

**Dissociative
Disorders:
Diagnosis, Stabilization, Internal
Communication and
Cooperation, facilitated by
EMDR**

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Workshop Overview

- **Risks of EMDR with this population**
- **Using EMDR adaptations to orient parts, development and installation of other skills**
- **EMDR protocol, etc.**
- **Post trauma stages, and use of EMDR**
- **Questions and discussion**

Janet's 3 Phases with Kluff's 9 Phases of DID/DDOS Treatment with EMDR and EMDR Adaptations

Phase I: Symptom Reduction and Stabilization

1. Establishing the psychotherapy

2. Preliminary interventions:

-Safe Space Imagery, other hypnotic coping skills

-RDI

-Current Time, Height, and Life Orientation

-Install Therapist and Therapist's Office

-Protocol for Clients with No Oriented Parts

Kluft's Stage 1: Establishing the Psychotherapy

Create an atmosphere of relative safety

- **With boundaries (phone call, cancellation policies – much easier to clearly state in advance, than to do it later)**
- **Teach client about the tx process and their responsibilities: homework, that you'll be working with them as a team, guard against compliance, let them know they don't have to answer questions, can ask questions, let you know re mistakes...**
- **Psycho ed on trauma tx**
- **Consider medication**

My Medication Recommendations

PS I'm a social worker!

- Antidepressants: Zoloft, Prozac, Lexipro, Paxil type
- Neuroleptics aka Antipsychotics: Geodone, Zyprexa, Respiradone
 - Can also be used PRN
- Benzodiazepines PRN: Ativan, Klonipen
- Naltrexone
- Clozeril: drug of last resort
- Install meds with bilat. Stim. /Cue!

Things to Keep in Mind re Clients with DID/DDNOS

Live with a “multiple reality disorder” in “... several parallel but incompletely overlapping constructions of the world and of life experience.” (Kluft)

The part of the DID person who shows up for treatment and seems like a whole person, is not.

Parts not addressed directly frequently are not listening, and they probably won't be learning whatever you're teaching.

**EMDR talks about helping clients maintain Duality.
DID therapists need to hold awareness of
Quadrality: Clients Past, Present, Part who's
present in session, Internal System**

More things...

- **Get to know the whole person**
- **Many parts may be stuck in the past, i.e. believing they are still children, living where they grew up, with their parents, being abused every day.**
- **All work with parts needs to be done with the system taken into consideration**

Kluft's Stage 2a: Preliminary Interventions Summary

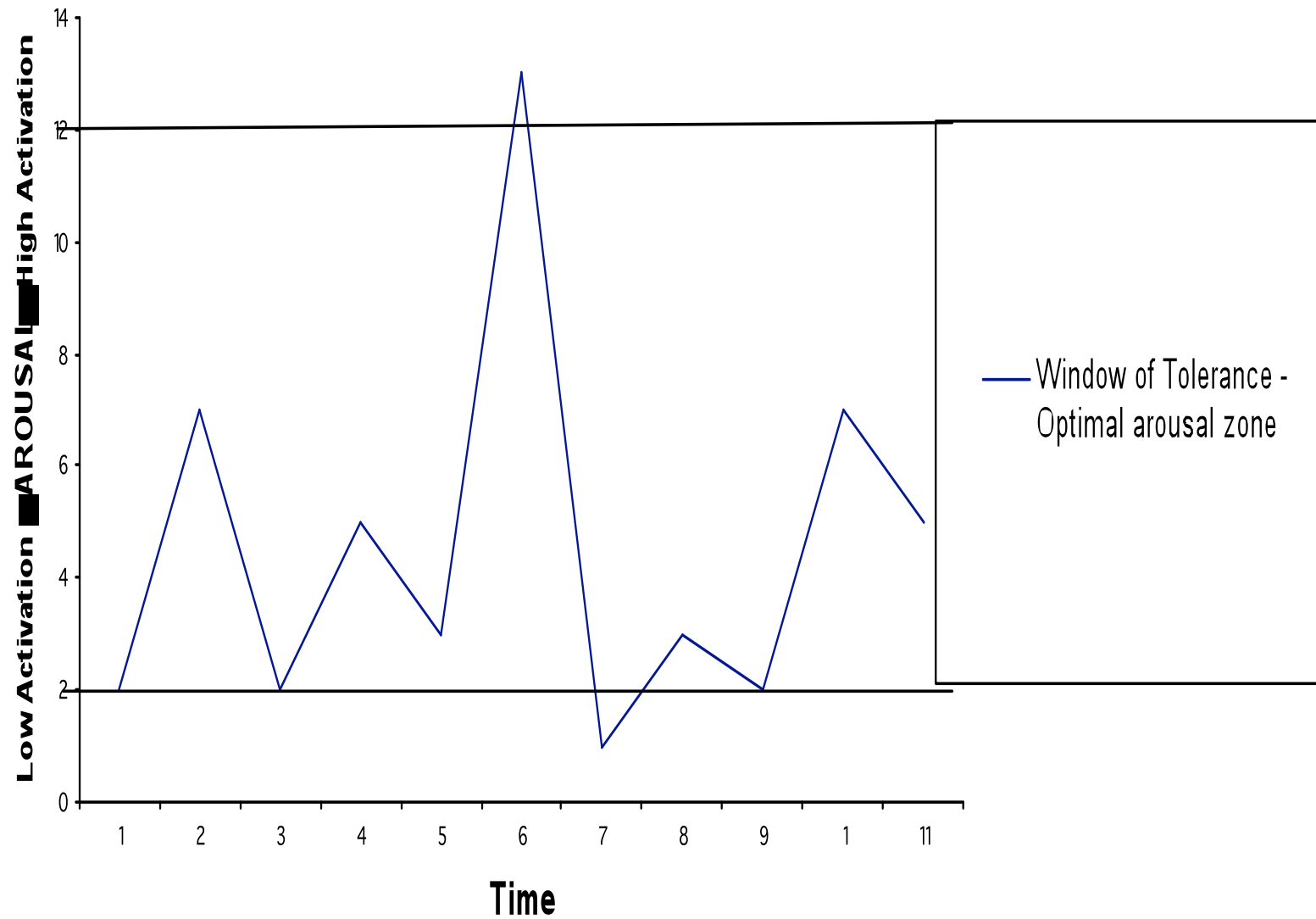
- Getting to know parts of the mind - thru host vs host and parts.
- Communication and cooperation with as many parts as possible or practical (some have lots/ layers), who's going to be out, negotiating, helping each other, empathy
- Dutch door comm. Is about today, permission to keep traumatic material dissociated
- Symptom management/coping skills/mastery
- Beginning to orient.

Stage 2c: Coping skills – Using Dissociative

Ability Proactively: Kluft article on temporizing techniques (1989)

- Symptom management: coping skills
- Psycho-ed piece: some think coping skill work isn't the real work. Some think their healing will happen if they “get the memories out”
- Explain: in a good enough childhood children develop a foundation of security and confidence that if something goes wrong, things will get better. Children also learn to manage strong feelings...
- Working on developing coping skills is working on trauma because it's teaching what you didn't get back then, and is giving you control over symptoms and your life in a way you never had... Mastery!

Modulation Model (Ogden and Minton, 2000)



Hypnotically Informed Wording to Facilitate Imagery (Brown, Kluft, etc.)

1. Watch for idiosyncratic negative responses to words
2. Keep track of words used by client and use them
3. Use of positive suggestion to anticipate and guide to positive response
4. Link suggestions: *as you do this/notice this, this will happen...*
5. *Repetition: More and more, easier and easier*

6. Reinforce success with ego strengthening comments to emphasize and develop self efficacy and control
7. Support communication with client through out exercise.
8. Pause to give clients time to visualize, learn client's rate of response..
9. State things in a confident, positive way. No negatives!

10. It's ok to suggest imagery, but it's best if it comes from the client.
11. In trance people are very concrete. Be aware of wording.
12. In the format of a post hypnotic suggestion, give suggestions to increase the possibility of unconscious progress during the week (e.g. As days pass you will find more and more ways to use SSI)
13. Make these general suggestions. E.g.
Whenever the time is right (vs every day at
4)

Safe Space Imagery

- **Explanation of Benefits of SSI – Preparation for Clients**
 - 1. Clients with dissociative symptoms will begin to learn to use their dissociative skills proactively.**
 - 2. SSI will be a helpful coping skill to have during any trauma processing, and to help manage triggers.**
 - 3. It is an exercise that will help the client learn to reach a state of relaxation, and block out intrusive thoughts and feelings.**

Explanation #2

- 4. In practice, use of Safe Space Imagery daily over time appears to help lower clients' biological reactivity level, resulting often in clients feeling calmer over all.**
- 5. Mind body savvy medical professionals recommend that we all do some kind of meditation, deep relaxation, or SSI everyday because it supports our physical health and immune systems.**
- 6. Predict the possibility of intrusions without suggesting them!**

Safe Space Exercise

- *You can have your eyes open or shut...*
- *Pick a place or space that is not from your childhood*
- *SS can be a place you've felt safe in before, can be made up or a combination of real and made up*
- *It's a place where nothing bad has ever happened*

(Tips: Focus on sensory experience in developing safe space. Ask: what are you seeing, hearing, smelling, touching

Use positive suggestion and words client uses.)

SSI #2

- ***Once you're in your Safe Space, look around and notice everything about it that makes it safe.***

(Tip: Some people have Safe Spaces that are totally made up of sound (e.g. being surrounded by a song) or feelings (e.g. soft blankets).)

- ***Notice what you're seeing, hearing, feeling, smelling, touching.***
- ***Notice if there's anything that doesn't feel quite right and if there is, look around and as you look around you'll either see something that will help, or some thoughts will occur to you that will help...***

SSI #3

Tips for clients practicing SSI at home:

What you see that helps doesn't have to make sense!

- **If you can't see or figure out something that helps, you can try adding a couple things like putting a force field or adding a friendly guard dog.**
- **Sometimes it can help to draw a picture of your Safe Space, see if it feels like a place you could feel safe in, and then add anything you need.**
- **Another option is to move to a different Safe Space that's even safer.**
- **If nothing works, or it feels too unsafe, stop working on it. Make a note about what made it too difficult and bring it to your next therapy session.)**

SSI #4

- *Once you are in your Safe Space you can just settle in to being there and relax.*
- ***When exercise is done, have client reorient to office!!!**

Note: Learning to do SSI is just like learning to do anything. It often takes a little practice, and like anything, is easiest learned when you are in a relatively clam state. Eventually, you will be able to use it to center yourself when you're having strong feelings, but that takes practice.

Remember: A goal is to work up to doing Safe Space Imagery everyday for 10 - 20 minutes. For most people, doing Safe Space Imagery every day will eventually help them feel calmer over all.

Teaching SSI to People with Parts

- Refer to parts directly or they won't think it applies to them.
- The goal is that all parts of the mind have a Safe Space either a group one or individual, it doesn't matter.

-

Option #1: We're going to work on SSI together. I'd like all of you who are willing to follow along with me and while we're doing the exercise I'd like everyone to ask me any questions you have and if you need help just let me know. Ok, now I'd like all of you to find a space or a place together or apart

Option #2

- Option #2: Especially useful if the client has a difficult time even beginning to trust is: ***Would one part to volunteer to try out SSI while all other parts watch and learn how it is done...***
- This provides permission to watch me and a positive use of the need to be hyper-vigilant in that parts who're watching can use their hyper-vigilantness to really learn how to do SSI.

SSI Variations

- **SSI for child parts/orienting and developmental catch up**
- **Help develop object permanence**
- **Symptom management: Violent parts, anxious parts, overwhelmed parts**
- **To assist with trauma processing**
- **As a respite for parts after trauma processing**
- **Playpen analogy**

SSI for child parts

- **Option #1: If child part is old enough, work directly her/him to develop a SS.**
- **Option #2: For parts who are too young, have an older part focus on the child part and develop a SS around it. Say:**
 - **What kind of place do you think the child needs...Look around the child's SS and notice everything's that's there that the child needs to feel safe to be there, what are you noticing...**

- **Support the client in doing as much of their own imagery as possible.**
- **If necessary, suggestions can be made: Try adding a soft blanket and a soft stuffed animal (soft light and quiet healing music)... how does that feel?**
- **Goal: An environment that's responsive and appropriate to the child part's needs and developmental stage.**
- **Then either have the older part look around with all his/her senses, or the child part itself, say:
look around with all your senses and you will see more and more that helps the child part (or "you") know that things are very different from the past...**

- Concrete suggestions to begin or enhance orientation to the present are important because 1. kid parts who are living in the past usually think they're still being abused, 2. You can't process trauma if parts still think it isn't over.
- Possible Suggestions Include: a calendar on the wall of the Safe Space with this year's date, a picture of the house they live in, and current pets (appeals to young parts).

- Once the Safe Space is finished say something like: and as the child rests in the SS she will be learning more and more about how things are different now...
- The child part may choose to stay in the SS, or to stay in it, or the older part may just decide to have the child stay there.
- Homework for the client is to either check on the child every once in awhile to see how she or he is doing, or to help the child part practice SSI or to remind the child part that going to the SSI is an option.
- Next session therapists need to check in about how it went during the week.

Other Safe Spaces variations

- **Symptom management: Violent parts, anxious parts, overwhelmed parts, addicted parts, parts consumed by great physical pain.**
- **To assist with trauma processing**
- **As a respite for parts after trauma processing**

SS For Child Parts who're tantruming or too anxious to relax

- Think: what kind of environment does this child part need to relax, stop tantruming, calm down, slow down, get oriented, notice what's different?
- See what the client comes up with, and if more is needed You can suggest things like...
- Have soft padded floors and walls so the part can't get hurt.
- Sound and feeling proofing:.. **...As you focus on the walls of the SS you will notice that the walls have sound and feeling proofing in them...**
- Add an intercom system, or a system so older parts can check in whenever the child part gets lonely, a soft gentle furry dog, add the therapist's presence in SS's and as long as it's appropriate.

More 2c Coping Skills

- Alter substitution (who's going to be out)
- Containers
- Affect tolerance, dimmer switches, slow leak
- Deep, dreamless, sleep
- Cognitive strategies
- Parts help each other learn, remember coping skills

Containers

Visualize:

- Bank vault with a night deposit slot. Door stays locked till the next session...
- Safety deposit boxes behind big locked door
- Computer with various files
- Hoover Dam

Deep, Dreamless Sleep

- **Go to your Safe Space**
- **Notice everything's there that you need to be safe and that there's a comfortable place where you can rest**
- **As you settle down, I'll count from 10 to 1, and as I count you'll fall gently to sleep, and end up in a deep, dreamless sleep.**
- **You can wake up at any time, or one of the others will wake you up...Any ?s?**
- **10..9.. Falling gently to sleep..at 8,and 7, deeper and deeper, 6, 5 in a deep dreamless sleep, at 4,3, deeper and deeper at 2, and 1.....**

Affect Dial/Dimmer Switch

- **Practice with an event that was mildly distressing (forgot something at the store)**
- **On a SUDs scale, how distressing was it**
- **Dimmer switch with a SUDs scale can be adjusted to that level, ok?**
- **Now, do you want to turn it up or down? (up is easier!)**
- **What's that like? What do you notice?**
- **Practice up and down, off and on.**

Installation and Transmission of Current Time and Life Orientation (Twombly)

- 1. Begin with the host and/or other oriented parts**
- 2. identify and list significant details about client's current life.**
- 3. Identifying concrete ways the present is different from the past helps the client differentiate past from present.**
- 4. Identifying concrete ways the present is different from the past helps the client differentiate past from present.**
- 5. Install the list with the host/other oriented parts**
- 6. Request that the part or parts to whom the information is directed be open to receiving it, without the expectation of belief.**

Request that the part or parts to whom the information is directed be open to receiving it, without the expectation of belief.

Ask the host and/or other oriented parts what that was like for them, and then ask the parts if there are any questions or comments.

For homework, parts who received the information are asked to check it out.

Follow up next session.

Height Orientation (Twombly)

- **Ask a child part how high up she/he can reach in a bookshelf or on a door.**
- **Ask if the child part would be willing to try it out (alone or co-conscious with other parts) and see how high they can reach.**
- **Positive effects can be installed and communicated to other child parts.**

Installing Therapist and Therapist's Office, Maintaining Duality (Twombly)

- **When client has had enough experience with the therapist and therapist's office, it is helpful to list, install and communicate concrete knowledge and observations to any parts who are willing to accept the information. Parts are then asked to keep watching, gathering information, and testing the therapist.**
- **Factual information about the appearance of the office**
- **Safety oriented information**
- **Significant interactions between the client and therapist**

Protocol for Clients with No Oriented Parts (Fisher, 2000)

Protocol useful for clients with no oriented parts or who rapidly switching

**Stand up with the client use bilateral movement.
Mirror client's movement**

Therapist who speaks continuously orienting client with current information

Key phrases: I want all of you to look around and see you're right here in my office, and in this moment in time there's no danger, everything's alright.

Can add comments to increase mindfulness.

Recommendation is to do this exercise for 5-10 minutes every session

Helpful Questions for Therapists and Parts (?s lead to solutions!)

- How is that (behavior) helpful
- What would happen if you:
 - answered the ?
 - said what you want to say?
 - stopped doing what you're doing?
- What's the evidence?
- Ask inside...
- Where does the part think she/he lives?

Stage 3: History Taking and Mapping

History: Take history with caution. Note:
Acts of omission and acts of commission.
Part specific history.

Mapping:

- Part that's out puts name on sheet of paper
- Invite others to put names/marks on sheet next to those they feel closest to
- Maps change as treatment progresses

Stage 4: Metabolism of the Trauma

- Pace processing of traumatic memories so client can be maintained at the highest level of functioning possible.
- Return to Stabilization and coping skills if things get out of control or the client gets overwhelmed in or between sessions.
- Follow Kluff's rule of thirds!!!!
- Work within the window of tolerance.

Introduction and Preparation for Targeting Traumatic Material *(Twombly)*

- This format was developed to provide a safe controlled way to begin using EMDR to process traumatic material with DID clients.**
- The goal of this structured format is to teach clients to have control during processing and to enhance the ability of parts to work together.**

Cont.

- **Clients are told: *You did not have control of what went on in your childhood, but you need to have control of your healing.***
- **Because maintaining stability in daily life is crucial, the host and/or daily life team are protected from the impact of trauma work for as long as possible.**
- **Processing with clients who are unable or unwilling to work in this way must be handled more carefully to protect stability.**

Review/Teach Coping and Titrating Skills

- Safe place imagery (Kluft, 1998)
- sound and feeling proofing
- secure safe places
- protective walls
- Team work: daily life team
- TV technique (Brown and Fromm, 1986) using Picture in a Picture TV technology (Twombly)
- Therapeutic sleep (Kluft, 1988)
- Bank vault (Kluft, 1988)
- Affect dial (Brown and Fromm, 1986)

EMDR Facilitated Fractionated Trauma Processing (Twombly's Ultra Control Protocol)

- **1. Identify target which is ideally on the less difficult side and is not held by the host/daily life team. Identify parts that need to work on it, and one to two helper parts (also not in the daily life team.). Helper parts remind processing parts about skills, and let the therapist know if there's a problem.**
- **2. All other parts go to safe places and put sound and feeling proofing up. *If the host/daily life team cannot be dissociated, the work must proceed with greater care to protect stability.**

- **3. Fractionate target, pick aspect to begin with, and store all other material in vault.**
- **4. Identify negative and positive cognition unless it disrupts this controlled process.**
- **5. Do RDI, reinstall coping skills, office and therapist, and install any wording the client would like to hear during the processing.**
- **6. Practice TV with PIP imagery. The big screen is generally tuned in to the therapist's office, while the client practices turning the PIP on and off first with benign imagery. Once the client is proficient, then proceed with 2 seconds of traumatic material.**

- **7. Practice skills e.g. affect dial and decide if the affect dial should be set at a certain level, e.g. 3.**
- **8. Process trauma in 2 sec sets and gradually increase time as the client gains confidence and control.**
- **9. Close down processing, “what’s the most important thing you learned”, feelings/traumatic material are stored in vault till next time. Parts may want to rest in safe place, or sleep, or use another resource.**
- **10. Have others return. Answer any questions. Plan for next session.**

Processing Variations

- **Permission for change of bilateral stimulation**
- **Kitchur language**
 - Bilateral stimulation allows the body to dump off/ let go of traumatic affects and sensations**
 - It teaches the body to let go thereby normalizing the body**
 - The more that's dumped off, the more energy is released**
 - Utilization**
 - “Focus on the sensations and your body's dumping it off...Notice the changes...”**
- **IFS: Self asks the part how the part wants to get rid of the burden of the T. material (air, fire, water, earth, etc.)**

Things to listen for:

- **Grieving is a part of healing every step of the way**
- **Possibility client experienced good feelings during the abuse.**
- **Possibility client perpetrated.**
- **Attachment issues.**
- **Neglect.**
- **“Incidental” abuses**
- **Therapy related trauma.**

Stage 5: Moving Toward Integration/Resolution

- **Work through material across parts, resolving conflict, boundaries softening**
- **Integration happens along the way as dissociative barriers aren't necessary.**

Stage 6: Integration-resolution

- **“First final integration”**
- **“Second final integration”**
- **“Third” ...**
- ** **Life Review facilitated with Bilat. Stim.**
- ** **Kitchur's Strategic Developmental Model**

**Strategic Developmental Model, Maureen
Kitchur (in “EMDR Solutions”)**

**Accomplishes a sweep through client’s
childhood**

Target Order:

- 1. Parents’ relationship between 4-11**
- 2. Each parent separately 4-11**
- 3. Siblings, gps and significant others**
- 4. Traumas, illnesses, major changes
4-11**

Kitchur, cont.

5. First order processing (0-4 yrs old)

Memories or memory fragments

Pictures or imagined images of parents, siblings, relatives with client

Pregnancy information

Pictures or imagined image of client at each age.

Somatic processing!

Kitchur cont.

**For age 12 – 19 follow same steps as 4-11
and add significant dating relationships**

**For 20 + years to present do traumas,
changes, significant relationships,
treatment traumas, traumas from the
disorder, maybe even treatment with
you!**

Stage 7: Learning New Coping Skills

- Adjustment to integration requires new coping skills. Delay big decisions. Normal isn't what's it's cracked up to be!
- **Future Template, More RDI**

Stage 8: Solidification of Gains and Working Through

- Whatever else is needed!
- Character issues
- Relationship issues

Stage 9: Follow-up

Open door policy!

Work from Self (Schwartz)

- Think about client who pushes buttons
- Focus on where you feel it somatically
- Ask part who holds feelings to step back
- Check how you feel twds part (look for curiosity, compassion, centered)
- Have any other parts step back
- Negotiate with part(s) to let you handle session from Self...

EMDR Self Care via Mark Dworkin, LCSW

- Bring up a memory of a challenging client
- What image best describes the memory?
- What does it make you think about yourself now.
(NC)
- What emotions come up
- SUDS
- Body Sensation
- Float back
- Process

Special Issues in Treatment

- **Prior negative treatment experiences**
- **Current abuse, families, hospitalizations, etc.**
- **Other on going therapies, groups, self help, etc.**
- **Adjunctive treatment**
- **Sadistic vs non-sadistic abuse**
- **Cult and ritual vs ritualized abuse**

Sadistic Offenders

- Aroused by their victim's pain, suffering, humiliation, and fear
- Less aroused by consenting sex, more aroused by nonsexual violence
- Think the child is perverted, bad, sick, evil, so she/he deserves it
- Get to know the child so know how to hurt them

Non Sadistic Offender

- Turned off by pain
- Manipulates/grooms the child into cooperating
- Rationalize their behavior, may fantasize that the child likes it or wants it, or explains: She didn't say No.
- Deny the harm it causes



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of Trauma and Dissociation

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