Recognizing and stabilizing those with dissociative disorders using EMDR therapy

Andrew M. Leeds & Dolores Mosquera

This presentation will:

- Outline issues related to early and severe traumatization beyond obvious symptoms
- Review DSM-5 criteria and screening tools
- Describe obvious and hidden dissociative presentations
- Demonstrate EMDR therapy procedures to stabilize dissociative clients
- Describe use of the meeting room procedure and ways to respond effectively with EMDR therapy
- Recognize and manage phobias of and conflicts between Emotional Parts of the Personality
- Demonstrate EMDR therapy interventions for working with hostile parts of the personality

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Dissociative Disorders: Multiple presentations

- Multiple personality disorder or dissociative identity disorder does not usually present itself with the spectacular images of the movie The three faces of Eve or the more recent sitcom United States of Tara, but instead hides behind many symptomatic conglomerates.
- Like a chameleon, it can adopt many different aspects and these patients often receive different diagnoses based on the most obvious symptoms during each period.

How many of you have discovered “dissociative disorders” while facing problems with EMDR reprocessing?
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The 5 Dissociative Disorders (1 of 4)

- **Dissociative Amnesia 300.12 (F44.0)** is the most common of dissociative disorders, often seen in hospital emergency rooms (Maldonado et al., 2002). Individuals suffering from Dissociative Amnesia are generally aware of their memory loss. These memory difficulties are in the retrieval process, not the encoding process and are generally reversible. Duration varies from a few days to a few years.

- **Depersonalization/Derealization Disorder 300.6 (F48.1)** is characterized by persistent feelings of being detached from one’s mental processes or body, as if watching from outside of one’s body with associated problems with concentration, memory and perception. Some researchers believe it to be the 3rd most common psychological disorder after depression and anxiety. (Guralnik et al., 2001).

The 5 Dissociative Disorders (2 of 4)

- **Dissociative Identity Disorder 300.14 (F44.81)** (previously Multiple Personality Disorder)
  - The most severe and chronic manifestation of dissociation, characterized by
  - Two or more distinct identity states that recurrently take control of behavior, and
  - An inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
  - These symptoms are not attributable to effects of substance use/abuse or a medical condition (partial complex seizures) and are not part of a broadly accepted cultural or religious practice.
  - These dissociated states are not fully-formed personalities, but rather represent an incomplete sense of identity.

The 5 Dissociative Disorders (3 of 4)

- **Other Specified Dissociative Disorder 300.15 (F44.89) includes**
  - 1. Chronic recurrent mixed dissociative symptoms (without amnesia) – milder discontinuities in sense of self or agency, alterations of identity, or episodes possession. Formerly DDNOS.
  - 2. Identity disturbance due to prolonged intense coercive persuasion.
  - 3. Acute dissociative reactions to stressful events (from hours to one month) depersonalization, derealization, perceptual disturbances (time slowing), micro amnesias, analgesia, paralysis.
  - 4. Dissociative Trance – lack of responsiveness to environment
The 5 Dissociative Disorders (4 of 4)

- **Unspecified Dissociative Disorder 300.15 (F44.9)**
- Dissociative presentations that may not meet full criteria for another dissociative disorder and
- The clinician chooses not to specify or lacks information as in emergency room settings.

### Theory of structural dissociation

**an introduction**

“The essence of trauma is the structural dissociation of the personality”

- In the model of Structural Dissociation (SD), the personality is viewed – following Janet (1907) – as a structure comprised of various action systems.

- In SD, dissociation is viewed not as existing on a continuum from normal to pathological, but in the degree of the structural division of the personality.
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Dimensions of Trauma-Related Dissociation
van der Hart, Nijenhuis, Steele, (2007)

<table>
<thead>
<tr>
<th>Primary Structural Dissociation</th>
<th>Acute Stress Disorder PTSD</th>
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<tbody>
<tr>
<td>Secondary Structural Dissociation</td>
<td>Complex PTSD/DESnos Borderline Personality Disorder Dissociative Disorder NOS</td>
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<tr>
<td>Tertiary Structural Dissociation</td>
<td>Dissociative Identity Disorder</td>
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</tbody>
</table>

Primary Structural Dissociation: PTSD
One Apparently Normal Part of the Personality (ANP) and One Emotional Part of the Personality (EP)

Primary – one Apparently Normal (part of the) Personality (ANP) and one Emotional (part of the) Personality (EP).

I. Acute Stress Disorder (simple types)
II. Posttraumatic Stress Disorder (simple types)
III. Simple types of DSM-5 Dissociative Disorder such as depersonalization/derealization disorder
IV. Simple types of ICD-10 Dissociative Disorders of Movement and Sensation.
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Secondary Structural Dissociation: DESNOS & Other Specified Dissociative Disorder One ANP, Several EP

ANP: action systems for functioning in daily life and survival of the species

EP: action systems for defense against major threat: survival of the individual

EP: action systems for defense against major threat: survival of the individual

EP: action systems for defense against major threat: survival of the individual

Adapted from Helga Matthes, 2006

Secondary – one predominant ANP and more than one EP.

i. Complex Posttraumatic Stress Disorder

ii. Disorders of Extreme Stress Not Otherwise Specified

iii. Trauma-related Borderline Personality Disorder
   › iv. Unspecified Dissociative Disorder
   › v. Complex ICD-10 Dissociative Disorders of Movement and Sensation.

Tertiary Structural Dissociation: Dissociative Identify Disorder
At least two (ANP) and several (EP)

ANP: action systems for functioning in daily life and survival of the species

ANP: action systems for functioning in daily life and survival of the species

EP: action systems for defense against major threat: survival of the individual

EP: action systems for defense against major threat: survival of the individual

EP: action systems for defense against major threat: survival of the individual

Adapted from Helga Matthes, 2006

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The maintenance of structural dissociation

- The development of structural dissociation of the personality starts during early chronic traumatizing experiences.
- But SD is predominantly maintained by a series of dissociative phobias that characterize trauma survivors and by a lack of social support (Van der Hart, Nijenhuis & Steele 2006)

Dissociative Phobias

Exploring dissociation: an essential part of Phase 1
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Please answer this short test

A: I am familiarized with dissociative symptoms and presentations and use standardized instruments on a regular basis
B: I just ask for some symptoms during the initial evaluation
C: During the basic trainings, my trainer told me I should use DES, but I don't know what to do with it
D: I explore dissociation when the client manifests evident symptoms in the session, but if there is no problems, I don't use it
E: What is the DES?
F: I am just curious about dissociation but I don't see dissociative disorders among my clients

The relevance of exploring structural dissociation

- Being able to perceive the presence of Structural Dissociation allows us to understand and to successfully treat complex or unusual presentations that have failed to respond to prior treatment episodes.
- Identifying milder cases of Structural Dissociation allows us to more quickly establish a therapeutic alliance and offer tools for stabilization and self-control.
- Exploring for and recognizing severe Structural Dissociation allows us to anticipate and prevent adverse reactions or decompensation after attempts to begin EMDR reprocessing focused on memories of traumatic experiences.

Tools for screening and assessment of dissociative disorders
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**Screening Tools for Dissociative Disorders**

- DES-II Taxon Calculator
- Multidimensional Inventory of Dissociation (MID)
  - Members’ area at: [http://www.isst-d.org/](http://www.isst-d.org/) or [PFDell@aol.com](mailto:PFDell@aol.com)
- Somatoform Dissociation Questionnaire SDQ-20 and SDQ-5
  - [http://www.enijenhuis.nl/sdq.html](http://www.enijenhuis.nl/sdq.html)
- The Dissociative Disorders Interview Schedule (DDIS) is available at:
  - [http://www.rossinsit.com/dddquest.htm](http://www.rossinsit.com/dddquest.htm)
- The Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D-R) (Steinberg, 1994)

**Using the DES-II**

"Values above 30 suggest the likelihood of a dissociative disorder.

Values above 45 suggest the likelihood of Dissociative Identity Disorder (DID).

It should be emphasized that these scores are not diagnostic, and scores may not be interpreted as proving any diagnosis. In fact, scores less than 30 do not exclude the presence of DID."

(Chefetz, 2000)

**The DES Taxon Calculator**

- According to Waller, Putnam and Carlson (1996), "normal dissociation" (such as the capacity for imaginative absorption) exists on a continuum within the general population, but "pathological dissociation" does not.
- In their reasoning, pathological dissociation is a class variable; either a person is a pathological dissociator, or a person is not; there is no continuum.
- The DES Taxon Calculator
Limitations of the DES-II

- In most based trainings in EMDR clinicians are strongly encouraged to screen every patient with the DES-II and DES-T before starting any BLS intervention.
- However, the DES-II is an extremely weak instrument and will only detect cases of dissociative disorder that wish to be identified.
- It does not have any internal validity scales for identifying “faking good”, “faking bad”, or defensiveness.

The Multidimensional Inventory of Dissociation (MID)

- A 218-item, self-report, multi-scale instrument that assesses pathological dissociation and diagnoses the dissociative disorders (Dell, 2006a, 2006b).
- Those who request a copy of the MID receive:
  - (a) the MID,
  - (b) its Excel-based scoring program,
  - (c) the directions for using that scoring program, and
  - (d) the MID Mini-Manual.
- The MID is the most comprehensive measure of pathological dissociation that has been developed to date (Dell & Lawson, 2009).
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**The Multidimensional Inventory of Dissociation (MID)**
- It has shown internal reliability, as well as temporal, convergent, discriminant, and construct validity as well as incremental validity over the DES.
- When brief screening with the DES-T, the SDQ, or clinical observations suggests that a more comprehensive assessment is needed, the MID is extremely useful for clarifying the diagnosis.
- The MID is in the public domain; it is freely available upon request—without charge—to all mental health professionals from the members’ area of the International Society for the Study of Trauma and Dissociation at: http://www.isst-d.org/
or by request from PFDell@aol.com.

**The Somatoform Dissociation Questionnaire (SDQ-5 and SDQ-20)**
- address somatoform manifestations of dissociative processes
- can detect aspects of structural dissociation that are not addressed in the DES II (Nijenhuis, et al., 1996, 1997).
- The 20-item SDQ-20 evaluates the severity of somatoform dissociation.
- The five-item SDQ-5 screens for DSM-IV dissociative disorders.
- They are both available without charge at: http://www.enijenhuis.nl/sdq.html

**Structured Interviews for the Dissociative Disorders**
- D. The Structured Clinical Interview for DSM-IV Dissociative Disorders- Revised (SCID-D-R) (Steinberg, 1994) has good-to-excellent reliability and validity (Steinberg, 2000).
  - Is widely accepted in forensic evaluations and
  - Is useful for treatment planning and differential diagnosis.
  - It is available commercially.
- E. The Dissociative Disorders Interview Schedule (DDIS)
  - is a structured interview developed to assist in the DSM-5 diagnosis of somatization disorder, BPD and major depressive disorder, as well as all five dissociative disorders (Anderson, Yasniki, & Ross, 1993; Ross & Joshi, 1992) for inpatient hospital diagnostic screening.
  - It includes questions about positive symptoms of schizophrenia, secondary features of DID, extrasensory experiences, substance abuse, and symptoms relevant to the dissociative disorders.
  - It is available free of charge from the Web site of the Ross Institute at: http://www.rossinst.com/ddis.html
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A case of “hidden” DID not shown in the DES-II

“Louise” provides an example of a complex case – as indicated on the PAC summary sheet, in which preliminary screening with the DES-II showed:

- an average of 20, well below the 30 point cut off and
- a taxon probability of .03749 or just a 1 in 3 chance of DID.

Follow up screening with the MID revealed a different picture.

- I have parts 31.7, I have DID 15.
- Child 37, Angry 30, Persecutor 50, Helper 10.
- Time loss 32.5, Being told of disremembered actions 22.5.

This case highlights the need for a more thorough screening when the diagnostic picture is complex
- not to overly rely on the DES-II.

Note: Psychotherapy Assessment Checklist available free of charge at:
http://affectphobiatherapy.com/forms/

Notice presence of many somatoform and personality disorder symptoms

Note: DES-T average is lower than DES average.
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**Dissociation may present:**

- In an evident picture
- In subtle, indirect ways during the therapy sessions or outside the consultation

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Evident presentations
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Obvious Dissociation

- The client does not remember the therapist in the second session or what they talked about
- Trance states or fugue states
- Conversion disorders
- Patient going to the emergency unit without "knowing who he is"

Subtle dissociative presentations

- Sometimes we can pick it subtle signals during the session but the most frequent situations we will encounter are patients describing dissociative symptoms which happen outside the session
- This is why it is so important to explore these issues
Hidden presentations in the consultation (frequent):

- Tiredness, headache, somatic symptoms
- Patient talking about her “very happy childhood” and “wonderful/perfect parents”
- Inconsistent or contradictory information
- Lack of contact with the emotions related to traumatic contents or as a continuous trait
- Reliving a memory as if it was happening
- Facial changes that can alert us to possible intrusions
- Marked changes between emotional states, cognitive level, memories, behavioral style…
- Wanting to “please the therapist” or be a “good” patient
- Tendency to minimize “it is not so important”, “I am over it”, “it doesn’t really bother me”… (rationalization of significant events)

The importance of Dissociation in EMDR therapy

Understanding the dissociative language

During Phase 1 we will need to remember

- The management of severely traumatized patients is not just a question of learning procedures
- These procedures (and how we teach them) need to keep in mind specific characteristics of early traumatization
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Traumatized clients usually have several dilemmas:

- Some parts might want to “tell” and get help
- Other parts don’t want to tell (for different reasons, some might be afraid, others think they “have to keep the secret” ….
- Protector parts can be experienced by the ANP as intrusions (somatic symptoms, etc.)
- The evaluation and interventions can activate different EPs
- And the patient (ANP) can be aware (or not) of these reactions

Indirect communication

What the client hears and says:

Of course! I want to overcome my problems as soon as possible

Would it be adequate to work with traumatic issues?
What the client hears and does not say:

I am not noticing my body at all. I can’t face the trauma or talk about it but I am not aware of this...

Let’s go to the trauma

Multiple meanings from different parts

- Different dissociative parts understand and express in a different way.
- Each part can be rooted by a different action system (submission, attachment, flight, fight…)
- This can be evident or not at all.

In order to work in a safe way, we will need to work with the system of parts

- We should never forget that the patient is not the ANP, but the entire system.
- We need to keep in mind how our messages and behaviors could be understood by other parts.
- The meeting place procedure or talking through are good ways to get direct access to these parts.
- Sometimes there are unknown parts who are very relevant. We can predict their existence by thinking: What is missing in this system? Some elements tell us about “holes”.
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Dissociative clients. Phase 1
We should look out for “what is missing”?

- Amnesia tells us about the most traumatizing events
- Silences can be a very relevant source of information
- Trauma-based disorders are illness of non-realization (Janet)
- Low levels of mentalization regarding of inconsistent or conflicting statements and attitudes
  - (e.g. Still wishing for “love” from parent while fearing being hurt by the same parent.)

During Phase 1 we will need to directly address the existence of:

- Memory lapses
- Aggressive reactions
- Self-harming behaviors
- Intrusive symptoms
- Auditory hallucinations
- Derealization
- Lack of basic self-care
  - (regular bathing, eating, sleeping)

Does this seem familiar?

I need to speak a lot during the session.

Bla, bla, bla

I am feeling a little bit limited with this patient.

I don’t have any space here.

This is the 10th talking about nothing session.

Look at the detail that has happened to me this past week.

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What could this mean? Possible translation

- I can’t approach trauma
- I can’t talk about feelings, I can’t contact them
- I can’t realize about trauma
- I am not prepared for EMDR, but I can’t say “no” or do the “stop signal”
- I don’t trust you (or part of me doesn’t trust you)

How about this? Does it sound familiar?

From crisis to crisis...

What could this mean? Possible translation

- I can’t approach trauma so I focus on other problems
- I’ve been living like this for so long that I don’t know there are other options; new options seem scary
- I am phobic of normal life
- As long as I have problems, others will see me: I felt invisible when I was a child, I needed to get attention with extreme behaviour
Phase 2

Phase 2 Stabilization in DD

To install a “Safe Place” is a basic stabilization technique. It helps to develop safety, and obviously safety is good.

But…. while installing a Safe place, a patient might experience severe decompensation for example, with imagery of monsters.

Translation: There is no “safety” in my world. Thinking about this reminds me of how unsafe my childhood was. My more intimate places: my home, my room, my bed... my body... were systematically violated. This is what the word “safe” means to me.

Phase 2. Stabilization in DD

To install resources in the ANP is a strengthening technique. It means that the patient becomes stronger. This will help to stabilize the patient.

But... Reinforcing the ANP, even without BLS, can provoke destabilization (intrinsic of an agressive EP: auditory hallucination).

Translation: ANP: I agree with the exercise, it will be ok for me.
EP: you are allied with my enemy (ANP) against me. A friend of my enemy is my enemy.
Phase 2. Relevant interventions for dissociative disorders

- Identifying the internal system.
- What information do we have?
- What is missing?
- Using Phase 1 information to adapt the preparation and stabilization phase.
- Meeting place procedure
- Identifying, understanding and reducing the conflict
- Identifying, understanding and reprocessing dissociative phobias
- Work with hostile parts of the personality
- Tip of the Finger Strategy
- Self-care work

The maintenance of structural dissociation

- As commented before, the development of structural dissociation of the personality starts during early traumatizing experiences.
- But is predominantly maintained by a series of dissociative phobias that characterize trauma survivors and by a lack of social support (Van der Hart, Nijenhuis & Steele 2006)
The concept of dissociative phobias is very relevant in EMDR therapy. If we try to re-process core trauma, without realizing the presence of these “protective layers”, we will probably encounter diverse problems. These layers should be carefully removed (and eventually reprocessed) in a step by step procedure, approaching the extreme pain that the patient is feeling in a gradual, safe and careful way.

Reprocessing Phobias (Gonzalez & Mosquera, 2012)

- It’s an example of I-DSI.
- Interoceptive - Dysfunctionally Stored Information
- The target would be any dysfunctional emotion (fear, rage, shame) and the somatic sensation that one part feels towards another part.
Reprocessing dissociative phobias
(Gonzalez & Mosquera, 2012)

- We focus on the emotion and somatic sensation that a part (ANP or EP) is feeling towards another part (ANP or EP)
- We do short sets of BLS and check how the system responds to this (both parts involved in the procedure and any other parts that might be affected by it)

The Meeting Place Procedure

- The Meeting Place procedure (Gonzalez & Mosquera, 2012) evolved from earlier procedures.
  - The Dissociative Table technique (Fraser, 1991, 1993)
  - The Conference Room (Paulsen, 1995, 2009)
  - Internal Group Therapy (Caul, 1984)
  - The hallucinated room (Watkins, 1984)
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The meeting place procedure in other approaches

- Usually when the meeting place procedure is proposed, the ANP is placed inside as another "part".
- In these other approaches, a specific part can play a mediator role, but the development of an integrated self would be developed as a consequence of the integrative process.

The meeting place procedure in the Progressive Approach (Mosquera & Gonzalez, 2012)

- In our procedure the ANP is not placed inside the meeting room, but instead we use it as a mediator to communicate with other parts.
- In our approach it is the ANP, as Adult Self, which will implement all actions regarding the internal system, borrowing and finally integrating different aspects from other parts.

Intervention: Working from the adult self

- The integrative capacity (metaconsciousness) is developed through the adult self.
- The patient learns to accept extreme and opposite tendencies from the adult that is developing now.
- Working from the meeting place, the adult self interacts with dissociative parts related with the opposite tendencies.
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Empowering the patient

- By working through the Adult Self we help the patient to be in control (real control).
- The patient learns to be attentive to his/her needs (including the internal needs of emotional parts).
- In our framework it is the Adult Self who, with our support and guidance, is leading the therapy; all interventions are implemented by the Adult Self.
- The patient’s autonomy is consistently reinforced.

Empowering the patient

- We do not talk directly to the parts, but instead we show the Adult Self how to talk and communicate with the parts.
- We help the Adult Self learn how to understand what they need, how they feel and how to take care of them.
- By doing this, patients develop their capacities for self-care and self-soothing, and become capable of using these capacities outside the consultation.
- The therapist places herself/himself from the beginning as peripheral, lowering the risk of excessive dependency from the patient.

Working on healthy self-care patterns

- Through consistently working with the Adult Self, we model a new way for patients to look at themselves.
- We foster their capacities to understand their needs, and to develop empathy and true communication with dissociative parts.
Goals

- Establish a good alliance with the whole system
- Avoid insults and negative comments
- Increase genuine curiosity
- Promote dialogue instead of arguments or fights
- Identify the adaptive function of each part
- Promote empathy, cooperation and negotiation
  - (compassion and understanding are crucial)
- Identify and promote the available resources
- Respect the rhythm of each part of the system

- By doing this we promote integration from the first session

Working with parts and voices

- Work through the Adult Self
- Initially this may be more cognitive than emotional
- We want to promote reflective functions
- Our messages should keep in mind the whole system
- Important to respect the feelings and thoughts of all parts
- We do not take sides
  - This would only increase the conflict
- Use the client’s language (parts, aspects, things in me, voices, …)
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Working with parts and voices
Basic aspects to keep in mind

- Each part has a role and a function
- Even the more hostile parts or voices are trying to help in some way
- We rename the parts when these names are negative, disrespectful or threatening
- It is important to understand why parts need to be separated
- If we don’t understand we less able to promote integration
- Remind clients that parts are not different people
- They represent different aspects of a person
- When we explore the internal system of parts
  - we should be sure we include all parts and voices,
  - even the ones that cannot show themselves.
- Clients tend to avoid them. We should not do the same.
- We accept how the client experiences what happens without necessarily agreeing with it.

Working with parts and voices
Procedures that can be used

- Talking through the Adult Self promotes dialogue and integration
- Meeting place procedure (based on Dissociate table)
- Drawings, playmobil…:
  - Promote externalization and
  - Allow the client to think about difficult aspects in a more stable way
  - Seeing the conflict represented outside is not as fearful as looking inside

Be careful with:

- Talking directly to parts
  - Might foster
    - regressive states,
    - dependency on and conflicts with clinician
  - Exercises such as talking to the “empty chair”:
    - Might promote parts taking control
Important aspect to keep in mind

- Hostile or aggressive parts might be blocked in a defensive state:
  - if this is the case, they need to know that the present is safe and there is no need to defend themselves now.
- Teaching new ways to protect the self are usually well received by all parts, including the most hostile ones.

The tip of the finger strategy

Gonzalez & Mosquera, 2012

- It targets intentionally part of the traumatic content.
- The tip of the finger strategy term follows from the hand metaphor that we use to explain the processing of a traumatic memory.
- In the standard protocol we start with the memory itself, and follow different associative chains (the fingers), periodically returning to the initial memory (the palm).
- In the TFS the target is not the traumatic memory, but a small part of a disturbing sensation or emotion that can be considered a peripheral consequence of the memory.
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The tip of the finger strategy

- In the standard EMDR protocol, working with single traumatic events, we choose the worst part of the earliest or worst memory as the initial starting point.
- In severely traumatized people, an inverse strategy can be implemented.
- Using the hand metaphor of EMDR memory processing, we should start from the "tip of the little finger" (a peripheral element), rather than the "back of the hand" (the memory), to progressively approach the core traumatic events.

Peripheral somatic sensations or emotions are ultimately the consequences of dysfunctionally stored memories, and we will first work with these peripheral elements.

The processing of these peripheral elements in combination with other procedures such as the meeting room or the work with parts constitutes an effective and useful intervention for the first phase of trauma therapy, stabilization and safety.

This concept is crucial in a progressive approach.

Our goal is to progress toward a complete processing of the traumatic experience, but when this experience is extremely overwhelming, we need to approach those memories in small steps, starting from the most tolerable interventions and processing small amounts.
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Thank you for your attention and time!
Sample DES Taxon.xls scores for a 45 year old female survivor of sadistic verbal abuse and hypercontrolling behavior by father and spouse

Name: Sample Patient
Date: 12/2/09 10:02

**INSTRUCTIONS**
Enter DES item scores in column E. Results will automatically be calculated.

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<td>28</td>
<td>90</td>
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</tr>
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</tr>
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</table>

**Explanation of Taxon Probability**
Taxon score varies from 0 = low probability to 1 = certainty of pathological dissociation

Average: 43.571428

Probability of taxon given X or $P_{X}$ = 0.82378

This spreadsheet calculates a single test-taker's score on the Dissociative Experiences Scale (DES). It also calculates the Bayesian probability that the test-taker belongs in the DES Taxon. Cell E30 computes the DES score by taking the mean of all the DES item scores. Cell E30, which is labeled as the "average DES-T," is actually the sum of the scores on the eight taxon items, divided by the DES score in Cell E30. This spreadsheet was written by Darryl Perry, who specified that it is to remain in the public domain and that its source code is to be distributed for free. The calculations in this workshop are a translation of the SAS computer program that may be found in the following article: Waller, N. G., & Ross, C. A. (1997). The prevalence and biometric structure of pathological dissociation in the general population: Taxometric and behavior genetic findings. *Journal of Abnormal Psychology*, 106(4), 499-510.

DES total average is computed automatically. This DES total average mixes pathological and non-pathological items.

Note: "Values above 30 suggest the likelihood of a dissociative disorder. Values above 45 suggest the likelihood of Dissociative Identity Disorder (DID)."

Copyright © 2010 Andrew M. Leeds, Ph.D.  Using the DES II
PAC SUMMARY FORM

The therapist uses this form to summarize important issues while scanning the completed PAC forms.
This summary can help guide the initial evaluation and diagnostic session(s).

Patient Name: Louise Date Sept 5, 2011

From Overview of PAC Forms completed by the patient:
Presenting Problems (brief notes): 1. Anxiety
2. Triggers, Fear & Authority
3. Physical Body Symptoms

Axis III Medical Conditions: No Yes Headaches Indigestion Diabetes
Current Medications: No Yes Pantoproc Zomig Allergy Medication

Axis IV Current Severe Stressors: No Yes Financial, Family

Axis V Overall Functioning: Mood 4 Social Functioning 5 Work/School 6

Other points to note:

Axis I Diagnoses to check further: **Suicidal Items Checked: Thoughts Plan Action**

- Major Depression
- Dysthymia
  - # depressive items 7
- Manic
- Past Manic
- Delusions
- Schizophrenia
- Alcohol Dependence/Abuse
- Drug Dependence/Abuse
- Panic Disorder with/without AGR
- Obsessive/Compulsive
- Past Major Depression
- Post-Traumatic Stress Disorder
- Agoraphobia
  - # anxiety items 9
- Social Phobia
- Simple Phobia
- Generalized Anxiety Disorder
  - # anxiety items 6
- Somatization/ Hypochondriasis
- Anorexia
- Bulimia
- Attention Deficit Disorder

Axis II Diagnoses to check further: (Note the number of 'yes' items in each category. The validity of each item
answered 'yes' needs to be verified, based on DSM-IV criteria; i.e., is there evidence of the behavior for
1) Lifetime persistence, 2) Pervasiveness, and 3) Problematic to the individual.

Cluster C (Anxious) Cluster A (Withdrawn): Cluster B (Impulsive)

4 Avoidant 5 Paranoid 1 Histrionic
6 Dependent 6 Schizoid 1 Narcissistic
6 Obsessive Compulsive 4 Schizotypal 1 Borderline
1 Negativistic
6 Depressive
6 Self-Defeating (No longer in DSM-IV)

25 TOTAL ITEMS/CLUSTER C 15 TOTAL/CLUSTER A 10 TOTAL/CLUSTER B

TOTAL ITEMS ANSWERED FOR ALL 3 CLUSTERS 63

© 1998 Leigh McCullough, Ph.D., Psychotherapy Research Program at HMS
<table>
<thead>
<tr>
<th>Item #</th>
<th>DES</th>
<th>DES-T</th>
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<td>1</td>
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<td></td>
</tr>
<tr>
<td>28</td>
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<td></td>
</tr>
</tbody>
</table>

**Average: 20**

Note: taxon average is lower than DES average

**Probability of taxon given X or Pt_x**: 0.03749 = 1 in 3
# Multidimensional Inventory of Dissociation:

## The MID Report

Paul F. Dell, Ph.D.

| Name: Louise | Date: 2/8/11 |
| Sex: F | Race: 0.0 |
| Age: 48 | Education: college |

### Validity Scales:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean (of 10)</th>
<th>Mean (of 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defensiveness</td>
<td>1 (of 12)</td>
<td>62.5 (of 100)</td>
</tr>
<tr>
<td>Rare Symptoms</td>
<td>4 (of 12)</td>
<td>9.2 (of 100)</td>
</tr>
<tr>
<td>Emotional Suffering</td>
<td>4 (of 12)</td>
<td>47.5 (of 100)</td>
</tr>
<tr>
<td>Attention Seeking</td>
<td>0 (of 7)</td>
<td>8.6 (of 100)</td>
</tr>
<tr>
<td>Factitious Behavior</td>
<td>0 (of 7)</td>
<td>0.0 (of 100)</td>
</tr>
<tr>
<td>Ten Count</td>
<td>0 (of 218)</td>
<td>8.8</td>
</tr>
</tbody>
</table>

### Pathological Dissociation:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean (of 10)</th>
<th>Mean (of 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MID Mean Score</td>
<td>26.4</td>
<td></td>
</tr>
<tr>
<td>Mini-MID Score</td>
<td>18.9</td>
<td></td>
</tr>
<tr>
<td>Severe Dissociation</td>
<td>92 (of 168)</td>
<td></td>
</tr>
<tr>
<td>Dissociative Symptoms</td>
<td>19 (of 23)</td>
<td></td>
</tr>
<tr>
<td>I Have DID Scale</td>
<td>15.0</td>
<td></td>
</tr>
<tr>
<td>I Have Parts Scale</td>
<td>41.7</td>
<td></td>
</tr>
<tr>
<td>Amnesia Symptoms</td>
<td>13 (of 31)</td>
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</tr>
<tr>
<td>Mean Amnesia Score</td>
<td>16.6</td>
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</tbody>
</table>

### Cognitive and Behavioral Psychopathology:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean (of 10)</th>
<th>Mean (of 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Distraction</td>
<td>1 (of 12)</td>
<td>37.5 (of 100)</td>
</tr>
<tr>
<td>First-Rank Symptoms</td>
<td>7 (of 8)</td>
<td>38.6 (of 100)</td>
</tr>
<tr>
<td>Psychotic Screen</td>
<td>2 (of 4)</td>
<td>12.5 (of 100)</td>
</tr>
<tr>
<td>Critical Item Score</td>
<td>3 (of 10)</td>
<td>12.0 (of 100)</td>
</tr>
</tbody>
</table>

### First-Rank Symptoms:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean (of 10)</th>
<th>Mean (of 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voices Arguing</td>
<td>30.0</td>
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<tr>
<td>Voices Commenting</td>
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<tr>
<td>&quot;Made&quot; Feelings</td>
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<tr>
<td>&quot;Made&quot; Impulses</td>
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<tr>
<td>&quot;Made&quot; Actions</td>
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<tr>
<td>Influences on Body</td>
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<tr>
<td>Thought Withdrawal</td>
<td>40.0</td>
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</tbody>
</table>

### Pre-MID Diagnosis:

PTSD Anxiety Disorder DES Score: 20 Taxon 18.75 of 4

### Clinician's comments about this person:

0.0

### C. Fully-Dissociated Actions:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Mean (of 6)</th>
<th>Mean (of 100)</th>
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</thead>
<tbody>
<tr>
<td>Time Loss</td>
<td>32.5</td>
<td>150</td>
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<tr>
<td>&quot;Coming to&quot;</td>
<td>2.5</td>
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<tr>
<td>Fugues</td>
<td>2.0</td>
<td>0</td>
</tr>
<tr>
<td>Being Told of Disremembered Actions</td>
<td>22.5</td>
<td>100</td>
</tr>
<tr>
<td>Finding Objects Among Possessions</td>
<td>15.0</td>
<td>100</td>
</tr>
<tr>
<td>Finding Evidence of One's Recent Actions</td>
<td>10.0</td>
<td>100</td>
</tr>
</tbody>
</table>

### Validity of this person's responses to the MID:

This person's validity scores are within acceptable limits, i.e. or more validity scales are subclinically elevated. It is appropriate to take such subclinical elevations into consideration when interpreting the test-taker's MID scores and MID Diagnostic Impression.

### Mean MID Score:

A MID Score of 21-30 suggests that the test-taker may have DDNOS, DID and/or PTSD.

### Axis I:

Posttraumatic Stress Disorder
Dissociative Identity Disorder

### Axis II:

No Diagnosis
“Recognizing and stabilizing those with dissociative disorders using EMDR therapy”
Workshop presented by Dolores Mosquera Psy. and Andrew M. Leeds, Ph.D.
Friday August 28, 2015 EMDRIA Conference Philadelphia

References


Dell, P. F. (2006) The Multidimensional Inventory of Dissociation (MID), Paul F. Dell, Trauma Recovery Center, 1709 Colley Avenue, Ste. 312, Norfolk, VA 23517. The MID is in the public domain; it is freely available upon request—without charge—to all mental health professionals from PFDell@aol.com. Members of the International Society for the Study of Trauma and Dissociation can request it or can download it directly from the members’ area at: http://www.isst-d.org/


“Recognizing and stabilizing those with dissociative disorders using EMDR therapy”
Workshop presented by Dolores Mosquera Psy. and Andrew M. Leeds, Ph.D.
Friday August 28, 2015 EMDRIA Conference Philadelphia


Knipe, J. (2010d, September/October). What the adaptive information processing model brings to the assessment and treatment of dissociative disorders. Plenary presented at the annual meeting of EMDR International Association, Minneapolis, MN.

Knipe, J. (2010e, September/October). Shame is my safe place: AIP targeting of shame as a psychological defense. Presentation at the annual meeting of EMDR International Association, Minneapolis, MN.

Knipe, J. (2010f, September/October). Dissociation through the AIP lens. Opening address at the annual meeting of EMDR International Association, Minneapolis, MN.


van der Hart, O., Solomon, R., & Gonzalez, A. (2010, September/October). The theory of structural dissociation as a guide for EMDR treatment of chronically traumatized clients. Presentation at the annual meeting of EMDR International Association, Minneapolis, MN.