Fall 2021

# Top TEN Things You Should Know about EMDR Therapy and Dissociation

Creating a "top ten" list about EMDR therapy and dissociation was not easy. There are too many options to include. Consider this list an invitation to curiosity rather than a user's manual.

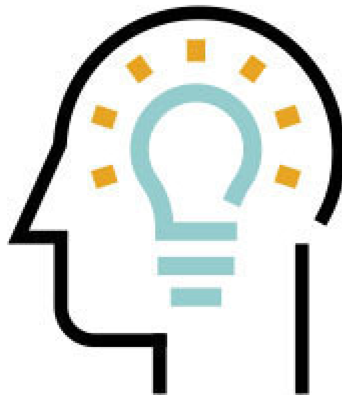
**By D. Michael Coy, MA, LICSW**

## 1. HOLD YOUR THEORIES LIGHTLY.

The Structural Dissociation model (Van der Hart, Nijenhuis, & Steele, 2006) is a theory. Shapiro's (2001) Adaptive Information Processing model is a theory, which evolved from a preceding theory, Accelerated Information Processing (Shapiro, 2001). Theories are not facts. They are *working models* that serve both as a framework for understanding and a means for testing hypotheses. Because of this, theories can and should evolve. The more a psychological theory becomes elaborated, the more helpful it can be for conceptualization and treatment. However, it's also easy for theories to morph into generally accepted fact. When that happens, we stop questioning, testing, and refining our theories. It's rare that a single theory provides a complete understanding of any phenomenon, including dissociation.

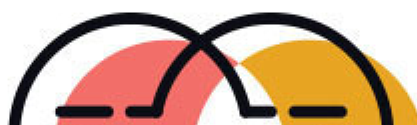
We rely upon a variety of theories in our work with clients, primarily because individuals are complex, and the interactions that unfold between two or more individuals, each with their history, beliefs, biases, fears, resiliencies, and both hidden and obvious emotional wounds, are that much more complex. The more facility therapists have with integrating a handful of practical frameworks for conceptualizing and understanding psychological and relational processes, the less likely they will miss something important. And, if we can hold them lightly, our clients might teach us something we didn't know that we didn't know yet.

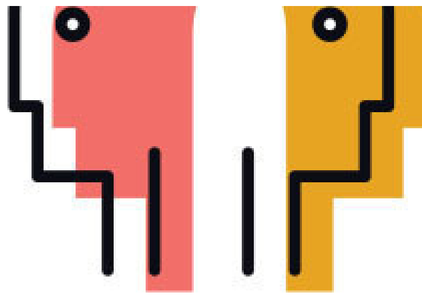
## 2. YOU CAN'T KNOW WHAT YOU DON'T KNOW YET, BUT YOU SURE CAN LEARN.



There is much to learn about EMDR therapy, dissociation, and the use of EMDR therapy to treat dissociation. When I completed basic training, I remember feeling equal parts overwhelmed and excited. In advertising that I offered EMDR therapy in my practice, I attracted more clients with complex histories and symptom features outside Shapiro's (2001) selection criteria for using EMDR therapy. Uh-oh. So, I started reading about dissociation. What I read sounded fantastical. Unreal. Unbelievable. Of course, it sounded that way because I had no frame of reference yet. I joined the International Society for the Study of Trauma and Dissociation (ISSTD; www.isst-d.org) when I joined EMDRIA. Then the real learning began.

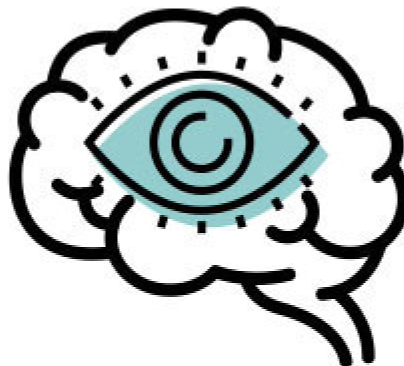
## 3. DISSOCIATION IS MORE THAN JUST A DISTANCING MANEUVER.





It took time for me to understand is that dissociation isn't just depersonalization (DP) and derealization (DR). As EMDR therapists, we see DP/DR often in working with persons with PTSD. It's not unusual to refer to/think of a client going away, but it is far less obvious what this means in the context of more complex dissociation, which also involves various degrees of compartmentalization between self-states. I had seen wellmeaning EMDR therapists trying to alleviate DP/DR by doubling down on using EMDR therapy—even when it was the use of EMDR therapy that exacerbated the original problem. Again, what we *see* may not be fully representative of what is. With more complex compartmentalization comes hiddenness (Franklin, 1988; Kluft, 1985), and hiddenness may require ongoing assessment, over time, to discern. However, understanding more about how a person's self-system functions makes it easier to devise effective interventions.

## 4. EMDR THERAPY IS AN INTEGRATIVE APPROACH, AND THERE IS A LOT TO INTEGRATE WHEN WE TREAT DISSOCIATIVE DISORDERS.



Several EMDR therapists I have consulted with are surprised to learn that there is a rich field of study of the dissociative disorders and a lot of valuable knowledge beyond the existing EMDR therapy literature on treating dissociation. Within the dissociative disorders field, there exists a wealth of as-yet-undiscovered learnings

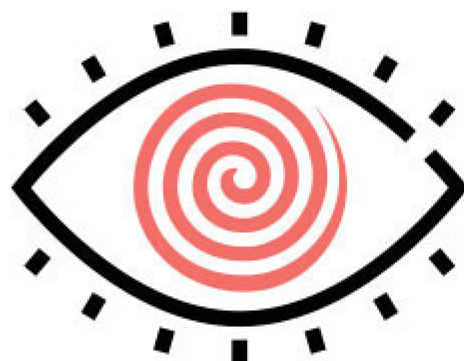
dissociative disorders field, there exists a wealth of as yet undiscovered learnings from people who have successfully treated trauma-related dissociation—even more complex forms—for decades without the use of EMDR therapy.

EMDR therapy is a relative newcomer in the treatment of dissociative disorders, at least insofar as it offers various techniques, interventions, etc. However, it carries with it, for the lay public, a solid reputation for being the wonder therapy that works wonders. This is a double-edged sword when it comes to working with clients with dissociative "stuff" happening for them—particularly when they are only dimly, or not yet at all, aware of it. Given the proper context(s), a solid therapeutic relationship, and a skilled practitioner, the impact of EMDR therapy in the treatment of dissociative disorders is indeed wondrous.

EMDR therapy, in its standard form, allows us to treat predictable problems, such as the typical features of PTSD, in a relatively predictable and rapid manner. This is a great thing! However, the more complex the client, the less dependent we can be upon a collection of isolated protocols or interventions to provide comprehensive treatment within a single psychotherapy approach.

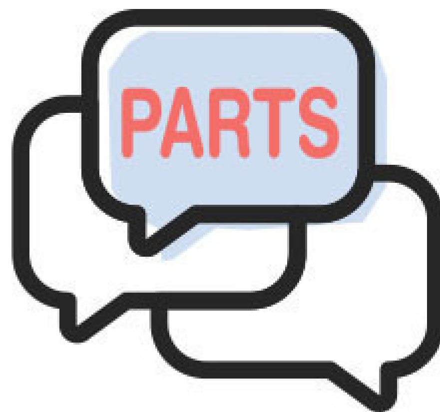
Catherine Fine (1999) states that "It is important to recognize that when working with DID, two things stand out with respect to the organizing treatment models: 1. Even though the therapist's preferred model of treatment is relevant, particularly to the therapist, the disorder itself will impose the therapeutic interventions and 2. The therapists need to be fluent in the traditional psychodynamic and cognitive perspectives aided by a clear understanding of hypnosis and the rules governing trance states to best help this patient population negotiate their own stability"(p. 362).

## 5. GET TRAINING IN PSYCHODYNAMIC PSYCHOTHERAPY AND CLINICAL HYPNOSIS.



I cannot count how many times my grad-level training in psychodynamic psychotherapy has saved my backside in my work with clients with dissociative symptoms, as what cannot be talked about or told to us is invariably acted out in the therapeutic relationship in some form or another. Additionally, training in clinical hypnosis was a total game-changer for me. I have heard EMDR and hypnosis framed in terms of an either-or proposition. Learning to embrace them as a both-and has made a profound impact on my work. Hypnosis is not a therapy itself, but it very much is a complement to many therapeutic frameworks. And, over time, a lot of techniques that originated in the hypnosis tradition have been integrated into EMDR therapy, which means you may already be using hypnotic techniques in some form without realizing it.

## 6. YOU CAN'T MAKE PARTS HAPPEN BY TALKING ABOUT THEM.

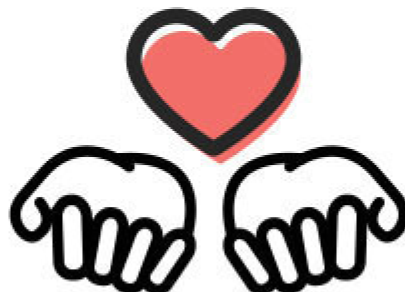



There is an abiding fear that either talking about parts or working directly with other parts (than the one who believes they "drive the bus" most of the time) can make them more "real" or reinforce the dissociation. On the first point, people talk about parts all the time: "A part of me wants this, and another part of me wants that." They are likely talking about ego states holding different feelings about the same issue. However, the more complex the dissociation, the more it seems both clients and therapists may become *phobic* of talking about, thinking about, acknowledging the existence of, or getting anywhere *near* other self-states. However, those other self-states are integral to the healing process. *See also Gonzalez & Mosquera (2012)*.

## 7.A "FRONT" PART ISN'T THE ONLY ONE WHO CAN BENEFIT FROM DIRECT ATTENTION.

Suppose the treating therapist understands the idea of "one person, one body, many self-states." In that case, working with different combinations and permutations of self-states at any given time is ultimately about working with ego energy in creative ways to achieve the desired effect. Somehow, over the past handful of years—at least in the EMDR world—the idea of working both directly *and* indirectly, always strategically, with different self-states has fallen out of favor as if it is somehow dangerous (or scary). And it just ain't so. Jack and Helen Watkins, who developed *Ego State Therapy*, offer helpful, illustrative vignettes in their 1997 book, *Ego States: Theory and Therapy*. I also recommend Kluft's (2006) article on working with dissociative alters in persons with DID. I can imagine the increasing, intentional use of Ego State Therapy in the context of hypnosis as the future of using EMDR therapy to treat dissociation. *See also Forgash & Copeley (2008), Paulsen (2009), and R. Shapiro (2016)*.

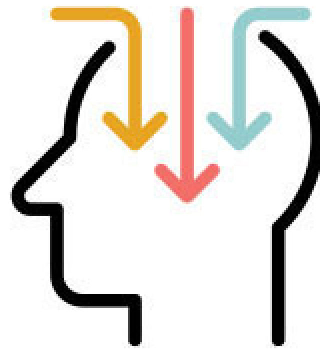
## 8. CONSENT IS AN ONGOING, MULTIFACETED PROCESS WHEN COMPLEX DISSOCIATION IS PRESENT.



Consent for treatment with persons who have a dissociative disorder is not once-

and-done. It can be easy to assume that we need to ask whoever is "up front" how they would like to proceed. However, with "small s" structural dissociation comes the challenges of conducting treatment with a person with more than one center of consciousness. Working with a person with different self-states, some of whom harbor their compartmentalized outlooks, feelings, and agendas, requires a significant paradigm shift, including how we understand consent. One part's freedom may be another part's oppression. It does not make a part of self any more or less "real" to ask permission. Rather, it demonstrates your commitment to treating the whole self with dignity and respect.

## 9. WORKING FROM THE TOP DOWN IS INEVITABLE.



The gravitational pull toward "saving the children," i.e., childlike self-states, is formidable. But I always think about a question from my social worker licensing exam about the appropriate approach to working with a patriarchal family system. The answer was to work first with the patriarch. To strengthen the therapeutic alliance enough to be allowed to spend time with the whole family, therapists must first work with those in charge: persecutory, anger-holding, and similarly protective parts. This applies whether we are discussing a community, a family system, or a self-system in the case of an individual. And just because you cannot see them, it does not mean they are not there. They hide. (This is no joke. They can—and do.)

## 10. "ALL INTERVENTIONS ARE RISKY WHEN YOU DON'T KNOW YOUR CLIENT."

This is a statement from Phil Kinsler, during a 2018 webinar series. And it's one of my favorite therapy-related quotes, so I had to include it here.

In closing, I would like to offer my sincere apologies for excluding references to additional, influential authors/thinkers owing to space limitations.

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