Dissociation of the Personality and EMDR Therapy in Complex Trauma-Related Disorders: Applications in the Stabilization Phase

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As proposed in a previous article in this journal, eye movement desensitization and reprocessing (EMDR) clinicians treating clients with complex trauma-related disorders may benefit from knowing and applying the theory of structural dissociation of the personality (TSDP) and its accompanying psychology of action. TSDP postulates that dissociation of the personality is the main feature of traumatization and a wide range of trauma-related disorders from simple posttraumatic stress disorder (PTSD) to dissociative identity disorder (DID). The theory may help EMDR therapists to develop a comprehensive map for understanding the problems of clients with complex trauma-related disorders and to formulate and carry out a treatment plan. The expert consensus model in complex trauma is phase-oriented treatment in which a stabilization and preparation phase precedes the treatment of traumatic memories. This article focuses on the initial stabilization and preparatory phase, which is very important to safely and effectively use EMDR in treating complex trauma. Central themes are (a) working with maladaptive beliefs, (b) overcoming dissociative phobias, and (c) an extended application of resourcing.

Keywords: dissociation; structural dissociation of the personality; dissociative disorders; EMDR; phase-oriented treatment; stabilization phase

Originally developed for the treatment of posttraumatic stress disorder (PTSD), eye movement desensitization and reprocessing (EMDR) has been increasingly used in the treatment of other mental disorders, including those rooted in complex traumatization such as complex PTSD, borderline personality disorder (BPD), and the complex dissociative disorders such as dissociative identity disorder (DID) and dissociative disorder not otherwise specified (DDNOS) Subtype 1. Related to these clinical developments regarding EMDR's adaptive information processing (AIP) model (Shapiro, 2001), there is a tendency to look for complementary theoretical models, in particular, concerning the application of EMDR in the treatment of complex trauma-related disorders, which may severely compromise the lives of those involved. Thus, Luber and Shapiro (2009) state,

> When we are dealing with the most debilitated patients, it is most important for us to incorporate the wisdom of other fields. The more we learn from other disciplines, the more efficient

 http://dx.doi.org/10.1891/1933-3196.7.2.81

> and effective we can become. In order for EMDR to be used as a psychotherapeutic approach applicable to the full range of psychopathologic situations, its theoretical model needs to integrate developmental neuropsychology with the effect of cumulative traumatic experiences. (pp. 227–228)

This article presents, as a follow-up of a previous article (Van der Hart, Nijenhuis, & Solomon, 2010), the theory of structural dissociation of the personality (TSDP) as a complementary approach, which includes neurobiological and developmental issues in the context of the understanding of traumatization as essentially involving a dissociation of personality. In TSDP, the concept of dissociation does not only pertain to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (*DSM-IV*) dissociative disorders but is regarded as a failure of integration that underlies all trauma-induced disorders, including PTSD. Thus, TSDP may provide a theoretical framework for all of these disorders.

We consider TSDP to be compatible with the AIP model; the theory may enrich it by providing an understanding of various phenomena involved in complex traumatization. Some of these phenomena are the dissociation of traumatic memories such that they are not easily accessible, the client functioning in daily life having amnesia for them, and the existence of a range of dissociative parts of the personality (more or less similar concepts are self-states, dissociative ego states, identity states, alters, among others). These dissociative parts are characterized by various degrees of mental autonomy, having their own point of view, including thoughts, feelings, emotions, perceptions of, and behavioral actions regarding themselves and other people, including the therapist. They refer to themselves as "I" and have their own consciously experienced first-person perspective (Nijenhuis & Van der Hart, 2011). In more complex cases, they may have different names, and some may even be experienced by other parts as completely different entities such as spirits, devils, or animals. There are also clients with dissociative parts who have only a very rudimentary sense of the self, described by the dissociative part functioning in daily life, that is, the apparently normal part of the personality (ANP) as "not me" experiences (cf. Van der Hart, Nijenhuis, & Steele, 2006).

Dissociative parts may interfere with any procedure that the therapist is trying to perform, either overtly or covertly. For instance, when, in terms of the AIP model, the focus is on processing some dysfunctional stored memories with one dissociative part of the personality, other parts may disagree with this work and interfere (the client may hear threatening voices or experience somatic distress, without disclosing this to the therapist). In such a situation, there is a risk of decompensation, hyperarousal, or blockage. In other cases, a particular traumatic memory may be divided among several dissociative parts, most of which remain undetected. The reprocessing then may initially look successful, although in reality, the most feared and abhorred aspects of the traumatic memory—that is, the pathogenic kernels (Van der Hart et al., 2006)—may remain untouched by EMDR procedures and continue to exist in isolation and eventually interfere with daily functioning. For example, after reprocessing a childhood memory of trying to please her mother, and feeling that "nothing was good enough," a client experienced relief of her distress and the subjective units of disturbance (SUDs) went down to 0. During the week, the client reported experiencing distress, so in the next session, the therapist re-accessed the memory and asked the client to look at the eyes of the 7-year-old girl in the memory and to try noticing what she was feeling. Just by looking at the girl's eyes, the client suddenly experienced an intense emotion—something that was extremely surprising for her. Focusing on this image as a new target, all the dysfunctional experiences related with the memory could be completely reprocessed. The ANP had learned to ignore the feelings and needs of this child part, mirroring the relationship between her depressive mother (too worried by her own problems to pay attention to her daughter) and herself.

Parallel to the search for AIP-compatible theoretical models, EMDR clinicians working with clients with a history of chronic/complex traumatization have adopted the phase-oriented approach that is the *standard of care* in the field (e.g., Brown, Scheflin, & Hammond, 2008; Herman, 1992; International Society for the Study of Trauma and Dissociation [ISSTD], 2011). First developed by Pierre Janet (1898; cf. Van der Hart, Brown, & Van der Kolk, 1989), phase-oriented treatment consists of three phases: (a) stabilization, symptom reduction, and skills building; (b) treatment of traumatic memories; and (c) personality (re) integration and rehabilitation. These phases are not always applied in a strictly linear fashion (Courtois, 1999; Herman, 1992; Korn, 2009; Van der Hart et al., 2006): Particularly in complex trauma-related disorders, there often is a recurrent need to return to previous phases as the treatment progresses.

Many clinicians have already combined phase-oriented treatment and EMDR therapy in their clinical practice (e.g., Fine & Berkowitz, 2001; Forgash & Knipe, 2007; Gelinas, 2003; Gonzalez & Mosquera,

2012; Hofmann, 2006; Korn & Leeds, 2002; Lazrove & Fine, 1996; Paulsen, 2007; Twombly, 2005). For clarity's sake, it is important to realize how the three phases of phase-oriented treatment compare with the eight phases of the EMDR standard protocol (Shapiro, 2001): Phase 1—stabilization, symptom reduction, and skills training—comprises Phases 1 and 2 of the EMDR protocol; Phase 2, treatment of traumatic memories, comprises Phases 3–8 of the protocol; and Phase 3, personality (re)integration and rehabilitation, is incorporated throughout EMDR therapy through evaluating treatment results, teaching new skills and building resources, applying appropriate protocols (phobia and recent event protocols are examples) and processing past memories, present triggers, and providing future templates for adaptive behavior.

In this article, the emphasis is on the clinical applications of EMDR in the first phase of phase-oriented treatment of clients with complex trauma-related disorders. The integration of TSDP with the AIP model may be very helpful not only in understanding the client's problems but also in guiding therapeutic decision making. TSDP offers a comprehensive framework that may help the EMDR therapist to do a thoughtful history taking, case conceptualization, and therapeutic plan. The focus of this article will be on procedures for reduction of symptoms, skill development, and preparation for trauma work. A future article will be dedicated to the safe and effective EMDR processing of traumatic memories with these dissociative clients.

The Theory of Structural Dissociation of the Personality in a Nutshell

TSDP proposes that trauma-related disorders are characterized by a division of clients' personality into different dissociative subsystems or parts as T. A. Ross's (1941) description of psychological trauma as a "breaking point" indicates that traumatic experiences can be conceptualized as failures of integration that involve a dissociation of the personality. This dissociation can either be resolved or become more entrenched. Each one of the dissociative parts has its own psychobiological underpinnings (Nijenhuis & Den Boer, 2009; Nijenhuis, Van der Hart, & Steele, 2002; Van der Hart et al., 2006) and is, as mentioned earlier, characterized by its own first-person perspective. Clients alternate between one or more ANPs and one or more *emotional parts of the personality* (EPs). ANPs are motivated by daily life action systems, whereas EPs live in *trauma time* and are mediated by the defensive action subsystem(s)—such as fight, flight, freeze, and (total) submission—that was activated during the trauma (see Van der Hart et al., 2010; Van der Hart et al., 2006 for elaborations of these characteristics).

Trauma-related dissociation of the personality can be more or less complex. *Primary dissociation of the personality* involves one ANP and one EP; *secondary dissociation* involves one ANP and two or more EPs; and *tertiary dissociation* is characterized by more than one ANP and more than one EP. In terms of TSDP, the EMDR therapist who follows the standard EMDR protocol with primary dissociation, such as in simple PTSD, will invite the client as ANP to focus on the traumatic memory as the target, thereby also reactivating the EP: This is what "one foot in the present and one foot in the past" (Knipe, 2007) is about. The focus of this article is not only on PTSD (primary dissociation), but TSDP may also help EMDR therapists to understand some phenomena observed while using the EMDR standard protocol in simple trauma; examples are losing dual attention and the extreme avoidance (phobia) of the traumatic memory.

When the division of the personality involves more than two parts, the EMDR therapist meets a different situation, one in which knowledge of TSDP might be most helpful. This is why we focus in this article on secondary and tertiary dissociation of the personality, characterized by more repetitive, severe, and prolonged traumatization, especially during childhood. In secondary dissociation of the personality, one ANP remains focused on daily life, but two or more EPs are fixated in defense and, when triggered, engage in reexperiencing or, rather, reenactment of traumatizing events.

The division of EPs is often based on failed integration among relatively discrete defenses of flight, fight, freeze, and (total) submission. Other EPs may hold intolerable affective experiences such as shame or intense loneliness. This level of dissociation likely characterizes clients with complex PTSD, trauma-related BPD, and DDNOS Subtype 1. This subtype involves clinical presentations similar to DID that do not meet the full criteria for this disorder (American Psychiatric Association [APA], 1994)—the most common form of dissociative disorder encountered in clinical practice (e.g., Johnson, Cohen, Kasen, & Brook, 2006; Şar, Akyuz, & Dogan, 2007). Clients with DID, who often have a history of chronic interpersonal neglect, maltreatment, and abuse that started early in childhood (Boon & Draijer, 1993; Putnam, Guroff, Silberman, Barban, & Post, 1986) are characterized by tertiary dissociation of the personality, where more than one ANP exists, in addition to multiple EPs. Division of ANP, mediated by daily life action systems, may occur to maintain functioning in certain inescapable situations that may trigger traumatic memories. This

division of ANP tends to occur along different action systems of daily life. For example, an ANP may develop in a child who is sexually abused with the sole function of eating—mediated by the subsystem of energy regulation—during breakfast while facing her father who just abused her.

In TSDP, dissociation of the personality is posited to be maintained by a series of phobias that characterize trauma survivors and oftentimes also by a lack of integrative capacity and social support (Van der Hart et al., 2006). The term "phobia" is usually relegated to anxiety disorders and is understood as a persistent fear for external elements (animals, social situations, etc.) that the individual tries to avoid. However, Janet (1904) described phobic reactions directed toward internal experiences such as thoughts, feelings, fantasies, and so forth. Individuals who are chronically traumatized are often extraordinarily fearful of internal mental actions and involved content, as well as of external cues, which trigger traumatic experiences (Steele, Van der Hart, & Nijenhuis, 2005; Van der Hart et al., 2006). The core phobia maintaining the dissociation of the personality is the *phobia of traumatic memories*, the essence of which is an avoidance of full realization of the trauma and its effects on one's life (Janet, 1904; Van der Hart et al., 2006). With chronic traumatization, increasing behavioral and mental avoidance, involved in the maintenance of dissociation of the personality, is needed to prevent what ANPs perceive as particularly unbearable realizations about self, others, and the world. Subsequently, ever-encompassing phobias seem to ensue from this fundamental phobia (Van der Hart et al., 2010; Van der Hart et al., 2006).

These phobic mental and behavioral actions, also denoted as defenses in the psychodynamic sense of the word such as avoidance and idealization defense (e.g., Dell, 2009; Knipe, 2007), can be seen as *substitute actions*, that is, not only less efficient actions that substitute for the more efficient but also (much) more difficult actions that constitute mental health. Both ANP(s) and EPs engage in these actions. Overcoming this complex of phobias and other ways of raising the survivor's efficiency (i.e., the quality of his or her mental and behavioral actions) and energy level are viewed as essential to successful treatment. Table 1 presents an overview of these trauma-related phobias as they are approached in the respective treatment phases.

Adaptive Information Processing Model and TSDP: Complementary Approaches

According to AIP, traumatizing events result in memories that are dysfunctionally stored, that is, stored in isolation, unassimilated into the comprehensive memory networks of the individual (Shapiro, 1995, 2001). As Shapiro (2001) explains,

> The pathological structure is inherent in the static, insufficiently processed information stored at the time of the disturbing event . . . [T]he lack of adequate assimilation means that the client is still reacting emotionally and behaviorally in ways consistent with the earlier disturbing event. (p. 17)

The dysfunctionally stored information includes memories "stuck in time" and contains the maladaptive mental and behavioral actions that were present

TABLE 1. Phase-Oriented Treatment: Overcoming Trauma-Related Phobias

Phase 1: Symptom reduction, stabilization, and skills building

- Overcoming the phobia of attachment and attachment loss, particularly with the therapist
- Overcoming the phobia of mental actions (e.g., inner experiences such as feelings, thoughts, sensations, wishes, fantasies)
- Overcoming the phobia of dissociative parts of the personality (ANP and EP)

Phase 2: Treatment of traumatic memories

- Overcoming attachment phobias related to the perpetrator(s)
- Overcoming attachment phobias in EPs related to the therapist
- Overcoming the phobia of traumatic memories

Phase 3: Personality integration and rehabilitation

- Overcoming the phobia of normal life
- Overcoming the phobia of healthy risk taking and change
- Overcoming the phobia of intimacy, including sexuality and body image

Note. ANP = apparently normal part of the personality; EP = emotional part of the personality.

at the time of the event, including the sensorimotor responses, affective responses (e.g., vehement emotions, in Janet's words (Janet, 1909), such as overwhelming fear, anger, shame, or guilt), cognitions, threat perception, and predictions (i.e., expectancies based on the past danger and threat experienced during the traumatizing event).

Janet (1925) wrote,

> [T]he (traumatic) memory was morbific because it was dissociated. It existed in isolation, apart from the totality of the sensations and the ideas which comprised the subject's personality; it developed in isolation, without control and without counterpoise; the morbid symptoms disappeared when the memory again became part of the synthesis that makes up individuality. (p. 674)

Janet's "dissociated" (Janet, 1925) and Shapiro's "in isolation" (Shapiro, 2001) refer to the same phenomenon. Although AIP is not an elaborated theory of personality, it points to the importance of learning, and hence memory networks, as a prime determinant of personality characteristics and behavior (Shapiro, 1995, 2001; Solomon & Shapiro, 2008). Thus, dysfunctionally stored memories (especially with chronically traumatized populations) can be conceptualized as dissociated from the remainder of the personality, which includes the wider system of memory networks that underlie behavior.

TSDP does not speak in terms of "stored information" and, instead, states that the mental and behavioral actions involved in traumatic memories belong to some conscious and self-conscious dissociative parts of the personality, each of them having its own first-person perspective. In AIP terms, then, EP and ANP have their own memory networks, with EP holding the dysfunctionally stored (stuck in time) memories. To add the concept of the EP, highlighting the fact that a dissociative part has a first-person perspective, to this "dysfunctional stored information" may help EMDR therapists to better understand what kind of preparation is needed in primary dissociation of the personality (simple trauma). This is particularly the case when the EP has a high degree of autonomy or when intense phobias between ANP and EP exist that first need to be dealt with.

Traumatic experiences—that are "dysfunctionally stored"—are also at the roots of secondary and tertiary dissociation. These levels of dissociation can perhaps be more comprehensively understood and phenomenologically elaborated by TSDP. This theory also states that EP's traumatic memories can only be integrated (processed) when these memories are shared among dissociative parts. In other words, ANP's skills (adaptive information) have to link into EP's dysfunctionally stored memory. To integrate dysfunctional and adaptive neuronetworks, dissociative parts, beginning with ANPs, must first develop empathy toward and constructive communication and collaboration with each other; dissociative barriers need to be gradually resolved. When successful, processing of traumatic memories constitutes a major contribution to such integration.

Phase-Oriented Treatment of Secondary and Tertiary Dissociation of the Personality

In cases of secondary and tertiary dissociation of the personality involving a wide range of dissociative parts, a phase-oriented treatment approach—the standard of care (Brown, Scheflin, & Hammond, 1998)—is needed. In particular, before engaging in the treatment of traumatic memories, therapy should focus on stabilization, symptom reduction, including risk behaviors, and skills building. All this involves working with the inner system of dissociative parts. In many cases, phase-oriented approach takes the form of a spiral process that requires revisiting trauma-based themes and beliefs, reactivating coping responses and resources, and continuing to challenge core issues again and again. For instance, it may be needed that Phase 2 treatment (the integration of traumatic memories) is periodically alternated with Phase 1 (stabilization). EMDR therapy may benefit from integrating TSDP perspectives in this initial phase, oriented to stabilize the client, to decrease symptoms and risk behaviors, and to prepare future trauma work. EMDR procedures can shorten this phase and increase therapeutic effectiveness.

The Need for Adequate Assessment and Comprehensive History Taking

Without proper assessment, therapists may underestimate the complexity of the trauma history and the degree of dissociation of the personality, thereby overlooking the various dissociative parts that should become involved in the therapy. Then, they may not provide sufficient stabilization and preparatory interventions. In the EMDR field, several authors have warned about the risks of ignoring these issues (Gelinas, 2003; Korn, 2009; Shapiro, 2001). For instance, unknown EPs can suddenly be activated and reenact different traumatic experiences than the target memory. These chain reactions involve intense fear and/or anger among other parts, eventually leading

to panic attacks, serious self-destructive behaviors, or decompensation of the overwhelmed client. In short, EMDR can be effectively and safely used even with highly dissociative clients when adequate assessment and preparation—stabilization, symptom reduction, and skills building—has taken place.

Phase-Oriented Treatment—Phase 1: Stabilization, Symptom Reduction, and Skills Building

A necessary precursor to treatment of traumatic memories in cases of complex dissociation involves (an often lengthy period of) stabilization and development of more reflective functioning (Gonzalez & Mosquera, 2012) and efficient emotion regulation and relational and life skills (Allen, Fonagy, & Bateman, 2008; Brown et al., 1998; Courtois, 1999; Gelinas, 2003; Kluft, 1997, 1999; Korn, 2009; Linehan, 1993; Ogden, Minton, & Pain, 2006; Shapiro, 1995, 2001; Steele et al., 2005; Van der Hart et al., 2006). This first treatment phase is aimed at improving daily life (including safety and attachment); increasing the integrative capacity and, related to this, widening the window of tolerance; improving internal cooperation; and improving coping skills for PTSD symptoms and dissociative symptoms. Necessary procedures and interventions for reaching these goals are psychoeducation; development of a flexible, empathic, cooperative, and well-boundaried therapeutic relationship; self-regulation (including affect regulation and self-soothing); self-care (including self-compassion, the capacity to be alone, basic energy management, development of daily routines and structure, and equilibrium between taking care of oneself and others); interpersonal skills; working with maladaptive beliefs (see also the next paragraph); and resourcing (including emotional, cognitive, sensorimotor, and relational resources; ego-strengthening strategies; and interventions for empowering the client). It is not possible to describe all this procedures and interventions in a single article; they have been developed and described elsewhere (e.g., Boon, Steele, & Van der Hart, 2011; Forgash & Copely, 2007; Gonzalez & Mosquera, 2012; Twombly, 2000, 2005; Van der Hart et al., 2006). In this article, the focus is on (a) working with maladaptive beliefs (crucial to facilitate the installation of positive cognitions in further trauma reprocessing), (b) overcoming dissociative phobias: a central treatment principle in TSDP that can guide EMDR therapists in planning and structuring therapy with these clients, and (c) an extended application of resourcing (a usual EMDR intervention that needs to be modified in the treatment of individuals who are severely traumatized).

It is important in Phase 1 to identify and treat maladaptive beliefs and behavioral actions (Van der Hart et al., 2006) of various ANPs and EPs. In clients with complex trauma, such beliefs are strongly rooted and usually need to be attended to already in the stabilization phase of phase-oriented treatment. In TSDP, these maladaptive beliefs are viewed as fixed, reflexive behavioral actions and are called *substitute mental and behavioral actions* (such as avoiding all men who have any similarity to the original perpetrator, lack of differentiation between internal and external realities, or past and present realities). These actions are substitutes for adaptive action in the present. Clients may have substitute fantasies that often involve being rescued (by one's family or the therapist), the wish to undo the past and make the "real" past go away, the wish to abdicate responsibility and be taken care of, the hope for a magical cure, the "golden fantasy" that every need can be met perfectly by another person, and the belief that dissociative parts do not belong to one's self. Each of these fantasies serves as a defense against facing and realizing the traumatic past and the necessary grief work that accompanies it. Thus, there must, to some degree, be treatment targets prior to working with traumatic memories. These substitute beliefs are unrealistic and related to the generalized nonrealization of the traumatizing events and their impact on one's self and one's life. Clients may come to therapy unaware how their history (if they can remember it) is related with their present problems. To go forward, therapists need to help their clients not only realize how past and present are related but also have to be distinguished, which are not simple tasks with people who are severely traumatized and should be gradual and adapted to the client's abilities and motivation (pacing).

Overcoming Trauma-Related Phobias

Stabilization, symptoms reduction, and preparation (Phase 1 in trauma-oriented treatment) can be organized by systematically addressing several trauma-related phobias that maintain dissociation of the personality (Steele et al., 2005; Van der Hart et al., 2006), which include (a) relational phobias of closeness, abandonment, loss, and rejection, particularly regarding the therapist; (b) phobia of mental actions such as having particular emotional feelings, body sensations, thoughts, images, fantasies, wishes, and

needs; and (c) phobia of dissociative parts (which have their own rigid mental actions and implied mental contents that may be unacceptable to other parts). There are other phobias that maintain dissociation, in particular the central phobia of traumatic memories (see Table 1), but overcoming these phobias belonging to the second and third phase of trauma treatment will be addressed in a subsequent article. The concept of dissociative phobias, in TSDP understood as substitute actions, is related to Knipe's (2007) notion of defenses that he regards as dysfunctionally stored information.

The basic approach in dealing with various phobias consists of helping clients realize their phobias, psychoeducation, and empathic exploration (Van der Hart et al., 2006). The order of exploration is based on their degree of severity. Guided by the action systems of exploration, cooperation, and caregiving, therapists explore cognitively with clients what they are afraid of and are avoiding while joining the client's experience with an open-accepting attitude. In this way, therapists help clients verbalize to the degree possible what they fear about approaching the experiences related to the respective phobias. Understanding the purpose of the defense is helpful preparation for Phase 2 of treatment when the defenses can be targeted as an entry point for gaining access to the traumatic memories, that is, dysfunctionally stored memory networks.

It should be emphasized that, no matter how systematic, overcoming the various dissociation-maintaining phobias does not involve a sequential approach. Rather, overcoming one type of phobia demands simultaneous work with one or more other phobias. For instance, overcoming the phobias of attachment and attachment loss requires helping clients to overcome their phobia of dissociative parts because these parts may be at war with each other regarding the therapeutic relationship.

Overcoming Phobias of Attachment and Attachment Loss

The development of a flexible, emphatic, cooperative therapeutic relationship with appropriate boundaries is essential in the early phase of treatment, as is work on the client's other current relationships, such that a degree of earned secure attachment may be achieved gradually (e.g., Kluft, 1993, 1997; Steele et al., 2001, 2005; Van der Hart et al., 2006).

The client's relational phobias manifest also in the therapeutic relationship, which evokes the chronic alternation of action systems of attachment and defense related to an abusive caretaker, which is the basis for severe insecure and disorganized attachment patterns (Liotti, 1999; Steele et al., 2001; Van der Hart et al., 2006). The client can alternate from an extreme attachment with the therapist to distrusting or a defensive, even hostile, attitude involving the activation of different parts of the personality. By definition, the resolution of such insecure attachment patterns involves management of the reenactment of relational trauma in the therapeutic relationship. These reenactments evoke intense emotions and action tendencies in both client and therapist, thus the therapy frame must be strong and clear. For instance, some EPs have a phobia of attachment loss, and thus cling needily to the therapist or persistently have contact with the perpetrator or other individuals who are likely to be harmful. It is crucial for overcoming such situations that the therapist maintains a high level of integrative capacity, has a calm attitude, and assists the client in understanding these opposite tendencies stemming from different parts of the personality. The therapist thus maintains a predictable and stable position of empathic curiosity and cooperation rather than becoming defensive or enmeshed with the client. Developing a secure attachment in the therapeutic relationship involves a secure therapeutic frame, including consistent boundaries and limits.

Overcoming the Phobia of Trauma-Related Mental Actions

Clients need to become increasingly aware of, tolerate, understand, and personify (take ownership of) various mental actions or inner experiences that they have so strenuously avoided. These mental actions include emotions, thoughts, body sensations, fantasies, needs, and memories. Overcoming this phobia of inner experiences is obviously essential for the challenge of accessing and reprocessing (integrating) traumatic memories. Gradually overcoming this phobia implies increasing affect regulation and reflective functioning, and the development of a mindful stance, which Shapiro (1995, 2001) considers a prerequisite for trauma reprocessing.

Clients thus need to be coached in accepting their mental actions, without assigning value judgments to them, and learn to first notice and then prevent the so-called "self-conscious emotions" (such as shame, fear, or disgust) in reaction. Therapists need to routinely encourage them to be aware of and explore their present experience, that is, to be mindful and to act reflectively to foster presentification. This is

especially important in the stabilization phase regarding teaching clients to identify and cope with internal and external triggers.

With instructions for containment imagery, therapists can help clients to create imagined containers for the containment of traumatic memories. Such imagery may consist of bank vaults, computer storage, DVDs, and the like (e.g., Brown & Fromm, 1986; Kluft, 1993; Van der Hart et al., 2006; Van der Hart, Steele, Boon, & Brown, 1993). It enables clients temporarily to "store" traumatic memories or other threatening inner experiences. These techniques support clients in learning the difference between maladaptive avoidance or suppression and healthy pacing and timing that is within their control.

Overcoming the Phobia of Dissociative Parts

Therapists need to engage the different dissociative parts in working with each other to diminish the rigidity and closure among them. Therapists begin treatment of the phobia of dissociative parts and their many manifestations with the most adult part(s) of their clients, typically ANP(s). They first strengthen these ANP(s) through the teaching of grounding, regulation, and reflective functioning skills, with the goal of improvement of daily functioning. In cases of tertiary structural dissociation, that is, when more than one ANP has developed, therapists support some positive form of communication and cooperation among these parts that function in daily life—always with the goal of helping clients function in a more integrated fashion. In general, an essential point of departure of helping ANP(s), and subsequently EP(s), is psychoeducation about the value that other parts have for daily living or survival; this is even the case with those EPs that are involved in self-harm and perpetrator-imitating parts, all of which are engaged in problem-solving attempts, which can be seen as substitute actions. It is extremely helpful for the therapist to repeatedly explain that these EPs are still living in trauma time, unable to differentiate between the traumatic past and the—hopefully safe—present (Van der Hart et al., 2010).

Within the context of the therapist consistently emphasizing the survival value of various parts, one way of initiating constructive communications between ANP and EPs involves the therapist encouraging the ANP to ask (in the session) an EP something and also suggest (if appropriate) that other parts listen in. An example is suggesting an ANP, who is hearing EP's threatening voice ordering him or her not to tell the therapist anything about the existence of other parts. In this indirect way, the therapist (while in contact with the ANP) can invite a particular EP to, for instance, share with ANP what it needs right now to feel more safe.

Helping ANPs to Accept EPs. Subsequently, therapists foster, still in the stabilization phase, in ANP(s) growing empathic acceptance of EPs and wider cooperation among dissociative parts (Kluft, 2006; Van der Hart et al., 2006). Several techniques may be helpful in this regard. They also help to improve self-regulation, self-soothing, and self-acceptance, which are necessary prerequisites for trauma reprocessing (Phase 2 of phase-oriented treatment). However, such techniques may also include small incursions into this treatment phase sometimes. Knipe's (2007) "Loving Eyes" visualization is such a technique. Implicitly stimulating the ANP's care action system, the therapist facilitates the opportunity that this part looks with love and respect at a previously avoided and despised child EP, for instance, a part stuck in the attachment cry or burdened by shame. While ANP follows the instruction of the therapist for looking at the other little part with love and care, the client receives bilateral stimulation (BLS) and processes (integrates) the thoughts and cognitions coming up. Based on this procedure, a more complex approach has been developed to restore a healthy self-care pattern in the client (as ANP) toward different dissociative parts (Gonzalez & Mosquera, 2012). In this work with self-care patterns, the client as ANP learns to identify and recognize the needs of each dissociative part, including infant EPs, and the internal system of parts is assisted in finding ways to meet these needs in such a way that a balance is maintained or established between the different needs among parts.

Gradually, dissociative parts can learn to acknowledge each other without undue phobic reactions, thus relinquishing maladaptive substitute actions. Next, each part can learn to appreciate the roles of other parts, and the action (sub)systems that mediate them, in helping the individual as a whole survive and slowly develop inner empathy. Finally, parts can begin to cooperate more effectively on tasks of daily life and on self-regulation.

Inner Meeting Place. Imagery work involving dissociative parts meeting with each other can be very helpful in fostering this understanding and cooperation among dissociative parts. Thus, after the phobia of dissociative parts has been overcome to some degree, therapists may instruct their clients in creating a so-called *dissociative table* (Fraser, 1991, 2003) or *inner*

meeting place (Boon et al., 2011; Gonzalez & Mosquera, 2012; Van der Hart et al., 2006). This may be a special room, a place in nature, or any other place that feels comfortable. It can be helpful to have the ANP be the part that communicates to the other parts and the therapist serving as a model in communicating to the parts through the ANP. These meetings initially may have the character of business meetings, and discussions should start with relatively small issues such as making the agenda for a specific day to practice the inner meeting and decision-making skills as a team. Eventually, they may also be used constructively for more personal, emotional encounters such as inner sharing of joyful experiences or sharing sadness and comfort. The meeting place can be a useful context to promote time orientation and develop cooperation and understanding/compassion among parts. This internal cooperation becomes more feasible when dissociative parts can be focused on and collectively share inner experiences, including resources, related to the present moment while containing traumatic memories and other distractions. Different variants of this procedure have been proposed in the EMDR literature (Bergmann, 2007; Forgash & Copeley, 2007; Gonzalez & Mosquera, 2012; Paulsen, 2007, 2009). Finally, the inner meeting place and imaginary safe places (see in the following texts) can eventually become parts of more complex inner structures, for example, an inner community (Van der Hart, 2012).

Targetting Blockages. The phobia of dissociative parts, manifesting in different points of blockage, involved can be repeatedly targeted with EMDR-specific procedures. These procedures can foster the internal development from conflict among parts to mutual empathy and collaboration (Gonzalez & Mosquera, 2012). One example involves enabling a dissociative part to make a much needed connection with another action (sub)system mediated by another part. Here, the therapist helps these two parts to temporarily blend with each other, which enables the part that needs it to gain access to this action (sub) system, and thus to the type of actions it needs. An example is a timid ANP of a client with DID who, through temporary blending with a fight EP, could become more assertive in daily life (H. Matthess, personal communication, June 5, 2009). Difficulties in performing these interventions can be overcome through psychoeducation and specific EMDR procedures. For example, when the ANP is afraid of a hostile EP who is always yelling at him or her, and cannot feel any empathy toward this EP, the therapist may ask the ANP to look at this EP, discuss the feelings toward the EP, and notice the somatic sensation that it is experiencing. A short set of BLS applied on that sensation tends to at least partially unblock the impasse, either by fostering a decrease of the negative sensation or an increase of reflective functioning in the ANP, although caution is indicated because the addition of BLS could result in more distress. When the ANP's reluctance to dialogue with the EP decreases, the therapist may propose the EP the same possibility. In this way, internal collaborative communication may be enhanced with a prudent introduction of BLS to resolve specific "blockage points" (Gonzalez & Mosquera, 2012).

Overcoming the Phobia of Perpetrator-Imitating Parts

Therapists' repeated explanations of the survival value of particular parts—especially those that are feared or despised most—and the interactions among them teaches other dissociative parts that positive interactions with these parts are possible and rewarding for all parts involved and models positive interpersonal skills. A major example is the extreme fear that ANPs and other EPs usually have of *perpetrator-imitating parts*, also known as abuser, perpetrator, or persecutory parts (Kluft, 2006; Ross, 1997; Van der Hart et al., 2006): dissociative parts that imitate the original perpetrators and are often regarded as such by other parts. Repeated psychoeducation about, or exploration of, their originally surviving function is needed; for example, being tuned into the perpetrators' (re)actions to the client as child and trying to prevent these (re)actions by punishing other parts in ways that they have learned from these perpetrators, such as their abusing and maltreating parents. These parts may have functional capacities as control or strength, but usually clients as ANP(s) reject them, and other EPs are scared of them, because they remind them of characteristics from the abuser's personality and abusive actions. This interferes with therapeutic gains. Realization in the form of differentiation between the external real abuser and the internal likeness of him or her is essential for therapeutic progress (Paulsen, 2009; Van der Hart et al., 2006).

Perpetrator-imitating parts, but not only these parts, are often involved in self-destructive behaviors, violation of boundaries in contact with other people, or are involved in ongoing physical or sexual abuse. Again, it is essential to understand that these destructive actions, however inappropriate, are attempts at problem solving developed in extreme

(abusive) circumstances. Therapists need to recognize and acknowledge the original survival function and help ANP to negotiate with these parts about alternative, less destructive, or rather constructive solutions (C. A. Ross, 1997). Explaining that these EPs still live in trauma time and thus respond to triggers in the same way as they did during the actual traumatization is basic. This can be followed up by helping these parts to be more oriented in the present: presentification (see in the following texts). The client's personality system as a whole can become remarkably more able to cooperate, to solve problems, and to make adaptive decisions.

Overcoming the Phobia of Young, Weak Parts

Also when ANPs or strong EPs, such as fight EPs, despise and reject vulnerable and weak child parts, the therapist's explanation of the action (sub)system that mediate such parts' survival function may be essential in fostering a more accepting and respectful attitude toward them. An example pertains to relating to the fight EP of a woman with DID who experienced, at age 17 years, a gang rape; during this rape, the fight EP was succeeded by a child part that surrendered to the massive assault. In response to the fight part expressing its disgust of this child part, the therapist asked, "Do you have any idea what would have happened if you would have continued fighting and the child part would not have taken over?" The fight part was quiet for a moment and then, obviously shocked, answered, "Then we would have been killed." This was followed by a guided acceptance of this formerly despised child part. Another example pertains to a woman who was sexually abused by her father during childhood. She had an enraged EP who could not tolerate a little child EP that was strongly attached to the perpetrator. Both parts could be helped by the ANP to experience each other as necessary, personifying the understandable contradictory tendencies vis-à-vis her father. Following psychoeducation, the ANP could understand the perspective of both EPs (the need to attach in a little girl part and the feeling of hate that the other EP had). As an adult, she could realize that as a child, her best option was to become divided to relate to her. Such an integrative view can be reinforced with short sets of BLS.

In short, it is vital that the client understands and learns to apply the key principle of gradual acceptance, acknowledgment, and realization of EPs and ANP(s) as parts of the same personality, and that each part is responsible to and for all other parts. Otherwise, particular parts of the client might use the therapist as a "babysitter"—for instance, using the session to cry and gain empathic support from the therapist without moving forward—or expect the therapist to get rid of, punish, or control various other dissociative parts instead of taking personal responsibility for their actions, which after all constitute the client as a whole system.

Resourcing

Resource development and installation (RDI) is a widely used intervention in EMDR therapy (Korn & Leeds, 2002), but for clients with complex trauma, the concept of resource should be extended. Resourcing includes calling on emotional, cognitive, sensorimotor, and relational resources; ego-strengthening strategies; and interventions for empowering the client. Working at the goal of basic energy management (adequate sleep, rest, eating), the development of somatic resources such as grounding and mindful awareness of one's body, and other use of sensorimotor experiences to foster boundaries and regulation (Ogden et al., 2006) are very important.

RDI, as any other intervention with clients with a complex dissociation of their personality, should be done with the agreement of the entire system of parts. For example, a client was very phobic of being abandoned by parent-like figures (including the therapist). When asked what she needed to diminish her arousal when she was alone in her room, she said, "Faith in connection, in alliance." The ANP asked the other parts to join her in the exercise, which they agreed to do. She drew the symbol of that faith: two hands holding together. While she was holding this drawing, the therapist using BLS installed this resource in the ANP while simultaneously suggesting that she (the ANP) keep internal contact with the EPs with whom she shared the same feeling.

Time Orientation

A specific resourcing procedure, most important in developing dual attention, is time orientation. As indicated earlier, EPs typically live in trauma time, and thus do not differentiate between past and present. The therapist, talking through the ANP and using short, slow sets of BLS, can help a particular EP become aware, to some degree, of the current year and that *the danger is over* (e.g., "Does this part know it's the year 2013 . . . that you are an adult . . . and that the danger is over and not happening now?"). Various additional interventions can be added, such as having the EP look at the client's hand, for instance, seeing the ring around a finger or looking at the date of

today's newspaper or an agenda. The addition of short sets of BLS may enhance co-consciousness, result in tension reduction, and further integration involving the linking in of adaptive information. However, caution is indicated to avoid the eliciting of material beyond the client's window of tolerance. If negative feelings start to surface, BLS should be stopped; further exploration to understand what is happening is needed; and/or grounding/stabilization should be implemented to keep the client within the window of tolerance. Along the same line, positive feelings of compassion or other adaptive feelings of one part (e.g., ANP) toward another (e.g., EP) can also be enhanced with short and slow sets of BLS.

Safe Place Imagery

Safe or quiet place imagery may help parts in dealing with predictable triggering situations in daily life, highly upsetting memories, beliefs, discussions among other parts that may trigger their traumatic memories, and other feared features. This involves images of a place where they feel safe and protected or, if the concept and experience of safety are still unknown to them, a place where they feel at relative ease (Brown & Fromm, 1986; Van der Hart et al., 2006). The safe place installation is a well-known intervention for EMDR therapists (e.g., Gelinas, 2003; Korn & Leeds, 2002; O'Shea, 2009). With dissociative clients, it can be applied in various ways such as creating a safe place for child parts who better not attend some interactions of the client with other people or some inner conversations among other parts. And in some cases, groups of dissociative parts may have a common safe place or each part may have its own place.

For example, a client had to cope occasionally with highly intrusive visits by his or her parents, who commented extremely negative about everything they noticed in him or her and his or her apartment. He or she had an assertive ANP, but when the parents arrived, they immediately triggered the emergence of highly submissive child EPs who fearfully obeyed the parents in every regard. The creation of a safe place for these child parts—who would go there whenever the ANP told them to do so—was one way to enable the client to stop his or her parents' interferences. The other was the creation, by the ANP, of an imaginary protective cloak, which increased his or her confidence in dealing with this major challenge (Boon et al., 2011; Van der Hart, 2012).

However, when the therapist uses such stabilization techniques without being aware of the internal system of dissociative parts, without having checked if all parts agree with the procedure and with the chosen images, and without having a good understanding of the characteristics of clients who are severely traumatized, the results can be the opposite of what was intended. For example, a hostile part may feel that helping a child EP find a safe place is an attempt to escape from his or her control and will sabotage its construction. Or the word "safe" may function as a traumatic trigger, being associated to "how unsafe my childhood was." The client may become distressed just by thinking about how many relevant things he or she lacked. Or, because of ANP's nonrealization of the traumatic experiences, the client may choose, as a safe place, the room (in which he or she was abused) from his or her childhood home.

Other Uses of Resourcing

As mentioned earlier, resource installation should be thought of in a wide range of applications in clients with a history of complex traumatization. RDI can be very useful not only for the main ANP but also for the other dissociative parts (including EPs). For ANP, examples of the needed resources are self-regulation, object constancy, courage, compassion with the inner system, and confidence. For EPs primarily mediated by a defense action subsystem, the needed resources or skills will pertain to experienced safety, attachment, strength, proactive adaptive coping style, and about orientation in the present. For RDI to be successful in these cases, often some work in overcoming various dissociation-maintaining phobias, such as the phobia of dissociative parts, needs to be done first. For instance, when the ANP is strengthened this way, some EPs may feel that their inner opponent is helped to become stronger and thus more able to defeat them. Thus, when the therapist was trying to install a resource in a client diagnosed as having a depression—the therapist did not know that she had DDNOS—the client heard a strong voice in his or her head yelling, "If you give her [the ANP] more energy, you will have to deal with me [the EP]." The therapist's awareness of the dissociation of the client's personality may prevent this kind of situations, making any intervention more safe and effective for clients.

Conclusion

TSDP and AIP are compatible models for working with clients who are traumatized and may complement each other. TDSP, on the one hand, provides a comprehensive framework to better understand the complex and dissociative inner world of clients with complex trauma-related disorders and guide

case conceptualization. The phase-oriented treatment approach widely accepted in the field of complex trauma-related disorders emphasizes the relevance of an adequate stabilization phase, including symptom reduction, skills training, and establishing a safe therapeutic relationship. It can give EMDR therapists important resources for the preparation of safe and effective trauma reprocessing. The inclusion, on the other hand, of specific EMDR procedures including BLS during the stabilization phase may shorten and enhance the therapeutic process. Throughout this article, TSDP proposals and specific EMDR procedures have been interwoven. Thus, it highlights the important work of resourcing and the TSDP principle of changing the so-called "substitute beliefs" that take the place of more adaptive and integrative mental and behavioral actions. Major forms of substitute beliefs and related mental and behavioral actions involve the various dissociative phobias, some of which need to be systematically addressed in the stabilization phase. In short, following this necessary groundwork, clients will be ready for EMDR reprocessing (synthesis and realization, in TSDP terms) of traumatic memories, which will be the main focus of a next article.

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