Chapter 2: Dissociation and Complex Trauma: Comprehensive Assessment and Strategies for Modifying Treatment (The Most Important Chapter)

This chapter focuses on a critical, often misunderstood element in trauma therapy: dissociation. Dissociation is not a complication of trauma; it is the mind's profound, life-saving adaptation to an unbearable reality. Yet, when clients bring these adaptations into therapy, standard EMDR protocols mostly falter, leading to stalled processing, heightened distress, or premature termination. For clients with complex trauma, modifying EMDR is not merely an option: it your job.

In this chapter, we will explore the mechanisms of dissociation and why it so effectively blocks healing. We will map the landscape of structural dissociation and the interlocking phobias that maintain it. We will redefine "integration" with precision, exploring the mental actions of synthesis and realization. We will review practical tools for assessing dissociation, including the Dissociative Experiences Scale-II (DES-II), and provide a sensory framework for understanding why clients get stuck. Finally, we will equip you with specific, body-based techniques and ego-state strategies to safely navigate freeze and dorsal vagal collapse, keeping clients grounded enough to process the unprocessable.

Definitions

Complex Trauma: Complex trauma results from repeated, prolonged exposure to traumatic events, typically beginning in childhood. Unlike a single-incident trauma (e.g., a car accident), complex trauma occurs within a relational context, often involving caregivers. This ongoing exposure fundamentally shapes the developing brain, leading to pervasive difficulties in emotional regulation, self-concept, and interpersonal relationships (Herman, 2015; Cloitre et al., 2014).

Dissociation: Dissociation is a psychological defense mechanism where the mind disconnects from overwhelming experiences. It involves a disruption in the normally integrated functions of consciousness, memory, identity, and perception. For survivors of complex trauma, dissociation served as a vital survival strategy, allowing them to endure inescapable abuse or neglect by mentally detaching from the physical reality (American Psychiatric Association, 2013; Van der Kolk, 2014).

Core Symptoms of Dissociation

- Amnesia: Inability to recall important personal information or traumatic events.
- Depersonalization: Feeling detached from oneself, as if observing one's actions, feelings, or thoughts from the outside.
- Derealization: Experiencing the external world as unreal, dreamlike, or distorted.
- Identity Alteration: A sense of confusion about who one is, or experiencing distinct personality states that take control of behavior (Chu, 2011; Dell, 2006).

Why Dissociation Blocks Healing

Standard EMDR relies on the client's ability to remain present while simultaneously accessing traumatic memories, a state of dual awareness. Dissociation fundamentally disrupts this process in several critical ways:

- Interference with Mindfulness and Dual Awareness: Dissociation pulls the client out of the "here and now." When a client dissociates during EMDR, they lose the dual awareness necessary for the brain to process the memory safely. They either become completely absorbed in the trauma (reliving rather than reprocessing) or entirely detached (feeling nothing), both of which halt the Adaptive Information Processing (AIP) system.
- Fragmented Identity: In severe dissociation, traumatic memories are compartmentalized within different ego states or parts. If the clinician is only communicating with a part that avoids the trauma, the memories held by other parts remain inaccessible and unprocessed.
- Reduced Body Awareness (Interoceptive Disconnection): Dissociation often involves numbing physical sensations. Since emotions are fundamentally physiological experiences, this interoceptive numbing prevents the client from feeling the emotions attached to the trauma, stalling the necessary emotional processing.
- Emotional Numbing: By muting overwhelming emotions, dissociation prevents the client from accessing the distress needed to activate and resolve the traumatic memory network.

The Therapeutic Relationship Through the Lens of Structural Dissociation

Effective trauma therapy requires a foundation of trust and safety. But here is what clinicians working with complex trauma must understand: you are not in a therapeutic relationship with one client. You are in a therapeutic relationship with a system: multiple parts with contradictory relational stances toward you.

The ANP may present as cooperative, motivated, and engaged. It may report that therapy is going well. Meanwhile, an EP fixated in the attachment cry action system may be silently terrified of the therapist's power. Another EP, organized around the fight defense, may harbor rage at being "forced" into vulnerability. A third EP may be desperately attached to the therapist in ways that mirror the original traumatic bond.

This means that a rupture with one part may not register with another. The ANP may arrive at the next session cheerful and apparently unaffected, while the EP that experienced the rupture has retreated further into avoidance. The clinician who only tracks the ANP's presentation will miss the damage entirely.

Practically, this requires the clinician to:

- Regularly check in with the system, not just the presenting part: "Is there any part of you that feels differently about what we just did?"

- Recognize that sudden shifts in demeanor, emotional flatness, or apparent disengagement are not resistance; they are switches between parts with different relational orientations.
- Understand that building trust with the ANP does not automatically build trust with the EPs. Each part may need its own relational repair.
- Expect that the therapeutic relationship will be tested in ways that mirror the original relational trauma. The client's system is assessing whether you will respond like the original attachment figures: with betrayal, abandonment, or exploitation (Van der Hart, Nijenhuis, & Steele, 2006).

The Theory of Structural Dissociation of the Personality (TSDP)

The Theory of Structural Dissociation of the Personality (TSDP), rooted in the pioneering work of Pierre Janet and developed by Van der Hart, Nijenhuis, and Steele (2006), provides a crucial psychological complement to the neurophysiological AIP model. TSDP posits that when an individual confronts traumatizing events without sufficient integrative capacity, the personality divides into dissociative parts to manage the overwhelming experience.

These parts fall into two broad categories:

- Apparently Normal Parts (ANP): The ANP is primarily mediated by the action systems of daily life (exploration, caregiving, energy regulation, sociability). Its primary function is to maintain daily functioning by avoiding traumatic memories and the emotional parts that carry them.
- Emotional Parts (EP): The EP is primarily mediated by defense action systems (fight, flight, freeze, feigned death, total submission, hypervigilance, and attachment cry). The EP is fixated on the traumatic experience itself, holding the intense emotions, sensations, and beliefs associated with the trauma.

Both the ANP and EP together constitute the whole, nonintegrated personality. The structural dissociation is maintained over time because the ANP actively avoids the EP's intrusions.

Why the Personality Splits Where It Does: Action Systems as the Organizing Principle

The division between ANP and EP is not random fragmentation. It follows the fault lines between evolutionarily hardwired action systems, innate motivational systems that organize behavior toward specific goals (Van der Hart, Nijenhuis, & Steele, 2006).

- Daily life action systems include: attachment, exploration, play, energy regulation (eating, sleeping), caregiving, sociability, and sexuality. These systems orient the individual toward survival and thriving in the present.
- Defense action systems include: fight, flight, freeze, feigned death (tonic immobility), total submission, hypervigilance, and the attachment cry (calling for help). These systems activate in the face of threat.

In healthy functioning, these systems operate flexibly; a person can shift from exploration to defense when threatened, and back again when the threat passes. In structural dissociation, this flexibility is lost. The ANP remains locked in daily life action systems, rigidly avoiding anything that might activate defense. The EP remains locked in one or more defense action systems, perpetually responding to a threat that, for that part, never ended.

This gives the clinician a diagnostic tool of considerable precision. When you identify which action system a part is operating from, you know three things simultaneously: 1. what that part is defending against, 2. what adaptive action it was unable to complete, and 3. what it needs in order to integrate. A client's "angry part" is not simply angry; it is fixated in the fight action system, mobilized against a threat that the ANP refuses to acknowledge. Treatment does not mean suppressing the anger. It means helping that part realize the threat is past (presentification) while honoring the protective function the fight response served.

Similarly, a part fixated in the attachment cry is not "needy" or "regressed"; it is organized around seeking the protection that was never provided. A part in total submission is not "passive"; it is executing the only survival strategy available when fight and flight were impossible. Recognizing the action system logic behind each part transforms clinical understanding from pathologizing to contextualizing.

Levels of Structural Dissociation

- Primary Dissociation: Seen in simple PTSD, involving a single ANP that manages daily life and a single EP that holds the traumatic memory.
- Secondary Dissociation: Common in Complex PTSD, Borderline Personality Disorder, and Other Specified Dissociative Disorder (OSDD). This involves a single ANP and multiple EPs. The single ANP handles daily functioning, while the various EPs are fixated in different defensive subsystems (e.g., one EP holds the "fight" response, another holds the "freeze" response).
- Tertiary Dissociation: Seen in Dissociative Identity Disorder (DID), which involves multiple ANPs and multiple EPs. Each part takes on distinct roles, managing different areas of life or specific trauma memories, creating a complex and highly fragmented internal landscape (Nijenhuis et al., 2004; APA, 2013).

In essence, TSDP suggests that the more severe, prolonged, and early the trauma, the more elaborate the dissociative organization becomes.

The Phobias That Maintain Dissociation

Structural dissociation is not static; it is actively maintained by a series of interlocking phobias. Understanding these phobias provides a roadmap for treatment sequencing:

- Phase 1 Phobias: We must first address the phobia of attachment and attachment loss (particularly regarding the therapeutic relationship), the phobia of mental actions (fear of one's own emotions, body sensations, thoughts, and wishes), and the phobia of the dissociative parts themselves.

- Phase 2 Phobias: As processing begins, we confront attachment phobias related to the perpetrator, attachment phobias in EPs related to the therapist, and the central phobia of traumatic memories.
- Phase 3 Phobias: In the final stages of integration, we face the phobia of normal life, healthy risk-taking, change, and intimacy.

Each phobia must be overcome in sequence for integration to proceed. The fundamental phobia keeping the dissociative organization in place is the ANP's phobia of the traumatic memories held by the EPs.

What Integration Actually Means

"Integration" is a term used constantly in psychotraumatology, but rarely defined with precision. Through the lens of TSDP, integration is a complex series of mental actions occurring at two levels: Synthesis and Realization (Piedfort-Marin, 2019).

Integrative Capacity: The Central Variable

Before examining the specific mental actions of integration, we must address the question clinicians rarely ask explicitly: Why does this particular client dissociate when another person exposed to comparable trauma does not?

The answer lies in integrative capacity, the individual's ability to perform the mental actions of binding, differentiating, personifying, and presentifying experience. Integrative capacity is both a trait and a state (Van der Hart, Nijenhuis, & Steele, 2006).

As a trait, integrative capacity is shaped by constitutional factors (temperament, neurobiological resilience), developmental history (secure attachment builds integrative capacity; disorganized attachment erodes it), and cumulative life experience. A child with a secure base who encounters a single traumatic event at age twelve has far greater integrative capacity than a child whose attachment system was disrupted from birth and who faced chronic relational trauma throughout development.

As a state, integrative capacity fluctuates. It drops with fatigue, sleep deprivation, physical illness, substance use, relational betrayal, anniversary reactions, and cumulative stress. It rises with adequate rest, social support, felt safety, and therapeutic stabilization.

This reframes Phase 1 stabilization entirely. You are not merely "grounding the client" or "building coping skills." You are systematically increasing integrative capacity so the client can perform the mental actions required for Phase 2. Every regulation exercise, every resource installation, every moment of co-regulation in the therapeutic relationship is building the structure the client will need to synthesize, personify, and presentify their traumatic memories.

The clinician's primary assessment question, revisited at every session, is: What is this client's current integrative capacity, and what is increasing or decreasing it?

Synthesis: Binding and Differentiating Experience

Synthesis is the lower-order mental action of perceiving, binding together, and differentiating the components of an experience.

- Core Synthesis occurs within a given moment. In therapy, this means linking and distinguishing perceptions, sensations, emotions, thoughts, and behavioral actions for each moment of a traumatizing event. When core synthesis is incomplete, a client might have a somatic sensation without understanding its source, or recall facts about an event while feeling emotionally disconnected. Treating a dysfunctionally stored memory means achieving core synthesis from the beginning to the end of the event.
- Extended Synthesis creates our life history and a consistent sense of self across time. It involves binding complex constellations of experiences over long periods. In EMDR, extended synthesis is addressed through the three-pronged protocol (past, present, future).

Realization: The Higher-Order Integration

Synthesis alone is insufficient. For a traumatic memory to become a fully narrative autobiographical memory, it must be realized. Realization comprises two distinct mental actions:

- Personification (Owning the Experience): This is the mental action by which an individual comes to feel, on a deep emotional level, that the traumatic events happened to them. It is not merely cognitive acknowledgment; it engages the full emotional body and typically involves profound grief. Personification is impossible without a working interoceptive channel (the ability to feel internal bodily signals).
- Presentification (Grounding in the Present): This is the mental action of integrating that the traumatizing events took place in the past and are over now, allowing the individual to be fully present. It relies heavily on the vestibular and proprioceptive systems (feeling the chair, knowing where the body is in space).

The Hierarchy of Mental Actions

These mental actions are not interchangeable options; they form a developmental hierarchy. Each level builds on the one below it. You cannot personify what has not been synthesized. You cannot presentify what has not been personified.

When processing stalls, the clinician must diagnose where in the hierarchy the failure is occurring. A client who reports “I can’t feel anything” during reprocessing may have a personification failure (interoceptive channel is offline). A client who keeps looping back to the same image without resolution may have a synthesis failure (elements of the memory are not yet bound). A client who processes fully in session but returns the next week as if nothing happened may have a presentification failure (the memory has not been located in the past). Each failure demands a different intervention, not a generic interweave or another set of ABLS.

Assessing Dissociation

Accurate assessment of dissociative symptoms is essential for tailoring treatment. Clinicians must gauge the extent of fragmentation and identify which sensory channels are dysregulated.

Mental Action	What It Accomplishes	What Failure Looks Like
Core Synthesis	Binding sensory fragments of a single moment	Body sensation with no narrative; facts recalled with no feeling; isolated images without context
Extended Synthesis	Coherent timeline across events; consistent sense of self	Gaps, jumps, contradictions in the trauma story; "I don't know how I got from there to here"
Personification	Emotional ownership: "This happened to me"	Intellectual knowing without felt sense; third-person narration; "I know it happened but it feels like it happened to someone else"
Presentification	Temporal grounding: "It is over now"	Flashbacks, time confusion, inability to feel safe in the present; "I know I'm in your office but it doesn't feel like it's over"

The Sensory Survey (The 8-Channel Framework)

Before initiating trauma processing, particularly with complex trauma, conduct a brief sensory survey across the eight channels through which trauma is encoded and held (Lanius et al., 2010). The goal is to map which channels are dysregulated and which can serve as resources.

- Visual: Does the client tolerate eye contact? Maintain a soft gaze?
- Auditory: Is the client startled by sound or hyper-reactive to specific tones?
- Tactile: Are there body areas that cannot be discussed without distress?
- Olfactory: Are there specific scents that act as triggers?
- Gustatory: Are there taste-linked memories or avoidances?
- Vestibular (Balance/Motion): Does the client report dizziness or feeling ungrounded?
- Proprioceptive (Body Position): Can the client locate their body in space?
- Interoceptive (Internal States): Can the client notice breath, heartbeat, or hunger? Or are internal signals absent or overwhelming?

Channels that are intact become grounding resources during reprocessing. Severely dysregulated channels identify the targets of preparatory work and dictate accommodations needed during Phase 4.

Figure 2.2

The 8-Channel Sensory Survey

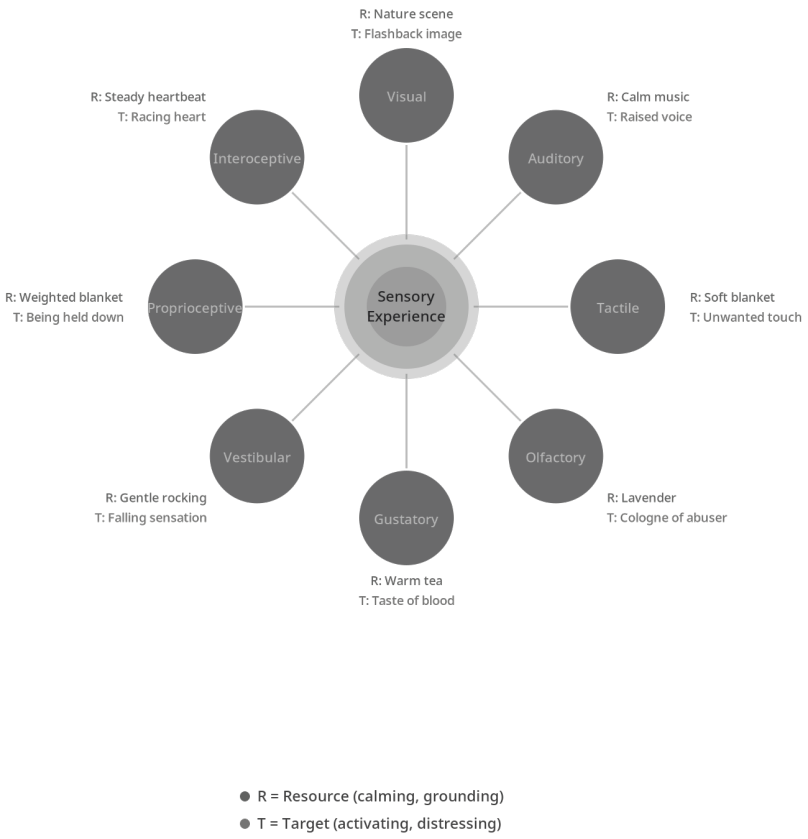


Figure 2.2. The 8-Channel Sensory Survey. Each channel may function as a Resource or a Target (based on Lanius, Harricharan, Kearney, & Pandev-Girard, 2025). Map the sensory landscape before processing.

Screening and Diagnostic Tools

- Dissociative Experiences Scale-II (DES-II): A 28-item self-report scale screening for depersonalization, derealization, amnesia, and identity confusion. A total score above 30 indicates significant dissociation. (See the Pre-Session Screening Battery for Clinician and Client versions.)
- International Trauma Questionnaire (ITQ): A brief, freely available self-report measure of ICD-11 PTSD and Complex PTSD (Cloitre et al., 2018). The DSO cluster ~ affective dysregulation, negative self-concept, disturbed relationships ~ maps the terrain this workbook exists to treat. (See Pre-Session Screening Battery.)

- Dissociative Disorders Interview Schedule (DDIS): A structured clinical interview evaluating a range of dissociative symptoms and co-occurring conditions. (Download: https://www.rossinst.com/ddis)
- Multidimensional Inventory of Dissociation (MID): A 168-item self-report inventory offering a highly detailed view of dissociative experiences. (Download: https:// www.mid-assessment.com/)

Reading the DES-II by Factor

The total score tells you how much dissociation. The factor structure tells you what kind ~ and the kind dictates the treatment modification. The color-coded scoring sheet (see Pre-Session Screening Battery) assigns all 28 items to five factors, following Fraser:

- Absorption (ABS). Getting lost in a movie, missing an exit, losing time to a daydream. This is the normal end of the dissociative continuum. High Absorption with low scores everywhere else is not pathology; it is a trait, and often a resource ~ these clients take to guided imagery quickly.
- Amnesia (AMN). Finding yourself somewhere with no idea how you got there. No memory for major life events. Evidence of actions you cannot recall. Elevation here is never trivial. Amnesia means material is being held out of awareness ~ the hallmark of structural dissociation ~ and it predicts exactly the processing failures Chapter 3 is built to diagnose.
- Depersonalization/Derealization (D/D). Watching yourself from the outside; the world behind glass or fog; a body that does not feel like yours. Elevation here maps onto the dissociative subtype of PTSD (Lanius et al., 2010) and tells you the client will lose dual awareness under activation. Expect to lean on the Back of the Head Scale and CIPOS during processing.
- Fantasy Prone (FP). Reliving memories as if present; uncertainty about whether a memory happened or was dreamed. Elevation here is a reality-monitoring signal. It calls for care with imaginal work ~ not avoidance of it, but explicit orientation before and after, so the client can tell installation from intrusion.
- Influence of Ego States (EGO). Unrecognized belongings, being called by another name, voices that comment or command, acting like two different people. This factor tracks parts activity. Elevation here points toward secondary or tertiary structural dissociation and routes you directly to the IFS-Based Dissociation Interview (see Appendix). Quantitative screening stops being sufficient at this point; you need to map the system.

A note on the taxon: the DES-T ~ a subset of eight items identifying pathological dissociation ~ is a separate overlay on this instrument, not a sixth factor. The five factors describe the architecture; the taxon flags severity.

The factor profile, not the total, is what modifies your treatment plan. Two clients can share a mean score of 35: one driven by Absorption and Fantasy Prone, one by Amnesia and Ego States. The first may tolerate processing with minor accommodations. The second is not ready, and no total score would have told you that.

IFS-Based Dissociation Interview

For clients presenting with secondary or tertiary structural dissociation, quantitative screening instruments alone are insufficient. The IFS-Based Dissociation Interview (see Appendix) provides a qualitative, relationally grounded assessment that maps the client's internal system using IFS language integrated with TSDP concepts. It covers parts mapping (protectors, exiles, managers, firefighters), co-consciousness and amnesia assessment, window of tolerance exploration for individual parts, and somatic/body-based awareness. Unlike the DES-II, which measures symptom frequency, this interview reveals the architecture of the dissociative system: who is inside, what each part carries, and how they relate to one another. Use Sections 1-4 during initial assessment; revisit as the system reveals itself over time.

Real-Time Monitoring of Dissociative States

- Back of the Head Scale (BHS): Developed by Jim Knipe (2005, 2018), the BHS asks clients to gauge their awareness along a continuum of locations in their head. Feeling located toward the front indicates full presence; feeling located toward the back indicates detachment or dissociation. This allows the therapist to adjust pacing in real- time.

- Constant Installation of Present Orientation and Safety (CIPOS): Also developed by Knipe, CIPOS uses body-based grounding techniques (like Alternating Bilateral Stimulation) to continuously anchor the client in the present, reducing the likelihood of dissociation during processing.

Working with Dissociation and Immobility

Dissociation, often tied to the body's dorsal vagal response, reflects a state of profound hypoarousal. According to Polyvagal Theory (Porges, 2011), the autonomic nervous system responds to threat in a hierarchy: ventral vagal (safety/connection), sympathetic (fight/flight), and finally dorsal vagal shutdown (immobility/collapse).

Differentiating Freeze from Dorsal Vagal Collapse

- Freeze Response: Associated with sympathetic activation. Clients feel immobilized yet hyperaware (muscle tension, shallow breathing, heightened alertness). The body is prepared for action but unable to execute it.

- Dorsal Vagal Collapse (Shutdown): Associated with the dorsal vagal complex. Clients feel disconnected, numb, and unaware of surroundings. It manifests as slowed breathing, diminished muscle tone, and profound detachment. Clients in freeze benefit from techniques allowing the gradual release of sympathetic energy. Clients in

shutdown need grounding techniques that gently re-engage awareness without overwhelming the system.

Sensory Processing Sensitivity and the Window of Tolerance

Sensory processing sensitivity is a trait, not a pathology ~ and it sets the width of the window of tolerance. A highly sensitive client processes more, startles faster, and exhausts sooner. That has direct consequences for this work: shorter ABLS sets, softer stimuli, longer recovery between sets, more frequent orientation to the present. The Sensitivity Questionnaire (see Pre-Session Screening Battery) screens for the trait at intake and opens one of the most useful conversations of the assessment phase. A score above 125 tells you to titrate everything ~ pace, intensity, session length ~ and to read overstimulation as a capacity signal, not resistance.

Body-Based Techniques and Sensory Infrastructure

Grounding tools and proprioceptive exercises help clients transition out of dissociative states by reconnecting them to their physical experience.

- Practical Grounding Tools: Mini trampolines, BOSU balance trainers, and tuning boards provide proprioceptive feedback, stimulating physical awareness without overwhelming the client.
- Proprioceptive and Kinesthetic Exercises: Guided rocking or slow, deliberate walking helps clients reconnect with their sense of position and movement.
- Interoceptive Reconnection (Foundation for Personification): For clients whose interoception is suppressed (they "feel nothing"), begin with the most accessible signals: the sensation of breath at the nostrils, or the warmth of the hands. Move gradually toward heartbeat or muscle tone. This must be done slowly, as internal contact can trigger panic in trauma survivors.
- Vestibular and Proprioceptive Anchoring (Foundation for Presentification): Seat the client stably. Direct attention to points of contact: feet on the floor, back against the seat. Add an orientation cue by having them locate three fixed objects in the room. This establishes the bodily infrastructure of "one foot in the present."

Applying ABLS for Stabilization

Alternating Bilateral Stimulation (ABLS) can stabilize dissociative clients when introduced carefully.

- Start with Short, Gentle Sets: Begin with 6-10 taps or eye movements to gently stimulate awareness.
- Observe and Prompt: Ask, "How does your body feel with this rhythm?"
- For Safe Discharge: For clients moving out of freeze into sympathetic activation, pairing ABLS with grounding movements (like rhythmic walking) helps discharge energy safely.

Clinical Example: When a client slips into dorsal shutdown (slumped posture, blank stare, reporting feeling "far away"), the clinician stops trauma processing. The clinician asks the client to press their feet firmly into the floor (proprioceptive anchoring) and introduces very slow, gentle alternating hand taps (ABLS). The clinician asks the client to focus only on the sensation of the taps and the pressure on their feet. Once the client reports feeling the room again and their breathing deepens, the clinician has successfully re-established core presentification.

Monitoring Mental Level and Pacing Treatment Accordingly

Van der Hart, Nijenhuis, and Steele (2006), drawing on Janet's concept of niveau mental, describe "mental level" as the individual's current capacity for adaptive mental actions. Mental level is not fixed; it fluctuates within sessions, across sessions, and across life circumstances.

Mental level drops with:

- Sleep deprivation or chronic fatigue
- Physical illness or pain
- Substance use (including prescribed medications that blunt affect)
- Relational ruptures (including therapeutic ruptures)
- Anniversary reactions and environmental triggers
- Cumulative life stress (job loss, financial strain, caregiving burden)

Mental level rises with:

- Adequate rest and physical health
- Felt safety in the therapeutic relationship
- Successful stabilization and resource development
- Social support and co-regulation
- Mastery experiences (completing tasks, exercising agency)

The clinical implication is straightforward but frequently violated: the treatment plan must flex with the client's mental level. On a high-mental-level day, the client may be ready for Phase 2 processing. On a low-mental-level day, the clinician must stay in Phase 1 regardless of where they left off last session. Pushing processing because "we did it successfully last week" is one of the most common errors in complex trauma treatment. Last week, the client's integrative capacity was sufficient. Today, it may not be. Respect the fluctuation.

Practically, this means beginning every session with a brief mental level assessment:

- How has the client slept?

- What stressors have occurred since last session?
- What is the client's current window of tolerance?
- Can the client maintain dual awareness right now?

If the answers indicate reduced mental level, the session plan changes, not as a failure, but as clinical precision.

> Clinical Vignette: Mental Level in Practice. Dana processed a childhood target cleanly on a Tuesday ~ SUD from 8 to 1, adaptive cognition installed, clean body scan, both of us happy with the results. The following Tuesday she arrived after less than four hours of sleep, a fight with her sister, and two missed meals. She announced her readiness to "keep the momentum going." The agreed upon session plan was to process a specific memory, but her mental level said otherwise. Unable to complete the dual awareness check, i.e., while accessing the memory, she lost the present, so, we spent the session on grounding and reinforcing imaginal resources. Dana left disappointed. Two sessions later, well-rested and resourced, she processed the target memory in less than forty minutes. The lesson here is not that Dana had regressed weeks earlier; it was that her integrative capacity fluctuated, exactly as capacity does, and the treatment plan flexed with it. Pushing memory processing because it had worked the previous Tuesday would have been an error ~ the most common error in complex trauma treatment. Last week's success is evidence about last week's capacity.

> Clinical Vignette: The Substitute Action in the Room. Marcus spent the first ten minutes of every session asking about me ~ my week, my health, whether I looked tired. He was warm, attentive, and genuinely skillful in his attention to my wellbeing. It took me a bit longer than I like to admit to see that I wasn't getting the entire picture: Marcus's system had learned that needing care was dangerous and giving care was the closest available substitute. When that action system activated, his vulnerability went unnoticed. Eventually, I said, "I notice you take care of me at the start of every session. I wonder what it would be like to let this hour be for you," he went silent, and then the EP that had been waiting behind the caretaking said, quietly, "I wouldn't know what to ask for." That sentence ~ not the caretaking ~ was the treatment target. The substitute action was not resistance. It was the map to the need it was protecting.

Mind-Body Reconnection Exercises

These exercises facilitate grounding and support the integration of dissociative parts.

Clinical Decision-Making: Use Creative Body Mapping or Emotion Wheels for clients struggling with alexithymia (the inability to recognize or describe one's own emotions) or depersonalization. Use Body Part Greetings for clients needing structured mindfulness to counteract numbness.

- Creative Body Mapping: Clients visualize the outline of their body and fill it with colors, textures, or symbols representing different sensations.
- Emotion Wheel for Color-Based Emotional Awareness: Clients use an emotion wheel to assign colors to feelings, creating an abstract representation of their emotional state.
- Body Part Greetings: A mental body scan where the client mentally "greets" each body part and notices sensations without forcing them.
- Color Palette Exercise: Clients create a palette of colors representing their emotional state over the past few days, externalizing emotions safely.

Ego-State Therapy Techniques

Ego state therapy provides a framework for engaging with the distinct parts of a client's personality (Watkins & Watkins, 1997). EMDR and traditional ego state therapy both underscore the necessity of treating suppressed ego states to achieve a cohesive internal structure.

- Mapping Ego States: Clients draw a "map" of their ego states, assigning colors, symbols, or names. This visual representation helps clients understand how each part affects their behavior and promotes self-compassion by revealing the protective function of even difficult parts.
- Internal Conference: The clinician facilitates an imagined meeting space where ego states can express needs and resolve internal conflicts (double binds). Gentle ABLS can be used during these conferences to maintain regulation and support brain integration.
- Dissociative Table Technique: A specific visualization where various ego states gather at an internal "table" to share perspectives and work toward harmonization (Fraser, 2003). Incorporating ABLS during this technique fosters calm and groundedness during communication between parts.

Identifying Substitute Actions and Substitute Beliefs

Van der Hart, Nijenhuis, and Steele (2006) describe a phenomenon that explains much of what clinicians experience as "resistance" in complex trauma clients: substitute actions and substitute beliefs. These are behaviors and cognitions that approximate, but do not fulfill, the intended goal of an action system, and they function to maintain the dissociative organization by making integration feel unnecessary or dangerous.

Substitute actions are behaviors that partially satisfy an action system's goal without requiring the integration that full satisfaction would demand. Examples:

- A client who compulsively caretakes others is executing a substitute for receiving care. The attachment cry action system is activated, but rather than risking the vulnerability of asking for help (which would require

acknowledging the EP's need), the client projects the energy outward. The substitute action maintains the dissociation: the ANP gets to feel competent and needed; the EP's desperate longing for care remains unacknowledged.

- A client who intellectualizes trauma, who can narrate the events with clinical precision but displays zero affect, is executing a substitute for personification. The mental action of knowing substitutes for the mental action of feeling that it happened to me. This is a coping skill that needs to be recognized for what it is: a dissociative maneuver that prevents integration.
- A client who engages in repetitive self-harm may be executing a substitute for the fight response, turning aggression inward because the EP fixated in fight cannot direct it toward the original perpetrator without destabilizing the system.
- Substitute beliefs are cognitions that justify the avoidance of integration. They often present as negative cognitions:
    - "I am weak" functions as a substitute belief that justifies the EP's continued defensive posture. If I am weak, then I need the dissociation to survive. Integration would mean acknowledging strength, and strength would mean I should have fought back.
    - "It wasn't that bad" functions as a substitute belief that prevents personification. If it wasn't that bad, I don't need to feel like it happened to me.
    - "I'll fall apart if I go there" functions as a substitute belief that maintains the phobia of traumatic memories. It predicts catastrophe as a way of avoiding the grief that realization would require.

The clinical implication: when you encounter what appears to be resistance, ask yourself whether the client is carrying out a substitute action or holding a substitute belief that makes sense given the dissociative organization. Never assume that resistance is pathological; it is a creative solution to an impossible problem. Treatment involves helping the client recognize the substitute, grieve what it protected against (usually the original helplessness or aloneness), and gradually attempt the original mental action with the support of the therapeutic relationship.

Structured Resource Installation: The Self Energy Activation Protocol (SEAP)

Before clients can process trauma, they need reliable access to an internal state of safety and self-leadership. The Self Energy Activation Protocol (SEAP) synthesizes three evidence- informed approaches to create a somatically grounded pathway to what Internal Family Systems (IFS) calls "Self energy," the 8 C's: Curiosity, Calm, Confidence, Compassion, Clarity, Courage, Creativity, and Connectedness (Schwartz, 2021).

Theoretical Rationale

Parts cannot "unblend" when the nervous system detects threat. Self energy is not achieved through cognitive understanding; it emerges when safety is neurobiologically established. SEAP creates the conditions for Self to naturally arise rather than trying to access Self through willpower or insight.

Context	Application
EMDR Phase 2 (Preparation)	Resource installation
EMDR Phase 7 (Closure)	Post-processing integration and grounding
EMDR Processing (Interweave)	Access Self energy as a resource during stalled processing
IFS	Pathway to Self when parts are highly activated; resource before unburdening
Stand-alone	Session opener for nervous system settling; session closer for integration

Clinical Applications

The protocol layers four interventions in a specific sequence:

- 4/7/8 Breath resets autonomic tone (vagal activation via extended exhale).
- Self-Havening Touch creates neurochemical safety (delta wave induction, serotonin/ oxytocin increase, cortisol reduction, Ruden, 2019).
- ABLS ~ the ingredient theorized to facilitate hemispheric integration and adaptive processing.
- Guided Imagery anchors Self qualities to embodied, somatic experience (consolidation).

The sequence matters. Each layer builds on the previous one. Attempting guided imagery without first establishing autonomic and neurochemical safety will activate parts rather than settle them.

Protocol Structure

Phase #	Phase Activity	Duration	Purpose
1	Autonomic Reset (4/7/8 Breath)	2-3 min	Vagal toning; shift toward ventral vagal safety
2	Neurochemical Foundation (Self-Havening)	3-4 min	Delta wave production; cortisol reduction
3	Hemispheric Integration (ABLS)	2-3 min	Left-right linking; processing readiness
4	Guided Imagery (8 C's)	10-15 min	Anchor each Self quality to somatic experience
5	Integration and Anchoring	2-3 min	Consolidate; create a rapid-access anchor

Example Script: Calm (Phase 4 Imagery)

"The second quality is Calm, the deep stillness beneath all the noise. Not the absence of feeling, but the presence of ground. [ABLS continue]

Imagine standing at the edge of a deep, still lake at dawn. The surface is perfectly smooth, a mirror reflecting the sky. There is no wind. No urgency. Just vast, quiet depth.

Notice where Calm lives in your body. Perhaps it is a heaviness in your limbs. Perhaps a softening behind your eyes. Perhaps a slowing of your heartbeat, as if your whole system is saying: there is nothing to run from right now.

Feel that quality now: Calm. Stillness. Ground. The part of you that knows how to simply be, without performing, without defending, without solving. [Pause 10 seconds]

Let one word or image arise that captures your Calm. Hold it lightly. [Pause 5 seconds]"

The remaining seven C's follow the same structure: name the quality, offer a sensory-rich image, invite the client to locate it in the body, and anchor it with a word or image. Full scripts for all 8 C's are available as a separate clinical resource.

Modifications for Dissociative Clients

- Start with breath and one quality per session (do not attempt all 8 C's in a single session).
- Keep eyes open with soft gaze.
- Use only palm havening (least intimate touch option).
- Shorten imagery scripts significantly.

- Add frequent orientation cues ("You are here, in this room, in this time").
- Avoid the Connectedness script (zooming out to the universe) until the client has demonstrated stable dual awareness; for dissociative clients, the sense of dissolving boundaries can trigger depersonalization.

The 3-Minute Reset (Between-Session Version)

For client use between sessions or when time is limited:

- Three 4/7/8 breaths (approximately 60 seconds)
- 30 seconds self-havening with the internal statement: "I am accessing Self."
- 15 seconds butterfly hug ABLS while bringing to mind the one C that is most needed in this moment.
- 15 seconds stillness with the anchor word or image.

Monitoring Your Own System: Parallel Process in Dissociation Work

Clinicians working with dissociative clients are not immune to the dynamics they are treating. Parallel process is not a metaphor; it is a clinical reality. When you sit with a client whose system is fragmented, your own internal parts activate in response. The rescuer part mobilizes. The professional part tightens its grip. The anxious part may wonder if you are in over your head. If these activations go unmonitored, they drive clinical decisions without your awareness.

The following self-assessment, grounded in IFS principles, is designed for use before and after sessions with dissociative clients. It is not optional self-care; it is a clinical tool that directly impacts treatment quality.

Pre-Session Check-In

Before entering the room, ask yourself:

- "What parts of me are active as I prepare for this session? (e.g., Rescuer, Professional, Anxious part, Avoidant part)"
- "What does each part need to feel prepared and present?"
- "Am I approaching this session from Self (curious, calm, compassionate), or is a part already running the show?"
- "Is there anything unresolved from the last session with this client that a part of me is carrying?"

If you notice a part is dominant, acknowledge it. You do not need to exile your own parts; you need to unblend from them enough to lead from Self. A 60-second version of the SEAP 3-Minute Reset (described earlier in this chapter) can facilitate this shift.

Post-Session Reflection

After the session, take 3-5 minutes:

- "What parts of me were activated during the session?"
- "Did I experience parallel process with the client's parts? (e.g., my Rescuer activated by their Exile; my Avoidant part activated by their rage)"
- "What am I carrying from this session? What do my parts need to release this?"
- "Were there moments I lost Self-leadership? What triggered the shift?"
- "How can I use this awareness to be more Self-led in future sessions?"

This is not self indulgent. Clinicians who do not monitor their own system with dissociative clients are at elevated risk for vicarious traumatization, compassion fatigue, and clinical errors driven by unrecognized countertransference. The therapist's internal system is a clinical instrument. It requires attention.

Concluding Remarks

Understanding and addressing dissociation is foundational in trauma therapy.

This chapter equips clinicians with theoretical insights (TSDP, the action systems framework, the hierarchy of mental actions, the sensory framework), diagnostic tools, and practical interventions to stabilize clients and create conditions for safe trauma processing. While complex trauma and structural dissociation demand extended time in stabilization (Phase 1), trauma processing can proceed with careful pacing, respect for the client's fluctuating mental level, and a precise understanding of what integration actually requires.

By utilizing ego-state mapping, sensory anchoring, mental level monitoring, and modified ABLS, clinicians can help clients navigate the complexities of dissociation and move toward true integration, not as a single event, but as an ongoing series of mental actions that build upon one another in a developmental sequence.

Further Reading

✦ Brand, B. L., Schielke, H., Schiavone, F., & Lanius, R. A. (2022). Finding Solid Ground: Overcoming Obstacles in Trauma Treatment. Evidence-informed strategies for stabilizing complex trauma and dissociation.

✦ Schielke, H., Brand, B. L., & Lanius, R. A. (2022). The Finding Solid Ground Program Workbook. A companion workbook providing practical exercises.

✦ Brand, B. L. (2023). The Concise Guide to the Assessment and Treatment of Trauma-Related Dissociation. A comprehensive clinical guide.

✦ Fisher, J. (2017). Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation. Explores therapeutic techniques for integrating fragmented self- states.

✦Lanius, U. F., Paulsen, S. L., & Corrigan, F. M. (2014). Neurobiology and treatment of traumatic dissociation: Towards an embodied self. Springer Publishing Company. Focuses on the neurobiology of dissociation.

✦ Steele, K., Boon, S., & van der Hart, O. (2016). Treating Trauma-Related Dissociation: A Practical, Integrative Approach.

✦ Boon, S., Steele, K., & van der Hart, O. (2011). Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists.

✦ van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization. The foundational text on structural dissociation.

✦ Ogden, P., & Minton, K. (2006). Trauma and the Body: A Sensorimotor Approach to Psychotherapy. Integrates body-based approaches into trauma therapy.

Appendix: Assessments and Worksheets

This appendix contains clinical tools, assessments, and client handouts referenced in Chapter 2. 1. Dissociation Screening ~ see the Pre-Session Screening Battery

The DES-II client screening and the five-factor clinician scoring sheet now live in the Pre-Session Screening Battery at the back of this workbook, alongside the ITQ, the Sensitivity Questionnaire, and the AAQ.

IFS-Based Dissociation Interview (Sections 1-3 and 5)

This interview integrates Internal Family Systems (IFS) principles with the Theory of Structural Dissociation. It is intended for use with clients presenting with secondary or tertiary dissociation. Approach with curiosity, compassion, and courage. The goal is not merely information gathering, but fostering a safe and collaborative relationship with the client's internal system.

Section 1: Initial Intake and Parts Mapping

1.1 Introduction to Parts Language

1. "I'd like to talk about the different parts of you. Sometimes we have different sides of our personality, like a part that's a people-pleaser, a part that gets angry, or a part that feels very young and scared. Does that idea make sense to you?"
2. "Have you noticed different parts of yourself with their own feelings, thoughts, or ways of being?"

1.2 Identifying Key Parts

1. "Let's see if we can get to know some of your parts. Can you tell me about a part of you that you know well?"
    - "What are some of the main 'characters' in your internal world?"

    For each part identified, ask:

    - ✓ "What is this part's name or what does it feel like?"
    - ✓ "How old does this part feel?"
    - ✓ "What is its main job or role in your life? How does it try to help you?"
    - ✓ "What is this part most afraid of?"
    - ✓ "What emotions does this part usually carry?"
    - ✓ "When did you first notice this part?"

1.3 Mapping Protector Parts (Managers and Firefighters)

1. Managers (Proactive Protectors):
    - ✓ "Is there a part of you that tries to keep things under control, organized, or perfect?"
    - ✓ "Do you have a part that is a strong critic or pushes you to be better?"
    - ✓ "Is there a part that tries to please others to keep you safe?"
2. Firefighters (Reactive Protectors):
    - ✓ "When you feel overwhelmed by difficult emotions, what happens? Is there a part that jumps in to distract you or numb the pain?"
    - ✓ "What does this part do? (e.g., self-harm, substance use, binge-watching, dissociating)"
    - ✓ "What is this part trying to protect you from feeling?"

1.4 Identifying Exile Parts (Young, Vulnerable Parts)

1. "Are there parts of you that feel very young, fragile, or carry a lot of pain?"
    - ✓ "What are the feelings that your protector parts are trying to keep you from feeling?"
    - ✓ "If you were to gently check inside for a part that feels sad, scared, or ashamed, what do you notice?"
    - For each Exile identified:
    - ✓ "How old does this part feel?"
    - ✓ "What does this part carry? (e.g., memories, emotions, beliefs)"
    - ✓ "What does this part need most?"

Section 2: Dissociation and Co-Consciousness Assessment

2.1 Awareness and Communication

- ✓ "Are your parts aware of each other?"
- ✓ "Can they communicate with each other? If so, how? (e.g., thoughts, images, feelings)"
- ✓ "Is there a part that knows about all the other parts?"
- ✓ "How much of the time do you feel like your true Self, the calm, compassionate you?"

2.2 Amnesia and Memory

- ✓ "Do you ever lose time? Have you been told you've done or said things you don't remember?"
- ✓ "Are there gaps in your memory of your childhood or other important life events?"
- ✓ "Do some parts have memories that other parts don't?"

2.3 Switching and Blending

- ✓ "Do you ever feel like a different part has taken over? What is that like?"
- ✓ "What are the triggers that cause a different part to come forward?"
- ✓ "How do you know when a different part is present or 'blended' with you?"
- ✓ "On a scale of 1-10, how much control do you feel you have when a part takes over? (1 = no control, 10 = full control)"

Section 3: Window of Tolerance Exploration

3.1 Understanding the Window "The 'window of tolerance' is the zone where we feel we can handle life's ups and downs. When we're outside the window, we might feel overwhelmed (hyperaroused) or shut down (hypoaroused). Does this idea make sense?"

3.2 Assessing the Client's Window

- ✓ "What does it feel like in your body when you are in your window of tolerance?"
- ✓ "What are the early warning signs that you are moving toward feeling overwhelmed? (e.g., racing heart, shallow breathing, tense muscles)"
- ✓ "What are the early warning signs that you are moving toward shutting down? (e.g., feeling numb, tired, disconnected)"

3.3 Parts and the Window of Tolerance

- ✓ "Do different parts have different windows of tolerance?"
- ✓ "Are there some parts that can handle more intense feelings than others?"
- ✓ "Which parts get activated when you are outside your window of tolerance?"
- ✓ "How do your protector parts try to manage when you are outside your window?"

Section 4: Somatic and Body-Based Awareness

4.1 Body Connection

- ✓ “How connected do you feel to your body on a daily basis?”
- ✓ “Are there times when you feel disconnected or numb in your body?”
- ✓ “Do different parts live in different areas of your body?”

4.2 Grounding and Centering

- ✓ “What helps you feel grounded in the present moment when you are feeling overwhelmed or disconnected?”
- ✓ “Let’s try a quick body check-in. Can you feel your feet on the floor? What does that feel like?”

Client Handout: Skills to Stay Stable

When therapists say a client has the skills to stay stable, they mean the client has developed, and practices, effective strategies to stay grounded in the present moment and maintain balance within their window of tolerance. This is the emotional and physiological range where you feel safe, connected, and able to manage stress. These skills address two primary challenges:

- Arousal reduction: Calming the hyperarousal of the sympathetic fight-or-flight response.
- Dissociation reduction: Counteracting the hypoarousal and shutdown associated with the dorsal vagal state. While hyperarousal and dissociation seem like opposites, the techniques to manage them often overlap. Both involve activating the vagus nerve, the body's pathway to calm and balance. In a Nutshell Stress and overwhelm hijack your nervous system, leaving you stuck in one of two dysregulated states:
- Sympathetic Overdrive (Fight-or-Flight): Racing thoughts, restlessness, sweating, a pounding heart, or feeling like you need to escape.
- Dorsal Shutdown (Collapse): Feeling heavy, disconnected, emotionally numb, or like nothing matters.

The Good News You can reset your nervous system with simple, practical exercises tailored to each state. Practice them regularly so they become second nature when you need them most.

35 Tools for Nervous System Regulation Instructions:

- Identify your current state: Are you feeling hyperaroused (sympathetic overdrive) or disconnected (dorsal shutdown)?
- Select a reset exercise: Choose one or more exercises tailored to your current state from the lists below.
- Practice regularly: Even when you're calm, practicing these resets builds muscle memory.
- Reflect on the impact: Notice how your body and emotions change after completing an exercise.

20 Exercises to Reset Out of Sympathetic Overdrive (Fight-or-Flight)

1. Reset & Dunk: Submerge your face in ice water for 10–15 seconds. Activates the mammalian diving reflex.
2. Reset & Swish: Hold warm tea or water in your mouth for 10–15 seconds. Swallow slowly.
3. Reset & Hum: Hum a tune or single note for 30–60 seconds, feeling the vibration in your throat.

4. Reset & Chill: Hold a cool washcloth against your cheeks, neck, or wrists for 30 seconds.
5. Reset & Tap: Tap on acupressure points (e.g., between eyebrows or on the chest) for 30 seconds each.
6. Reset the Flow: Run warm water over your hands for 30 seconds, alternating with cold water.
7. Reset & Gaze: Find a neutral object and softly focus on it for 1–2 minutes while breathing slowly.
8. Reset & Scribble: Scribble randomly on paper for 1–2 minutes, letting your hand move freely.
9. Reset & Wrap: Wrap yourself in a blanket or hug a weighted pillow for 1–2 minutes.
10. The Mindful Sigh: Inhale deeply through your nose. Take a second, shorter inhale. Exhale slowly and completely through your mouth. Repeat for 1–5 minutes.
11. Cognitive Override: Simple affirmations like "I'm just triggered" to counteract negative cognitions.
12. Journaling After Nightmares: Writing about a nightmare and then containing it (e.g., folding the page).
13. Dual Awareness: Simultaneously attending to internal sensations and external surroundings.
14. Neurovascular Hold: Placing one hand on the forehead and the other at the base of the skull, combined with slow breathing.
15. Containment Pose: Crossing the arms and holding the shoulders or triceps.
16. Breathing Exercises: Techniques such as the Reset Breath or Bee Breath.
17. Rub Hands Together or Clench Fists: Generating heat or physical movement engages sensory pathways.
18. Havening Touches (Face Strokes): After rubbing palms together, use fingertips to lightly stroke from the center of the forehead outward to the temples, and under the eyes down the cheekbones, similar to washing your face.
19. Tapping Acupressure Points: Stimulating specific points like the forehead or chest.
20. Mantra Practice: Repeating a soothing phrase such as "I am safe."

15 Exercises to Reset Out of Dorsal Vagal Shutdown (Freeze or Collapse)

1. Reset & Shine: Sit in sunlight for 2–5 minutes, stretching upward as you breathe deeply.
2. Reset & Wiggle: Wiggle your toes and fingers, letting the movement spread through your body.
3. Reset & Roll: Roll a tennis ball under your feet for 1–2 minutes. Focus on the sensations.
4. Reset & Sway: Stand with feet shoulder-width apart and gently sway side to side.

5. The Half-Salamander: Shift your eyes to the right, then tilt your head toward your right shoulder. Hold for 30 seconds. Repeat on the left.
6. The Full Salamander: On all fours, twist your spine and tilt your head gently to each side. Hold for 30 seconds.
7. Tap or Press Acupressure Points as you remind yourself of things you know are inarguably true.
8. Reset & Ground: Sit with your feet flat on the floor. Press them firmly into the ground while breathing deeply.
9. Stand on one foot or sit on an exercise ball/mini-trampoline to enhance balance and proprioception.
10. Reset & Sip: Alternate between sipping warm tea and cold water, focusing on the contrast.
11. Awareness Calling: Change your phone's notification tones to bring you back to awareness.
12. Count on It: Try counting by a specific interval (3s, 4s) or multiplying numbers.
13. Don't Act Senseless: Open your eyes and look around. Uncover your ears. Speak, hum, or sing. Smell clove or peppermint. Eat something sour.
14. Broadcast Safety: Talk to the parts inside of you that are triggered. Remind them that they are safe.
15. Grounding Stone: Keep a grounding stone in your pocket. Run your fingers over it, noticing the texture and temperature.

Worksheets for Clients

1. The Persona Dialogue

Purpose: Facilitates communication between different aspects of self to enhance personal connection and identity.

Instructions: Identify two aspects of your self (e.g., Emotional Self and Rational Self). Have a written dialogue in your journal between these two personas using two different colored pens to distinguish the voices. Discuss feelings of depersonalization, concerns, and desires from each perspective.

2. Sensory Reality Checks

Purpose: Promotes verification of the real world through focused sensory checks.

Instructions: Set a timer to go off at random intervals during the day. When the timer goes off, draw a "Reality Check" card (sight, sound, touch, etc.) and immediately engage that sense to verify your environment. Note your observations in a journal.

3. The Reality Anchor Chart

Purpose: To create a physical reminder of reality to refer to when feeling derealization.

Instructions: Cut out images and words from magazines or old photos that remind you of real experiences, happy memories, or important people. Arrange these on a poster board to create a collage. Place it somewhere you will see it often.

4. Reality Captioning

Purpose: Connects emotions with environmental perceptions, reinforcing the reality of experiences.

Instructions: Select a photo that feels somewhat unreal or dreamlike to you. Write a detailed caption describing what is happening in the scene as if explaining it to someone who has never been there. Under the caption, write about how this place makes you feel and why, linking your feelings to specific sensory details in the photo.

5. Environmental Engagement Map

Purpose: Enhances active engagement with surroundings through a creative mapping exercise.

Instructions: Draw a map of a route you frequently take. Mark significant landmarks. Next to each landmark, write a sensory detail you recall (e.g., the rough texture of the brick wall). Take the route again, actively noting if the details align with your experience. Add new sensory details.

6. Urge Surfing for Dissociation

Purpose: Urge surfing is a mindfulness technique adapted to help observe and ride out the urge to dissociate without engaging in dissociative behaviors.

Instructions:

- Grounding: Notice 5 things you can see, 4 you can touch, 3 you can hear, 2 you can smell, 1 you can taste.
- Observe the Urge: Pay attention to the sensations in your body and thoughts that signal an urge to dissociate.
- Visualize and Surf: Imagine the urge as a wave. Focus on your breathing and stay with the experience until the urge subsides.

(Note: Incorporate Alternating Bilateral Stimulation, such as tapping your thighs, while reflecting on triggers or practicing this technique to help process the urge.)

Chapter 3: Processing Trauma with Dissociative Clients: Modified Phase 4 and Beyond

In standard EMDR, Phase 4 Desensitization is often taught as a relatively straightforward mechanism: apply Alternating Bilateral Stimulation (ABLS), let the brain's Adaptive Information Processing (AIP) system do the work, and stay out of the way. "Trust the process." "Just notice that."

For clients with complex trauma and structural dissociation, this passive approach is not just ineffective; it is often destabilizing. When the personality is divided into an Apparently Normal Part (ANP) and various Emotional Parts (EPs), "just noticing" can quickly lead to flooding, severe dissociation, or looping. The processing stalls. The clinician feels stuck. The client feels broken.

This chapter redefines what processing actually looks like for dissociative clients. It moves beyond the generic instruction to "do EMDR" and provides a precise diagnostic framework for understanding why processing fails and how to intervene. By integrating the AIP model, the Theory of Structural Dissociation of the Personality (TSDP), and a sensory-systems framework, we can fractionate Phase 4 processing into manageable, targeted mental actions: synthesis, personification, and presentification.

1. When Is the Client Ready to Process?

The transition from Phase 2 (Preparation and Stabilization) to Phase 4 (Desensitization) is the most critical juncture in complex trauma treatment. Move too slowly, and the therapy stagnates in endless grounding exercises. Move too quickly, and the client decompensates.

Readiness is not determined by the passage of time or the completion of a specific number of coping skills worksheets. It is determined by the client's integrative capacity and the resolution of specific Phase 1 phobias.

Criteria for Moving to Processing

Before initiating trauma processing, the clinician must ensure the following criteria are met:

- Resolution of the Phobia of Mental Actions: The client can tolerate their own internal experiences (thoughts, feelings, bodily sensations) without immediate, severe dissociation or behavioral acting out.
- Resolution of the Phobia of Dissociative Parts: The ANP is aware of the EPs, feels a degree of compassion or at least neutrality toward them, and can communicate with them. The internal system has agreed to the processing work.
- Adequate Sensory Infrastructure: The client can accurately identify their internal state (interoception) and use the environment to ground themselves (exteroception) when dysregulated.

- Capacity for Dual Awareness: The client can simultaneously hold the reality of the past memory and the safety of the present room.

The Dual Awareness Readiness Test

If you are unsure whether a client is ready for processing, you can test their capacity for dual awareness directly. Ask the client to bring up a mildly distressing memory (Subjective Units of Disturbance [SUD] 3 or 4, not a core trauma target).

As they hold the memory, ask: "While you are noticing that memory, can you also feel the chair supporting your back? Can you see the color of the wall behind me?"

If the client loses the memory when focusing on the room, or loses the room when focusing on the memory, their integrative capacity is insufficient for Phase 4. Return to Phase 2 stabilization. If they can hold both simultaneously, they have the dual awareness necessary to begin processing.

2. What Processing Actually Looks Like

To effectively modify Phase 4, we must understand what we are actually trying to achieve. "Processing" is not a single event; it is a complex psychological achievement that requires the successful execution of multiple mental actions.

We can view this achievement through three complementary lenses:

- The AIP Lens: Unprocessed trauma is stored in state-specific, isolated neural networks. Processing involves linking these isolated networks to adaptive information networks, allowing the memory to be metabolized and integrated.
- The TSDP Lens: Unprocessed trauma is held by isolated EPs. Processing involves overcoming the phobia of traumatic memory, allowing the ANP to synthesize the experience, personify it ("this happened to me"), and presentify it ("it is over").
- The Sensory Lens: Unprocessed trauma is fragmented across different sensory channels (visual, auditory, interoceptive, vestibular). Processing involves binding these fragmented sensory elements into a coherent narrative.

These lenses do not conflict; they describe the same phenomenon from different angles (Van der Hart, Nijenhuis, & Steele, 2006). When processing stalls, it is because one of these mental actions has failed. The clinician's job is to diagnose the failure and apply the specific intervention required to overcome it.

3. Modified Phase 4: Working with Synthesis Failures

Synthesis is the fundamental building block of integration. It is the mental action of binding disconnected elements of an experience into a coherent whole. In complex trauma,

synthesis frequently fails because the sensory, cognitive, and emotional elements of the memory are held by different parts or isolated in different sensory channels.

A synthesis failure looks like fragmentation. The client may have a vivid visual flashback but feel no emotion. They may experience intense somatic pain but have no narrative memory of what caused it. They may recount a horrific event with a flat, detached affect.

When synthesis fails, standard ABLS will often result in looping (re-experiencing the same fragment repeatedly without resolution) or dissociation. The clinician must intervene to actively facilitate the binding process.

The Sensory Bridge (Core Synthesis)

When a client experiences a somatic sensation or emotion without a corresponding narrative, or a narrative without a somatic connection, the Sensory Bridge can facilitate synthesis.

Procedure:

- Identify the disconnected fragment (e.g., a sudden tightness in the chest).
- Ask the client to focus on the sensation.
- Apply a short set of ABLS (6-10 passes).
- Ask: "As you notice that tightness, what memory, image, or thought comes to mind?"
- If a connection is made, apply another short set of ABLS to strengthen the link.
- If no connection is made, do not force it.
- Contain the sensation and return to stabilization.

Narrative Tracking (Core/Extended Synthesis)

For clients who have fragmented, disjointed memories, Narrative Tracking helps build a coherent timeline.

Procedure:

- Ask the client to recount the traumatic event from a point of safety before the event to a point of safety after the event.
- Track the narrative carefully. Listen for sudden jumps in time, sudden shifts in affect, or points where the narrative becomes vague or confused.
- Stop the client at these points of fragmentation.
- Say: "You just jumped from being in the car to being in the hospital. Let's go back to the car. What happened next?"
- Apply short sets of ABLS as the client bridges the gap.

The Three-Pronged Synthesis Check (Extended Synthesis)

Extended synthesis involves connecting the synthesized memory to the client's broader life narrative, encompassing past, present, and future. This maps directly onto EMDR's three-pronged protocol.

Procedure: After a specific target memory appears to be processed (SUD is 0 or 1), verify extended synthesis:

- Past: "How does this memory connect to other experiences in your past?" (Check for feeder memories).
- Present: "When you think about this memory now, how does it affect your current life?" (Check for present triggers).
- Future: "Imagine a future situation that used to trigger you. How do you respond now?" (Check for future templates).
- If distress arises in any of these domains, synthesis is incomplete.
- Target the new distress with ABLS.

4. Modified Phase 4: Working with Personification Failures

Synthesis is necessary but not sufficient for healing. A client can have a perfectly synthesized, coherent narrative of a traumatic event and still feel entirely detached from it. This is a failure of personification.

Personification is the mental action of taking ownership of the experience: "This happened to me." In complex trauma, personification is fiercely resisted because it requires the ANP to fully acknowledge the vulnerability, terror, and helplessness experienced by the EP. It is the confrontation with the unbearable reality of the trauma.

A personification failure looks like intellectualization. The client can tell the story calmly, perhaps even analyzing it psychologically, but there is no felt sense of ownership. "I know it was abusive, but I don't feel anything about it."

The Depth of Feeling Inquiry

To move a client from cognitive knowing to embodied knowing, use the Depth of Feeling Inquiry. Procedure: When a client presents a synthesized but detached narrative, pause the ABLS. Say: "You have a very clear understanding of what happened. You know it was wrong. But do you feel that it happened to you? Do you feel the impact of it in your body right now?" If the client says no, the target is not the memory itself, but the phobia of personification. Say: "Notice the part of you that is keeping those feelings away. It is doing a very good job of protecting you. Let's just notice that protection." Apply a short set of ABLS.

The Substitute Action Check

Often, clients will substitute a more tolerable emotion or action for the unbearable feelings of helplessness and grief. Anger is a common substitute. A client may become enraged at the perpetrator, and the clinician may mistake this for successful processing

(empowerment). However, if the anger is a defense against the underlying grief, processing will stall.

Procedure: When a client exhibits a strong emotional response (like anger or an urge to fight back), assess whether it is a genuine completion of a truncated survival response or a substitute action. Ask: "If that anger were to soften for just a moment, what feeling is underneath it?"

If the client connects with sadness, fear, or helplessness, the anger was a substitute. Target the underlying emotion with ABLS.

The Helplessness and Aloneness Exploration

The core pain of complex relational trauma is rarely the physical danger itself; it is the profound aloneness in the face of that danger. Research consistently shows that social support is the strongest protective factor against PTSD (Bryant et al., 2017). The absence of that support is the true trauma.

Personification requires confronting this aloneness.

Procedure: When the client is able to tolerate the reality of the memory, guide them toward the core pain.

- Say: "As you look back at that younger you, what was the hardest part?
- Was it what was happening, or was it that no one was there to help?"

Allow the client to connect with the profound helplessness and aloneness. This will almost inevitably lead to deep grief. The clinician's role here is to provide the compassionate presence that was missing at the time of the trauma. Apply slow, continuous ABLS to support the processing of the grief.

5. Modified Phase 4: Working with Presentification Failures

Presentification is the final mental action of integration. It is the realization that the trauma belongs to the past and that the present is fundamentally different. "It happened to me, but it is over, and I am safe now."

A presentification failure looks like the trauma is still happening. The client may have synthesized the memory and personified it, but they are still living in the emotional reality of the past. The nervous system remains mobilized for a threat that no longer exists.

The Pacing-and-Leading Bridge

To facilitate presentification, the clinician must actively bridge the gap between the past reality and the present reality. This can be done using an Ericksonian pacing-and-leading technique. Procedure: - Pace (Acknowledge the past reality): "Yes, you were completely alone and terrified in that room. No one came to help you."

- Soft Lead (Present-tense evaluation): "That is a very sad and terrible thing for a child to endure."

- Explicit Lead (Bridge to the present): “You were alone then. As you sit here with me now, in this office, is it the same? Are you alone right now?”
- Reinforce: If the client can connect with the present safety and the therapeutic relationship, apply ABLS to strengthen that realization.

Dual Awareness Practice During Processing

Presentification requires robust dual awareness. If the client begins to lose contact with the present moment during processing, the clinician must actively intervene to re-establish it. Procedure: - During ABLS, interject brief orienting statements:

- “Notice what you are seeing in the memory, and feel your feet on the floor right now.”
- “Hear the sounds from the past, and hear the sound of my voice in this room.”
- These interweaves do not interrupt processing; they provide the necessary present- moment scaffolding for processing to continue safely.

The Future Self Visualization

Presentification is consolidated when the client can project their integrated self into the future. Procedure: Once the memory is processed and the client feels grounded in the present, ask them to visualize a future scenario that would have previously triggered the traumatic response. Ask: “As you imagine that situation now, how does it feel different? What do you notice about how you handle it?” Listen for statements of integrated self-efficacy (“I feel solid,” “I can handle it,” “I am stronger than I thought”). Apply slow ABLS to install this adaptive future template.

6. The Cognitive Interweave Framework (Reconceptualized)

In standard EMDR, cognitive interweaves are often taught as a way to “jump-start” processing when it stalls, usually by introducing adaptive information (e.g., “I am safe now”).

However, for dissociative clients, the stall is rarely just a lack of information. It is a structural failure of synthesis, personification, or presentification.

We must reconceptualize interweaves not as generic “nudges,” but as precise diagnostic interventions targeted at the specific mental action that is failing.

When processing stalls, the clinician must ask: Which mental action is failing right now? The answer dictates the interweave.

7. Guided Realization: The Grief Work

Realization is the higher-order integration of synthesis, personification, and presentification. It is the profound, embodied understanding that “this terrible thing happened to me, and it is over.” When a client achieves synthesis but struggles with realization, the clinical presentation often shifts from fear to profound grief. This is a

critical transition. The client is no longer fighting the memory; they are mourning what the memory cost them.

The Guided Realization Procedure

When the SUD drops but the client remains deeply sad or heavy, do not mistake this for incomplete processing. This is the grief of realization.

Procedure: - Acknowledge the shift: “The danger is gone, but the sadness remains. That makes sense.” - Validate the loss: “It is a terrible thing to realize what was taken from you.” - Support the grief: Apply slow, continuous ABLS (often slower than standard processing sets) to help the client metabolize the grief. - Do not try to “fix” the sadness with positive cognitive interweaves. The goal is not to make the client happy about the trauma; the goal is to help them tolerate the reality of it.

8. Processing Across Ego States

Standard EMDR assumes a single, unified consciousness experiencing the trauma. TSDP recognizes that in complex trauma, different ego states (parts) may hold different, sometimes contradictory, pieces of the memory. Processing across ego states requires the clinician to act as a facilitator of internal communication, rather than just an administrator of ABLS.

The Internal Conference During Phase 4

If processing stalls because parts are in conflict (e.g., an angry part is blocking a terrified part from processing), the clinician must pause the trauma processing and facilitate an internal conference. Procedure: - Stop the ABLS. - Ask the ANP to invite the conflicting parts to a safe internal meeting space (the “dissociative table” or a similar construct). - Facilitate communication: “Ask the angry part what it is afraid will happen if the terrified part shares its memory.” - Negotiate permission: “Can the angry part step back just 10 percent, so we can help the terrified part feel safer?” - Once permission is granted, resume processing, explicitly including the parts: “Let all the parts that need to hear this know that it is over.”

9. When Processing Stalls: A Decision Tree

When you hit a wall in Phase 4 with a complex client, do not simply apply more ABLS or throw random cognitive interweaves at the problem. Stop and use this diagnostic decision tree:

- Is the client dissociating (losing dual awareness)?
  - Yes: Stop processing. Return to Phase 2 grounding and stabilization.
  - No: Proceed to step 2.
- Is there a sensory or emotional fragment with no narrative context?
  - Yes: This is a Synthesis Failure. Use the Sensory Bridge or Narrative Tracking.
  - No: Proceed to step 3.
- Is the client recounting the memory with flat affect or intellectualization?

- Yes: This is a Personification Failure. Use the Depth of Feeling Inquiry or check for Substitute Actions.
- No: Proceed to step 4.

- Is the client experiencing the memory as if it is happening right now, despite knowing they are in your office?
  - Yes: This is a Presentification Failure. Use the Pacing-and-Leading Bridge or Dual Awareness Practice.
  - No: Proceed to step 5.
- Is the SUD stuck at a 2 or 3, accompanied by heaviness or sadness?
  - Yes: This is likely Realization and Grief. Switch to slow ABLS and support the mourning process.
  - No: Check for part interference (Internal Conference) or an unprocessed feeder memory.

Target Mental Action	Purpose of Interweave	Examples
Synthesis	To bind disconnected sensory, cognitive, or emotional fragments.	"What does your body know that your mind hasn't caught up with yet?" "Notice that tightness in your chest. What memory goes with it?"
Personification	To deepen emotional ownership and move past intellectualization.	"You know this happened. But do you feel it?" "Notice the part of you that is keeping those feelings away."
Presentification	To bridge the past reality with present safety.	"You were alone then. What about now?" "Look around this room. Does the danger belong here?"

10. Clinical Vignettes

To illustrate how these transitions happen in real time, consider the following clinical vignettes.

Vignette 1: From Synthesis Failure to Personification

Sarah, a survivor of childhood physical abuse, was processing a memory of being locked in a closet. She reported a SUD of 8, but her affect was completely flat. She described the memory like she was reading a grocery list.

Clinician: "You are describing a terrifying situation, but your voice is very calm. What do you notice in your body right now?"

Sarah: "My chest is tight. It feels like a band of iron."

Clinician (identifying a synthesis failure): "Focus on that band of iron." (Applies short ABLS). "What memory goes with that tightness?"

Sarah (gasps): “It’s not the closet. It’s him holding me down before he put me in the closet.”

The clinician successfully synthesized the somatic fragment with the narrative. However, Sarah immediately intellectualized the new memory.

Sarah: “Well, he was an alcoholic. He didn’t know what he was doing.”

Clinician (identifying a personification failure): “You understand his psychology very well. But do you feel what it was like for that little girl to be held down by him?” (Depth of Feeling Inquiry).

Sarah (begins to cry): “She was so small. She couldn’t breathe.”

Clinician: “Go with that.” (Applies ABLS).

Vignette 2: From Personification to Presentification

David was processing a combat memory. He had successfully synthesized the sensory details and personified the terror, but his SUD remained stuck at a 7. He kept repeating, “They are coming over the wall.”

Clinician (identifying a presentification failure): “Yes, they were coming over the wall. You were in terrible danger.” (Pacing). “That was a horrific day.” (Soft lead). “As you sit here in this chair, looking at the trees outside my window, are they coming over the wall right now?” (Explicit lead).

David (blinks, looks around the room): “No. I’m in Ohio. It’s quiet here.”

Clinician: “Notice that quiet. Notice that you are in Ohio.” (Applies ABLS).

David (exhales deeply): “It’s over.”

By diagnosing the specific mental action that was failing, the clinicians in these vignettes were able to apply precise, effective interventions, moving the clients through the complex architecture of trauma processing.