

Treating posttraumatic stress disorder through eye movement desensitization



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Eye Movement Desensitization and Reprocessing and the Structural Dissociation Model for Treating Posttraumatic Stress Disorder

Abstract

This paper reviews the research and efficacy of treating posttraumatic stress disorder (PTSD) with Eye Movement Desensitization and Reprocessing (EMDR) and the Structural Dissociation model developed by Nijenhuis, van der Hart, and Steele (2010).

Historical Overview

The term Posttraumatic Stress Disorder (PTSD) was first introduced in the 3rd edition of the Diagnostic and Statistical Manual (*DSM-III* ; American Psychiatric Association, 1980), however the initial account of traumatic stress was put forth in a treatise by Janet in 1889 where he noted that some patients developed such intense emotional activation that they were unable to function effectively. Although early pioneers in the field of psychology reported case studies of individuals developing severe emotional problems, the fact that many patients were women alleging sexual abuse and trauma at the hands of family members only served to curtail systematic study. The idea that families could be something less than safe and loving havens, and that brutality was possibly occurring in “ civilized” societies was something many psychologists could not reconcile (Van der Kolk, 2014). As a result of this, interest in and research on the impact of traumatic events was initially focused on war veterans. In *The Traumatic Neuroses of War*, Kardiner (1941) described men who had returned from battle unable to function effectively.

His patients, he observed, were responding as if they were still in
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threatening situations, having developed heightened sensitivity to threat and an accompanying need to be hypervigilant to their environment.

Introduction of PTSD into the DSM in the 1980's opened the field of research. Single event trauma such as rape, motor vehicle accidents, and natural disasters were being studied, adding to the general understanding of trauma and the human response. In addition to the significant emotional overwhelm and/or emotional numbing noted by early researchers, new findings suggested that many trauma survivors experienced shame, mistrust and feelings of worthlessness (Bremner & Marmer, 1998). The early work of Janet (1889) was confirmed by investigators who noted that trauma survivors may experience amnesia for part or all of the traumatic events(s), making it difficult to connect the events from the past with current behaviours, and creating challenges for positive therapeutic outcomes. There may be a "splitting off and isolation of memory imprints" (van der Kolk, 2014, p. 180.) referred to as dissociation which prevents the traumatic memory from being incorporated into the individual's narrative memory.

Although it was initially thought that compartmentalization of personality into distinct parts was extremely rare, and limited to patients meeting criteria for Dissociative Identity Disorder, research conducted by Sar (2011) determined a prevalence rate of dissociative features in 10% of a general population of patients seeking psychiatric services. Without specific methods to address this common symptom of trauma, psychological interventions and treatments were often less than effective, and many trauma survivors continued to suffer.

Neurobiological Research and Trauma Interventions

Incorporating the research of neuroscience, especially the concept of the triune brain (McLean, 1990) led to some significant advances in trauma treatment. McLean suggested that the brain stem, the limbic system, and the neocortex are responsible for specific and distinct functions and mental activities. Activation in the most basic and primitive parts of the brain could result in compulsively repetitive responses and changes to one's physiology such as breathing and heart rate. Certain survival responses and emotional reactions were, according to the theory, located in the mid brain or limbic system. Activation of the mid brain areas resulted in the fight, flight, freeze responses similar to those seen in traumatized individuals who were triggered by stimuli. McLean also speculated that there is a corresponding decrease in higher order thinking, the good decision-making and logic associated with the cortex, when the basic survival parts of the brain are activated. This is similar to findings of traumatized individuals who re-enact their trauma history long after it has ended.

More recently, neuroimaging studies of the brain have demonstrated that unprocessed traumatic memories, remain "stuck" in the subcortical areas of the brain, particularly the amygdala, thalamus, hippocampus, hypothalamus, and brainstem. Trauma subjects exposed to scripted versions of their trauma memories also showed a distinct shut down in the area of the brain most associated with speech, leaving many trauma survivors literally without words to process their experiences, while the parts of the brain connected to autonomic arousal and heightened emotionality become highly active (Van der Hart, Nijenhuis, & Steele, 2006). The evidence that traumatic memory is <https://assignbuster.com/treating-posttraumatic-stress-disorder-through-eye-movement-desensitization/>

not accessible to the logical and rational parts of the brain suggests that some trauma memory may be incompatible with certain therapeutic approaches. Interventions that rely exclusively on talking through the traumatic events may serve only to re-traumatize the individual as triggers and reminders of the events are discussed. Furthermore, traditional talk therapy may not account for the automatic limits and override of the prefrontal cortex by the limbic system. As a result, when individuals are triggered, the frontal lobe, that area of the brain most associated with purposeful decision-making, thought and speech, becomes impaired and traumatized individuals may be unable to effectively communicate the experience (Van der Kolk, 2014).

General Guidelines in the Treatment of Trauma

It is understood that there are certain fundamentals in the treatment of trauma. Effective interventions, adapted from the writings of Janet (1923) and Herman (1992), include a phase of stabilization and safety where the traumatized individual begins to achieve a sense of body safety, the management of self-injurious or suicidal behaviours, and emotional regulation. The ability to self-soothe, control impulses, calm the body, and manage PTSD symptoms triggered by mundane events is essential and therapy must not proceed until such a state is achieved (Fisher, 2011). Psychoeducation aimed at increasing understanding of the impact of trauma and typical trauma reactions is useful here, as are specific interventions and techniques to manage emotional overwhelm and help the individual maintain within the window of tolerance (Courtois, 2014). Once there is a sufficient level of stabilization, the next phase, coming to terms with traumatic

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memories, can begin. Here, work focuses on overcoming the fear and avoidance of the trauma memories.

In order for traumatic memories to become fully integrated, the traumatized individual requires sufficient psychological distance from the trauma.

Unfortunately, many survivors achieve a level of psychological distance through dis-remembering the trauma. Effectively processing the traumatic memories can be challenging since most trauma survivors actively avoid specific memories associated with the events.

Treatment Approaches

Although there are a number of validated PTSD treatment approaches, including prolonged exposure, cognitive processing therapy, stress inoculation training and pharmacotherapy, Gold (2008) noted that there is particular risk associated with exposure techniques since the intense affect resulting from exposure methods promotes deterioration. This section will highlight two distinct therapeutic interventions for trauma: EMDR and the Structural Dissociation Model. Both approaches have been selected for their ability to address specific limitations of other interventions - specifically, EMDR, with its controlled focus on trauma detail reduces the likelihood of re-traumatization, and Structural Dissociation, with its ability to address the prevalence of emotional parts that develop as a result of trauma.

EMDR

EMDR consists of eight phases designed to stabilize the trauma survivor and allow for the effective accessing and processing of traumatic memory

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without the need for a detailed re-telling of the trauma history. The intervention relies on bilateral stimulation, facilitated through eye movements, tapping or pulsar use, to reduce and eliminate the intensity and intrusiveness of disturbing images and the accompanying emotional arousal (Shapiro, 1989; Shapiro & Liliotis, 2010), and since EMDR does not require clients to detail their trauma, it allows for the story to be experienced, processed and reintegrated into an accessible narrative in relatively few sessions.

Initial research into the positive effects of EMDR hypothesized that the memory and associated stimuli of traumatic events are inadequately processed, leading to a disturbance or disruption in the excitatory/inhibitory balance in the brain (Shapiro, 1989). Only with the advent of brain imaging and fMRI research was there supporting evidence that the executive functions of the brain become impaired when traumatic memory is accessed. Traumatic memory “located” in much deeper regions of the brain, are barely impacted by thinking and cognition. Therapists who rely on interventions that target the cortex or that rely on the verbal part of the brain, risk traumatizing individuals already highly subject to overwhelm. Unlike exposure therapy that results in the traumatic material becoming desensitized, EMDR supports the integration of the traumatic material so that it becomes a coherent part of the past (van der Kolk, 2014).

Shapiro (1996) noted that EMDR is an empirically validated intervention for treating trauma. Comparing the effectiveness of cognitive behavioural therapy interventions such as Stress Inoculation Training with Prolonged

Exposure (SITPE) to Eye Movement Desensitization and Reprocessing
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(EMDR), determined that there was no discernable difference in participants self-report and observer-rated measures on measures of depression and global PTSD symptoms, while on measures of the degree of intrusion, EMDR did significantly better than SITPE. Follow-up studies also confirmed that trauma survivors in the EMDR condition showed greater gains on all measures over those in the STIPE condition.

EMDR provides specific techniques for managing the strong emotional reactions found in those with PTSD. During the initial phase of treatment, the trauma survivor is taught specific grounding and containment strategies. Emphasis on a snapshot of trauma, rather than the whole trauma history, further serves to mitigate risk of decompensation. Preparation for the desensitization process often involves guiding the client to experience the material from a safe distance - as if moving through a tunnel on a train - giving the client a sense of control; that even if it is uncomfortable now, the train will emerge from the dark. During the actual desensitization phase, the bilateral stimulation is usually employed for between 30-45 seconds followed by the specific instruction to "take a deep breath" (grounding) and to "let it go" (it's over). Mindful awareness is easily achieved by the therapist asking, "What's coming up for you now?" While the instruction to "just notice that," assures the client that a deeper exploration into the content is not required.

Support for the efficacy of EMDR for PTSD can be found in the practice guidelines of the International Society for Traumatic Stress 2009 position paper in which EMDR is regarded as a Level A, evidenced-based treatment for PTSD. Similarly, in 2010, the Department of Veterans Affairs and Defence endorsed EMDR as a treatment of choice for soldiers experiencing combat <https://assignbuster.com/treating-posttraumatic-stress-disorder-through-eye-movement-desensitization/>

related trauma, and Van der Kolk (2014) noted that EMDR surpassed pharmacology, exposure therapy for the treatment of trauma in adults.

Recognizing that the specific needs of very young children, including those who have experienced prenatal and perinatal trauma, may not be suited to the standard protocol format of EMDR, researchers have developed the early trauma protocol (O'Shea, 2009); interested readers are directed to the reference section for further resources.

Structural Dissociation Model

Working with traumatized individuals, especially those who have experienced complex posttraumatic stress disorder (CPTSD) can pose tremendous challenges for therapists. Often activated by seemingly benign stimuli, they are flooded with painful emotions of their traumas. These individuals cope through dissociation in attempts to distance from the emotional pain, resulting in some or all of the traumatic story becoming inaccessible to the conscious mind (Wright, Ost & French, 2006).

Janet (1907) noted that some traumatized individuals seemed to lack synthesis of personal experiences, which he described as a form of hysteria characterized by "(1) retraction of the field of personal consciousness and (2) a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality." (p. 332).

To address this, Nijenhuis, van der Hart and Steele (2010), proposed the theory of structural dissociation where the personality becomes divided into distinct and, at times, competing parts based on the severity of the trauma.

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In her previous therapy, Annie had complied with her therapist's insistence that she repeatedly recall and re-experience traumatic events, stimulating recurrent flashbacks in and out of therapy. She remembered wanting to tell the therapist that the excavation of memory was making her worse. But, under the influence of young "attach for survival" parts wanting the therapist to care for them, she just did as the therapist said (Fisher, 2017, p. 46).

The link between early-life stress in the form of childhood abuse and neglect (Sar, 2011) and the severity of abuse (Draijer & Boon, 1993) has been linked to dissociation. Disruptions in the parent-child attachment bond, such as is characterized in disorganized/disoriented attachment styles (Liotti, 1994, Liotti, 2004) is also noted a contributory factors in the development of complex trauma and thus dissociation, and given the high rates of adverse childhood experiences (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards et al., 1998) and their lifelong health implications, it is imperative that therapists are able to recognize and manage this common trauma symptom.

Steele, van der Hart and Nijenhuis (2005) developed a phase oriented treatment protocol for overcoming complex trauma and associated dissociation. These researchers noted that traumatized individuals generally have a part of their personality that is responsible for the daily life functions, (referred to as the Apparently Normal Part or ANP), and Emotional Parts (or EP's) that are fixated in the trauma and primarily serving a defensive function. However, the ANP's normality is only apparent, since this part of the personality physically and mentally avoids trauma-related cues,

including his or her inner world, resulting in life "lived on the surface of
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consciousness” (Appelfeld, 1994, p. 18). EPs, on the other hand, fit their perceptions and predictions to their traumatic memories, responding to triggers with repetitions of past actions.

The boundaries between parts are maintained by “ phobias of traumatic memories and phobias that dissociative parts have regarding each other” (Nijenhuis & Van der Hart 2011, p. 418). Through the appropriate therapeutic interventions, the boundaries between the parts can be resolved into an integrated sense of self.

Psychoeducation is provided in the initial phase of this trauma informed treatment. By working in the here and now, rather than recounting the trauma story that can be so triggering for survivors, the therapist explains the neurobiology of trauma, including the attach (part), the fight (part), flight (part), freeze (part) responses that are automatic and outside of conscious awareness. The therapist will also normalize the reactions, those thoughts, feelings, body sensations, and action tendencies that occur in response to a trigger, labelling them simply as communications from parts.

Helping clients to understand the survival function of these symptoms is a fundamental aspect of treatment in this phase and leads to improved understanding, acceptance and safer problem solving for the trauma survivor. As situations occur in therapy that trigger the individual, the therapist guides the client to simply notice the reactions being experienced and to develop a curiosity about them, setting the stage for the dual awareness necessary to process the trauma. As facility with this develops, the individual who can “ recognize and “ befriend” their triggered reactions

(Fisher, 2017, p. 43) begins to reduce the avoidance patterns so typical for trauma survivors. New actions can be integrated, thoughts can become measured and mindful, and emotional responses that she/he failed to achieve at the time of the trauma altered.

Research on the Structural Dissociation Model does not easily fit the gold standard of randomized controlled studies for obvious reasons however do not let this dissuade you from incorporating it into your treatment repertoire. While there has been some research, the main body of interventions are derived from years of work with trauma survivors - the clients who are the experts.

Conclusion

Steele and Van der Hart (2008) stated that mental health is demonstrated through ones capacity to integrate a broad range of psychological phenomena within one personality. Healing from trauma requires recognition and acceptance of ones history and present circumstances so that traumatizing events are remembered as narrative memory that can be recalled and shared at will rather than uncontrollably relived.


Our current understanding of trauma, and specifically the inclusion of factors related to complex posttraumatic stress disorder, coupled with the high prevalence of dissociation in individuals with trauma histories requires us as conscientious practitioners to remain open to effective interventions and novel approaches; EMDR and the Structural Dissociation Model are two such approaches recommended.


References

- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, D. C.: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, D. C.: American Psychiatric Association.
- Appelfeld, A. (1994). *Beyond despair*. New York: Fromm.
- Bremner, J. D. & Marmar, C. R., Eds. ((1998). *Trauma, memory, and dissociation*. Washington, D. C.: American Psychological Association.
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, and Training*, 41, 412-425.
- Davidson, P. R. & Parker, K. C. (2001). Eye movement desensitization and reprocessing (EMDR): a meta-analysis. *Journal of Consulting and Clinical Psychology*, 69(2), 305-316.
- Draijer, N., & Boon, S. (1993). Trauma, dissociation, and dissociative disorders. In S. Boon & N. Draijer (Eds.), *Multiple personality in the Netherlands: A study on reliability and validity of the diagnosis* (pp. 177-193). Amsterdam/ Lisse: Swets & Zeitlinger.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death of adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventative Medicine*, 14, 245-258.

- Fisher, J. (2011). Psychoeducational aids for working with psychological trauma (10th ed.). Janina Fisher, PhD.
- Fisher, J. (2017). Healing the fragmented selves of trauma survivors: Overcoming internal self-alienation. New York, NY: Rutledge.
- Gold, S. N. (2008). The relevance of trauma to general clinical practice. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(1), 114-124. Retrieved from: <http://dx.doi.org/10.1037/1942-9681.5.1.114>.
- Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
- International Society for Traumatic Stress Studies. *Posttraumatic stress disorder treatment guidelines: Methodology and recommendations*. Retrieved from: https://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_PreventionTreatmentGuidelines_FNL.pdf.aspx
- Janet, P. (1907). *The major symptoms of hysteria*. London & New York: Macmillan.
- Janet, P. (1923). *La médecine psychologique*, Flammarion, Paris. (Reprint: Societe Pierre Janet, Paris, 1980. English edition: *Principles of Psychotherapy*, George Allen and Unwin, London, 1925).
- Kardiner, A. (1941). *The traumatic neurosis of war*. New York: Hoeber.
- Liotti, G. (1999). Disorganized attachment as a model for understanding dissociative psychopathology. In J. Solomon and C. George (Eds.). *Attachment disorganization*. New York: Guilford Press.
- Liotti, G. (2004). Attachment, trauma and disorganized attachment: three strands of a single braid. *Psychotherapy: Theory, Research, Practice, and Training*, 41, 472-486.

- McLean, P. D. (1990). *The triune brain in evolution: Role in paleocerebral functions*. New York, NY: Springer.
- Nijenhuis, E., Van der Hart, O. Steele, K. (2010). Trauma-related structural dissociation of the personality. *Activitas Nervosa Superior*, 52 (1), 1-23.
- Nijenhuis & Van der Hart 2011
- O’Shea, K. (2009). The EMDR early trauma protocol. In R. Shapiro (Ed.), *EMDR solutions II: For depression, eating disorders, performance, and more* (313-334). New York: W. W. Norton & Company.
- Sar, V. (2011). Epidemiology of Dissociative Disorders: An Overview. *Epidemiology Research International*, vol. 2011. Retrieved from: <https://doi.org/10.1155/2011/404538>.

 **Shapiro, F. (1996). Eye Movement desensitization and reprocessing (EMDR): Evaluation of controlled PTSD research. *Journal of Behavior Therapy and Experimental Psychiatry*, 27 (3), 209-218.**

 **Shapiro, F (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*. 2(2), 199–223.**

- Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). New York: Guilford.
- Shapiro, F. & Laliotis, D. (2010). EMDR and the adaptive information processing model: Integrative treatment and case conceptualization. *Clinical Social Work Journal*. 39(2), 191–200.
- Skykes Wiley, M. (Jan/Feb. 2004). The limits of talk therapy: Bessel van der Kolk wants to transform the treatment of trauma. *Psychotherapy*

Networker: The Magazine for Today's Helping Professional. Retrieved from <https://www.psychotherapynetworker.org/magazine/current> .

- Steele, K., van der Hart, O., & Nijenhuis, E. R. S. (2005). Phase-oriented treatment of structural dissociation in complex traumatization: Overcoming trauma related phobias. *Journal of Trauma and Dissociation, 6* (30), 11-53.
- Steele & Van der Hart (in press, 2008)
- Van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: structural dissociation and the treatment of chronic traumatization*. New York: W. W. Norton.
- Van der Kolk, B. A. (2014). *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma*. New York, NY: Viking Press.
- Wright, D., Ost, J., French, C. (2006). Recovered and false memories. *The Psychologist, 19* (6), 352-355.