Integrating EMDR and Ego State Treatment for Clients With Trauma Disorders

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This article is an excerpt from *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* (edited by Carol Forgash and Margaret Copeley, 2007, pp. 1–59). The preparation phase of eye movement desensitization and reprocessing (EMDR) is very important in the therapy of multiply traumatized clients with complex posttraumatic stress disorder (PTSD) and dissociative symptoms. EMDR clinicians who treat clients with complex trauma will benefit from learning specific readiness and stabilization interventions that are inherent to Phase 1 of a well-accepted phased trauma-treatment model. Extending the preparation phase of EMDR by including these interventions provides sequential steps for the development of symptom-management skills and increased stability. Additional focus is placed on helping clients work with their ego state system to develop boundaries, cooperative goals, and healthier attachment styles. Following an individually tailored preparation phase, the processing of long-held traumatic memory material becomes possible.

Keywords: EMDR; ego state therapy; dissociative disorders; complex PTSD

The powerful benefits of EMDR in treating posttraumatic stress disorder have been solidly validated. In our book *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* (edited by Carol Forgash and Margaret Copeley, 2007), we proposed combining EMDR with ego state therapy—developed by John Watkins and Helen Watkins in the 1970s— to target the dissociated parts of the psyche (ego states) that arise in response to severe and prolonged trauma. The key to safe and effective treatment of complex PTSD (involving dissociation) and other challenging diagnoses is careful preparation of clients to stabilize them, strengthen internal resources and present orientation, teach affect management skills, and clarify the goals and course of the therapy.

New Help for Clients With Trauma Disorders

Through many collective years of practice, we (Forgash & Knipe, 2007) have treated clients with a combination of complex diagnoses, including trauma and PTSD and attachment, personality, and dissociative disorders. We have found that these clients have borne the most extensive suffering of all those we treat. The intricacy of their internal worlds, their struggles with symptom management, and their relationship problems often compel our empathy, our interest, and our horror at what they have experienced. The miracle is in their perseverance to become whole, often in the face of repeated previous treatment failures.

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Since the discovery of EMDR by Francine Shapiro in 1987, therapists dealing with traumatized clients have found that EMDR has filled a long-standing need in their treatment approaches. Previously, many traumatized clients, even those who had obtained insight into their difficulties after years of therapy, were still suffering from unwanted emotions, body sensations, and PTSD flashbacks. EMDR has provided a way to rapidly resolve the underlying troubled feelings associated with traumatic life experiences.

However, as Janet (1907) stated over 100 years ago, for certain clients with complex diagnoses, treatment must provide stabilization prior to uncovering (desensitizing and reprocessing) traumas, and therapists must keep in mind individual needs for extensive stabilization. In part, this involves providing a lengthened preparation phase, often longer than necessary for most clients with single- or recent-incident traumatic events (J. Chu, 1998; Gold, 2000; Herman, 1992). The sequelae of trauma—especially the intrafamilial spectrum of physical, sexual, and emotional abuse and neglect—predict chronic PTSD and other serious problems. Additionally, the preconditions to trauma, common for children from abusive and neglectful families, include chaos and disorganized attachment styles, as well as lack of nurturing and guidance from parents who have limited parenting skills (Gold, 2000; Schore, 1994; Siegel, 1999). This often means that multitraumatized clients may be lacking in social and life skills development, have problems with attachment as adults, and have many of the defenses and issues associated with dissociative disorders and Axis II personality disorders. These clients are especially vulnerable to trauma in adult life, such as partner battering and self-harming behavior. Such early-childhood history also indicates that these clients may have difficulty dealing with intense emotions and managing dissociative symptoms as well as enduring problems with trust. Therefore they may be hindered in their development and maintenance of adult relationships, including the therapeutic relationship (Dworkin, 2005; Forgash & Knipe, 2001; van der Hart, Nijenhuis, & Steele, 2006; van der Kolk, McFarlane, & Weisaeth, 1996). They may be unable to move beyond present symptomatology and become stuck in impasses, resistance, increase in symptoms, and frustration with therapy. They also may have great difficulty managing the normal stresses of adult life, suffer with ill health, and have few life supports (Forgash & Monahan, 2000).

Additionally, many clients with trauma histories will dissociate or have destabilizing abreactions in treatment if stabilization and skills training in managing affect, dissociative symptoms, and stress is not provided. These clients are often low responders who cannot complete treatment and have very incomplete and frustrating therapy journeys.

Where there has been repeated and prolonged trauma, we often find that the client has traumatic responses that include more than the typical PTSD symptoms. Herman (1992) writes that these posttraumatic response patterns "are best understood as a spectrum of conditions rather than as a single disorder" (p. 119). She calls this spectrum *complex posttraumatic stress disorder*, also known as disorders of extreme stress (DESNOS). Complex PTSD includes a set of additional problems that constitute "profound systemic alterations" (Herman, 1992, p. 121), including alterations in affect regulation, consciousness, systems of meaning, relations with others, and perceptions of the self and perpetrator (van der Kolk et al., 1996). Clients with complex PTSD often present with intricate layers of symptoms that are daunting to therapists. In order to understand the underpinnings of these complex disorders one must pay attention to the complex ways that family attachment styles and family relationships interact with the kinds of trauma, as well as the duration of traumatic occurrences.

Potential Problems With Using EMDR With Dissociative Clients

For clients who are vulnerable to dissociation, problems can arise if the standard EMDR procedures are used without additional measures to help the client experience sufficient safety and orientation to the present, so that posttraumatic material can be accessed and processed to resolution. The most frequent problem is that the processing is blocked and the client reports, "Nothing is different. This isn't helping." This result, which can be discouraging to the client, may be an indication that one ego state opposes the processing that is being attempted by another.

This opposition may be due to a difference—an internal disagreement—regarding the identified goals of therapy. For example, one part of the personality may want to learn to be more assertive, while another may oppose this goal because of fear that assertion could lead to loss of a relationship. To give another example, a common conflict with individuals with addictive disorders is ambivalence regarding sobriety. Often this conflict is between an ego state that wishes to quit and another that has strong urges to continue the addictive behavior. A very dangerous conflict that frequently occurs in clients with DID is between states that wish to live and learn to enjoy life and states that are suicidal.

For all of these situations, the therapist and client must carefully define overall therapy goals and, when needed, establish separate contracts with different ego states. In all instances, of course, suicidal ego states must agree to contain their self-destructive urges, or submit to the control of other ego states that will monitor the suicidal state to insure safety.

Clients with PTSD often experience intrusion, accompanied by fear and confusion as their conscious awareness is invaded by fragments of unresolved memory material. Even with clients who are amnesic for traumatic events, intrusive symptoms of nightmares, auditory hallucinations, and fragmented visual flashbacks often occur. Switching itself can be regarded as a phenomenon that results from the intrusion of traumatic memory material that overwhelms and displaces the person's normal sense of self.

Therefore, it is necessary with clients who show dissociative symptoms to discuss in advance the possibility of high levels of affect and establish appropriate safeguards. Specifically, it is necessary prior to trauma work to strengthen the client's present orientation and sense of safety and mastery in the face of the threatening memory. This is accomplished through an extended preparation phase and through additional procedures to maintain emotional safety during the desensitization phase.

Unique Challenges of Working With Clients With Complex Trauma

Accessing Isolated Ego States and Fragmented Memories

Ego states—both those that constitute the apparently normal part of the personality and those that originate in traumatic experience—can be conceptualized as separate memory networks with a physical existence (Paulsen, 1995).

We can surmise that this separation of different locations of memory storage has occurred to protect the person, through fragmentation of awareness, from the horror of overwhelming affect and complete cognitive disorganization. One client in the later stages of therapy described it this way: "I had the choice: either reject my own feelings and try to look normal, or go completely crazy. I learned to leave my body and go up to the ceiling so I wouldn't have to go crazy." If pathological dissociation begins in this way, and if traumatic stress continues in the child's environment, the risk of continued fragmentation of consciousness increases. In the extreme, this process results in distinct personality parts that are isolated and inaccessible to each other.

Enhancing Present Safety and Grounding

When we ask a client to access a disturbing memory, we are requesting that the client reassociate the memory that has been separated. This can be therapeutic only if the person is able to maintain dual attention, that is, simultaneous activation of both the neural networks of present orientation and safety and the networks holding the disturbing memory. Initially, this is difficult for many dissociative clients because the positive networks are absent or weak, or the posttraumatic memory network is intrusive and strong. For these clients, the EMDR preparation phase must be emphasized and carefully implemented in order to enhance access to the resources of present safety, empowerment, and mastery over the memory material.

It is very helpful during preparation to use bilateral stimulation to increase the felt sense of positive affect (Kiessling, 2003) for many aspects of functioning. For some clients (for example, those who have never had the life experience of trusting or feeling safe with another person) this process of preparation may be complex and extend over many sessions of therapy.

Even for those dissociative clients who have been able to establish trust in the therapist, dual attention can sometimes be difficult to achieve. An additional and sometimes crucial element in maintaining emotional safety is to "lead with the cognitive" (Fine, 1995). In other words, a clear cognitive understanding of the anticipated steps in trauma processing is potentially grounding for the client, and it helps if this understanding is both verbal and visual. Specifically, it is useful for clients to have a clear sense of the path along which treatment will proceed, and also to create a map of their own dissociative structure.

As endorsed by the International Society for the Study of Dissociation (ISSD, 2005), it has long been clinical practice to use a three-part phased model in the treatment of trauma and the dissociative disorders.

The terminology used to name and describe the three standard phases of treatment varies from author to author. There is general agreement on the tasks central to each phase in spite of the different wording. According to Herman (1992), the task of the first phase is to establish safety; the second-phase tasks concern remembrance and mourning; and the third phase task is to reconnect the client with life. F. Shapiro's (2001) eight phases of EMDR roughly parallel the three phases described by Herman. We will adopt the terminology used by van der Kolk et al. (1996) to describe the three phases and their tasks:

Phase 1: Stabilization, to help clients control their reactions to the trauma and prepare for trauma work

Phase 2: Identifying and successfully processing the traumatic experiences

Phase 3: Resolution, to clear symptoms, reconnect with self and others, and have efficacy in life domains

In practice, specific therapeutic interventions (working with dissociation and affect management, developing safety and internal stability) need to be applied in more than one phase. After Phase 1 skills have been developed, the client may need to return to stabilization and safety interventions during trauma work, even after the reconnecting/resolution or integration phase of treatment.

Phase 1: Stabilization and Symptom Reduction

The important tasks in the first phase of therapy are development of co-consciousness of ego states, providing orientation to the present, and affect management. We help clients gain mastery over their experiences and reduce symptoms, as well as build trust and comfort within the therapy relationship. Another Phase 1 focus is diagnosis and treatment planning, based on extensive history taking and dissociative interviews. Available tools include the Dissociative Experiences Scale (DES; Carlson & Putnam, 1993), the Dissociative Disorders Interview Schedule (DDIS; Ross et al., 1989), the Structured Clinical Interview for (*DSM-III-R*) Dissociative Disorders (SCID-D; Steinberg, Rounsaville, & Cicchetti, 1990), and the Multidimensional Inventory of Dissociation (MID; Dell, 2006).

EMDR work in Phase 1 includes history taking, preparation, and introduction of EMDR concepts and procedures. The latter will be introduced only when the client is stabilized. Since life continues while clients are dealing with each phase, it is important to help them avoid being flooded and overwhelmed (in and outside of sessions) and improve current functioning. An essential goal in this phase is to begin to enhance the evolution of the internal system. Part of the legacy of trauma and dissociation is not only the problems with attachment but the missing personal and interpersonal skills. Many of our clients describe trying to function in adult life without the blueprints. Extending the preparation phase allows for time to build up structures that were disabled and broken down by issues such as trauma, loss, or unstable family life.

Psychoeducation

A psychoeducational approach—teaching clients about their symptoms and how they may be resolved—will create the proper environment for stabilization. Being armed with information will give clients hope for resolution and a sense of normalization about their problems. We often struggle to find a way to help clients understand what has happened to them. Their PTSD and dissociative symptoms are often terrifying and confusing. Many clients need slow and careful doses of information about trauma and abuse.

History Taking

With complex cases, it is not possible to get a full history in one or two sessions. Extended history-taking sessions should be planned around the client's comfort level. History taking needs to be detailed, but structured at the client's pace to be as non-triggering as possible. The therapist's empathy and considerate questioning are extremely important. History taking should include these aspects of the client's past and present experiences:

1. *Current issues*. Physical and mental health issues—PSTD symptoms, depression, anxiety, and dissociative symptoms in the present; present stressors and triggers; current support from family, friends, coworkers, and clergy.
2. *Developmental history*. Early-childhood and family history that includes family attachment styles and conditions in the home; a complete physical and emotional health history beginning with infancy, for the client as well as family members (for example, the mother's physical and emotional health in pregnancy); compulsive disorders for the client and family; losses in early life.
3. *Trauma history*. Over time, safely explore the trauma history, which can include early losses and other situations that have been experienced as traumatic (including health issues), such as clusters of small-t traumas, interpersonal connections, inability to love, feelings of isolation, fragmentation of self, chronic stress responses, and early reports of dissociative symptoms. Looking for strengths and resources over the client's lifetime is important because clients need to know that they are not just a collection of problems and symptoms.

Always pace history taking according to the client's ability to stay present. Make it clear that the client is in control of the amount of information the client is willing to contribute during a session. Stress that comfort rather than time is important. Call a time-out when necessary.

Unfortunately, it can be difficult or impossible to elicit a complete history when the client presents with either recent-incident trauma or one major traumatic event (Type 1 trauma). Caution is necessary in this case because the therapist will not be aware of the full

extent of the big and small-T traumas that influence growth and development. With clients with multiple trauma events (Type 2 trauma), proceeding to trauma target selection, desensitization, and so forth without this information may impede processing or be destabilizing. In these circumstances, therapists need to be alert to the emergence of history as therapy proceeds.

Bilateral Stimulation in Phase 1

Sets of bilateral stimulation (BLS) such as eye movements, tapping, and audio stimulation may be introduced during this phase to support stabilization activities. The decision to use BLS is always predicated on assessing clients for sufficient stability and grounding. BLS seems to increase focus and reinforce stability and activities related to safe-place development, resource development, ego strengthening, and stress reduction.

In addition to the above, one study has concluded that BLS in general also has the effect of inviting unresolved posttraumatic material into consciousness. Since bilateral eye movements enhance the retrieval of episodic memories and other negative material, audio tones or tactile stimulation can be substituted if this retrieval is too intense for the client. For those more fragile, less grounded, or more dissociative clients, BLS will be used only to reinforce readiness activities when it is safe and necessary—it may be postponed to when trauma targeting takes place.

Initial Ego State Work

The voices or inner conversations described by our clients are those of their internal parts. They sometimes appear to clients to be in a chaotic situation that often echoes their families and childhood homes. What is important for both therapist and client to keep in mind is that ego states also have the capacity to change, combine, grow, and adapt, through dialogue with each other, and through the increased reality orientation that can occur with effective trauma processing.

Clear explanations about the ego state system and its functioning in the past and present continue to give the client a framework for self-understanding. Without being too technical, an explanation that clients can understand is that dissociated ego states are neural networks holding aspects of memory, narrative, and physical sensations. Although the client may be skeptical, provide assurances that there are also healthy ego states that are well-functioning, adaptive resources. Explain that treatment will help the client get to know and understand the ego state system and reconnect with these resourceful, healthy parts.

Accessing the Ego State System

A means must be chosen to facilitate the client's introduction to the ego state system. For some clients, concretizing the ego state system via mapping, listing, drawing pictures of the parts, or creating an internal landscape is helpful. The therapist can also ask, "If the internal family or parts could come into this office now, who might you see?"

The client and the system may know directly or only indirectly of each other's existence and roles. The when and where of meeting the ego state system will be client specific.

Clients' attitudes toward their parts vary. We must accurately gauge empathy for the system parts and developmental readiness for this work by observing the client's verbal and body language. Are the parts described or describing themselves with self-hatred, loathing, loneliness, and isolation? We note if the client's descriptive language is abusive, empathic, distant, or stern. A balance must always be maintained between two important considerations: preserving the stability of the adult ego state that is being asked to access the child or other ego states, and allowing validation and expression of the ego state's unprocessed experience. This is sometimes a thin line to walk.

The therapist should note if there are stern, harsh critics or perfectionists among the states. Bullies can be reframed as once having had a protector role. It is important to tell the client that having an inner critical voice might have prevented punishment from parents in childhood (by reminding the child to stay quiet and invisible).

In helping the client learn about the parts, questioning interweaves may be used: "How old were you when that part had to take on that critical function?" "What was going on in your life?" "What was good about having that part function in that way?"

The Relationship of the Therapist to the Ego States

Through all three phases, the therapist must continue reassuring the ego states that they cannot and will not be expelled, abandoned, or "killed off." Even if the parts change their roles over time, they are necessary to the existence of the ego state system.

The therapist has to form alliances with the ego states during the treatment. This particularly applies to angry, self-hating, destructive, punitive parts. Identifying them and acknowledging their pain, qualities, and roles is

crucial to successful treatment. The therapist's consistency in this encourages the client to look at the parts through new lenses.

Creating a Home Base

The home base (Forgash, 2004) is a place where the ego states can find safety, privacy, and relaxation. The creation of a home base is a new idea for many survivors who did not have those things in childhood.

For some clients and their parts, a home base is impossible in the beginning because no place is yet safe. When the client first develops this space, it may look barren and unprotective, or it may be a lovely structure. In time, the client and the ego state system together invent a beach cottage, a cabin on a lake, a greenhouse with climate and shade controls. Sometimes the home base has to be part of the client's actual home.

Once the home base has been created, some parts want to move in, while others may refuse to go to there initially. Some parts are shunned by others or feared, and may need a separate space or one connected by a hall or breezeway, or they may even live in a separate structure. This usually evolves positively over time. Some activities to build a working relationship with the ego state system involve the client and ego states decorating the house and developing the outside environment.

Choosing and Installing a Workplace for the Ego State System

A workplace, office, or conference room where ego states can be accessed and joint work can take place is also created in this phase. Many types of workplace or conference rooms are suggested in the literature. In Fraser's (1991) Dissociative Table Technique, the client sits at an oval table and invites ego states to sit in the empty chairs around the table.

Clients may want to include a conference room in their home base. They may wish to use the therapist's office setting or a familiar place for the workplace. The client and ego state system may equip this room with microphones, speakers, a TV, or movie screens.

Orientation to Present Reality

Because EMDR reprocessing of trauma is based on simultaneous attention to past and present, it is important that the client be aware of and have the skill to remain grounded in present reality. Often ego states that experienced trauma in the past—especially child states—may not be oriented to the present. The exercise called Orientation to Present Reality (OPR) (Forgash, 2005; Twombly, 2005) helps the ego states learn about present time and place and can enhance feelings of reality and security and a sense of appropriate caring by the adult.

Parts can use an imaginal screen in their workplace to view images of the therapy office or the adult client and the adult's present age, body, gender, roles, and so on. They can imagine sitting or standing next to the client and noticing the size differences. A video tour of the adult's home, job, present life, family, and so on is helpful.

This sets the stage for an acceptance of current reality and changed conditions. For example, the ego state system may need to learn that perpetrators are dead, that the adult lives independently, and so forth. This information can be shocking. Parts may feel they are being tricked and lied to by the therapist and client.

This OPR work is titrated as needed. OPR generally needs to be repeated many times during treatment, as parts who need orientation or reorientation may appear at any phase.

Constructive Avoidance

Constructive avoidance is a technique for managing current life stressors (Forgash, 2004; Kluft, 1993). The adult client needs to be able to function in life while therapy work is proceeding . The therapist must teach the client not to expose immature or unhealed parts to potentially triggering or frightening events (medical procedures, sexual intimacy) or to situations for which they have no understanding or skills (public speaking, employment interviews, or arguments with spouses).

It is helpful for the client to explain the upcoming situation to the parts—the time and place of the event and what will be happening. The client then encourages the parts to stay in the home base until the adult says, "I'm home" or "It's over." This is very different from what was experienced in the family of origin, where the needs of the child were not considered. Supporting the more vulnerable parts in this manner requires practice in and out of session. Repetition of this work with many different situations fosters mastery and ends the client's past avoidance of necessary situations and life engagement.

Boundaries for Participation in Ego State Work

In working with an ego state system that includes children who experienced trauma, the therapist must establish parameters of respect, consideration, and care that were most likely absent in the childhood

home environment. The pacing of any work is set by the system. Appreciating differences in developmental abilities and readiness among the parts helps therapists time their interventions based on accurate ongoing assessment. Consent must be obtained from the states prior to any activity. To identify treatment priorities, the therapist can ascertain which ego states are hurting the most and ask the permission of the other states to work with those that most need relief.

Ego states cannot be coerced into participation. Some may not be willing, for example, to listen to important psychoeducation about stabilization. In that case, the skill is taught to the parts who are willing to listen. Not every state has to participate, but all must agree to not sabotage the client or other parts who participate. The therapist must be careful to not impart negative judgment concerning these decisions, which simply can be defined as unreadiness. An activity or exercise can be put off until there is agreement on participation among the states.

Ego state conferences will be used to problem solve these issues. This results in an increase in acceptance of all ego states by opening lines of communication and increasing understanding of their motives and intentions.

The clinician and client can define acceptable participation of the ego states in sessions and set some stable rules for behavior. For example, if one state always gives the client a headache when the client wants to be present in session, the therapist and client state why this is not acceptable. This does not occur only in clients with a diagnosis of DID, but with many highly dissociative clients. Respectful engagement should be encouraged. If the part refuses to give up the behavior, the negotiating continues until there is resolution. Sometimes another part is willing to mediate or be helpful.

These old behaviors are framed as once having been adaptive on the part of protective states, but they are not currently helpful. These states are very fearful of change. Contracting for work with a particular part may involve setting very small goals. It will help to acknowledge all ego states' desire to increase the person's chances for survival (even when their strategies appear counterproductive).

Interventions for Managing Dissociation and Affective Symptoms

Containment. We teach the concept of containers for dealing with troubling or overwhelming emotions, thoughts, and sensations. The client is encouraged to imaginally develop containers such as safes, closets, boxes, or bubbles to hold this material temporarily. A room in the home base can be designated to hold the containers. Clients can then imagine letting feelings flow into the container and observe what effect that has on them (reduction of intensity, relaxation). They learn that containment is different from the old behavior of "stuffing," or repressing feelings. This temporarily contained material will be brought back to sessions, not hidden permanently.

Containment can be taught and practiced with some or all parts. It provides a new reality: an awareness that feelings can be put away and that one is not at the continual mercy of emotions.

Affect Regulation. It is common for complex trauma clients to be unable to identify terrifying and overwhelming feelings. Over time, the client and ego state system need to develop the ability to identify feelings and understand their functions. It may be very helpful for the client to identify the traumatized ego state that is the origin of disturbing feelings

Self-Soothing. Clients need to learn self-soothing in order to manage affect both during and between sessions. They can take on a parental role by asking the ego states what they need to be comfortable. The response may simply be a blanket or a hug. Consistent caretaking of the ego states is encouraged, as is dialogue with the parts to problem solve or to discuss internal or external change. These activities help clients develop parental responsibility over time.

Grounding. This involves teaching the skill of understanding the body and self in temporal reality, and being able to stay or return to present reality. When clients gain the ability to deal with symptoms by using grounding strategies, they gain a sense of safety and control.

These questions will help the client be grounded in the present: "Can you feel the couch behind you? What does that feel like? What are your arms resting on?" Grounding procedures are particularly helpful for clients who dissociate.

Screen Work and Affect Dial. The affect dial (Forgash, 2005; Kluft, 1993) is a distancing mechanism that can be imagined as the on/off button on a radio or a television remote control. This dial can be used by the client or by individual ego states to turn off or turn down overwhelming images, thoughts, emotions, colors, or shapes on the TV or movie screen. The size, clarity, or voice volume can be controlled through the dial.

The client starts out by imagining a screen in the conference room or workroom. The client then puts

benign images on the screen using a remote-control device that has many buttons or knobs on it—for color and black and white, a fade button, a size, and volume knob. This activity is limited only by imagination. Often this imagery does not work immediately but becomes a useful client tool with practice, if the client is ready for the work.

Somatic Work. According to van der Kolk et al. (1996), a central feature of PTSD is a loss of the ability to physiologically modulate stress responses. This can lead to a diminished capacity to utilize bodily signals and may also be responsible for immune system impairment. It is well documented that the chronic PTSD population suffers greatly from a variety of stress-related illnesses and syndromes.

EMDR places emphasis on identifying and recognizing body sensations, which normalizes the presence of physical sensations that are often troubling to the ego state system. Clients will subsequently be less fearful of processing sensations, symptoms, and the memories to which they are tied.

In the preparation phase, there is an emphasis on somatosensory exercises that utilize identification of positive (calm, serene, tension-free, and relaxed) body sensations as resources. This work prevents hyperarousal and numbing episodes and eventually allows clients to stay in their body even when processing difficult material. If practiced regularly, it helps reduce fear, making it easier to process. This work may be enhanced with BLS.

All sessions during Phase 1 end with some debriefing, containment work, relaxation, or somatosensory activity. All of the above interventions and activities can be enhanced with BLS if this is perceived as safe by the system.

Conclusion

The healing benefits of EMDR can be extended to a much wider population of clients by extending the length and scope of Phase 1 (the stabilization and preparation phase of trauma treatment) and adding work specific to EMDR Phases 1–3, that is, specific ego state work and dissociative symptom management interventions. Enhanced preparation helps clients come to an awareness and acceptance of their ego state system and develop the ability to self-soothe and manage dissociative and PTSD symptoms.

Clients with many complex diagnoses who are thus empowered can then deal effectively with their unresolved memory material—looking at their life experiences with both compassion and objective understanding. In Phase 1 of this integrated treatment model, the internal family system of ego states is recognized for having played purposeful, honorable roles during the earlier times of terror and chaos. With increased internal respect, symptom management skills, and stability, the processing of long-held traumatic memory material becomes possible. As this occurs, the client and ego state system can increasingly implement a more effective blueprint for living.

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