THE BENEFITS AND MITIGATED RISKS OF INTENSIVE TREATMENT IN EARLY TRAUMA TREATMENT

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Why is this Important to Discuss?

EMDR Therapy typically:
- 45-90 min in regular or variable intervals over months or years
- Most common use: target Big or Small T’s held in explicit memory with imagery and narrative
- Process to an adaptive resolution for symptom reduction

Some Protocols Target Implicit Memory

- Early Trauma approach to address trauma and neglect from the attachment period (O’Shea, 2003; O’Shea & Paulsen, 2007; see especially Paulsen, 2017 as basis for this presentation)

- May be entirely without narrative or imagery as its held in implicit memory in the right hemisphere (Schore, 2009 EMDRIA Plenary)

- Problems with Conventional Format for Implicitly Held Memory

In short session:
- 10-15 minutes settling in
- 10-15 minutes distancing from material in wrap up, any homework or follow up planning, scheduling
- Client’s attention outward, distracted by travel
- Although that’s fine for work in explicit memory...
- Hard to drop into the felt sense in the body when working in implicit memory

Intensive Treatment Format Benefits

- Half, full, or several full days
  Start up and wrap up time greatly reduced
  Much more time to get into the deeper work
  Much easier to drop into the felt sense of the body
  Soma key in early trauma/implicit memory work
  Those who need instruction how to do that have time to learn

Intensive Treatment Format Benefits
  Therapist has time to learn client’s non-verbal
  Enactment information unfolds in relationship field
Therapist has time to drop into own mirror neurons to read information

- **Intensive Format Has Risks**  
  Shouldn’t Enter Into it w/o Awareness, Mitigants
- **Highly dissociative clients not suitable**  
  Unless highly resourced, insightful, co-conscious
  Likely to unravel, destabilize in the format
  Many dissociative folks are not so diagnosed
  Many therapists don’t know how to diagnose

- **Intensive Format Has Risks**  
  Shouldn’t Enter Into it w/o Awareness, Mitigants
- **Risk of harm greater than in the shorter format**  
  Work is intense
  Little between session recovery time
  Days are long and arduous even with breaks

- **Attachment Injury Special Risk**  
  Three full days is sufficient for many to get very sizable symptom relief but what if it isn’t?  
  e.g., inability to somatically connect, alexythmic interference with reporting affective states, or defensive processes interfering with change
  Skillful therapist can address all these but maybe eats up the available scheduled time
  Client leaves and feels as if therapist left THEM

- **Attachment Injury Special Risk**  
  Therapist may not be available for ongoing follow up care, and that may feel abandoning or betraying
  Reenacting infancy parent/child dynamics with client going home to no one.

- **Attachment Injury Special Risk**  
  Quite injurious to make the incision but not complete the surgery or stitch up
  Client leaves with emotional guts hanging out
  Same old story, “you’re on your own, kid” but out thousands of dollars

- **Therapist Must Have a Means to Assess Client Suitability for the Work**  
  That takes into account that dissociation is often hidden to therapist and client, all we see is the porch of the house

- **Therapist Must Have a Means to Assess Client Suitability for the Work**

- **Prior therapist report – But that’s no guarantee**

- **Initial brief in person or phone intake**  
  Not just for history but to assess self system
  Questions that search for hidden signs of dissociation
  One part of client asserts client is strong and capable, while other part(s) feel helpless, fearful, guarded, protective, “no way will I permit change”

- **To Prevent Catastrophic Outcomes**
• I require a therapist to make referral or its no go
  Describe why they think client is resourced enough
  How they know not DID
  Agree to be available to receive when client goes home for “soft landing”
  It’s a team approach, I’m like a surgeon releasing post surgically to the
  GP/Internists care
• I alert both regular therapist and client to this possibility so both inoculated

• Preliminary Assessment
• Formal assessment for dissociation: MID
• Informal assessment for dissociation: Embedded questions in initial interview
• Preliminary Assessment
• Also assessment for capacity to tolerate:
  Affect - positive and negative
  Soma – positive and negative
• In vivo “dropping down” into the bodily felt sense
• Preliminary Assessment
• Consider getting Low Dose Naltrexone to increase access if referring therapist and client
  indicate impaired ability to access soma and affect
• LDN not suitable for DID – precipitate fight/flight
• Intake by Phone or In Person
• Not only to get sense of degree of dissociation and trauma and access to affect and soma
  and not only to get history
• Even if not DID, want to be able to discern whether the self system “honchos” are amenable

• Intake by Phone or In Person
• How insightful? Most of my practice is EMDR Therapists – pretty insightful
• Easier to maintain dual attention awareness if they understand it, lest believe annihilation
  terror if hit a pocket

• Referring Therapist Indicate
• How long and how well knows client
• How have they assessed for structural dissociation (if they haven’t they or I need to do MID)
• How resourced are they?
• Referring Therapist Indicate
• How fragile are they?
• Do they have financial resources?
• Will therapist provide follow up?
• I get permission to send email updates to referring therapist
• Never Know What’s Being Reenacted in Relationship Dynamics
• If intensive work feels like a forced march, and their whole childhood was a forced march,
  guess whom you remind them of?
- Will they say so or just silently suffer?
- Never Know What’s Being Reenacted in Relationship Dynamics
- E.g., if client locked in a basement three days, and we do three days of work, guess what’s triggered?

- I’ve cleaned up a bunch of messes where client didn’t tell therapist how abandoned they felt any more than they would complain to Mother
- Lots of Pressure on Therapist
  - Have to be highly competent
  - Have to know your realistic limits
  - Have to deliver results
  - Have to be good with somatic dissociation, alexithymic, unpleasant defenses, stalemates
- Lots of Pressure on Therapist
  - Have to be able to hear the story in the non-verbals, read mirror neurons, or intuition
  - People may be spending thousands on flying in hotels rented cars and several full days of therapy.
  - Time limited.
  - Better deliver.
- More Pressure on Therapist
  - Can’t be phony bologna – must be authentic and really “show up” as a person, because this is about their attachment injury and not being seen or humanity valued
  - Can’t hide behind structure of brief sessions
  - We can think we’re capable and be wrong
  - In intensive format all is revealed, no way out
  - High stakes.
- Not for everyone.
- More Pressure on Therapist
  - We can have frailties that get triggered by this particular client’s particular issues
    - Either what happened to them resembles our story
    - Or we remind them in some way of mom or dad
    - We have to have done our own work or it shows
- Methods to Mitigate Reenactment Ruptures
  - Inoculate client to all these areas ahead or as we go
  - Explicit discussion with client and referring therapist about what to expect

Methods to Mitigate Reenactment Ruptures
- Have a very comfortable healing environment, retreat setting, healing center, natural surrounds, chairs MUST be comfortable
- Canine or equine assisted beneficial

- Good News Is....
  - When spending that much money
People HIGHLY motivated
Huge benefit of placebo “believes therapist walks on water” so client opens to their own opportunity to make a miracle
All or nothing, this is it, sensibility

- Structure of the Intensive Format
- Initial Arrival
  - Settling in, Reviewing course of treatment
  - Outline breaks and lunch, creature comforts
  - Client restroom, waiting area, microwave/refrigerator, tea, areas outdoors to walk in forest, to horse barn
- Structure of the Intensive Format
- Other Logistics
  - Client doesn’t stay on premises but on island
  - Timing of breaks based on requirements of the work
  - Typically approximate three two-hour segments or four 90 minute segments, with brief breaks except lunch is longer, most bring lunch
  - Lunch breaks negotiated based on needs
- Mechanics
  - Recliner or very comfortable chair or sofa and foot rest
  - Work is “regressive” in sense we visit younger ego states and time periods in order to hear the story in the non-verbals and do the repairs in imagination
  - Regression in service of the ego, because we are growing them up in the repairs, meeting developmental milestones as we go
  - I prefer to have their feet on ground so they are grounded. Poodle grounding beneficial
- Hearing the Story in the Non Verbals
  - Drop into the felt sense of the body
  - Tracking in a moment to moment fashion
  - Must be embodied first to discern the nuances of the story as experienced in the felt sense
- Hearing the Story in the Nonverbals
  - Therapist needs to be trained somatically or innately capable of tracking resonantly with the top attunement, mirror neurons
  - Highly cognitive people will go very slowly or get impatient with the requirement of dropping down
  - Some are somatically or affectively cut off
  - Low dose naltrexone 4.5 mg can be helpful
- In Summary
  - Format can be helpful especially working in implicit memory
  - Shouldn’t be undertaken without awareness that there are risks associated
  - Those risks can be mitigated with informed consent process, and appropriate structure, process and planning
REFERENCES


Paulsen S.L. (2017). When There Are No Words: Repairing Early Trauma and Neglect from the Attachment Period With EMDR Therapy. Bainbridge Institute for Integrative Psychology Publications.