  - ✓Explaining the procedures and effects in EMDR therapy
  - ✓Orienting to/agreeing upon forms of DAS
  - ✓Introducing the 'Stop!' signal
  - ✓Setting the stage for accurate client feedback between sets of DAS
  - ✓Answering questions
- Evaluating and widening the Window of Tolerance (WoT)
- Preparation decision tree & red flags

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Phase III: Assessment

- *Activates the neural network you have identified for processing*
- *Only begin Assessment of a target memory when you intend to move directly into the Reprocessing phases of EMDR*
- *The language and order in which we collect information during Phase III is very intentional and, though it may feel 'scripted' or 'clunky' at first, use it as written until you've absorbed it and it becomes reflexive*

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Phase III: Assessment

7 distinct components:

- *Picture / Worst Aspect of the Memory*
- *Negative Cognition (NC)*
- *Positive Cognition (PC)*
- *Validity of Positive Cognition (VoC)*
- *Emotion(s)*
- *Subjective Units of Disturbance (SUD)*
- *Location(s) of Disturbance (in the body)*

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Phases IV-VI: Reprocessing

Remember…

- "Reprocessing" = Phases IV, V, and VI
  - Desensitization
  - Installation
  - Body Scan

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Phase IV: Desensitization

- To begin Phase IV: Desensitization, we focus in on the most charged information—the *picture/image* that represents the *worst part*, the *Negative Cognition* (NC), and the *body location(s) of the disturbance* these bring up.
  - Successive sets of BL-DAS are then administered to allow all maladaptively stored or unprocessed material related to the Incident to be reprocessed and cleared.

Phase IV is complete when the SUD=0.

- Any 'blocks' in processing are addressed by attempting to manually redirect the course of processing.

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Phase V: Installation

- After the SUD=0, the *initial Positive Cognition (PC) is re-evaluated* to see if it still fits for your client.
- Within the AIP Model, the increased subjective Validity of the Positive Cognition (VoC) is not the result of correcting cognitive errors, *but rather the organic, adaptive result of clearing/processing the previously maladaptively stored memory material*.
- Sets of BL-DAS, at the *same speed and intensity* as in Phase IV, are again administered while the client holds the Target Memory/ Incident in mind with the PC until the they report that the VoC = 7 (completely true).

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Phase VI: Body Scan

- The Body Scan is the third and final 'quality control' step in reprocessing, after achieving a SUD=0 in Phase IV: Desensitization and a VoC=7 in Phase V: Installation.
- The client is asked to hold the Target/Incident and the PC together, mentally scan their body, and report where in their body they feel anything disturbing.
- *Any latent disturbance is processed using additional sets of DAS*, returning to the Target/Incident until there is no evidence of disturbance at all.

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Phase VII: Closure

During Closure, containment and shifting to a positive or neutral affect state is facilitated, safety is assessed, and the client is instructed how to log and otherwise respond to any related material that comes up between sessions (TICES).

Closure processes should be applied…

- ✓ at the end of every session in which any Phase of EMDR therapy occurs
- ✓ any time traumatic and/or maladaptive material has been accessed.

Closure is not about re-opening: *Summarization of the session may occur, so long as traumatic material is not rehashed or re-accessed.*

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Phase VIII: Reevaluation

REEVALUATION FOLLOWS ANY REPROCESSING SESSION

We are interested to learn about our client's post-processing experience

- ✓ Signs of reduction in symptoms or increased functioning?
- ✓ Signs of decreased functioning or increased symptoms?

We also want to check our work from the previous session

- ✓ Have symptoms and issues directly related to the incident resolved?
- ✓ Have any associated events or material been activated? How does this need to be addressed or considered…?

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3 Temporal Prongs | Points of Entry: Past – Present – Future

All 3 Prongs are essential!

Resolve underlying past experience

+ address present concerns (present 'triggers')

+ ensure lasting results and equip for future

- ❖ Adapted EMDR protocols and procedures may re-order the Prongs, but still include completion of all 3 Prongs.
- ❖ Processing of a Present/Recent event requires a modified approach due to unconsolidated memory networks and possible feeder memories

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3 Temporal Prongs | Working in Present and Future Prongs

Present Prong

After completing Past prong target(s):

1. Identify ***recent*** life experiences (previous triggers) ***related*** to Past prong addressed in treatment plan
2. If recent experience evokes disturbance, Target and Reprocess it
3. If no disturbance, move to Future Prong

Future Prong

After completing Past and Present prongs and target(s):

1. Identify ***anticipated*** life experiences ***related*** to Past & Present prong addressed
2. If anticipated experience evokes disturbance, Target and Reprocess it
3. If no disturbance, complete a Future Template

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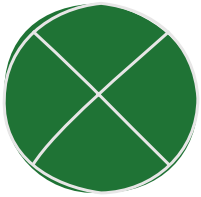
Scope of Treatment | *Single Incident*

Single Incident

- Focused on symptom relief
- May fractionate target (EMD)
- State change expected



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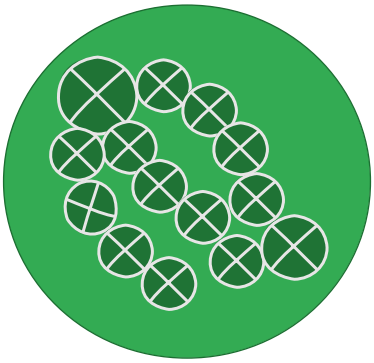
Scope of Treatment | *Timeline, Symptom- or Issue-driven*

Single Incident

- Focused on symptom relief
- May fractionate target (EMD)
- State change expected

Timeline, Symptom- or Issue-driven

- Focused on more long-standing or generalized symptoms
- Multiple Past-prong targets
- State change + some trait change



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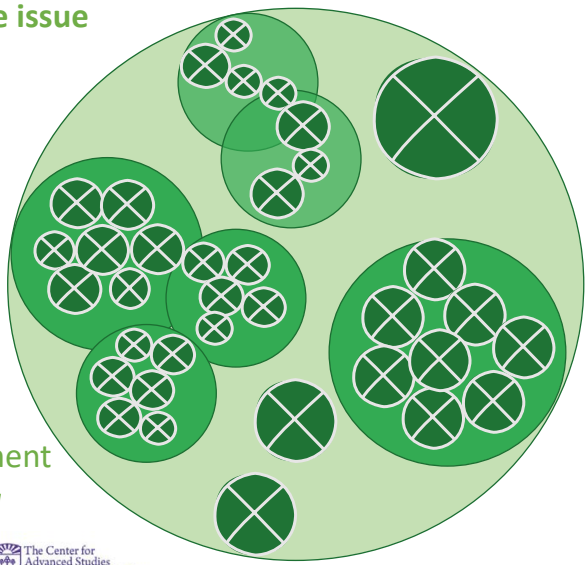
Scope of Treatment | *Comprehensive*

- **Client may initially present with single issue**
- A combination of single incident, symptom-focused, and issue-driven targeting sequences
- Standard Protocol, contained and restricted processing, and 'specialty' protocols, techniques, and methods for specific symptoms and issues
- Integrates multiple practice models
- May not be (and often isn't) linear
- May involve months or years of treatment
- Strives to effect both state change *and* trait change



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STRETCH
BREAK
5 min

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EMDR Therapy with Younger Children and Adolescents

Training Manual, pp. 166-171

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Phase I: History Taking and Treatment Planning

- Bio/psycho/social/spiritual intake and developmental history as part of a three-step process

  Assessing readiness for trauma accessing:
  - ✓ Screening for dissociation with child, caregivers, and relevant third parties
  - ✓ Assessment of the environment and attachment system

  Green lights* or *red flags?

- Determining readiness and appropriateness for EMDR therapy
- Identifying focus of EMDR treatment plan

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Phase II: Preparation

- Educating the client and caregiving system
  - ✓Use of metaphors, analogies, and stories
  - ✓Orienting to and choosing forms of DAS
  - ✓Introducing the 'Stop!' signal

- Modifications
- Evaluating and widening the Window of Tolerance (WoT)
- Working with caregivers and relevant third-party systems
- Preparation decision tree & red flags

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Phase III: Assessment

- *Modifications that physicalize and include play and movement*
- *Modifications for young children*
- *Only begin Assessment of a target memory when you intend to move directly into the Reprocessing phases of EMDR (Phases IV, V, VI)*

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Phases IV, V, VI

- Same procedural steps as we utilize with adults, modifying language and incorporating elements that support a child to hold focus and presence.
- Often moves faster.
- Any 'blocks' in processing are addressed through the use of interweaves, which may include repair from caregiving systems and providing greater adaptive information.

Phase IV is complete when the SUD=0.

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Phase VII: Closure

- Length dependent on child's unique needs and often incorporates time for free play.
- Use of container for containment and shifting to a positive or neutral affective state is facilitated (up regulation or down regulation) and safety is assessed.
- Caregiving system and third-party systems support logging of information and changes between sessions.

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Phase VIII: Reevaluation

REEVALUATION FOLLOWS ANY REPROCESSING SESSION

We are interested to learn about our client's post-processing experience, which may be done dyadically with the caregiving system

- ✓ Signs of reduction in symptoms or increased functioning?
- ✓ Signs of decreased functioning or increased symptoms?

We also want to check our work from the previous session

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Additional Considerations

- All three prongs are essential, however, additional modifications may be needed when co-morbidity and complex trauma are present.
- Adaptations are based on the child's developmental level and are aligned with EMDR specific child adaptations, which may include greater distancing and titration, more direction, and simplifying instructions and steps.
- Child specific protocols, resources, and trainings (Manual, pp. 166-167)

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BRIEF BREAK
15 min

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Advanced Considerations I

Phase II: preparation

Phase III: assessment

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Phase II: preparation

Training Manual, pp. 101-102

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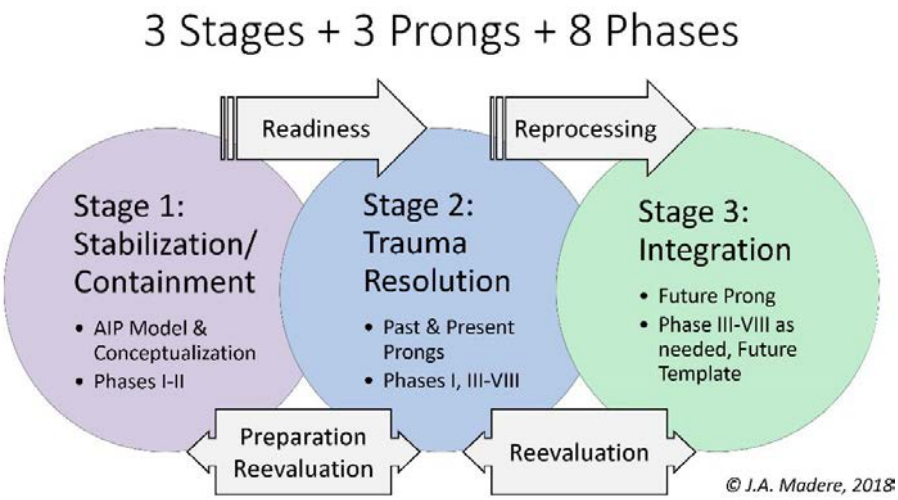
Advanced Considerations | *Phase II: Preparation*



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Advanced Considerations | *Phase II: Preparation*

Both Phase II in EMDR therapy *AND* an ongoing task throughout the course of treatment

- ✓ Whenever the client requires more resourcing to remain within their Window of Tolerance for continued trauma accessing/processing
- ✓ Customized to the needs and abilities of the individual client
- ✓ There are some advanced techniques that can aid in keeping the less complex (and better resourced dissociative) clients within their Window in the midst of reprocessing

The more complex your client, the more need there may be to revisit preparatory work/resourcing frequently, for reasons such as…

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Advanced Considerations | *Phase II: Preparation*

- *Pathological Dissociation*
  - ✓ If screening/assessment indicated presence of significant and pathological dissociation, a longer Preparation/Stabilization period is likely warranted and necessary.
  - ✓ Interventions such as the following are recommended:
    - Dissociative Table (aka Conference Room, Meeting Place)*
    - Parts mapping*
    - Targeting/resolving of defenses*
    - Identifying and addressing trauma-related phobias*

*Please see manual for references

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Advanced Considerations | *Phase II: Preparation*

- *Attachment Trauma*
  - ✓ Individuals who have experienced emotional abuse, neglect, or other attachment-oriented trauma may require nuanced and extended Preparation due to lack of adaptive memory networks.
  - ✓ Within the AIP Model, if adaptive memory networks are lacking, resolution of maladaptive material is much more difficult.
    - Resourcing, in AIP, is the process of finding positive memories, attributes, images, etc., in the person's experience, and strengthening them to build adaptive memory networks
  - ✓ Several suggestions are listed in the manual

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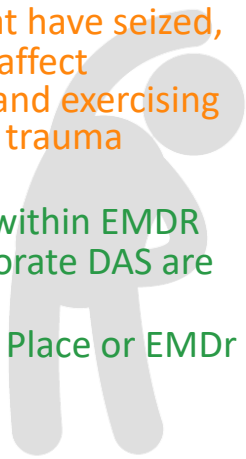
Advanced Considerations | *Phase II: Preparation*

- *Affect Intolerance (pleasant and/or unpleasant affect)*
  - ✓ Imagine that the limits of the WoT are muscles that have seized, atrophied, or otherwise lost pliability… increasing affect tolerance is the process of stretching, massaging, and exercising those "muscles" in order to walk to the journey of trauma resolution without serious injury.
    - ✓ Several approaches that have been developed within EMDR therapy to increase affect tolerance and incorporate DAS are listed in the manual.
    - ✓ Most will appear to be a variation of Calm/Safe Place or EMDr applied to affective experience.



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Resource Development and Installation (RDI; Leeds, 1995)

THIS SECTION ALREADY PRESENTED IN MODULE III 2022

"A set of EMDR-related protocols which focus exclusively on strengthening connections to resources in functional (positive) memory networks" (Korn & Leeds, 2002)

- RDI initially was a strategy that combined positive imagery with short sets of BL-DAS.
- RDI has expanded to include resources such as skills, metaphors, art therapy
- Dysfunctional memory networks are deliberately not stimulated.
- Brief sets (6-12) of BL-DAS are used to develop as well as 'install' or strengthen the resource.
- BL-DAS increases the affective intensity of the resource as well as the associations to other positive memory networks.

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➢ Resource Development and Installation (RDI; Leeds, 1995)

- Early case reports describe this procedure (Leeds, 1998; Leeds & Shapiro, 2000)
- A summary of the RDI procedure was included in the appendix of the second edition of Shapiro's standard reference text on EMDR (Leeds, 2001), and included in the third edition (Shapiro, 2018, pp. 248-250)
- In 2002, Korn and Leeds published a treatment case series on the use of RDI in the stabilization phase of treatment of Complex PTSD.
  - They demonstrated clinically significant changes post-treatment and on 1 month follow-up on behavioral measures (negative self statements, negative emotions and self-destructive behaviours) and the SCL-90-R (Global Severity Index and the Positive Symptom Distress Index). (Korn & Leeds, 2002).
- Fisher offers an expanded modification of the RDI protocol on her website (Fisher, 2001).

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➢ Resource Development and Installation (RDI; Leeds, 1995)

Significance:

- RDI revolutionized the stabilization phase in Complex Trauma and DDs. Now EMDR could be used for stabilization and not only for trauma processing.
- Now taught in many EMDR basic trainings

Significance to Dissociation:

- One of the most important EMDR protocols for Stage 1 treatment of DDs
- Can be used to install calm, trust, safety, and grounding, which are usually absent in DDs

Clinical Pearls:

- Any positive social interaction or experience or memory can be developed and installed
- Chose a new resource if anything negative at all comes up.

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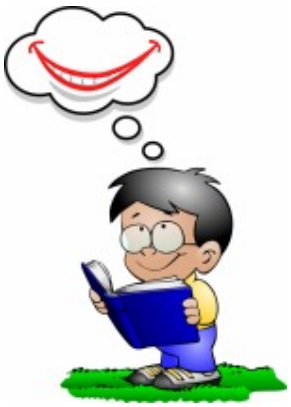
➢ Resource Development and Installation (RDI, Leeds, 1995)

Examples of needed resources:

- I'd like to feel more safe, strong, wise, connected, grounded, confident, courageous, hopeful, determined, flexible and committed to healing.
- I'd like better boundaries. I want to be able to soothe myself and tolerate and manage my feelings.
- I want to believe in myself. I want to feel lovable.

(Leeds & Korn, 2002)



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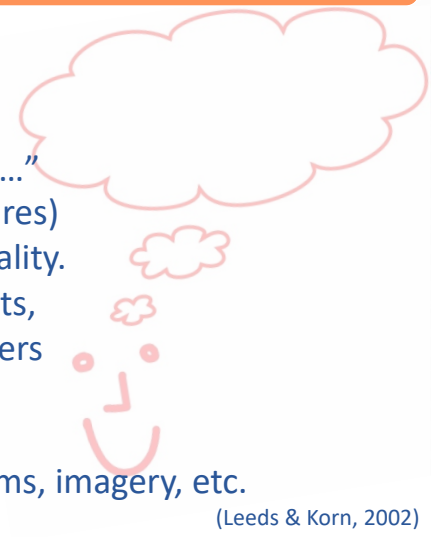
➢ Resource Development and Installation (RDI, Leeds, 1995)

Examples of Types of Resources:

- *Mastery experiences and images*
  - "Think of a time when you felt…
    ….when you were able to behave with more…"
- *Relational resources* (Models and supportive figures)
  - People now or from past who possess this quality.
  - Friends, relatives, teachers, mentors, therapists, pets, spiritual guides, public figures, characters in books/movies.
- *Metaphors and symbolic resources*
  - Images, symbols or metaphors from art, dreams, imagery, etc.

(Leeds & Korn, 2002)



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Advanced Considerations | *Phase II: Preparation—DAS, or no DAS?*

A heated debate…

- Hornsveld, et al. (2011) reported that *eye movements may decrease the strength of positive and resourceful autobiographic memories.*
- Some advocate for tactile DAS or no DAS in Phase II, some say EMs are just as fine.

Our conclusion for now: try without DAS and with DAS, and notice what fits for each person.

- *Still need to orient to EMs before Phase IV*

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Phase III: assessment

Training Manual, pp. 113-116

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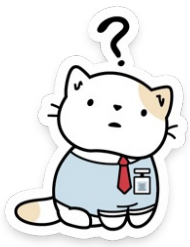
Advanced Considerations | *Phase III: Assessment*

The Subtleties of Setting Up Targets

- Most common struggle identifying appropriate and accurate NCs and PCs
  - ? We are used to avoiding cognitive distortions
  - ? May have practice using positive self-affirmations
  - ? May be practiced in identifying "my part in it"



NCs: a negative belief that feels true but is objectively false in some way

PCs: a positive belief that is objectively true but feels less than fully true

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Advanced Considerations | *Phase III: Assessment*

In the 3 Stages of Complex Trauma Treatment

- Phases and Stages may progress in a less linear fashion. Common examples:
  - If a *lack in adaptive connections* is evident, reprocessing may be paused to complete additional resourcing (eg. RDI)
  - If a *conflict between parts* of self is identified, stabilizing the relationship among parts may be necessary (briefly, or for several sessions)

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Advanced Considerations | *Phase III: Assessment* | 3 Stages cont'd

Most clients who meet criteria for a dissociative disorder require some fractionation or titration of the traumatic material for reprocessing.

- BASK model (Braun, 1988, described in Fine, 1999), Fractionated Abreaction Technique (Kluft, 2013)
- Within EMDR therapy: EMD, EMDr, Recent Event protocols, etc

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Advanced Considerations | *Phase III: Assessment* | 3 Stages cont'd

Listing the 10 worst events or developing a comprehensive trauma timeline may be difficult or unwise…

- *Consider a developmental timeline or genogram-focused approach, such as Kitchur (2005) – see next slide.*

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Advanced Considerations | *Kitchur's Strategic Developmental Model*

- ✓ A genogram is used to elicit the nodal events in the client's life
- ✓ Targets are selected for processing in the following age group order:
  - middle childhood (4-11)
  - early childhood (0-3)
  - adolescent (11-17)
  - adult
- ✓ Within each age group (except for early childhood), the memories are targeted as follows: most disturbing memory of parent's relationship, most disturbing memory of one parent then the other, and then known traumas in chronological order.
- ✓ Early childhood memories are targeted if there is a memory, corroborated event or attachment wound.

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Advanced Considerations | *Phase III: Assessment*

Identifying Emotions and Body Sensations

Under-feeling/sensing

- Alexithymia
- Depersonalization

If gentle inquiry and reflection of noticed non-verbal indications is received well, that's a good sign….If met with argument, dismissal, guardedness, caution may be indicated.

Example: plotting emotion and sensation by quadrant

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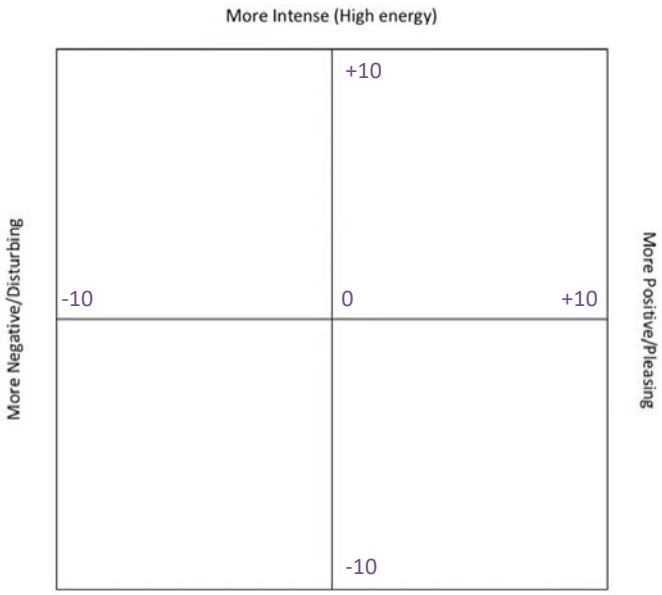

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Advanced Considerations | *Phase III: Assessment*

Identifying Emotions and Body Sensations

Over-feeling/sensing

Be certain that:

1. The targeted memory network(s) are activated;
2. The client is and stays within their WoT
3. The 'train' keeps moving down the track and dual attention is sustained

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MEAL BREAK
60 min

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Advanced Considerations II

Reprocessing in phases IV-VI

Phase VI: closure

Phase VIII: reevaluation

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Reprocessing in phases IV-VI

Training Manual, pp. 133-134, 139, 140-141

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Advanced Considerations | *Phase IV: Desensitization*

Three Domains of Experience – they always matter!

- *The stuck point reveals where attention is needed*

Intentionally Bridging to Implicit Memory

- Affect Bridge (John G Watkins, 1971; see also 'affect scan)
- Somatic Bridge (Helen H Watkins, 1992) - similar to Affect Bridge focusing on a body sensation
  … let your mind scan back to an earlier time…

Important: awareness of trance, language, frame and intention always matter, particularly when working with traumatized individuals.

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Advanced Considerations | *Phase IV: Desensitization*

Relationship Still Matters!

- With practice in the procedural steps, you will find that less attention is required to follow the script/worksheet, and more attention will be available to offer a (mostly) non-verbal supportive presence

Remember the Phases and Prongs

- When the level of disturbance related to an incident drops, it is tempting to turn attention to other issues or incidents.
  Completion of all 8 Phases is essential to ensure that the wound heals fully!

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Advanced Considerations | *Phase V: Installation*

2nd Quality Control Check

Most common: need to clarify that the scope of processing is on the memory currently being targeted (rather than related events)

"When you think of this incident we've been working on, how true do the words (PC) feel to you now…?"

In a 3-prong treatment plan, multiple Past, Present, and Future experiences may be targeted before reprocessing generalizes fully

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Advanced Considerations | *Phase VI: Body Scan*

3rd Quality Control Check

Francine Shapiro used the body to discover any remaining fragments of disturbance of associations, such as grief or anger, following Installation of the PC.

Three D's of the Body Scan according to D. Michael Coy:

- *Disturbances* – any residue of disturbance?
- *Disagreements* – any somatic evidence of disagreement in the self-system?
- *Deficits* – anything that feels 'missing?'

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Advanced Considerations | *Phase VI: Body Scan*

When using EMDR therapy with clients who have a conflicted relationship with their body or present complex somatic experiences, *it can be helpful to check each of these aspects* as it relates to the targeted event.

3 types of information:

- ✓ Inner body sensation
- ✓ Movement impulses (tension is often a precursor to movement)
- ✓ 5 sense perception

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Phase VII: closure

Training Manual, pp. 145-147

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Advanced Considerations | *Phase VII: Closure*

Safety First, Safety Last

- ✓ Reliable, predictable, and adequate Closure is essential to safe and effective EMDR therapy. We can support ego-strengthening by assisting or allowing the client in doing as much as they can at a given time…

Is Your Client Truly Present at Closure?

- ✓ Data gathered in Phase I via the DES, MID and/or other assessment tools may guide you to identify areas to check at Closure
  - Signs of depersonalization, derealization, trance

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Advanced Considerations | *Phase VII: Closure*

Many clients benefit from multiple steps of closure, for example:

1) Container
2) Lightstream or Emotional Shower
3) Brief attention to Calm/Safe Place
4) Orienting to present and safety assessment
5) Closing the Meeting Place / Conference Room and ensuring all parts are where they need to be prior to the end of session

Suggested: have many options available, give choices, and use at least two each session.

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Advanced Considerations | *Phase VII: Closure*

The Howard Alertness Scale

➢ See Manual p. 146

Pre-Intervention

✓ Measure alertness, gather information from five senses

Post-Intervention

✓ Check back in with five senses and level of alertness

Ensure that your client has returned to at least their baseline level of alertness before they leave the session/office.

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Advanced Considerations | *Phase VIII: Reevaluation*

Discerning when EMDR processing is working, when to adjust course, and when to slow down…

Common dilemmas:

- Intrusions come up related to a different memory between sessions
  - *Can the new memory be contained? Is it an earlier (feeder) memory?*
- Significant reactivity, emotionality, or "discombobulation" after a reprocessing session, especially persisting into the next day
  - *Consider slowing down. Options include EMD or EMDr, reducing time focused on Desensitization, increasing time allowed for Closure, spacing reprocessing sessions.*

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Advanced Considerations | *Phase VIII: Reevaluation*

Common dilemmas (cont'd.):

- Post-reprocessing symptoms such as headaches, nightmares, body memories
  - *Consider reevaluation of dissociative features and symptoms, and your client's subjective experience of these symptoms. Headaches and nightmares in this context can indicate 'backlash from within.'*

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Advanced Considerations | *Phase VIII: Reevaluation*

Common dilemmas (cont'd.):

- Possible looping (revisiting the same material repeatedly)
  - *Consider whether reprocessing is re-addressing the same material at different levels (e.g., three domains), and/or whether the client seems to be gaining perspective.*
  - *'Lighthouse metaphor' (Danylchuk & Connors, 2016)*

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BRIEF BREAK
15 min

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Module IV,
Day 1

Questions
and
Wrap-Up

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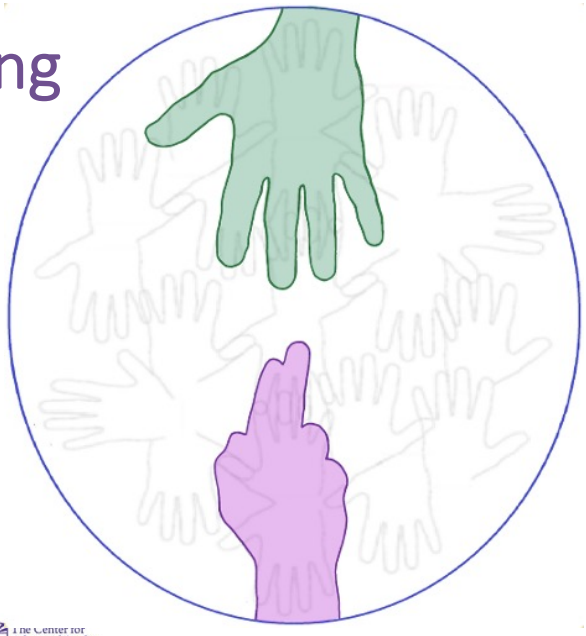
EMDR Therapy Training

Module IV:

Children & Adolescents and Advanced Treatment Considerations

Friday, June 2, 2023 –
Saturday, June 3, 2023



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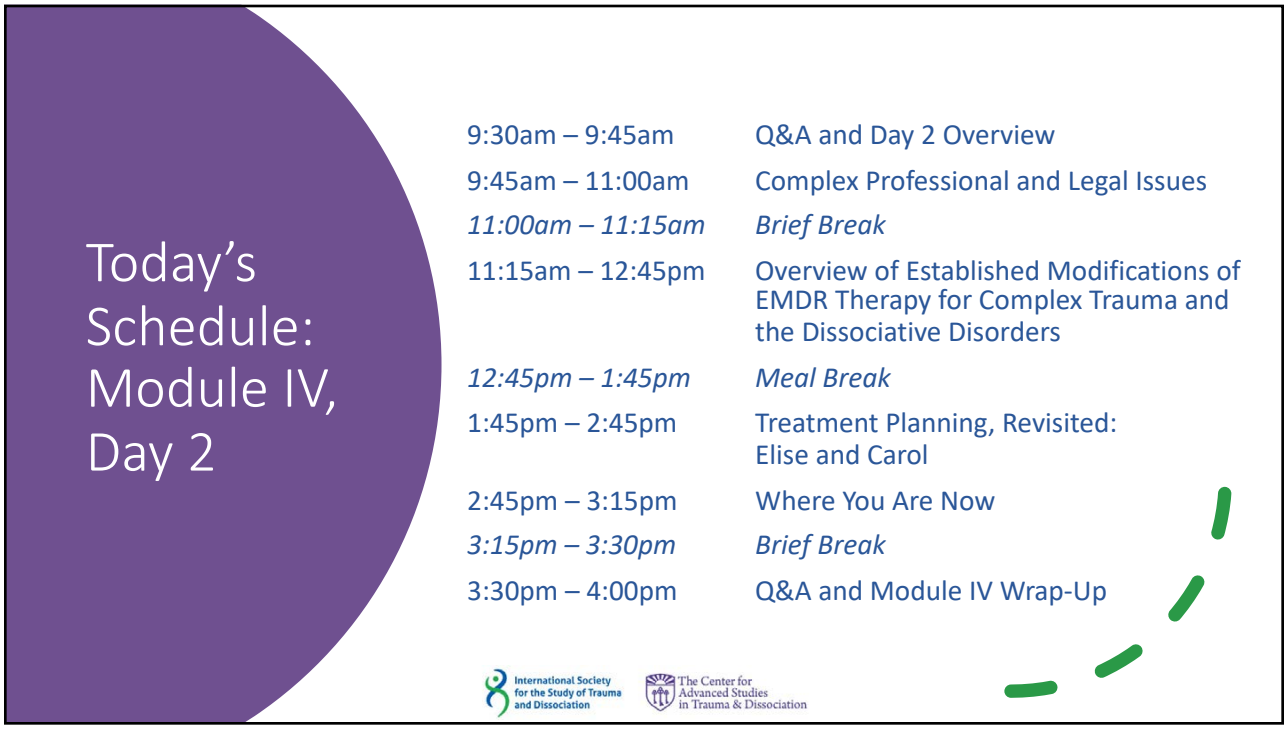

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Professional and Legal Issues | *Case Vignette*

PRESENTING CONSULTATION/TREATMENT ISSUES:

A clinician presented the following case summary for consultation after standard EMDR therapy did not go as expected. A man in his early 30s presented for therapy after the loss of a pet and an apparently positive transition in his work role. He reported that he had been calling in sick to work and was considering filing for temporary disability due to feeling unable to return to work.

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Professional and Legal Issues | *Case Vignette*

BRIEF CLIENT BACKGROUND/HISTORY:

A history of adoption at age 1 was reported, but no events or memories related to his adoption were considered relevant, and he viewed it as insignificant and irrelevant to the present struggle. The client described the adoptive parents as 'hard working' and 'strict sometimes', which at times resulted in the client missing out on social and extracurricular activities during his school-age years.

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Professional and Legal Issues | *Case Vignette*

BRIEF CLIENT BACKGROUND/HISTORY:

The client described his current relationship status as 'single', with a history of satisfying relationships but no marriages or children.

He reported completing a Bachelor's degree in a field related to human services and had since advanced to supervisory roles in several organizations.

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Professional and Legal Issues | *Case Vignette*

SCREENING AND A CHOICE POINT:

Administration of the DES-II yielded a mean score of 14. The consultant noted that two items measuring features of amnesia were endorsed at a frequency of 10%.

Since the client reported functioning well until the death of his pet, for which he blamed himself, the clinician had begun standard EMDR reprocessing of this memory of loss in the third weekly therapy session.

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Professional and Legal Issues | *Case Vignette*

REPROCESSING AND REEVALUATION:

After two sessions of EMDR reprocessing focused on the loss of his pet, the client reported severely decreased appetite and heightened anxiety that interfered with his ability to sleep. Upon presenting for what was to be his third session of reprocessing, he reported to the clinician that he had not eaten in 2 days. He reported that when he did sleep, he experienced disturbing dreams during which he would awake in a cold sweat and feeling utterly alone.

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Professional and Legal Issues | *Case Vignette*

REPROCESSING AND REEVALUATION:

Although the client reported no memory of events or people prior to his adoption, he identified feeling "very young" upon waking from these dreams.

He described feeling as though he could not go on living, although active suicidal ideation was denied, and he voiced his displeasure to the clinician for not helping him, but instead making things worse such that he might lose his job.

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Professional and Legal Issues | *Case Vignette*

RESULTS:

The clinician reported that the client cancelled his next appointment and had not responded to the clinician's attempt to reach him by phone or secure messaging - although the clinician could verify that the latter had been opened by the client.

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Professional and Legal Issues | *Case Vignette*

RESULTS:

In consultation, the clinician recognized that several possible indicators of a dissociative disorder had been present, and that those were disregarded in the interest of proceeding to address the person's presenting concerns. The consultant recommended revision of the clinician's intake process to include a more thorough mental status evaluation and instructed the clinician on how to conduct a follow-up interview on items endorsed on the DES-II.

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Professional and Legal Issues | *Case Vignette*

RESULTS:

The clinician intended to follow up once more with the person to offer a repair attempt and the option of referral to another clinician specializing in treatment of early attachment trauma.

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Professional and Legal Issues | *Case Vignette*

QUESTIONS:

1. Is there anything more you think you'd want to know about this client before beginning reprocessing?

2. Is there anything that stands out to you as potentially problematic or concerning about the DES results?

3. If this were your client, what considerations would be important for you in treating them, based on your current knowledge base, either related to using EMDR therapy or more generally, owing to the symptoms that showed up?

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STRETCH BREAK
5 min

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Consent: A Moving Target in EMDR Therapy

- Orienting to EMDR therapy—both for you AND your client
  - ✓ It's not just an intervention! 8 phases, and 3 prongs
  - ✓ EMDR ≠ Desensitization…
  - ✓ The 3 prongs really do matter—healing is a process
  - ✓ Listen for unrealistic expectations
- Phase VIII: Reevaluation is critical for discerning…
  - ✓ WoT issues—clients may not just tell you!
  - ✓ Feeder memories
  - ✓ Challenges for treatment—whether circumstantial or internal
- Your client may not understand ANY of this, which is why you MUST

YES!

NO!!!!!!

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Integrating EMDR Therapy into Your Practice

Common questions and areas of adjustment:

- ? Intake forms/procedures: *Integrating existing & new*
- ? DES, MID-60, or other method to detect dissociation
- ? Setting and insurance: *Any limitations on using EMDR?*
- ? Notes/documentation: *How are you documenting?*
- ? Session length: *Brief, standard, or extended sessions?*
- ? Scope of treatment: *Setting, length of tx, etc.*
- ? Established vs. new clients: *Introducing EMDR*

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Reflections

- How much you think you know… versus how much you don't know you don't know.
- Mistakes and mis-applications with EMDR can be very different than mis-applications of other treatment models
  - Ex: Decompensation, couple/family dynamics, active legal case, documentation implications
- Standards of Care for EMDR therapy and dissociation
  - ✓ Shapiro, F. (2018). Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols and procedures. Third Edition. *Of particular note—Appendix E: Safety*
  - ✓ International Society for the Study of Trauma and Dissociation. (2011). Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma & Dissociation, 12, 115–187.*

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BRIEF BREAK
15 min

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Overview of Established Modifications of EMDR Therapy for Complex Trauma and the Dissociative Disorders

Training Manual, pp. 171-177

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Dissociation, Red Flags, and EMDR Therapy

The EMDR Dissociative Disorder Task Force published their report (Shapiro, 1995, p. 365-369; reprinted in Shapiro (2001) and Shapiro (2018)), identifying the following factors as 'red flags' for employing standard EMDR therapy methods:

- on-going self-mutilation
- active suicidal or homicidal intent
- uncontrolled flashbacks
- rapid (dissociative) switching
- extreme age or physical frailty
- terminal illness
- need for adjustment of medication
- ongoing abusive relationships
- alter personalities that are strongly opposed (to treatment)
- extreme character pathology
- serious comorbid disorders

The use of eye movements too early in treatment risks premature penetration of dissociative barriers. This could produce such results as: flooding of the system, uncontrolled destabilization and increased suicidal or homicidal risk.

Shapiro, 1995, p. 501

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Treading Carefully, and with Caution

Since early on in its existence, the use of EMDR therapy with persons with dissociative disorders has been viewed in two rather polarized ways, either:

a) it's not a big deal and 'just do it', or

b) it's risky or even dangerous, and don't do it at all, ever; even its application for persons with less structurally complicated complex trauma was seen to pose significant treatment challenges.

The reality is somewhere in between those poles

Earliest contributors to this discussion: Young (1994), Paulsen (1995), Lazrove & Fine (1996), and Gelinas (2003).

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Treading Carefully, and with Caution: A Word of Warning

The EMDR therapy techniques discussed in Part III of the manual, and more briefly in this training segment, are for your information.

We teach you about them to help you be more aware of the wide variety of frames, protocols, and interventions you can study and develop skill in using with complex clients once you have a firm grasp of both EMDR therapy basics and dissociation.

Using advanced trauma processing techniques without appropriate qualifications—or using the basic protocols you're learning in this training without a firm understanding of working with persons with dissociative disorders—can result in adverse and possibly harmful results for both you and your client.

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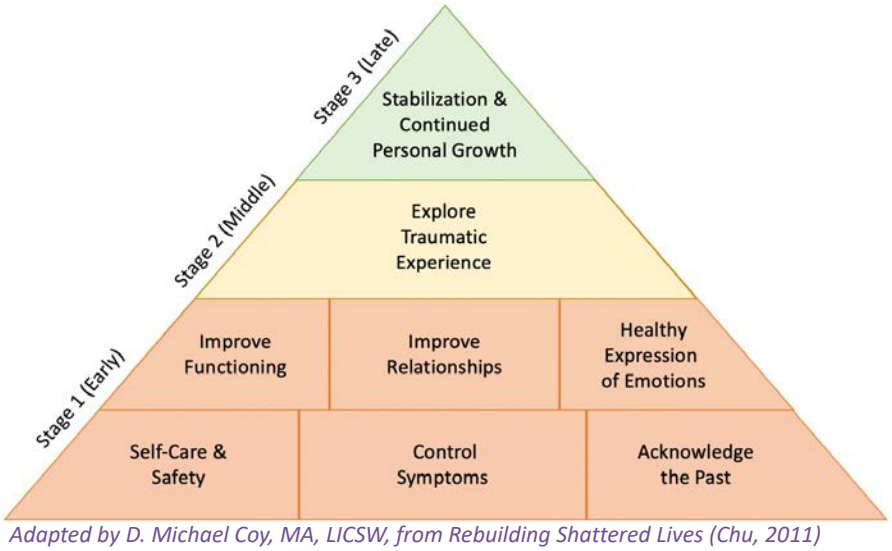
Stages of Complex Trauma Treatment



Adapted by D. Michael Coy, MA, LICSW, from Rebuilding Shattered Lives (Chu, 2011)

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When Is Extended Stabilization Necessary?

- ✓ An extensive history of childhood abuse or neglect;
- ✓ Evidence of prolonged, repetitive trauma in adolescence or adulthood;
- ✓ Active self-harm, suicidality, or ongoing aggressive behavior;
- ✓ A lack of physical and/or emotional safety and stability in the present;
- ✓ Active comorbidities: depression, substance abuse, disordered eating;
- ✓ Severe personality dysfunction;
- ✓ Limited or poor affect regulation skills;
- ✓ Significant dissociative features;
- ✓ Chaotic relationships or poor social support in the present;
- ✓ Poor therapeutic alliance or engagement; and,
- ✓ Unstable medical problems.

(Courtois & Ford, 2019)

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EMDR Therapy Techniques for Stage 1: Stabilization/Containment

These techniques are appropriate for use by early-learner EMDR practitioners with an understanding of dissociation and working with dissociative parts

- ➢ EMDR Techniques to Enhance Orientation
- ➢ Back of the Head Scale

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➢ EMDR Techniques to Enhance Orientation (Twombly, 2000/2005)

- ❖ Current Time and Life Orientation
  - ✓Designed to help ego states with time distortions/disorientation
- ❖ Height Orientation
  - ✓Helps child ego states realize that the body is adult
- ❖ Installation of the Therapist and the Therapist's Office
  - ✓Help lay the groundwork for dual attention awareness

(Twombly, 2000 & 2005)

Significance to Dissociation

These EMDR techniques are specifically designed to orient dissociated parts/alters to the present

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➢ EMDR Techniques to Enhance Orientation (Twombly, 2000/2005)

Example of Current Time and Life Orientation:

- The ANP/front part and the relevant younger parts discuss how they know what year it is, how many years since they were abused, how they know they are safe in the present, where they live and work, that they drive, etc. The host can also visualize this information in pictures or a movie
- Install with BL-DAS
- Ask the parts to check out the information during the week; the ANP/front part can play this movie when having a flashback

Clinical Pearls

- Introduce the skills by asking the younger parts to do an "experiment"—unless you are aware that "experiments" are triggering for your client; then, find other language (e.g., 'try something out')
- The timing of these interventions is important, because movement toward greater awareness may be distressing

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➢ Back of the Head Scale (Knipe, 2008/2019)

- ❖ Used to assess the client's level of dissociation (DP/DR)
- ❖ The therapist can check where the client is on the BTH scale every time there is concern about their level of dissociation

BTH scale:

- Imagine a line extending from the back of your head through to a point 14 inches in front of your face.
- The point 14 inches in front of your face means that you are completely aware of being present here with me in this room. The point at the other end of the line, at the back of your head, means that you are completely in a memory from the past.
- Rate your current level of dissociation by pointing to where you feel you are at the present moment (Knipe, 2008).

Significance to Dissociation:

Useful in therapy in general to assess level of dissociation and specifically as part of the CIPOS protocol (see below)

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EMDR Therapy Techniques for Stage 2: Trauma Resolution

These techniques are appropriate for use by more advanced EMDR practitioners with an understanding of dissociation, memory fractionation, working with dissociative parts, and clinical hypnosis (where indicated)

- ➢ Flash Technique
- ➢ Titration of the Memory
- ➢ Wreathing Protocol
- ➢ Level of Urge to Avoid (LoUA)
- ➢ Constant Installation of Present Orientation and Safety (CIPOS) + Back of the Head Scale

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➢ Flash Technique (Manfield et al., 2017)

"The goal of the intervention is to painlessly reduce the disturbance associated with a target memory to a level that the client is no longer resistant to fully accessing it and processing it with standard EMDR" (p. 198).

Starting from a resourced state, a brief glimpse of the painful trauma picture allows clients to reduce the disturbance without actually feeling the pain. (Manfield, Lovett, Engel, & Manfield, 2017; Wong, 2021).

- ❖ Advanced Preparation Phase technique used to reduce the client's dissociative phobias toward accessing traumatic memory material, without the client needing to feel the distressing emotion/sensation associated with the phobia, thus reducing the likelihood of dissociative responses when reprocessing proceeds.
- ❖ Can be used without BL-DAS (Wong & Forman-Patel, 2022)

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➢ Flash Technique (Manfield et al., 2017)

Example

Client without contemporaneous amnesia symptoms who very much wants to approach a traumatic memory to resolve it, but finds that they have a strong, negative reaction—acute fear and depersonalization—every time they think about the target memory. In a relatively brief amount of time, using the Flash Technique, the client's reaction to the memory subsides to the point that both the fear of the memory and accompanying depersonalization are no longer present. The client is then able to reprocess the target memory.

Clinical Pearls

- The Flash Technique in an unmodified form is ideal for working with clients with complex PTSD and OSDD, where there is only one predominantly executive self-state—but it is not a replacement for Standard Protocol/full reprocessing
- Advanced knowledge/experience in treating dissociative disorders (beyond an EMDR therapy frame) is recommended before employing this technique with clients who experience contemporaneous amnesia symptoms or partial switching

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➢ Titration of the Memory (Kluft, 1988)

Abreaction: Reliving an experience to purge it of traumatic emotional elements

Kluft developed the "*fractionated abreaction*" technique (1988) in order to make the processing of traumatic memories more tolerable.

Kluft recommends starting with a very small piece ("dosage control") to make sure it is a positive experience and then picking up the pace as confidence grows (Kluft, 2013).

The following dimensions are suitable for fractionation:

A. temporal (selecting a short segment of the memory),
B. percentage (of distress),
C. BASK dimensions (behavior, affect, sensation, knowledge) and
D. alter participants (selecting participants carefully; Kluft, 1997).

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➢ Titration of the Memory (Kluft, 1988)

Clinical Significance

Clients feel in control of the memory when they work with the therapist to select a portion of the memory to work on and then stick to that plan (Kluft, 2013).

Significance to Dissociation

- Clients with DDs have complicated and horrendous memories. Titration helps them face the pain in doses they can handle and gives them a sense of accomplishment.
- No matter how much the memory work is planned, there are often dissociated bits of the memory that surface. Titration keeps surprises to a minimum.
- Titration also prevents "flooding" with emotion, and decompensation with unrelenting flashbacks or uncontrolled switching.

Clinical Pearls

"The slower you go the faster you get there" (Kluft, 1993). The important thing is for the client to have success with memory processing.

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➢ Wreathing Protocol (Fine & Berkowitz, 2001)

- The most disturbing or relevant BASK (behavior, affect, sensation knowledge) element is chosen for the EMDR target, and dissociative parts to be involved in work are identified
- SUD and NC (Not PC: mis-attuned, what therapist wants, unachievable)
- EMDR processing is interwoven with hypnotic interventions to maintain dual attention awareness, dilute and modulate affect, and provide containment
- Common hypnotic interventions: grounding, talking through, reconfigure parts (ask the upset one to go to safe place or bring her forward to help her), focusing, safe place, rheostat, slow leak, distancing maneuvers, directed relaxation, symptom substitution (turn the pain into a shape and color), vault, dreamless sleep, and permissive amnesia
- Expect rapid shifting from one BASK dimension to another
- Hypnotic interventions may also be necessary to shut down processing and contain the material.
- At session end - a secure hypnotic closure (Fine & Berkowitz, 2001).

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➢ Level of Urge to Avoid (Knipe, 2015/2019)

For clients who want to reprocess a traumatic memory, but for whom defenses are a frustrating barrier, the individual's avoidance defense may be the best point of access. Derived from A. J. Popky's 'Level of Urge' (1994, 2005).

Knipe (2015) targets the disturbance(s) associated with the avoidance:

"How much would you rather think/talk about anything else (but this)".

- Instead of a SUD, the disturbance that surfaces with this question is the Level of Urge to Avoid, or 'LoUA'.
- Knipe cautions that clients MUST be resourced enough and there needs to be sufficient time remaining in the session to process intense traumatic affect that may emerge once the avoidance urge dissolves (Knipe, 2015).

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➢ Level of Positive Affect (Knipe, 2005/2019)

Targets the positive affect associated with a defense, in other words, the dysfunctional positive affect.

The level of positive affect associated with the defense is the 'LoPA' (Knipe, 2005).

❖ Sources of 'positive' (or pleasant) affect include:

- ✓ comfort in hiding (from responsibility)
- ✓ procrastination
- ✓ dysfunctionally positive image of self (a "false self")
- ✓ idealized distortion of another person
- ✓ codependence
- ✓ dissociated part emotionally invested in a dysfunctional action.

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➢ LoUA and LoPA: Targeting Avoidance Defenses (Knipe)

Clinical Significance

These techniques can short cut many minutes or hours of discussion.

Significance to Dissociation

- Defenses should be targeted very carefully in DDs. Recommend exploration of the purpose of the defense with the part that is "creating" the defense and assessment of the readiness of the parts holding the memory or issues being defended to look at the work. Get full consent from all parts involved.
- These techniques help to avoid debates between parts and with the therapist.

Clinical Pearls

- These techniques can work beautifully. The LoUA or LoPA usually drops steadily with each set. Clients are amazed that the urges or "good" feelings from the defense disappear
- These techniques can work with all kinds of avoidance, even relationship issues and substance abuse

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➢ Constant Installation of Present Orientation & Safety (Knipe, 2008/2019)

Reinforces, with short set of BL-DAS, awareness of being present in the therapist's office, alternating with quick (2-10 second) "looks" (with no BL-DAS) at the traumatic material (Knipe, 2008).

- ❖ Short term memory of present orientation generally stays available for a period of 2-20 seconds. Thus, the client has an easier time returning to the present within that period.
  - ✓Describe the procedure and obtain permission from relevant parts.
  - ✓Begin reinforcing/installing the awareness of the present/the therapists office with BL-DAS. Check with Back of the Head Scale.
  - ✓Client and therapist agree how long the "looks" at trauma material will be, and whether the therapist should count out loud.
- ❖ Over-enthusiastic clients should be limited to 8 -10 seconds.

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➢ Constant Installation of Present Orientation & Safety (Knipe, 2008/2019)

Clinical Significance

Excellent way to help a client begin to tolerate a peek at an unbearable memory. Really gives them a sense of control over the flashbacks. CIPOS "breaks the ice" on a difficult memory.

Significance to dissociation

- For clients that cannot be simultaneously present in the office with the therapist and look at the memory (dual attention), this is a good way to train this ability.
- They also learn how to come out of the trauma and back to the present
- This technique can be used to reduce the phobia of internal parts (e.g., a frightening EP)

Clinical Pearls

Therapist and client can work collaboratively on deciding whether to increase the length of looks or how many looks to take. It depends on their goals (tolerate memory, process memory, learn dual attention, reduce dissociation) and the goals may change between rounds of CIPOS.

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STRETCH
BREAK
5 min

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EMDR Therapy Techniques Spanning All 3 Stages of Treatment

These techniques are appropriate for use by intermediate-to-advanced EMDR practitioners with an understanding of dissociation, working with dissociative parts, and clinical hypnosis (where indicated)

- Dissociative Table Technique
- ACT-AS-IF Model
- Dissociation of the Personality in Complex Trauma-related Disorders
- EMDR and Dissociation: The Progressive Approach
- Strategic Developmental Model for EMDR
- Inverted EMDR Standard Protocol for Complex PTSD

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➢ Dissociative Table (Fraser, 1993/2003)

- This is a powerful imagery technique that offers "access to the inner ego system of those suffering from disorders of dissociation" (Fraser, 1991)
- It creates an opportunity for the client to become familiar with their "internal cast" and creates opportunities for inner dialogues that can be useful throughout treatment (Fraser, 2003)
- Briefly, the client is asked to imagine a boardroom (aka, "conference room" or "meeting place") with a table and chairs; ego states are all invited to enter the space and to take a chair
- Fraser, in his original (1993) and "revisited & revised" paper (2003) outlined cautions on the use of the technique as well as additional techniques such as the "spotlight", the "screen" (a hypno-projective technique in the hypnosis tradition), the "middleman" and the "change room"
- Martin (2012) builds on Fraser's original instructions in 8 clearly defined steps and adds several innovations specifically for use by EMDR therapists; she suggests that the dissociative table technique first be used in Phase II: Preparation, and then throughout treatment

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➢ Dissociative Table | *Example*

- Therapist is using EMDR therapy Standard Protocol with a client with Complex PTSD to reprocess a present trigger relating to his professional life—specifically, a male peer who gets under his skin—where there were no noted connections to the past (based on attempt at floatback, etc.)
- During the course of reprocessing, associations from set to set begin to 'loop' on content specific to client's colleague
- Standard approaches to keep processing moving (changing direction/speed of EMs, cognitive interweaves, etc.) are ineffective
- Therapist opts to employ Dissociative Table technique to attempt to link up any dissociated memory networks
- Therapist obtains consent from client to proceed with intervention
- Therapist asks client to imagine their (already established) "meeting place in the mind's eye", then talks through the adult…

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➢ Dissociative Table | *Example*

"This is a message for the whole self:

I'd like to invite into the meeting place anyone who who might have feelings about 'that man.'

Whenever you're ready, just say 'here'."

*

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➢ Dissociative Table | *Example*

As a child part comes into conscious awareness, the client appears to shift into a light trance; he exhibits a wavering, tentative, younger tone of voice; a mixture of fear and sadness visible in the face; and abdominal upset

- *Therapist: Hello there. I wonder what you can tell me about the man?*
- Client: I'm afraid he's going to hit me.
- *T: Who is 'he'?*
- C: My dad.

Therapist checks for any previously undetected perpetrator parts (e.g., introjects) that are connected to this child part; none show up in the meeting place, and no disturbances are evident beyond those already noted. The therapist proceeds to obtain consent from the self-system to work with the child part to proceed with processing, and consent is granted; reprocessing continues

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➢ Dissociative Table | *Example*

- The client moves through the disturbance, and reports feeling significantly calmer and more present. The adult checks in with the child part, who reports that he no longer feels afraid
- Reprocessing of the original target continues through Phase V: Installation and Phase VI: Body Scan without additional 'looping'

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➢ Dissociative Table | *Example*

Clinical Significance

This technique is deeply rooted in the Ego State Therapy (Watkins & Watkins, 1997) and hypnosis traditions, but, with less dissociative clients, it can easily be used in the context of other 'parts' therapies and without eliciting trance

Significance to Dissociation

- This technique is a valuable and versatile framing device for mapping a client's self-system
- It's also great as an imaginal setting for conducting all phases of EMDR therapy (e.g., Martin, 2012; Paulsen, 2009)

Clinical Pearls

- Some clients cannot do this from an adult, executive point of view—particularly those whose front part (in DID/OSDD) does not (yet) have access to what's going on inside
- This technique can be made even more powerful when used in the context of clinical hypnosis

120

➢ ACT-AS-IF Model (Paulsen, 2009)

Paulsen's (2009) illustrated book 'Looking Through The Eyes of Trauma and Dissociation' explicates her model, which is an integration of EMDR and primarily Ego State therapy and other theoretical approaches in a stage-oriented approach.

Heavy emphasis on establishing safety, containment, assessment for dissociation, explaining how dissociation and dissociative systems work, and guidelines/ suggestions for ego state work and dealing with specific dissociative symptoms.

ACT-AS-IF:

- **A**ssessment, goes beyond history taking to include affect/soma tolerance, presence/extend of dissociation, cooperation (or lack thereof) amongst parts, etc.
- **C**ontainment and stabilization, including solidifying boundaries and ego strength, educating the client about dissociation, increasing affect/soma tolerance, resource development/containment, and realigning parts' loyalty away from perpetrators and back toward the self

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➢ ACT-AS-IF Model (Paulsen, 2009)

- **T**rauma accessing, to get the "lay of the land" (p. 123) with an aim to address double-binds, trance logic, dysfunctional internal dynamics and internal perpetration; recognizing and addressing dysfunctional interpersonal dynamics (e.g., projective identification, splitting) employing internal imagery to frame the work; effectively employing amnesia barriers (when present) to avoid premature integration or flooding; linking up the felt sense to ensure trauma processing can occur; identifying traumatic material, and developing a clear plan for what will be addressed, by which parts of self, and when
- **A**breactive association, using EMDR therapy, ego state therapy, and somatic methods, in a planful, intentional, and responsibly (and responsively) paced manner; standard EMDR therapy methods must be modified to accommodate the special conditions imposed by more acute forms of dissociation; the frame for this stage of the work is a process Paulsen calls ARCHITECTS

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➢ ACT-AS-IF Model (Paulsen, 2009)

- **S**kills strengthening, to introduce or reinforce the achievement of missing or incomplete developmental milestones, to enhance life functioning, and to reduce/eliminate cognitive distractions
- **I**ntegration, an ongoing process wherein dissociative barriers between parts become more permeable, as would be the case with healthier ego states; later int the process, during this stage of the work, comes more intentional and ceremonial connections amongst parts of self who have moved from surviving to healing to thriving
- **F**ollow-up, to ensure that all material has been addressed (including grief) and that the client continues to have a touchstone, when needed, in the form of the therapist

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➢ The Work of Sandra Paulsen (to date)

Clinical Significance

Paulsen's is an effective, comprehensive approach, which she has broadened in scope and deepened over a period of many years, and is a very good starting place for an EMDR therapist who may have no background in the approaches described

Significance to Dissociation

Paulsen was the first, and remains one of the few, of the practitioners and thinkers in the EMDR therapy field who has brought into her work a richness infused with concepts, theory, and practices from the dissociative disorders field (e.g., Paulsen, 2018)

Clinical Pearls

- Start here, but then build on these learnings by delving into the dissociation literatures
- Get training in clinical hypnosis, because it'll change your practice for the better

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➢ Dissociation of the Personality in Complex Trauma-Related Disorders

A series of 3 articles (Van der Hart et al., 2010, 2013 & 2014) that outline the therapeutic tasks in treating the structural dissociation of personality and how to incorporate EMDR as an intervention in all 3 stages of trauma treatment.

❖ Stage 1 Interventions:

✓Resourcing

✓Overcoming the phobias of

- attachment,
- trauma,
- trauma-related mental actions,
- dissociative parts,
- perpetrator-imitating parts, and
- young, vulnerable parts

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➢ Dissociation of the Personality in Complex Trauma-Related Disorders

❖ Stage 2 Interventions:

✓ Preparation,
✓ Exploration,
✓ Fractionating,
✓ Structuring processing,
✓ Determining the respective roles of parts,
✓ Keeping the client within their Window of Tolerance,
✓ Resolving attachment to the perpetrator,
✓ Containment, and
✓ Guided realization

❖ Stage 3 Interventions:

✓ Grief work, and
✓ Overcoming the phobias of fusion (or integration), normal life, and intimacy

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➢ Dissociation of the Personality in Complex Trauma-Related Disorders

Significance to Dissociation

- The Structural Dissociation of the Personality is a major theoretical perspective on Dissociative Disorders.
- These articles explicate how to treat DDs using EMDR from a Structural Dissociation perspective.
- Gonzalez & Mosquera were co-authors and there is a lot of overlap with their Progressive Approach. These articles are more like the theoretical background to their more practical Progressive Approach.

Clinical Pearls

The goal of treatment of structural dissociation is

- ✓ to reduce dissociative phobias and
- ✓ to help an ANP connect with the reality of the trauma (realization) and the whole person (personification) and EPs connect with the 'here-and-now' (presentification)

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➢ EMDR and Dissociation: The Progressive Approach (Gonzalez & Mosquera, 2012)

The Progressive Approach is a comprehensive EMDR treatment of dissociation that is based on Structural Dissociation theory (Gonzalez and Mosquera, 2012).

- ❖ The EMDR-AIP model is expanded by redefining "dysfunctionally stored memories" as "dysfunctionally stored information" (DSI). DSI includes trauma memories as well as related dysfunctional elements generated in the client's intrapsychic experience such as defenses, affect intolerance, dissociative phobias, dysfunctional positive affect, and the interaction among the different parts.
- ❖ The progressive approach involves the gradual and dynamic application of DAS to the processing of DSI from the very early stages of therapy.
- ❖ Goal is to reduce dissociative phobias, internal conflict, and lack of integration
- ❖ Therapists work through the adult part to develop communication, empathy, and collaboration with other parts, as well as metacognitive processes, integrative capacities, and self-care.

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➢ EMDR and Dissociation: The Progressive Approach (Gonzalez & Mosquera, 2012)

Tip of the Finger Strategy (TFS)

- A way to fractionate the traumatic memory. It's really an introduction to trauma processing by selecting a very small fragment.
- "Tip of the Finger" strategy uses the EMDR hand metaphor.
- The target in TFS is not the memory itself, but a small part of a disturbing sensation, emotion or behavior that may be considered a peripheral consequence of the memory.
- Use an outside perspective, beginning in the periphery and slowly approaching the central aspects of the memory.
- Don't ask for the elements of Phase 3 of EMDR. Just focus on the one element that has been chosen.

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➢ EMDR and Dissociation: The Progressive Approach (Gonzalez & Mosquera, 2012)

Significance to Dissociation

- Gently and respectfully chips away at dissociation by reducing dissociative phobias with a few sets of EMDR judiciously placed.
- May not be suitable for persons with DID, in some instances, because of the emphasis upon working 'through the adult' (see also Mosquera, 2019)

Clinical Pearls

- The tip of the finger strategy can work beautifully to reduce phobias.
- "Less is better than too much". Better to stop and congratulate client on insights, progress, improvement in affect…
- It is worth attending Dolores Mosquera's workshops just to see the videos, though she may have curtailed use of videos due to more recent changes in EU privacy laws. The book is step by step with many details and examples.

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➢ Strategic Developmental Model for EMDR (Kitchur, 2005)

- 1996, Alberta, Canada. Maureen Kitchur, MSW. Published 2005
- High risk, high needs clients, short-term funding
- Designed for Complex PTSD & personality disorders (Successfully but cautiously used in DDNOS, DID)
- Designed to be an efficient and comprehensive method for maximally delivering the benefits of EMDR
- Targets unresolved early-life negative experiences (neglect, abandonment, abuse, losses, and traumas)
- Uses EMDR to "clear out" all the nodal events in an individual's life that are likely to have impeded developmental progress
- Core principle: "Wherever possible and appropriate, effective psychotherapy should not simply alleviate a presenting problem, but should facilitate developmental catch-up."

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➢ Strategic Developmental Model for EMDR (Kitchur, 2005)

- ❖ Memories are "strategically developmentally sequenced"
  - "Strategic" = structures, techniques and language are employed to produce a climate of safety, to engage cooperation, to minimize dissociation, regression, and resistance and to facilitate "developmental catch-up".
- ❖ Younger ego states are healed before the adult trauma work
- ❖ Dissociation is less necessary as a protective coping strategy when ego states are not asked to participate in work that belongs to an earlier developmental stage
- ❖ Less need for lengthy RDI or ego strengthening
- ❖ Results in:
  - ✓ faster and/or more comprehensive resolution of all other targets
  - ✓ psychologically older clients
  - ✓ shrinkage or disappearance of symptoms before they are directly targeted (Metaphor: Key bricks in foundation)

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➢ Strategic Developmental Model for EMDR (Kitchur, 2005)

Major Components of Model

- ✓ Deliberate utilization of transference & attunement (esp. with regards to developmental level)
- ✓ Structured, directive history taking and assessment format via use of genogram
- ✓ Sensitive, facilitative, flexible language that assures clients of their safety and rapidly engages them in a "healing trance". Profound belief in the inevitability of healing.
- ✓ Flexible therapy for diverse populations: trauma victims, fragmentary memory or amnesia
- ✓ Sessions are 75 minutes, weekly

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➢ Strategic Developmental Model for EMDR (Kitchur, 2005)

Targets are selected in the following age group order:

- ✓ middle childhood (4-11),
- ✓ early childhood (0-3),
- ✓ adolescent, and
- ✓ adult.

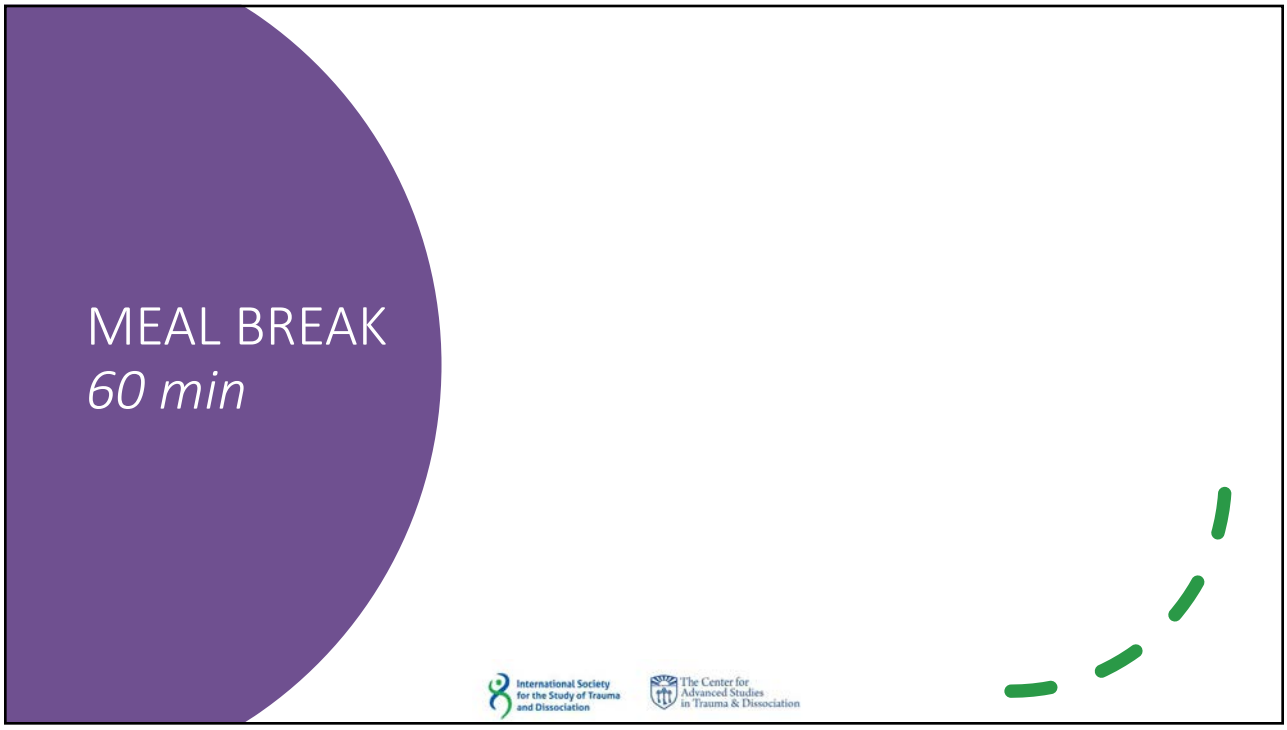
Within each age group (except for early childhood), the memories are targeted as follows:

- ✓ most disturbing memory of parent's relationship,
- ✓ most disturbing memory of one parent then the other, and then
- ✓ known traumas in chronological order. (Kitchur, 2005).

➢ Inverted EMDR Standard Protocol for Complex PTSD (Hofmann, 2010)

Developed by German-American psychiatrist and EMDR innovator Arne Hofmann:

- ✓ Addresses the three prongs in reverse order: Future, Present, Past
- ✓ Inverted order aids in gradually increasing client's affect tolerance and sense of mastery over self-regulating affect, etc.
- ✓ Moves gradually *backwards* to process touchstone memories that, in Standard Protocol, are typically the first to be processed
- ✓ Protocol in print form offers particulars of structuring treatment, including benchmarks to help determine when it is safe to move to the next (i.e., previous) prong of treatment



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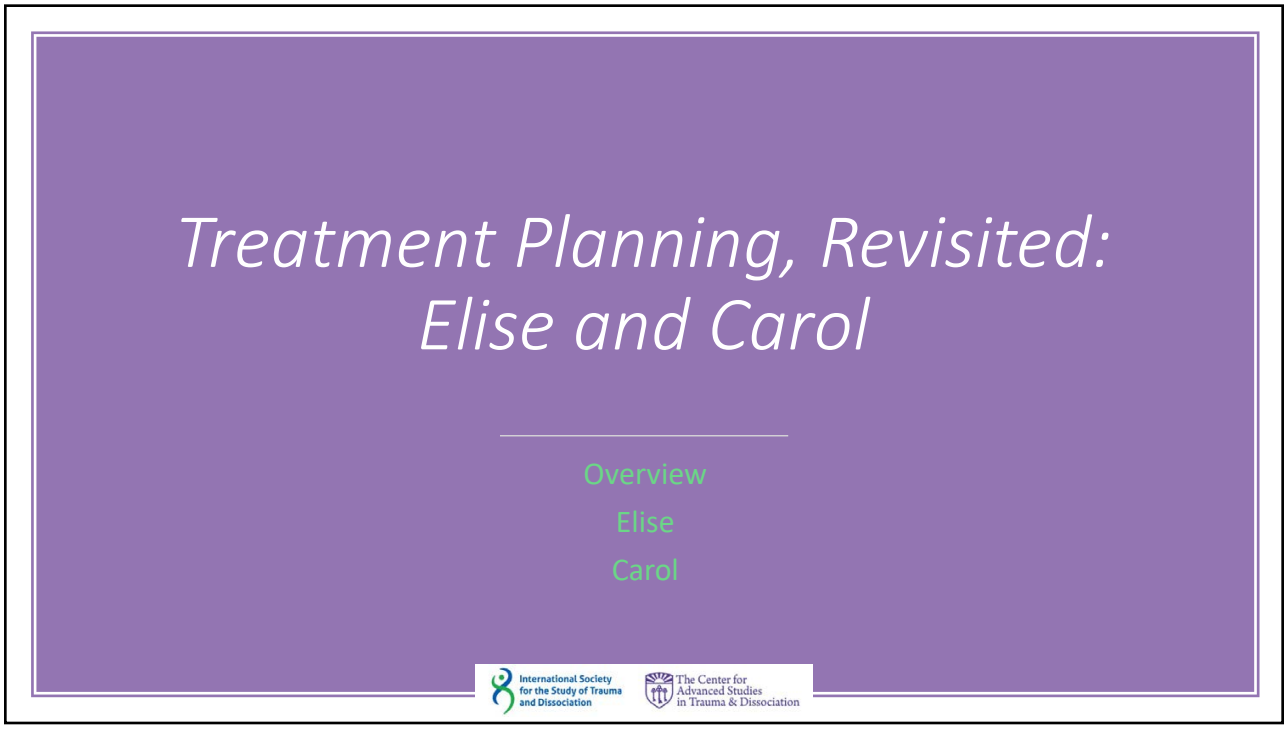

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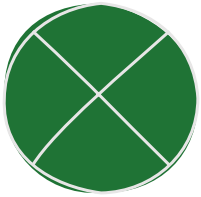
Scope of Treatment | *Single Incident*

Single Incident

- Focused on symptom relief
- May fractionate target (EMD)
- State change expected



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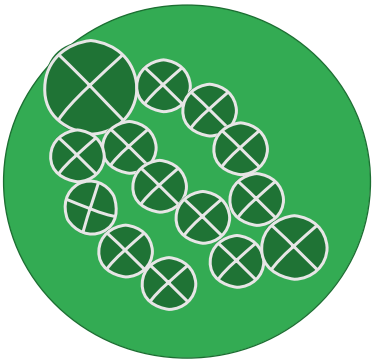
Scope of Treatment | *Timeline, Symptom- or Issue-driven*

Single Incident

- Focused on symptom relief
- May fractionate target (EMD)
- State change expected

Timeline, Symptom- or Issue-driven

- Focused on more long-standing or generalized symptoms
- Multiple Past-prong targets
- State change + some trait change



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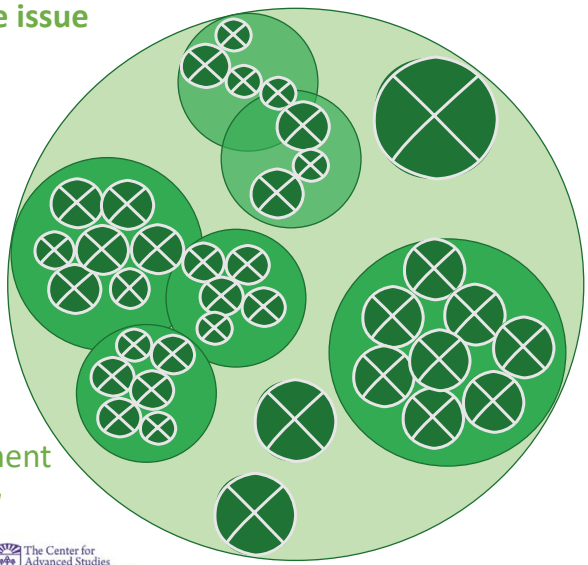
Scope of Treatment | *Comprehensive*

- **Client may initially present with single issue**
- A combination of single incident, symptom-focused, and issue-driven targeting sequences
- Standard Protocol, contained and restricted processing, and 'specialty' protocols, techniques, and methods for specific symptoms and issues
- Integrates multiple practice models
- May not be (and often isn't) linear
- May involve months or years of treatment
- Strives to effect both state change *and* trait change



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Target Selection & the 3 Stages | *Complex Trauma*

When treating clients with COMPLEX trauma <u>without</u> dissociative features indicating that there are independently functioning self-states…

- ✓ A multitude of events, developmental or attachment trauma, various manifestations of dissociation, and other confounding factors such as life stability, etc.
- ✓ Titration/fractionation may be necessary to successfully reprocess traumatic memories

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Target Selection & the 3 Stages | *Complex Trauma*

When treating clients with COMPLEX trauma <u>without</u> dissociative features indicating that there are independently functioning self-states…

- ✓ Treatment may need to 'toggle' back and forth amongst Stages 1, 2, and 3, during and between reprocessing sessions
  - ✓ Window of Tolerance issues may demand more robust and ongoing resource development
  - ✓ Internal conflicts amongst wounded ego states and/or perpetrator-identifying and other protective parts may need to be addressed over one or more sessions—*self-states are still a feature of complex trauma!*

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Target Selection & the 3 Stages | *Dissociative Disorders*

When treating clients with more complex dissociative features or a DISSOCIATIVE DISORDER…

- ✓ A multitude of events, developmental or attachment trauma, other confounding factors, such as life stability, etc.
- ✓ Extensive stabilization/containment work WILL be necessary, or may even be the sole focus of treatment
- ✓ Titration/fractionation and negotiation with a self-system is CRITICAL to successfully reprocess traumatic memories and memory material

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Target Selection & the 3 Stages | *Dissociative Disorders*

When treating clients with more complex dissociative features or a DISSOCIATIVE DISORDER…

- ✓ The flow of treatment amongst Stages 1, 2, and 3 is rarely linear, and is often recursive, returning again and again to each Stage
  - ✓ Window of Tolerance issues require continual evaluation and, as with general complex trauma, demand more robust and ongoing resource development
  - ✓ Internal conflicts and phobias amongst wounded self-states and/or perpetrator-identifying and other protective parts can be profound, and addressing them may span the entire course of treatment

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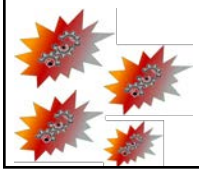
Target Selection & the 3 Stages | *Complexity = Caution*

REMEMBER, the more complex the client's difficulties...

- The more difficult and/or destabilizing it may be to identify the earliest experiences upfront—*amnesia for childhood experience is a significant indicator to proceed slowly and with caution*
- The more difficult and/or destabilizing it may be to reprocess the most painful, scary experiences upfront using Standard Protocol. For some, even attempting to use a modified form of EMDR such as EMD or EMDr may feel like too much at first—or EVER



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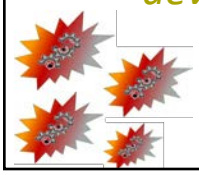
Target Selection & the 3 Stages | *Complexity = Caution*

According to ISSTD's Guidelines for the Treatment of Dissociative Disorders, EMDR therapy is <u>not</u> a front-line treatment for more complex dissociation and dissociative disorders. Significantly more training, ongoing consultation, and experience with both EMDR and dissociative disorders is required to ensure safety and effectiveness!

Comprehensive trauma timelines may be replaced with developmental or genogram-based timelines, which may be more tolerable and effective in treating <u>some</u> clients with more complex histories



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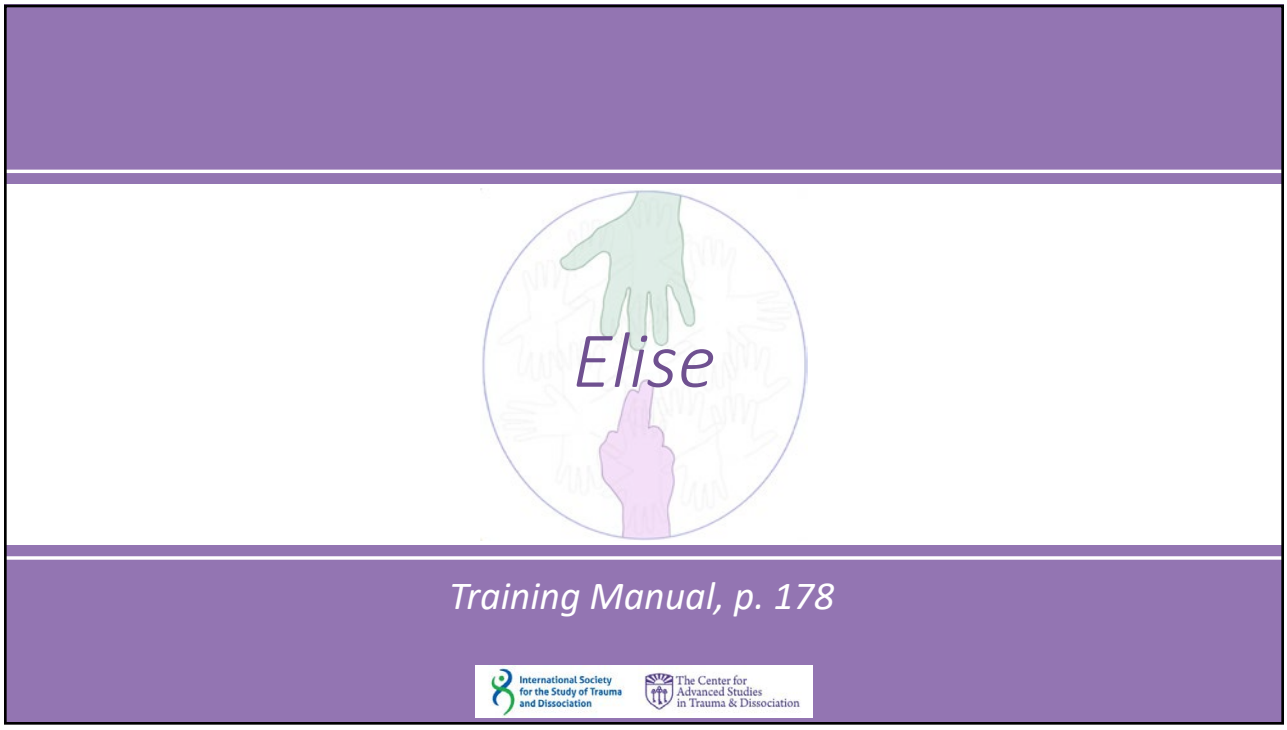

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Elise | *Initial Indicators of Complexity*

Presenting Problem: Uncontrolled outbursts of anger

History: Complex trauma history indicated by history taking

Screening and Diagnostic Evaluation: Although we saw indicators of post-traumatic and dissociative symptoms in Elise's DES and MID results, Elise's therapist did not evaluate as thoroughly, and opted to proceed with reprocessing via Standard Protocol based on superficial indicators-–primarily, both Elise's response to resourcing methods and her enthusiasm to 'try' EMDR to address what appeared to be classic posttraumatic stress.

Processing: Elise responded better to EMD, after flooding occurred with unrestricted processing using Standard Protocol…

So, let's look back at Elise's situation through our current lens…

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Elise | *Dissociative Symptoms – Barrier or Opportunity?*

MID Results: *CRITERION A: Memory problems (amnesia for history), depersonalization, derealization, flashbacks, trance*

CRITERION B: Voices/internal struggle, intrusive emotions, intrusive actions, puzzlement about oneself

CRITERION C: No clinically significant symptoms, but mean scores elevated (OSDD range) and clinical significance scores also fall in OSDD range

Readiness: *Elise has heard about EMDR and really wants to work on memories fueling her anger*

Likeable, with a good sense of humor

Physical health is good

Works hard at skills she is taught; no hx of being taught skills

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Elise | *Preparation: What Kind and for What Purpose?*

Identifying and Stabilizing Individual Self-states

The first task is to carefully help her gain control of her anger, which precipitates the suicidal urges.

Options include overall mapping of the self-system (Fine, 1991, 1993; Prince, W. F., 1916) the dissociative table technique, Ego State Therapy (Watkins & Watkins, 1997), the Loving Eyes technique and the Progressive Approach to reduce phobias of voices and other self-states, the Flash technique, CIPOS and Installation of the Therapist and the Therapist's Office. Knowledge of and experience with clinical hypnosis will enhance the impact of this work.

State Shifting

Container, calm/safe place, lightstream, and the four elements; training in a somatic therapy may also be of value here.

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Elise | *Preparation: What Kind, How Much, How Long?*

Grounding/Alertness/Orientation

Employing the Back-of-the-head Scale and CIPOS, the Howard Alertness Scale (Howard, 2017) and orientation enhancement (Twombly, 2000, 2005), etc.

These interventions are not the ONLY options, but are often used in the context of EMDR therapy, to ensure adequate stabilization and orientation to one's present circumstances to allow for successful reprocessing

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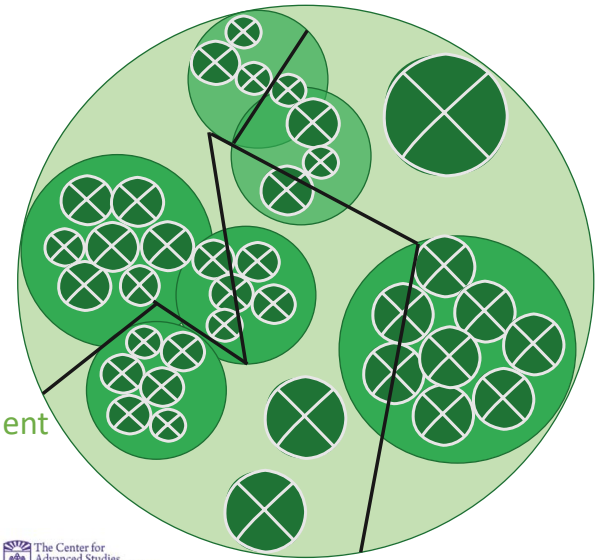
Elise| *Comprehensive, Integrative Treatment*

- A combination of single incident, symptom-focused, and issue-driven targeting sequences
- Standard Protocol, contained and restricted processing, and 'specialty' protocols, techniques, and methods for specific symptoms and issues
- Integrate multiple practice models
- Likely will not be linear treatment
- May involve months or years of treatment
- Strive to effect both state change *and* trait change



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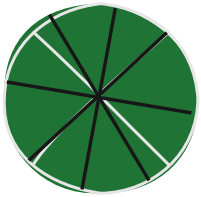
Elise| *Processing Symptoms and Issues as Single Incidents*

Single Incident

The date rape memory will need to be fractionated and processed over several sessions with careful attention to Window of Tolerance and Dual Attention.



The Flash Technique (to reduce the intensity to allow for full reprocessing), CIPOS (to offset depersonalization during processing), and EMD (restricted processing) are options.

Work with different self-states will be ongoing, and tracing symptoms back to specific self-states or internal dynamics. Conceptualizing them as single incidents may be of value to help determine the best approach for each issue.

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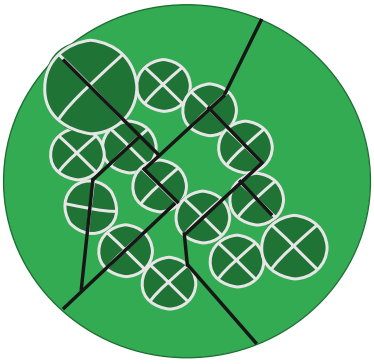
Elise| *A Timeline Encompassing Different Self-states?*

Timeline, Symptom- or Issue-driven

- Focus on more long-standing or generalized symptoms, once it feels less unsafe to do that
- Multiple Past-prong targets, employing fractionation and titration
- **Inverted protocol may be helpful**
- State change + some trait change is likely



For pre-age 3 experiences, the Early Trauma Approach is a solid option, along with attachment-focused EMDR to install a felt sense of imaginal nurturing figures.

Considering the needs of different self-states along a timeline of traumatic/wounding events may be helpful to organize the work.

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STRETCH
BREAK
5 min

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Carol

Training Manual, p. 179

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Carol | *Complexity Rules*

Presenting Problem: Chronic flashbacks/flooding; severely impaired functioning

History: Sexual assault by father one year ago, and sexual abuse by father in childhood

- *Had no recalled prior abuse history until more recent assault*
- *Now, earliest memory of childhood abuse by father is associated with a house family moved from when she was 4 years old*

Mother angry at her for making 'false' accusations against father

- *Hasn't spoken with M for a year; has threatened to call police if he ever shows up again*

Older brother has unspecified drug addiction

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Carol | *Dissociative Symptoms – Cautious but Curious Exploration*

Symptoms: *Uncontrolled flashbacks/flooding*
Severely impaired daily functioning

DES Results: *Mean Score—49.6*
DES Taxon Probability—just shy of 100 percent

MID Results: *CRITERION A: Memory problems, depersonalization, derealization, flashbacks, trance*
CRITERION B: Child voices; voices/internal struggle; persecutory voices; speech and thought insertion; intrusive emotions, impulses, and actions; intrusive actions; experiences of self-alteration; puzzlement about oneself
CRITERION C: Meets clinical significance criteria for all six Criterion C symptoms; minimal temporary loss of knowledge (Criterion B)

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Carol | *Preparation: What Kind and for What Purpose?*

Identifying and Stabilizing Individual Self-states

The first task is to carefully work to reduce the pervasive day to day amnesia and helping her gain control over the toxic flashbacks that make her want to hurt herself.

Options include overall mapping of the self-system (Fine, 1991, 1993; Prince, W. F., 1916) the dissociative table technique, Ego State Therapy (Watkins & Watkins, 1997). Knowledge of and experience with clinical hypnosis is a must in this work.

State Shifting

Establishing a container and teaching hypnotic methods (assuming you're trained in hypnosis!) may be the best initial means for this.

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Carol | *Preparation: What Kind, How Much, How Long?*

Grounding/Alertness/Orientation

Employing the Back-of-the-head Scale and CIPOS, the Howard Alertness Scale (Howard, 2017) and orientation enhancement (Twombly, 2000, 2005), etc.

These interventions are not and should not be the ONLY options, with some being borrowed from EMDR therapy, to ensure adequate stabilization and orientation to one's present circumstances to allow for successful reprocessing

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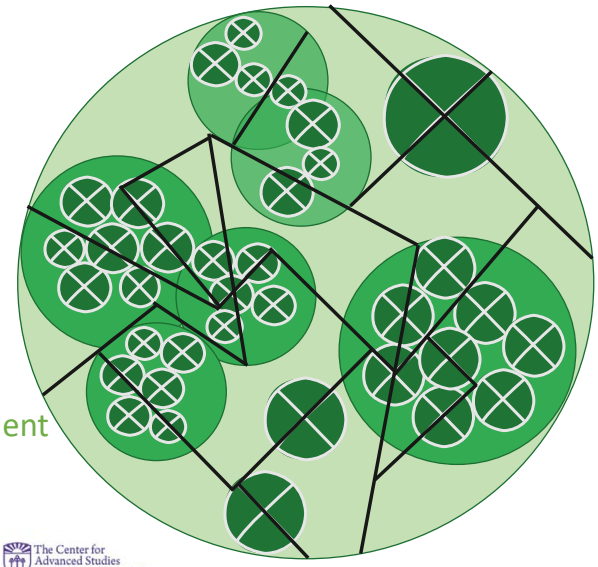
Carol | *Comprehensive = Integrative, Using EMDR Very Judiciously*

- A combination of single incident, symptom-focused, and issue-driven targeting sequences
- Standard Protocol, contained and restricted processing, and 'specialty' protocols, techniques, and methods for specific symptoms and issues
- Integrate multiple practice models
- Likely will not be linear treatment
- May involve months or years of treatment
- Strive to effect both state change *and* trait change



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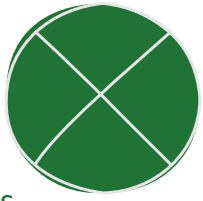
Carol| *Processing Phobias, Symptoms, and Issues as Single Incident*

Single Incident?

Some techniques within the context of EMDR therapy may be helpful, others may be too much for the client to tolerate.



As with Elise, a targeted approach to address some phobias, isolated symptoms, and discrete issues may be possible using EMDR therapy methods—either restricted processing (EMD) or a specialty protocol, for example, to reduce the impact of a particularly trauma-bound introject (Coy, 2020).

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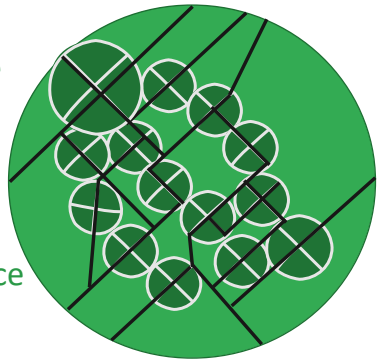
Carol | *A Highly Fragmented Timeline = A Challenge to Sequencing*

Timeline, Symptom- or Issue-driven?

It will very likely be some time, possibly even years, before a clearer sense of the full picture of the trauma history comes into focus.

There likely will be layers of phobias, both for different self-states and the trauma material itself, making it difficult to sequence trauma targets in the way you've learned during this training.



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Where You Are Now: Bringing It All Together, Moving Beyond the Basics

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Integrating What You're Learning with What You Already Know

- What from the training has and hasn't (yet) integrated into your memory networks?
- Is anything you're learning a paradigm shift for you? If so, how does that feel?
- How freeing (or limiting) does the practice of EMDR therapy feel to you at this point compared to a handful of months ago?
- What, if any, concerns do you have about using EMDR therapy at this point, and moving forward, with your clients?
- How might your way(s) of practicing continue to evolve to to more fully incorporate EMDR therapy?

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Continued Training & Consultation

- What is your level of competency & scope of practice?
- What will your next chapter of learning be?
  - Journal of EMDR Practice and Research
  - EMDR International Association (EMDRIA) membership
  - EMDRIA On Demand
  - EMDRIA Annual Conferences
  - EMDRIA Special Interest Groups
  - EMDRIA Certification
  - Training in clinical hypnosis, psychodynamic psychotherapy, an ego state ('parts') therapy, Deep Brain Reorienting, or a talk-based body-oriented psychotherapy
  - Journal of Trauma & Dissociation
  - ISSTDWorld Online Community, Webinars, ISSTD News, Book Club
  - Annual, Regional, and Virtual Conferences
  - Professional Training Program (PTP)
  - Adult and Child/Adolescent treatment guidelines for dissociative disorders
  - Special Interest Groups

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BRIEF BREAK
15 min

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Module IV, Day 2

Questions and Wrap-Up

- Group Consultation (via Zoom conference)
  - Attend one group to complete course requirements
  - Prepare to present one case, focusing on reprocessing through 3 prongs (past-present-future)
    - Other questions will be addressed toward the end of each group as time allows
- Complete Learning Assessment
  - OPEN BOOK
  - 80% 'pass' required to complete course and earn certificate of completion
- Complete Course Evaluations
- DEADLINE: July 31, then Certificate of Completion issued

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