"Conference Room" Checklist

George Abbott, Ph.D.

(Inspired by Sandra Paulsen, PhD, George Fraser, MD, Richard Kluft, MD, and clinical experience)

Note: All wordings are suggested and are modifiable according to specific situations and clinician's style.

A. When Therapist Decides to Use the Conference Room Technique

____ Explain reason for proposing to use the conference room
____ Request patient's permission (usually, this means asking an ANP)

B. When the Conference Room is Established and Populated by Parts

____ Immediately ask, "Is there anything to be stated or asked by any part of the mind?
____ (if yes to previous), "Is there anything else to be stated or asked?"
____ (repeat above until there is nothing new)

C. Pre-Closure of Conference Room

____ Ask, "Is there anything to be stated or asked before all parts tuck/pack back-in to the body, comfortably and securely?
____ (if yes to the previous) Is there anything else that needs to be stated or asked...?

D. Closure and Reorientation to the Therapy Office

____ Ask patient as ANP to "please close the conference room now and come back into the office with me. Let me know when you are back.

E. Checking for Parts that have Remained Activated Following Closure

____ Ask patient to conduct a 'body scan'
____ (If there is any slight disturbance in sensory feeling, emotion, or perception): Ask the patient (as ANP) to reopen the conference room and search for the part or parts that has remained active, and to let you know what they find.
____ (When patient reports discovering a part of personality anywhere in the CR): Ask what needs To be stated or asked before you can tuck/pack back-in to the body, comfortably and securely?"
____ (Following the part's expression, provide an empathic response, then) "Thank you, please tuck/pack back-in, comfortably and securely."

F. Re-Closure and Reorientation to the Therapy Office

____ Ask patient as ANP to "please close the conference room now and come back into the office with me. Let me know when you are back."

G. Re- Checking for Parts that have Remained Activated Following Closure

____ Ask patient, as ANP, to repeat 'body scan.'
____ (If there is any slight disturbance in sensory feeling, emotion, or perception)
Repeat the balance of steps F & G.

Various Uses for the Conference Room

- Structural analysis of a personality system (mapping)
- History taking
- Establishing co-consciousness between or among parts
- Fostering internal communications about past / current events
- Conducting negotiations between and among parts
- Therapeutic restructuring between and among parts for expedient purposes
- Cognitive restructuring within parts
- Treatment planning
- Gaining informed consent for various treatment strategies and techniques from parts
- Employing any of a number of techniques for processing traumata memories, e.g., EMDR, Guided synthesis and guided realization, etc.
- Tactical integration...

Tactical Integration in the Conference Room…
George Abbott, Ph.D.

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Tactical Integration in the Conference Room: A Safe and Efficient Path to Healing Structural Dissociation with EMDR

Presented by
George Abbott, Ph.D.

Western Massachusetts EMDR Regional Network

Amherst, MA
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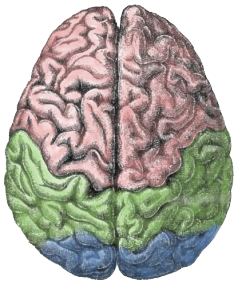

Simple PTSD

OTHER SPECIFIED or UNSPECIFIED DISSOCIATIVE DISORDER

(Dissociative Disorder, NOS)

COMPLEX-PTSD

The “Conference Room”

Dissociative Identity Disorder

OTHER SPECIFIED or UNSPECIFIED DISSOCIATIVE DISORDER

(Dissociative Disorder, NOS)

COMPLEX-PTSD

EMDR With

OTHER SPECIFIED or UNSPECIFIED DISSOCIATIVE DISORDER

(Dissociative Disorder, NOS)

COMPLEX-PTSD

Disclosure of Diagnosis

&

Informed Consent to Treat

&

Necessary Stabilization

Explaining Tactical Integration to “Parts” of a Personality

CHECKING FOR OBJECTIONS

Explaining “Preparatory Processing”

CHECKING FOR OBJECTIONS

The Tactical Approach

Inquiry Before Closure

Tuck Back-in /
Pack Back-in

Body Scan to Check for
Silent Activations

Introduction

"Theories and models are wonderful things, but they don't prevent other things from existing. …It is an unpleasant fact that there is no proof that any model or theory out there that works best for all traumatized individuals."

–R. Kluft (8.18.16). Dissociation Listserve

EARLY RECOGNITION OF PROBLEMS USING EMDR w/DD

- *A General Guide to the Use of EMDR in the Dissociative Disorders: A Task Force Report"* *(Fine, Paulsen, Rouanzoin, Luber, Puk, & Young, 1995)*

  "EMDR should not be attempted with highly dissociative patients with problematic characteristics, unless the clinician is

  1. *Already highly experienced with Dissoc. Dis. populations*
  2. *And has as a controlled setting in which to conduct EMDR"* …

"EMDR has a special and intriguing relationship to the phenomenon of dissociation, in that EMDR seems to act as a *dissociation finder*, whether or not the practitioner has previously suspected dissociation in a given patient"

(Paulsen, 1995)

EARLY RECOGNITION OF PROBLEMS USING EMDR w/DD

- Using EMDR Cautiously *(Paulsen, 1995)*

"Treatment failures occur…when EMDR is used without:

1. *making diagnosis of …dissociative condition*
2. *modifying EMDR procedures to accommodate it*
3. *careful informed consent…" (frequently)*

"Red Flags" Contraindicating EMDR with DD Patients (Paulson, 1995)

- ❑ Lack of complete safety in patient's environment
- ❑ Ongoing self-mutilation
- ❑ Active suicidal and/or Homicidal intent
- ❑ Uncontrolled flashbacks
- ❑ Rapid switching
- ❑ Extreme age and/or Physical frailty
- ❑ Terminal illness
- ❑ Need for concurrent adjustment of medication
- ❑ Ongoing abusive relationships
- ❑ Alter personalities strongly opposed to the procedure
- ❑ Extreme character pathology, esp. Narc., Sociopath., BPD
- ❑ Serious concomitant dx, e.g., Schizophrenia; Subst. Abuse

RE: "Red Flags"

"Therapists who are highly experienced with abreactive work with patients with the ('red flags') may be able to proceed to use EMDR safely with good results.

"However, this work is considerably more complex than using EMDR with a more cooperative dissociative patient, and therefore a careful risk-benefit analysis should be undertaken and appropriate preparation made." (Paulson, 1995)

FOUR ELEMENTS COMPRISE THIS WORKSHOP

- ➢Conceptual Tools from The Theory of the Structural Dissociation of the Personality
  (Van der Hart, Nijenhuis, Steel, 2006)
- ➢ 'Conference Room' Procedure
  (Fraser, 1991; 2003; Paulson, 2009)
- ➢ Tactical Integrationist Approach
  (Kluft, 1988; Fine, 1993; Paulson, 2009)
- ➢ EMDR –MODIFIED *FOR DISSOCIATIVE PARTS*
  (Shapiro, 1993; 2001; Paulson, 2009)

SOME CONCEPTUAL TOOLS FROM THE THEORY OF THE STRUCTURAL DISSOCIATION OF THE PERSONALITY

- ▪Mental Level
- ▪Two Types of Personality Parts
- ▪Vehement Emotion vs.
- ▪Reflectively Expressed Emotion

▪ MENTAL LEVEL

=

Level of Mental Energy

- Dissociative patients often feel and appear beleaguered

***In Ratio to*:**

Level of Mental Efficiency

- Mental efficiency connotes skill development for managing mental and physical energy.
- Dissociative patients typically have low metal efficiency

- MENTAL LEVEL

A relatively high Mental Level is required to integrate components of memory.

[EMDR/AIP: "Integrative Capacity"]

Dissociative patients and their parts often have insufficient Mental Level to integrate the narratives, emotions, sensations, etc. stored within their various parts. Thus, wholesale use of EMDR / BLS procedures can challenge them to do what they cannot do.

- MENTAL LEVEL

What happens if a clinician stimulates the access of traumatic memories in a patient who can not integrate those memories at the moment ?

- 2 TYPES OF PERSONALITY PARTS

(1) ***Apparently*** **Normal Parts (ANP)**

- Built upon & directed by innate biological "action systems for daily life" (e.g., exploration, caretaking, attachment, repro., etc.)
- Generally, have insufficient mental level to integrate trauma memory
- Tends to avoid & not realize the fact that trauma occurred
- Concerned with carrying on everyday life activities

- 2 GRPS OF PERSONALITY PARTS

(2) ***Emotional* Part (EP)**

- Built upon and directed by innate bio. "action systems of defense"
- Fixated in one or another *defensive* posture (e.g., fight, flight, freeze, submission, recuperation, hypervigilance)
- Tends to activate when reminded of trauma
- Tends to activate during BLS procedure ("*dissociation finder*")
- Usually does not realize the trauma is over
- Tends to have even lower mental level than ANP
- Holds "vehement emotion"

CONCEPTUAL TOOLS

- **VEHEMENT EMOTION**
  - Excess mental & physical energy—
  - Insufficient mental skill (efficiency) to use this energy
  - Can lead to disorganized behavior

Vs.

- **REFLECTIVELY EXPRESSED EMOTIONS**
  - Adequate mental efficiency for integration of information
  - Expressed in interpersonally appropriate ways
  - Expression gives "enduring rather than temporary relief"
  - Abreaction of intense affect within adequate mental level can lead to healing and more adaptive living.

CENTRAL DILEMMA & SOURCE OF CONFUSTION FOR THE DISOSCIATIVE PATIENT – VIEWED BY STRUCTURAL THEORY

The patient as ANP does not realize or fully believe that the traumatizing events happened to him/her = Failure of realization

- meanwhile-

The patient as EP does not realize that the traumatizing events are *over*

The conditions of processing with BLS should not exceed the mental efficiency (skill) of the patient –or *part* of the patient being addressed

Listening to a patient during use of EMDR / BLS:

It is crucial to distinguish between *vehement emotion* and *reflectively expressed - integrative emotion*–

…Especially when ANP is present for BLS

With insufficient mental level, ANP will either shut down the processing or become overwhelmed by it

OPERATIONAL STANCE OF THE THERAPY—VIEWED BY STRUCTURAL THEORY

- Support the everyday adaptive strivings of ANP
- Acknowledge the existence of the EP's without aggrandizing them as separate "people" & help curb their intrusions on ANP—e.g., by assisting the release of their excess affect

"THERAPEUTIC PLURALISM"

(Kluft, 1988)

VARIOUS APPROACHES TO DELIVERING TREATMENT TO DISSOCIATIVE PATIENTS

1. Nantucket Sleigh Ride Therapy
2. Modality Maven Therapy
3. Personality Focused Therapy
4. Ignore It and It Will Go Away
5. Adaptationalist Stance
6. Strategic Integrationism
7. Tactical Integrationism

Strategic Integrationism

- Focuses on "rendering the dissociative defenses and structures that sustain (dissociation) less viable, so that the condition in essences collapses from within."
- "With experience and increasing equanimity in the face of the vicissitudes of work with (dissociation), many therapists move toward this orientation."

-- Kluft, 1988

Strategic Integrationism

- A continuation of the psychoanalytic strategy of targeting, analyzing, and resolving dysfunctional defenses across the personality as a whole.

Strategic Integrationism is the Tried and True Approach to Psychodynamic Therapies

"Patients can be told to relate all of their thoughts, dreams, and memories as best they can, whoever they are at the time…They can be assured that the analyst will help them to sort out intense feelings, anxieties, and fears, and to "relive" traumatic episodes so that they can be brought to the conscious mind."

-- Wilbur, 1986

The Problem with Strategic Integrationism for EMDR

- Herein lies the central problem of using EMDR with dissociative patients
- EMDR may be less the source of treatment crises with dissociative patients than is the Strategic Integrationist approach to it's application
- The Strategic approach has long proved its value when used with psychoanalytic methods
- However, EMDR is a too powerful a *defense disrupter* to employ across a dissociative personality system as a whole

Tactical Integrationism

- "Involves mounting many specific planned avenues of intervention addressing a number of deliberately chosen short- and long-term goals at the onset of treatment, rather than initiating a more broadly based attack on the dissociative defenses in general." *

-- Fine, 1993 _____

* Fine writes about the TI approach with respect to a cognitive – affective therapy, not EMDR in 1993.

Tactical Integrationism

- "…espouses the same ideal goal as strategic Integrationism, the integration of the personality in the course of the overall resolution of the patient's symptoms and difficulties in living
- "However, an examination of treatments conducted by therapists with this orientation * reveals a predominant focus on tactics, toward interventions that serve as … devices for the accomplishment of objectives.

-- Kluft, 1988

_____

* EMDR unknown to Kluft in 1988

Tactical Integrationism

- "… at a particular moment in treatment, it is possible to be working with personalities who can not easily contain strong affect and must remain in a suppression of affect mode…whereas other personalities may be involved in the therapy…"

-- Fine, 1993

Tactical Integrationism

- "Each personality needs to adjust to the sheer horror of its individual story line before it can possibly face the knowledge that the other personalities' story lines are also part of its life experience."
- "The …therapist will initially prefer to work with the affect shared within the same cluster, rather than across clusters or between a cluster and the host.
- "Structuring the work in this fashion is designed to make abreactive work less traumatizing to all personalities." -- Fine, 1993

Dissociative Table Technique
a.k.a., "The Conference Room"

(Fraser, 1991, 2003)

- "The DTT offers a technique to allow patients to recognize internal ego states and to structure and control switching and internal communications.
- "Allows therapist to teach (a patient) to facilitate interaction of ego states, to eventually … (develop) a consistent sense of self…" - Fraser, 2003

FRASER'S PHASES OF DISSOCIATIVE TABLE WORK

I. **Pre-Table Work**: Educating patient about purpose and use of the DTT

II. **Setting the Table**:

1. Ask patient to imagine being in a safe, relaxing place
2. Ask patient to now change this image to that of a safe room, with a table and chairs. "One chair is for you; the other chairs are for others who play a role in your internal life."

III. **Therapeutic Use of the DTT**

1. Spotlight Technique "Now that you are at the table, I would like to set up a way in which you can speak with me and to each other. We will arrange for a spotlight to shine on the speaker…"

FRASER'S THERAPEUTIC APPLICATIONS OF THE DTT

- Fraser's therapeutic uses revolve more or less around the strategic integration approach, to wit:
  - Gently, persistently challenging the overall dissociative divisions among dissociative "parts" via frequent communications around the DT
  - Conducted slowly, respectfully, flexibly, so as not to overwhelm or send the patient into crisis
  - Carefully guiding patient through periodic abreactions

CONFERENCE ROOM CAN SERVE MANY PURPOSES

- Structural analysis of a personality system (mapping)
- History taking
- Orienting given parts to present time
- Correcting cognitive errors of thought in given parts
- Fostering internal communications re: past / current events
- Conducting negotiations between and among parts
- Expedient restructuring of parts for problem solving
- Treatment planning
- Gaining informed consent for various treatment procedures
- Using a given approach to processing traumatic memories, e.g., EMDR, Hypnosis Guided synthesis & guided realization, etc.
- Tactical integration…

Tactical Integration in The CR

A. Similarities with Strategic Uses:
- ✓ A safe, respectful gathering point for "parts"
- ✓ Efficient way to assess the "internal system"
- ✓ Efficient way to deliver psychoeducation
- ✓ Opportunities for patient self-understanding
- ✓ Efficient way to "stage" the therapy
- ✓ Coached "sharing" of dissociated narratives between / among dissociative "parts" of the personality

B. Differences from Strategic Uses:
- ✓ No "challenging" of personality-wide dissoc. defenses
- ✓ Rather, making planned <u>use</u> of dissociative defenses

Tactical Integration in The CR

A. Unique aspects of Tactical Integrationism:
- ✓ Specifically encourages the patient to *<u>use</u> his/her ability to dissociate*
- ✓ Working with one "part" at a time, *more or less* in isolation from other parts
- ✓ Encouraging systematic abreactive processes, thus raising mental level and allowing integration of narratives between and among parts

Differential Treatment of Dissociative Parts – *Informed* by Structural Theory

A. **ANP(s)**
- ✓ Encouraged and supported in their adaptive every-day life strivings to adapt to life (work, caregiving, relationships, energy management, etc.)

B. **EP(s)**
- ✓ Acknowledged for their presence & defensive roles
- ✓ Not engaged in extensive dialogue
- ✓ Systematically engaged in abreactive processing (BLS)
- ✓ Encouraged to share their narratives internally and externally, post abreaction (in and after sessions)

Dissociative Table Technique
a.k.a., "The Conference Room"

- **NOTE**
- Opening a CR often means opening to the dynamic forces of a troubled, conflicted mind, including the *vehement emotions* of a patient's EP's.
- At first opening, there may be energy that the patient may not know how to handle, i.e., for which the patient may lack mental efficiency (skill)
- All the more important when using EMDR / BLS

Dissociative Table Technique
a.k.a., "The Conference Room"

Fraser (2003): "It cannot be overemphasized that the (DTT) delves very quickly to the dissociative phenomenology by readily engaging ego states that may or may not welcome this internal probing…

"One must be well prepared to manage the consequences of interaction with ego states, who often view themselves as separate entities and expect recognition as such once they agree to relate with the therapist"

"The Conference Room"

- **SOLUTIONS**
- **Upon *each and every opening* of a "conference room,"** once "parts" are invited to enter the area, inquire:

  "Is there anything that needs to be said or asked by any part of the mind?"

- Prior to *each and every closing* of a CR, inquire:

  "Is there anything that needs to be said or asked by any part before the parts all 'tuck-back in' securely and comfortably?"

"The Conference Room"

- **SOLUTIONS (CONTINUED)**
- **After *each and every* closing of a CR**, ask the ANP to come fully back to the office with the therapist, and inquire:
  "How are you feeling?"
- Respond to integrative emotional expressions, e.g., "I'm so angry," etc., with appropriate empathy, e.g.,
  "I am sorry you had to go through that;"
  "I am glad you are safe now and can heal, and learn more of the stories of your life."

"The Conference Room"

- **NOTE**
- Experience also teaches that it is crucial to make sure all EPs, "tuck back-in" / "pack back-in" prior to ending a therapy session
- Some dissociative "parts" evade closure until they have a chance to express something, e.g., a painful emotion, or even a simple "thank you for helping," etc.

"The Conference Room"

- **SOLUTIONS**
- **After 'return' from the CR, Ask the patient to do a body scan.**
- **If the patient reports disturbance of sensation** (e.g., "headache", "a slight fogginess", "funny feeling," etc., Direct the patient to re-open the CR, search for a part that remains 'out.' (a "*silent activation*")
- **Solicit that part's expression (a statement or question)** and then "tuck/pack back-in."
- Re-Close Conference Room
- **Repeat body scan, etc.**

❖ Fatigue is normal, not a sign of "silent activation"

“The Conference Room Checklist”

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- ____ Explain reason for proposing to use the conference room
- ____ Request patient’s permission (usually, this means asking an ANP)

•When the Conference Room is Established and Populated by Parts
- ____ Immediately ask, “Is there anything to be stated or asked by any part of the mind?
- ____ (if yes to previous), “Is there anything else to be stated or asked?”
- ____ (repeat above until there is nothing new)

•Pre-Closure of Conference Room
- ____ Ask, “Is there anything to be stated or asked before all parts tuck/pack back-in to the body, comfortably and securely?
- ____ (if yes to the previous) Is there anything else that needs to be stated or asked…?

•Closure and Reorientation to the Therapy Office
- ____ Ask patient as ANP to “please close the conference room now and come back into the office with me. Let me know when you are back.

•Checking for Parts that have Remained Activated Following Closure
- ____ Ask patient to conduct a ‘body scan’
- ____ (If there is any slight disturbance in sensory feeling, emotion, or perception): Ask the patient as ANP) to reopen the conference room and search for the part or parts that has remained active, and to let you know what they find.
- ____ (When patient reports discovering a part of personality anywhere in the CR): Ask what needs
- To be stated or asked before you can tuck/pack back-in to the body, comfortably and securely?”
- ____ (Following the part’s expression, provide an empathic response, then) “Thank you, please tuck/pack back-in, comfortably and securely.”

•Re-Closure and Reorientation to the Therapy Office
- ____ Ask patient as ANP to “please close the conference room now and come back into the office with me. Let me know when you are back.”

•Re- Checking for Parts that have Remained Activated Following Closure
- ____ Ask patient, as ANP, to repeat ‘body scan.’
- ____ (If there is any slight disturbance in sensory feeling, emotion, or perception) **Repeat the balance of steps F & G.**

Tactical Integration in The Conference Room

- BLS “preliminary processing” of trauma with “parts”
- Processing is generally with one “part” at a time, or with a cluster of parts sharing a memory
- Used only when a patient is sufficiently stabilized
- Used only with consent of the index “part” AND major “parts’ –including those who initially disagree oppose, i.e., perpetrator-introjects and protector EP’s

Achieving Consent from Objectors

When there is objection to proceeding w/proc.

▪Explain: You've done a very good job of protecting him/her all these years. Will you let me help?

▪If Still Resistant: Perhaps you are telling me that there are important conditions that must be met before we proceed with this work. Is that right?

▪If Hostile: What terrible thing happened to you, so that you want him/her to suffer?(said w/compassion)

▪Or, You are the internal (dad, uncle, etc.). Do you know that <u>you are not</u> the external (dad, etc.) who did those awful things?

Tactical Integration in The Conference Room

E. EMDR-BLS procedures are initially modified to meet the *mental level* capacity of the patient
   - ❖ EP not asked to articulate components of a traumatizing memory
   - ❖ EP not asked to articulate observations between sets of BLS

F. Processing is first conducted EP's –generally one at a time –often by cluster

Tactical Integration in The Conference Room

G. Tactical Integration is explained to the ANP

H. ANP is asked to use his / her capacity to dissociate --to leave the therapy field, e.g.,
   - Leaving the CR (not always possible, esp. in DD,NOS)
   - Enter a "sound-proof booth" within the CR
   - Stand behind a Plexiglas shield
   - Go to the far end of the room

"Please raise a hand when you are there"

Tactical Integration in the CR

I. Rationale for abreactive processing is explained to the EP that is selected to go first (or next)

- "I know you want to tell (ANP) your story, but this is not yet possible because you are carrying too much pain
- "_too much pain for you to be able to put it into words
- "_too much pain for (ANP) to be able to listen take
- "_even if you could tell your story now, s/he would shut you off because s/he does not have the ability to take it in

Tactical Integration in The CR

- "So our job is to first drain-off that pain
- "—so you can put your part of the story into words
- "—and so s/he (the ANP) can listen and understand *your part of the story of his/her life*
- "Please nod 'yes' if this is OK
- "Please nod 'no' if this is not OK

Tactical Integration in The CR

J. Instructions to EP before beginning sets of BLS

- "It won't be necessary for you to speak, but you can speak whenever you like
- "Meanwhile all you have to do is nod, 'yes' or 'no' to my questions when I turn off the BLS. OK?
- "Is it OK to begin to let go of some of that pain now?

Tactical Integration in The CR

K. EP is informed about the use of BLS (auditory / tappers)
- "Please just notice what you feel now
- "Now listen through the ears (feel through the hands) when the BLS is turned on
- "Just watch as various feelings and perhaps images come up
- "If you just notice things coming up as you are listening to (feeling) the BLS, the stuff that comes up will pass through you and out of you
- "Any amount of upset that passes out of you is an amount of that upset that you will never have to deal with again

Tactical Integration in The CR

L. Instructions to EP between sets
- "Do you notice stuff moving up?
- "Remember you can just nod 'yes' or 'no'
- (when patient nods 'yes'): "Is it OK to let go of a little bit more of the painful stuff?

M. If EP nods 'no'
- "Is there a part of the mind that objects to this work?

L. Negotiate to continue –as per *Achieving Consent From Objectors* (above) or,
- "Do you think you've done enough for today?

Texture of the Work

Encouraging words from therapist during difficult abreactions:
- "You are safe here in my office (eyes open)
- "It's just old pain (fear, etc.); it can't harm you
- "Any amount of that old pain (fear, etc.) that you let go of now is an amount of that old pain that you will never have to deal with again
- "The more pain you drain off, the easier it will be for you to tell your story

Texture of the Work

When *access* of disturbance obviously exceeds patient's ability to *express:* It is often possible to continue processing when therapist:

- Coaches extended deep-breathing *between* sets
  - "Take a long deep breath now; imagine you're breathing right into the part of your body that hurts… Now slowly exhale right from that area, releasing more of the hurt and tension from there –Repeat coaching until patient is clearly re-stabilized
- Teach 'silent scream' "If you feel you'd like to scream, press your fingers and thumb together and then open them to experience the release of a scream

Texture of the Work

Recognizing Intrusions by ANP (DD,NOS)

- It is common for ANP to intrude between sets
- The clinician can hear this in the patient's responses to questions between sets:
  - The patient as ANP will typically speak in full sentences, whereas the patient as EP will speak in single words or phrases, at best
  - The patient as ANP may not "own" emotional experience… refers to the suffering part in 3rd person
  - May give intellectualized or interpretive accounts of what is going on

Texture of the Work

Responding to Intrusions by ANP (DD,NOS)

A. If there is no ownership of emotion, e.g.,

- "*She* is feeling very scared about…
- "Actually, it was a very difficult time…

Therapist should remind ANP that it is best for him/her to be out of the field for the work to be effective, e.g.,

- "I know this can be difficult, but remember what we discussed about you being out of the field…s/he won't be able to do this work if you're close-by. It will hurt you too much. Please go back to where you were at a distance, and raise a hand to let me know you're there

Texture of the Work

Responding to Intrusions by ANP (DD,NOS)

B. When therapist hears *integrative emotional expression* by patient --ANP-feeling-and-tolerating EP's feelings, e.g.,

- "This is very frightening; I am scared to say it"
- "It makes me so angry that he did this to me"

Therapist responds:

- "Is it OK to continue to release some more of it?"

If "yes"

- "Go with that." (Note: ANP is allowed to 'stay' when ANP is engaging in *integrative emotional expression*)

Tactical Integration in The CR

Advancing to the Standard EMDR Protocol

If and when the ANP continues to enter the therapy field with sustained *integrative emotional expression*, it is time to introduce the *standard EMDR protocol* with the patient as ANP, targeting memory aspects formerly held by one or more EP's.

The therapy may need to move in recursive fashion over time depending on

- the patient's varying mental level
- the particular EP experiences being targeted

SIX HINDRANCES TO USING EMDR WITH DISSOCIATIVE PATIENTS

1. EMDR's Bilateral Stimulation (BLS) can cause a sharp drop in dissociative defenses—overwhelming the patient
2. Patients may experience re-traumatization and be alienated from the therapist & therapy
3. In AIP terms, dissociative patients typically have insufficient *integrative capacity*

SIX HINDRANCES TO USING EMDR WITH DISSOCIATIVE PATIENTS

4. Un-seen "parts of personality" may be activated, silently, and remain vulnerable after a session
5. Different dissociative 'parts' may perceive things differently, with different memories, different NCs & PCs for the same events; they (& therapist) may become very confused
6. EMDR creates exposures that can activate various phobias found in dissociative patients that block productive therapy

"Red Flags" Contraindicating EMDR with DD Patients (Paulson, 1995)

- ❑ Lack of complete safety in patient's environment
- ❑ Ongoing self-mutilation
- ❑ Active suicidal and/or Homicidal intent
- ❑ Uncontrolled flashbacks
- ❑ Rapid switching
- ❑ Extreme age and/or Physical frailty
- ❑ Terminal illness
- ❑ Need for concurrent adjustment of medication
- ❑ Ongoing abusive relationships
- ❑ Alter personalities strongly opposed to the procedure
- ❑ Extreme character pathology, esp. Narc., Sociopath., BPD
- ❑ Serious concomitant dx, e.g., Schizophrenia; Subst. Abuse

RE: "Red Flags"

"Therapists who are highly experienced with abreactive work with patients with the ('red flags') may be able to proceed to use EMDR safely with good results.

"However, this work is considerably more complex than using EMDR with a more cooperative dissociative patient, and therefore a careful risk-benefit analysis should be undertaken and appropriate preparation made." (Paulson, 1995)