Dissociation of the Personality and EMDR Therapy in Complex Trauma-Related Disorders: Applications in Phases 2 and 3 Treatment

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Eye movement desensitization and reprocessing (EMDR) psychotherapy can play a major role in phase-oriented treatment of complex trauma-related disorders. In terms of the theory of structural dissociation of the personality and its related psychology of action, a previous article described Phase 1 treatment—*Stabilization, Symptom Reduction, and Skills Training*—emphasizing the use of EMDR procedures in this phase. Phase 2 treatment mainly involves applications of EMDR processing in overcoming the phobia of traumatic memories and their subsequent integration. Phase 3 treatment focuses on further integration of the personality, which includes overcoming various phobias pertaining to adaptive functioning in daily life. This article emphasizes treatment approaches that assist therapists in incorporating EMDR protocols in Phases 2 and 3 of phase-oriented treatment without exceeding clients' integrative capacity or window of tolerance.

Keywords: structural dissociation; EMDR; traumatic memories; integration; phase-oriented treatment

As is repeatedly emphasized in the eye movement desensitization and reprocessing (EMDR) literature (e.g., Forgash & Knipe, 2007; Gelinas, 2003; Hofmann & Mattheß, 2011; Korn, 2009; Lazrove & Fine, 1996; Paulsen, 1995, 2007; Shapiro & Forrest, 1997; Shapiro & Gelinas, 1999; Twombly, 2000, 2005; Young, 1994), EMDR clinicians need to integrate their therapeutic approaches within phase-oriented treatment of complex trauma-related disorders, including the following *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*) dissociative disorders: Dissociative Identity Disorder (DID) and Dissociative Disorder Not Otherwise Specified (DDNOS, subtype 1). The standard of care (Brown, Scheflin, & Hammond, 1998; International Society for the Study of Trauma and Dissociation [ISSTD], 2011) is usually described in terms of three phases: (a) *Stabilization, Symptom Reduction, and Skills Building*; (b) *Treatment of Traumatic Memories*; and (c) *Personality (Re)Integration and Rehabilitation*. The more complex the dissociation of the personality, the less these treatment phases are applied in a linear fashion. Rather, they have to be recursive over time, with the need to periodically return to a previous phase or the occasional short excursion into the next phase (Courtois, 2010; Korn, 2009; Van der Hart, Nijenhuis, & Steele, 2006).

Thus, the treatment of traumatic memories—the main focus of this article—should be preceded by a treatment phase in which the foundation is made for successful and safe processing. This was the subject of our previous article, using the theory of structural

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dissociation of the personality (TSDP) and the related psychology of action as its conceptual framework (Van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2013). Janet's psychology of action, integrated in TSDP (Van der Hart et al., 2006), has a point of departure that all psychological facts observed in human beings can be understood in terms of actions—behavioral and mental. Simple actions usually are easily performed but other more complicated actions, such as the integration of traumatic memories, require a high integrative capacity (cf., Van der Hart et al., 2006). TSDP postulates overcoming specific inner- and outer-directed phobias, that maintain dissociation of the personality, as major goals for the respective treatment phases (Steele, Van der Hart, & Nijenhuis, 2005; Van der Hart, Nijenhuis, & Solomon, 2010; Van der Hart et al., 2006). The most basic phobia that maintains dissociation is the phobia of traumatic memories (Janet, 1904), which cannot be the first focus of treatment in most clients with complex trauma-related disorders: hence, phase-oriented treatment.

The goal of this article is to discuss how TSDP and the related psychology of action may guide the application of EMDR for survivors of chronic traumatization during Phase 2, Treatment of Traumatic Memories (equivalent with Phases 3–8 in the standard EMDR protocol), and Phase 3, Personality (Re) Integration and Rehabilitation.

As described in previous works (cf., Nijenhuis, Van der Hart, & Steele, 2002; Steele et al., 2005; Van der Hart et al., 2013; Van der Hart et al., 2010; Van der Hart et al., 2006), during trauma the survivor's personality becomes unduly divided among two or more dissociative parts, each with its own at least rudimentary first-person perspective or mental autonomy (Nijenhuis & Van der Hart, 2011). Dissociation of the personality basically takes place between two prototypes of dissociative parts, that is, emotional part(s) of the personality (EP; Myers, 1940) and apparently normal part(s) of the personality (ANP; Myers, 1940). The EP(s) live in trauma time, are fixated in traumatic reenactments, and are mediated by defensive action (sub)system(s) such as flight, fight, and total submission. The ANP(s) are fixated in avoidance of traumatic memories (and often of the person's inner experience in general), and mediated by action systems of daily life, such as exploration, care, and energy regulation. When an ANP is intruded upon by an EP's traumatic experience, the person experiences problems in continuing dealing with everyday life and facing life challenges. Hence the ANPs need to keep the EP(s) at bay, that is, to maintain the dissociation of the personality. TSDP postulates that the more chronic the traumatization, the more the personality becomes divided among these parts. The phobia of traumatic memories plays a major role (but not the only one) in maintaining this division; thus, it is an essential target in the EMDR therapeutic plan, guiding when and how to prepare and perform the processing or integration—as TSDP calls it—of traumatic memories.

Overcoming the Phobia of Traumatic Memories: Its Relevance for EMDR Therapy

The resolution of the phobia of traumatic memories is a major treatment goal and involves the *processing of traumatic memories*. This type of processing is understood in terms of TSDP as the *integration* (consisting of *synthesis* and *realization*) of traumatic memories. Processing (i.e., synthesis and realization) renders dissociation unnecessary (Van der Hart et al., 2010; Van der Hart et al., 2006), although the client at times might still be hesitant to let go of the various dissociative parts. Regardless of the path to the processing or integration of traumatic memories, it always includes the client being able to engage in integrative mental actions. TSDP distinguishes different levels of the integrative process with regard to traumatic memories.

First, during the processing (integration) of the traumatic memory, the memory becomes *synthesized*, that is, shared among dissociative parts of the personality. At this level, EMDR processing (i.e., EMDR standard protocol including the eight phases and three prongs of past, present, and future; Shapiro, 1989, 2001) represents a basic integrative approach in which experiences such as perceptions, movements, thoughts, sensations, affects, memories, and a first-person perspective are bound together (linked) and differentiated (distinguished from each other). For example, a client may present the problem of feeling anxious and scared when dealing with an authoritarian boss. The present situation may be linked to painful childhood experiences with a dominating parent. Thus, the past memories and present triggers can be targeted, such that the client becomes able to differentiate between the two, and a future template installed, enabling the client to feel grounded and in control when dealing with this boss.

However, for complete integration to take place, synthesis needs to develop into realization, sometimes a spontaneous phenomenon in EMDR sessions and referred to as *insight*. Realization is a higher order level of integration (Janet, 1935; Van der Hart et al., 2006). In terms of Janet's psychology of action, realization is defined as developing a high

degree of personal conscious awareness of reality because it is acknowledging and reflectively adapting to it. Realization involves much cognitive and affective work, particularly grieving of what was and was not and what cannot be. Realization includes the promotion of two types of mental actions: that is, *personification* and *presentification*. Personification is making one's personal experience and actions one's own (Janet, 1935; Van der Hart et al., 2006). Presentification involves being mindfully present while remaining aware of the context of one's past and future (Janet, 1928; Van der Hart et al., 2006). In the previous example, the client can say,

> My experiences with my domineering father were hard for me; they have influenced how I dealt with some situations, and how I felt about myself. But now I realize that am [*sic*] an adult who has options and resources, even when dealing with my boss, that I didn't have as a child.

EMDR and Primary Dissociation of the Personality

The EMDR standard protocol can usually be applied in a straightforward way with clients suffering from simple PTSD (primary dissociation of the personality). Because the EP, with its rudimentary first-person perspective, consists of little more than the traumatic memory, successful reprocessing of the traumatic memory automatically involves the fusion of ANP and EP—that is, their respective memory networks integrate completely. However, even in some cases of simple posttraumatic stress disorder (PTSD), the EP may also be characterized by some secondary elaboration, that is, have a slightly wider repertoire of (dys)functional actions in addition to reenacting traumatic experiences. When secondary elaboration exists, some more work is probably needed on the relationship between ANP and EP than only the integration of traumatic memory.

An example pertains to a 52-year-old woman, characterized by primary dissociation of the personality, with whom the therapist was working on her memory of a five-days hospital stay at the age of 5 years, most of the time without the parents' presence because doctors would only allow short visits. During the session, she was focusing on the image of herself at night, in the hospital, being afraid, and feeling "I am not safe." Believing that the client was not really connected with her traumatic memories and the part containing them, the therapist asked her to look at the child's eyes. The client responded, "The little child is turning back, she is afraid of me." This little child seemed to be an EP with a rudimentary first-person perspective. The therapist helped the client as ANP to communicate with the child EP, using, among other things, Knipe's (2007) loving eyes procedure. The client as ANP was able to look at the child part's eyes, subsequently sharing in, and thus processing, the fear that this EP had kept for so long and which was previously inaccessible for the ANP. In this way, ANP and the single EP were able to integrate.

EMDR and Secondary and Tertiary Dissociation of the Personality

With clients who have more complex trauma-related disorders, and thus secondary and tertiary dissociation, modifications of standard EMDR procedures are necessary—as the EMDR publications on phase-oriented treatment mentioned earlier give testimony to. These would include modifications in the application of a wide range of procedures during Phase 1 treatment that are oriented toward stabilization, symptom reduction, and skills training (cf., Van der Hart et al., 2013). Phase 2, Treatment of Traumatic Memory, with its emphasis on overcoming the phobia of traumatic memory, also involves a host of modified procedures and interventions. Here, special attention needs to be paid to resolving the client's inner conflicts between attachment to and defense against the perpetrator, when the traumatic memory involves abuse within the family. Such conflicts would strongly interfere with effective reprocessing (see in the following text).

Cautions About Initiating Phase 2, Treatment of Traumatic Memories

To safely process a traumatic memory with EMDR (guided synthesis in the TSDP terms), a graduated exposure of the dissociative parts to a particular traumatic memory is needed. This graduated exposure must remain within the client's integrative capacity, and thus his or her regulatory tolerance, to prevent maladaptive reactions (e.g., further dissociation, panic, shutting down, avoidance). This regulatory tolerance has been described as *window of tolerance*, above which the client is hyperaroused and below which he or she is hypoaroused (Ogden, Minton, & Pain, 2006; Siegel, 1999). Different authors in the EMDR field have proposed interventions to prevent extreme activation during EMDR processing (e.g., Fine, 2010; Fine & Berkowitz, 2001; Lazrove & Fine, 1996; Luber, 2009, 2010; Twombly, 2000).

The therapist should be cautious with regard to initiation of this phase and take several factors

into account in the decision making with the client. Prematurely starting EMDR processing of traumatic memories may have negative consequences. Without a thorough assessment and an overview of the inner dissociative world, accompanied and followed by sufficient stabilization, several problems can appear. Clients may become overwhelmed by symptoms, intense emotions, or difficulties in daily life coping; acting out may occur as a result of inner chain reactions of dissociative parts; or, somewhat less obviously, processing may be unsuccessful or different blockages can make it difficult. In general, the lower the client's integrative capacity and energy, the slower this phase of treatment should proceed including frequent returns to Phase 1, Stabilization, interventions.

In all cases, Phase 2, Treatment of Traumatic Memories, demands from both client and therapist a stable collaborative relationship between them (including having overcome the phobia of attachment to the therapist), a healthy motivation, and a realistic investment of energy. For the client, this also involves constructive internal collaboration and empathy among parts, their commitment to EMDR, as well as some capacity for coconsciousness and for reflection and mentalization. Possible objections that parts may have should be explored and dealt with. Therapists should be aware, while having in mind the parts who disagree or cannot participate, that decision making at each step of the therapeutic process also introduces a new collaborative style in the internal system, which is the basis for an effective and safe trauma processing. There must be sufficient dual attention such that during processing, the client remains involved with the traumatic memory *and* connected with the therapist and the present.

Many authors consider some situations as contraindications for Phase 2, the Treatment of Traumatic Memories (e.g., Boon, 1997; Gelinas, 2003; Kluft, 1997; Korn, 2009; Lazrove & Fine, 1996; Steele et al., 2005; Van der Hart et al., 2006; see also the *EMDR Dissociative Disorders Task Force Guidelines*, in Shapiro 1995, 2001). Major examples are ongoing interpersonal abuse, ongoing substance abuse or other self-destructive behaviors, acute external life crises, times when extra energy and focus is needed in daily life, pregnancy, old age, severe physical illness, psychosis, severe character problems that prevent the development of a focused and collaborative treatment frame, uncontrolled switching among dissociative parts, and the therapist being the one and only attachment figure in the client's life. In all these situations, more stabilization work is usually needed first. An alternative to do long-term stabilization work in these cases is proposed by Gonzalez and Mosquera (2012), in their so-called *progressive approach*, described in the following text.

Processing Disturbing Sensations and Emotions: A Bridge Toward Phase 2, Treatment of Traumatic Memories

The progressive approach (Gonzalez & Mosquera, 2012) is a gradual processing of experiences that are related with the traumatic memory, such as dissociative phobias or disturbing emotions and sensations, rather than targeting the traumatic memory itself (as in the standard protocol). In other words, the focus is on relieving the distress caused by the outer "layers" of the traumatic memory. From this perspective, there is not a clear distinction between Phase 1 (Stabilization) and Phase 2 (Treatment of Traumatic Memories) in phase-oriented treatment but rather a continuous and joined therapeutic decision-making process. During the stabilization phase, more small fragments of trauma-related actions are gradually targeted according to the client's integrative capacity, ability to self-sooth, and internal and external stability. Processing of such actions, like emotions and sensations related to trauma, while avoiding the traumatic memory itself, could be considered as a Phase 1—Stabilization—intervention, which prepares the client for Phase 2 (Phases 3–8 of EMDR) of trauma work. However, in some ways, it can be also understood as "trauma work" because therapist and client are working with the "outside layer" of the traumatic memory. These interventions bear some resemblance to other proposals made in the literature such as Knipe's (2010) protocols for working with psychological defenses. In TSDP terms, this involves overcoming the phobia of traumatic memory.

Tip of the Finger Strategy. The distressing emotions and sensations held by EPs are often, more or less directly, related to traumatic memories. Here, the tip of the finger strategy (TFS; Gonzalez & Mosquera, 2012) can be helpful. The goal of TFS is only to decrease certain disturbances in an EP that are blocking this part's capacity to become more oriented to the present to collaboratively communicate with other parts and become more capable of reflection. Using the metaphor of a hand, in which the palm of the hand refers to the traumatic memory, TFS targets just a small fragment of a peripheral sensation, emotion, or irrational belief that may be represented by "the tip of the finger." The following case example illustrates the application of TFS in which the client is asked to

simply focus on the experiences "at the tip of the finger" while engaging in bilateral stimulation (BLS).

Brian is a 41-year-old man with severe aggressive behaviors that he related to a hostile voice. The therapist helped him as ANP to establish a dialogue with this male EP, who said that urging the ANP to beat other people made him (the EP) feel stronger. The EP despised the ANP because he is weak: "He is no more than a worm." After intense negotiations, the EP agreed to sign a contract of "not-harming" until next session. When the patient returned, he had seriously beaten another person. The EP said that he had wanted to fulfill the contract, but that the pressure inside him had been extremely intense, and that he exploded. The EP agreed to process "part of this pressure" to feel more in control. The ANP also agreed to let the EP work in the session. TFS was proposed as an experiment, with EP checking if it could be useful for him. The therapist reminded the EP to use the stop signal when he felt the need to do so.

The therapist then asked the EP to focus on "the part of your inner sensations where you want relief," and let the ANP and the therapist know when he was noticing it. When the client made a signal indicating his readiness to get started, the therapist applied a short set of BLS, with the expectation that BLS would lower the affective arousal. Then the therapist asked the EP how he was feeling, and the EP responded that the pressure was lower. Two sets were applied, with no significant associations or insights arising. After this session, internal communication between ANP and EP improved and aggressive outbursts ceased. The disturbing sensations in the EP were probably related to a traumatic memory, but the therapist did not search for a specific connection. The goal was only to decrease a small amount of pressure. However, in other cases, it would be advisable to first explore the nature of the pressure or where it actually comes from: It could be the influence of a perpetrator-imitating part, for instance, which would need special attention.

Like with any other interventions, it is important that the EP as well as the entire system of dissociative parts agree with doing this work. The application of BLS is done in sets, which are shorter and slower than usual, and the impact of each set should be evaluated. If there is a decrease in intensity or the client is engaged in making adaptive associations, more sets can be provided. If emotional intensity is increasing, self-soothing strategies should be implemented. TFS may have powerful effects, even with a single set of BLS. Thus, the initial use should be very tentative, with the therapist having in mind that less, rather than more, is the safest way.

Phase 2, Treatment of Traumatic Memories: Resolving Insecure Attachment to the Perpetrator

When traumatic memories pertaining to abuse in the family are reactivated and become the treatment target, the client's inner conflict between attachment to and defense against the perpetrator becomes heightened (Steele, Van der Hart, & Nijenhuis, 2001, 2005; Van der Hart et al., 2006). Therefore, the therapist should not set the client against the perpetrator. EPs regarded as fixated in the "attachment cry"—an attachment action subsystem aimed at regaining attachment upon separation from an attachment figure that the client may have experienced as a child—may engage, not in crying per se but in clinging, maladaptive dependence, and submission toward the perpetrator. At the same time, other dissociative parts of the individual may hold strong feelings of hatred, anger, shame, or terror toward the family perpetrator and others. Some clients as ANP may be enmeshed with their families in the present, unable to set healthy boundaries and limits. Fostering presentification, including time orientation of dissociative parts, the therapist must empathically explore *all* the conflicted feelings and beliefs among parts related to the perpetrator(s) without taking sides, remembering that one part of the client can hold one view of the perpetrator (e.g., "I hate my father for what he did to me!"), whereas another part espouses a completely different view ("I love my father! He was the only one at home who cared about me and gave me some warmth!"). The therapist should empathically help this part understand that the goal of processing (integrating) traumatic memories of abuse is not condemning the father as all bad, but rather to help parts become liberated from living in trauma time.

Furthermore, the client needs to be helped to develop an integrative perspective about parts attached to abusive caregivers and parts fixated in defensive actions toward the same persons. During trauma time, both types of reactions had survival value. BLS can be helpful in fostering such an integrative perspective among parts and thus better acceptance of each other. This can be done when the client is aware of the conflicting perspectives, by asking the client to focus simultaneously on both parts' perspective, and adding slow, short sets of BLS.

Accompanied by psychoeducation about healthy boundaries (Boon, Steele, & Van der Hart, 2011),

the therapist needs to guide the client in setting boundaries toward abusive people that ensure both emotional and physical safety despite these contradictory feelings. When the client is still being abused, the therapist must first support her or him in becoming safe.

Phase 2, Treatment of Traumatic Memories: Stages and Variations

In cases of secondary and tertiary dissociation, the application of EMDR therapy for processing of traumatic memories may vary considerably from client to client because dissociative individuals are a quite heterogeneous group. *A particular adaptation of EMDR may work well for one client but be ineffective or even dysregulating for another*. Thus, therapists need to be flexible in their approaches to the treatment of traumatic memories, having an arsenal of tools and techniques at hand, and always carefully dealing with difficulties in the therapeutic relationship. Therapist need to collaborate with each individual client regarding what might be most effective *and* bearable within a stable treatment frame.

Stages of Processing (Integration) of Traumatic Memories

Responsible treatment of traumatic memories involves dividing this major task into a number of more or less discrete stages: extensive preparation for the procedure; EMDR processing at the level of guided synthesis; and EMDR processing at the level of guided realization, which, however, may evolve spontaneously during the processing.

Stage 1: Preparation

Careful preparation of EMDR processing at the level of guided synthesis maximizes the probability that the work proceeds within the window of the client's integrative capacity, minimizing the risk for uncontrolled (defensive) interference from dissociative parts during the session. Therapist and client aim to prevent vehement emotions that are, by definition, outside this window and subsequent self-destructive behaviors. Thus, the therapist is well-advised to discuss with the client what the risks might be during this intensive treatment phase. Items include effects on daily life, risk of acting out, consequences for social relations, and risk for the urge to repeat the trauma. Before the start of EMDR sessions, the therapist has to work out with the client a plan for how to cope afterward, including rest and safety, social support, appropriate self-care, and self-soothing. Planned extended sessions may be helpful, not to increase intensity and duration of experiences but rather to more slowly titrate traumatic experiences and to leave the client with plenty of time to become regrounded and fully reoriented to the present before leaving the session.

Psychoeducation about the process of integration of traumatic memories by EMDR is needed for the client to know how the integration process will be structured and directed, what targets come first and which later and why; in other words, how processing will be navigated. Part of this EMDR treatment plan can be the construction of a lifeline for ordering the traumatic memories. This can be helpful in creating clusters of the types of traumatic experiences and in creating an order in which they will be targeted (Lombardo, 2012; Morrow, 2008; Shapiro, 2001). Criteria for clustering could be, among others, episodes, perpetrators, domains of the negative cognitions (NCs), and involved emotions. However, most important is joining the client's own way of categorizing. The order also depends highly on the client's wishes and actual suffering (caused by specific memories). For each cluster, a representative memory or a self-made summary of the pathogenic kernels can be chosen to be targeted. Observing parts can help with that using a helicopter view.

Different Ways to Structure Processing of Traumatic Memories. EMDR processing, at the level of guided synthesis, can be done in a more encompassing and rapid manner or in a very gradual way depending on the client's integrative capacity and preferences. However, most authors suggest a very gradual way of targeting (e.g., Fine & Berkowitz, 2001; Gelinas, 2003; Gonzalez & Mosquera, 2012; Knipe, 2010; Lazrove & Fine, 1996; Paulsen, 1995, 2009; Twombly, 2000, 2005), emphasizing the client's need to maintain stability, sense of control, and mastery, thus gradually overcoming the phobia of traumatic memories. A basic principle is to frequently alternate Phase 2, Treatment of Traumatic Memories, with Phase 1, Stabilization.

The question where to begin with processing traumatic memories has been dealt with in different ways. It may be good practice to start with one experimental EMDR processing session targeting a recent, mild, and isolated negative incident involving the main ANP with other parts watching from a distance. This enables the client to become familiar with the method and to give the therapist a chance of assessing

the client's ability and idiosyncrasies of processing and regulating emotions.

A similar strategy is to target a more recent present trigger that is interfering with coping. This strategy may trigger past traumatic memories beyond the client's capacity. A premature evocation of early memories can be prevented by identifying them before and making it clear that these experiences can be "tagged" for future work and will not be opened now. The agreement must be that if the past experiences begin to come up during processing, the client is to tell the therapist, and together they will implement containment strategies such as locking them in imaginary vaults. In any case, extended associative changes should be avoided, and one way of accomplishing this is going back to target after a few sets. Dellucci (2010) suggests desensitizing present triggers before focusing on traumatic memories of past events, following which she usually targets the earliest traumatic memories. Hofmann and Mattheß (2011) propose to start, not with a traumatic memory of a recent or old event, but with future distressing events; for example, an upcoming confrontation with one's boss rather than the underlying conflict with one's father that could be accessed using an affect bridge. However, utmost care must be taken to prevent this strategy from prematurely triggering past traumatic memories.

Another approach is starting with the synthesis of the traumatic memory that currently underlies the heaviest burden in daily living or the main presenting problem (e.g., Leeds, 2009; Van der Kolk et al., 2007). It is also possible that therapist and client opt for the cluster of memories associated with the strongest and most damaging negative self-beliefs or pathological kernels: If successful, this might involve a tremendous positive change as an effect of generalization, but they need to be quite confident this challenge is not over-asking the client. Finally, instead of following a particular order, with some clients it is best to target each time the memory that is bothering the client the most, following his or her natural inner process. In such cases, a highly functioning ANP with high integrative capacity needs to be in charge. In general, therapists could be willing to rely more on their clients' capacities, including their "inner source of wisdom" (Krakauer, 2001), than on their own fixed treatment plan. However, they should also take care of maintaining some kind of structure and direction. A dynamic equilibrium between flexibility and structure, between the client's awareness about his or her problems and capacity, and the therapist's mindsight, can guide the pace of trauma work. One example from the EMDR literature is Kitchur's "Strategic Developmental Model for EMDR" (Kitchur, 2000; see also Gelinas, 2003), developed for the treatment of complex PTSD. Based on collaborative work with the client and adapted to his or her specific characteristics, she designs a trajectory map, processes targets along a developmental sequence. Her idea is that, for protective reasons, younger parts should not be asked "to participate in therapeutic work that belongs to a later developmental stage" (p. 6). (However, this can also be accomplished by having these parts remain in inner safe places when the targets to be processed involve the traumatic memories of older parts.)

Exploration of Target Memory. If possible, it is useful to prepare the client by cognitively exploring the general content of the traumatic memory, including its beginning and end (preventing clients from getting "stuck in the middle"), as well as particular aspects that are most threatening, known as *pathogenic kernels* (Van der Hart et al., 2006) or *hot spots* (Brewin, 2003). The concept that aspects of the memory can be pathogenic refers to the clinical observation that overlooking them during processing results in a continuation of the traumatic memory. A careful discussion should take place about which aspect(s) or dimension(s) of the traumatic memory should first be targeted and which is next (in some cases, this needs to be done in great detail; see in the following texts, under "Fractionated Processing"). This is often best done with those (observing) parts who can report the memory from an objective third-person perspective without evoking reexperiences.

Parts that are not yet ready to participate should have withdrawn to their safe places prior to a cognitive discussion of the event. There is discussion about, and agreement between, the client and therapist regarding which life domains (e.g., work, parenting) and related dissociative parts should be protected from the current experience of synthesis, if necessary and possible. In other words, heavy emphasis should be on the decision making regarding which dissociative parts will be present during the processing and which ones should be in their own inner safe places. Van der Hart and Boon (1997) presented the example of Betty, a 32-year-old, high-functioning client with DID, who, while doing well during Phase 1 (Stabilization), started to suffer from nightly crisis during which an EP tried to strangle herself using a nylon stocking. With other dissociative parts remaining in their safe places, an observing part could relate to the therapist that this involved nightly reenactments of a 6-month period, at age 15 years, during which she was repeatedly sadistically abused by a boyfriend. This part and the

therapist established that 10 pathogenic kernels could be distinguished, which should successively be targeted, including the anticipatory fears and the worst pain. They also discussed which parts would be present and which should remain in their own safe places during the processing. Successful synthesis of these 10 targets took altogether 20 min.

Not investigating which parts were, in various ways, included in the target trauma may lead to painful surprises that might have been prevented: The client may continue to be overly aroused because other parts remain stuck in this traumatic experience.

Determining the Respective Roles of Parts. For a few clients with DID or DDNOS, Phase 1 work on stabilization, symptom reduction, and skills training has been sufficient such that all dissociative parts can participate in synthesis (processing) simultaneously. For most clients, apart from content, planning focuses on decisions about which parts should initially participate in processing a particular traumatic memory (or series of related traumatic memories): (a) EP(s) that hold aspects of the traumatic memory, that is, parts who were active during the traumatizing event and are stuck in the actions of, for instance, flight, fight, freeze, and/or (total) submission; (b) parts (ANP and/or EPs) with whom the traumatic memory can be shared during the EMDR processing; and (c) parts that can fulfill a helping role depending on the action (sub)system that mediates their actions—such as offering courage, structure, or comfort—during or directly after the synthesis. For example, providing care and comfort can be best provided by an ANP mediated by, at least, the care action system. Also, decisions can be made concerning which parts should not participate, and perhaps can go to a safe place or "another room." For example, child parts may not initially want or need to be present when processing a negative interaction with the parent, and can be taken to a safe place by a caretaking part.

In short, careful and thorough preparation of the EMDR sessions for dissociative clients is essential for success and the prevention of complications. Although the whole of Phase 1, Stabilization, can be seen as preparation for Phase 2, Treatment of Traumatic Memories, the specific preparatory work mentioned here may take several sessions.

Stage 2: EMDR Processing at the Level of Guided Synthesis

This is a modulated and controlled therapeutic approach, using the EMDR standard protocol (or as much as possible), in which the client as a whole is or some selection of dissociative parts are helped to remain oriented in the present while simultaneously synthesizing (processing) the traumatic memory, that is, with its cognitive, affective, sensorimotor, and behavioral components. Processing at this level is a guided effort of collaborative and controlled reactivation of the traumatic memory and the involved EP(s). Not each and every detail of the traumatic memory need to be shared or processed. What is essential to eventually share are the pathogenic kernels, that is, the most threatening aspects of the traumatic experience that the client has so far avoided at all costs. An often overlooked pathogenic kernel consists of the experience of shame, an incapacitating emotion that clients usually do not report on their own. Thus the therapist should inquire about the client's experience of shame (Kluft, 2013). During the EMDR processing, the involved EPs share their respective experiences—mental and behavioral actions and their contents—of the traumatizing event with each other as well as with other specified parts. These parts need to be able to remain oriented to the present and the therapist.

In determining the pathogenic kernel, it is important to stay close to the experience of the client instead of the therapist making his or her own judgement. The therapy of Nadia, suffering from severe emotional neglect and sexual abuse by her father and in treatment for complex PTSD (secondary dissociation of the personality), provided an example. After a period of Phase1 (Stabilization) work, the target for the very first EMDR session (a tryout) was the memory of an accident. The image was of herself laying with her severely damaged leg under a huge vehicle directly after a traffic accident; a big wheel was pressing on her leg. She reported a subjective unit of disturbance (SUD) of 8. The therapist was surprised by Nadia's answer to the question about the cause of the SUD in that image. It was not the huge wheel which had just destroyed her leg, but rather her mother running toward her that upset her the most. (This example also indicates the importance of inquiring about how the traumatizing event ended.)

Keeping the Client Within the Window of Tolerance. EMDR processing can also be paced by using slower and shorter than usual sets of BLS (Forgash, 2010; Shapiro, 2001), talking more and/or grounding in between sets of BLS, and going back to target more frequently. The therapist should keep in mind that even these short sets may have intense effects, and be prepared to use different interventions to help the client to remain within the limits of his or her window of tolerance or integrative capacity. In case

of hyperarousal, it may be helpful to ground the client with stabilization exercises learned in Phase 1, Stabilization. If the client is able, the therapist may ask which part is activated and what the issue is. Perhaps time orientation, enhancing compassion, or more therapeutic engagement with the therapist is needed. Furthermore, suggestions can be given to parts for going to inner safe places and call upon needed resources.

When the client becomes hypoaroused, which may be part of the targeted traumatic memory, the therapist should keep on talking and providing cues about the here and now. Constant installation of present orientation and safety (CIPOS; Knipe, 2007) is a strategy with which the therapist can continually help the client being grounded in the present with a sense of safety. Grounding and feeling safe in the present is taught during Phase 1, Stabilization (EMDR Phase 2, Preparation), and can be used as necessary during the desensitization phase (EMDR Phase 4) of processing. Also, the therapist can help the client to go back to target, perhaps use appropriate touch to help soothe the client, focus on the body sensations, or by asking some helper parts what helps to reconnect with the traumatic memory. In case of severe hypoarousal (collapse), in which the clients appears completely uncommunicative, the therapist could touch a finger (if agreed upon before) and ask the parts inside to lift the finger a bit when they need the therapist to continue. However, the most useful intervention in this regard is to prevent such collapses from happening. The client can be trained to detect subtle signals of disconnection, hypoarousal and hyperarousal, and to use these signals as substitutes of a "stop signal" that severely traumatized clients may find too difficult to communicate clearly to the therapist (Gonzalez & Mosquera, 2012). Short but respectful, controlled and manageable work is always better than doing too much, and the client should often be reminded of it.

It is important to remind clients that they "need only share that which is necessary to know, to understand, and to heal." Taking short rest periods (suggesting, for instance: "you can let go of all tension, knowing you are safe in this time and this place"), suggestions for controlled breathing as well as advising that they respect and maintain their own boundaries, and requesting that they nod or say "yes" when they are ready for the next round. The latter is especially important because many survivors of chronic childhood abuse and neglect never had their boundaries and limits respected.

Even when parts who should not be present are in their inner safe places and other traumatic memories are contained in an imaginary fault, there is still a high risk with some clients that processing a particular memory will inadvertently activate other unresolved memories that belong to the parts involved in the processing. In these cases, it is most helpful that the therapist repeatedly emphasizes that now only this particular memory (or this part of the memory), mentioned by name, is being integrated—nothing else.

Time orientation of parts that may be overly activated (e.g., "Does this part know the danger is over and not happening now?") may also be helpful (Forgash, 2010; Twombly, 2005, 2010), as well as hypnotic suggestions for time distortion, such as experiencing the actual processing (synthesis) as much shorter than real time and experiencing the breaks in between as much longer than real time, also can be helpful. Various suggestions and imagery for healing may be offered toward the end of the processing (synthesis).

With regard to ending the session in a way that enables clients to leave the office while being sufficiently oriented to the present, therapists do well in applying Kluft's (1993a) rule of thirds: starting the session with the main ANP on here and now issues; subsequently working with parts (e.g., processing of the traumatic memory); followed by helping the client to reach closure and a necessary reorientation, which involves having the ANP who came to the session back in executive control.

Fractionated Processing (Guided Synthesis). This pertains to a series of much more gradual techniques—called *fractionated abreaction* by Kluft (1990, 2013), who pioneered them and who included various hypnotic interventions in their applications—in which the synthesis (processing) of one traumatic memory or one series of traumatic memories is divided into a number of smaller steps, which may encompass several or even many sessions (Fine, 1993; Gonzalez & Mosquera, 2012; Kluft, 1989, 1990a, 1990b, 1997, 2013; Lazrove & Fine, 1996; Van der Hart et al., 2006; Van der Hart, Steele, Boon, & Brown, 1993). Such an approach is indicated when the client's integrative capacity and anxiety tolerance are limited, but the task of integrating a specific traumatic memory seems unavoidable (Kluft, 1990a, 2013).

Variations of fractionated processing (at the level of guided synthesis) are endless. For instance, processing initially might be limited to the sensorimotor aspects of the EPs' traumatic experiences, as part of a so-called *bottom-up approach* (Ogden et al., 2006), followed by the emotions involved and the NCs. Processing may even be limited to only one sensory or emotional dimension at a time, such as pain, fear,

or anger. It can also involve the sharing of only one EP's experiences as part of a more encompassing traumatic memory at a time (e.g., first the experience of the fight EP (instead of a flight EP); or a specific time segment of the traumatic experience. Sometimes the client's dissociative structure around traumatic memories provides excellent points of departure. For instance, one client with DID had several EPs keeping segments of the sexual abuse perpetrated by her father when she was a girl: hands part, breasts part, mouth part, and so on. Sessions were sequentially focused, beginning with the hands part, while the other parts involved remained in their safe places.

With emotionally very intense memories or sensations (such as pain), the therapist may structure the processing with shorter sets of BLS (for instance, 5 or 10 movements). However, for some clients, rather longer sets help them process through an intense memory, enabling them to go through the most intense level of arousal. It is important for the therapist to fine-tune BLS according to client responses and affect tolerance. In this context, EMDR processing is a "dance" between client and therapist, with rate of BLS, length of sets, and tempo determined by the client's responses. Finally, suggestions can be given for a very gradual or slow sharing of affect over time outside the session, for example, 5% per day of the overall affect or 1%–2% of the pain pertaining to a specific traumatic memory (Kluft, 1990b).

Cognitive Interweaves. Cognitive interweaves are designed to facilitate the processing by linking in adaptive associations when the client's processing is blocked or the client is getting outside of his or her window of tolerance (e.g., Fine, 2010; Fine & Berkowitz, 2001; Gelinas, 2003; Shapiro, 2001). Thus, they are not to be seen as fractionated processing or synthesis. Nor are they designed to restrict the intensity or amount of experiences to be integrated. Often, repeated cognitive interweaves—directed to the process or the content—are needed to encourage this linking in of adaptive information, that is, ANP's adaptive mental actions. This is especially relevant in case of looping and blocking during the processing. The interweaves must be timed precisely to be effective; that is, in the moment of confusion, for example, about the time and reality of the experiences during processing. Examples of interweaves regarding time orientation are as follows: "Can you notice which year it is?"; "How old are you now?"; "How long ago did this happen?"; "Remind yourself this is old stuff"; "Your parents are dead now." Apart from time orientation, self-care interweaves are also useful. For instance, "What do you notice that this part needs?" and "How can you help her?" Sometimes, psychoeducational interweaves are useful, not only to facilitate the development of a more adaptive adult perspective but also to help the client gain a stronger sense of the therapist's safe and supportive presence and, eventually, to foster reflective thinking and an overall perspective. For example, "The EP who kept all this is part of you," "Indeed, it happened to you," and "You are grown up and safe now."

Sensorimotor interweaves, in the line of Janet (1919/1925) inspired "acts of triumph" interventions from sensorimotor psychotherapy (Ogden et al., 2006) can be useful in some cases. These involve helping clients to complete blocked bodily movements that began as incomplete defensive acts during traumatic experiences. A brief example pertains to a woman with very tense muscles in her right arm: She could only relax them when she initiated and completed the same movements she made when she was raped as a child (i.e., stretching her arm, making a fist to keep off the perpetrator). Furthermore, when processing is blocked or the client is getting outside the window of tolerance, the therapist can help the client to check within using the meeting place and evaluate whether one or more parts are overly aroused, objecting, or if a new part has joined.

In summary, within a cognitive framework and the preparation phase as described earlier are applied, various adaptations of EMDR may be highly effective for actual synthesis (processing) of traumatic memories in clients with complex dissociation.

Containment in Between Sessions. In general, in future EMDR sessions, processing should include any remaining unshared aspects of a previously targeted traumatic memory. During the closure phase of EMDR processing (Phase 7 of the EMDR basic protocol), precautions are taken that these remaining aspects do not overwhelm the client in the meantime. Examples of containment are storing these aspects in an imaginary bank vault and having dissociative parts agree not to share them with each other between sessions. The client should receive recognition and praise for the collaborative and hard work done thus far. Reviewing strategies for comfort and management of feelings in between sessions are essential. After EMDR sessions, it might be helpful to have a short follow-up contact by telephone or e-mail (as a form of containment). In addition to keeping a journal or log about other memories, triggers, dreams, and the like, it may be helpful to give a homework assignment that facilitates containment such as finding out what

the parts who worked so hard during the session need and finding ways of fulfilling that need; for example, asking ANP to provide consolation and comfort to a child part who experienced and shared deep grief in the session. Preparation at home for the next session can also be helpful. For example, ANPs could find out which parts have to participate in the next session and what they will need to participate in the EMDR processing. In addition, it is always good practice to suggest that the client strive for a balance between a focus on integrative work on one hand, and work, daily tasks, rest, and recreation on the other.

Stage 3: EMDR Processing at the Level of Guided Realization

For the traumatic memory to become a fully narrative autobiographical memory, it must be realized. Realization is a frequent spontaneous mental action observed during processing. However, when the client has complex dissociation, the therapist often needs to help the client to succeed in this high-order integration. Thus, after synthesis, the clinician should evaluate levels of realization and continue treatment in this direction if needed. After all, the basic reason for most clients why a particular traumatic memory continues to exist is the phobia of realization. This is illustrated by a mother with traumatic grief, who one and a half years after the sudden death of her only son stated, "The idea that he will not be there ever again, I don't let that sink into my mind. Otherwise one becomes crazy. Otherwise one would indeed not want to continue living" (*De Volkskrant* magazine, December 24, 2011). This phobia of realization might be a proper target for further processing, accompanied by cognitive interweaves pertaining to presentification and personification.

When the client is able to maintain these high level actions regarding past trauma, he or she can remain in the present when giving a coherent and flexible narrative of a traumatizing event, neither reliving it nor being depersonalized. Engaging in the acts of realization enhances his or her capacity to change and adapt in the present. Eventually, the client as a whole has realized that the event happened and is now over, that the actual present is different from the past and far more real, and that the event is part of his or her life history and had, and may continue to have, certain consequences for his or her life. The narrative must be further integrated within and across each part of the personality. Memories can be targeted using EMDR processing several times to further foster such synthesis and realization. Each time a traumatic memory is targeted, other parts that were involved may participate, preferably in an agreed upon sequence, and deeper levels of realization and meaning may develop. The necessity of continued targeting of traumatic memories to process or integrate all channels of association and dissociative parts involved (including the various levels of synthesis and realization) is usually one of the differences between treating early chronic traumatization and treating a single traumatizing episode.

Phase 3 Treatment: Personality (Re)integration and Rehabilitation

Once enough work has been done in Phase 2, Treatment of Traumatic Memories, and the phobia of traumatic memory has largely been overcome, the client usually has gained a higher overall integrative capacity. Then, Phase 3, Personality (Re)integration and Rehabilitation, can be initiated. The realization of the past has to include new images of oneself, caretakers, and the world. The main goals of Phase 3 are as follows: (a) overcoming the phobia of fusion that characterizes some clients; (b) grief work with regard to all the losses that the client suffered and continues to suffer related to the traumatization; and (c) overcoming other phobias that prevent further personal development. A fourth goal, also well-known in EMDR therapy from an adaptive information processing (AIP) perspective is achieving appropriate, adaptive, and ecological resolution of presenting problems; incorporating new skills, behaviors, and beliefs about self; and optimizing clients' capacity to respond adaptively in the current context of their lives and in the future (Shapiro, 2001). In some less complex cases, these goals might be reached spontaneously after EMDR memory processing, but in most cases they need special attention.

Overcoming the Phobia of Fusion

In many clients, some dissociative parts involved in the integration of a particular traumatic memory may unify, become one (Kluft, 1993b, 2013; Twombly, 2000), as an immediate result of EMDR processing at the levels of synthesis and realization. Other parts have a more extensive life history and a wider range of experience. For them, a natural process of sharing more and more of these experiences may take place, eventually resulting in a spontaneous fusion without the need for specific therapeutic interventions. Other parts may benefit from an imaginary fusion ritual, such as imagining that they embrace each other and become one (Kluft, 1993b; Van der Hart et al., 2006).

Because a more fluid and less dissociative personality is developed, dissociative parts become better oriented to the (safe) present, the main ANP more and more experiences other parts as parts of self, amnesia among parts diminishes. There is less need for EPs to remain fixed in defensive actions and other automatic reactions to triggers. EPs are going to help in the daily life, and ANPs become more able to deal with emotions, and a natural process of gradual unification takes place. However, some clients, or specific parts of them, are invested in separateness among parts and thus have a phobia of fusion. For example, therapists should be aware that one reason the phobia of fusion might reemerge in this phase is that one or more of these parts have traumatic memories that clients as ANP wants to avoid at all cost, such as those involving the most difficult realization that their own mother rejected them from birth or even before or instances where the client (as EP) abused his or her children. When this is the case, a return to Phase 2, Treatment of Traumatic Memory, eventually is necessary. But some clients need time before they are ready to face these existential challenges; in the meantime, they invest their attention and energy in the consolidation of their previous gains.

To the degree that this phobia still exists in Phase 3, *Personality Integration*, exploring the fear and targeting this fear directly with BLS (e.g., strategies for overcoming dissociative phobias, described earlier) may be helpful. It is also possible to ask the client to make a picture of how he or she imagines the future results of personality integration and make this the target of EMDR, and by doing so overcoming (processing) the fear of fusion. This procedure is similar to the flashforward protocol (Logie & De Jongh, 2014). However, with dissociative clients, therapists must be cautious about not making them feel forced to imagine this future. Phobias of fusion can be overwhelming. Perhaps a small experiment, where the client imagines one part feeling what it might be like to experience fusion, can help a part decide to go further with this procedure.

Whatever the pathways toward unification of the personality, most clients with a fully integrated personality are more resilient when facing stressful life events than clients who decided not to go all the way (Kluft, 1993b). This affirms the notion that gradually overcoming the phobia of fusion among parts is an essential treatment principle.

Grief Work

When clients make progress in therapy, they may experience moments of relief and joy. Therapists should be aware that such experiences may alternate with renewed grief about losses suffered as clients realize ever more deeply what they have missed for so long. Grief therapy is an essential approach during all phases, but particularly in Phase 3, Personality (Re) Integration and Rehabilitation, when full realization of losses occurs (Van der Hart et al., 1993) and clients are facing the more difficult challenge of acceptance and resignation (Janet, 1919/1925). Performing these acts can be facilitated by targeting the losses (Shapiro, 2001). This can be done by using standard protocol on moments where losses were realized. Therapists need to support clients also by emphasizing that grieving is part of healing. Clients are confronted with their lost childhood that can never be recovered; the existential loneliness and the pain that have been and must continue to be endured; the lost relationships, including for some not having been able to have a partner and/or children, time, education, jobs, and money; when they have children, all that they were unable to give to them; and the fact that they have to spent so much energy instead in avoiding or struggling with the aftermath of chronic traumatization. Such grieving includes intense feelings of loss, pain, sadness, remorse, anguish, desperation, and panic, sometimes resulting in existential crises complete with suicidal tendencies (Van der Hart et al., 1993).

Some clients internally experience grief because they lost the relationship with their dissociative parts while they are still having difficulties relating with other people. Thus, for them unification of their personality temporarily involves an increase in loneliness.

Overcoming the Phobias of Normal Life

The phobias related to normal life are more evident in this period, representing specific challenges. The appearance of these phobias may explain some otherwise incomprehensible crises in some clients who were evolving well.

Overcoming the Phobia of Healthy Risk Taking and Change. The phobia of healthy risk taking and change is rooted in (early) life experiences in which taking risks and changes eventually became catastrophic, as well as in a lowered integrative capacity that made adaptation to ever-changing circumstances extremely difficult or impossible. Indeed, there are many aspects of life that they have avoided, or lack the adaptive skills for, and will now face. After processing (integrating) past traumas and present triggers, the client may be freed up and learn new skills and ways of interacting with the world that were not acquired in childhood. Resource development and installation

(RDI; Korn & Leeds, 2002) and future templates may provide the client with what is needed to meet life challenges, engage in life, and experience developmental growth (Gelinas, 2003; Shapiro, 2001). Working with flashforwards (i.e., catastrophic images of doom scenarios regarding a future confrontation with an object or situation) can liberate the client from the experiences that maintained the phobia of normal life (Logie & De Jongh, 2014).

Overcoming the Phobia of Intimacy. Clients also need to overcome their phobia of intimacy, which is rooted in traumatic childhood experiences of betrayal by parents and other caretakers (Freyd, 1996), often repeated by future partners. Intimacy takes many forms, such as emotional, physical (nonsexual), and sexual. The phobia of intimacy may be related to some or all of these forms (Steele et al., 2005). To some degree, this phobia has been addressed in earlier treatment phases, within the therapeutic relationship which hopefully has offered the experience of secure attachment. In Phase 3, Personality (Re)integration and Rehabilitation, a specific goal is to overcome this phobia with regard to other individuals. Clients can still struggle with feeling insecure in new safe relations and feeling less insecure in the old familiar unsafe situations and relations. They should be assisted in overcoming the fear of emotional intimacy prior to physical and sexual intimacy because the last two require the first to be in place. For emotional intimacy to be experienced in a healthy way, clients need to learn to set good personal limits and boundaries as well as to respect others' boundaries (Boon et al., 2011). Effective boundaries reduce the phobia of intimacy, giving some sense of personal control, and equalizing the balance of power in relationships (Steele et al., 2005).

Resourcing

RDI may be very helpful in developing the necessary skills in all instances of skill building and personal growth (Gelinas, 2003; Korn & Leeds, 2002). As stated earlier, future templates can enable more effective and adaptive responses to future stressful events (Hofmann & Mattheß, 2011; Shapiro, 2001).

In general, there is rather spontaneous movement back and forth into Phase 3, Personality (Re) Integration and Rehabilitation, because clients generally have an increasing desire to "get on with life" in the present. Progress will manifest in the ability to initiate, perform, and successfully complete even more integrative actions in daily life, resulting in joy and relief. This helps them to further raise their integrative capacity and, thus, to engage high-level actions (Ellenberger, 1970; Janet, 1919/1925; Ogden et al., 2006; Van der Hart et al., 2006), including a full realization of their own history and present circumstances and preparation for a realistically optimistic future.

Termination of Treatment

Even though all of the above is enabling the client lead a more adaptive and rewarding life, appropriate termination of therapy is a major transition that should receive careful and long-term attention by both therapist and client. Issues to deal with are, among others, overcoming the phobia of detachment, evaluating the meaning of the therapy and the therapist in the client's life, and phasing out the therapeutic relationship, which also includes the therapist critically exploring possible unresolved countertransference issues. Successful navigation of termination is necessary for a well completed therapy (Van der Hart et al., 2006).

Conclusion

For clients with a history of chronic trauma and a complex dissociation of the personality, the integration of traumatic memories—including their full realization—constitutes a major challenge that easily compromises their integrative capacity. Therefore, like other approaches, EMDR treatment of traumatic memories needs to be embedded in a much more encompassing therapy—usually defined as phase-oriented treatment. And with such therapy, a high quality of the therapeutic relationship is essential. This pertains to a most respectful and compassionate attitude from the therapist, as well as the development of "collaborate teamwork" of both therapist and client, including eventually all the client's dissociative parts. Severe traumatization involves extreme abandonment, loneliness, and helplessness. The therapist's safe presence during the healing journey is the single most relevant factor for success.

In this article, the emphasis is on the contributions that TSDP can provide for effective and safe EMDR practices in phase-oriented treatment, in particular Phase 2 (Treatment of Traumatic Memories) and Phase 3 (Personality (Re)Integration and Rehabilitation) of clients with complex trauma-related disorders. The AIP model remains essential in guiding the attainment of various therapeutic goals such as case conceptualizing involving the identification of traumatic memories, present triggers, and the construction of a positive future template (Shapiro, 2001). The TSDP and its related psychology of action provide a more specific cognitive framework for the respective treatment goals, mostly described in terms

of overcoming specific phobias that maintain the dissociation of the personality and thus the existence of the traumatic memories. Within the context of phase-oriented treatment and guided by AIP and TSDP, and with careful indication, timing, and preparation, EMDR therapy can be applied in a flexible, safe, and efficient manner. Not only the traumatic memories become fully integrated but also dissociative parts become more and more united and thus the personality as a whole more integrated. Furthermore, clients become increasingly able to cope with daily life challenges and develop a more positive self-esteem.

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