Complex PTSD and EMDR: A Multi- layered Approach

Presented by: Joanne H. Twombly, LICSW
781-264-2403
J.Twombly@verizon.net

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Workshop Overview

Containers
What is Complex PTSD
Symptoms/core issues of survivors/ACES
Memory Dynamics, Etiology, and Attachment
Screening and Diagnostic Tests
3 Stages of Trauma Treatment with EMDR
Crash course on hypnotic language
Stabilization/Coping Skills/RDI
EMDR for Trauma processing
Wrap up and Questions

2

Why Start with Containers???

- Lots of us have trauma histories
- Some have unworked through chunks
- And/or may not be aware them because:
  - Developmental stage not reached
  - Haven't been triggered yet…
- This presentation may trigger something, and these clients can be triggering!

Note: We have an ethical responsibility to work on our own stuff (Steven Frankel, Ph.D, Esq.)

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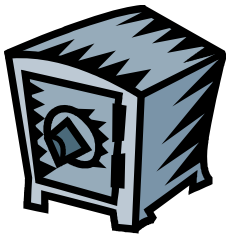
Containers

Visualize or Imagine :

- A container
  - A Tupperware container
  - Bank vault
  - Computer with various files

- Put traumatic material that could get triggered or whatever might distract you into the container in just the right way…
- Sign on all Containers: To be opened when it serves my healing



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PTSD and Dissociation

- **Classically all PTSD is a biphasic disorder with alternating phases of intrusion and numbing.**

"This biphasic pattern is the result of dissociation: traumatic events are distanced and dissociated from usual conscious awareness in the numbing phase, only to return in the intrusive phase".

(James Chu, 1998)

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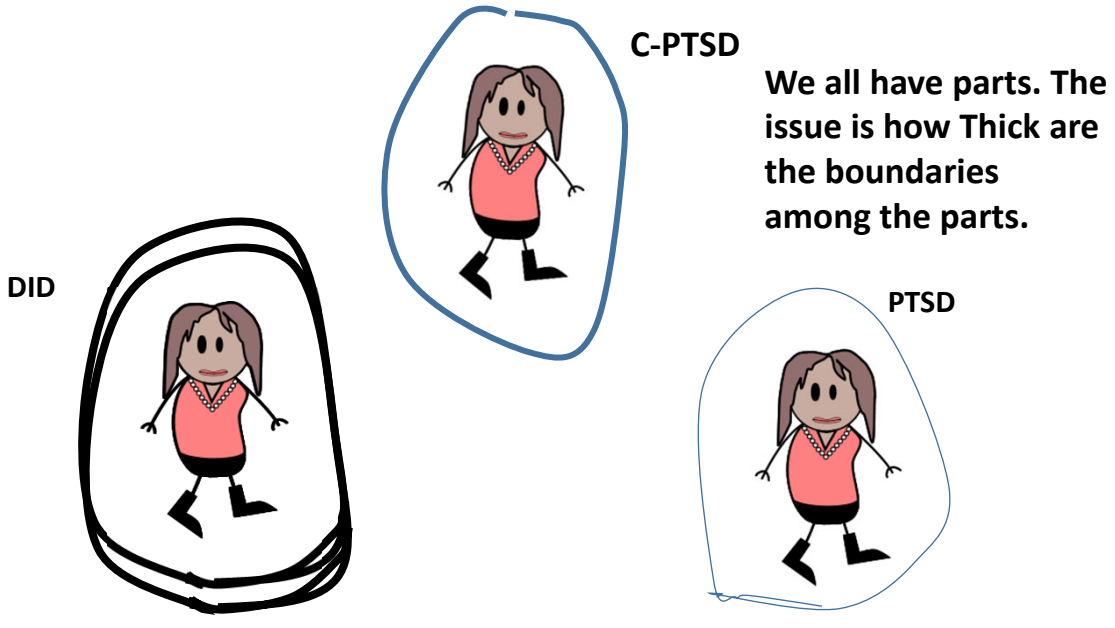

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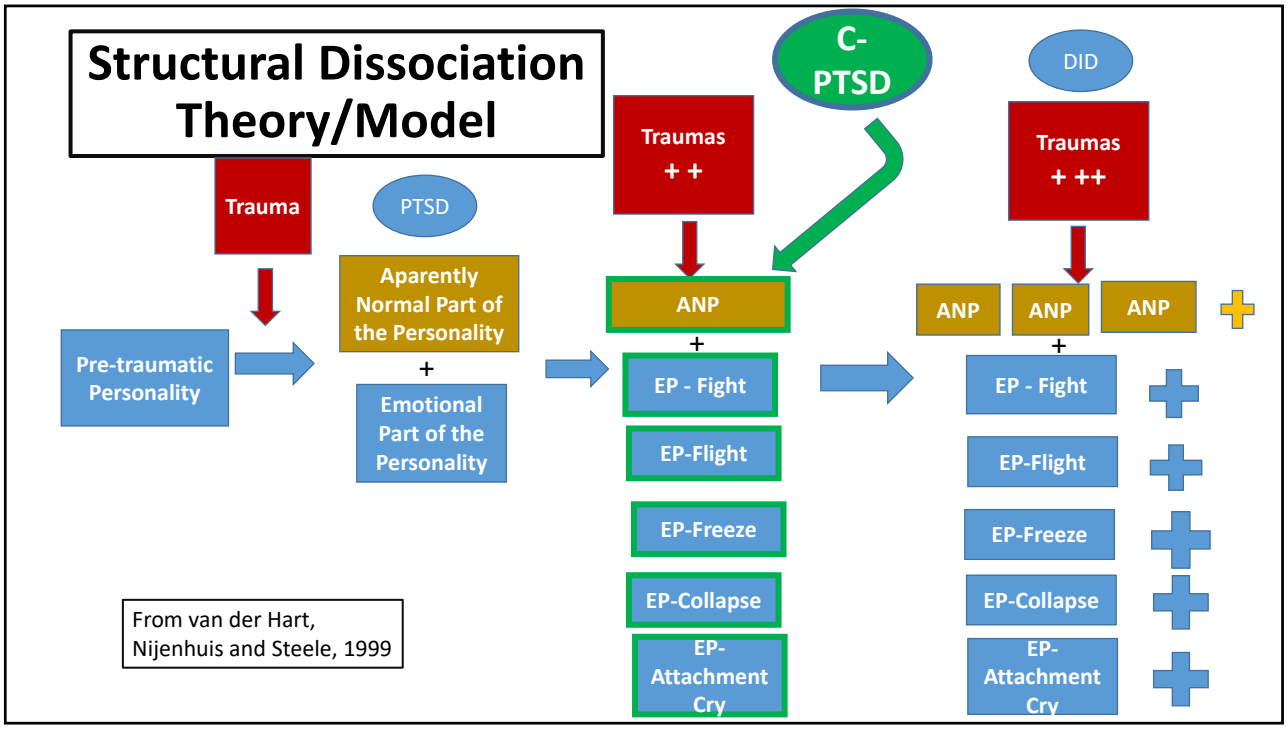
Structural Dissociation Theory/Model
Trauma
PTSD
Pre-traumatic Personality
Aparently Normal Part of the Personality
+
Emotional Part of the Personality
Traumas + +
C-PTSD
ANP
+
EP - Fight
EP-Flight
EP-Freeze
EP-Collapse
EP-Attachment Cry
DID
Traumas + ++
ANP
ANP
ANP
+
EP - Fight
EP-Flight
EP-Freeze
EP-Collapse
EP-Attachment Cry
From van der Hart, Nijenhuis and Steele, 1999

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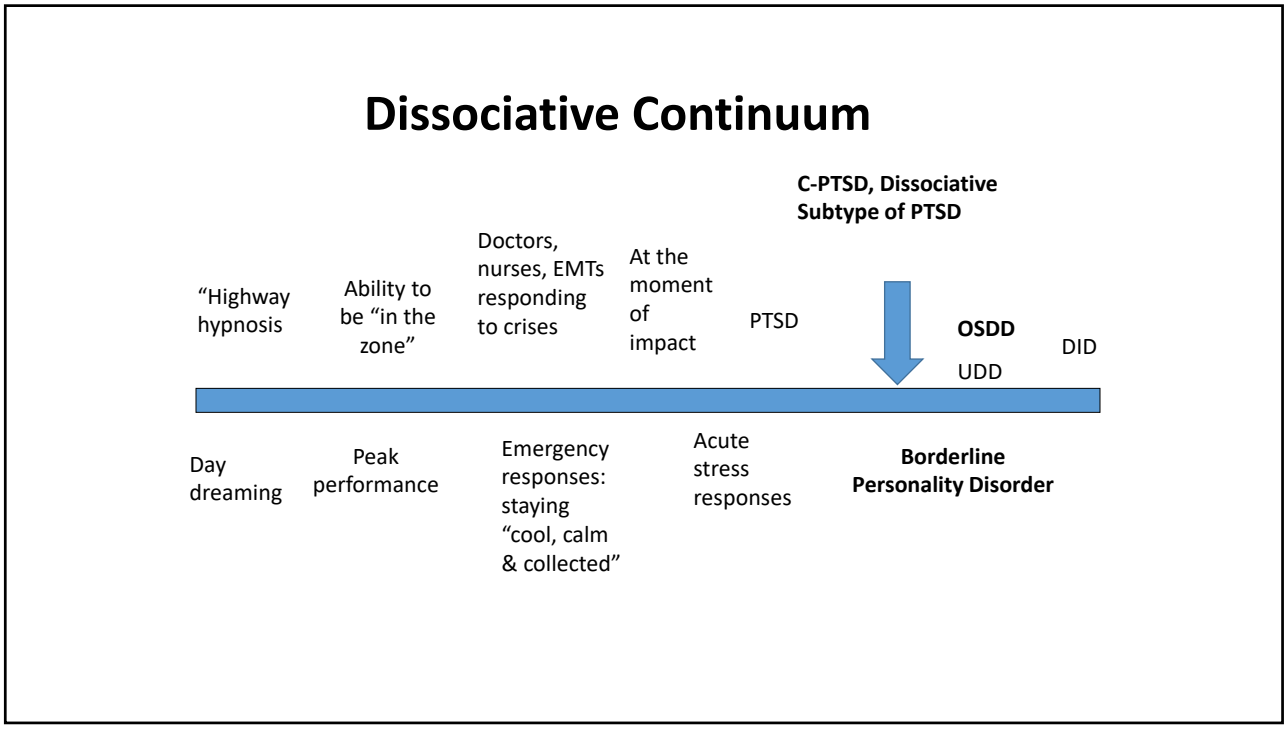
Dissociative Continuum
C-PTSD, Dissociative Subtype of PTSD
"Highway hypnosis
Ability to be "in the zone"
Doctors, nurses, EMTs responding to crises
At the moment of impact
PTSD
OSDD
UDD
DID
Day dreaming
Peak performance
Emergency responses: staying "cool, calm & collected"
Acute stress responses
Borderline Personality Disorder

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Adverse Childhood Experiences Research

- Felitti and Anda from the Centers for Disease Control and Prevention (CDC) collected data between 1995-1997 from
- 17,337 Kaiser Permanente patient volunteers.
- 74.8% were white; average age was 57; 75.2% attended college; all had jobs and good health care
- Each asked 10 Questions about ACEs.

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Adverse Childhood Experience Scale: ACEs Matter!

- When an ACE occurs, the child's brain is flooded with adrenaline ⟹ "Fight or Flight". This helps the child react to immediate dangers but becomes toxic when turned on for too long.
  - 4 or more ACES: 32X more likely to have learning or behavior problems in school
  - Brain development is paused to deal with threats to safety
  - This stunted growth can lead to poor decision making and an inability to process, and
  - Respond to daily stress with higher anxiety and sense of life being dangerous

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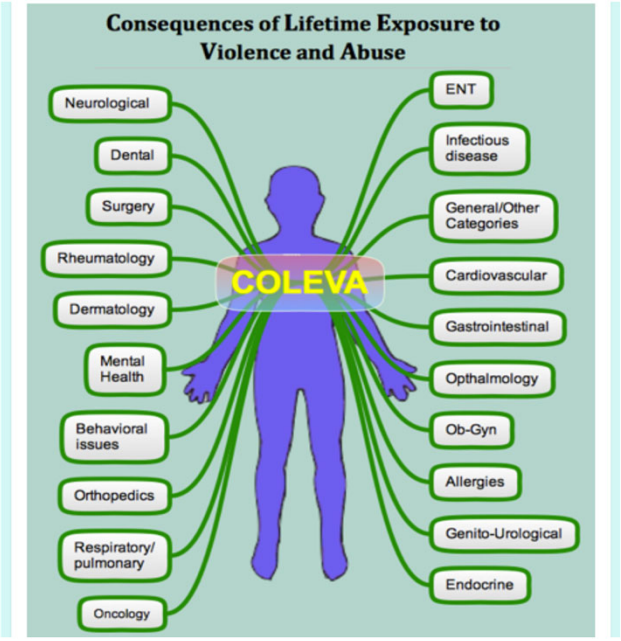
Physical/Somatic

- What % is physical
- What % is somatic
- Feelings not allowed to be expressed are often somatized.
- These feelings need expression-
- One easy route is to use an existing route, i.e. to toss gas on physical symptoms.

*Focus into the _____ feeling.

Ask your unconscious to change it into words, images and feelings… What do you get?



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Adult Attachment 101

(Main, Kaplan, and Cassidy 1985)

- **Secure**
- **Dismissing/avoidant: dismissing of attachment-related experiences and relationships**
- **Anxious/Preoccupied: Parent angry, passive, fearful**
- **Disorganized: characterized by confused and inconsistent attachment behavior.**

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Attachment 101

- **Secure parents** → **Secure babies**
- **Dismissive parents** → **Avoidant babies**
- **Preoccupied parents** → **Anxious, resistant babies**
- **Unresolved/disorganized parents** → **Disorganized babies**

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Etiology of DDs and BPD

(Lyons-Ruth, 2001) – Relational Trauma

- **Neglect in infancy**
- **Physical unavailable of primary caretaker in the first 2 years of life**
- **Disorganized attachment**
- **Caregivers who are frightened or frightening (Liotti, 1999)**
- **These factors in early childhood were significant for developing BPD and DDs by the age of 19.**

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PTSD Summary: PTSD is a DD:
Hallmark is numbing and intrusion!

Boon, Steele, & Van Der Hart 2011

Intrusion Symptoms

- **Flashbacks and Nightmares**
- **Hallucinations and delusions**
- **Severe recurring anxiety or panic**
- **Feeling paralyzed with fear and/or wanting to run away**

Avoidance Symptoms

- **Efforts to avoid thoughts, feelings, or situations that might evoke traumatic memory;**
- **Amnesia for traumatic events**
- **Emotional numbness**
- **Feeling like you're on automatic pilot**
- **Isolation and avoidance of other people**
- **Inability to enjoy life or feel love**

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***Hyperarousal Symptoms**

- **Persistent physical symptoms of tension**
- **"On Alert": hypervigilant symptoms**
- **High startle response, hypersensitive to noise, smells, air temperature, other environmental stimuli**
- **Irritability with outbursts of anger and rage**
- **Emotional outbursts and Sleep difficulties**
- **Concentration and Attention problems**

Hypoarousal Symptoms

- **Emotional and/or Physical Numbness**
- **Blank mind, unable to think or speak**
- **Profound detachment**
- **Inability to move or respond**
- **Extreme drowsiness or temporary loss of consciousness**

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Dynamics of "Memory"

(Courtois, 1999)

- **The therapist strives to practice from a neutral perspective regarding memory.**
- **The therapist understands the malleability of human memory and the differences between historical and narrative truth.**
- **The therapist's goal in attending to traumatic memories is to facilitate mastery and resolution.**
- **"Traumatic Material" vs "Memory"**

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Truths and Screens and Misinformation

- **We (therapists) are not judges, we don't have to figure out what's exactly right or wrong. Our goal is healing.**
- **"We need to spread everything out on the table and figure out what makes sense."**
- **False, Confusing and Screen Memories include:**
  - **You were born bad. You are bad. You made me do it.**
  - **"The principal did it!" The father did, but the principal was a nice guy who wouldn't punish the child.**
  - **I am mentally ill. Or I was abused in a neighborhood cult.**

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In Session Therapist Stance

- Hold awareness of non-verbal communications
- Adjust expectations according to ability of the client: treatment trajectories
- Try to be non-defensive with criticism and apologize if need to!
- Porges: if you want people to be open and engaged, communicate acceptance.
- Your voice needs to be modulated, relaxed, nonjudgmental and curious!
- If you're working harder than the client, there's something wrong – No Attachment to Outcome
- Have and gently project confidence and the belief that healing is and will be happening.

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Phase 2 and 3 of Trauma Treatment

- Phase 2: Treatment of traumatic memories and related symptoms, working through the transference
- Twombly Protocol
- Phase 3: Personality integration, mourning, and reconnection, promoting intimacy and life not fixated on trauma/neglect/abandonment!
- RDI
- Life Review

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Phase 1 Trauma Treatment

- Safety, skills building, stabilization, and symptom reduction, establishing the therapeutic alliance
- EMDR: Resource Development and Installation (RDI)
  - EMDR Adaptations
  - Other coping skills
  - Create an atmosphere of relative safety
  - With boundaries (phone call, cancellation policies – make clear in advance)
  - Teach client about the tx process and their responsibilities: homework, that you'll be working with them as a team, guard against compliance…
  - Psycho ed on dissociation and neurology
  - Consider medication

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Parts and Medication

Twombly

- Invite all the parts who're willing to take meds.
- Invite parts who don't want to watch others, and maybe try it if want to.
- Talk with parts who have concerns about meds and answer concerns As you take the medication, visualize it traveling to every part of your mind, to every cell of your body… Bringing soothing, relaxing (whatever it's supposed to do)…
- Note: Meds have side effects, not taking meds also has side effects…
- Note: medication, food and vitamins are for all

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- **Dutch door comm. Initial communication is about today, permission to keep traumatic material dissociated (Note: Impact on History taking!)**
- **Only the headlines…**
- **Don't get a list of the 10 worst traumas**
- **Beginning to orient person/parts to the present**

Watch For…

- **Prior treatment failure. Prior EMDR treatment failure**
- **Therapy interfering behaviors**
- **Current crisis or "flashbacks" can be a way to avoid trauma work**
- **Show enough but not too much warmth, empathy…**
- **Client as their own affect regulator**

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Neurology: Radically Simplified Version (Twombly)
Psycho-ed

- **All experiences enter the brain thru the primitive parts of the brain, mostly the right brain.**
- **Non-traumatic and processed experiences cross over to the left brain and get stored in the Frontal lobes (memory, logic, and thinking).**
- **Brain scans of people having flashbacks show the Frontal lobes and Brocas area (speech center) are more or less offline, while the primitive parts of the brain/right brain are lit up like a Christmas tree.**

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- **Unprocessed trauma gets stuck in the right brain.**
- **Thinking/knowing is in the left brain. That's why you can know for a fact you're safe (left brain), and still feel not safe (right brain). This can make you feel crazy.**
- **Therefore you can be in traditional talk therapy without getting anywhere or making enough progress.**
- **To heal trauma you have get treatment that helps you get into the material stuck in the right brain.**
- **Therapies like hypnosis, EMDR, IFS, and ego state work help do that…**

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Teach Coping skills

- **For symptom management**
- **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…**
- **This is working on trauma because it's teaching what you didn't get back then. This will help you manage symptoms and have control over your life in a way you never had… Mastery!**

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Phase 1 Grounding Strategies

- **Grounding strategies/Five Senses:**
  - **Use sight, smell,**
  - **touch (holding a stone - is it hot or cold, hard or soft, play toss the Kleenex box),**
  - **Taste**
  - **sound**
- **Mindfulness of the Body (get up, stretch, mountain pose, etc.)**
- **Work within the "Window of Tolerance" to modulate hyper or hypo arousal**

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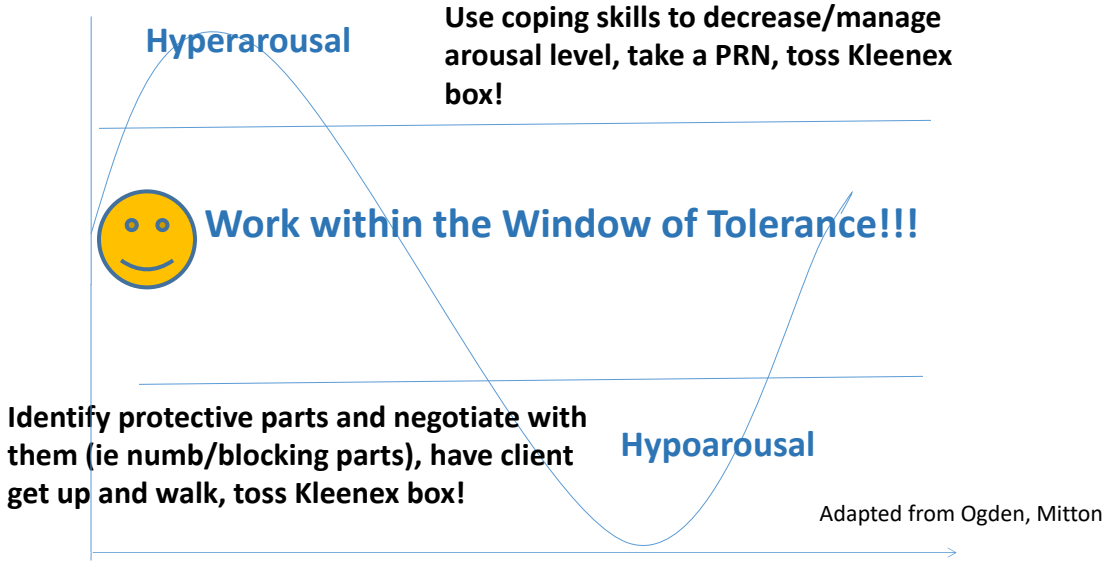

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Cognitive Distortions and Blocking Beliefs

- **Responsibility/Defectiveness/ Action**
  - **I'm bad –I'm evil, slime**
  - **I deserve to be miserable**
  - **I don't deserve anything good**
  - **I did something wrong**
  - **I wanted it, I made it happen**
- **Safety/Vulnerability**
  - **I'm going to die**
  - **Bad things are always going to happen to me**
  - **It's not ok to feel/show my emotions**
- **Power/Control/Choices**
  - **I am powerless – I'm helpless**
  - **I have to be perfect**

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Cognitive Distortion Exercise (Burns)

Situation	Feelings (in %)	Automatic thoughts	Identify the cognitive distortions	Correct the automatic thoughts	Feelings (%) Look for small changes

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Words are the most
powerful tool
health care
Professionals possess.

Like a double-edged sword, they can either maim or heal.

(Lown, "The Lost Art of Healing")

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Why Knowing Something About Trance/Hypnotic Language is Useful!

- **Dissociation is a trance state.**
- **Anxiety attacks and flashbacks are negative trances.**
- **In trance there's increased learning (being in the "zone"), and increased problem solving.**
- **Use hypnotic language to increase the impact of any therapy!**

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Natural Trances

- **People in the "Zone"; Meditators**
- **People in extreme situations of fear, abuse, pain or stress are in a natural trance state, an altered state of consciousness.**
- **And in trance people are more susceptible to positive and negative suggestions and if are in pain, will take something that's been said and hear it negatively.**

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"The Alchemy of Wolves and Sheep"

Harvey L. Schwartz

A primary imperative of a perpetrator is to maintain the secrecy of the perpetration to insure the ongoing viability and sustainability of the abusive situations. From the single molester of a child to multi-member cults, they all use amnesia techniques (hypnotic suggestions, threats, shaming, drugs, classical conditioning, dissociation training) to erase the victims' memories of incidents, names and faces. Many confusion, and amnesia inducing techniques… (p. 94)

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

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

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6. **Reinforce success with ego strengthening comments to emphasize and develop self efficacy and control**
7. **Support communication with client through out exercises.**
8. **Pause to give clients time to visualize, learn client's rate of response..**
9. **State things in a confident, positive way. Avoid negatives and words like "try"!**

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10. **It's ok to suggest imagery, but best to get it from the client.**

11. In trance people are concrete. Be aware of wording, make suggestions general.

12. Like 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"… "As time you (or all the parts) will learn more and more about how things are different now"…].*

***** Make Sure You Get Client out of Trance and Back Grounded in Office**

- **Ok take a few deep breaths and bring yourself back here now. Look around my office make sure you're here…**
- **I'm going to count backwards from 5-1, and when I reach 1…**

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Words to Avoid!

- **Can**
- **You <u>might</u> see..**
- **Try (implies failure)**
- **I want you too**
- **"But" (negates what came before)**

Words to Use!

- **Is**
- **You <u>will</u> notice more and more**
- **'And' (connects two ideas)**
- **You will notice…**
- **Soon…**
- **Notice the changes**
- **Yet…**

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Hypnosis and EMDR

- Kitchur's Strategic Developmental Model of EMDR (EMDR Solutions 1: 1st chapter)
  - Seeding the expectation that EMDR will work
  - Reframing of almost everything as helpful twd the goal of healing. (p.24)
  - Organizes targets systematically
  - 1st Tgt is focus on a characteristic interaction of your parents during your age from 4 to 11.
- Safe Space Imagery, Light stream, Float back/affect bridge
  - FB/Affect Bridge: Focus on the negative cognition, the feelings and the sensations, go back in time…

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Hypnosis and EMDR

- RDI: Use hypnotic language to facilitate, e.g. remember a time when you felt courageous. Bring up all the feelings associated with it, describe it, feel how it felt in your body, describe…
- In the preparation phase: Safe space Imagery aka Provision of sanctuary (Kluft, 1989)
- Container Imagery: (Kluft, 1989)
- Notice when people go in trance during EMDR.
- Cognitive Interweaves: Notice what changes…, Something will occur to you…

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Safe Space Imagery (SSI)

- **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 will help the client reach a state of relaxation and learn to block out intrusive thoughts and feelings.**

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Explanation Cont.

4. **Use of SSI daily over time appears to help lower clients' biological reactivity level, resulting often in clients feeling calmer overall.**

5. **Mind body medical professionals recommend we all do meditation, deep relaxation, or SSI everyday - it supports our physical health and immune systems.**

6. **Predict the possibility of intrusions without suggesting them!**

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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*
  Or a place you'd like to feel safe…
- *It's a place where nothing bad has ever happened.. Just picture yourself there…*

[Focus on sensory experience in developing SS. Ask: ***what are you seeing, hearing, smelling, touching.*** **Use of imagery deepens the experience. (Torem, 1992) Keep track of words client uses and use them. It's empathic, facilitates attachment, and helps deepen the experience**

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SSI #2

- ***Once you're in your Safe Space, look around and notice everything about it that makes it safe.*** **[positive suggestion + focusing attention]**
- ***Perhaps you can describe where you are…***
  - **[Establish communication and use words client uses + pace your communication with theirs]**
  - ***As you settle into this field, feeling the warmth of the sun, noticing no one is around,***
- ***Notice what else you're seeing, hearing, feeling, smelling, touching.*** **[the more dimensions, the more intense the experience is]**
- ***Notice if there's anything that doesn't feel quite right… and perhaps you can describe what you're noticing…***

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SS #3

- **Option 1: Client reports there's an intrusion:** ***Just keep looking around and as you look around, you'll either see something that will help, or some thoughts will occur to you that will help… what are you noticing…***
- **Whatever client notices say:** ***Focus on ____ and notice what changes…***

Notice you're just learning this, and you've already been able to make things more [comfortable]… **[ego strengthening]**

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SS#4

- **Option 2: Client has massive traumatic intrusions.**
- **Say:** ***You find yourself on a path, a path that's heading for a new even safer SS.. You're getting further and further away from the old one, getting closer and closer to the new one…***
- **Or:** ***You'll automatically find yourself in a new SS that's even safer…***

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SS #4

- **Option 2: Client has no intrusions, or once intrusions are dealt with:**
- ***Focus on your feelings and they'll get stronger and stronger. Perhaps you can describe what you're feeling…***
- ***You can just settle in to being there breathing in all the _____ with every breath… feeling them settle deep inside you to the cells of your body… Just taking in all the feelings of…***

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SS #3: Teach Problem Solving!

Tips for at home practice (and for in the office):

- **What you see that helps doesn't have to make sense!**
- **If you can't see or figure out something that helps, try adding a couple things like a force field or a friendly guard dog.**
- **Sometimes it helps 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 next time.**

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When Exercise is Finished

- **Make Sure You Get Client out of Trance and Back Grounded in Office:**
- **Stretch**
- **Count back**

From 5-1

Slowly

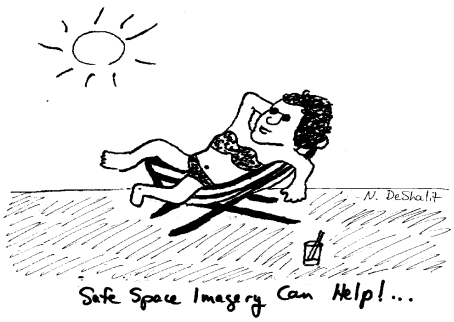
Becoming

Louder!

- **Ask are you**

Back here in

The office??



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You did great, and as you practice SSI you'll find more and more ways it is helpful… [PHS]

Note: Learning to do SSI is just like learning to do anything. Practice when you are in a relatively calm state. Eventually, you will be able to use it to center yourself when you're having strong feelings, that can take 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 overall.

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Teaching SSI to People with Parts

- **The goal is that all parts of the mind have a Safe Space either a group one or individual as parts sometimes have different needs.**
- ***Would one part to volunteer to try out SSI while all other parts watch and learn how it is done...***
- **This provides hyper-vigilant parts with permission to watch therapist and a positive use of the need to be hyper-vigilant Parts who're watching can use their hyper-vigilatness to really learn how to do SSI.**

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SSI for C-PTSD child parts

- **Option #1: Have the adult ask the child part what kind of SS they want.**
- **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…**
- **Have orientation info present…**
- **Finish with: And as the child is resting in her SS She'll be learning more and more about how things are different today… (Similar to a Post Hypnotic Suggestion)**

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Bilateral Stimulation

- Bilateral stimulation can be used to install information and communicate it among parts
- It appears to help reach parts
- Install developed resources
- Use Bilateral Stimulation to communicate the resource and the capacity to develop the resource…
- Or anything else useful
- Cue the resource

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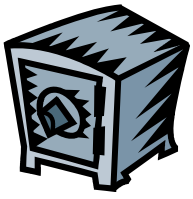
Containers

- What kind of container would
- you like?
- Bank vault with a night deposit slot. Door stays stays locked till the next session…
- Safety deposit boxes behind big locked door
- Computer with various files
- The container has a commitment built into it to work on everything stored inside when it's the right time.

Note: "As traumatic material is going in the container, it's getting stronger and stronger…"

Note: "And it's already changing, it's never been contained before…"



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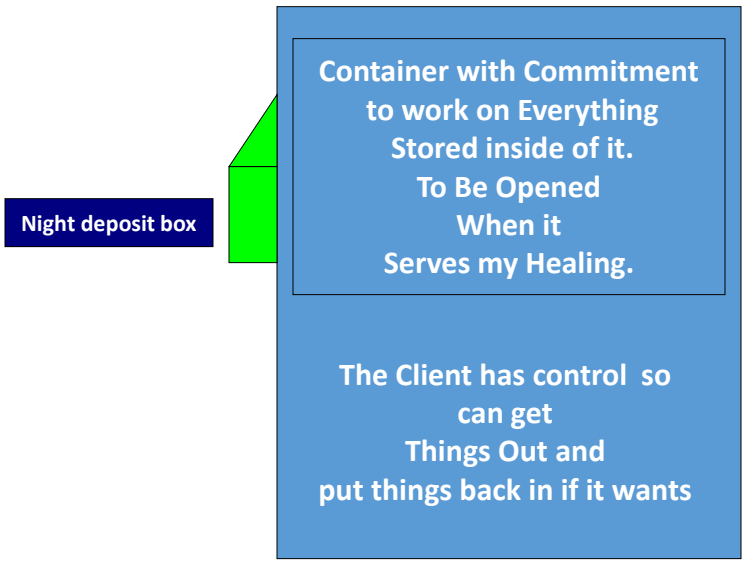

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Orienting to the Present for Parts and for People from Traumatic Experiences

- Parts who believe they live in the past…
- With their parents who abused and/or neglected them every day…
- This continues to add to anxiety in the present.
- Sometimes no treatment can be done before parts are oriented.
- Do before trauma work to assist with stability
- May need to retrieve/invite to a Safe Space nearer to the present
- Be concrete

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How to Orient (Twombly)

- Make a list with host/adult/oriented parts
- Can Install it with bilateral stimulation
- Invite all parts who are willing to take in the information and they don't need to believe it
- Communicate list to all parts with bilateral stimulation
- Ask for comments and questions from host/parts
- Ask parts to check out the list during the week and report next time about any inconsistencies or questions
- Ask host/adult to point out things on list to parts during the week
- Identifying concrete ways the present is different from the past helps the client differentiate past from present.

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Orienting Options

- Orienting to present: fast forward visualized video of life since last abused.
- For Military: From last trauma to present
- To house live in now, to how know you aren't being abused by anyone who lives there
- Differentiate past from present.
- Height!
- How old does the child part think the host/adult is? Child looks in eyes of adult/host and adult/host looks back and shows the child how old she/he is and what resources and strengths has now that didn't have in the past.
- Orient parts to info about therapist
- Must be done over and over!

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Self Harm Behaviors in C-PTSD and DDs

- **ETOH, drug, prescription med. Abuse**
- **Cutting and Burning, Head and body banging**
- **Eating disorders**
- **Compulsive sexual behavior**
- **Sometimes to externalize internal pain**
- **Sometimes as an alternative to suicide**
- **To punish or suppress another part.**
- **To make things more real (decrease derealization) by seeing blood**
- **To quiet voices, to bring relief**
- **To release endorphins (addictive)**
- **Because it's supposed to happen**
- **Control, maintenance of toughness, preparedness**

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More!

- **"What safety means to the clinician is often not the same as what it means to the patient." Courtois**
- **Many people use the possibility of suicide as a coping measure.**
- **Find out how it's helpful.**
- **Work collaboratively on safety planning**
- **It's a process and a part of healing.**

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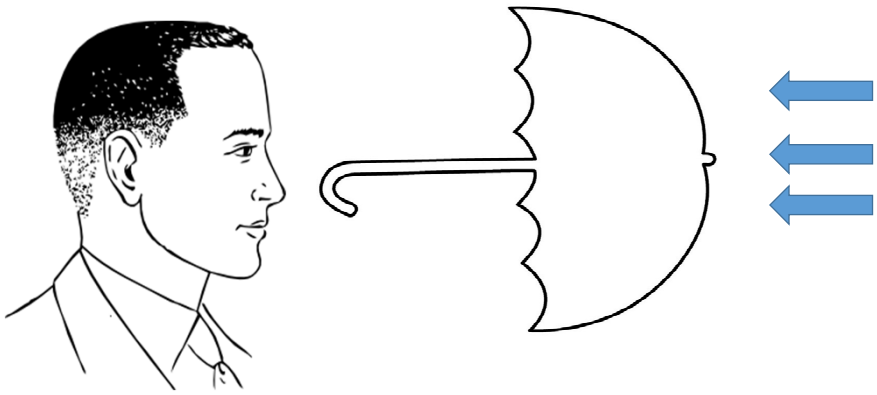

Energy Boundary

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Reasons for Non-verbal Communication

- **Pre-verbal trauma, neglect, and attachment trauma**
- **Trauma is not encoded verbally (drugs, unconscious)**
- **Dissociated material not available to the part who's talking**
- **Client who has to keep secrets**
- **Perpetrator maneuverings**
- **Projective Identification, Enactments, Countertransference Patterns**
- **Because it's the only way to express it!**

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Enactments

- **(Baker, 1998): Patient and therapist become the inevitable participants in transference enactment, each unwittingly playing a role written from the patient's past. [note co-created!]**
- **…projective identification and enactment may both be viewed as a powerful type of communication, allowing the therapist to understand in a uniquely empathic way the experience of the patient.**
- **By creatively welcoming inevitable enactment, the playing out of the patient's unconscious dynamics in the therapy, the therapist and patient can work through otherwise uninterpretable clinical material.**

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5 Transference and Countertransference Patterns

(Davies and Frawley, 1994, 1999)

- **The Unseeing, Uninvolved Parent and the Unseen, Neglected Child**
- **The Sadistic Abuser and the Helpless, Impotently Enraged Victim**
- **The Seducer and the Seduced**
- **The Idealized, Omnipotent Rescuer and the Entitled Child**
- **The Certain Believer, the Chronic Doubter**

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Common Rational Reenactments Between Therapists and Patient
(P 59 Steele, 2017)

• Neglectful	⟷	Neglected needy or avoidant
• Sadistic abuser	⟷	Masochistic victim
• Frightened appeasing	⟷	Punitive-controlling, entitled
• Needy self-absorbed	⟷	Caregiving-controlling
• Overwhelmed anxious	⟷	Overwhelmed anxious
• Avoidant withdrawn	⟷	Avoidant withdrawn
• Intrusive pursuing	⟷	Avoidant withdrawn
• Idealized rescuer entitled victim	⟷	Helpless and needy or
• Shaming, critical inadequate	⟷	Shamed, incompetent,
• Overwhelmed, frantic	⟷	Inconsolable
• Seducer (not always sexual)	⟷	Seduced
• True believer	⟷	True sceptic

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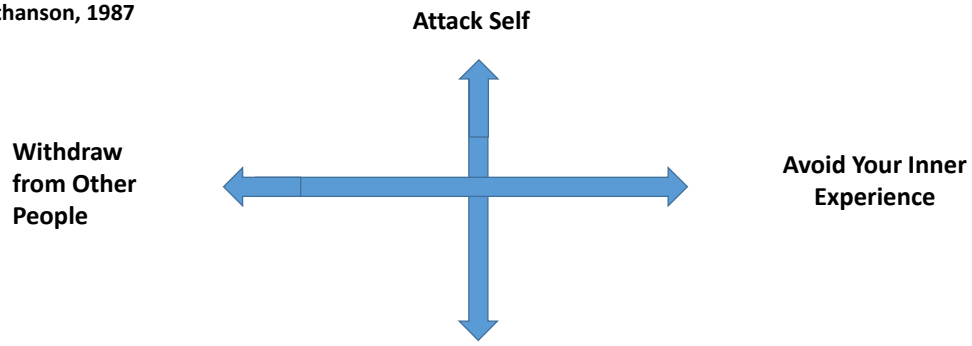
Compass of Shame:
Nathanson, 1987



66

Healing Shame/Guilt:
Over time shift perceptions, beliefs and feelings (Boon et al, 201i)

- **Identify and recognize shame and guilt reaction. (Everyone's better than me. They're all going to hate me. I'm too stupid. Somatic feelings – hunching, tension, flushing)**
- **Learn patterns (where are you/client on the compass?)**
- **Interrupt them with time, correcting the cognitive distortion**
- **Negotiate and dialog with internal parts to understand and problem solve, develop empathy and compassion**
- **Identify % of shame/guilt that's related to the past**
- **Talk about it in therapy – shame thrives in secrecy!**

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Healing Shame, cont. (Pulver, 1999) (Chefetz, 2014)

- **Identify Shame producing enactments as the occur in the session and help client understand them**
  - **Clients can identify almost anything as shaming.**
  - **Anger (chaos, fear, etc.) can be a reaction to and defense against shame.**
  - **Watch for subtle idealization and devaluation in the transference and countertransference – can be a foreshadowing of shame to come.**
- **Identify where you (therapist) are on the Shame Compass. Have compassion for yourself!**
- **Recognize and help client understand the use of Shame to regulate distance in relationship.**

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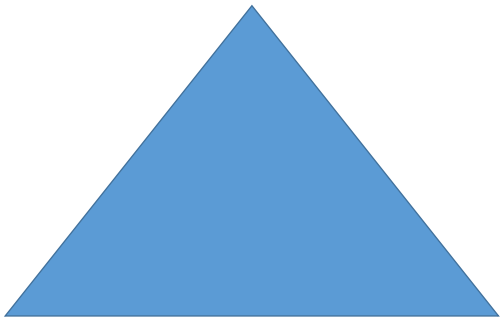
Karpman's Drama Triangle

Updated by Turkus and Kahler, 2006 + Twombly

Persecutor



Victim

Rescuer/non-rescuer
Bystander/Persecutor

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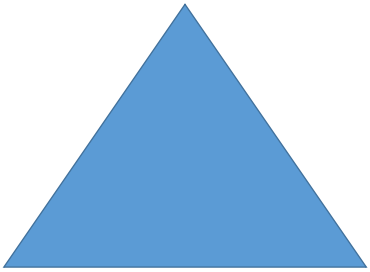
Evolution of the Drama Triangle via "The Power of TED*" (David Emerald)

Creator (former victim)



Challenger
(former Persecutor)

Coach (former Rescuer)

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What to do when in the grips of repetition compulsion

- **Ask client: What am I doing that's making things worse?**
- **Say: Let's look for patterns and if we find some, I'm willing to look at my part and do my bit to unhook us…**
- **Realize it's a normal part of trauma treatment and that it's a communication of sorts.**
- **Use IFS or EMDR to sort through your own responses!**

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EMDR Strategy for Dealing With Countertransference (Dworkin)

1. **Visualize patient and recall patient acting in ways that bring up the worst of your countertransference reactions/feelings.**
2. **Target with EMDR.**
3. **Do floatback.**
4. **Process.**
5. **Visualize patient acting in the way that brought up countertransference reactions/feelings and notice how it feels now!**
6. **Plan for next session with patient.**

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When is it time to move to phase 2???

- When the client comes in talking about using coping skills to manage symptoms during the week.
  - I got upset with the boss, went to the bathroom did 5 minutes of safe space imagery and felt grounded
  - I got woke up from a bad dream, but I had my night light on, I reminded parts they are in the present and we went back to sleep
  - I took a Klonapin

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Note prior to Phase 2: The goal is not "memory processing", it's healing!

Colin Ross (1997) says treat:

- **The attachment to the perpetrator**
- **The locus of control**
- **Cognitive errors characteristic of the disorder e.g. "It was my fault, I'm bad"**
- **Variations on the victim-rescuer-perpetrator triangle**
- **Conflicts in the personality system**

Overcome the phobia of Traumatic Memories (van der Hart, 2014 et al): : must own your experience, and be able to be "mindfully present while remaining aware of the context of one's past and future"

Liberation from life in Trauma Time!

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Attachment to Perpetrators

- **We are biologically driven to attach to and love our parents**
- **To keep the attachment to parents, abuse must be dissociated or blamed on one's self, or a part(s)**
- **The perpetrator may be also the child's source of love and affection. Therapists must respect that.**
- **Or be using the child's normal feelings to "blame" the child for the abuse. "I loved Daddy, it felt good, I wanted it."**
- **Once the abuse memories are processed, then the pain of having parents who didn't love, protect, or did love, but didn't protect, betrayed, etc. will need to be processed. This is the worst pain…**

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Phase 2: Metabolism of the Trauma

- **Pace processing of traumatic memories so client can be maintained at the highest level of functioning possible.**
- **Evaluate ego strengths and if client can tolerate standard EMDR.**
- **Return to Stabilization and coping skills if things get out of control or the client gets overwhelmed in or between sessions.**
- **Child abuse is often repetitive – target representative examples. Do not need to go through every detail – only what's needed for healing.**
- **Follow Kluft's rule of thirds!!!!**
- **Work within the window of tolerance.**

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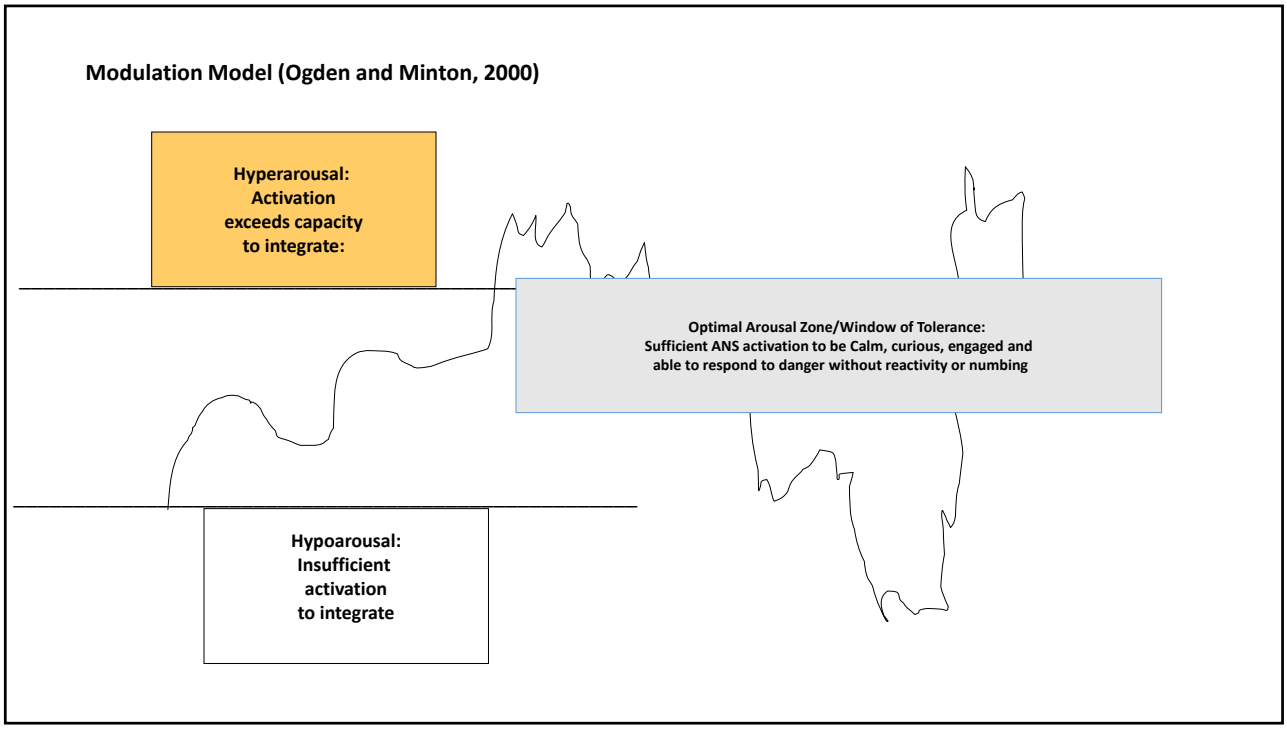

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Introduction and Preparation for Targeting Traumatic Material (Twombly)

- **This format was developed to provide a safe controlled way to begin to process traumatic material**
- **Goal: teach clients to have control during processing and to enhance the ability of parts to work together.**
- **Clients are told: *You didn't have control over your childhood, you need to have control of your healing.***
- **Maintaining stability in daily life is important**

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Twombly Control Freak Version

- **Pick piece of traumatic material to work on, on the easier side, . Put all else in a vault.**
- **Have any parts not involved go to Safe Spaces with sound and feeling proofing up**
- **Develop/adjust any necessary coping skills**
- **Practice picture-in-a-picture (PIP) imagery first with benign imagery, then with 2 seconds of traumatic material**
- **Start and stop processing. Until client develops confidence. Then can do more seconds.**
- **This protocol gives you many choices – use all the layers if you need more control, or segments if you don't.**

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Coping and Titrating Skills

- **Safe place imagery (Kluft, 1998) with sound and feeling proofing**
- **RDI**
- **Protective walls**
- **Bank vault (Kluft, 1988)**
- **Affect dial (Brown and Fromm, 1986)**
- **TV technique (Brown and Fromm, 1986) using Picture in a Picture TV technology (Twombly)**

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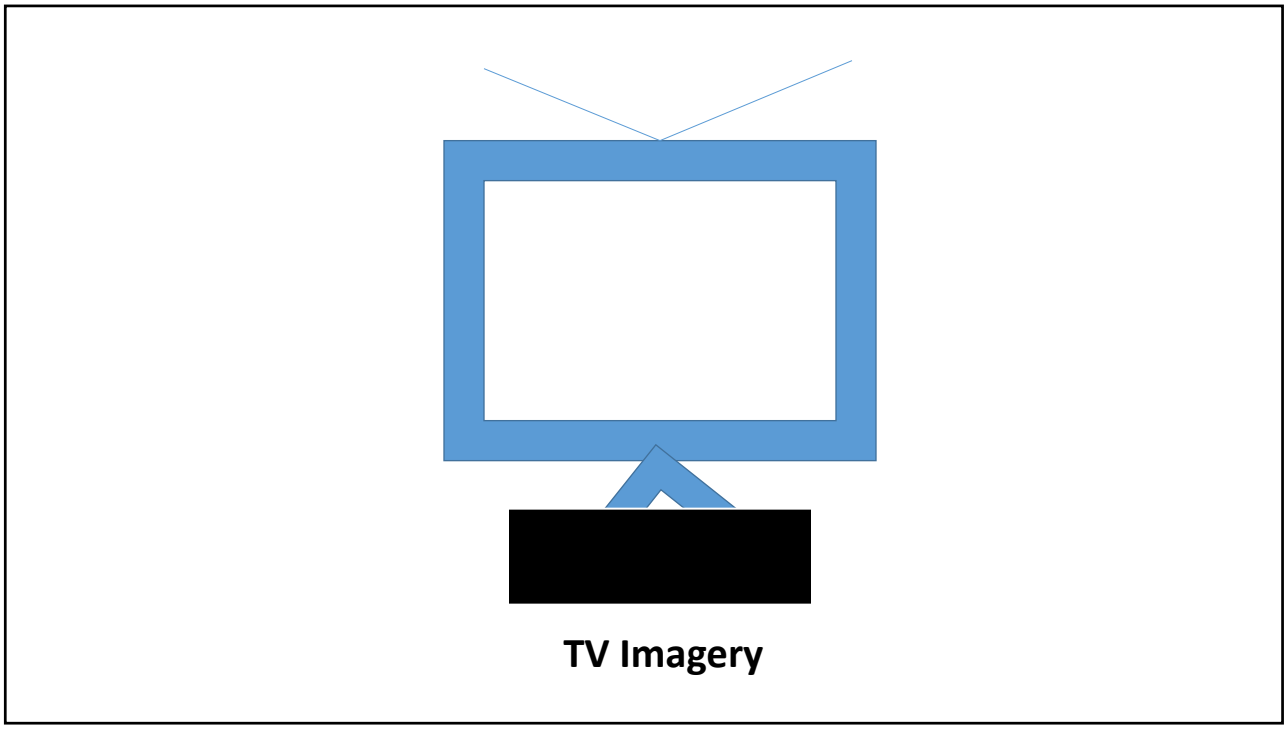

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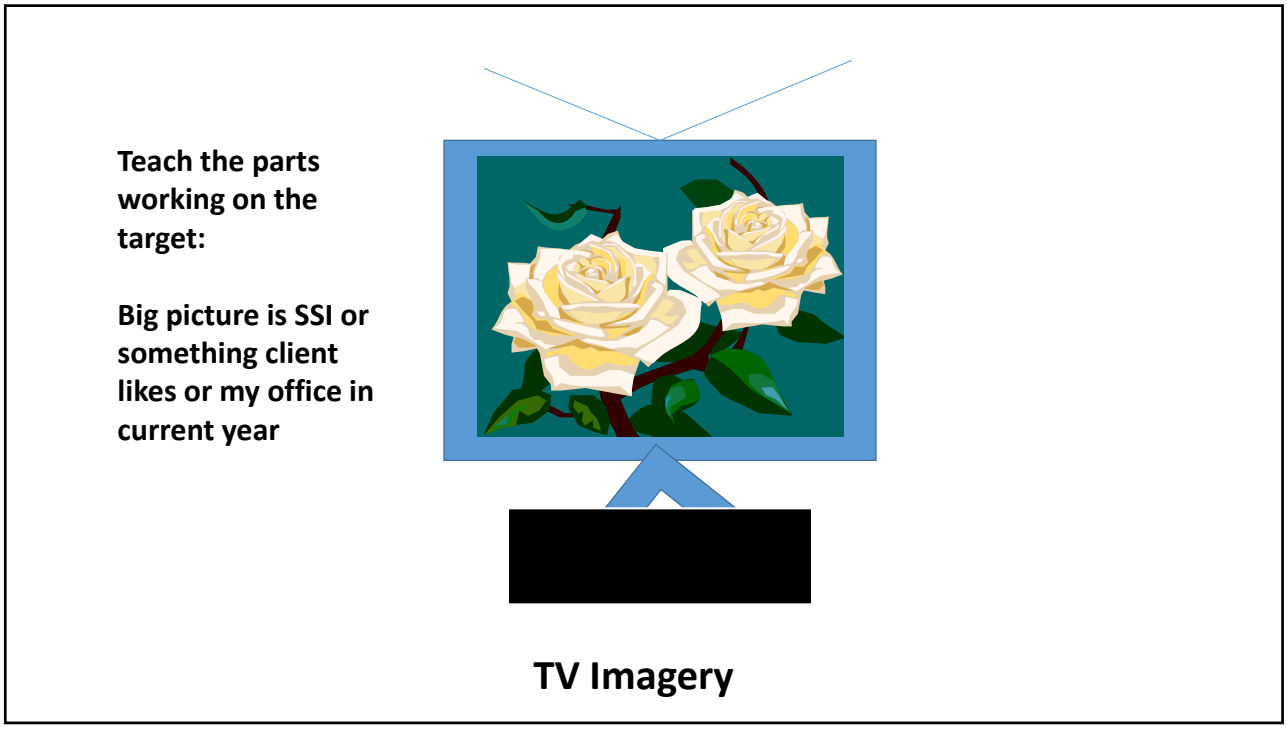
Teach the parts working on the target:

Big picture is SSI or something client likes or my office in current year



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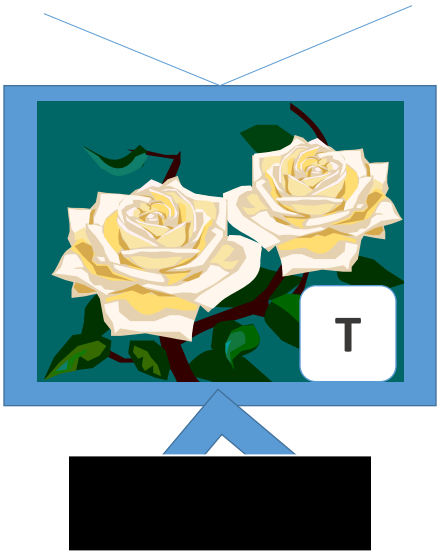

Picture in the Picture (PIP) is where trauma processing happens

TV with PIP

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Fractionated Trauma Processing (Kluft) with Controls Built In (Twombly)

- **1. Identify target**
  - **Ideal first target: Something that happened once, that's less complex**
  - **Or, target something recent that can be isolated**
- **2. If working with parts, id who needs to be present and who can be in their safe spaces and put sound and feeling proofing up.**

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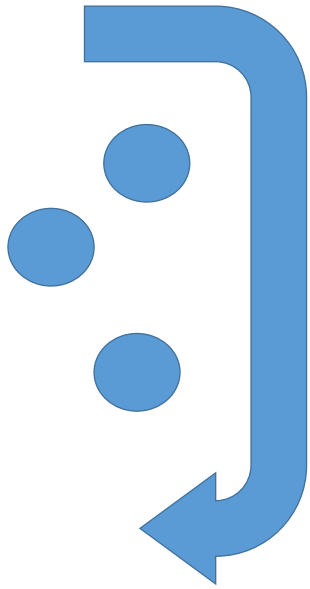
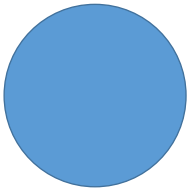


Ego State Version of Titrating



Adult Processing Something

Parts protected in a Safe Space

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- **3. Fractionate target, pick aspect to begin with, and store all other material in vault.**
- **4. Review coping skills, office and therapist, and identify wording the client would like to hear during trauma work . Also any RDI necessary.**
- **5. 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, Install ability…**

6. Then proceed with 2 seconds of traumatic material.

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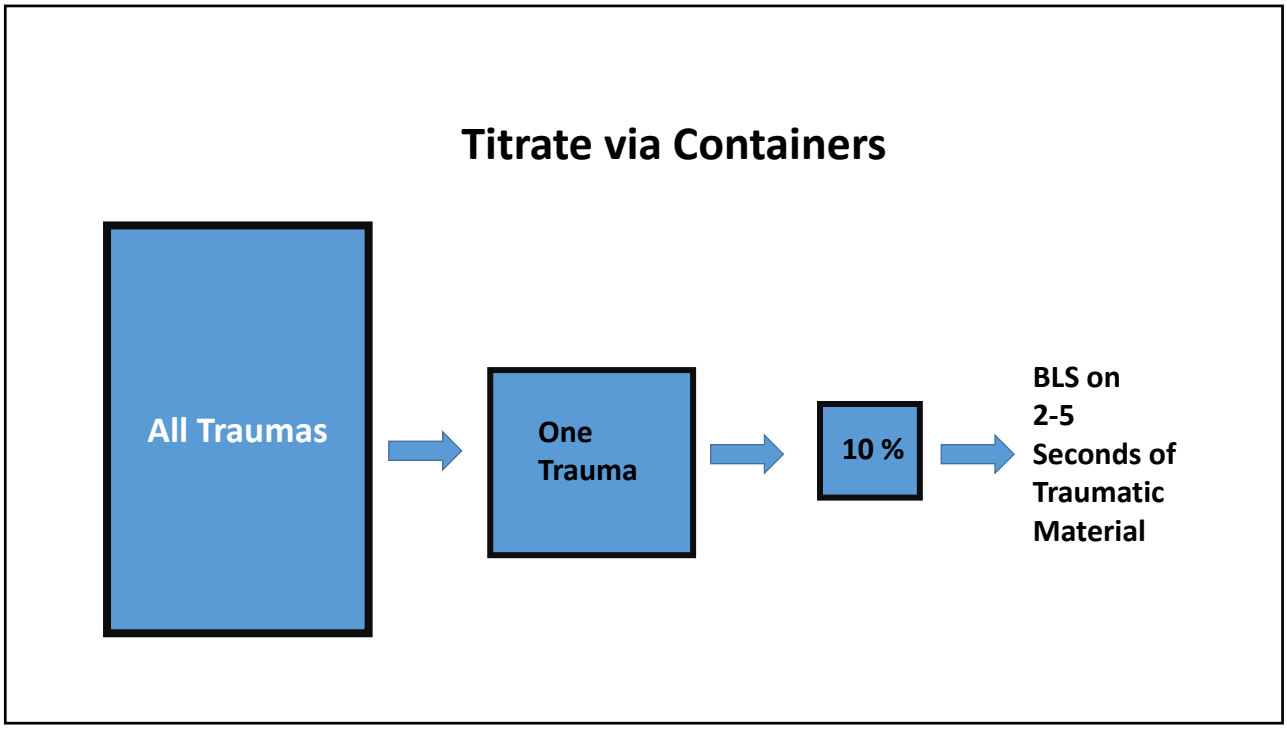
Titrate via Containers
All Traumas
One Trauma
10 %
BLS on 2-5 Seconds of Traumatic Material

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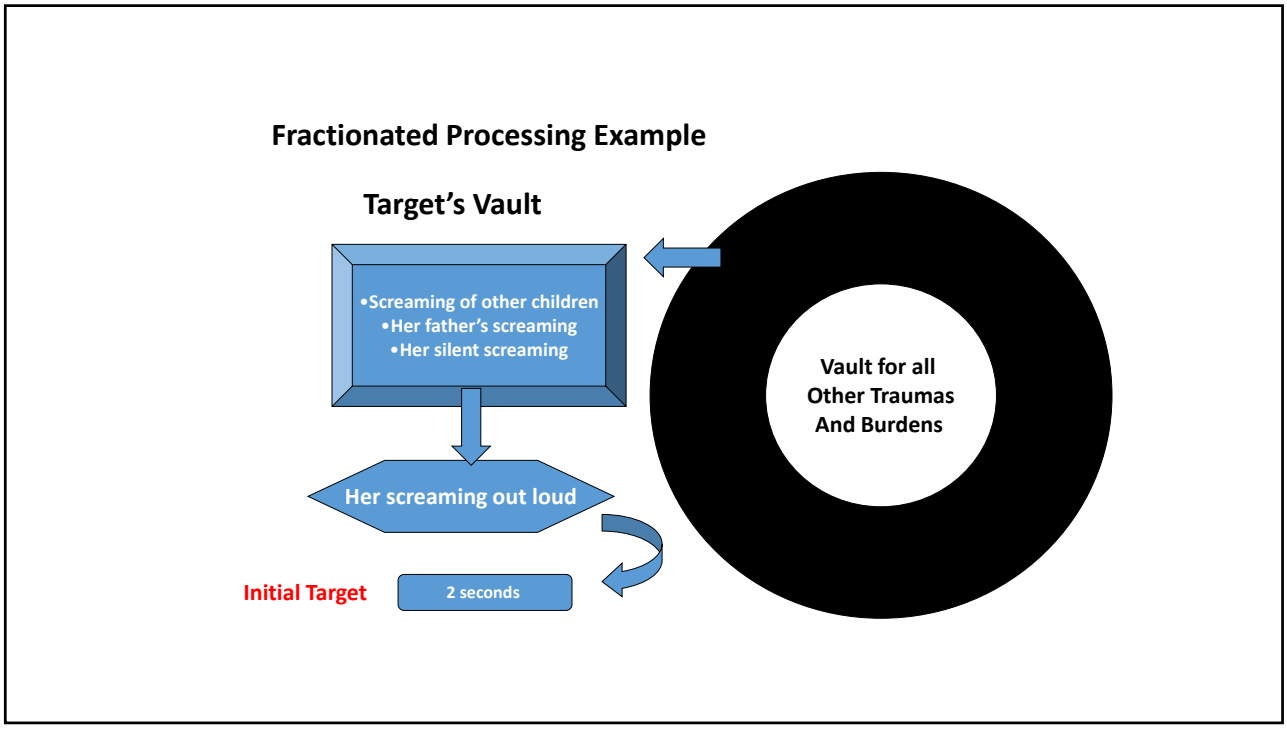
Fractionated Processing Example
Target's Vault
•Screaming of other children
•Her father's screaming
•Her silent screaming
Her screaming out loud
Initial Target
2 seconds
Vault for all Other Traumas And Burdens

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7. Start with 2 seconds of trauma work (with or without Bilat stim) then gradually increase time as the client gains confidence and control.
8. At end ask: "what's the most important thing you learned", Use Bilat Stim to install.
9. feelings/traumatic material are stored in vault till next time. Parts may want to rest in safe place, or sleep, or use another resource.
11. Plan agenda for next session.

Note: My goal is to have client have control over the processing. It's easier to have too much control, than to get it back once it's lost
On the other hand, perfection is not an option!

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The BASK Model (Braun)

Negative Symptoms	**B A S K**	**Positive Symptoms**
Paralysis	**B**ehavior	Out of awareness pattern of acting
Numbing	**A**ffect	e.g. Anxiety attack, FB
Numbing	**S**ensation	Somatic memory Eg pain
Amnesia	**K**nowledge	Flashback

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Situation	Feelings (in %)	Automatic thoughts	Identify the cognitive distortions	Correct the automatic thoughts	Feelings (%) Look for small changes
Going to job interview	**Anx 98% Dread 74% Avoid 99%**	**I can't do it They'll hate me and laugh me out of there I'm stupid They won't hire me**	**1 4 7 9**	***I actually meet all the job requirements and exceed a couple of them. *There's no proof they'll hate me or laugh at me – it's a professional interview, they won't laugh at me. *I feel stupid therefore I think I'm stupid. I'm not stupid even if I feel stupid. *The last 2 jobs hired me. If they don't, I'll keep looking like I did the last time.**	**Anx 75% Dread 60% Avoid 49.999%**

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Cognitive Distortion Exercise: Tips

- ***If you're jammed up about correcting cognitions, ask yourself: What would my therapist say????? What would a friend say?**
  - **Joanne would say: Remember, you got those other jobs? Remember you didn't get hired at that one place and it was a drag, but you got another job and liked it.**
  - **Joanne would say: What % of this anxiety has to do with your childhood?? (Possible answer: *Rats, lots*)**
  - **Joanne would say: What's the evidence – has anyone ever laughed at you at a job interview, or at school?**
  - **Joanne would say: Take an Ativan/do safe space imagery/put anxiety in a container/call her after the interview!**

***Go to a bookstore and read a couple examples in the book "Feeling Good".**

***Pretend a friend of yours has the same issue and do the exercise on his/her behalf.**

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Cuing

Cueing can be used positively or negatively

Negative:

- **Sometimes people find themselves acting or feeling without knowing why**
- **If you start thinking of telling, cut yourself…**
- **Ball point pen click cuing time to be abused…**

- **Positive**

Cue Safespace imagery
Cue the ability to create a SS or other resource
Cue presence of a helper part

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Unoriented Parts have trouble figuring out things about today!

?

Messages from parts living in the past:

- He's going to hurt us
- We're not safe
- Danger, danger
- Run away
- Freeze
- We're little and helpless

Random harmless looking guy we don't know, or a guy we do know

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Other Options

- **EMD: Come up with target. Return to target every set. (Suggest putting everything else in a vault)**
- **Tip of the Finger Strategy (Gonzalex and Mosquera, 2012): fractionate by processing a fragment of traumatic material contained in the tip of the finger**
- **Flash**
- **Is it ok to dump off the top layer of the trauma? There will still be plenty to work on. (Twombly)**
- **EMDR 2.0**

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Things to listen for

- Grieving is a part of healing every step of the way
  - Judy Herman (1992): "Survivors of chronic childhood trauma face the task of grieving not only for what was lost, but also for what was never theirs to lose. The childhood that was stolen from them is irreplaceable."
- Possibility client experienced good feelings during the abuse.
- Possibility client perpetrated.
- Attachment issues.
- Neglect.
- Therapy related trauma.
- ***Reminder: Don't forget to screen for dissociative disorders with the DES.

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Phase 3: Personality integration, mourning, and reconnection, promoting intimacy and a life not fixated on trauma/neglect/abandonment!

- RDI
- Life Review (Picks up incidental traumas)
- Learning New Coping Skills
- Solidification of Gains and Working Through
- Whatever else is needed!
- Character issues
- Relationship issues
- Facing the loss of the treatment

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