Navigating the Complexity of Complex Trauma

“An Introduction To EMDR & Dissociation Theory”

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Learning About You...

EMDR Therapy
What it is & What it isn’t
So, What have you heard?
What We Will Cover Today

- EMDR – Dispelling The Myths
- Research
- Defining Trauma(s)
- Staged Approach as the Standard of Practice
- EMDR – Adaptive Information Processing (AIP)
- EMDR – 8 Phases/Three Prongs/Client Examples
- What To Know When Referring

Addressing Myths...

- EMDR is an integrative therapy, not an intervention.
- If the EMDR therapist is focusing on eye movements and nothing else, it’s not EMDR
  - We are always doing EMDR - Eight Phases
- EMDR Is Not a Quick Fix
  - Recent Event / Simple PTSD / Complex PTSD
  - Also necessary and standard of practice to evaluate for dissociation.

“Between The Hemispheres”

*Video Segment*

1:00-6:25
8:45-6:35

EMDR As A Treatment of Choice
World Health Organization (2013) guidelines for treatment of stress-related conditions clearly states that trauma-focused CBT and EMDR are the only psychotherapies recommended for children, adolescents and adults with PTSD.

- American Psychiatric Association determined EMDR is an effective treatment for trauma and placed it in its recommended treatment guidelines for Acute Stress Disorder and PTSD (2004)
- Department of Veterans Affairs and Department of Defense placed EMDR in the “A” category for the treatment of trauma (2004)
- Israeli Council for Mental Health places EMDR as one of only 3 methods recommended for treatment of terror victims (2002)
- Clinical Division of the American Psychological Association places EMDR as one of three methods empirically validated for the treatment of PTSD (1998)
- International Society for Traumatic Stress Studies lists EMDR as an efficacious study for PTSD (2000)
- Northern Ireland Department of Health, Social Services and Public Safety deems EMDR and CBT to be the treatments of choice trauma victims (2003)
- Dutch National Steering Committee Guidelines Mental Health Care places EMDR and CBT as the treatments of choice for PTSD (2003)
- Many insurance companies now place EMDR as a treatment of choice for trauma

The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency of the U.S. Department of Health and Human Services (HHS). This national registry (NREPP) cites EMDR as evidence based practice for treatment of PTSD, anxiety, and depression symptoms. Their review of the evidence also indicated that EMDR leads to an improvement in mental health functioning.

- At least 30+ randomized controlled and 22 nonrandomized studies on EMDR and the treatment of trauma.
  - In single trauma cases, 77-100% elimination of PTSD symptoms in 3-6 sessions
Research...

- EMDR was superior to both control conditions in the amelioration of both PTSD symptoms and depression. Upon termination of therapy, the EMDR group continued to improve while Fluoxetine (Prozac) participants again became symptomatic.


- 10 child molesters w/ reported histories of childhood sexual abuse -EMDR as adjunct to standard cognitive-behavioral therapy-relapse prevention (CBT-RP) group treatment.
- Consisted and sustained decline in deviant sexual arousal compared to the control condition – this was measured by the Sex Offender Treatment Rating Scale (SOTRS) Journal of Forensic Psychiatry and Psychology, 17, 538-562.
- As predicted by the Adaptive Information Processing model the EMDR treatment of the molesters’ own childhood victimization resulted in a decrease in deviant arousal, a decrease in sexual thoughts, and increased victim empathy. Targeted the worst of the offenders’ own CSA history.
- Effects maintained at one year follow up.

Research...

- EMDR treatment resulted in lower scores (fewer clinical symptoms) on all four of the outcome measures at the three-month follow-up, compared to those in the routine treatment condition. The EMDR group also improved on all standardized measures at 18 months follow up.
Defining Trauma
Single Incident Vs. Developmental Trauma

Three Ways Trauma Affects The Brain

Bessel Van der Kolk

Three Ways Trauma Affects The Brain

Bessel Van der Kolk

• “In childhood, traumas are comprised not only of acts of commission (such as sexual assault), but of acts of omission as well (such as neglect or abandonment) where the absence or withdrawal of certain resources may create a threat to the child’s survival and physical well-being.

• (sexual abuse, physical abuse) as well as other experiences more broadly understood as maltreatment (neglect, emotional abuse, absence of parent).”
“The Many Faces of Trauma”

Childhood Trauma
This is the foundation for many of our adult clients

“Posttraumatic stress disorder symptoms themselves have been described as a form of a chronic dysregulated emotional response to traumatic reminders as reflected in the co-occurring symptoms of hyperarousal/emotional numbing and hypervigilance/poor concentration (e.g., Frewen & Lanius, 2006; Litz, Orsillo, Kaloupek, & Weathers, 2000).”

Bessel Van der Kolk

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Predictor Variable

• The accumulation of a variety of traumas that have occurred rather than how long or amount of times of occurrence
• Thus, the impact of sustained and chronic trauma (vs. single incident events) suggests that presence of multiple co-occurring traumatic events (e.g., childhood sexual abuse, physical abuse and neglect), which, in turn, lead to the complexity of symptoms.
Stabilization

- NOT about processing, memory work, or narrative
- IS about strengths building, skills building, grounding techniques, addressing any phobias to calm, tolerating and identifying feelings, learning how feelings were handled by history
- Conceptualizing HOW the trauma creates symptoms, creating a plan. Treat dissociation 1st.
- We identify when NOT to process trauma memories vs. return to stabilization to help to reduce phobia to the traumatic material

Processing

- Processing and being able to titrate into working on the traumatic memories, accessing while keeping the client within the window of tolerance
- Reprocessing NOT reliving
- “Personification” and “Presentification” are necessary.
Integration

- Addressing other life issues, daily life, integrating what is learned and applying into life, spiritual relationships, work, recreational experiences, application of personal growth experiences.

AIP Model

- Traumatic events and/or disturbing adverse life experiences can be encoded maladaptively in memory resulting in inadequate or impaired linkage with memory networks containing more adaptive information.
- Memories thereby become susceptible to dysfunctional recall with respect to time, place, and context and may be experienced in fragmented form.
- Under optimal conditions, new experiences tend to be assimilated by a natural information processing system that facilitates their linkage with already existing memory networks associated with similarly categorized experiences.
- This impairment in linkage and the resultant inadequate integration contribute to a continuation of symptoms.
- Helping to bring the maladaptive to become adaptive

EMDR Therapy & AIP

(Adaptive Information Processing Model)

Theory of Mechanism of Action

EMDRIA

- The most widely accepted theory is that EMDR activates the healing mechanism that occurs during REM sleep.
- It is further possible that the orienting response induces neurobiological mechanisms, which facilitate the activation of episodic memories and their integration into cortical semantic memory. It is additionally possible that EMDR’s sensory stimulation and procedures repair thalamic and thalamo-cortical function, facilitating the repair of maladaptive neural linkage of information processing.
- This theory has lately obtained experimental support (Richardson et al., 2009). Further, studies have shown a direct relationship between the orienting response and thalamic activation (Friedman, Goldman, Stern, & Brown, 2009; Menon, Ford, Lim, Glover, & Pfefferbaum, 1997; Minamimoto & Kimura, 2002), findings that are highly consistent with information processing.
What This Means For Our Clients

- Our thoughts, sensations, emotions, & our perceptions of self & world are “stuck” & drive NOW as if THEN.
- The past is experienced as the present.
- Symptoms are the “recorded soundtrack” of the trauma, manifested in the NOW.

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What This Means For Clients

- Fragmentation - All aspects ARE the memory - even without the narrative
- The fragments of that material images, sounds, sensations, cognitive errors, are unprocessed and are the foundation of what creates their symptoms including the internal dissociative processes
- Trauma as a issue of time orientation - our clients are stuck in “trauma time” their system does not feel “safe” because it is not really in NOW and its over.

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Demo Video(s) Disclaimer ;)

AIP
Let’s briefly “Map” a case & the client/s symptoms through the lens of AIP and EMDR’s three pronged approach

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Demonstration
(*Watch Through The Lens of AIP*)
Note: This is Phase 8

March Accident > Trailering > 7 Years Old Event > Grief EAP Colleague

The Eight Phases

We Must Know The Broad Goals of Each Phase

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Eight Phases

- Phase One: History Taking
- Phase Two: Preparation
- Phase Three: Assessment
- Phase Four: Desensitization
- Phase Five: Installation
- Phase Six: Body Scan
- Phase Six: Closure
- Phase Eight: Reevaluation

History Taking
Phase 1

- Clinician begins the process of treatment planning using the concept of incomplete processing and integration of memories of adverse life experiences.
- The clinician prepares a treatment plan with attention to treating past usually 1st, then present, completing with future.
- Note: Order of the prongs may be change and prongs omitted depending on client stability, readiness, and situation

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History Taking Phase 1

• Note: The clinician may need to postpone completing a detailed trauma history – with complex trauma we often get history in “pieces” over time with increased personification, personification, & increased “realization” i.e. treatment of the dissociation.
• Don’t Grow the PHOBIA!

Treatment Planning

• Explore what other unprocessed experiences the symptoms are “attached to” i.e. like a “door” into the neural network. What needs to be reprocessed?
• Present Events and Triggers: What current situations trigger disturbance? We assume its “left over” unprocessed material.
• Future template - Checks for any unprocessed disturbance while the client imagines the desired behavior

Preparation Phase Phase 2

• The client develops mastery of skills in self-soothing and in affect regulation as appropriate to facilitate dual awareness during the reprocessing sessions and to maintain stability between sessions.
• Some clients may require a lengthy preparation phase, which can also be circular with those with complex trauma

It is necessary to assess for dissociation in this phase, but to have tracked it even BEFORE this phase. To not do so can push the client through the window of tolerance and further post-traumatic deline

Therapists MUST treat the dissociative symptoms before even considering going to even fractionated processing
Knowledge of dissociation theory and experience working treating complex trauma and *assessing for dissociation.*

- This is not just about PTSD but about developmental traumas, the impact of trauma i.e. the *reactivation* of that neuro-network = symptoms
- We MUST understand, now how to identify, & treat dissociation to work with complex trauma or we *can* cause harm.

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Growing The Phobia

- You CAN increase the client’s dissociative process if the phobia to the traumatic material increases.
- The phobia will increase if we reenact, reactivate, or reengage with the traumatic material while the client is outside of the window of tolerance and not able to maintain *dual attention.*
- Growing the phobia results in longer treatment & the material won’t “budge” and feels “stuck.”

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Window of Tolerance

### Hyperarousal Zone

2. *Sympathetic “fight or flight” Response*
   - Increased sensations, flooded
   - Emotional reactivity, hypervigilant
   - Intrusive imagery, Flashbacks
   - Disorganised cognitive processing

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### Optimal Arousal Zone

1. *Ventral Vagal “Social Engagement” Response*
   - State where emotions can be tolerated and information integrated

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### Hypoarousal Zone

3. *Dorsal Vagal “inhibitory” Response*
   - Relative absence of sensation
   - Numbing of emotions
   - Disabled cognitive processing
   - Reduced physical movement

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Window of Tolerance

- Our goal is to increase client’s tolerance of affect, Yes.
- But we must always start with increasing tolerance of positive affect and calm 1st vs. dissociation as “channel changer.”
- The client system has to know and have the feel of being able to get itself out of distress, using calm, instead of shut down.
- If you don’t “own” the emotion, how can you regulate it?
Window of Tolerance

• Can my client tolerate calm?
• IF processing the traumatic material, can my client tolerate being present in the now, while doing so?
• Can I track moment to moment the when the client goes in and out of the window of tolerance?

Keep this in mind....

• Your client’s dissociative process sounds like “resistance” but is the dissociative process in place
  - I don’t wanna think about it
  - It’s no big deal
  - It isn’t that bad
  - I’m over that
  - That has nothing to do with how I feel
  - I don’t feel
  - I don’t wanna feel it

Assessment Phase (Phase 3)

• Clinician identifies the components of the target/issue and establishes a baseline response.
• Once the memory or issue (with a specific representative experience) has been identified, the clinician asks the client to select the image or other sensory experience that best represents it. “Worst part”
• We ask for the various aspects of the memory to activate the neuro-network
Desensitization Phase
Phase 4

- Memory is activated and the clinician asks the client to notice his/her experiences while the clinician provides alternating DAS
- The clinician uses specific procedures and interweaves if processing is blocked.
- The desensitization process continues until the SUD level is reduced to 0 (or an ecologically valid rating).

Desensitization

- Three Pronged: Processing past disturbances, present triggers, disturbances, future templates
- Dual Attention Stimuli
- Imperative that client maintains dual attention one foot in the past and one in the future.

Installation Phase (Phase 5),

- Therapist first asks the client to check for a potential new positive belief related to the target memory. The client selects a new belief or the previously established positive cognition.
- The clinician asks him/her to hold this in mind, along with the target memory, and to rate the selected positive belief on the VOC scale of 1 to 7. The therapist then continues alternating bilateral stimulation until the client's rating of the positive belief reaches the level of 7 (or an ecologically valid rating) on the VOC Scale.
About Processing…

- Goal is accessing the traumatic material, stimulating, then reprocessing it.
- This is different from reliving i.e. being outside of the window of tolerance, dissociating, which impedes the healing of trauma and can actually make the client worse i.e. post-traumatic decline.

Body Scan Phase (Phase 6),

- the therapist asks the client to hold in mind both the target event and the positive belief and to mentally scan the body.
- The therapist asks the client to identify any positive or negative bodily sensations.
- The therapist continues DAS to process remaining body sensations and associated material.

Closure Phase (Phase 7)

- Occurs at the end of any session in which unprocessed, disturbing material has been activated whether the target has been fully reprocessed or not.
- The therapist may use a variety of techniques to orient the client fully to the present and facilitate client stability at the completion of the session and between sessions.

Reevaluation Phase (Phase 8),

- If any residual or new targets are present, these are targeted and Phases 3-8 are repeated.
- Same target if not completed. Don’t need entire assessment phase again – partial.
Overall What To Know/Ask When Referring

- Is this a single incident, recent event, or a case of developmental trauma? If developmental know that this is not short term.
- SAFETY in the present is the priority
- What calming skills, if any, does the client have vs. “shut down” skills?
- Does the client have substance abuse issues and if so, resources for treatment as well?
- Ask if your EMDR therapist is knowledgeable about working with EMDR & dissociation, or willing to get consultation to provide clinically/ethically sound txs? EMDR Basic, Certified, and/or consultant?

Case Review
Consultation

How I Can Help You...

* Consultation – Trauma & Dissociation (Grounded in Structural Dissociation Theory)
  Do NOT have to be EMDR Trained
** EMDR Basic Training Consultation Hours (HAP)
  *
** EMDR Certification if Basic Trained
** What is EMDR YouTube For Clients/Staff

Questions / Take Aways
Grounding Skills Card

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