

Volume 2

# Frontiers in the Psychotherapy of Trauma & Dissociation

*The Official Clinical Journal of  
the International Society for the  
Study of Trauma and Dissociation*

**Eye Movement Desensitization  
and Reprocessing (EMDR) in  
Complex Trauma and  
Dissociation: Reflections on  
Safety, Efficacy and the Need  
for Adapting Procedures**

*Anabel González, MD, PhD*

# Frontiers in the Psychotherapy of Trauma & Dissociation

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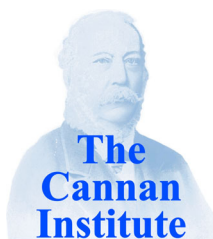
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## ARTICLE

# Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation: Reflections on Safety, Efficacy and the Need for Adapting Procedures

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*Currently there is a heated debate in the scientific community between supporters and detractors of Eye Movement Desensitization and Reprocessing (EMDR) therapy as an alternative for the treatment of dissociative disorders. In my opinion, this debate is being raised in terms that lead to some conceptual confusion. In this article, I will discuss the reasons for the existence of such contradictory perspectives and define proposals to solve what I see as a false dilemma. In order to guide the application of EMDR in complex trauma and dissociation, I discuss the following main topics: keeping in mind some kinds of emotion dysregulation, helping the patient to be part of a collaborative decision-making, and introducing bilateral stimulation in a progressive way.*

**KEYWORDS** EMDR, complex trauma, dissociation, emotion regulation

Eye Movement Desensitization and Reprocessing (EMDR) therapy (Shapiro, 1989, 2018) is a trauma-oriented treatment initially proposed for treating posttraumatic stress disorder (PTSD) that has been applied to a wide range of clinical problems (Valiente-Gómez et al., 2017). The theoretical model of EMDR proposes that adverse and traumatic experiences that

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cannot be integrated are at the basis of many pathologies. The processing of those traumatic memories is the main goal of EMDR therapy, and it is done through a procedure that includes repetitive eye movements or other forms of bilateral stimulation of the brain as one of its active elements (Lee & Crujipers, 2013). Nevertheless, beyond the work with traumatic memories, EMDR is a psychotherapeutic approach structured in eight phases. The first two phases are dedicated to evaluating, understanding, and reformulating the case from the perspective of trauma (phase 1) and to stabilizing and preparing the patient for the processing of traumatic memories (phase 2), which will take place in later phases (3 to 8). One of the first sources of confusion is equating EMDR only to phases 3–8, thereby omitting the first two phases. It is true that for patients with isolated traumatic events, a history of adequate early attachment, reasonably adequate emotional regulation skills, and no relevant dissociative symptoms, phases 1 and 2 can be brief and limited to a few sessions and simple procedures such as the installation of the safe place. However, in severely traumatized individuals, phases 1 and 2 of the treatment may last for years. Francine Shapiro notes in the third edition of the book *Eye Movement Desensitization and Reprocessing Therapy* (2018, p. 289), regarding patients with complex trauma, that “the preparation phase needs to be carefully implemented, potentially over a longer period of time than usual, to ensure stability during processing and between sessions.” With respect to the dissociative disorders, Shapiro states, “No clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population. . . The clinician should also have a clear understanding regarding strategies for assisting the client in managing intense affect during EMDR processing, the client’s dissociated system, and the client’s defensiveness and resistance. The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously” (2018, pp. 342–343).

Even though EMDR phases related to trauma processing have been thoroughly defined and standardized, the preparation phase has not been described and developed beyond some very basic procedures. A comprehensive definition of the whole process has not been established in the EMDR community, leaving it up to the wisdom and intuition of each individual therapist who must then decide which additional approaches (techniques, strategies and elements of other therapies) should be used, when they should be implemented and how they should be adapted. This perspective is not completely convincing because working with EMDR has its specificities and may require a more explicit and thoughtful procedure. Several authors have published different proposals integrating approaches and techniques (Forgash & Copeley, 2008; Gomez, 2013; Gonzalez & Mosquera, 2012; Knipe, 2014; Lichtenstein & Brager, 2017; Paulsen, 2009, 2018; Tounsi, et al., 2017; Van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon,

2014a, 2014b), and many others have presented integrative models for case conceptualization in scientific conferences and workshops. However, we do not have a consensus model from EMDR therapy for these cases. EMDR therapists are occasionally lost after the basic EMDR training modules, especially in countries where advanced training in complex trauma and dissociation is not structured.

Although Shapiro's (2018) proposals stress the importance of working with the dissociative structure, some of her statements may be somewhat confusing. For example, she (Shapiro, 2018, p. 500) says that it is important "to assess patient suitability for EMDR treatment by ascertaining whether the patient has (1) good affect tolerance; (2) a stable life environment; (3) willingness to undergo temporary discomfort for long-term relief; (4) good ego strength; (5) adequate social support and other resources; and (6) a history of treatment compliance." Shapiro also says that the presence of the following signs tend to *contraindicate the use of EMDR*: (1) ongoing self-mutilation; (2) active suicidal or homicidal intent; (3) uncontrolled flashbacks; (4) rapid switching; (5) extreme age or physical frailty; (6) terminal illness; (7) need for concurrent adjustment of medication; (8) ongoing abusive relationships; (9) alter personalities that are strongly opposed to abreaction; (10) extreme character pathology, especially a severe narcissistic, sociopathic, or borderline disorder; and (11) serious dual diagnosis such as schizophrenia or active substance abuse.

This paragraph raises two questions. The first one is that "assess[ing] patient suitability for EMDR treatment" seems to imply that all the preparation work of improving affect and distress tolerance, therapeutic compliance, and self-strength is not an integral part of the EMDR therapy preparation phase; so, EMDR is considered to be the equivalent of the processing of traumatic memories, defined in phases 3 to 8, as if phases 1 (history taking) and 2 (preparation and stabilization) were removed from the EMDR protocol of treatment. As explained above, EMDR needs to define a global therapeutic process, by stating (1) how to get a comprehensive case conceptualization in phase 1, including the assessment of severe traumatization and dissociation as one of the essential elements, and (2) which components have to be incorporated in the preparation phase 2, when it may be more complex and prolonged in severely traumatized patients. Otherwise, if we equate "to do EMDR" with "processing traumatic memories," the question of "when to use EMDR" in dissociative patients would be equated to "when to proceed with trauma work." In my opinion, approaching cases from the EMDR perspective is not reduced to the processing of memories, even though this is a main goal of the treatment. Although therapists work with EMDR from an integrative perspective, incorporating input from other models, it is essential to define a coherent model to guide the decision-making process in the field of severe traumatization. Without this comprehensive model, working with these patients can end up being a patchwork of poorly integrated techniques.

The second issue concerning the recommended cautions and possible contraindications for working with EMDR in complex trauma and dissociation is how to decide *when* a patient is ready for EMDR therapy. Actually, if I tried to apply those guidelines to most of the patients that come to my Trauma and Dissociation Program, few would meet the prerequisites to do EMDR, but in fact, many of them benefit from this kind of work. It is good to be cautious with highly vulnerable patients, but excessive caution can make us face a paradox: “first cure the patient, and only then, do EMDR.” A great deal of damage can be done by approaching traumatic memories without taking into account the underlying dissociation, but we can also cause harm by omission. If we have a powerful therapeutic tool, should the most severely disturbed patients be deprived of it? In my opinion, it makes more sense to develop methods and procedures to apply EMDR in these cases in the safest possible way.

Recently another area of controversy has appeared, related to the need for adaptations for working with trauma in severe traumatization and dissociative disorders. There are many polarized views on the need for a preparation phase in these cases; some of these opposing or extreme positions are: clinicians vs. researchers, EMDR therapists vs. non-EMDR therapists, and PTSD-oriented vs. dissociation-oriented trauma approaches. The visions that are arising in the scientific community are so conflicting that they seem to describe completely different realities. On one hand, clinicians working with approaches that are different from EMDR, but also many EMDR therapists are reluctant to implement EMDR in dissociative cases except when patients are very stable and functional. These professionals describe severe and frequent problems when applying EMDR in complex trauma populations and dissociative disorders, leading to an *underuse of EMDR* in these cases. On the other hand, authors such as De Jongh et al. (2016) argue that the dissociative symptomatology does not seem to influence the level of response to EMDR therapy in some studies, and that patients with complex trauma do not need any kind of stabilization, with the sole exception of severe dissociative identity disorder (DID) cases. Numerous EMDR therapists do not evaluate the presence of dissociation. In many countries, the dissociative symptomatology is not routinely taken into consideration in differential diagnosis processes, and similarly, the professionals who work with EMDR in those locations would not contemplate it. We may think that this second group of professionals *overuses EMDR trauma work*, and some even defend the idea that there is no problem in doing so. The patients seen by these different groups of professionals cannot be so different as to explain such opposite perspectives.

It is true that science evolves from the conflict among different perspectives, but it is also true that many heated debates in social and psychological sciences end with a new integrative approach to the problem (everybody

wins), and the sentence “more research is needed” is usually the only possible conclusion. We need a new metaphor to raise the problem, and in this line, the old Indian fable of the wise blind men and the elephant could help us understand this dilemma. All the blind men touched the elephant trying to identify what it was, and depending on the part of the elephant that they touched, they drew conclusions, and argued with one another about whose perception was right. From this metaphor, my hypothesis is that all perspectives derive from one or another part of the reality that we have to take into account, and it is not productive to consider any one of them as unimportant. The following cases illustrate the various aspects of this “elephant.” I will then show some clinical vignettes to develop this in more detail. Patients’ identifying details have been changed to protect their anonymity.

### Perspective 1: EMDR therapy can be damaging in patients with severe trauma and dissociation

Joan has a clear PTSD diagnosis. She witnessed an assault, which resulted in death, and survived because she escaped, and the murderer was unable to catch her. After that, she could not stop talking about the event; she dreamed about it, had flashbacks, and drank alcohol in a pathological way, becoming angry toward policemen and doctors for not having been protective in that situation. She described “a good childhood,” without any major problems, and an excellent relationship with her beloved parents. With my very recent basic training in EMDR and without much knowledge of dissociation, her PTSD symptoms seemed to me to be a clear indication for EMDR trauma work. During the therapy session, the memory of the assault was not entirely processed, and the level of disturbance decreased only a little bit. The patient appeared stable when she left my consultation, but during the next visit, she told me that the morning after our previous session she had woken up inside a garbage container, with no knowledge of how she had gotten there. After this incident I evaluated dissociation in more depth, and during the exploration of dissociative symptoms, the patient revealed a history of incest at the hands of her alcoholic father. In the next session, the patient denied these facts. It was clear that the patient had a DID that I had not identified before. If this patient had not come back to my consultation, or if I had not considered dissociation as a possible explanation for what happened, I would never have learned a relevant lesson from my patient: working with EMDR on traumatic memories in cases with underlying dissociative symptoms can lead to serious side effects.

This was not the only patient that I treated that has had these kinds of problems. A woman who also had a DID diagnosis told me a story of sexual abuse in childhood. When I asked her if she wanted to work on her traumatic memories she said, “Yes, of course.” She presented a marked



emotional disconnection, so her awareness of what was good or harmful for her was underdeveloped. Shortly after this, in the same session the patient told me, "When I talk about these things, I always think about how to commit suicide." Although she did not explicitly refuse to work on those memories, her comment about suicide ideation was, in my opinion, an indicator of extreme caution.

In my career, I have gone through several stages with respect to the use of EMDR in this profile of patients. I started trying to implement it in the first patient, with the result that I have already mentioned, after which I went through another stage in which I avoided using bilateral stimulation for a long time, utilizing other tools to work with the patient in the stabilization phase, sometimes for years. Finally, because of the length and lack of progress in treatment for many patients, I resumed EMDR use tentatively. In one of those attempts, I treated a patient with severe dissociative symptoms, who recounted several previous traumatic events. The patient was very interested in addressing these memories and came to my consultation with the idea of doing EMDR with them. Given her insistence, we tried to work on one of these memories, and during the processing, a hostile part emerged and the patient (from her apparently normal part) became very afraid. After this experience, the patient canceled all the subsequent appointments, told me that the session had been too hard, and never came back to therapy with me.

To say that a preparation phase is not necessary is risky because cases like those that I have described are not infrequent. Regardless of the number of times in which these situations arise, it is important to prevent re-traumatization and treatment drop out. Ignoring this problem would be tantamount to removing the side-effects information from a drug leaflet, arguing that they only affect up to 5% of cases.

## Perspective 2: EMDR can help the treatment of patients with severe dissociation from the earliest stages of therapy

Many patients tolerate procedures, including bilateral stimulation, from the early stages of the therapeutic process well, even when they present dissociative symptoms. After many years working without including bilateral stimulation, I started to incorporate it in cases that, despite procedures for stabilization, did not progress or in which improvement was extraordinarily slow. With bilateral stimulation, many of these patients experienced more marked improvements than they previously presented. In the majority of these cases, we worked on more peripheral memories or present situations, but in some patients, we chose childhood and complex events. Targets were intrusive memories or traumatic situations that were very connected to the patients' current difficulties, and in general, they led to an improvement in

the status of those patients. In contrast to the previously described examples, these other patients benefited from using EMDR early in therapy. Waiting would have been harmful for them.

This encouraged me to look for ways to apply EMDR earlier, still in a safe way. One of the cases that taught me something important was a man with significant aggressive behaviors, and who had previously been in jail as a result of some of them. His aggressive behaviors were generated by a hostile part, which manifested itself through a voice with which we had established communication through the front part of the patient. This part agreed to stop the violent behavior to avoid returning to prison; however, the behavior recurred. The hostile part explained that the pressure he was feeling inside was so huge, that even though he did not want to explode, he could not avoid this outcome. Things could not have gotten worse, so I suggested to this part that we work on his internal tension using EMDR, in order to give him some relief, and the part agreed. Then I used bilateral stimulation in a more limited way, focusing on “the bit of the feeling that the part needed to relieve,” doing short sets, and exploring how many sets were necessary with the part. (This intervention is inspired by the fractioned abreaction technique from Kluft, 2013). After three sets, the part said that his internal tension had decreased, and he could move from rage to the underlying pain. The aggressive behaviors ceased, and we were able to continue therapy.

After this experience, I continued using bilateral stimulation within the preparatory work, to process dissociative phobias, for example one part's phobia of another part, or to strengthen the connection with adaptive elements. All of these procedures are described in the book *EMDR and Dissociation: The Progressive Approach*, co-authored with Dolores Mosquera in collaboration with different EMDR therapists who were working on modified protocols for applying EMDR in cases of complex trauma and dissociation (Gonzalez & Mosquera, 2012). These cases taught me a second relevant lesson: that not using EMDR procedures from the beginning can be dangerous in some patients, but also that there are many different ways of working with EMDR and using bilateral stimulation.

### Perspective 3: Dissociation does not predict a worse response with standard EMDR therapy

De Jongh et al. (2016) stated that: (a) the research supporting the need for phase-based treatment for individuals with complex PTSD (cPTSD) is methodologically limited; (b) there is no empirical support showing that front-line trauma-focused treatments have unacceptable risks or that adults with cPTSD do not respond to them; and (c) there is no empirical support

showing that adults with cPTSD benefit significantly more from trauma-focused treatments when preceded by a stabilization phase. The results presented by Ad de Jongh, despite being partially questionable based on the experience with the patients described above, offer some evidence that cannot be ignored. The level of dissociative symptomatology does not seem to be related to the level of response and potential problems with trauma-oriented treatments in some studies (Hagenaars, Van Minnen, & Hoogduin, 2010; Van Minnen, Harned, Zoellner, & Mills, 2012), or it has a minor negative influence on response (Wolf, Lunney, & Schnurr, 2015). In a systematic review, Van Minnen, Zoellner, Harned, and Mills (2015) did not encounter evidence of worse outcomes using prolonged exposure in patients with more dissociative symptoms. These data are not specifically related to EMDR therapy, and they were not confirmed in other research (Bae, Kim, & Park, 2015). Furthermore, these results could have to do with the type of dissociation being measured, usually dissociative symptoms based on the DES, which includes both normative and pathological dissociation, and might not be directly applicable to severe dissociative disorders. However, they could also reflect that the level of dissociative symptomatology is not the only factor to consider when working with EMDR for dissociative patients.

Actually, patients who meet criteria for DID or incomplete forms of it, or subjects with conversion symptoms, present very different responses to EMDR procedures. In some cases, bilateral stimulation produces a consistently positive effect with a direct response of relaxation and a decrease in the level of disturbance. In these patients, we can even address traumatic memories, with good tolerance to the procedure and further clinical improvement. In other cases with similar dissociative symptomatology, the situation can be diametrically different. Regardless of the target to which the bilateral stimulation is applied, those patients are concerned about experiencing discomfort, connect with sensations that are unmanageable, and cannot use these procedures until very late in therapy, sometimes even after several years. By doing a clinical analysis of the differences among them, it appears that patients with greater difficulties tend to be people with a strong tendency toward emotional control, significant disconnection from their emotions, or who are highly ruminative or avoidant. On the other hand, patients who work well with bilateral stimulation are not as phobic to their internal world, their affects or their memories. They connect better with their emotions, and their difficulties in emotion regulation are more related to infra-regulation (i.e., the patient does not use internal regulatory strategies), being frequently overwhelmed by their intense feelings.

A hypothesis that might explain these differences is that they are the emotion regulation styles, and perhaps some specific regulatory strategies, which may actually disrupt the access to the memories and their efficient

processing. Although emotional regulation is often dysfunctional in dissociative disorders, it is also present across the posttraumatic spectrum (Del Río-Casanova, González, Páramo, Van Dijke, & Brenlla, 2016) so problems with EMDR would not be limited both by dissociation in itself, but they would be mediated by the emotional dysregulation associated with it (González, Del Río-Casanova, & Justo-Alonso, 2017).

A few more cases support this hypothesis. A few years ago, there was a catastrophic train crash in my area in which many passengers were killed or badly injured. Among the survivors there were high rates of PTSD, and many of them were treated with EMDR. Two of my patients, neither of whom had significant dissociative symptoms, had an unfavorable outcome. One, a man who had been functional prior to the accident but presented with some alexithymic features, went to therapy because he had developed some phobic symptoms. When addressing the memory of the accident with EMDR, he suddenly connected with very vivid and intense perceptions of that memory which surprised and overwhelmed him. After this experience, he did not want to continue with the therapy. The other case, also a patient with a normal premorbid functioning, presented an enormously avoidant reaction with respect to the memory of the accident, and he became overwhelmed even with the possibility of talking about the issue. In spite of trying to work on his avoidance by using different methods, it was not possible to process the memory of the accident effectively.

Conversely, a patient with a severe DID successfully processed an early memory of her mother's emotional abuse, and the work on that memory with EMDR led to a very positive change in her coping with situations with her mother. Another patient with a main diagnosis of borderline personality disorder was able to process many nuclear traumatic memories, despite having clear dissociative symptoms, including a hostile intrapsychic voice that sometimes interfered in her conduct. Another patient with a conversion disorder only began to improve when interventions involving bilateral stimulation were added to her treatment. In this case, these procedures introduced bilateral stimulation progressively, and the initial targets were not traumatic memories, but dissociative phobias, co-consciousness exercises, self-care procedures, and so on. In these and many other patients with relevant dissociative symptoms, interventions involving bilateral stimulation had a mostly positive and regulatory effect, while some of them had not tolerated other interventions which were supposedly kinder and friendlier, such as mindfulness techniques or somatic therapy.

If, hypothetically, we included all the previous patients in a study on PTSD treatment with EMDR and calculated the mean scores, we would be able to conclude that dissociation does not predict a negative but instead, a positive response to EMDR therapy.

## A CLINICAL CASE

The progressive application of EMDR is a dynamic procedure to introduce all the necessary elements to prepare for further memory processing. I call it a dynamic system because each procedure is implemented according to the specific characteristics of each patient. When working with EMDR in simple trauma, we directly search for the memories that are connected to present symptoms, and access and process them following an eight-phase protocol. In complex trauma and dissociation, we may find many difficulties in memory access and in maintaining dual attention, as well as blockages during processing; we may even find that establishing a therapeutic relationship is challenging. The progressive approach is one proposal of adaptation of basic procedures to these patients' characteristics, but also to each individual person's structure. I will describe a concrete example to illustrate how to guide the therapeutic decision-making process in this approach.

Sarah is a 32-year-old woman with a conversion disorder, with involuntary movements as the predominant symptom and additionally, episodes of blockage and paralysis, fainting, and psychosomatic symptoms (asthma and recurrent pneumonia). In the initial evaluation, psychoform dissociation seemed to be absent. These symptoms started just after a traffic accident two years before the beginning of therapy. In the history taken by her initial therapist, she presented good premorbid functioning, and there was an apparent absence of traumatic events prior to the accident. Sarah was efficient and effective at work, and always performed well. She had played competitive sports during her childhood and adolescence. She described her family of origin as very positive and had what she defined as a supportive partner.

The EMDR therapist who was treating Sarah decided to start processing the car accident because it was a traumatic event, labeled in EMDR as a "T trauma" (which meets DSM-5 criteria for PTSD) and was directly related to the onset of symptoms. The patient agreed to address this issue, and she had no problem talking about the accident and describing its consequences. However, in repeated attempts, simply starting with the first eye movement, conversion symptoms became intensely activated, and EMDR reprocessing could not continue. The therapist decided to stop doing EMDR and treated the patient with sensorimotor psychotherapy, which the patient tolerated better. However, after a year of this kind of work, there was no progress, and my colleague referred the patient to me to explore again the possibility of doing EMDR therapy.

The first day I saw Sarah we simply talked about what had happened to her. Her previous therapist had told me that she had described her family of origin with many elements of minimization and idealization. The therapist also considered that due to the type of symptoms that she had and the way in which she talked about her childhood, it was likely that there

were issues that she did not remember. This made a lot of sense to me, so I tried to be very cautious when exploring these stages. Despite this, just after I mentioned the word “childhood” in a very general way, the patient automatically folded over herself, and she could not recover a normal posture for 45 minutes, despite my suggesting various interventions. One of these was a suggestion for self-care, in which I asked her to put her hand over the place in her body where she felt the most disturbing sensation, which would symbolically help her take care of her feelings. This intervention, which is usually regulatory in many patients, actually increased the symptoms in Sarah’s case. She finally recovered her normal posture, and we made an appointment for another session.

On the next visit, I started by establishing communication with the internal system. The reaction of the previous session was, in my opinion, generated by a dissociative part, but the patient did not hear voices or experience intrusive thoughts. My hypothesis about that situation was that it was an attempt to prevent me from going into areas that the patient felt were dangerous, but she was unaware of this. Therefore, I asked her to “look inside” and “send a message to her inside.” I asked her to close her eyes and notice any internal reaction. After doing it, I told her to let “her inside” listen, and that we would not do anything she was not prepared for. This phrase generated a visible and dramatic decrease in body tension. Sarah was very surprised by her body’s reaction, and this gave us an indirect communication route with the internal system.

From this point, I always asked “the inside” or “the body” through the adult part of the patient whenever I suggested an exercise. Many of these suggestions involved bilateral stimulation from the beginning. When “the inside” or “the body” agreed to perform a procedure, bilateral stimulation resulted in consistently positive effects. This is the first point of reflection: bilateral stimulation, far from worsening the symptoms, led to faster and much more positive evolution than when working without it. In a dissociative system, it is important to find a system for internal communication, in order to make collaborative decisions. Without the system’s agreement, the same intervention that could be useful (with or without bilateral stimulation), may become ineffective or even damaging.

We could not target the car accident first, given that my colleague had tried to work on it several times with unfavorable results. Although this memory seemed to be very relevant, processing it at that stage of the therapy probably would have been a complex task, so I decided to start with the more accessible issues. For working with complex trauma in EMDR therapy, we need to keep in mind what memories are more connected to the present problems, and we know that the best order is from the oldest to the more recent events. Nevertheless, this chronological order of memory targeting has to be modified depending on two more factors: tolerability and accessibility. Some memories are very significant, but because there is a very

intense phobia of these experiences, the level of emotional disconnection is very significant, or there is a total or partial amnesia; we may not have this access. In Sarah's case, the memory of the accident was not accessible, and it was likely that something had happened in her childhood that she could not even remember or identify as traumatic, so we could not work on those memories. We needed more tolerable and accessible targets to start with.

But which targets could we process? What would be the friendliest way to introduce bilateral stimulation in this case? The problem in real practice is that an intervention can be useful and well-tolerated by one patient, and very complicated or disturbing for another. More than general guidelines, which do not work the same in every case, I proposed the use of short bilateral stimulation tests in order to introduce a third element to plan the therapy: the very specific and particular effect of bilateral stimulation in each individual.

In general, it makes sense to start from resource installation (Leeds, 2001). Even if this intervention does not work, the patient will not associate bilateral stimulation with going into painful things; in this way, a phobic reaction to doing EMDR will be prevented. It is important in complex trauma to help the patient to find truly functional resources because they may select things as positive that are, in fact, idealized moments or figures, magic solutions to problems, or different dysfunctional elements. In Sarah's case, we started installing pleasurable sensations associated with everyday experiences, but always asking "the inside" or "the body" if each sensation was also positive for it, and if it agreed with doing the procedure. I installed these resources on co-consciousness, with the patient (from the apparently normal part) and "the inside" (the part or emotional parts) experiencing the positive sensation at the same time.

Working with self-care is one of the interventions included in the progressive approach that is oriented to prepare the patient for further trauma work. Self-care has to do with three aspects: cognitive (sentences that patients say to themselves before their emotions, feelings, and actions), sensorial (different exercises to take care of the body sensations), and symbolic (looking at, understanding and caring for the child inside or child parts). Although the last two interventions are very important and useful in many patients, I thought that Sarah might have problems with them. The technique of taking care of the sensation was one that I tried in our first meeting, and at that time it made things worse. Somehow the idea of self-care seemed to be more of a trigger than a help for the patient to learn self-regulation. In the same first session I could see how problematic just saying the word "children" was (which had made her fold over), and her description of her own childhood seemed enormously minimizing or defensive, so working with the inner child would have been very overwhelming for this patient at that moment. Therefore, I worked more with cognitive self-care—"What do I say to myself?" in different situations—and

cognitive self-regulation of emotions. Metaphorically, the apparently normal part represents the cognitive regulation, and the emotional part—"the inside" in Sarah's case—represents the emotions that the patient has to regulate. We explained that at some point in her life she had disconnected from her emotions and learned to avoid and suppress them, and she now had to re-learn to feel and regulate her emotions properly. Whenever she was able to pay attention, listen to her inside, understand and say things that helped her feelings to regulate, we reinforced these advances with bilateral stimulation.

Another specific procedure of EMDR that I used in Sarah's case was the processing of dissociative phobias. In a session, trying to make the functioning of the system of dissociative parts clearer, I drew a circle on a piece of paper, and I asked Sarah to draw what she felt was in it. Initially she drew a cross on the circle, as if she was crossing it off, but with bilateral stimulation she continued to draw and something like a face appeared. I was satisfied with the result; the emotional part was starting to come out. However, in the next session things went back to the beginning, so I used the same technique with similar results. In the third session, only seeing the circle began to cause Sarah discomfort. My hypothesis here was that there was an intense phobia to internal processes and to the dissociative part(s). For some unknown reason, the internal system needed to stay hidden. Trying to force her to face or show it would have been a mistake. Then I suggested that Sarah check with "the inside" to see if it agreed to process the rejection by looking at the circle, and I added bilateral stimulation on this target. Her discomfort noticeably decreased, and Sarah became more aware of her avoidant tendency. Not forcing was extremely important in this case, so I never tried again to directly explore the internal system. We had good communication with the emotional part(s), and the patient was making progress, so going beyond her limits did not make sense.

In some sessions, I used another intervention, which in the Progressive Approach we have called "the tip of the finger strategy." With daily life issues the patient (from her apparently normal part) asked "the inside" or "the body (the emotional part) if it needed to relieve any disturbance related to a present situation. When the internal part(s) expressed agreement, I used bilateral stimulation to process the part of the sensation that the emotional part wanted to relieve. In other patients, this intervention is very delicate because even when the therapist titrates it carefully, they are, in a way, approaching traumatic contents. Nevertheless, Sarah tolerated it very well, and this intervention helped her very much improve her daily functioning.

I introduced sensory self-care little by little. I asked Sarah to locate her feelings in her body and put her hand on that area, making a gesture of care. The patient imagined her feelings as if they were for a puppy—an animal that evoked tenderness in her. Then I asked her to imagine herself taking care of the puppy, and giving it all the time that it needed. At the



beginning, this apparently kind technique was difficult for her, but after several attempts, she started to tolerate the intervention better. In some sessions the tendency to fold onto herself appeared. I suggested that she follow her body's tendency until its very end, and then, by using bilateral stimulation, we installed the feeling of protection that she felt when she was completely folded over. With bilateral stimulation and by encouraging her not to force anything, she spontaneously unfolded. By doing so, she learned to listen, respect, and understand her rhythm.

At this point, Sarah became aware that her partner was treating her badly. Until then she had considered his abusive ways and insults to be justified, but her improvement made her value more and protect herself better. She left that relationship, and although she was happy with the decision, we had to work for three months on situations related to her adaptation to this change and the grief for the good aspects of the relationship. During this period, we worked with EMDR on present targets, with good results.

Sarah's mood was improving so she therefore was able to stop taking all her medication. Although she had lost her job due to the accident, she had started an independent business that was growing and providing her a good income. Six months later, she began a new relationship that was much healthier and more positive for her. Conversion symptoms did not disappear, but they did decrease a little. Then, we commented on the possibility of working on the memory of the accident, and both the patient and "the inside" agreed. I accessed that memory, according to the standard EMDR protocol, and we were able to adequately process it, simply by adding some interweaves based on previous interventions of self-regulation and self-care.

A year and a half of therapy had passed. I had seen her once a month, interspersed with shorter sessions of 10 minutes, every one or two weeks, due to time limitations at the hospital in which I work. In almost every session we did an intervention including bilateral stimulation. The patient viewed the changes in this past year as much more relevant and faster than the changes prior to EMDR therapy. She was able to perceive a very powerful relief effect when applying bilateral stimulation. Then I decided to evaluate her early history with the Early Adverse Experiences scale in order to understand what happened before the accident. The patient said that she was willing to fill out the questionnaire, but it was partially a mistake on my side. The "inside" did not feel respected and blamed me for reneging on the promise I made at the beginning of the therapy, i.e., that I would not work on issues that she was not prepared for. I apologized for my mistake, but she recognized that she had realized that her childhood was not as happy as she thought. We worked on the discomfort that the scale had caused, using the EMDR procedure for processing dissociative phobias, and dedicated a few sessions to repairing the relationship breakdown that had occurred. These sessions served to speak of her fear of looking at this

period, and to identify some relevant experiences from the scale. I did a lot of psychoeducational work on attachment and emotion regulation learning, as well as suggesting several readings to her, to expand her understanding of her history. Sarah read Shapiro's book *Getting Past Your Past* (2013), and *It's Not Me* (González, 2018), a text that I wrote just for patients with complex trauma and dissociation. After reading the books, she came to the session saying, "I already know what the origin of everything is, and 'the inside' really wants to work on it with EMDR."

In this session, we targeted a core memory. When she was very little, an uncle visited her home frequently, and she was frightened of him because he was a portly man with a deep voice. He never treated her badly, but her mother forced her to see and kiss him every time he came. She always escaped from this situation and hid under a table. The image was of Sarah being under the table, pulling on the tablecloth in a very scared way, while her mother was tugging on her and trying to get her out from under the table. Only after 10 minutes of processing, she became aware of the worst part of that experience: "Wow, my mother did not protect me. She was on his side. She did not care how afraid I was... I have never thought that this would be so painful!" Sarah cried for the first time in therapy. In this session, we were also able to understand the connection of this childhood memory with the car accident and with the triggering of the conversion symptoms: "At that time I thought that I had to protect myself... During the accident, the danger was coming, and I could not protect myself, there was no way to hide under the table... This is why I often fold over on myself, I didn't understand until now why I did that."

We worked on this memory using the EMDR standard protocol, adding self-regulation and self-care interweaves taken from the previous preparatory work. Interestingly, conversion symptoms fell by 80%. Gradually she gained access to aspects of her history that had remained hidden, and she became aware of memories linked to many difficult attachment experiences with her parents. Sarah's mother was an insensitive and demanding woman who believed that Sarah was self-reliant and strong, even when she was very little. Sarah's father did not tolerate emotions such as sadness or anger, and often violently repressed them in his children. The sports training in which she participated from the age of eight also contributed to worsening her emotional disconnection and her tendency toward extreme self-reliance. Her emotions became more and more hidden, even to herself. As we processed these experiences, improvements in her day-to-day functioning, symptoms and relationships increased. The processing of these memories with the standard EMDR protocol became more fluid, and resources for self-care and self-regulation spontaneously appeared. At this time, I introduced the work with the inner child, and she was able to see her emotional child part more clearly, and be aware of another aspect representing

her father's introjection. Exploring the internal system and self-care procedures, which can be one of the initial stabilization interventions in many patients, was possible with Sarah only in later stages of the therapy, after we had accessed and processed many core traumatic events.

Before we processed Sarah's core traumatic memories, during the preparation phase the following EMDR interventions (all of which included the use of bilateral stimulation) were employed: the installation of resources in co-consciousness, the processing of dissociative phobias, the tip of the finger strategy, and the work with cognitive, sensory, and symbolic self-care. The understanding of Sarah's dissociative structure, and the respectful, progressive introduction of these procedures (which were adapted to her specific characteristics) allowed us to effectively approach traumatic memories later on. The introduction of EMDR represented a very positive turning point for the patient and greatly accelerated the therapeutic progress. It is important to note that initially EMDR therapy had been considered counterproductive by an experienced EMDR therapist. Another point of reflection is that the general guidelines that establish which intervention has to come first may not be applicable to every patient.

Sarah's case shows us that the real questions are *not* whether or not to do EMDR, whether or not this therapy is appropriate for dissociative patients, or even whether or not a preparation phase is necessary. The real question to answer is this: How can we apply EMDR to each individual patient at the appropriate moment in their therapeutic process in a way that is as effective and safe as possible?

## CONCLUSIONS AND PROPOSALS

The problem in science, especially when we are trying to understand how the human mind works, is that all of us are blind, and no one can see the whole picture. It is important not to forget that our observation methods only allow scientists to access one piece of the puzzle. In addition, our way of understanding cases frequently does not follow a truly scientific perspective. We may base our opinions on isolated cases that are favorable to our beliefs and our perspectives.

The question, "Which perspective is the right one?" should become, "How can each perspective help me make decisions?" A good therapeutic process does not come from rigid guidelines but from the integration of theoretical models, research data, and our knowledge of the unique person that is in front of us. Shapiro (2018, p. 289) explains, "It should be kept in mind that the amount of time needed for preparation will vary from one client to another." The need for an individual approach toward each client should be the main conclusion of the different clinical vignettes presented in this article. It is true that we need guidelines and references to approach

our cases; however, it is the field of dissociation where we probably will find greater individual variability. Although severely traumatized patients share many common elements, their personality structures, their styles of emotional regulation, the difficulties that they present at a relational level, or even the traumatic contexts from which their symptoms derive, can be enormously different. So, how can we orient the therapeutic process?

As I have argued above, not harming patients that are already seriously damaged should be the golden rule of psychotherapy, but an overly cautious approach can delay interventions that could be very beneficial when used prematurely. Having general recommendations may give us security, but when we use them as immutable rules, they lead to a rigid perspective, which is counterproductive to adapting to the various clinical situations that we need to deal with in each case. The problem disappears when we understand that this debate is just a dilemma, that is, a false choice between extreme opposites. So, we need a third way. Some patients would benefit from EMDR interventions including bilateral stimulation from the very beginning of the therapy; others need to be prepared for a longer time in order to increase connection, identify the dissociative structure, have some emotion regulation and stability, improve therapy commitment and the therapeutic relationship, and work on many other aspects. How can we identify when a specific patient is in one group or the other?

My proposal is to include the patient in the decision-making process. On one hand, the person in therapy needs to take responsibility for the therapeutic process (Herman, 2015). The therapist has to help the patient reflect on each situation, and not let their phobic tendencies or lack of awareness overly influence their decisions. Even if the process is slower than necessary, the patient will feel that their needs and ideas are profoundly respected, and this can be more relevant than the decrease in PTSD symptoms. On the other hand, we need a way to check each individual's idiosyncratic response to bilateral stimulation, which is not clearly predicted by any specific factor. The only way we can do this at the moment is through empirical testing. If these tests are time-limited, and we use only small amounts of bilateral stimulation, a possible side effect would be also limited.

All these reflections can be made concrete in a therapeutic procedure for EMDR in complex trauma and dissociation that is not structured in phases, but in a continuous progression. Bilateral stimulation would be included in small amounts at the beginning of the treatment, and it would increase depending on the results of these initial tests, to finally be able to access and process traumatic memories with the standard EMDR procedure. The moment for doing these small tests would depend on the presence of some types of severe emotion dysregulation. Examples are when there is a strong tendency toward emotional suppression (alexithymia, disconnection from or control of emotions), emotional avoidance and pervasive

rumination, because in these cases performing EMDR procedures is difficult, and the patient is not aware of many issues that are relevant for cooperative decision-making. After this period, or in patients with other types of emotion dysregulation, we can progressively introduce EMDR procedures including bilateral stimulation. The effectiveness and tolerance of these small trials give us relevant information to make decisions. We can apply one or two sets of bilateral stimulation to a target, which is selected according to the characteristics of the patient, observe the response, and use this information to perform the next session. Some examples of these initial targets are: processing the phobia that the main personality has toward one part, working on the disturbance that a dissociative part presents, incorporating bilateral stimulation in a self-care procedure with a child part, or using it to promote co-consciousness among different parts. All these interventions are aimed at stabilizing the patient but also have the function of introducing bilateral stimulation in a progressive and gradual way. In patients who tolerate this work well, we can further try to process a recent memory, an event that does not seem connected to the worst experiences, a very intrusive memory, or a traumatic experience that is very connected with a patient's current problems. In these early trials of memory work, the goal is not to achieve complete processing, but rather to guarantee a good first experience with EMDR reprocessing. This means selecting memories that are more accessible, more likely to be processed by the patient without going into more complex areas, and whose processing can lead to improvement in daily functioning. A good first experience with bilateral stimulation and memory reprocessing increases a patient's motivation to continue with EMDR therapy on other more complex targets. The procedure will be contained and limited, and will not allow associative chains to be very long, thus preventing the connection with other very disturbing memories or the possible activation of multiple targets. If this work is productive, then we can proceed with more complex events. The emotional state of the patient between sessions will guide the therapist along this path, adapting the rhythm of the process to the patient's timing. The therapist should be attentive to nonverbal cues and indirect communication of potential difficulties due to trauma processing, because severely traumatized people sometimes do not identify when something is harmful for them, or do not express their distress openly and easily. Some patients would not need so many precautions, but by using a progressive approach, we may prevent problems in those who need it, and at the same time do effective interventions as soon as possible in those that can benefit from them.

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