

ADAPTING EMDR TECHNIQUES IN THE TREATMENT OF DYSREGULATED OR DISSOCIATIVE PATIENTS

Janina Fisher, Ph.D.

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Since its inception, EMDR [Eye Movement Desensitization and Reprocessing] has been understood by both clinicians and patients as a powerful vehicle for processing traumatic experience but one to be undertaken only when the patient has achieved some degree of stabilization (Shapiro, 1992). In DID and DDNOS patients, that baseline stability is also supposed to include a level of internal communication and consensus that would permit cooperation between parts of self about how to tolerate the memory processing and how to re-stabilize afterward. However, as any clinician who works with this population knows, some dissociative disorder patients never achieve that degree of internal coherence, and some have a long, rocky, tumultuous, exhausting road to travel before they get there. Faced with the DID or DDNOS patient who cannot tolerate affect or associations to traumatic memories; who cannot control switching, get grounded, or resolve internal struggles over power and control; who is unable to manage self-destructive impulses; who cannot differentiate past and present experience; who is even unable to tolerate Resource Development (Korn & Leeds, 2002) or create a Safe Place inside—is there any way that EMDR can be helpful?

The answer is “Yes.”

Just as we titrate or phase or pace traditional treatments during stabilization phase work, there are some thoughtful modifications of EMDR that can be extraordinarily valuable in working with dysregulated, de-stabilized dissociative disorder patients. All of these modifications are premised on the assumption that the need for stabilization arises from the psychobiological dysregulation characteristic of all of the Post-traumatic Stress Disorders, resulting in “persistent intrusions of sensations related to the trauma, which interfere with attending to other incoming information;” generalized problems with attention, distractibility, and stimulus discrimination; loss of the ability to modulate bodily responses to stress; avoidance or compulsive re-exposure to reminders of the trauma; and alterations in self-perception and cognitive schemata (van der Kolk et al, 1997).

The types of technical modifications of EMDR that decrease the potential for hyperarousal and thereby increase self-regulation of affect include the following:

- ❑ Ultra-short sets of bilateral stimulation [2-6 sets]
- ❑ Ultra-short EMDR “sessions-within-a-session” [5-15 minutes]
- ❑ Use of tactile, auditory, and “standing” bilateral modalities, individually and in combination with each other or with eye movements
- ❑ Use of continuous bilateral stimulation throughout the whole session (Grand, 1996)
- ❑ Installation of **imagined** internal resources rather than actual experiences of mastery or symbolic images (Korn & Leeds, 2001)
- ❑ Installation of **actual** experiences of safety rather than imagined safe places

The target symptoms for which these techniques can be beneficial, the items that comprise a “Stabilization Shopping List,” include:

- ❑ Increased affect tolerance
- ❑ The ability to “ground” or stay grounded
- ❑ Relaxation skills
- ❑ The ability to self-soothe and self-comfort
- ❑ The ability to make use of internal resources
- ❑ Increased mindfulness
- ❑ The ability to differentiate past and present
- ❑ The ability to challenge negative cognitions rooted in the traumatic past

Affect tolerance

EMDR can be very effective in increasing affect tolerance when it is used to enhance mindfulness, the ability to notice a feeling or bodily sensation and “let it go by.” For example, a two-minute EMDR session-within-a-session can be initiated each time a strong feeling comes up: the patient can be asked to stop for a moment, notice the feeling and where she feels it in the body, and then “let it go by” as the therapist provides 2-6 ultra-sets of bilateral stimulation. Tapping techniques, breathing, or the rocking motion of standing EMDR (Withers, 1998) can also facilitate this experience of “letting the feeling go by.” The therapist instructs the patient to “notice the feeling and **tap** it by” or “**breathe** it by” or “**rock** it by.” By encouraging the patient to “just **notice**,” the therapist is combining DBT mindfulness techniques (Linehan, 1995) that enhance affect tolerance by teaching the patient how to regulate distance from affect with EMDR techniques that facilitate installation of experiences of affect mastery.

Bilateral stimulation that is continuous throughout the session (Grand, 1996; Bergman & Forgash, 1999) is also very helpful in increasing affect tolerance. Certain bilateral modalities, used throughout either a talking or EMDR session, seem to enhance feelings of calm and well-being: for example, the tones or musical sounds of a Biolateral audio tape, rocking from foot to foot using standing EMDR (Withers, 1998), tapping, butterfly hugs, or Tac/Audio pulses. Over time, the association that develops between these stimuli and the safety of the therapist’s office provides the experience of **having a feeling while in a safe place**, minus the intensification effects inherent in having the feeling in what is experienced as an unsafe world. If the patient does not yet experience

the therapist's office as "safe," experiencing feelings in the context of a Safe Place that has been previously installed using bilateral stimulation produces similar effects. For example, if there is unrest or conflict in the patient's internal system, going to an already installed Safe Place can facilitate lowering arousal sufficiently to allow an internal conference between distressed parts or soothing of the distress by the Adult Self.

Getting or staying grounded

Using continuous bilateral stimulation in any modality that increases focus, rather than encouraging dissociativeness, is grounding. All kinds of tactile stimulation can be useful for grounding. For example, for some patients, the Tac/Audio Scan pulsars can be either mildly irritating or simply enhance attention to bodily sensation. The first time I used them with one DID patient, she noticed that her annoyed awareness of the pulsing had allowed her to stay in the room for the whole session! Another DDNOS patient finds that his ability to simultaneously "stay present" but still attuned to communications from his system is enhanced by continuous tactile stimulation.

Standing EMDR (Withers, 1998) also provides a wealth of opportunities for teaching grounding skills. With a patient whose rapid switching repeatedly defied other grounding techniques that are usually effective, I developed a mini-protocol for learning how to be present in the body using continuous standing EMDR. Standing EMDR is a form of bilateral stimulation for which both patient and therapist stand facing each other approximately 4-6 feet apart and mirror each other's rocking from foot to foot. Although the therapist usually initiates the rocking motion, s/he thereafter follows the patient's lead and pace. Initially developed by Withers (1998) for use with children, this type of bilateral stimulation is also very effective with dissociative disorder patients and with patients who have difficulty staying grounded when talking about emotionally activating topics. In this **Grounding Protocol**, EMDR techniques are combined with Hakomi sensorimotor psychotherapy (Ogden, 2000) techniques:

- The therapist initiates the rocking motion of standing EMDR and states the target: "Let's focus on getting grounded" or "Let's focus on getting present in the body."
- "Notice your feet as you rock from side-to-side. Notice the balls of your feet, the heels, the bony ridge along the side of the feet. Notice the texture of the carpet [or flooring] under your feet."
- "Bring your awareness to your ankles. . . to your legs. . . Notice how your legs support your body. . . Notice what it is like to feel the bones and muscles of your legs."
- "Bring your awareness to your spine, and notice each vertebrae, one by one, all the way up to your neck and head. . ."
- "As you rock, scan your body for any places where you might be holding tension or distress. . . any areas that do not feel grounded. . . What do you notice?"
- The patient then is asked to describe where and how s/he is holding tension in the body: e.g., tense muscles in the stomach, heaviness in the chest, sadness around the eyes, throat tightening.

- “Now rock [that part of the body] and notice the [sensation in that area]. . . Notice what happens next. . . You might notice the tension easing a little. . . You might notice the sadness coming in and going by.”
- “Notice if there are any other areas holding tension and distress in your body. . . Focus on the [area and sensation described] and go with it. . . . Notice the feelings and sensations coming up and going by.”
- These last steps may be repeated several times until the body is calmer and the patient more focused and grounded.

Using this protocol, the work of every session begins with “getting the patient into the room,” and each time s/he begins to dissociate or become disorganized, all or parts of the protocol can be repeated until she literally “has her feet on the ground.” The narrow focus on bodily sensations and affects without interpretation or conscious connection to content, minimizes the chances of either overarousal and dissociative responses (Ogden, 2000). An additional benefit of this mini-protocol for dissociative patients is that it is almost completely non-threatening and inclusive of the whole system. Even the most recalcitrant ego state is usually willing to allow such a benign activity to take place.

The ability to self-soothe, self-comfort, or self-reassure

Self-soothing and self-comforting can be enhanced by the same kinds of techniques. Continuous bilateral stimulation in the safety of the therapist’s office builds up felt experiences of distress coming up and then being soothed and going by. Gradually, the particular form of bilateral stimulation employed (the tones of the Biolateral tape, the rocking motion of standing EMDR, the tactile sensations of tapping or butterfly hugs) becomes associated with the experience of soothing. Even when the soothing itself cannot be installed (for example, with a hypervigilant patient for whom calmness is triggering), the association can be installed and then deliberately re-evoked as coping resource at times of stress. For example, the association between certain Biolateral tape sounds and visual images of the calm and safety of the therapist’s office can be connected to particular bodily sensations such as calmness or lightness or warmth. Whether these are spontaneous experiences of the association or deliberately evoked experiences, the weekly or twice-weekly repetition over weeks and months is a titrated installation process. As the association gradually becomes more deeply installed, use of future templates can help to strengthen it: the patient is asked to imagine a future image of a potentially or actually stressful event and then use the familiar soothing images, feelings and sensations to manage the distress. [For some dissociative patients whose hyperarousal or hypervigilance increases with any increase in positive affect, displacement techniques can facilitate the successful use of soothing imagery. The Adult Self can be asked to comfort or soothe child parts with butterfly hugs or by rocking them using standing EMDR when she experiences “their” distress.]

When hypervigilant or persecutory alters consistently block or sabotage self-soothing, as is often the case with de-stabilized trauma patients, brief Resource Development (Korn & Leeds, in press) sessions can be used to develop whatever

resource is needed by the system to allow comfort and reassurance to be tolerated. With one DID patient, I polled the relevant parts of self that were so adamantly opposed to the child parts (or themselves) being reassured or comforted. Asking the Adult Self to act as “interpreter,” I asked each of them in turn, “What would you need to feel or believe to accept support instead of taking action when you feel threatened?” Each of the four responded, “I would have to believe that everything will be OK, that no one will get hurt, that we will get through this.” That statement became the resource: the belief that “everything will be OK.” We then worked on that resource for ten minutes out of every session, using ultra-short sets of eye movements, while the system focused on “imagining what it would be like to believe that everything will be OK.” Over time, the calmness and state of well-being that could be imagined in this way became a resource that the patient could use at home: when she started to get overwhelmed, she would imagine how she would be feeling or reacting if she believed with absolute certainty that “everything will be OK.”

Developing Internal Resources and Safe Places

When we ask the unstable, overwhelmed, self-hating dissociative patient to think of experiences she has had of feeling resourced, she will most likely answer, “None!” When we ask the same patient to imagine a place in which she would feel perfectly safe, she will most likely find that every attempt to imagine such a place triggers intrusive images that render unsafe even an imaginary Safe Place. With such patients, it pays to do the opposite of the usual Safe Place and Resource Development protocols: to have the patient imagine a resource, rather than trying to remember an actual experience of mastery, and remember an actual experience of safety in the here-and-now, rather than trying to imagine one.

The other modification that increases the ability of the unstable patient to utilize these techniques successfully is to be more concrete and to provide more structure. For example, “What would you need to feel or believe to get through the night without hurting yourself?” is very concrete, and it is more structured in the sense that it has a very specific goal. The therapist is focusing the work on a resource that would help the patient to inhibit unsafe impulses: to develop the ability to feel a feeling or make a mistake or encounter a problem or have a success and not get overwhelmed and self-destructive. The therapist is choosing the target in this instance based on his or her judgment about treatment priorities, about what step toward better self-regulation is the next priority.

In more structured and contained Resource Development work, the therapist helps the patient to develop an imagined, more resourced Future Self by installing each resourcing schema or capacity one by one. In response to every challenge to safety and stability, the therapist asks, “What would you need to feel or believe in order to [_____]?” And the patient is asked to think of the needed developmental belief or feeling, such as “It will be OK” or “It wasn’t my fault” or “I am not a bad person” or “I’ll get through this.” Then, rather than asking the patient to associate to images of actual or vicarious experiences of mastery, as the traditional protocol would

suggest, the patient is asked to “imagine what it would be like” to have that feeling or belief. As a word picture gradually develops with its associated affective and sensory stimuli, short sets of bilateral stimulation can be used to begin to install these associations with cautious attention to the potential emergence of intrusive affects and images. Many trauma survivors have as much or more difficulty tolerating positive affect as negative affects (van der Kolk et al, 1997; Leeds, 2001). The resource work therefore has to be carefully titrated and stopped just short of the emergence of negative intrusions. Titration can also be facilitated by use of continuous stimulation techniques or brief “sessions-within-a-session.” By keeping Resource Development work at this level of concreteness, with ultra-short sets and titrated installation techniques, it is possible to install imagined experiences of well-being without unduly challenging the system or triggering intrusive anxiety.

With Safe Place work, concreteness and structure still prevail, but the targets chosen are somewhat different: the patient is asked to recall a time in the recent past when he or she felt safe or relaxed or at peace even for a moment. Because instability and dysregulation result from a paucity of safe experiences, particularly early experiences, often this “moment of safety” will have been a moment in the therapist’s office. Or, if the patient is a parent, it might have been a moment of safety with a child, or a moment in a natural setting (for example, the patient whose moment of safety was experienced at the top of a mountain on her skis all by herself). Once the moment of safety has been identified, it can be easily evoked and is relatively impervious to post-traumatic intrusion by virtue of its being a real experience. Again, ultra-short sets are used for installation, and the work is contained and time-limited. The patient is asked to focus on the images associated with the identified “moment of safety” and to notice what the experience of feeling safe is like: What changes? Her tension level? Her anxiety or hypervigilance? Feelings and beliefs about herself? As the feelings and sensations associated with the “moment of safety” gradually become better installed and more easily evoked, the patient can then be asked to focus on a image of doing something mildly challenging and notice how it seems different when she feels safety inside. With one DID patient, we “practiced” the Future Template in vivo by having her try to stay with the feelings associated with safety while both of us stood up and moved around the office. Using her mindfulness skills, she was able to observe that she could hold onto the sensations until she got excited by the feeling of mastery! Then the positive affect or the increased arousal or both triggered intrusive feelings of anxiety and dread. Rather than being a setback, this experience was instrumental in her subsequently noticing how often that same phenomenon happened in daily life and how frequently it led to unsafe behavioral responses.

To enhance the effects of Safe Place work, two modes of bilateral stimulation (one continuous and one for installation) can often be better than one: the continuous modality gradually becomes installed along with the resource or safe place and later helps to more easily evoke it. For example, I might use a Biolateral tape continuously and

short sets of EMs to install a safe experience or imagined resource, then give the patient the tape to take home for use in re-connecting with the experience of safety or mastery. (Butterfly hugs and hand taps are also useful modalities for use outside of sessions.)

Differentiating Past from Present

Building on the modified Resource or Safe Place work, unstable dissociative patients can begin to work on differentiating past and present and on combating trauma-related cognitive schemas. This phase begins with some cognitive-behavioral work focused on increasing mindful attention to sensory and affective perceptions and how those are interpreted. For example, the patient might be asked to keep a log tracking her daily experiences: at particular “anchor points” in the day, she notes what she is doing, what feelings she is experiencing, what beliefs about herself are evoked by the feelings, and whether those feelings and beliefs fit better with her past or her present. The log facilitates observation of the paradox inherent in doing ordinary, normal things while feeling rage, terror, self-loathing or revulsion and experiencing those feelings as confirmation of internalized, trauma-related beliefs that interpret her present experience as if it were past. When the patient has been mindfully logging her daily experience for long enough to hold this concept in mind even for short periods of time, then EMDR can be used to challenge these internalized beliefs that keep her stuck.

For this particular purpose, the trauma processing protocol is modified to focus primarily on the cognitions while briefly acknowledging the connection to traumatic memory using the “Four Steps to Freedom” model developed by Claudia Black (1999). The Four Steps is a concrete, structured format for use in connecting post-traumatic triggers with an original traumatic event and consequent internalized beliefs and can be used as a cognitive-behavioral technique or combined with EMDR techniques. As used here, the Four Steps to Freedom (adapted from Black, 1999) consist of the following sequential steps:

- ❑ **Assume that your distress has been triggered and is related to past trauma**
- ❑ **Connect that distress to its roots in the traumatic past**
 [This is a mindfulness step, not an exploration of memories! It is best to ask the patient to “rewind and fast forward through the traumatic past for thirty seconds, and tell me where these feelings and bodily sensations best fit.”]
- ❑ **Identify the internalized old beliefs that developed as a result of that experience**
 [That is, identify the negative cognition]
- ❑ **Challenge the old beliefs so that you can begin to develop the new beliefs needed to live in today’s reality**
 [A challenge might be simply identifying the belief as an “old” belief, or identifying a positive cognition, or going to the Safe Place and noticing if the old belief is different there, or beginning to develop a resource that would enable the patient to begin challenging the old belief]

A clinical example of how this format might work is the following vignette from the therapy of a DID patient with whom I do continuous bilateral stimulation twice a week for fifty minutes. The bilateral modality utilized is standing EMDR because of its unique ability to facilitate staying grounded rather than switching during sessions.

In this particular session, the target was the distress triggered by having arrived twenty minutes late for her appointment because she had become inexplicably confused about what time it was. The feelings triggered were despair and sadness, which she connected to a sick feeling in the pit of her stomach. Rather than try to find out what part of her was responsible for this sabotage of the therapy appointment, we focused on her distress in the moment and followed the Four Steps protocol. Yes, the feelings had obviously been triggered: but where in the traumatic past did they best fit? After a 20-second “rewind and fast forward” review of her childhood, she connected them to memories of pervasive physical and emotional neglect by her alcoholic mother. The particular neglect memories had to do with experiences of wanting interpersonal connection and inclusion and, when that was unavailable, being left with feelings of shame, disappointment and despair. The internalized old belief was, “There is something wrong with you—you don’t deserve to have what you want.” Then we challenged that belief simply by going to her Safe Place, the beach cottage where she vacationed last September and where she had her first felt experience of living in the safe here-and-now rather than in a nightmarish traumatic past. After a few minutes of evoking the images and feelings associated with that experience, she felt calm, happy and relaxed. She commented positively as she left the session on how much we had gotten done in that short amount of time!

Notice that just being able to go to her Safe Place constituted the challenge of the internalized old beliefs because she had been gradually installing feelings of “being OK” and “deserving to have a good time” through the process of re-visiting the images and sensations associated with this “moment of safety” at every session, twice each week, for approximately six months. Two years ago, this patient was reporting uncontrollable rapid switching, night terrors, cutting and headbanging, and ruminative self-loathing so intense that all other thoughts and preoccupations were excluded from consciousness. She could not stay grounded for more than a few minutes, and she could not maintain one ego state for long enough to do any piece of therapeutic work. Over the past eighteen months, the EMDR techniques described here, carefully paced and prioritized, have had a substantial impact on all these symptoms and entirely eliminated the self-injury. Session after session, using continuous stimulation, she works on staying grounded throughout the whole hour, tolerating the affects that come up in the moment, further installing her Safe Place, developing needed Resources and applying them to Future Templates within the context of the Safe Place, and using the Four Steps to process negative schemas connected to tiny and well-contained memory fragments.

In stabilization phase work, whether the treatment is psychodynamic, relational, or cognitive-behavioral, pacing and titrating well-established traditional techniques is the most effective method for ensuring that the therapy itself does not further overstimulate the dysregulated trauma patient. The very same principle can be applied to the use of EMDR. The keys to the judicious use of EMDR techniques in the service of promoting stabilization can be found in the following guidelines:

- ❑ Use a little EMDR, not a lot
- ❑ Choose techniques that increase affect tolerance rather than stimulate affect
- ❑ Keep the focus of the work narrow and contained
- ❑ Use more, rather than less, structure
- ❑ Work “in the moment”
- ❑ Choose techniques that the patient can “take home” and use outside of the therapy
- ❑ Remember that “slower is faster”

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For copies of this unpublished manuscript, write to:
Janina Fisher, Ph.D., 23 Main St., Watertown, MA 02472
or email Dr. Fisher at: DrJFisher@aol.com

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