What are complex cases?

- EMDR was initially developed for the treatment of and has been found to be an evidence based treatment for PTSD.
- Complex cases are those that involve greater impairments in symptoms related to problems with mood, interpersonal functioning and self-care.
- These cases can be viewed on a spectrum related to the degree of structural dissociation ranging from
  - Disorders of Extreme Stress Not Otherwise Specified (DESNOS) – also referred to as Complex PTSD
  - Personality Disorders (secondary structural dissociation)
  - Dissociative Disorder Not Otherwise Specified (DDNOS)
  - Dissociative Identity Disorder
What is Complex PTSD?

1. Herman (1992a; 1992b) proposed the diagnosis Complex PTSD.
2. Van der Kolk proposed the diagnosis Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Pelcovitz et al., 1997).
3. It is associated with Secondary Structural Dissociation of the personality (van der Hart, et al., 2006).

DESNOS is not always Complex + PTSD

- Studies with veterans (Ford, 1999) and civilians (McDonagh-Coyle et al., 1999) found that 25%-45% of patients diagnosed with DESNOS failed to meet criteria for PTSD.
- “Of critical importance to the discussion at hand is the finding that a DESNOS diagnosis predicts poorer PTSD treatment outcome in diverse clinical populations” (Korn, 2009, p. 265).

-- Korn (2009)

DESNOS involves symptoms of dysregulation in seven areas:

1. Regulation of affects and impulses
2. Attention or consciousness
3. Self-perception
4. Perception of the perpetrator
5. Relations with others
6. Systems of meaning
7. Somatization
When should we think about complex trauma?

Indicators of "complexity"

- History includes persistent, prolonged and/or multiple Adverse Childhood Experiences
- Caregiver substance abuse
- Caregiver chronic medical or psychiatric illness (diagnosed or not)
- Caregiver abandonment
- Domestic violence
- Physical, sexual or verbal abuse
- Parent-child role reversal (parentification) or other dysfunctional attachment relationship
  - Sometimes these issues are hidden in claims of a “wonderful” childhood.
- Difficulty or inability to regulate emotions
- Self-harm and suicidal behaviors
- Impulsivity and risky behavior
- Problems identifying, feeling, or managing anger
  - They are unable to feel anger adaptively, and become overwhelmed by this emotion, become tearful or passive-aggressive.
- Amnesia and dissociation
- Somatic symptomatology
- Difficulty noticing issues related to their traumatic experiences
When should we think of Complex Trauma?

- Persistent guilt
- Persistent sense of worthlessness
- Severe problems in interpersonal relationships
  - Not just intense relationships, also the need to avoid them for protection or due to fear of intimacy.
- Tendency to idealize and/or devalue others
- Difficulty trusting others / marked and frequent susceptibility to being exploited
- Hopelessness since “always”
- Compensatory behaviors for emotional regulation
  - Drugs, alcohol, self-medication, sex, cutting…

The foundations for EMDR case formulation in complex cases

Phase 1 – Stabilization and History Taking
Essential elements of case conceptualization

- Case conceptualization requires:
  - Thinking beyond the patient's immediate symptoms (maladaptive attitudes, thoughts, behaviors and defensive emotional responses)
  - To form a mental model of these problems grounded in a model of psychotherapy.

Case conceptualization produces a mental model that leads to a treatment plan

- A mental model of the patient's difficulties – based on
  - Adaptive Information Processing model (AIP)
  - Attachment theory and
  - Theory of Structural Dissociation of the Personality (TSDP)
- leads to a set of hypotheses about the causes of the patient’s symptoms.
- These hypotheses provide the outline for building the treatment plan.
- If these hypotheses are correct and the methodology is correctly applied then the patient’s symptoms should improve.
Case conceptualization produces a mental model that leads to a treatment plan.
Case conceptualization produces a mental model that leads to a treatment plan

Case formulation in complex cases

- The Adaptive Information Processing model (Shapiro, 2001)
  - The AIP model directs us to identify the dysfunctionally stored information (memory networks) that need to be reprocessed and the adaptive coping tendencies to be reinforced and enlarged.
  - Attachment classification represents a working model of self and significant others.
  - By definition it is the earliest template by which the person processes information regarding self-regulation and interpersonal stressors.
- Theory of Structural Dissociation of the Personality (TSDP; Van der Hart, Nijenhuis, Steele, 2006)
  - Allows us to recognize structural divisions within the personality.
  - Helps us to comprehend and address the dissociative phobias that maintain dysfunctional coping patterns.

Dimensions of Structural Dissociation of the Personality

Van der Hart, Nijenhuis, Steele, (2006)
Dimensions of Trauma-Related Structural Dissociation of the Personality

- Van der Hart, Nijenhuis, Steele, (2006)

**Primary Structural Dissociation**
- Acute Stress Disorder
- PTSD
- Depersonalization/derealization disorder
- Complex PTSD/DESnos
- Borderline Personality Disorder
- Complex ICD-10 Dissociative Disorders of Movement and Sensation

**Secondary Structural Dissociation**
- Complex PTSD/DESnos
- Borderline Personality Disorder
- Complex ICD-10 Dissociative Disorders of Movement and Sensation

**Tertiary Structural Dissociation**
- Dissociative Identity Disorder

---

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

Adapted from Helga Mattes 2006

---

Secondary Structural Dissociation: DESnos and Dissociative Disorder NOS
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

Adapted from Helga Mattes 2006
Tertiary Structural Dissociation: Dissociative Identity Disorder
At least two (ANP) and several (EP)

EP: action systems for defense against major threats: survival of the individual
ANP: action systems for functioning in daily life and survival of the species

Insecure and Disorganized Attachment in Complex PTSD
Recognizing and working with Dismissing, Preoccupied, and Disorganized Attachment
Attachment Classifications and Characteristics
Based on the Adult Attachment Interview (AAI)

The Adult Attachment Interview (AAI)
- A quasi-clinical semi-structured interview
- Developed by Carol George, Nancy Kaplan, and Mary Main in 1984
- It involves about 20 questions and has extensive research validation.
- Requires several weeks of specialized training to learn to administer, code and interpret it validly.
- See summary in Hesse (1999).

To incorporate AAI questions into your clinical interviews, the full AAI can be found here:
- [http://www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf](http://www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf)

Secure/autonomous – AAI narrative
- The person speaks coherently and interactively with the interviewer about their experiences, whether favorable or unfavorable.
- They answer questions with sufficient, but not excessive elaboration and provide a coherent narrative that may even include traumatic issues.
- Individuals with secure/autonomous classification seldom present with Complex PTSD, but Complex PTSD patients may achieve an earned secure classification after a stable adult relationship and/or successful therapy.
Dismissing – AAI narrative

- The person minimizes the discussion or importance of attachment-related experiences.
- Responses are typically internally inconsistent, and often excessively short.
- Relationships with parents are usually described as highly favorable, but without supporting evidence, or when it is given, tends to contradict the global evaluation.
  - Avoid generalized questions about “love” from caregivers.
  - Ask for concrete examples of when a caregiver offered:
    - Physical affection, physical soothing when hurt, anxious, or frightened
    - Verbal or practical support when coping with social stress (e.g., bullying)
    - Recognition and praise for persistent efforts and achievements
    - Putting the child's needs ahead of the caregiver's
    - Mindsight: verbalizing recognition of their inner feelings, hopes, fears, and dreams.

Dismissing – presentation

- With constricted affect and narrative, they tend to show little of their affective or physiological distress in faces or postures until they reach the point of overwhelm or breaking down and then may feel betrayed that the clinician failed to recognize their signals of distress.
- It is important to inquire carefully during history taking and preparation about their inner experiences.
- With constricted affect, check on their physiological states.
- Consider monitoring with the emWave.
- It is essential to re-evaluate how they were affected by the prior session.
- Ask about functions of daily living; behaviors more than emotions will signal responses in early phases of treatment.
- Initially assume any currently reported disturbance and any past traumatic experiences are more disturbing than their self-rating would indicate until this can be better calibrated.

Preoccupied – AAI narrative

- The memories aroused by a question seem to draw the subject’s attention and guide the subject’s speech.
- This can result in lengthy, angry recounting of childhood interactions with parents, which may inappropriately move into discussions of a present relationship.
- The speaker may also digress to remote topics, use vague language, and describe a parent negatively and positively in the same sentence.
- Be prepared to narrow the focus of attention and to defer further discussion of disturbing topics until later.
Preoccupied – Presentation

- They often seem overwhelmed and tormented by feelings.
- Their narratives reflect an absence of structures to contain their abundant emotions.
- They present themselves as needy and dependent, and demand much of attachment figures and clinicians.
- Yet, structure offered by others, including clinicians, seems to be completely inadequate or to disappear, leaving intense affect in its place (Slade, 1999).
- When describing traumatic childhood events or abandonments, their narratives emphasize the intolerability of these experiences and a sense of hopelessness for recovery.

Disorganized – AAI narrative

- These subjects frequently demonstrate substantial lapses in reasoning or discourse.
- They may express childlike beliefs or lapse into prolonged silence or eulogistic speech.
- With indications of disorganized narrative the attention should shift from gathering a history to exploring
  - Internal structure of the self
  - Meeting place, maps or drawings of the internal system, play mobile ...
  - Degree of structural dissociation
  - Clarifying difficulties in current functioning
  - Developing reflective functioning

Exploring the Internal System through drawings or maps

- Examples of maps of the internal system.
  - These are omitted from the handout for confidentiality.
Exploring the Internal System through drawings or maps

- Examples of maps of the internal system.
  - These are omitted from the handout for confidentiality.

Video

Disorganized – Presentation

- Different aspects of the personality may at various times show different, even conflicting attachment classifications.
- Structures for affect regulation may vary across different aspects, from apparently rigid and highly contained, to apparently fluid and highly permeable.
- At follow up sessions they may have little to no recall for significant aspects of previous sessions.
- Uninformed attempts at standard EMDR reprocessing
  - Can occasionally dramatically and disruptively reveal hidden and unprepared aspects of the personality (Paulsen, 1995)
  - Can lead to apparently complete reprocessing in an unusually short number of sets of reprocessing, but the disturbing material has merely been hidden from the ANP.
### AAI classifications distribution

<table>
<thead>
<tr>
<th>AAI Classification</th>
<th>Secure/Autonomous</th>
<th>Dismissing</th>
<th>Preoccupied</th>
<th>Unresolved/Disorganized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community non-clinical</td>
<td>55%</td>
<td>16%</td>
<td>9%</td>
<td>19%</td>
</tr>
<tr>
<td>Low-socioeconomic (SES) mothers</td>
<td>30%</td>
<td>32%</td>
<td>7%</td>
<td>32%</td>
</tr>
<tr>
<td>Pregnant incarcerated women</td>
<td>35%</td>
<td>20%</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Clinical samples of men and women</td>
<td>21%</td>
<td>23%</td>
<td>13%</td>
<td>43%</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>14%</td>
<td>51%</td>
<td>35%</td>
<td>28%</td>
</tr>
</tbody>
</table>

### Clinical Assessment of Adult Attachment Status

Based on reported behaviors of childhood and adult attachment figures:

- **Reported history**
  - Consistent contingent supportive behaviors
  - Inconsistent contingent supportive behaviors mostly supportive
  - Consistent absence of contingent supportive behaviors
  - Prolonged Periods of Frightened or Frightening behaviors

- **Attachment classification with that attachment figure**
  - Suggestive of secure attachment
  - Suggestive of insecure preoccupied
  - Suggestive of insecure avoidant
  - Suggestive of disorganized
  - Suggestive of secondary or tertiary structural dissociation

### Chris Fraley’s Online tools for assessing adult attachment

- **a. On-line Attachment Questionnaire (CRQ/ECR-R)**
  - (Fraley, Waller, & Brennan, 2000)
  - This web survey is a broad-based measure of attachment styles in close relationships.
  - [http://www.web-research-design.net/cgi-bin/crq/crq.pl](http://www.web-research-design.net/cgi-bin/crq/crq.pl)

- **b. ECR-Relationship Structures**
  - This web application is designed to assess individual differences in attachment across multiple relationships. The application also provides within-person correlational structure of a person’s attachment ratings.
  - [http://www.yourpersonality.net/relstructures/](http://www.yourpersonality.net/relstructures/)
Phase I in Complex Trauma

Balancing the pace of history taking with the management of phobias, defenses and the development of coping skills

Phase 1 Janet – Phases 1 and 2 EMDR

As with any patient, Phase I is basic for an adequate therapeutic planning

In patients with complex trauma, this Phase implies a greater complexity and has some particular characteristics


1. Present symptoms – dysfunctional, behaviors, emotions, beliefs; frequency, location, etc.
2. Duration – When did symptoms start? How have they changed overtime?
3. Initial cause – Original occurrence, primary event, and modeling or lessons as genesis.
4. Past occurrences – List participants, cluster past occurrences.
5. Other complaints – possibly hidden by primary complaint.
Gathering information in Complex Trauma

In complex trauma the gathering of information has greater complexity and challenges than in cases of PTSD.

---

Gathering information in Phase 1

- The foundations of stabilization and an adequate treatment plan are built on
  - Establishing rapport
  - Developing a clinical assessment and case formulation based on AIP, TSDP, and attachment classification(s).
  - Understanding the patient’s current strengths and difficulties
- There can be a great tendency on the part of clinician and patient to move too rapidly toward identifying and/or uncovering traumatic material without first understanding:
  - The patient’s capacity to cope with day to day challenges
  - Degree of dissociative symptoms, Dissociative Parts and Phobias
  - The challenges of confronting traumatic material.

---

Gathering information in Phase 1

- The gathering of information must be balanced between being comprehensive enough and being tolerable for the patient.
- The greater the degree of structural dissociation, the more careful we must be when entering areas in which the patient cannot yet be aware, cannot remember, or cannot stand thinking about or feeling.
History Taking and Preparation for EMDR Therapy in Complex Cases

Approaching formative experiences

<table>
<thead>
<tr>
<th>Good affect tolerance</th>
<th>Some affect tolerance</th>
<th>Little affect tolerance</th>
<th>Risk of self-injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Cautious</td>
<td>Deferred</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adequate coping resources</th>
<th>Some coping resources</th>
<th>Seriously impaired functions of daily living</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Cautious</td>
<td>Deferred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Flexible permeable defenses</th>
<th>Some dysfunctional defenses</th>
<th>Multiple, rigid primitive defenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Cautious</td>
<td>Deferred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Absence or minimal dissociative phobias</th>
<th>Some dissociative phobias</th>
<th>Multiple complex dissociative phobias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Cautious</td>
<td>Deferred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Early direct gathering of list of traumatic targets often via homework</th>
<th>Focus on building therapeutic alliance</th>
<th>Identifying traumatic targets is deferred as initially destabilizing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Cautious</td>
<td>Deferred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minimal need for RDI, affect tolerance or defense restructuring</th>
<th>Meeting place may help identify parts and defenses</th>
<th>Focus on building trust, therapeutic alliance, and reducing conflict among parts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Cautious</td>
<td>Deferred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targets related to worst symptoms can be addressed in classic past-present-future sequence</th>
<th>History is taken in sessions - mixed with RDI, affect tolerance or restructuring defenses as needed</th>
<th>Meeting place for identifying parts of the personality and phobias. Reprocessing phobias and Tip of the Tongue Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Cautious</td>
<td>Deferred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well-rehearsed targets can be represented early and should lead to immediate symptom reduction</th>
<th>Affect tolerance and mentalization can be enhanced with modified EMDR procedures</th>
<th>Work on improving functions of daily living and self-care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Cautious</td>
<td>Deferred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Traumatic targets can be represented after adequate preparation</th>
<th>Developing higher order mental function and restructuring phobias and defenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>Cautious</td>
</tr>
</tbody>
</table>

How to gather relevant information in the first sessions? The therapist’s attitude

- Caution and tactfulness
- Finding an equilibrium between proximity and maintaining an appropriate distance
- Do not act as investigator; instead offer “gradual” interest
- Act as “regulator” (help the patient to go on if needed and slow down if he or she does not know how)
- Maintain clear boundaries and predictability
- Provide structure (we cannot function in a chaotic way when chaos is the norm)
- Follow a structured (but flexible) plan for stabilizing and gathering information.

How to gather relevant information in the first sessions? Basic steps

- Important not to focus just on traumatic events,
- Identify skills; strong points.
- Allow the patient to tell his or her story (as long as it can be tolerated and is helpful) without getting into too much detail (debriefing)
- Explore aspects related to phase 2.
- For example can a calm or safe place be accessed and/or if it is possible to create it. At times it is a trigger.
- Resources for strength, courage or discernment may be initially more helpful and better tolerated than “calm” or “safety”.

EMDRIA Conference Denver 2014
“Standard history taking” can trigger idealization defenses

- The client says: “I need help, I need to accept the truth about my past life.”
- When the therapist tries to comply and explore relevant information, she becomes very upset, crying like a little girl and hardly able to breathe.
- Then she becomes hostile and looks at the therapist in a defiant way. “How dare you sit there and judge my parents?! Who the hell do you think you are?”
- The therapist apologizes and explains that this was not his intention
- without anticipating (or recognizing) the switch from ANP to first a submissive EP and then a hostile EP.
- The client apologizes “It’s not your fault, I just get crazy sometimes, I can’t even understand myself”

What happens inside

<table>
<thead>
<tr>
<th>ANP</th>
<th>EP 1</th>
<th>EP 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I need help, I need to know the truth”</td>
<td>Crying</td>
<td>Rage</td>
</tr>
<tr>
<td>Childhood fearful and victimized part</td>
<td>Enraged, hostile protective part</td>
<td>Idealizing defense</td>
</tr>
</tbody>
</table>

“Standard history taking” can trigger dissociative defenses including amnesia

- The client demands EMDR therapy to resolve past traumas and the therapist quickly moves forward to gather relevant history.
- After mentioning nightmares and memories of childhood rape, the client breaks down and cries, mumbling “It can’t be true, I must be making it up”
- Suddenly she calms down and says “Where were we? I got lost” (not remembering what just happened).
- The therapist decides to go slower thinking that this case might need more time
- In the next session the client seems to be doing much better and does not remember what they talked about. She says she is happy with her life and does not think she needs therapy.
What happens inside

ANP 1
“I want to work with trauma”
(memories are felt as invasions)

EP 1
Stuck in trauma time
Containing memories

EP 2
Attachment to perpetrator: “It can’t be true, I must be making it up”

ANP 2
“I am fine, I don’t need therapy”

Symptom Informed Target Sequencing in milder cases of DESNOS and PTSD

Selecting clusters of activated memories by symptom severity

Four principles for symptom informed target sequencing (Leeds, 2009) 1 of 2

1) Earlier experiences set the foundation for responses to later events.

2) Starting with the most debilitating of the patient’s symptoms, first reprocess the target memory associated with the development of this symptom.
   - If the target involves a cluster of memories, start with earliest, then the worst, then others, then most recent. Complete each memory before going to the next.
   - The continue to present triggers and finally future template.
   - After the worst symptoms resolves, then select the target(s) related to the next remaining worst symptom.
Four principles for symptom informed target sequencing (Leeds, 2009) 2 of 2

3) Focus on adverse and traumatic events that are clearly distressing to the patient — known as “activated” memories (Korn et al., 2004).

4) A treatment plan must be a collaboration between clinician and the patient.
   - Early contributory memories may be obvious to clinician as essential targets, but they may not initially be relevant to the patient until more recent memories have been targeted and the patient gains confidence in EMDR reprocessing and insight into the linkage.

Be prepared to recognize defenses or dissociative phobias and to shift to preparation/stabilization

- Your initial case formulation may suggest a milder presentation and you may believe the patient is able to tolerate “standard history taking”.
- Remain sensitive and alert during history taking to indications of defenses (such as idealization and/or minimization) or dissociative phobias.
- Be prepared to shift to defense recognition, presentification (grounding), psychoeducation, resource installation, affect tolerance and other preparation phase interventions.
Frequent problems in Phase 1

- In complex trauma, taking a complete history is not always possible and can be destabilizing.

- In severely traumatized people, amnesia is frequent so it can be difficult to get a complete history.

- "Sometimes I would like to cut my heart out to avoid feeling all this pain."
- When the pain is too intense, dissociation is a resource.
- To ask about trauma too soon can be overwhelming.
“The pain is so intense
I can’t find words to express it.”

“I wanted to show you how I feel with
images”

Frequent problems in Phase 1

- Lack of differentiation
Frequent problems in Phase 1

- Chaos
- Identity issues
- Who am I?
- What do I think?
- What do I like?
- What do I need?
- I don’t know really understand what happened

Frequent problems in Phase 1

- In severely traumatized people, trusting the therapist is complicated
- Defenses can interfere with the history taking
Other problems in Phase 1

- Lack of realization can also interfere with the history taking
- Some patients have difficulty identifying “targets”. They do not recognize those experiences as disturbing or problematic – common with insecure attachment.
- The relationship between past experiences and present symptoms is not evident for them
- Therapists tend to focus on the list of the top ten traumatic events; overlooking foundational issues.
- Foundational issues – Called “contributory experiences” by Leeds (2009) - often involve early attachment experiences defended by minimization, idealization and/or structural dissociation.

Stabilization (Preparation) may need to precede History Taking

What are the essential tasks to be accomplished in the Stabilization Phase?

- (1) reduce physiological hyperarousal and develop capacities for self-soothing
- (2) reduce re-experiencing
- (3) establish a working therapeutic alliance
- (4) begin work with dissociative phobias
- (5) reduce the level of chaos, so therapy rather than chronic crisis intervention can ensue
- (6) develop tolerance for both “negative” and “positive” affect
- (7) maintain an inner sense of connection with others
- (8) regulate self-criticism and/or self-loathing
- (9) maintain a positive sense of self

Preparation phase tasks in Complex PTSD

- (1) reduce physiological hyperarousal and develop capacities for self-soothing
- (2) reduce re-experiencing
- (3) establish a working therapeutic alliance
- (4) begin work with dissociative phobias
- (5) reduce the level of chaos, so therapy rather than chronic crisis intervention can ensue
- (6) develop tolerance for both “negative” and “positive” affect
- (7) maintain an inner sense of connection with others
- (8) regulate self-criticism and/or self-loathing
- (9) maintain a positive sense of self

Gelinas (2003)
Four Criteria suggestive of the need to use RDI or other preparation in complex cases

1. Seriously impaired self-regulation skills
   - self-injurious or therapy interfering behaviors
   - maladaptive tension reduction behaviors
   - dangerous substance abuse
   - and standard methods for self-control (progressive relaxation, breathing exercises or calm place exercise) have proven insufficient.

2. A substantial risk of premature termination if standard EMDR reprocessing were started due to
   - intolerable shame over acting out
   - chronic intrusions
   - intense fears of starting EMDR reprocessing

3. Episodes of being overwhelmed by affect, depersonalization, unable to express a coherent narrative.

4. EMDR reprocessing has led to chronically incomplete treatment sessions or to adverse impacts on subject’s day-to-day functioning.

   For detailed criteria see reference list for download link: Leeds, 2006.

Invalid reasons to use RDI before starting standard EMDR for PTSD

- The patient is clearly suffering from symptoms of PTSD, meets readiness criteria, and the clinician has:
  - A vague sense the patient is “unstable”.
  - Anxiety about possible patient abreaction.
  - Aversion to the content of patient memories.
  - Preference for helping the patient to “feel good.”
  - Fear of not being able to “complete” the session.

- Instead, the clinician should obtain additional education, training, consultation or EMDR to resolve their issues and make appropriate use of EMDR.
History Taking and Preparation for EMDR Therapy in Complex Cases

What we see

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

Would it be adequate to work with traumatic issues?

What happens inside

Let’s go to the trauma

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...

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
Multiple meanings from different dissociative parts

- Video

- We should never forget that the patient is not the ANP, but the entire system
- We need to keep in mind how our messages, questions and behaviors could be understood by other 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”

Internal communication

- A lot of communication in the inner world may contrast with difficulties in communication with the outside world.
- The patient has to dedicate a lot of energy to deal with internal conflict between parts
- This conflict can interfere with the gathering of the history
Bodily communication

- In dissociative clients, sometimes the body "talks" more clearly than words: sensations, stance, movement tendencies (action tendencies)

- Video

What we see

- My throat hurts, I don't know why
- And then what happened?

What happens inside

- It's a secret!!!!
- Keep quiet!!!
- We cannot trust him!!!
The body uses this language

- Gestures
- Sensations
- Actions
- Inmobility
- Subjective discomfort
- Physical stance
- Movements or micro-movements
- Distance
- Pain

Dual Attention

Dual attention is one of the active elements of EMDR therapy (Shapiro, 2001; Leeds, 2009).

1. The patient needs to process the traumatic memory, and feel the emotions of there and then, while being in the here and now (One foot on the past, one foot on the present).
2. With inadequate memory activation or defense activation, we encounter "Two feet in the present."
3. If there is a dissociative process, the patient is completely disconnected from traumatic emotions and the safety of the present (Both feet in the air).
4. With intense activation – above the window of tolerance – it as if he/she were merely reliving the past (Two feet in the past). In complex PTSD the client will oscillate between being disconnected and reliving the past. History taking can be overwhelming.
But dual attention is not always easy…

Video

Useful tools to gather information
Phase 1. Useful tools to gather relevant information

- Family Experiences in Childhood Scale (FECS; Gonzalez, Mosquera & Leeds, 2010)
- Self-care Patterns Scale (SCPS-R; Gonzalez, Mosquera, Leeds & Knipe, 2012)
  - Both can be downloaded at: http://www.intra-tp.com/escalas/

- DES-II (Bernstein & Putnam, 1986) and DES taxon (Waller & Ross, 1997)
- The Multidimensional Inventory of Dissociation (MID; Dell, 2006)
- The Psychotherapy Assessment Checklist (PAC) Forms (McCullough, 2001)

Family Childhood Experiences Scale (FCES)

Anabel Gonzalez & Dolores Mosquera (2009)
Anabel Gonzalez, Dolores Mosquera & Andrew Leeds (2010)
See reference list for download link.

- The scale is a 89-item self-applied tool
- These questions refer to the patient's primary caregivers from birth to age 15
- The patient must circle the percentage that best reflects her childhood experiences (0 to 100%)
- The items are grouped by attachment types (secure, avoidant, preoccupied, and/or disorganized)
- It is not intended as a new classification.
- Our goal is to use it for clinical purposes (to have an idea of possible attachment related issues in the patient)
Why do we use this scale?

- The concept of trauma keeps being interpreted as all-or-nothing.
- For many professionals, patients, and family members the word “trauma” is only equal to “sexual or physical abuse.”
- The concept of trauma is much broader and, at times, much more subtle.

The FCES

- Goes beyond the “top ten” traumatic memories.
- It helps us to explore a wide range of adverse life experiences.
- Allows a more detailed and comprehensive exploration and
- Brings out aspects that may otherwise remain unidentified even in a long interview.

Early “minor” traumas are also relevant

- In childhood, many perceived threats stem from the caretaker’s affective signals and lack of availability (more than from the actual level or physical danger or risk for survival).
- These “hidden traumas” are related to the caretaker’s inability to modulate affective dysregulation (Schuder & Lyons-Ruth, 2004).
Attachment types

- The 89 items are classified by attachment types (secure, avoiding, preoccupied and/or disorganized)

- Secure Attachment
  - Good enough parents

- Attachment issues: Lack of attunement, parents focused on family problems, depressed or dismissive or preoccupied attachment patterns in their own childhood

- Attachment trauma
  - Parents with a history of childhood trauma, with structural dissociation of the personality. Disorganized attachment

- Physical or emotional abuse and sexual abuse
  - Usually happens in the context of a disorganized attachment and the effects of both factors are exponential

Can this mother regulate her baby?

The FCES is not a humdrum tool. It must be used with caution

WHAT WE MUST EXPLORE FURTHER

- The experiences related to attachment do not come out in a spontaneous story.

WHAT IS NOT APPROPRIATE TO EXPLORE IN THE FIRST SESSIONS

- In patients with complex traumatization, “digging” into the past too soon may be intolerable or destabilizing.
Self-care Patterns Scale (SCPS-R)

Anabel Gonzalez & Dolores Mosquera (2009)
Anabel Gonzalez, Dolores Mosquera, Andrew Leeds & Jim Knipe, 2012

Physical care
- I don't sleep as much as I need to
- I eat poorly
- I don't exercise, even though I should
- I only go to the doctor or the dentist at the last minute
- I miss medical check-ups that I should attend
- If I feel bad, I let myself go

My needs and duties
- I can't ask for what I need
- Duties go before pleasure
- Other people's needs are always more important than mine
- I fulfill my duties and worry about what other people need
- I don't know when to stop, I do too much, I end up exhausted

Personal recognition
- I have trouble dealing with how I feel when I read others
- I take what I don't see in others
- I feel very good care of people but they don't value it or recognize everything that I do
- I am not able to see all the ways that very few people have always felt I am being treated unfairly and don't understand why
- I fulfill my duties and worry about what other people need
- I would never do this

Accepting compliments
- I am told positive things about myself
- If something is mentioned, I don't say anything or manipulate me or describe me
- I don't even recognize that people want to manipulate me or describe me
- Sarcasm or compliments that people want to manipulate me or describe me
- I say something to neutralize them
- I say something to neutralize them
- I mistrust compliments
- I think people want to manipulate me or deceive me
- Compliments make me feel uncomfortable

Protecting myself
- I have relationships with people that don't care for me or repress me
- I can't get an accurate value of other relationships
- I have been using or repress me for too long
- If I want to do something there is no encouragement for me or that I don't want to do
- I am unable to say no
- When people provoke my anger, even if it is obvious and uncomfortable
- When I have to stand up for my rights I shouldn't myself or people can make me stand very weakly

Asking for help, allowing myself to get help
- I don't take care of others
- I deal with my own problems
- When I feel bad, I am unable to ask for help or allow myself to get help
- I always take care of others, but no one takes care of me
- I frequently feel used
- There's always a balance between what I give and what I receive
- I don't get any care
- I don't want to do things for people that I really don't want to do
- I don't feel responsible
- I don't take care of others
- I don't take care of others
- I don't take care of others

Treating myself well
- I do things that I know are harmful for me
- Sometimes I behave in self-destructive ways
- I don't deserve to treat myself well
- Sometimes I drink or take drugs to feel better
- Sometimes I eat pills or feel uncomfortable
- When I'm not feeling well, I get angry or get upset for feeling like this
- When I'm not feeling well, I do things that make me feel even worse
- When I'm not feeling well, I do things that make me feel even worse

The relevance of Self-Care in Phases 1 and 2

- How can we get realistic information from a client who sees himself or herself through the abuser's eyes?
- How can we expect clients to be able to care for themselves when nobody taught them how to do this?
- How can we expect positive connections in cases where clients were treated like objects and not human beings?
- By exploring how they take care of themselves we can find out relevant information about where they learned to take care of themselves like that and
- Introduce adaptive information regarding adequate care

Copyright 2014
Andrew M. Leeds and Dolores Mosquera

EMDRIA Conference Denver 2014
Screening for Dissociative Disorders

The DES-II and DES Taxon
The Multidimensional Inventory of Dissociation (MID)
Psychotherapy Assessment Checklist (PAC)

Longitudinal study of high-risk sample from birth to age 19

- What predicts the development of adolescent dissociative symptoms (as measured on DES II)?
- Early childhood maltreatment did not predict adolescent dissociative symptoms.
- Maternal psychiatric symptoms—including anxiety, depressive, dissociative, and posttraumatic stress disorder symptoms did not predict adolescent dissociative symptoms.
- Instead, the strongest predictors of dissociation in young adulthood were lack of positive maternal affective involvement, maternal flatness of affect, and overall disrupted maternal communication.
  
  Dutra, Bianchi, et al. (2009, p. 87)
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

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.
The development of structural dissociation of the personality starts during early maternal-infant neglect and elaborates over chronic, 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).
Dissociative Phobias

Phobia of attachment

- In early stages the therapeutic relationship is the most challenging issue, because relationships in general are extremely difficult for people who grew up in severely traumatizing and neglecting environments.
- The **phobia of attachment** is manifested in many ways, but in therapy they will be mainly focused in the figure of the therapist.

Phobia of trauma-derived mental actions

- The patient may be phobic toward many necessary procedures in psychotherapy
- They may avoid thinking, feeling, noticing their bodies
- This is related to the **phobia of trauma-derived mental actions**, and it is usually more evident in early stages of therapy.
Attachment Phobias related to the perpetrator

As we get closer to the core trauma, more profound phobias appear.

All the aspects related with the perpetrator, and the difficulties in attachment with this figure are more complex to assimilate for the patient.

So at this point, since we are closer to very sensible material, to the most unbearable memories, some emotional parts may present new difficulties in the therapeutic relationship.

The external world

There are other phobias that are more related with the external world.

People who grew up in severely traumatizing and neglectful environments have extreme difficulties to deal with normal life, to have intimate relationships, to trust and believe in a possible healthy future and to take the risk of change.

These phobias help us to understand why some patients, for example, decompensate after improving.

The phobia of dissociative parts
Internal conflict

- When we approach the internal system of parts, some degree of conflict between these parts is often present.
- Some parts might want to work with trauma and therefore talk about their experiences, but others parts might not agree and scare other parts (hostile parts).
- Some parts might not know "they are parts," or the ANP can not accept other parts as "parts of the self.

Processing Phobias

- The procedure for processing phobias consists of focusing on the emotion and somatic sensation that a dissociative part (ANP or EP) is experiencing towards another part.
- We ask the part who is active in the consultation (frequently an ANP) to ask the other part (frequently an EP) if he wants relief from the dysfunctional emotion(s) he is feeling towards any other part.

Video
The tip of the finger strategy

The tip of the finger strategy (TFS)

- 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.

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.
The tip of the finger strategy

- We use an outside-to-inside perspective, starting from the periphery (e.g., the emotion) and slowly approaching the core aspects (e.g., the core memories).
- Metaphorically, this would be like peeling onion layers, little by little.

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.
The tip of the finger strategy

- The underlying mechanism of both this procedure and the standard protocol is the same.
- We are activating the innate processing system in the brain, which has been blocked by the traumatic experience.
- To untangle a simple knot and a tangled ball of wool, we use similar movements: the first step in untangling a ball of wool will be to start from a more accessible, peripheral, and small knot.

The target in the TFS

TFS-steps

1. Psychoeducative intervention
2. Explaining the procedure and EMDR
3. Explaining to the dissociative part how it can help him/her
4. Explaining to the adult self what he/she might gain from this procedure
5. Explaining the specific procedure
6. Selecting the target
7. Desensitization
8. Checking the effect for the part
9. Closure
10. Stabilization
11. Re-evaluation
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)

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.
History Taking and Preparation for EMDR Therapy in Complex Cases

Copyright 2014
Andrew M. Leeds and Dolores Mosquera

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.

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.

- 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 her/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.

Reinforcing integration

- As a part of the natural process of integration, an integrated self gradually develops and appears.
<table>
<thead>
<tr>
<th>Reported history</th>
<th>Consistent contingent supportive behaviors</th>
<th>Inconsistent contingent supportive behaviors mostly not supportive</th>
<th>Consistent absence of contingent supportive behaviors</th>
<th>Prolonged Periods of Frightened or Frightening behaviors</th>
<th>History suggestive of disorganized attachment with periods of physical or sexual abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment classification with that attachment figure</td>
<td>Suggestive of secure attachment</td>
<td>Suggestive of insecure preoccupied</td>
<td>Suggestive of insecure avoidant</td>
<td>Suggestive of disorganized</td>
<td>Suggestive of secondary or tertiary structural dissociation</td>
</tr>
<tr>
<td>Mother or other primary Childhood Maternal figure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father or other primary Childhood Maternal figure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant attachment figure from primary family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First adult romantic attachment figure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second adult romantic attachment figure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most recent adult romantic attachment figure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted with permission Figure 4.12 Leeds, 2009 p. 71
<table>
<thead>
<tr>
<th>Age at time.</th>
<th>Ongoing stressors and traumatic life experiences</th>
<th>Significant achievements, people who supported you, and experiences that helped you cope.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Item #</th>
<th>DES</th>
<th>DES-T</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>30</td>
<td>90</td>
</tr>
<tr>
<td>12</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>13</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>14</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>23</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>28</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</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

**DES-T item scores indicating pathological dissociation are noted in this column**

- Item #12 derealization: "feeling that other people, objects, and the world are... not real."
- Item #13 depersonalization: "feeling that their body does not belong to them."
- Item #22 alternate identity: "feel almost as if they were different people."

**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)."

---

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 F30, 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.
**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**
- Headaches
- Indigestion
- Diarrhea

Current Medications: **Yes**
- Pantopoc
- Zomig
- Allergy Medication

Axis IV Current Severe Stressors: **No**
- Financial
- Family

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

Other points to note:

**Axis I Diagnoses to check further:**

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

**Suicidal Items Checked:** Thoughts Plan Action

**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):**
- Avoidant
- Dependent
- Obsessive Compulsive
- Negativistic
- Depressive
- Self-Defeating (No longer in DSM-IV)

**Cluster A (Withdrawn):**
- Paranoid
- Schizoid
- Schizotypal

**Cluster B (Impulsive):**
- Histrionic
- Narcissistic
- Borderline
- Antisocial

**TOTAL ITEMS/CLUSTER C: 15**
**TOTAL/CLUSTER A: 10**

TOTAL ITEMS ANSWERED FOR ALL 3 CLUSTERS **53**

© 1998 Leigh McCullough, Ph.D., Psychotherapy Research Program at HMS

History Taking and Preparation for EMDR Therapy in Complex Cases page 52
Name: LA
Date: 16/08/2011 14:33

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

<table>
<thead>
<tr>
<th>Item #</th>
<th>DES</th>
<th>DES-T</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>23</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>28</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Average: 20  18.75

Probability of taxon given X or Pt_x 0.03749
### Multidimensional Inventory of Dissociation: The MID Report

Paul F. Dell, Ph.D.

**Validity Scales:**

<table>
<thead>
<tr>
<th>Defensiveness</th>
<th>1 (of 12)</th>
<th>Mean = 62.5 (of 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare Symptoms</td>
<td>4 (of 12)</td>
<td>Mean = 9.2 (of 100)</td>
</tr>
<tr>
<td>Emotional Suffering</td>
<td>4 (of 12)</td>
<td>Mean = 47.5 (of 100)</td>
</tr>
<tr>
<td>Attention Seeking</td>
<td>0 (of 7)</td>
<td>Mean = 8.6 (of 100)</td>
</tr>
<tr>
<td>Factitious Behavior</td>
<td>0 (of 7)</td>
<td>Mean = 0.0 (of 100)</td>
</tr>
<tr>
<td>Manipulativeness</td>
<td>4.4 (of 100)</td>
<td></td>
</tr>
<tr>
<td>Ten Count</td>
<td>0 (of 218)</td>
<td></td>
</tr>
<tr>
<td>BPD Index</td>
<td>8.8</td>
<td></td>
</tr>
</tbody>
</table>

**Pathological Dissociation:**

| MID Mean Score | 26.4 |
| Severe Dissociation | 92 (of 168) |
| Dissociative Symptoms | 19 (of 23) |
| I Have DID Scale | 15.0 |
| I Have Parts Scale | 41.7 |
| Amnesia Symptoms | 13 (of 31) |
| Mean Amnesia Score | 16.6 |

**Cognitive and Behavioral Psychopathology:**

| Cognitive Distraction | 1 (of 12) | Mean = 37.5 (of 100) |
| First-Rank Symptoms | 7 (of 8) | Mean = 38.6 (of 100) |
| Psychotic Screen | 2 (of 4) | Mean = 12.5 (of 100) |
| Critical Item Score | 3 (of 10) | Mean = 12.0 (of 100) |

**A. General Dissociative Symptoms:**

| Memory Problems | 38.3 | 160 |
| Depersonalization | 8.3 | 50 |
| Derealization | 16.7 | 175 |
| Flashbacks | 40.8 | 200 |
| Somatoform Symptoms | 8.3 | 100 |
| Trance | 23.3 | 120 |

**B. Partially-Dissociated Intrusions:**

| Child Voices | 30.0 | 100 |
| Voices/Internal Struggle | 64.4 | 300 |
| Persecutory Voices | 38.0 | 150 |
| Speech Insertion | 23.3 | 50 |
| Thought Insertion | 50.0 | 133 |
| Made/Intrusive Emotions | 34.3 | 100 |
| Made/Intrusive Impulses | 46.7 | 150 |
| Made/Intrusive Actions | 30.0 | 150 |
| Temporary Loss of Knowledge | 34.0 | 200 |
| Experiences of Self-Alteration | 19.2 | 150 |
| Puzzlement about Oneself | 37.5 | 200 |

**C. Fully-Dissociated Actions:**

| Time Loss | 32.5 | 150 |
| "Coming to" | 2.5 | 0 |
| Fugues | 2.0 | 0 |
| Being Told of Disremembered Actions | 22.5 | 100 |
| Finding Objects Among Possessions | 15.0 | 100 |
| Finding Evidence of One's Recent Actions | 10.0 | 100 |

**Pre-MID Diagnosis:**

PTSD Anxiety Disorder DES Score: 20 Taxon 18.75 of 4

**Clinician's comments about this person:**

0.0

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

This person's validity scores are within acceptable limits, 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.

**MID Diagnostic Impressions:**

Axis I:

- Posttraumatic Stress Disorder
- Dissociative Identity Disorder

Axis II: No Diagnosis
“History Taking and Preparation for EMDR Therapy in Complex Cases.”

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/](http://www.isst-d.org/)


Knipe, J. (2010, 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.


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.
