Treating Complex Posttraumatic Stress Disorder with EMDR and Ego State Therapy

Combining Ego State Psychology with EMDR enables psychotherapists to better deal with the complex consequences of psychological trauma

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Summary

In this adaptation of her keynote address presented at the European EMDR Annual Conference in Frankfurt, Germany, in May, 2002, psychotherapist Carol Forgash explains that the context of psychotherapeutics has changed since the early years of EMDR. This change supports the combining of EMDR with ego state psychology to better deal with the complex consequences of serious trauma. Forgash proposes that ego state conceptualizations provide a constructive, efficient, and accessible means for therapist and client to work through these complexities.

Historical Perspectives on Traumatology

In this paper I will describe how a combination of EMDR and ego state therapy, along with interventions used to treat dissociation, can be used to treat complex posttraumatic stress disorder, resulting in a treatment model that is more powerful than the use of any of these methods alone. I will particularly emphasize the extended stabilization and preparation phase that is necessary before beginning EMDR work with clients with complex PTSD.

We begin by reviewing the history of traumatology so that the present context and need for a new treatment method may be better understood.

The effects of trauma have been known since the end of the 19th century. And yet, that important knowledge was subsequently "forgotten" for many years and was not available to clinicians. Judith Herman, in her book Trauma and Recovery (1992), describes society's tendency to sometimes remember what trauma is and what it does to individuals, groups, and institutions, and then to forget those important concepts. This is of course a shift from awareness of reality into denial and dissociation-exactly what our clients with complex PTSD and dissociative disorders do! They want desperately to remember their traumas, but when they do, they want just as desperately to forget.

Therefore we have needed, over the past 25 years, to rediscover what was already known about trauma-concepts that were as correct then as they are now-and to relearn to apply that information.

Secrecy, **avoidance**, and **denial** - common reactions to trauma - are all too prevalent in the public and private domains. Arne Hoffman and Peter Liebermann, in their presentation at the 2001 ISSD conference (New Orleans), spoke of this as a "collective dissociation." They added that when this happens, there is frequently also concomitant loss of empathy for others-in this case, for trauma victims. The mental health profession is not immune to this phenomenon. Fortunately, over the last 25 years we appear to have returned to the remembering and discovery phase.

One hundred years ago Janet and Freud began to study and develop theories about childhood sexual abuse. This was the first important research into trauma. We know that Freud later retracted his seduction theory due to many factors. Clearly, it was threatening material.

After World War I, theorists, researchers, and clinicians began studying the effects of combat on soldiers. Their conclusions about the trauma of war were equally unpopular and virtually disappeared for 75 years. Society treated trauma survivors with a lack of empathy that mirrored these clients' feelings about themselves. They are different, hard to deal with, and remind us of the results of human cruelty that we don't want to see.

Listen to the descriptive language used in the past century to describe casualties of war and abuse: They have been called "malingering," "lying," "cowardly," "factitious," "schizoid," "hypochondriac," and even "slutty." It has been said that they deserve what they get; they exaggerate; they're bad, lazy, borderline, impossible clients. This unempathic language, reported to me by my own clients and spoken by family, military officials, health professionals, and mental health clinicians, doomed people to further suffering. This language has also affected and threatened those of us who do this work. In the United States, the False Memory Syndrome Foundation spent much of the 1990s suing therapists for allegedly implanting false memories in their clients. The work we do with our clients diagnosed with complex PTSD must remedy these historical biases.

From the Beginnings of EMDR to the Present

In 1995, when I was trained in EMDR, the compelling question about treating the dissociative disorders and PTSD with EMDR was, "Can you use EMDR to safely treat complex, chronic posttraumatic stress disorder and the range of dissociative disorders?" The answer was, as Sandra Paulsen (1995) wrote in one of the first publications on the use of EMDR for the treatment of dissociation: Yes, but cautiously. It was to be used for the reprocessing of trauma. As we now know, this was a sensible goal given the state of the art and development of EMDR at that time. Paulsen called EMDR a "divining rod" for dissociation, to be used carefully.

At the EMDR level 1 training we were reminded not to treat people presenting with dissociation unless we had sufficient prior knowledge and experience. After that training I returned to an office filled with dissociative survivors of child sexual abuse. After 15 years as a trauma specialist, I knew how to use the prevailing treatment modalities, but I knew nothing about the potential impact of EMDR in ameliorating the problems of these clients diagnosed with DDNOS or DESNOS. Many clinicians found, to their distress, that if the EMDR trauma protocol was used with dissociative clients without the prior development of a secure therapeutic relationship, and without screening for dissociation and extensive preparation for trauma work, destabilization and increased dissociation would follow. Clearly a new treatment approach was needed to meet the needs of this large population of trauma survivors who did poorly with the standard EMDR protocol.

Now, 15 years after the introduction of EMDR by Francine Shapiro, we have made further strides in understanding the treatment of severe trauma. There is much in the way of new biopsychosocial research and clinical studies to inform our questioning-material that is beyond the scope of this paper. There is current research into understanding the effects of trauma; the relationship between early attachment conditions and the later development of PTSD; the disorders of affect regulation that follow abuse; the manifestations of dissociation in PTSD; the neurobiology of PTSD and dissociation; and so on.

Why EMDR and Ego State Therapy?

As clinicians, we want to know how to use EMDR most effectively and efficiently in the treatment of complex PTSD and the dissociative disorders. We need to ask, What can be achieved in treatment? What kinds of resolution and changes can we expect? How can we be most helpful as therapists? Do we want to merely eliminate symptoms, or help people with these most complicated diagnoses find a way out of suffering?

I propose that we utilize EMDR and ego state treatment to help trauma survivors develop more functional inner boundaries, ego state systems, stability, mastery of life skills, and most importantly, empathy for themselves. We want to help them move from victim status to thriving and leading a full life.

Integrating ego state work with EMDR can allow us to achieve goals beyond elimination of PTSD and dissociative symptoms. In the model I describe here, the standard EMDR protocol is blended with effective interventions and phased treatment approaches often used to treat dissociative and posttraumatic stress disorders, and ego state psychotherapy strategies. Working with our clients in this way, and from a position of empathy and understanding of the legacies of trauma, we can help them resolve their most critical issues and go on to develop and utilize a blueprint for healthy living.

Introduction to Ego State Therapy

Ego state theory was developed initially by Paul Federn (1932, 1943) and extended by John Watkins and Helen Watkins (1995), Richard Erskine (1997), Eric Berne (1963), and Richard Schwartz (1997). It posits the existence of an internal family variously termed **parts**, **ego** or **self states**, or **selves**, or conceived of as neural or memory networks.

The ego state system can be thought of as a segmentation of the personality into self states or parts at points along the dissociation continuum that comes about due to normal differentiation, introjection, or trauma,

Ego states may be described as an organized system of behaviors and experiences that have varying boundaries. The states may be organized to enhance adaptability in coping with events or problems. Some ego states are delineated by time dimensions: a five-year-old, teenager, or infant, for example. Others are delineated by function, trait, or role, for example self-hater, nurturer, critic, executive, bratty kid, daredevil, curious, nature lover, parent, grandparent, and so on.

Ego states may have normative imaginal or creative functions, such as daydreaming. However, ego states formed in childhood may function maladaptively in present life situations. They seek to protect their existence and roles, even if those are counterproductive. This is similar to organizational maintenance theory: no corporation willingly goes out of business. Ego states can conflict with each other, leading to intrapsychic conflict. Finally, they have the capacity to change, combine, grow, and adapt.

Ego state work utilizes individual, group, and family therapy techniques for the resolution of conflicts among the ego states that constitute the internal family. The ego state techniques and procedures I will describe draw upon the work of Kluft (1993), Fine (1993), and others. They were developed to treat dissociative identity disorder specifically, but have been successfully extended to treat the range of dissociative disorders. A number of EMDR therapists have presented and written about their use of this integrated treatment with varied populations. They include Bergmann (2000), Forgash (2002), Grand (2001), Knipe (2001), Paulsen (1995), Phillips (2000), Schmidt (1998), and Twombly (2000).

A Portrait of Complex Posttraumatic Stress Disorder

If we look at the symptoms of posttraumatic stress disorder we can begin to get a sense of what the client with complex PTSD and dissociation brings into treatment. The following is a sample scenario of childhood trauma with negative consequences, leading to complex PTSD.

A trauma such as a disaster or major loss occurs and no parental help is available. There is no comforting or mirroring by a parent or other attachment figure. No systemic self-soothing or empathy is available internally or externally with any consistency. Chaos and instability follow. Dissociation or freezing occurs. This can lead to a sense of nothingness or emptiness.

The trauma may be repeated or become episodic, perhaps involving ongoing physical damage. In response to repeated severe trauma a network of dissociated ego states or neural networks may form, and dissociation, amnesia, and somatization may ensue. A possible explanation for this is that the traumatic material is dissociated and moved to disconnected neural networks. Memories and behaviors associated with the trauma are sometimes stored in fragments and therefore not available for information processing. When the client is cued or triggered, these distressing memories can invade the person's consciousness. These trauma victims suffer from emotional dysregulation and cannot close down the disturbances when triggered.

Following are the main diagnostic symptoms of PTSD that these clients frequently present: intrusive recollections of the trauma, a sense of reliving traumatic events, hypervigilance, exaggerated startle response, flashbacks, nightmares, night terrors, sleep disorders, irritability or agitated behavior, difficulty concentrating, anger dyscontrol, avoidance of people and triggers that are reminders of the trauma, a range of dissociative symptoms, numbing, flat affect, anhedonia, distress following internal or external triggers, feelings of isolation, detachment, and lack of trust.

Others symptoms commonly seen include phobias, obsessive-compulsive disorder, ill health, hopelessness, learned helplessness, affect intolerance, self-injurious behaviors, and risk-taking behavior. Diagnoses of Axis 2 disorders and anxiety and mood disorders are frequently seen in this population.

Additional problems described by Judith Herman (1992), who developed the concept of complex PTSD, are explained as "profound systemic alterations." Those include alterations in systems of meaning (loss of sustaining faith and a sense of hopelessness and despair); alterations in relations with others (failure to protect oneself, isolation, withdrawal, and disruption or avoidance of intimate relationships); alterations in perceptions of the perpetrator (power imbalance, the victim taking on responsibility for abuse, Stockholm Syndrome). Additionally, there are self-perception alterations: guilt, shame, self-blame, and stigma.

So many natural processes and developmental stages become disrupted, delayed, and negatively impacted by childhood trauma, war, atrocities carried out on individuals and groups, familial abuse, losses, and natural disasters. Often there are feelings of disrespect and betrayal. These disruptions can lead to poor functioning as an adult. In many areas, full potential of the self has not been reached. Clients with these problems often present with intricate layers of symptoms and problems that seem daunting to therapists.

According to van der Kolk, McFarlane, and Weisaeth (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 as well. It is well documented that the chronic PTSD population suffers greatly from a variety of stress-related illnesses and syndromes.

Treatment Goals

A successful EMDR and ego state integrated treatment model permits our overarching goals of treatment to become more expansive. These goals include helping clients in a number of crucial areas:

• To provide safety and develop stability in treatment and in current life experiences.

• To help clients become affect tolerant and able to regulate emotional responses.

• To reprocess trauma and manage and eliminate symptoms of PTSD and DD.

• To repair damage to boundaries and the internal structure.

• To resolve relational and trust issues (attachment breaks and losses, fears of intimacy).

• To enable the person to develop empathy for self and the internal family system.

• To help clients reach their potential in a number of crucial areas, including the ability to meet their own needs more effectively and to become effective parents to themselves.

These goals are also described from an attachment perspective by Barach and Comstock (1996), who emphasize stabilizing self-other object representation through facilitation of the development of an internal "secure base."

The Treatment Challenge of Complex PTSD

Organization of Psychic Processes Viewed Historically

Michael Levine speaking at a 2002 literary forum about trauma survivors' attempts to write about their experiences of horror, referred to Freud's writings on hysteria and suggested that trauma survivors frequently engage in a traumatic repetition in which the self attempts to return to, transform, and gain some control over a traumatic past. Levine said that the survivor has to deal with competing drives: wishing to return to the same place, and also wishing to go to another place, one where the trauma has been at least partly changed. Yet the survivor who cannot arrive at this new place may become trapped in a black despair from which there seems to be no exit.

Once again we turn to Janet (1919), who wrote that traumatized clients have lost the ability to progress in the evolution of their lives. They cannot integrate traumatic memories, and further lose their capacity to assimilate new experiences as well. According to Allan Schore (1994), Janet postulated that traumatized people may have immature personality organization with vulnerable and inefficient coping capacities. Their response to stress is expressed in alternating experiences of hyperarousal and dissociation.

Specific Ego State System Concerns

Here is the crux of the matter: treatment of trauma survivors and the ego state issues that come into play in their therapy are complex issues for therapists to grapple with. If we ignore them it will be to the detriment of the client.

Trauma victims commonly have an internal ego state system with parts that function maladaptively in the present. Parts may become pathologically dissociated, with serious conflict among some of the parts. Some parts may fear annihilation if they lose their perceived roles and know that they are not honored or respected for their original role as system protectors. We need to recognize those parts. Some ego states (as well as the client) may not be aware of the existence of other parts, and may not be orientated to the present (time, place, year). There may be no co-consciousness--that is, the client may not be aware of ego states and their influence, and the parts may not be aware of each other. Clients may only have perceptions of differentness and alienation from others and almost certainly are ignorant as to the causes of their present problems.

Challenges within the Therapeutic Relationship and Process

Additionally, the intrusive and dissociative aspects of posttraumatic stress symptoms produce treatment difficulties that can include destabilization and dissociative episodes as well as resistances that therapists are not commonly trained to recognize in non-ego state psychotherapy. These resistances may involve ego states who fear exposure for violating taboos against "telling." Fearful anticipation of painful, punitive sequelae to disclosure of abuse-secondary to the experience of abandonment by parental figures, siblings, other relatives, and even by parts of the ego state system-may become a major treatment obstacle. Such a painful consequence is often what the client expects due to past threats or actual experience with abusers or other family members. The client may experience overwhelming shame, guilt, distrust, and fear of rejection by the therapist.

Many clients are aware of their problems with affect dysregulation and fear being flooded by feelings and memories coming up in treatment that will prevent them from functioning. Therapists, even those who are EMDR trained, are often not aware of containment techniques and stress management strategies that the client needs to learn prior to working with traumas. If these fears persist with no reduction, or in fact escalate into higher levels of distress, clients may experience increased levels of frustration, feelings of defeat, depression, and anxiety. Loss of belief in the efficacy of therapy can follow. We will be perceived as not helpful or as unempathic. It is important to note that many of these clients have already been given multiple and conflicting diagnoses and have experienced many failed prior therapies.

Implementing Integrated EMDR and Ego State Therapy

Using an integrated EMDR and ego state model allows us to diagnose readiness for trauma work, stability, and specific needs of the individual with a complicated trauma history. Eventually we can work with issues and problems involving trauma and dissociation with safety and precision. Protocols in this model are individually tailored and ego-state specific. SUDS levels can go to zero and remain there. This is a longer EMDR treatment model, one in which deep work can be accomplished.

In contrast, in conventional EMDR treatment with clients who are diagnosed with PTSD, dissociative disorders, or personality disorders, ego state treatment usually has not been integrated into the treatment planning or into the protocol. If uncovering work or desensitizing and reprocessing work is prematurely attempted, these clients will often destabilize or experience other treatment difficulties. Therapists report that there are many processing sessions where SUDS levels don't go down, or if they do, they do not stay down and symptoms continue. This is due to the presence of one or more unacknowledged ego states who have not been included in treatment. Over time, this interferes with treatment and with the therapeutic relationship. With the integration of ego state work at an appropriate point in the preparation phase of treatment, these problems can be resolved.

Levels of Dissociation

The standard EMDR protocols only address the primary and secondary dissociation that frequently accompany and follow traumatic events. These two types of dissociative symptoms typically are symptoms of posttraumatic stress disorder.

Primary dissociation consists of flashbacks, intrusive thoughts, and somatic symptoms. Secondary dissociation consists of depersonalization and derealization.

In contrast to the former, tertiary dissociation, which is addressed by the proposed treatment model, includes the formation of a range ego states, from normal functional parts to less functional self fragments or alters. Tertiary dissociation is considered ubiquitous--Bromberg (1994) and Watkins and Watkins (1996) describe the formation of ego states as a line of normal human development.

In the EMDR treatment of dissociated, traumatized clients who are dealing with these less functional parts, ego state work needs to be an essential part of the preparation stage. If it is not, as mentioned above, there may be diminished response or non-response to treatment.

The Preparation Phase

Particular importance must be placed on the preparation phase, which becomes greatly extended to meet the needs of the client with complex PTSD and dissociation. In this phase we will lay the foundation for a new and respectful building of relationships: between the client and therapist, the client and the internal system, and among the parts. In the 21st century, we return to the Janet's late-19th-century phased treatment in which stabilization must precede trauma treatment. In fact, the techniques that are a fundamental part of the preparation phase will continue to be necessary throughout the treatment relationship.

An essential goal of the preparation phase is to enhance the evolution of the internal system. One of my clients called this work a "second course in childhood" for her. In this phase a strategic and procedural approach is individually tailored to each client. The work allows for the building up of structures that were disabled and broken down by issues such as trauma, losses, or unstable family life. We initiate systematic and consistent sequencing of developmental work, starting where the client is. The client is eventually able to deal more safely with traumatic material because of the extensive preparation involving work toward affect and dissociative symptom management. This work can lead to mastery and control in present life.

It is a clinical decision when in this phase to introduce ego state concepts as well as information about EMDR. Screening for the range of dissociative symptoms and assessing the client for stability are key to the decision to proceed. There are many stabilizing interventions that can be taught prior to the introduction of ego state work if the client is too dissociative or unstable to attempt parts work. Elements of the EMDR protocol can be introduced as a framework for discussion about the client's problems and traumas that eventually will be reprocessed after stability is achieved.

Bear in mind that we utilize a psychoeducational approach to create the environment for ego state work. Providing information about the ego state system gives the client a framework for understanding the effects of trauma. In order to normalize ego state concepts it is best to use descriptive vocabulary that fits the client's language: words and phrases such as **states of mind**, **fragments**, **internal objects**, **internal family system**, **part selves**, and **inner children**. This will usually be perceived as respectful. For some clients, concretizing this system via mapping, listing, drawing pictures of the parts, or creating an internal landscape is helpful. The time in which this can be accomplished varies. Humor helps! One of my clients with 11 years of analysis, when asked about internal parts, said, "Oh, you mean the Committee. You know, Freud was right on target, but why did he stop at three parts?" Co-consciousness begins to be developed in this phase as the parts feel safer about being "known" to the client.

In this integrated approach key components of the preparation phase include readiness activities, creation of a home base and workplace, and orienting the ego state system to present reality. Somatic work, managing symptoms, creating safety, and constructive avoidance are also key concepts.

If possible, dual attention stimuli (DAS) or bilateral stimulation such as eye movements, tapping, and audio stimulation should be introduced during this phase. DAS can be used throughout sessions while working on readiness activities with clients who are sufficiently grounded. For more vulnerable clients, bilateral stimulation will be used only to reinforce and strengthen readiness activities if and when the client system can tolerate it without distress. Bilateral stimulation seems to increase focus and reinforce stability and activities related to safe place development, resource development, ego strengthening, and stress reduction. With more dissociated people, use of DAS may have to be postponed.

Getting Acquainted with the Ego State System

Those voices or inner conversations described by our clients are those of their internal parts. They appear to clients to be in a chaotic situation that often echoes their families and childhood homes. It makes sense that they are "living" in the client's mind or brain, even if the client is not happy with that idea and doesn't particularly want to interact with the parts. This work marks the beginning of building functional structure and differentiation.

The client needs to meet the ego states. The client and the system may know directly or only indirectly of each other's existence and roles. The when and where of this meeting will be client specific. Clients may feel as if they are taking in very abused foster children. Their attitudes toward the parts vary. We must accurately gauge empathy for the system parts and developmental readiness for this work by listening to language and watching body language. Do we hear the parts describe themselves with self-hatred, loathing, loneliness, and isolation? We note if the client's descriptive language is abusive, empathic, distant, or stern.

Clients are informed about the ways in which they are likely to be misinterpreted by the system: like actual children, the parts may be listening when clients least expect it. Even if they are angry at these parts, they may be able and willing to modify their language. They need to criticize the behavior, not the part. We note if there are stern, harsh critics or perfectionists in the group. Bullies can be seen as once having had a protector role. It is important to tell the client that having an inner critical voice could prevent punishment in childhood. In helping the client learn about the parts, interweaves are 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?"

Creating a Home Base and a Workplace

The creation of a home base is a new idea for many survivors. It can offer safety, privacy, and relaxation for the internal parts system. This is a different place from the adult client's safe place. An explanation I use is that metaphorically speaking, the ego states "have to be somewhere."

Home base is also a metaphor for privacy, with doors and boundaries for some clients who had none, or have lost them. For some clients and their parts, a home base is impossible in the beginning because no place is safe. When the client first develops this space, it may look barren and unprotective. Alternatively, the home base may have to be part of the client's actual home. Once found, some parts want to stay close by, while others may refuse to go to the home base initially. Some parts can be shunned by others and may need a separate space or one connected by a hall or breezeway. This usually evolves positively over time.

A workplace where ego states can be accessed and therapy sessions with the ego states can take place is also created. Clients may be comfortable including a conference room in their home base. They may wish to use the therapist's office setting or a familiar place for the workplace. There are many techniques for accessing ego states: the round table (also known as a conference table), the Gestalt empty chair, and so on.

Some parts will not be visible, especially at first. Some are "ghosts" and shadows; some will just be sensed. This is to be expected and respected, never forced.

Orientation to Present Reality (OPR)

The exercise called Orientation to Present Reality (OPR) 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 that may be of your office or the adult clients and their present age, body, gender, roles, and so on. 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 reality and changed conditions. For example the ego state system may need to learn that perpetrators are dead, that the adults lives independently, and so forth. This information can be shocking. This OPR work is titrated as needed. OPR

might need to be repeated many times during treatment, as parts who need orientation or reorientation may appear at any phase

Somatic Work

Recognition of physical sensations is an important part of the preparation phase. The emphasis that EMDR places on identifying and recognizing body sensations 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 (see Levine, 1997) that utilize identification of positive body sensations (calm, serene, tension free, and relaxed) as resources. This can be enhanced with bilateral stimulation for clients who have difficulty identifying these sensations. The client learns to focus on the positive body resource. The body is felt as a physical safe place, to be returned to whenever necessary. This helps clients master the ability to consciously distance themselves from often overwhelming memories, events, and emotions. In this way, clients develop an interior safe space. This work prevents hyperarousal and numbing episodes and eventually allows clients to stay in their body even when processing difficult material.

Helping Clients Manage Affect and Dissociation

Management of affect and dissociation is an aspect of parenting work that continues to grow throughout treatment. We are providing clients with tools to create safety for the ego state system both in session and in between sessions.

Containment: We teach the concept of containers for troubling or overwhelming emotions, thoughts, and sensations and encourage the imaginal development of containers such as safes, closets, boxes, and bubbles to hold this material temporarily. Clients must 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.

Self-soothing activities: Clients need to learn self-soothing in order to manage affect both during and between sessions. First we teach them to ask the ego states what they need to be comfortable. This could be a blanket or a hug. Grounding and centering procedures are helpful for clients who dissociate. This is especially important if dissociation occurs while driving. While driving clients need to be able to feel the steering wheel in their hands, or differentiate between different textures and materials in the car. If they cannot, they need to learn to pull off the road until they feel more present.

Other self-soothing activities include stress reduction activities, safe place imagery, progressive relaxation techniques, and conscious distancing techniques. One distancing mechanism is the "affect dial," which can be imagined as the on/off button on a radio or a television remote control. This can be utilized by the ego states to turn off overwhelming images, thoughts, and emotions. Regular practice is important.

Clients should be reminded to encourage their ego states to remain at the home base in between sessions to avoid dissociation. We encourage clients to develop a "check in" system by the adult ego state. 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.

Stop Signals: The client and the ego state system need to develop a stop signal to stop work if the system is experiencing distress during a session.

All sessions during the preparation phase end with debriefing, containment work, relaxation, and somatosensory work. All of the above interventions and activates of the preparation phase are enhanced with DAS if this is seen as safe by the system.

Constructive avoidance: This is a technique for managing current life stressors. The adult client needs to be able to function in life while therapy work is proceeding. The teaching point here is that we don't 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, 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 presents a very different reality than that learned in the family of origin where the needs of the child were not considered.

What Does the System Need to Proceed into Trauma Work?

Negotiating ongoing permission and system wide consensus for the part or parts to work on traumatic events is always necessary. We work on continuing to develop benevolent communication and developing resources (or rediscovering them). Exploring conflicts and resolving issues is ongoing work. Clients continue to explore their ability, resistance, and motivation to work with the ego state system. Resource building continues throughout. Providing information encourages security and trust. The system should be reassured whenever necessary that ego states cannot and will not be killed off. If they choose to change roles and jobs, they will still be necessary to the existence of the ego state system.

The therapist must form alliances with the ego states during the treatment. This particularly applies to angry, self-hating, destructive, or punitive parts. Identifying them and acknowledging their pain, qualities, and roles is crucial to successful treatment. This encourages the clients to look at parts through new lenses. As therapists we provide continuous reassurance, education, and respect. The pace of the work is always set by the system.

Appreciating differences among clients in developmental abilities, readiness, and so on is an important part of our work. We can then time our interventions based on accurate ongoing assessment.

The client and ego state(s) can develop and view targets together. They may spontaneously combine in a temporary merger for strength and security (also called "blending"). This leads to the formation of internal alliances. We keep encouraging self-nurturing and parenting.

This desensitization and reprocessing work is utilized in combination with techniques and strategies common to dissociative disorder treatment to provide safety during treatment. It is important to use fractionated work with frequent breaks. This is not one- to three-session EMDR, but long-term work.

When the timing is appropriate, the therapist must always obtain permission to begin processing. This may require negotiation at several stages of the treatment. The system is informed that all of the parts do not have to be present during processing. They can choose to stay away or not participate. They can stay present, but have speakers and microphones that they can turn off to distance themselves from the processing. The only agreement necessary is that they not sabotage the work taking place. If they cannot commit to this promise, desensitization has to wait until the problem is resolved through discussion and negotiation.

Elements of Trauma Treatment

In working with clients with complex PTSD, the following special considerations need to be accommodated during the trauma treatment.

Target choices: Targets can focus on events, memories, and body parts. They may be specific to one or more ego states. Each ego state may require a separate VOC, SUD, NC, and PC.

Assessment: The therapist will need to assess whether the client has gained the necessary resources and ego strengths to begin trauma processing. If the work was started prematurely, we return to readiness work and resume when the system is ready.

DAS: Length of sets and type of stimuli are also selected by consensus, both between therapist and client and among the ego states.

Interweaves: In some situations, interweaves can be lengthy, continuing over many sessions. They can include resource building, ego state work, and cognitive, somatic, and psychodynamic interweaves. Body processing can be lengthy, with frequent returns to target. In a typical session, fractionated work (on a fragment of the event) is usually necessary to prevent flooding or over stimulating the system.

Structuring sessions: Processing may take only a small amount of session time. It may be typical to begin with a discussion of the client's week between sessions and a safe place exercise; then there will be a short amount of trauma processing in the middle section of the session, and the session will end with debriefing, relaxing, and containing. The work is paced by the parts system, which now is competent to tolerate processing and can make use of containment, debriefing, and other management techniques. Safety techniques are rehearsed when necessary. Processing stops to orient "new" ego states and to solve conflicts, or if overwhelming reactions to trauma material are encountered.

Ego state changes: Individual and system wide ego state changes can be expected. As desensitization and processing proceed adaptively, ego states change or merge. They observe and help the desensitization and reprocessing. Several ego states may watch the session or be supportive. Working with several states simultaneously means that there may be parallel processing of different perspectives of the event. Long-range systemic changes are seen as a result of EMDR and ego state treatment. Ego States evolve and change roles during the EMDR protocol.

Conclusion

We have seen that extending the length and scope of the stabilization and preparation phase of the standard EMDR protocol and adding ego state work allows clients who might otherwise have been deemed ineligible for EMDR to profit from trauma work.

During the important preparation work clients come to an awareness and acceptance of their ego state system and develop the ability to self-soothe. The system can now deal effectively with issues of safety, responsibility, and choice from the position of empathic understanding The client acts more independently, tries out new situations-sometimes in the presence of the ego state system-and then develops a future template for positive behaviors. The client practices new skills in real-life situations. We end the work, not as it was begun, but with a more evolved, self-loving human being who is interested in living life fully. We have come more than full circle.

In conclusion, within this integrated treatment model, the internal family system is recognized for having played purposeful, honorable roles during the earlier times of terror and chaos. In the course of treatment, the ego states have been treated with care and respect and given structure and healthy boundaries. The traumatic material has been reprocessed. The system can now implement a more effective blueprint for living. EMDR therapists are thus able to provide effective treatment to address complex traumatic stress disorder and its sequelae in our clients.

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