

# Challenges in the Use of EMDR Therapy with Dissociative Disorders

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Clinicians using Eye Movement Desensitization and Reprocessing (EMDR) therapy often run into difficulties when clients present symptoms indicative of dissociation of the personality involving different dissociative parts. Not only do inexperienced clinicians have doubts about how to work with complex trauma cases, so do experienced clinicians. Therapists often seek consultation due to feeling unsure about the work that can be done, especially with dissociative disorder cases.

EMDR therapists know that during the reprocessing phase of EMDR, the patient's adaptive information processing (AIP) system tends to flow spontaneously toward resolution and integration (Shapiro, 1995). In simple trauma cases that do not involve a dissociative disorder, the therapist's intervention is often minimal, and most blocking points will easily be resolved with brief interweaves. However, using the standard EMDR protocol in complex trauma

cases involving dissociative disorders will be more challenging and require a longer preparation phase, a well-defined structure, and fractioned work. Gradually introducing trauma processing or desensitization by titrating and fractioning the work will help these clients remain within their window of tolerance, which will increase their capacity for effective processing.

Because of the limitations presented by these clients, many EMDR clinicians turn to other approaches, hoping to find more tools to treat their clients effectively. Although this might not be necessary when clinicians can acquire sufficient knowledge and tools to adapt to these cases, it is a personal choice that can be integrated in interesting ways. The Adaptive Information Processing (AIP) model (Shapiro, 1995, 2001) offers EMDR therapy a stable structure and great flexibility. Such a reliable foundation, together with its empirical evidence, allows for therapists to safely integrate their knowledge of other approaches into their EMDR sessions when processing trauma. Any approach that can bring better understanding to trauma-related difficulties will fit

nically with the AIP model. Many are available: Some focus on helping clients develop skills and capacities (Boon, Steele & Van der Hart, 2011; Linehan, 1993; Mosquera, 2014; Porges, 2011), others work with ego states, modes, and/or dissociative parts (Fisher, 2017; Kluft, 1993a, 1993b, 2013; Knipe, 2018; Mosquera, 2019; Paulsen, 2008; Schwartz, 1995; Van der Hart, Nijenhuis, & Steele, 2006; Young, Klosko & Weishaar, 2003; Van der Hart, Groenendijk, Gonzalez, Mosquera & Solomon, 2013; Watkins & Watkins, 1997), others place a strong focus on correcting cognitive errors (Brand, 1997; Ross & Halpern, 2009), and others are body-oriented (Levine 2015; Ogden & Fisher, 2015; Ogden, Minton & Pain, 2006).

This article aims not to go over every approach that has been developed for trauma work but to offer a broad view of some of the aspects that every EMDR therapist should be familiar with when working with dissociative disorder cases. Andrew Leeds states that "knowledge is power" (2016), referring to clients understanding their difficulties and having adaptive realistic information about behaviors they present that are

puzzling and of concern. This idea can be generalized to therapists working with trauma-related disorders, especially those with dissociative symptoms.

In this article, the focus will be the classical or narrow understanding of dissociation as a division of personality or self, since this type of presentation is the most challenging regarding trauma work and requires some interventions that go beyond the tools clinicians will most likely learn in the basic training.

### FREQUENT DIFFICULTIES

One of the main difficulties for EMDR therapists working with complex cases, those including dissociative disorders, is knowing or deciding *when* trauma processing can begin and *how* to do so. Other common difficulties are related to how much stabilization should be done and how to titrate or combine trauma processing with containment in a safe, tolerable, and effective way. All the previous difficulties are related to the complexity of the case.

On the one hand, simple trauma cases that do not involve a dissociative disorder are quite easy to conceptualize and organize the treatment plan; target selection seems clear, and clients are willing to join us in the work regardless of how difficult their traumatic experiences have been. The history gathering can be done without too many complications and without having to pace or do any type of intervention to help clients stay focused, grounded, and present. But complex cases, on the other hand, present difficulties from the very first session. These cases can be extremely confusing for clinicians, not just at the level of symptom presentation but also at the relational level. Some

## Figure 1 Comparative Overview of Simple Trauma Cases vs. Dissociative Disorder Cases

Simple Trauma Cases	Dissociative Disorder Cases
<ul style="list-style-type: none"> <li>• No dissociative symptoms</li> <li>• Trauma work can be initiated without complications.</li> <li>• Not much need for containment or to titrate trauma work</li> <li>• Basic stabilization tools can be applied without difficulties (safe/calm place, RDI, grounding, etc.).</li> <li>• History taking is easy and straightforward. Clients can remain focus and grounded.</li> <li>• Clear case conceptualization and treatment plan</li> <li>• Easy target selection</li> <li>• Client is willing and ready to do the work.</li> </ul>	<ul style="list-style-type: none"> <li>• Dissociative symptoms</li> <li>• Difficulty knowing or deciding when trauma processing can begin and how to begin</li> <li>• Difficulty knowing how to titrate or combine trauma processing with containment in a safe, tolerable, and effective way.</li> <li>• Difficulty knowing how much stabilization is needed</li> <li>• Simple stabilization exercises can be triggering.</li> <li>• Specific interventions that go beyond basic stabilization are required.</li> <li>• History taking can be complicated and confusing, both at the level of symptom presentation and at the relational level. We must pace interventions to help clients stay focused, grounded, and present.</li> <li>• Case conceptualization is more complicated.</li> <li>• Target selection can become challenging and confusing.</li> <li>• Defenses may slow the process down.</li> </ul>

of the frequent differences between simple and complex cases are described in Figure 1.

Another major difficulty has to do with the fact that in the literature, there is much confusion about the concept of dissociation (Kluft, 2009; Liotti 2009; Rodewald, Dell, Wilhem-GöBling & Gast, 2011). Thus some authors have a relatively broad understanding of dissociation and regard the following phenomena as dissociative in nature: (1) alterations in awareness and consciousness (attentional problem); (2) physiological shut down (physiological problem); (3) depersonalization/derealization (perceptual problem);

and (4) dissociation of self/personality (For critical reviews, see Steele, Dorahy, Van der Hart, & Nijenhuis, 2009; Van der Hart et al., 2006).

These phenomena can be present in the same individual in different moments and need different interventions and pacing. The first three descriptions—which, from a narrow understanding of dissociation, are merely alterations in consciousness (e.g., Steele et al.)—can be addressed with many of the tools that EMDR therapists often have: safe/calm place, resource development, and installation, grounding, and emotional regulation skills, presentification abilities, etc.

### CAN WE SAFELY PROCESS TRAUMA WITH DISSOCIATIVE DISORDER CLIENTS?

Yes, of course. Trauma can be safe and effectively processed with all clients. As long as we understand the case well and have a strong focus on assessment and conceptualization, even the most challenging cases can benefit from trauma work.

Clients with complex trauma and dissociative disorders face many challenges. As therapists, we need to understand the complexity of their trauma history and how the internal dissociative system of their personality is organized. To survive an often-life-threatening upbringing, clients must compartmentalize their experiences from early ages. By the time these clients grow up and have a chance to experience healthier settings, their way of dealing with daily challenges has become automatic,

and there is not much space to think or reflect on other choices, options, and alternatives. Many of these clients are not even aware of their difficulties: They might identify some challenges, even some triggers, but do not have a broad perspective on past-present-future difficulties and how they are interrelated.

### WHY DO SOME CASES NEVER SEEM STABLE ENOUGH?

Some clients with dissociative disorders can disclose their history and are aware, at least at some level, that they should work with their traumas but never seem stable enough nor ready to tolerate trauma work. On the other hand, others cannot even talk about their traumatic experiences, and a third group of clients cannot even remember what happened to them. During phase 2 of

EMDR therapy, therapists identify with their clients the resources and capacities that might need to be reinforced and/or developed. However, what tends to work with simpler cases, does not work as well with dissociative disorder clients and, in some instances, may even be triggering and/or destabilizing.

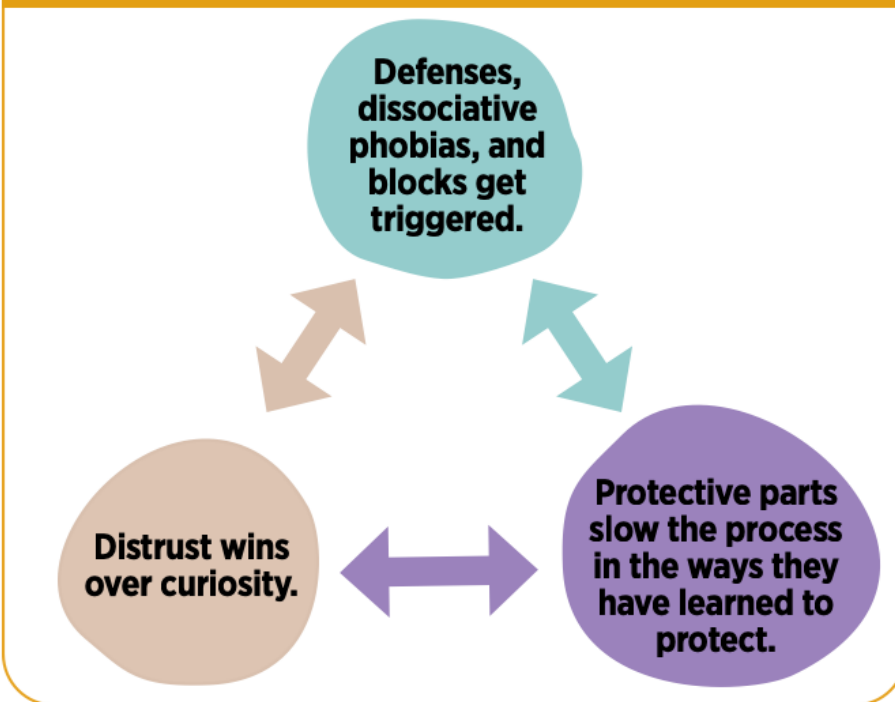
Why is this? A person with a good enough upbringing might have limitations but often has developed and experienced “how things are supposed to be,” which is a good source of adaptive information for the future adult. However, based on their (early) life experiences, individuals with dissociative disorders usually experience life in an extremely distorted way. They need first to learn fundamental aspects about healthy and adaptive interactions with self and others. In addition, the internal system of dissociative parts may have completely opposing ideas or perceptions of both past events and personal needs.

A simple intervention, such as the imaginary calm/safe place, can turn into a nightmare when the different internal system parts experience safety or feel calm as potentially triggering and dangerous. When the enemy resides at home, where one is supposed to feel protected and cared for, and the figures meant to protect the child fail to protect, but also harm; the meaning of safety, protection, and calm becomes usually distorted. Often, one or more parts would like to feel safe, but when they think about this possibility, other parts can get triggered that argue adamantly that danger still exists.

### HISTORY TAKING: WHAT DO WE NEED TO UNDERSTAND?

Clients with dissociative disorders have *specific internal dynamics* that need to be understood and kept in mind to adequately organize

**Figure 2**  
**Trying to Speed Up the Process Usually Slows It Down**



treatment. Although the assessment is done with one client, a lot of the information is compartmentalized, that is, kept by different dissociative parts, especially in the beginning of treatment. In addition, some of the information that might not be compartmentalized can be defended by both the client and the different parts using attempts to not (fully) realize it.

When therapists meet with dissociative disorder clients for the first time, the presenting parts may not be aware of the most relevant pieces of their history. Dissociative parts withhold information, bring it forward unconsciously, or share it consciously, depending on many aspects. Some of the dissociative parts stuck in trauma-time are usually on alert during the history taking and could be scanning the therapist for any danger signals.

It is essential to keep in mind that the faster we try to go, or the faster clients try to proceed when they are not yet ready, the more the system becomes slowed down.

However, even if the previous difficulties are identified, they should not become the main exploration focus. The therapeutic stance and good training in trauma and dissociative disorders can make a big difference when these clients reach our office and sit with us for the first time.

The issue resides in trying to obtain this information without triggering a state of alert in the different parts. Though conceptualization is often based on gathering information obtained from clients, this information should never be mostly about trauma content. Given that there is a basic phobia of traumatic content, too much exploration may reactivate traumatic memories and the parts that keep them. So, it is not just about what happened to them, but about how this affects them and how they are trying to cope. A good

way to begin is to keep in mind the following:

- Identify and help clients understand the interpersonal relational dynamics that were learned to protect the self and why they are so entrenched.
- Identify the often-automatic learned responses and defenses that are not working anymore and why. Clients often get confused because some of their coping strategies were useful in different moments of their lives.
- Identify the internal relational dynamics that the system learned for survival, including the phobias that parts may have of each other and their purpose and what needs to be addressed for better functioning.

History taking should be balanced between being enough to start working and tolerable for both the client and the system of parts in those cases presenting dissociative parts.

#### TIPS FOR CASE CONCEPTUALIZATION AND TREATMENT PLANNING

A guide to conceptualizing dissociative disorder cases is described in Mosquera (2019). Given that the scope of this article is to simply offer an overview of the type of information that can be explored, we list the five areas suggested without explaining them in-depth:

1. History of symptoms and presenting problems: relational problems, level of functioning in daily life, history of the symptoms, and difficulties as well as triggers
2. Resources, capacities, and support: sources of adaptive information, self-regulation capacities, social support, and other resources (A timeline of best memories can be useful.)
3. Structural elements of the internal system: client's awareness of

having parts, internal structure, degree of differentiation, time orientation and perception of safety, mentalizing capacities, and adaptive information in the different parts

4. Relational aspects of the internal system: acceptance of parts, relationship among parts (including the phobias they may have of each other), degree of cooperation/collaboration, and parts that might have difficulties with therapy
  5. Trauma-related phobias and other potential blocks: focusing in particular on any phobias of traumatic memories, of inner experience, and of dissociative parts
- Case conceptualization goes

hand in hand with assessment and clinical judgment. Relational aspects and timing can be as important as what and how to assess (Mosquera, 2020). Conceptualizing clinical cases is relevant in all approaches and types of psychological problems, but it becomes vital when working with complex trauma, personality disorders, and dissociative disorders. In these cases, it is easier to lose perspective and join clients in their avoidance tendencies without even realizing it.

The AIP model offers a guide for understanding and organizing a structured and flexible treatment plan for many cases. However, the best tools for an EMDR practitioner include in-depth knowledge of the client, dissociation of the personality or self, and the flexibility of EMDR therapy. A good case conceptualization or comprehension of complex cases can help us implement a progressive and effective approach.

Therefore, the first step is being aware of the frequent difficulties so they can be identified and included in the treatment plan. There are a series of questions that can increase

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our understanding of the case, both to get a sense of the difficulties that we may run into and to organize the treatment plan:

- How did the symptoms develop?
- What is the function of the symptoms?
- What *or who* is maintaining the symptoms as they are?
  - Other dissociative parts
  - Other people in the client's life
- What triggers symptoms, behaviors, or problems?
- When do symptoms or problematic behaviors get worse?
- How do others respond?
- What are the maladaptive memories related to the symptoms?
- How was the emotional environment while growing up?
- Who has had more influence on the client's perspective, both positively and negatively?

Trauma therapists often have questions about organizing a suitable treatment plan when clients present with so many different complications. A sound treatment plan will need to rest on the foundation of a comprehensive clinical case conceptualization. One of the goals of the conceptualization in EMDR therapy is to introduce a way of looking at cases that can help with decision-making. Once the therapist gathers the information included in the tips suggested for case conceptualization, EMDR clinicians will have a better idea of where to begin (see Figure 3 for an overview).

### CASE CONCEPTUALIZATION: FREQUENT ISSUES AROUND GOAL SETTING

Setting goals in the beginning is important for different reasons and can guide the decision-making. Goal setting gives therapists an idea of:

- Where the client and any other family members that come in are at;

**Figure 3**

## General Overview on Where to Begin the Work

### The Basics

- Pacing history taking
- Establishing a good enough alliance
- Setting therapeutic goals
- Reaching agreement

### High-Risk Behaviors or Symptoms Affecting Self and Others

- Suicidal ideation
- Aggression
- Self-harm and any other risky behaviors
- Any other behavior that can interfere with therapy

### Working with the Internal System of Parts

- Reducing internal conflict
- Improving collaboration and cooperation
- Establishing teamwork

### Resources and Emotional Regulation Strategies

- Calm/safe place
- Grounding and presentification exercises

### Trauma Work

- Targets that are more tolerable (and there is agreement of the system of dissociative parts)
- Titration/fractionation

- What stands out the most for the client and for family members or other relevant people that are involved in therapy; and
- Where or with what do clients and others think they need help.

As therapists, we need to check that the goals sound right and fit with our clinical impression. We should also make sure that future goals are realistic and determine if we have to intervene to improve them. A description of typical difficulties around goal setting is illustrated in Figure 4:

For practical purposes the relevance of setting goals in the beginning of treatment will be illustrated through a complex case example.

### CASE EXAMPLE: "I JUST WANT TO BE HAPPY"

A 40-year-old woman is referred for trauma therapy after many failed treatments. The referring clinician believes that the client has a dissociative disorder and might benefit from EMDR therapy. During the initial intake session, the client shares very little information, saying things such as, "I don't even know where to begin," "I don't want to get ill again," "If I talk about things that hurt, anything can happen." She admits having multiple problems and knowing that they might related to a very difficult upbringing. However, when she tries to speak about it, she cannot complete a sentence and becomes

extremely agitated, to the point of having trouble continuing with the interview. There was much confusion about the information shared in the first sessions, long and frequent silences, difficulties in engaging in eye contact with the therapist, and dazing off. The client displayed a tendency to avoid feeling or noticing anything that could somehow activate her and had become extremely skilled at focusing on other things and topics. The therapist also suspected that the client had a dissociative disorder. Still, it was impossible to explore any issues around dissociative symptoms or her history in the first few sessions. Nevertheless, she was able to share what had stood out for most of her previous therapists.

Her main difficulties are:

1. Spending most of her day in bed.
2. Losing her job, having no income, and barely functioning in daily life. Not engaging in any activities.
3. Self-harming in different ways, including severe cutting and over-eating until her stomach hurts to punish herself.
4. Taking medication to sleep, even during the day. It helps her not to think of “what happened to her” (avoids triggers).

The therapist and client agreed to pace history taking (learning from her previous experiences where she got worse when she tried to share more information than she could). Psychoeducation about not needed details of trauma history was done and the relevance of paying attention to her “internal *no* signals,” meaning that any information that was too triggering could be shared later, as she felt ready to disclose. This intervention had an immediate calming effect on the client, who seems to be able to engage in the interviews with less fear of what could happen. Both therapist and client agreed to focus on present goals. When the therapist asks the client about her goals, she says *she wants to be happy and be thin again*. What can be done with these goals? What type of difficulties can be found? Where and how to begin? Let us see how these types of goals can be used to explore information and keep the process moving:

#### GOAL 1 – BE HAPPY

- What does unhappy mean to her?
- When did she realize she was unhappy?
  - What was happening then?
  - How did others respond?
- What makes her unhappy now?

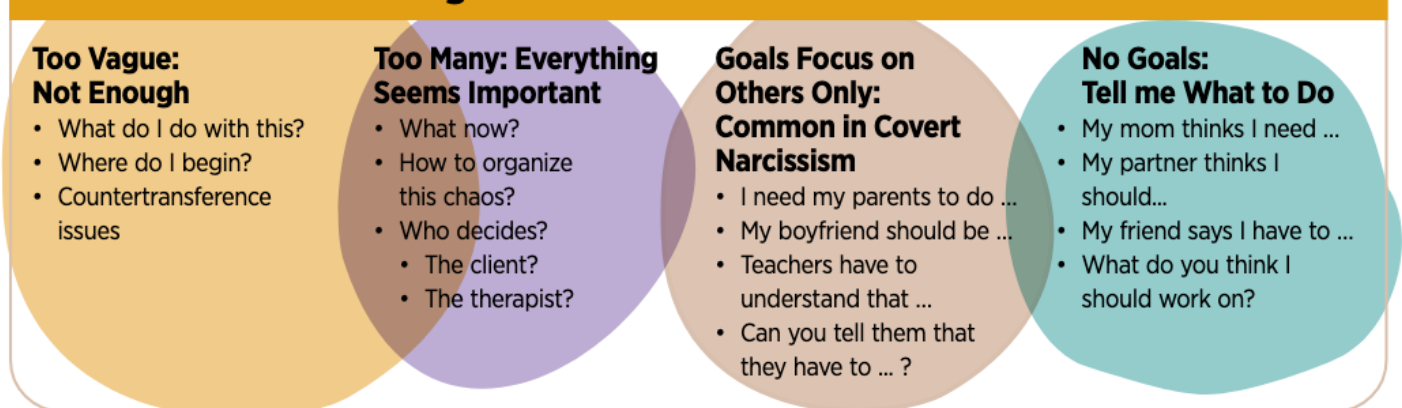
- How can we work on that now?
- Does she know what she would need to be less unhappy?
- Can we help her find out if she doesn't?
- Are there exceptions to being unhappy?
  - Search for moments when she feels happier now.
  - Search for moments when she felt happy in her life. Get examples.
  - Check if we can use those examples as resources.
- Are there memories that we need to identify in her history?

#### GOAL 2 – BE THIN AGAIN

- What would be thin again mean for the client?
- Is she aware that her eating habits are related to her weight gain?
  - Some clients are not aware of consequences of diverse actions.
- How can we work on that now?
  - Self-care?
  - Healthier habits?
  - Processing memories underlying her punishment with food?
  - Processing the urge to hurt herself with food or cutting?

By validating her goals and using them to clarify her needs, more specific and realistic goals were established, providing a better sense

**Figure 4**  
**Common Issues in Setting Treatment Goals**



of the work ahead. It also allowed the therapist to explore and access the system of parts, which the client had not even mentioned initially. Many of these dissociative parts were still stuck in trauma-time and, therefore, kept getting triggered due to the constant feeling of being in danger. Once the system of parts was on board and a bit calmer to allow some space for the client to reflect about her actual needs and options in the here and now, her goals became more concrete:

- Improving self-care.
- Increasing emotional tolerance.
- Being able to stay grounded in moments of distress.
- Resorting to healthier coping alternatives. We identified a personal list for her that basically consisted of strategies that had worked for her in the past and she had not been using lately, as well as new skills to develop such as grounding tools.
- Identifying triggers and memories that will eventually need to be addressed.

Though having a complete list of goals may be desirable, in cases like this, we can start working once we have a better understanding of her problems and difficulties to function in daily life. This allows us to set achievable goals and unpack them to get some perspective. An increased perspective will help the client to feel more motivated, and the clinical case will feel less confusing. Starting with the basics will give us access to additional information that will be useful when revisiting goals in the future.

Three months later, the client was following a healthier routine, which included exercising and organizing her eating habits. She had also signed up for a class to improve her artistic abilities. Even though she still had difficulties with emotions, she had improved greatly at understanding

and tolerating them. The client was able to remain increasingly grounded without resorting to self-harm. She was also becoming aware of triggers and had learned to avoid some of them. In addition, she realized that some of the parts of her internal system, especially the younger ones, were related to the triggers and her difficulties to cope. We were able to do psychoeducation that was useful for the different parts, and the client had been able to identify some memories that will need to be processed once the system of parts is ready to do so.

Currently, her goals are more specific and easier to assess:

- Ability to accept her different feelings.
- Learning to accept the younger parts of her that she still fears.
- Learning more coping strategies, for both her and the parts stuck in trauma-time.
- Working with unresolved trauma history: *"I understand we need an agreement for this."*

The client of this example illustrates one of the many cases in which we can easily find ourselves going around in circles without reaching any therapeutic changes or achieving any goals. Trying to dive into trauma work in a case like this would lead to more avoidance in the client and confusion for the therapist. Instead, focusing on the client's goals and using them both as motivation for therapy and as a guide to structure, the initial work will lead to a better understanding in both clinician and client and increased readiness for trauma processing. From here on, the focus could be placed on addressing traumatic memory. The overall goal was, from the beginning, knowing the client's history, to gradually progress towards processing the traumatic experience.

However, when the client is not yet ready to work with all the elements of the experience that require using EMDR Standard Protocol and this experience is too overwhelming, memories should be titrated and approached in small steps. EMDR therapists should start with the most tolerable interventions and processing small quantities (Gelinias, 2003; Hofmann, 2010; Kluft, 2013; Knipe, 2001; González & Mosquera, 2012; Mosquera, 2019; Popky, 2005; Steele, Boon & Van der Hart, 2017; Van der Hart et al., 2014; Van der Hart, Steele & Nijenhuis, 2017).

### HELPING CLIENTS ACHIEVE COMPETENCE DEALING WITH THE EVERYDAY

Working with dissociative disorders is challenging for different reasons; some have been described in this article. When clients have sufficient adaptive capacity, therapists can use standard EMDR procedures. Still, if clients lack this capacity, therapists will need to adapt the stabilization phase to the specific challenges of this population before engaging in memory reprocessing. In the stabilization phase, therapists can combine the use of emotional regulation tools, time orientation, and psychoeducation to improve the available adaptive information that might be lacking, increase the clients' understanding and integrative capacity, and improve how they adaptively cope with everyday life problems. Resourcing strategies and skill-building during phase 2 of EMDR therapy can also be used to address and improve many of the difficulties presented by these clients.

During EMDR reprocessing, the patient's AIP system tends to flow spontaneously towards resolution and integration. However, due to the fragmentation present in dissociative disorders, some information is not

accessible using the standard EMDR protocol and needs to be developed in phase 2.

As clients achieve competence dealing with everyday challenges, staying present, and understanding the system of parts so agreements and cooperation can take place, the therapist can begin addressing traumatic memories in a gradual, titrated way. Doing so will help clients progressively feel more capable of addressing the whole experience with standard EMDR protocol.

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*Dolores Mosquera is a clinical psychologist. She received the David Servan-Schreiber award for outstanding contributions to the EMDR field in 2017. She was made a Fellow of the International Society for the Study of Trauma and Dissociation in 2018 for her contributions to the trauma and dissociation field.*

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