Treating Complex PTSD and Dissociation with Integrated EMDR Therapy: A Resilience Informed Approach

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PTSD, Chronic PTSD, C-PTSD

- **Acute Trauma or PTSD**: single incident (crime, accident, natural disaster)
- **Chronic PTSD**: Repeated, prolonged trauma (domestic violence, war)
- **Complex PTSD (C-PTSD)**: Chronic, trauma, childhood onset, often interpersonal

Symptoms of C-PTSD

- Emotional Dysregulation
- Disturbing Somatic Sensations
- Cognitive Distortions (Inaccurate beliefs)
- Interpersonal Problems
- Avoidance
- Dissociation
- Health Problems (ACE)
Symptoms of Dissociation:
A range of symptoms:
• Disconnected from body, thoughts, or emotions
• Feeling fuzzy
• Having a hard time verbalizing their experience
• Feeling dizzy
• “Loss of control”
• Disoriented
• Lack of distinction between past and present.
• Lapses of memory or “lost time”
• Multiple parts or sub-personalities.

Dissociation and the Divided Self
• Structural Dissociation Theory
  (van der Hart, Nijenhuis, Steele, The Haunted Self)
• Apparently Normal Part:
  Focused on daily life but feels disconnected or as if “going through the motions”
• Emotional Part(s): Holding the unwanted or unrealized emotions and memories from traumatic events
• Defensive Part(s): Keeping the EP(s) away from awareness

Dissociation: Disorder of Perception
• Client unable to realize:
  – The traumatic event happened
  – That the traumatic event happened to “me”
  – The traumatic event is over
  – I am here and now (not then and there)
  – My body is part of me
  – The me of then is part of the me now
  – My actions in the present belong to me
The Challenge

Realities of working with Complex Trauma:
- Helplessness
- Hopelessness/Despair
- Isolation/Loneliness
- Injustice/Unfairness
- Suffering
- Rage
- Evil
- Meaning/Purpose put in question

Personal Inquiry

• What resources help you stay present with your clients as they experience helplessness, despair, suffering, uncertainty, disappointment, and loss?

• What meaning making, spiritual perspectives, or self-care practices help you attend to the weight of this work?

Defenses Maintain Dissociation

• Repression: “If I don’t talk about or acknowledge my painful past it doesn’t exist.”
• Denial: “Yeah, I was abused but it wasn’t a big deal”
• Avoidance: “If I just stay in bed and sleep I don’t have to face reality”
• Fantasy: “If I just act like everything is okay then it will be okay.”
• Self-Blame/Idealization: “If only I hadn’t been so bad I wouldn’t have been abused”
**Phobias Maintain Dissociation**

**Phobia of:**
- Traumatic memories
- Inner experience (arousal state, affect, body sensations)
- Parts of self that carry shame
- Attachment, relationship, and loss
- Adaptive risk taking
- Change
- The world

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**Treating C-PTSD**

- Increase your client’s capacity to stay present with and effectively respond to (regulate):
  - States of mind
  - Emotions
  - Sensations
  - Interpersonal exchanges

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**Develop Tolerance For:**

- Uncertainty
- Ambiguity
- Disappointment and loss
- Conflict and Compromise
- Difference
- Competing needs and desires
- Conflicting ideas and emotions
**Goals of Treatment**

The client is able to say:
- I am aware of my past and how it affects me in the present
- The past is differentiated from the present
- I have a coherent understanding of my triggers and the parts of me that get activated.
- I can flexibly and resourcefully respond to my (internal and external) environment
- I have choices now about my thoughts, emotions, and behaviors
- I can orient toward the future

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**EMDR Therapy**

- **A Theoretical Orientation:** Not an Intervention, 8 Phases
- **Adaptive Information Processing** (AIP Model): Inherent capacity in the person to heal given sufficient support

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- **Dual Attention:** Client remains aware of the present moment experience while simultaneously addressing memories related to the traumatic event
- **Dual Attention Stimulation** (DAS): Bilateral Stimulation in the form of bi-lateral eye movements, pulsers, taps or tones that alternate between the left and right side of your body
8 Phases of EMDR Therapy

- **Phase 1 History Taking:** Develop case conceptualization of client within context of life, identify trauma history.
- **Phase 2 Preparation:** Establish therapeutic relationship, Stabilize and build skills, Resource Development Installation (RDI)
- **Phase 3 Assessment:** Target development, “light up” the traumatic event with the disturbing image, emotions, beliefs, and body sensations
- **Phase 4 Desensitization:** Uses DAS to process the disturbing material related to trauma target until the client reports no disturbance (SUDS)
- **Phase 5 Installation:** Strengthens positive beliefs that arise after the successful completion of desensitization.
- **Phase 6 Body Scan:** Release lingering tension
- **Phase 7 Closure:** Ensures client is resourced prior to ending the session, Containment
- **Phase 8 Re-evaluation:** Review of efficacy of treatment from previous session.

Integrative EMDR Therapy for C-PTSD

**CBT:**
- Identify Negative Cognitions and Positive Cognitions
- Challenge “thinking errors”
- Develop more effective thoughts
- Cognitive Interweaves
CBT in Action

Nurture a positive view of yourself and your life:
• Research indicates the human tendency to focus on the negative and the benefits of positive thinking. (Rick Hanson, Buddha’s Brain)
• Reflect on five things you are grateful for in your life. Notice how you feel in your body.

Integrative EMDR Therapy for C-PTSD

Dialectical Behavioral Therapy (DBT):
• **Zen Buddhist** philosophy, contemplative practice
• **“Dialectical”** refers to a synthesis of opposites
• **Primary Dialectic**: Radical acceptance is a necessary condition for change and growth.
• **Skills**: Mindfulness, Interpersonal Effectiveness, Distress Tolerance, Emotional Regulation

Wise Mind
DBT Practice

**DBT Half Smile:**
- Engage a “half-smile” to change your mental state and cultivate a serene feeling in the moment.
- Relax your face and slightly turn up your lips. As you smile, imagine your jaw softening and a relaxed feeling spreading across your face, your entire head, and down your shoulders.

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Integrative EMDR Therapy for C-PTSD

**Somatic Psychology:** Body Centered Therapy

- **Embodied Self Awareness:** Attention to body sensations and breath
- **Grounding:** 5 senses (hearing, seeing, smelling, tasting, touching) anchor client in here and now
- **Regulation Model:** Physiological regulation with the Window of Tolerance
- **Sequencing:** Movement of tension out from the core of your body through arms and legs.

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**Window of Tolerance**

- Hyper-arousal, sympathetic, fight/flight, anxiety, hyper vigilance
- Hypo-arousal, parasympathetic, depression, despair, dissociation
Integrative EMDR Therapy for C-PTSD

Mind-Body Therapies:
- Complementary and Alternative Medicine (CAM)
- Nutrition
- Massage
- Acupuncture
- Trauma Sensitive Yoga
- Tai Chi, Qigong

Integrative EMDR Therapy for C-PTSD

Ego States and Parts Work
- Assessment of and treatment of dissociation: subtle signs as well as overt symptoms (e.g. DID)
- Parts Work: IFS, Ego states, Structural Dissociation
- Treatment of Preverbal memories: Attachment trauma, Pre and Perinatal trauma

Parts Work
- Self
- Defenses
- Exiled emotions/memories
Integrative EMDR Therapy for C-PTSD

**Relational Work:**
- Explore Transference and countertransference
- **Relational Interweaves:** Your task is to accept what the client cannot and to facilitate greater integration at a pace that the client can tolerate
- **Rupture and Repair:** Re-enactments, become aware of ruptures in therapy and repair when necessary

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The Healing Relationship

- Relationship is not just about the “other”
- Allow yourself to be moved, touched, and ultimately changed by the exchange
- “Receive the gift” of the client
- Cultivate a state of appreciation for who they are and what they have endured

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**Love Sorrow** by Mary Oliver
Integrative EMDR Therapy for C-PTSD

Emphasis on Self-Care
• Prevention of Stress and Burnout
• Clinician provides External Regulation
• Own embodiment and mindfulness practice
• Own supervision and/or therapy

Resilience Informed Therapy

• Biopsychosocial: not Medical model (Doctor/Patient), Partnership and Collaborative
• Strength Based: What is already working?
• Emphasis on Mindfulness and Embodiment: Both clinician and client

Resilience Informed Therapy

• Support Systems: resilience factors (Social Connection, Self-Care, Exercise, etc.)
• Health and Wellness: ACE Factors, Collaborative Treatment
• Trauma Treatment: Single Incident, Chronic PTSD, Complex PTSD
• Family History: Understand the Roots of Symptoms (Childhood Development, Family history, Transgenerational trauma)