DEEPENING EMDR TREATMENT EFFECTS ACROSS THE TRAUMA SPECTRUM:

INTEGRATING EMDR AND EGO STATE WORK

CAROL FORGASH, CSW, BCD
EMDR Institute Facilitator/EMDRIA Approved Instructor and Consultant

353 North Country Road
Smithtown, NY, 11787
Tel: 631 265 3194
Fax: 631 265 8676
cforgash@optonline.net
www.emdrandegostatevideo.com

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Introduction

The concepts, interventions, and techniques presented in this workshop are culled from theory and techniques of working with the range of the dissociative disorders). They have proved to be an effective addition to the preparation stage of the EMDR protocol. In other words, they can be used with clients who dissociate under certain conditions but do not have a dissociative disorder

Most of the traumatized clients seen for EMDR treatment have a range of dissociative symptoms as well as symptoms of PTSD. This combination of PTSD and a dissociative disorder is often labeled DDNOS. However, people with a more complex variety of PTSD usually have experienced very early and enduring severe physical or sexual abuse (generally perpetrated by a family member), atrocities, war, or severe environmental disruption such as earthquakes. They are more accurately diagnosed with disorders of extreme stress (DESNOS). For these clients, the dissociated neural networks, or dissociative fragmentation, cause serious problems in adult life.

The adaptive information processing system is on hold for these dissociated fragments or parts. They are easily triggered by internal or external cues to which they can have extreme reactions, (flashbacks, amnesia, losing time and place, and so forth.)

Our goal as therapists is to use EMDR to help clients (and their internal dissociated neural networks or parts) find stability and resources to function adaptively in their present life, and then desensitize and reprocess the dissociated trauma memories and the PTSD symptoms.

We aim to help our clients manage their symptoms. It is not our goal to eliminate dissociation, which has been a major survival strategy, but to help the client utilize it with conscious control.

It is important to note that attachment issues are an aspect of development that are especially impacted by trauma. The attachment styles of the family pre trauma may have already affected the client in negative ways, impacting the client's resources and responses to trauma.

One way to look at this set of problems is to utilize two approaches in the preparation phase of EMDR. These approaches combine the treatment of dissociative symptoms with ego state work and are an essential aspect of treating these clients with EMDR. This work may extend the preparation phase considerably, but will add safety and structure to the trauma processing experiences for these clients.

I. **Introduction to the Model**

EMDR is increasingly being utilized to treat these challenging patients. These patients often do not meet the criteria for the standard EMDR protocol. They frequently require EMDR treatment that includes an extensive preparation phase prior to any trauma work to deal with development of a therapeutic relationship, developmental issues, stabilization, affect regulation, dissociation, and resistances.

In this presentation, EMDR and ego state theory to help your challenging clients prepare for desensitization and reprocessing for more extensive resolution. Additionally, the sequential strategies implemented in the preparation phase supply safety and structure to a client whose childhood may have been affected not only by overt trauma, but by chaotic or disorganized parenting styles.

When used within the context of an established psychotherapeutic relationship, this integrated approach will enable EMDR practitioners to address the developmental lesions, attachment problems, and dissociative phenomena that are among the causative factors behind these clients' presenting problems. Theories of dissociation and ego states will provide a foundation for this integrated approach. This presentation will consist of lecture, demonstrations, case vignettes, and small group practica.

II. Strengths of the Model

A. Integrated Approach: This includes a systematic preparation utilizing ego state work to enable the dissociative or low functioning patient with complex diagnoses to profit from the later phases of the EMDR protocol. Without this approach, such patients can have disabling abreactions and destabilize when EMDR processing is attempted.

B. Complex Problems: Clients with dissociative problems as well as childhood trauma and loss histories have complex issues involving profound distrust and difficulties relating (attachment issues) as well as difficulties processing trauma material. The therapist must develop a relationship with the client and the client's internal system over time and employ interventions and strategies to achieve stabilization, thus enabling a sense of safety to develop. The therapist is seen as a dependable collaborative explorer. This enhances security within the system and frequently allows the client to venture into deeper work.

C. Technical Innovations: The use of alternating bilateral stimulation (also called Dual Attention Stimuli, or DAS) during the preparation phase and the development of ego-state-specific EMDR targets within the protocol permits a deep level of trauma reprocessing and new level of integrative healing. In mid- and high-level dissociative and personality-disordered patients, the specific targeting of ego state conflicts amplifies the EMDR protocol work. This systematic method of integrating EMDR and ego state work can be utilized by therapists of different orientations.

D. Treatment Goals

- Provide safety and develop stability in treatment and in current life experiences
- Help clients become affect tolerant and able to regulate emotional responses
- Reduce the level of life stress and help client deal with stress successfully
- Reprocess trauma, manage and eliminate symptoms of PTSD and DD
- Repair damage to boundaries and the internal structure
- Resolve relational and trust issues (attachment breaks and losses, fears of intimacy)
- Enable the client to develop empathy for self and the internal family system
- Help the client reach potential in a number of crucial areas, including the ability to meet own needs more effectively
- Help the client develop executive and parental capabilities
- Development of an enhanced internalized secure base of attachment
- Development of coherent self and object representations
- Formation of a cohesive sense of self

III. Dissociation and PTSD Symptoms

According to *DSM-IV* dissociation is defined as an alteration or retraction in the field of consciousness and disruptions in the usually integrated functions of consciousness, memory, identity, or perception of the environment. Dissociative disorders (DD) include symptoms of dissociation. The Types of DD included in *DSM-IV* are Dissociative Amnesia, Dissociative Fugue, Depersonalization Disorder, Dissociative Disorder Not Otherwise Specified, and Dissociative Identity Disorder. Dissociation can also be described as *primary, secondary*, and *tertiary*. The standard EMDR protocols only address primary and secondary dissociation. Typical manifestations of dissociation that clients describe and that you may see in the office setting are the following:

A. Primary dissociation

1. Flashbacks
2. Intrusive thoughts

B. Secondary dissociation

1. Depersonalization and derealization
2. Somatic aspects

C. Tertiary dissociation

1. Formation of ego states, inner children, self fragments, or alters
2. Tertiary dissociation is ubiquitous (Bromberg, Watkins & Watkins)
   a. A line of normal development
   b. Needs to be addressed diagnostic categories such as dissociative disorders and personality disorders of patients: If tertiary dissociation is not addressed in the therapy with such patients, it may lead to diminished or no response.
3. Neurobiological evidence for ubiquity of dissociation (van der Kolk)

D. Structural Model of Dissociation (See van der Hart, Nijenhuis et.al.).

E. Definitions of Trauma

1. A physical and psychological shock following an event of threat to personal, familial or societal integrity
2. A cutting of bonds: familial and societal
3. Reactions may reflect many variables:

a. if the event was of human design, reactions are often more severe.
b .the relationship and degree of attachment between the perpetrator of the event and the victim/survivor, age of the survivor.

F. Symptoms of Posttraumatic Stress Disorder (PTSD):

1. Subsequent to trauma, there may be a loss of safety, sense of aloneness, helplessness, vulnerability to triggers, isolation, lack of support. This is often compounded by a history of earlier trauma and pre-existing or chronic PTSD**.**
2. According to *DSM IV,* PTSD is defined as a person's response to exposure to a traumatic event. This includes intense fear, helplessness, or horror expressed in combinations of the following persistent symptoms:
   a. Intrusive recollections of trauma
   b. Sense of reliving trauma
   c. Hypervigilance, exaggerated startle response, and flashbacks
   d. Nightmares, night terrors, sleep disorders
   e. Irritability and agitated behavior
   f. Difficulties in concentration and focusing
   g. Anger dyscontrol
   h. Avoidance of people, places, and triggers or reminders of trauma
   i. Range of dissociative symptoms
   j. Numbing
   k. Flat affect, anhedonia
   l. Distress following triggers
   m. Feelings of isolation, detachment, and trust issues

G. Symptoms of Complex PTSD or Disorders of Extreme Stress (J. Herman):

A diagnosis that describes the traumatic adaptations to severe and chronic childhood neglect and abuse (Korn and Leeds). It includes alterations in seven areas:

1. Systems of meaning, loss of sustaining faith, hopelessness and despair
2. Relations with others, failure to protect oneself, isolation, withdrawal from and avoidance of intimate relationships
3. Perceptions of the perpetrator
4. Self-perception, guilt, shame
5. Regulation of affect and impulses
6. Attention and consciousness
7. Somatic alterations (somatization)

IV. Ego States

A.**Development of ego state concepts** (see Federn, Watkins and Watkins, Berne, Erskine, Kluft, Fine, Kluft and Fine, and Schwartz for historical background, theory and practical considerations). Ego state therapy utilizes individual, group, and family therapy techniques for the resolution of conflicts among the ego states that constitute the internal family.

B.**Description of ego states include the following:**

Segmentation of personality into ego states at points of the dissociation continuum due to normal differentiation, introjection, or trauma
Organized system of behaviors and experiences
Neural networks (functioning on a range from normal to dissociated)
States have varying boundaries
The system may be organized to enhance adaptability in coping with specific events/ problems
Some ego states delineated by time dimensions
Other states delineated by function, trait or role, e.g., self-hater, nurturer, critic, executive, child states, exiles, managers, firefighters, core self, etc.
Ego states formed in childhood may function maladaptively in present situations.

Ego states function to protect their roles and existence, even if counterproductive to the adult. They may fear annihilation if they "lose their jobs".
Ego states can conflict with each other vis-à-vis their roles, leading to intrapsychic conflict.
Ego states have the capacity to change, combine, grow, and form adaptively in throughout the life span: both in childhood and adulthood.
Ego states may have normative imaginal and creative functions, for example daydreaming.
Ego states may be seen as having existence in body parts.
The existence of ego states may not be known to the client, or to the individual ego states.
Ego states collectively may be described as: an ego state system, internal family system, parts of the personality, or states of mind.

V. Utilizing the Model: Integration of Ego State Techniques and EMDR Trauma Work with Dissociative Clients

(see Bergmann and Forgash; Fine; Paulsen; Twombly)

A. The preparation phase (or stabilization phase) of the EMDR protocol involves phased sequential work. The goals of this phase include some development of skills by the patient that foster stabilization and safety and developing readiness for desensitization and reprocessing.

1. History taking, (including genograms), and the building of the therapeutic relationship, affect management, and dissociation symptom management are among initial activities.
Resource development/enhancement and ego strengthening are extensive for these clients.
In this phase, the client may learn about ego state concepts and also may start to work with the ego state system.
Timing and assessment will determine readiness for ego state work
This stage always precedes trauma or other targeted work (desensitization and reprocessing) with dissociative clients.
Length of phase varies with varies with client's ability to develop and master affect management skills/ resources and effectively deal with dissociative symptoms
It is essential that clients be screened for dissociative disorders prior to any treatment with screening interviews such as the SCID-D or DDIS.
Psychoeducational information: other important information such as description of the treatment process and information about EMDR, PTSD, dissociation, triggers, etc. is offered to the client in this phase.
The rate at which the client can take this in comfortably must be arrived at by the client and respected by the therapist.
Learn what the client knows about dissociation (which they may understand and describe as "going away", numbing out, leaving their body, feeling flooded) and under what conditions these symptoms occur.
The questions on the DDIS refer specifically to these dissociative phenomena.

2. Creating the environment for ego state work: psychoeducational approach.
(Readiness must be ascertained and reassessed if necessary.)

a. To teach and normalize ego state concepts.
Always ascertain readiness to tolerate this information.
Always use descriptive terms that fit the client's language and style:
States of mind, fragments, internal objects, internal family system, a committee, core or part selves.
For some clients, the term "adult" is the same as "core self."

b. Some clients will be hostile, unwilling or anxious about discussing ego states.
Explore the issues rather than persuade the client.
Remember there may be fearful, traumatized, protective or hostile states for whom revealing anything about their existence is dangerous.
The client's capacity to empathize with traumatized or dissociative parts may be diminished.

For these clients, provide more information about the ego state system in general (ex. all humans apparently have ego state systems; or we all say "a part of myself or parts of myself don't agree) and provide any specific information needed.
(ex. These are metaphoric, imaginal language concepts; parts exist only inside of us etc) and postpone further exploration of the client's internal system.
For some clients, concretizing this system via mapping, internal genogram, making lists of known strengths (client personal resource list), or drawing is helpful. Some clients only recognize negative traits

c. Develop an understanding of the client's emotional and physical reactions, awareness, experiences, and sensations as the client accesses the parts.
For some, this may have to be postponed.
In this work, it is always important for the therapist to notice if the client can stay present (not dissociated). Check to see if they are "in their body."
If this remains a problem, do not use ego state approaches. (see Soothing Work, below)

d. Utilizing ***Dual Attention Stimuli*** (DAS), also called Bilateral Stimulation (eye movements, tapping, and audio)
The use of DAS may enhance this preparation work. Use diagnostically to see if client can develop a calm, relaxing or **safe space** or use other visualization exercises. If not, postpone use of DAS. Knowledge of your individual client and diagnostic use of DAS will help you decide whether short or long sets work more effectively. Always begin with a few short sets.
For clients who are not well grounded, DAS will be used to reinforce and strengthen specific exercises **when** the client is able to **tolerate** this usage without dissociating or experiencing distress or agitation.

3.**Readiness Activities**: sequential steps to help the client and ego state system build safe and stable internal structures become acquainted, establish boundaries,learn techniques to manage symptoms in present life)

a. Creating an area for the ego state system to live and play.

Home base (HB): a place of stability for the internal ego state system. It may be visualized by the client as a metaphorical place such as: a comfortable scene in nature, house in the country, the beach, a log cabin, a room in the client's house, etc. It is generally a different place from the ADULT client's place for relaxing (watch language—for some clients, no place has been safe! Use other words like "comfort" or "relaxation" place). It may be installed or strengthened with DAS. Initially, it may be very sketchy, unclear and difficult for the client to use this metaphor. For a client who grew up in a chaotic, violent or abusive family environment, this may be an impossible thought at first. They may be angry or disown the system, and therefore not want to give the parts a home, or think it is a foolish idea. It is a metaphor. The parts may be described as living in the home base which ***only exists*** inside the patient (usually in their head).

Workspace (WS): This can be a conference room, family room or other safe suitable place inside the home base, or in the woods, to work with the ego state system. Other terminology includes:
- Round table (also known as the conference table)
- Empty chair
- Interweave: "If a part of you who knows about this problem could come through the doorway, who would it be?"

b. Getting acquainted (using the workspace to facilitate meetings)
The client needs to meet the ego states; they need to meet each other, at some point. They may know directly or indirectly of the existence and roles held by parts.
The client needs to know that at first, they may only sense parts and not see them.
Not all parts have to come to the workspace /conference room when invited.
This is a process and may take time.
Reactions in the client and within the system can range from surprise to relief, feelings of normalcy, disapproval, disgust, revulsion, somatic reactions, and so on.
Negative responses may predict early negative relational and traumatic experiences.
Encourage discussions, dialogue, sharing of information.

4. Anticipating problems

a. Client refuses to work with or acknowledge ego states: educate, explore and reassure.
b. Client feels inadequate or stupid doing this work. Educate, reassure, discuss alternate ways.
c. Client cannot "see" or visualize parts; may only have a "sense" about them. This is fine.
d. Client is too dissociative or overwhelmed or panics. Educate and reassure, work on therapy relationship, implement strengthening skill building activities.(see below).
e. Do not use ego state work at this time. Utilize readiness and other management techniques with the client (see F below).

5. Orienting the ego state system to present reality

a. It is important for both the therapist and client to realize that ego states may have varying beliefs about time and space, past and present, the client and the therapist, etc.
b. You will notice that dissociative clients frequently come into the office and look around as if they have not been there before. Suggest they look around the office. Notice how the client does this to get an idea of the age of the ego state that may be present. Have the client ask the ego state (ES) if it knows you (the therapist) and knows why it is in your office.
c. Encourage dialogue between the client and ES about this.
d. The ES (or ES system) needs to be oriented to the current year, perhaps the season, even the month.
e. The following information about the adult client needs to be identified to the ego state system: age, gender, roles, job, home, current family, etc. Use a visual approach: a movie of the current life, split screen showing childhood home, adult home. The screen can be movable to create safety. The rate at which this information can be disseminated varies with the client and system and stage of treatment.
f. The following need to be diplomatically stated and **frequently restated** over time:
- All ego states exist within the "adult" client's body or brain.
- No ego states live in their childhood home, or with their parents (if factual).
- The childhood trauma has ended.

g. Expect resistance and emotional reactions from the client and ego states.
h. Orienting traumatized ego states to the present may alter the fixed quality of the state-specific memory or neural network that holds the traumatic material.
i. Use DAS as appropriate.

6. Safety and soothing work

a. Creating and maintaining safety and control for the system in sessions and in between sessions: Enhances ability of patient to stay present in session. Use prior to any ego state work if the patient does not have readiness. Use with DAS if appropriate. Patient can learn these techniques in the presence of the ego state system and practice with them in session, and in between sessions. Increases feelings of self control.
b. Help client create and practice with—
- Containers (for the temporary containment of overwhelming, stressful thoughts, emotions, and memories). Client learns to put such feelings in a box or other container. They may develop a room in their homebase which holds these containers. Examples: a hatbox, Tupperware with a tightly fitting top, central American worry dolls, blackboard (To write upsetting thoughts, and then erase.)
- Affect dial or remote control box (with radio or tv or movie screen): for distancing from target scene or putting feelings and thoughts at a distance. Clients become very adept at using an imaginal "remote control" for putting pictures, words, feelings on the screen and manipulating them; making them large, small, turning them off
- Centering/grounding exercises (particularly for stressful situations and driving where they may begin to dissociate). This is somatosensory work. Examples of questions to ask clients:
  Can you feel the couch behind you.
  Can you distinguish between the fabric of the couch and your jeans.

Can you feel your feet in your shoes.
Clients can learn to discriminate between textures etc.
In the car, if they feel they are beginning to dissociate, they need to know if they can feel the steering wheel under their fingers, or feel the material of the seat: if not, they agree to pull the car over and practice these exercises until they feel present.

- Stress reduction activities (progressive muscle relaxation, meditations)
- Regular reminders to stay in safe place or home base (set up times, events for which this will be helpful)
- Check-in by adult in between sessions: develops affect tolerance and "parenting skills.".
  Is client willing to visualize themselves saying "hello" once a day just to see how the group is doing
- Resource development work

c. Soothing work can be initiated here if the client has empathy with any/all of the self states (or parts). Inability to soothe indicates further ego state work.

1.The above exercises are often felt as soothing to the person or system. Other soothing work can include holding or rocking a part, visiting a part or parts, assuring the willingness to work on problems, promises to not abandon, adding and furnishin new rooms in the home base, taking a part or parts to the client's safe space, doing visualizations together, and reassuring a frightened, shamed part.

2 It is extremely important to let the ego state system develop a ***stop signal*** to use whenever necessary.

3. You must negotiate a pace for the work and be flexible about changing it whenever necessary.

4, Help clients develop coconsciousness, self-talk, and inner dialogue so that they can develop an awareness of the "inner landscape." Practicing the exercises(above) in the presence of the "parts" help promote co-consciousness

5 Continue to teach *grounding, centering, protective,* and *distancing* exercises that will help the person come out of dissociative episodes (both in and out of sessions) and improve management of dissociative symptoms.

6..Somatosensory work: using the body as a positive resource
(Visualizing the most relaxed part of your body) can be used for stress reduction, will be used to prepare client for trauma work.
Client learns to focus on this body resource when they feel they may be triggered or flooded by emotion, flashbacks etc. (Peter Levine).
Issues related to body image, bodily experiences of abuse, and symbolic and actual somatic problems must be addressed.

7. End sessions with debriefing and relaxation (for example, lightstream exercise).

8. Journaling, drawing, or other expressive work can be used as homework—acts as a container and helps in target selection.

d.Back of the Head Scale (BHS)

1 *Purpose:* for assessing degree of dissociation (Jim Knipe)

2. The **BHS** is introduced to the client during the preparation stage, before any EMDR trauma work is begun. The therapist says, "Think of a line that goes all the way from here" [Therapist holds up an index finger about 15 inches in front of the persons' face].
"Let this point on the line mean that you're completely aware of being present here with me in this room. Let the other point on the line, at the back of your head [therapist moves index finger] mean that you are so distracted by disturbing thoughts that you feel like you are somewhere else."
The therapist should check to make sure the client gets this idea.
The BHS can then be used at any point in the session to assess whether the client is sufficiently oriented to present reality to continue trauma processing.
Client can learn to recognize degree of dissociation with this technique

3.Constant Installation of Present Orientation and `Safety` (CIPOS)

a.The CIPOS method seems to be useful with clients who are highly frightened and disoriented with regard to their own post-traumatic memory material.

b.These clients are not generally ready for protocol work if they dissociate during discussion of any traumatic memories.
c.Teach CIPOS at this point.
d.If protocol work has begun and the client appears to be dissociating, stop the protocol and teach CIPOS.
e. The components of this method are as follows:
High level of rapport, preparation, and stability. Identification of the disturbing memory. Permission of the system is necessary.
f. Ample session time—at least 90 minutes recommended for highly disturbing memories.
g. The client must be able to acknowledge that objectively and factually the trauma is in the past, and not currently happening.
h. The therapist then asks a series of simple questions relating to the present reality of the therapist's office (e.g., "Where are you right now?" "Can you hear the cars outside?" "Can you see that tree out that window?" etc.) When the client answers accurately, a short set of eye movements is initiated to strengthen the sense of present orientation.
i. Through the use of the Back of the Head Scale (BHS) the therapist is able to assess the effectiveness of the CIPOS interventions.
j. When present orientation is sufficiently established, the client is asked if they are willing to close the eyes and think of the memory image for a very brief period of time (two to ten seconds, *without bilateral stimulation*).
k At this point, the therapist says something encouraging ("That's right") and then resumes the CIPOS interventions with questions like "Where are you right now in actual fact?" The answer is followed by another short set of ems.
l. As the process is repeated, the client develops increasing ability to "stay present" as well as greater confidence in confronting the disturbing memory.
m. The client's answers to the CIPOS questions may reflect the reality of the therapist's office, but may also express information regarding the trauma itself
n. The BHS can be used not just to assess clients' current orientation but also to provide additional positive resources during the processing.

7. Constructive Avoidance (CA)

a. Purpose*:* For dealing with anxiety or stress-provoking present situations. Clients in treatment still have to function in their communities, jobs, roles and deal with situations that cause anxiety, triggering, stress, etc. in current life. Many clients with severe ego state disturbances or dissociative symptoms do not have the skills to cope with these situations.
b. Components
1.The client and ES system need to create a home base where the ESS (EGO STATE System) can "live"—a place where the client can talk to, comfort or play with the ES system outside of sessions.
2.When the client is going to encounter a situation that has caused high stress or triggering in the past, and has not completed (or begun) processing, or focusing on that target, chances are that the ES involved are not yet ready to deal with the situation. They can remain at the home base while the client is in that actual situation (i.e. Job interview, medical appointment etc). Practicing this prior to the situation is necessary and helpful.
3.In some cases, the system functions with less agitation if the ES can view the situation (depending on the appropriateness) on a screen as it is occurring.
4.Clients can become very adept and creative about situations and events in which they have previously been uncomfortable by using this aproadh.

8. What does the system need to proceed?

a. Always ask permission for the system to work. System-wide consensus is needed to work on traumatic material.
b. Developing means of communication for exploring conflicts and resolving issues.
c. Resource building and enhancing activities
d. As frequently as necessary during the treatment the therapist must reassure the client system that the ego states will not be killed off or expelled. Give information that they were all, at one time, formed for survival purposes (adaptive) even though in the present

the behaviors, beliefs, etc. may not be adaptive.

9. Long-range systemic changes

a. Over time during the course of treatment parts may evolve, change, give up roles, and develop empathy. This will occur through internal decisions, cooperation, and trauma reprocessing. This will be an evolutionary process.

b. The therapist has to form alliances with the ego states throughout the phases of treatment. This particularly applies to the angry, self-hating, destructive, and punitive ego states. Identifying them and acknowledging their pain, qualities, and roles is crucial.

c. The client needs to learn to self-soothe, reparent, end denigration of self and parts, and develop acceptance of the parts and the system. Deal with issues of safety, responsibility, and choice.

VI. Moving toward Trauma Work

The following activities can be used diagnostically to check readiness. They can also be previewed and practiced to facilitate and enhance EMDR treatment.

A. Obtaining permission to undertake trauma treatment. This may require negotiating at several stages of the treatment.
B. Patient and ego state view the target together on screen
C. Facilitating self-nurturing and parenting
D. Exploring and reworking conflicts: facilitate with drawing, journaling, dialogues, and conferences
E. Combining ego states (also called "blending" one state to the other, a temporary merger) to strengthen specific parts, prevent flooding
F. Forming internal alliances
G. Developing communication system: therapist to part(s), patient to part(s), part to part

VII. Utilizing Trauma Work (Desensitization, Reprocessing and Installation Phases)

The EMDR trauma processing in the treatment of clients who dissociate is utilized in combination with techniques and strategies common to treating dissociative disorders. These include fractionated work, (working on small sections of a memory in a session) learning to titrate affect, learning to stay present, and regrounding. In other words, skills learned and practiced in the preparation phase may be used throughout the trauma processing as needed. However, for some clients preparation work may no longer be necessary, and the trauma processing may proceed as usual.

A. For patients who do not have internal resources and ego strengths and cannot identify emotions or body sensations, the use of the full protocol can produce feelings of failure, frustration, and regression. Strategies as described in the preparation section will have to be developed and practiced until the client's readiness is established.
This phase may take months for clients with severe symptoms of dissociation to complete.
B. As clients gain the resources and ego strengths, trauma processing is either begun or, if started prematurely with patients who were not prepared for ego state work, resumed after the readiness work is completed.
C. Protocols may be ego-state specific. More than one ego state may participate along with the adult client if requested.
D. Some ego states may require separate VOC, SUD, NC, and PC (although if they participate, they often agree with the “adult’s” ratings and target selection)
E. Utilize fractionated work when necessary. **Be prepared to work in Kluft's rule of thirds.**
F. Interweaves can be lengthy (many sessions), including resource, ego state, cognitive, dynamic, and somatic. Positive somatic awareness is encouraged as necessary resource. Targets can be body parts; body distortions and NCs can refer to distorted belief about body part.
G. Body processing can be lengthy, with frequent returns to target if necessary.

H. Imagery work is used to go back into a past event with a specific self state or part for speaking out and reworking. Also used for bringing a part out of the past to see what its needs are for nurturing or developing targets.

I. Sessions end with debriefing, containment, safety, and relaxation work.

J. As desensitization and processing proceed adaptively, ego states change, merge, integrate, leave, disappear, join, help, and observe the protocol and other work.

K. As with all EMDR protocols, work on present triggers and future template

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