when there are no words

EMDR for Early Trauma and Neglect Held in Implicit Memory

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The challenges of using EMDR for early trauma and neglect are that a) EMDR readily targets explicit memories, but early trauma is held in implicit memory in the right hemisphere (Siegel, Schore) and is not typically subject to direct recall, and b) Accessing the felt sense of early experience can be overwhelming if it includes the paucity of internal resources of a neglected baby. This workshop addresses both problems by careful preparation and systematic trauma reprocessing. The preparation includes 1) containment, 2) safe state, and 3) resetting innate emotional resources, which appears to directly act upon primary process affective circuits (Panksepp, 2009) to down-regulate the experience of emotional intensity. After the three preparation steps, the method systematically reprocesses early trauma, in the absence of explicit memory. The method targets consecutive time periods beginning before birth, and installs positive experience imaginally. As a result, the client builds a foundation of a felt sense of attachment and belonging, with emergent positive cognitions, enabling the client to meet the next developmental milestone in sequence. This process meets the requirements laid out for a therapeutic reparation of early trauma by Fosha. The procedures were developed by Katie O'Shea as an outgrowth

INTRODUCTION – NEURODEVELOPMENTAL CONSIDERATIONS

FOSHA'S CRITERIA FOR A THERAPY TO TREAT EARLY TRAUMA

Processing early trauma requires certain elements. A therapy informed by affective neuroscience and attachment studies must include several elements (Fosha, 2000) including:

1. An ability to access emotion and harness its healing resources by engaging the relevant neuro-biological processes, which for early trauma, is not language and logic, but the right hemisphere's language of images, sensations, impressions and urges.
2. Promoting a felt sense of safety in the therapeutic relationship is essential, sharing in the hard emotional work.
3. A means to work directly with defensive responses (fight/flight) to gain experiential access to feared/unbearable emotional experiences.
4. Once the patient feels safe, and the impact of defenses is cleared, the therapy must have a means for not only accessing but also processing strong emotions without being re-traumatizing, so the experience can be integrated and coherence achieved

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The early trauma processing protocol put forward in this workshop meets Fosha's criteria for a therapy informed by neuro-affective and attachment studies and more, within a modification of the standard protocol of EMDR, the most efficient means for processing trauma. It adheres to the standard protocol wherever possible. It secures:

1. Accessing somatically and implicitly held experience without requiring explicit memory,
2. Promotes a sense of safety with containment and a safe state procedure,
3. Engaging the therapist with empathic and somatic resonance,
4. Works directly with defensive responses by a) resetting the fight/flight and other emotional circuits to produce a calming effect, and when needed, using ego state interventions, and
5. Systematically processes time periods from earliest years of life to an adaptive resolution, installing the felt sense of getting developmental needs met.

Additionally, it takes into account additional neurodevelopmental phases by both addressing brain levels in developmental sequence (first circuits, then relationship template, and then subsequent learning) as well as fractionating content by time period in temporal sequence (Paulsen, 2009, in press).

Neuro-Development, Traumatic Relationship & the Self

This workshop is proposing a protocol for clearing early trauma, with a systematic preparation method to ensure safety, success, and efficiency. Recent findings in developmental and affective neurobiology include:

1. **Very early experience is held in implicit memory in the right hemisphere of the brain (Schore, 2009).**

2. **The polyvagal system organizes basic survival emotions.** The human animal has a polyvagal system that includes not only the fight/flight (sympathetic arousal) and freeze responses (dorsal vagal) but also a social engagement system (ventral vagal) based on the neurobiology of attachment (Porges, 2001).

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3. **Brain organization reflects self organization.** Human emotions constitute the fundamental basis the brain uses to help organize its functioning, so affective regulation is the essence of self organization. Parent/child communication about emotions directly shapes the child's ability to smoothly organize his or her self (Siegel).

4. **The brain has several levels at which it processes affect.** Panksepp describes the primary process level as that subcortical level at which the basic affective circuits occur, which require no learning, and are hardwired; the secondary processing level includes the amygdala and other basal ganglia, and is the locus for initial learning during the attachment period, and so includes relationship templates and object relations, the tertiary level is the neocortical layer where subsequent learning occurs.

5. **We have hardwired basic affective circuits.** The human being shares with other mammals basic hardwired affective circuits that are subcortical (Panksepp). Unlike other animals, humans have a complex cortical overlay of state dependent learning acquired during attachment and socialization. That learning can result in those circuits working optimally or being inhibited. Awareness that there are hardwired affective circuits raises the possibility of using EMDR to conduct information processing on a system or circuit level.

6. **Adaptive neuro-development occurs in healthy relationship.** Positive affective states in the context of moment-to-moment brain-to-brain interactions between mother and infant are the basis of secure attachment, which is itself the basis of mental health and resilience (Siegel, Schore).

7. **Clinical syndromes result from early trauma including relationship trauma.** Many clinical syndromes, including dissociative disorders, affect and state regulation disorders, borderline and other personality disorders, are established early in life through failed navigation through developmental milestones because of early trauma, and its impact on: the ability to smoothly change affective states, lack of integration of states related to affective circuits and state dependent learning (Putnam, 1988).

8. **Early trauma results in dissociated states.** States of consciousness are discrete self-organizing patterns of behavior differing along axes of affect, access to memory, attention and cognition, regulatory physiology, and sense of self. Ego state disorders are the result of dissociated and affectively dysregulated states (Putnam).

9. **Pre-natal trauma may contribute to lifelong problems.** Some contributors are formulating the first trimester as being a seminal time in laying down patterns of clinical syndromes and lifelong psychopathology (Schore, 2009, Lynn, 2000; Lake, 1978)

10. **Unresolved trauma remains trapped in the nervous system.** Adaptive information processing theory defines trauma related syndromes as resulting from raw and unprocessed traumatic information trapped in the nervous system (Shapiro, 2001). Neural networks may correspond to dissociated ego states (Paulsen, 1995) and affectively dysregulated states.

11. **Standard EMDR protocol requires explicit memory**. In the basic EMDR protocol, one formulates a target from an explicit memory in order to activate neural networks, catalyze the brain's innate capacity for healing, and process raw traumatic experience to an adaptive resolution (Shapiro, 2001). The standard protocol does not directly address memory held in implicit memory as in the case of early trauma.
12. **Processing of early trauma should take neuro-development into account.** This should occur both in terms of the levels of the brain addressed in the sequence in which they were developed, but also in terms of fractionating the work temporally from the beginning of life (Paulsen, 2009; in press).

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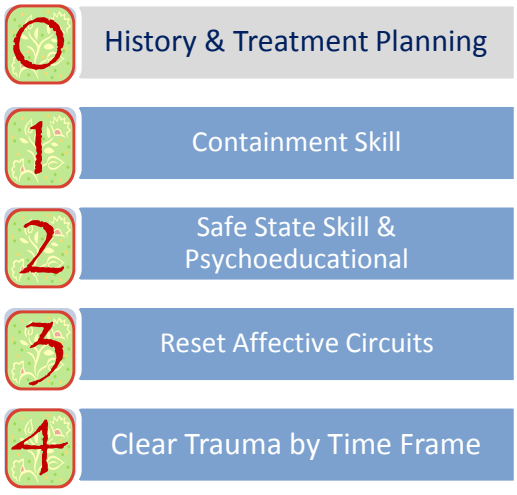
The EARLY TRAUMA PROTOCOL & THE 8 PHASES OF EMDR

EMDR PHASE	EARLY TRAUMA PROTOCOL ACTIVITY
1 - History & Treatment Plan	History, Early History, DES/DID, Attachment
2– Preparation	Containment Skills, Resourcing Skills, Reset Shame & Basic Affective Circuits
3 –Targeting	Target by Time Frame, Fraction size based on history and capacity
4 – Desensitization	Desensitization by tapping, eyes closed, knees or ankles if reclining , capturing NC/PC as they emerge in the processing
5 – Installation	Installation of spontaneous or captured PC by time frame
6 –Body Scan	By time frame, not at end of session if incomplete session
7 – Closure	Ensure closed with containment and safe state, body scan if complete
8 – Re-Evaluation	Once implicit is clear, use standard EMDR, ensure captured NCs resolved, captured PCs VoC 7

POSSIBLE SESSIONS SEQUENCE FOR NON-DISSOCIATIVE CLIENT

The following table shows how typical treatment sessions might proceed, following the initial history and treatment planning session(s). This pace is typical for many clients, but is less likely to apply for the severely injured. Individuals with either formal dissociative disorders or serious attachment injury histories, or both, will require a slow and more in-depth pace, which we call "zooming in."



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POSSIBLE INDICATIONS OF EARLY TRAUMA AND NEGLECT

- **Under 3 when appear in treatment**
- Traumatic or neglectful experience
- **Adopted, multiple placements**
- **Traumatic pregnancy or delivery**
- **Mother's distress, physically or emotionally, or during pregnancy, delivery, emotionally, after birth …**
- **Failure to thrive**
- **Early surgeries or hospitalizations**
- **Early medical illnesses**
- **Premature birth, cleft palate**
- **Abuse or neglect**
- **Can't respond to standard protocol assessment memory/image, nc, pc, suds/voc ratings**
- **Floatback goes to very early trauma or the patient senses it is**
- **Fetal Alcohol Syndrome**
- **RAD Or Other Attachment Problems**
- **Autism, Asperger's**
- **ADHD**
- **Sleep Disorders**
- **Eating Disorders**
- **Elimination Disorders**
- **Pervasive Emotional Distress**
- **Anxiety (Flight)**
- **Depression (Landry Wildwind's Work)**
- **Anger (Fight)**
- **Dissociative Symptoms**
- **Memory Loss**
- **Can't Remember Time Periods**
- **Headaches**
- **Child Sits And Stares, "Glued" To The TV**
- **Daydreams, Spaces Out, In A Fantasy World**
- **Somatic Symptoms Predominate**

PTSD & DISSOCIATION

The following is a heuristic for conceptualizing how complexity of trauma and attachment histories combines to manifest as PTSD, DDNOS or DID. It is intended as a heuristic, not a diagnostic tool, because there is more variability than this chart expresses.

PTSD	Complex PTSD, DDNOS	DID
Single Event **Good Attachment**	**Neglect** **Intermittent Trauma**	**Neglect and** **Severe Chronic Trauma**
• Car Accident • Medical Procedures • Life Threatening Diagnosis • Adoption placements • Assault violence • Natural disaster	• Childhood PAB/SAB • Childhood PAB/SAB • Neglect • Multiple Trauma • Multiple Losses • Crimes • Terrorism/War	• Severe PAB/SAB • Severe PAB/SAB • Neglect • Very Early Trauma • Domestic • Torture

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HISTORY & TREATMENT PLANNING

DOMAIN	ASSESS FOR
Trauma	Big T and Little T – if client can tolerate it. If not don't push, this is diagnostic.
Schema	Key relationships, beliefs, expectancies
Symptoms	All, but including dissociative: amnesia, derealization, depersonalization
History	Presenting problems, family, educational, work, treatment, medical, substance, legal, military, avocation, etc
Resources	Affect and soma tolerance (positive and negative), coping style, coping skills, affect regulation ability, spiritual resources, social resources
Stability	Suicidal/homicidal ideation, self harm, anorexia, recent hospitalization, etc
Other	DES-II and if high, MID or SCID-D
Formulation	Per your training and experience (e.g., psychodynamic, cognitive behavioral, etc), but also within AIP Theory, trauma theory, dissociation and attachment theory. Summary of how you understand the cause of the symptoms and the client's capacity for the work. Helps to write it out even if no report needed.
Diagnoses	As appropriate for your practice and licensure. If this client's diagnosis is not within your training, refer out or seek consultation as needed if discrepancy is small. We should never work with a population we are not trained to treat without additional training and consultation.
EMDR Plan	1. If EMDR is indicated, is preparation needed and if so how much, or are they ready for EMDR 2. What are the target domains and initial targets suggested by history 3. Psycho-educational about containment and resourcing, emotional first aid handout? According to needs of client.
Containment	Close history taking session with containment, logical way to conclude, tucking in anything that might be disturbing.

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WORKSHEET FOR CLIENT: | | |

1. CONTAINMENT(to ensure client has the capacity to titrate affect & fractionate trauma) DATE:

Choose at least one strategy:

- ☐ **Container** (see script) Cue Word is: _____
- ☐ Rheostat (imaginal dimmer switch they can feel under their hand to turn down intensity)
- ☐ Screen (to view disturbing material at a distance)
- ☐ Waiting Room (to hold material or states not the subject or "star" of today's work)
- ☐Other:

2. RESOURCING (to ensure client is in an empowered state to increase processing capacity) DATE:

Choose one:

- ☐**SAFE state (how you feel when nothing bad is happening)** (see script)Cue Word is: _____
- ☐ Resourced state (imagine how it would look and feel to have that attribute)
- ☐ Somatic resource (how it feels in your body when you think about your favorite place)
- ☐ Safe place (a place where you feel calm and safe)
- ☐ Other:

3. CLEARING AFFECTIVE CIRCUITS (to ensure emotional system is free to work and transmit info) DATE:

Having resourced client (in 1 above) and set up a titration procedure (2 above), Instruct client that we are making sure their dashboard wires are hooked up, that we aren't working on their feelings about anything, but just checking to make sure the wires work. What does (name emotion) look like?

- ☐ Shame (Learned social circuit)

BASIC CIRCUITS (Subcortical, hardwired, not learned)

- ☐ FEAR (concern to terror)
- ☐ RAGE (irritation to rage)
- ☐ PANIC/SAD (you may wish to do this as two, first panic when can't get help then sadness at not getting help)
- ☐ SEEKing (curiosity, initiation, motivation)
- ☐ PLAY
- ☐ CARE (nurturance, caretaking, love)
- ☐ LUST (desire)

OTHER EMOTIONS TO CONSIDER "REBOOTING"

- ☐If needed, additional protective/life preserving emotions: such as hurt, betrayal, abandonment, self-pity
- ☐ If needed, additional life enhancing (such as happiness, joy, pleasure, connectedness)
- ☐Other such as: pain, disgust, hunger, touch, as needed
- ☐ If client can't do above without felt sense of emotion, target safety systems first Alarm/Fight/Flight/Freeze

4. EARLY PROCESSING (to clear early trauma by time frame in fractionated dosages) DATE:

To "clear the desktop", start every session saying, **"Let every thing that still needs to be reviewed go into your** (container cue word) **and say to yourself** (resource cue word or phrase)." Pause, and when they are ready, say:**"Now let's take out anything that needs to be reviewed during**(targeted time frame)" and add BLS. If you know there were early traumas, break the time frames into smaller fractions, e.g. half a year, months or even the next important experience to titrate the intensity.

- ☐ Pre-Conception & Conception
- ☐ Gestation Trimesters
- ☐Birth itself:
- ☐First year:
- ☐Second year:
- ☐Third year:

CAPTURED NCs/PCs:

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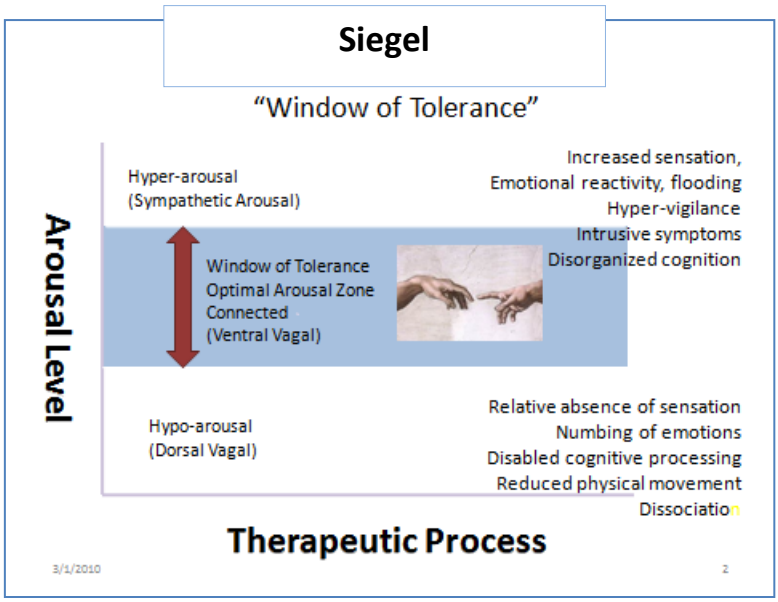
INTRODUCTION TO STEP 1 - CONTAINMENT



- Siegel (1999), Ogden & Minton, Bessel van der Kolk and others have described a "window of tolerance" as where therapeutic change occurs.
- At high levels of arousal, there is overwhelm and flooding. At very low levels of arousal, numbing and dissociation occur.
- Change and healing only happens in the optimal window of arousal.
- Hard for people to maintain dual attention awareness if in a baby's terror state, they get confused about what's happening when.
- With trauma in explicit memory (image of fiery car crash) it's easy to know one is in a flashback. But with baby states there are no images or thoughts, just a felt sense of terror, or abandonment, hurt, or shame. They may think it is about you, and now.
- We utlize the brain's innate capacity to compartmentalize and set aside all except the piece being worked on.
- The emphasis in the hypnosis tradition is on "pacing" and "fractionating" the work (e.g., Kluft).
- They'll use this capacity to set material aside between sessions, to prevent overwhelm during sessions, and in general in life to increase affect regulation ability.

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STEP 1 –FRACTIONATE WORK USING A CONTAINER METHOD

SAMPLE SCRIPT

""We know there is a lot of material that needs to be reviewed, so we need to have a way to set it aside until we can take it out a piece at a time and review it. Our right hemisphere stores experiences, knowledge and information until we can give them our full attention and learn all that we need to learn. We can help our right hemisphere set things aside when we're not working on them, by having an mage of a place or container to put them in. What comes to mind as a place where whatever you still need to review can be stored until you can give it your full attention? It can be an image in your mind, or you can leave it with me in my container." (pause and when they are ready, say)***"Now, just focus on the (container), and let whatever still needs to be reviewed go into the container in whatever form it takes. Tell me when it is all in, or if you are having trouble."***

(pause until they indicate it is all in their container) "I'd like you to begin practicing using your container between now and the next appointment, and you'll get better and better at using it. If the container changes or develops, that's fine."

Additional Notes:
1: Container should not be one they see frequently in day to day life, or it may be triggering, because the material is so ready to be cleared.
2: Container should have a lock or lid or a method to keep material inside it.
3: Ego states should NOT be placed in a container, but may be "tucked in" in a nurturing fashion, e.g. Paulsen(2004).

TYPICAL PROBLEM	SAMPLE SOLUTION
If client can't think of anything, problem may be performance anxiety or trying	***"Trying is the biggest problem, just think of needing to have a place and see what comes to mind"(or in conference room or on internal TV screen). Or,*** ***"It's like watching the Containment Channel on television. You don't have to do anything, just watch, as your brain knows how to do it, so we just let it do what it knows how to do."***
If client says it won't go in the container	***"Are you TRYING to make it go in, or just looking at it, easily and effortlessly, to see what happens" or,*** ***"Ask yourself what's the danger of just letting it go in"*** ***"Ask yourself what's keeping it from going in"***
If most material is in container but some pieces are still out	***"Ask yourself what's keeping these pieces from going in?"***
If it doesn't feel safe to set troubling material aside	***"Everything you need is always available. What's being set aside is only what hasn't yet been reviewed. You've already learned a lot from your experiences and anything you need is always available."***
If there is an urgency about the material	***"Something in your system is ready to be reprocessed, so you are REALLY ready to review it. It is important for us to pace the work so you stay comfortable. Together we can decide when is the best time to target it, now, next session or later."***
FOR HIGHER LEVELS OF DISSOCATION	(Note: We never put ego states in a container, but rather "tuck them in" in a nurturing fashion, until the time is right. See Paulsen, 2009***.***

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INTRODUCTION TO STEP 2 – SAFE STATE/RESOURCED STATE

POLYVAGAL THEORY - UNDERSTANDING THE PATH TO SAFETY

The Polyvagal Theory is a theory of three nervous systems, one sympathetic, and two parasympathetic and was developed by Stephen Porges (2001). The addition of the social engagement parasympathetic system, offers a new perspective and approach to modifying behavior. According to this theory, it is possible to intervene in compromised social behavior and modulate the autonomic state by engaging the nervous system planfully. According to Stephen Porges "the *perception* of safety is the primary requirement for our intervention."

Three Brain Systems

1. **Immobilization System** – *Dorsal Vagal Shutdown***.** When activated, the environment is perceived as immediately life threatening, with no way out except to freeze. In this oldest and unmyelineated neurological system, the organism goes into a feigned death response, radically slowing the respiratory, digestive and cardiac systems. The only pathway out of dorsal vagal shutdown is through sympathetic arousal, the fight or flight response.

2. **The Fight or Flight System.** - *Sympathetic System.* When an organism is in the state of sympathetic arousal, the environment is perceived as dangerous. The sympathetic nervous system mobilizes for defensive response by increasing metabolic activity to achieve super-ordinary performance. At times of threat, the sympathetic system produces adrenaline and cortisol to increase cardiac output and facilitate the ability to fight off an aggressor or to flee a dangerous situation. If arousal is thwarted the unresolved energetic charge is held frozen in the body, and may be compartmentalized into a range of symptoms. When this state is activated as an organism is coming out of immobilization through sympathetic arousal, there can be high levels of disturbance.

3. **Social Engagement System.**-*Ventral Vagal System.* An organism in this state perceives the environment as safe. The Social Engagement System, a myelinated system, is the newest system. It likely came into being to provide for the attachment and nurturance requirements of the long infancy and childhood of the human. Through attachment and engagement, social relationships are established that provide for safety, for communicating distress in relationship with others, and provide learning opportunities through reinforcement. With social engagement, oxytocin (OT) is released to foster calm and connection. For example, the infant engages caretaker through facial expression and vocalization to create safety and bonding. It is theorized that successful psychotherapy typical involves the mutual engagement of the ventral vagal systems of both client and therapist. Moreover, early trauma processing to remediate attachment injuries necessitates the planful evocation of ventral vagal states in oscillation with traumatic states, whether dorsal vagal or sympathetic arousal.

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STEP 2 – STRENGTHEN A RESOURCED STATE

SAMPLE SCRIPT

For Safe State (one type of resourced state):

"Sometimes we may stay on guard even when we are actually safe. Our amygdala is on duty 24/7, asleep or awake, scanning every aspect of our environment, internal and external, with the ability to respond in half a millisecond, so we don't need to be consciously vigilant. That's exhausting and makes us less able to respond to danger when we need to. So, would it be okay to FEEL safe when you ARE safe, when nothing bad is happening? In order to feel safe when we are safe, we need to be sure that everything that still needs to be reviewed/sorted through is in our container. Just focus on the image of your (container cue word) ***and let anything that needs to be set aside go in.*** (When they confirm, continue). ***Your body already knows what to do, so let's rely on it ….and just notice, easily and effortlessly… with curiosity… how your body feels. I'll add some right/left stimulation to accelerate the process and we'll just see what happens. Is it okay if I tap your knees?"..."Just notice."***

Continue BLS, checking in periodically, until they reach a state of relaxed awareness, our natural state when no danger is present. Say, ***"As you focus on what you're feeling now, what word or words come to mind? I want you to have a way to quickly call back this feeling, so hold that word (or words) in mind while you focus on the feeling, and I'll add BLS."*** Tap for about 30 seconds, then ask, ***"Did those words stay or change?"*** If it stayed, ask them to practice it in order to get in the habit of feeling safe when they are safe. If it changed, add BLS until it appears to be set.

Note: May also use instead: safe place or other highly resourced state. We want them in a ventral vagal state so that 1) they feel strong enough to withstand any disturbance that arises in subsequent steps and 2) so that they have a relatively clear backdrop against which to notice any disturbance that arises in subsequent steps.

"It takes about 2 weeks of practice for your system to get out of the habit of being in an on-going distressed and fragmented mode and into a healthy, natural, relaxed, aware mode. You'll respond very rapidly if there is danger present. Your amygdala is on duty 24/7 like a fire alarm, so we don't need to be vigilant". Instruct them to **Contain and Resource: b**efore sleep, upon awakening, and when they change activities**.**

PROBLEM	**SOLUTION**
Emotional distress comes up	***"Let that go in*** *(container)* ***for now. We'll come back to it.***
Disturbance comes back repeatedly	***"There is something that you are really ready to review, let's decide together whether to target it today or next week, or later."*** Use clinical judgment to determine whether it's a readiness to proceed or a dissociative incapacity to distance from felt sense
If the client speaks of never relaxing, always being on alert:	***"That's exhausting and makes us less able to respond to danger when we need to. So, would it be okay to FEEL safe when you ARE safe, when nothing bad is happening? In order to feel safe when we are safe, we need to be sure that everything that still needs to be reviewed or sorted through is in our container. "***
Client continues to be unable to experience a good, comfortable, or safe feeling	May have overlooked a dissociative disorder; use an ego state approach. CAUTION: Do not use this procedure with a highly dissociative client unless you are trained and experienced with treating dissociative disorders.
Client says, "It's stupid to ever feel safe" etc	Do extensive education on amygdala and safety systems of fight, flight, freeze. Consider using animal examples. Spend considerable time on animals states of social connection, caring, other ventral vagal states, then human states of safe connection.

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INTRODUCTION TO STEP 3 – RESETTING THE AFFECTIVE CIRCUITS

BASIC AFFECTIVE CIRCUITS – THE HARDWARE FOR TRANSMITTING EMOTIONS AS INFORMATION

Reviewing scientific evidence from affective neurobiology, Panksepp (1998) described a very few basic emotionswhich are hardwired in the brain in affective circuits. These are anger/rage, fear/terror, sadness/panic, seeking/motivation and social circuits. There may be other circuits for which evidence is not currently available. Affective neurobiology underlies the functioning of the human organism, and the dysregulation of affect is an essential and underlying factor in many clinical conditions, including those associated with trauma and attachment.

The following descriptions of some of the basic emotional circuits are from Panksepp (1998), who capitalizes the names of his systems to signify that he is referring not only to an emotion, but an affective brain circuit. Shame is not a subcortical circuit, but learned, per Panksepp. Paulsen and O'Shea hypothesize that excessive shame, a crucial aspect of trauma based syndromes and other emotional disorders, Needs to be cleared with the basic circuits. Shame is a basic underlying emotion in many clinical syndromes (e.g., Nathanson, 1992; Tomkins, 1995) and is implicated in disorders related to impaired attachment (Schore, 2001).

The SEEKING System. *"This system makes animals intensely interested in exploring their world and leads them to become excited when they are about to get what they desire. It eventually allows animals to find and eagerly anticipate things they need for survival, including of course, food, water, warmth, and their ultimate evolutionary survival need, sex. In other words, when fully aroused, it helps fill the mind with interest and motivates organisms to move their bodies effortlessly in search of the things they need, crave, and desire. In humans, this may be one of the main brain systems that generate and sustain curiosity, even for intellectual pursuits. When this brain system becomes underactive, as is common with aging, a form of depression results. When the system becomes spontaneously overactive, which can happen as a result of various kinds of stress, an animal's behavior becomes excessive and schizophrenic or manic symptoms may follow." "Neuro-anatomically, the seeking system corresponds to the major self-stimulation system that courses from the midbrain up to the cortex, which has long been misconceptualized as a 'reward or reinforcement system'. In fact, it appears to be a general purpose neuronal system that helps coax animals and humans to move energetically from where they are presently situated to the places where they can find and consume the fruits of this world. A very important chemical in this system is dopamine. These dopamine circuits tend to energize and coordinate the functions of many higher brain areas that mediate planning and foresight and promote states of eagerness and directed purpose in both humans and animals."*

The FEAR System. ***"****A FEAR circuit was probably designed during evolution to help animals reduce pain and the possibility of destruction. When stimulated intensely, the circuit leads animals to run away as if they are extremely scared. With very weak stimulation, animals exhibit just the opposite motor tendency---a freezing response, common when animals are placed in circumstances where they have previously been hurt or frightened. Humans stimulated in these same brain areas report being engulfed by intense anxiety."*

The RAGE System. ***"****Working in opposition to SEEKING is a system that mediates anger. RAGE is aroused by frustration and attempts to curtail an animal's freedom of action. It has long been known that one can enrage both animals and humans by stimulating very specific parts of the brain, which parallel the trajectory of the FEAR system. This system not only helps animals defend themselves by arousing fear in their opponents but also energizes behavior when an animal is irritated or restrained. Human anger may get much of its psychic energy from this brain system."*

The PANIC System.

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"*To be a mammal is to be born socially dependent. Brain evolution has provided safeguards to assure that parents (usually the mother) take care of the offspring and the offspring have powerful emotional systems to indicate they are in need of care (as reflected in crying, or, as scientists prefer to say, separation calls). The nature of these distress systems in the brains of caretakers and those they care for has only recently been clarified; they provide a neural substrate for understanding many other social emotional processes."*

Special-Purpose Socio-emotional Systems. ***"****In addition to the preceding primitive systems that are evident in all mammals soon after birth, we also have more sophisticated special-purpose socio-emotional systems that are engaged at appropriate times in the lives of all mammals---for instance, those that mediate sexual LUST, maternal CARE, and roughhousing PLAY. Each of these is built around neural complexities that are only provisionally understood. Sexual urges are mediated by specific brain circuits and chemistries that are quite distinct for males and females but appear to share some components such as the physiological and psychological effects of oxytocin, which also promotes maternal motivation. We now realize that maternal behavior circuits remain closely intermeshed with those that control sexuality, and this suggests how evolution gradually constructed the basic neural substrates for the social contract (i.e., the possibilities for love and bonding) in the mammalian brain."*

See Panksepp also on the PLAY, CARE and LUST circuits.

ADDITIONAL PRINCIPLES BEHIND STEP 3

When Attachment goes Wrong, the Circuits Can't Flow. The circuits Panksepppp described are there to function like dashboard indicators on a car. These subcortical affective circuits include: seeking, sad/panic, fear, rage, lust, play, and care. But very early in life, that function can be thwarted by experience that tells the child it isn't safe to have emotions. If the milestones of intersubjectivity and mirroring and secure attachment fail, the child may need to "clip" his/her dashboard wires of these circuits. On the secondary process level, this manifests in early learning about relationship templates (Schore, 2009) and object relations (Panksepp, 1998).

When Emotions Can't Flow, Trauma Piles Up. If the child cannot have normal integrative attachment experience to learn affect regulation, there is no integration of the circuits on a horizontal level of the brain. Rather, early learning begins to "pile up" like so much trash thrown over a wall, in a columnar fashion Eventually these become established as ego-invested dissociated states, or in extreme cases, alter personality (Lanius & Paulsen, in press)..

If the Self Can't Develop, Defenses Stop Embodiment. If the child cannot safely develop a self through normal attachment processes, and if the caretaker requires his/her own needs to take precedence over the child's, then the child will introject the caretaker, seeing him/herself through that caretaker's eyes. This serves an adaptive function of insuring that the child's survival chances are maximized through alliance with the requirements of the environment, however malignant they may be to the normal developmental needs of a child. To accomplish this survival task, the child may need to truncate sensory, affective, cognitive and behavioral information. With that information truncates, the child cannot have a felt sense of living in her/his own body, or "embodiment" (Lanius & Paulsen, in press)

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EGO STATE THEORY – ADDING ENERGY TO DISPARATE NEURAL NETWORKS

Paul Federn (1952) observed ego states operating in his patients and thereby expanded psychoanalytic theory. He considered the patient's habitual addition or subtraction of ego and/or object energy to ego states as underlying trauma related psychopathology. J.G. Watkins in the 1970's (Watkins & Watkins, 1997) applied Federn's theory in the development of a specific therapeutic approach. Ego state therapy involves adding or subtracting ego energy therapeutically in order to give a voice to dissociated or disowned aspects of self (Paulsen & Watkins, 2004). Early in the history of EMDR, Paulsen (1992, 1995) combined EMDR and ego state therapy in order to resolve blocked EMDR processing and other resistance. Subsequently, she described1) a phased approach using the acronym ACT-AS-IF to using ego state therapy and EMDR in the treatment of complex trauma cases (Paulsen, 2009a, 2009b, 2007), and 2) a stepwise method using the acronym "ARCHITECTS" for using EMDR with dissociative clients (Paulsen, 2009a, 2009b, 2007).

Together these methods help to: enhance stabilization and containment, increase affect tolerance and affect regulation, disarm ego state based resistances (Paulsen, 1995),mobilize ego resources to increase client processing capacity (Paulsen, 2004), mobilize object energy to increase patient compassion for self (Paulsen, 2007). Paulsen asserts that ego state therapy enables the EMDR therapist to variously increase or decrease the level of activation of a traumatic, defensive, or other neural network. This serves to help maintain an optimal level of arousal during therapy and during EMDR processing, and to decrease the probability of flooding or numbing in cases of complex trauma. Titrating affect with ego state therapy is a key means to fractionate the volume of material (Paulsen, 2007) during the resolution of trauma.

Important application of these principles: in step 3 of the ET protocol, we deliberate add object awareness and withhold ego awareness in order to flush out the affective circuits without an affective load on them.

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STEP 3 – RESETTING THE BASIC AFFECTIVE CIRCUITS

SAMPLE SCRIPT

"Before we begin reviewing your early experiences, we need to make sure your emotions are working the way they were intended to work – as sources of important information to help us learn what's dangerous, what's unfair, what's connected, and more. They are there at the beginning of our lives. If you watch a newborn baby, – no one has to teach them how to feel. Many people have been taught to ignore feelings, and may even have learned that it's not OK to feel some feelings, so they disconnect from their feelings. That's like clipping the dash board wires in our car, just because we get uncomfortable when we see a red light that says the engine is overheating! When that happens there is often shame present about having other emotions"

For individuals who need basic education about the role of common emotions as information, give or read to them the Client Handout about emotions. Ensure sufficient education about the function of emotions before proceeding with the following. Some can proceed directly, and some need much education, especially re: shame.

"First, let everything unresolved in your system go into your (container) and remind yourself it's ok to feel safe when you are safe, with your *(cue word from Step 2 – Resource state)*(Pause long enough for them to do that)**.** ***"With your permission, I'll provide bilateral stimulation by tapping on your knees (or ankles), and you can close your eyes if you want and notice the pictures that come. We'll take one emotion at a time, and all you need to do is notice what the feeling looks like, and watch with curiosity, to see if the picture is changing or staying the same. When the picture stops changing, that means the emotion will be ready whenever you need it, and not when you don't need it. We'll clear the protective emotions first, because they need to be working well before we can fully experience the regenerating, life enhancing emotions. Let's begin with 'shame.' What does 'shame' look like? "***(They report what they see) ***"Notice that" and "What does shame look like now?"*** It's okay if it transforms, is symbolic, a story, or shows a thwarted response. Do tapping sets until the picture stops changing. It may become positive, neutral, or just stop changing. Repeat for each emotion in the sequence:

Some may benefit from resetting learned emotions or the safety circuits themselves. If high levels of dissociation are present, use a formal ego state approach (i.e., Paulsen 2009). DO NOT use this procedure with highly dissociative clients unless you are trained and experienced in treating dissociative disorders.

PROBLEM	SOLUTION
The client sees no image.	***Usually is trying, remind them to just allow an image to be there*** ***Just notice while I read what this emotion does, and tell me when an image comes to mind***
The image doesn't stop changing or become neutral.	Go to the next emotion, and come back to this one later. Go through them as many times as necessary, until the essence becomes neutral and stops changing, developing.
They have made many connections	Periodically bring them back to an image, saying, ***"what does __ look like now?"*** and continue until it stops changing,.
They can't observe from a distance and slide into the felt sense	Teach the difference between being in an emotion and looking at an emotion. If needed, use a "prosthesis" like a cartoon of an emotion. If they still slide in after two tries, they may need to reset safety systems and amygdala first. *"What does fight look like"* and *"flight"* and *"freeze."*
If they still can't observe an emotion from a distance instead of feeling it	They may need more work using ego state therapy or somatic resourcing before they can do this step

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BENEFITS & SUMMARY OF THE THREE PREPARATION STEPS

- Provides an active, user friendly psycho-education about normal emotional functions.
- Reduces fear of emotions so abreactions later are rare.
- Past unresolved trauma is easier to set aside.
- Improved affect regulation and higher functioning becomes possible.
- Trauma processing goes better than standard EMDR because they tolerate the affect better.
- Can take two weeks to two years (for very complex cases – don't use for DID at this time please).
- May need to practice steps 1 and 2 for some weeks.
- Step 3 is typically done once unless something has been overlooked or omitted.
- We focused here on those few skills most efficient and systematic, most time efficient for most clients.
- Implicit is that the clinician directs the client's focal attention in a sequence, with a mindfulness stance.
- If a client can't do these steps it is a red flag for slowing down and needing more preparation
- By end of preparation steps, most will have skilled capacity for: containment/compartmentalization that is deliberate and conscious, accessing a resourced and ventral vagal state or "safe state;" and the innate affective circuitry will be clear, ready to utilize in processing without defensive resistance for many.
- For some very complex cases, preparation will include substantially more work, including tolerating somatic sensation, ego state preparation, lengthy establishing of trust and rapport.

INTRODUCTION TO STEP 4 – CLEARING EARLY TRAUMA BY TIME FRAME

Neuro-Developmental Building Blocks:

- **Gestation counts as experience, exposure:** Maternal affective experience including gestation affects neural development (Schore, 2003);
- **Secondary Processing (Panksepp, 1998) is our early focus.** Amygdala and other basal ganglia is the locus for the relationship templates and object relations learning that may have interfered with ability to utilize emotions naturally, especially when shame is involved, when child learns s/he doesn't get to have emotions, only the caretaker does.

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STEP 4 – PROCESS EARLY TRAUMA BY TIME FRAME

SAMPLE SCRIPT

"Now we'll review the time" (name an appropriately sized time period, e.g., 'second trimester,' 'your birth,' '12 to 15 months," to be sure that any trapped energy is released and conflicting information is cleared up. All you need to do is notice what happens, just like you're viewing a video." The following shows the natural sequence of processing that occurs for many people. It is included below to help the clinician be aware of phase completeness, and adaptive resolution. Incompleteness at one phase will result in inability to clear the next phase.

Contain & Resource

- ***First, let everything that still needs to be reviewed, go into your (container)*** and say (resource cue word*) to return to feeling relaxed and ready (***or ***"to help your amygdala").*** *(*Pause until they accomplish that.

Review

- ***"Now, just let your focus go to the time ('before you were born' or 'of your birth' or 'from (age) to (age), while I tap, to see if there's anything left that needs to be reviewed, released or repaired.*** We don't emphasize verbalization, which may interfere with the felt sense of subtle shifts associated with right hemisphere processing."

Release

- If emotions loop, say, **"imagine what you need or need to do."** If physical sensations loop, say, ***"Imagine it (physical sensation) happening."***

Relearn & Repair

- If the following doesn't happen spontaneously, say, ***"Imagine getting everything you needed",*** or ***"Imagine your parents being /doing what they couldn't be/do back then,"*** or ***"imagine everything being the way you needed it to be."***

Install

- ***"Is there a positive statement (thought) that comes to mind when you focus on the*** *(time* frame). If so, install that and say ***"I'm also going to add some thoughts that came to me, so let whatever feels OK stick and whatever doesn't, just slide off."*** Complete Standard Installation.

Body Scan & Close

- If session is complete, ***"Hold the thought(s) with the (time frame),"*** tap until they are in a resourced state. Whether complete or not, say ***"Let everything else that still needs to be reviewed, go into*** *(container),* **and say** *(resource cue word).* ***We'll continue at our next session"***

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MECHANICAL TIPS
TAPS VS OTHER BILATERAL STIMULATION
Rationale: Early experiences are stored in the body. Experience indicates that choosing the form of BLS that matches the way the information is stored, works best. Tapping the knees or ankles allows the client to relax their body. Having to hold their hands in a position so they can be tapped, requires tension. Taps can be very light. A wand may be used if the client is uncomfortable with the therapist touching them. A heartbeat cadence seems useful for prenatal and birth time periods.
RECLINER
Body awareness is enhanced by allowing the client to lean back. Not needing to hold a position, even holding the head erect, facilitates awareness of sensations as wells as relaxation (during Safe State and pre and peri-natal time periods). Having the feet up makes it easier to tap the knees or ankles with less intrusion. You can sit quite close to the client without it feeling too close.
PHYSICAL PRESENCE
Physical touch allows the client to actually feel the presence of the clinician, which seems necessary for reprocessing early trauma and may positively impact the ventral vagal system. At the same time, one must be aware of one's state licensing board and scope of practice issues regarding physical touch, as well as client preferences and comfort with physical touch. If legally or ethically unwise to physically touch, the client may tap him or herself.
EYES OPEN OR CLOSED
Either is fine. If the client is ready to do this work, they are less likely to dissociate. For some clients, the physical touch (tapping) seems to facilitate a greater sense of safety.
SELF -CARE
A chair that has wheels and arm rests allows the clinician to vary positions in order to prevent damage caused by repetitive motions. Tapping from the shoulders rather than the wrist or elbow is better, varying the movement is beneficial.
SESSION LENGTH
Because processing of early trauma rarely occurs on its own, for many individuals, having time between sessions for residual processing does not appear to be beneficial. For many individuals, the optimal session length is about three hours. That length allows time for clients to feel sufficient safety to open up these early experiences. Three to six hours a day, two to three days in a row has been useful with many clients. Where there was early trauma, hence complex PTSD, we need to consider more frequent and possibly longer sessions, which would be cost effective over time. Note that for dissociative individuals, very long sessions can be destabilizing and are not recommended. Remember not to use these procedures on highly dissociative clients without being trained and experienced in the treatment of severe dissociative disorders.

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<table>
<tr><th colspan="2">EARLY PROCESSING – PROCEDURE FOR INFANTS, TODDLERS, CHILDREN</th></tr>
<tr><td colspan="2">

Can also use for teens and adults if there is someone else available who knows what happened to them.
The procedure is an adaptation of Joan Lovett's Story Telling Method.
Pictures and props may enhance the work if they are available, but aren't generally necessary.
Adapt the language and length to the age of the client.
Tell the story by time periods manageable size pieces, such as: before birth, birth, birth to 3 (the more trauma and neglect there is, the smaller the time periods should be for each fraction of time).

</td></tr>
<tr><td>DESENSITIZATION</td><td>REVIEW-RELEASE</td></tr>
<tr><td rowspan="3"></td><td>When possible, have caretaker:

1. Read or tell the story of what happened, including behaviors and feelings of others, who was responsible for what, acknowledging what could and couldn't be done at the time. Start before the time or incident when things were OK. Pause story if distress is apparent and keep tapping until all indications of distress are released, then continue story. Reread or retell the story until no distress is apparent.

2. Have client review story on their own. Say something like:

"Let's see if there is anything that still needs to be remembered in your mind or body. I'll add taps to help you learn from it, so you won't need to feel bad anymore."</td></tr>
<tr><td>RELEARN/REPAIR</td></tr>
<tr><td>3. Tell what would have happened if things had been the way they <u>needed</u> to be.

4. Then say something like:

"Let's be sure you got everything you needed. I'll tap while you see if there's anything else you needed. See if any pictures come into your mind or your body feels anything."

5. Add BLS, then check in. Go back as many times as necessary until nothing new emerges. Of course, the younger the child, the briefer the instruction, but allow <u>focus time</u> even for infants.</td></tr>
<tr><td>INSTALLATION/SCAN</td><td></td></tr>
<tr><td></td><td>6. Combine positive statements about the child with BLS (what they needed to hear then).

7. Ask the child to think about what really happened and see if there are any "yucky" (or other child-friendly term) feelings left anywhere in their body.

8. Add BLS until it clears or indicates that there is associated material that still needs to be targeted.</td></tr>
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EARLY PROCESSING – PROCEDURE FOR TEENS & ADULTS	
• Use knee or ankle taps is possible. • Length of sets varies widely. • Monitor their physiology. • Have them tell you when things stop changing during Imaginative Interweaves.	
DESENSITIZATION	**REVIEW**
	1. Focus on the experience (if you know what happened) or time period (this is best because there may be things you don't know about) and add BLS. ***2.*** Focus on whatever amount of time is manageable, e.g., ***"the time before you were born/the first month of your mom's pregnancy/your first distressing experience/the worst thing that happened."*** *3.* The greater the amount of trauma, including neglect, or intensity of symptoms, the small the bits of time need to be. Be sure that **responsibility** is appropriately assigned in this phase.
	RELEASE
	4. If distress (physical or emotional) occurs and does not release spontaneously, use an Imaginative Interweave, by saying, **"*Imagine what you need(ed) or need(ed) to do."* ****** 5. This allows them to fight, flee, obtain protection, or whatever their needs are or were in order to achieve a sense of **safety**. Go back over each time period until there is no distress, emotional or physical, remaining.
	RELEARN/REPAIR
	6. If repair doesn't spontaneously occur, use an Imaginative Interweave by saying, ***"Imagine what would have happened if everything could have been the way you needed it to be."*** Or ***"Imagine getting all you needed."*** 7. It is **CRITICAL** to go back as many times as necessary until a) there are no more changes, and b) they have imagined getting all that a child need by those who should have provided it, not an adult part of themselves. If they aren't able to imagine all that a child needs, provide video or pictures of what that would look like, then redo the Repair/Relearn focus at the next session. This provides actual **choices** for the future.
INSTALLATION & BODY SCAN	
	8. Complete after each time period, adding your own pc's when indicated. 9. If there was no trauma during a time period, a Resource Installation is likely to spontaneously emerge.

*For some individuals, interweaves may include: experiential (holding tiny shoes a la Deb Wesselman), ego state (would whoever has a concern come into the mind's eye at this time?, or orientational (are you remembering that Mom's dead now, and its 2010, and you are 5'7" tall?)

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PROBLEM SOLVING FOR STEP 4 – CLEARING EARLY TRAUMA	
TYPICAL PROBLEM	**SAMPLE SOLUTION**
They don't think they can recall anything from before a certain age.	*Explain that most people don't have conscious memory before about age 3, but that we seem to have the ability to remember more than we think we do. What we learned early we learned so well that we don't realize it, and it is now automatic. Our brain works a lot like the internet and we just need to "Google" it (give it our attention) and our brain also will help us check on what still needs to be reviewed, or find the information that's in conflict with what we know now.*
Client doesn't get anything.	*They are probably trying. Suggest they* ***"just notice how your body feels."*** *Let them know it usually takes people a while to get used to not trying.* *Or, say,* ***"what's dangerous about reviewing this?"*** *Depending on what they say, decide whether to re-explain the process or add more safety measures.*
They get overwhelmed with distress, and If it is memory from the time you focused on that is overwhelming them: If it is memory from a later time that is overwhelming them:	*If saying* ***"Imagine what you need or need or need to do" doesn't work, consider:*** *Break the time period into small increments.* *Have the client consciously set it aside for later reprocessing, using their container.* *Remind them that the overwhelm is part of the baby's story, it actually isn't about the PRESENT MOMENT. (Felt Flashback)*
If you are trained and experienced in treating dissociative disorders and this client is dissociative, and if the client switches to another ego state before you can finish the reprocessing:	*Be sure you have cooperation of their system and have developed a treatment plan based on their degree and type of dissociation,* *Go back to earlier time frame to ensure earliest trauma is resolved, so the system can come together at the base of experience to work on these experiences without overwhelm. Do not continue to use this procedure if it causes destabilization for any dissociative client.*
IF THERE IS SIGNIFICANT KNOWN EARLY TRAUMA	*For teens and adults, fractionate the information by time and severity. Depending on the amount of trauma, you may need to break the time period down into months, weeks or "moving forward to the next trauma" within the time period. Use knee taps if possible (with a heartbeat cadence for before birth and birth), monitoring their physiology and supporting them in just noticing whatever they notice. Set length often varies greatly.*
KEY CAUTION	*DO NOT ATTEMPT TO TREAT A HIGHLY DISSOCIATIVE (DISSOCIATIVE IDENTITY DISORDERED) CLIENT WITH THIS PROTOCOL UNLESS YOU ARE TRAINED AND EXPERIENCED IN THE TREATMENT OF DISSOCIATIVE DISORDERS. THE PROCEDURE IS DIFFERENT FOR DISSOCIATIVE CLIENTS, REQUIRING MORE EXTENSIVE PREPARATION AND EGO STATE WORK. IGNORING THIS CAUTION COULD RESULT IN HARM TO YOUR CLIENT IF FLOODING OCCURS OR DISSOCIATIVE BARRIERS ARE PREMATURELY TAKEN DOWN, OR IF KEY EGO STATES ARE NOT ON BOARD WITH THE WORK.*

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TYPICAL AND NOTABLE ADULT RESPONSES TO EARLY PROCESSING	
PHYSICAL SENSATIONS	*The following are the most likely and most common experiences. In fact, Dr. Shapiro calls this the "Somatic Protocol". It's vital that they "just notice" what the feeling is, and don't try to do anything to stop it. It seems necessary for our system to do whatever worked at the time of the trauma, in order to realize that other responses are available now.*
Nausea	*Nausea sometimes occurs during prenatal processing – have an airplane bag handy though it may rarely be used*
Spinning	*Spinning sensations have occurred. O'Shea hypothesizes they may be associated with the blastocyst stage.*
Pain/discomfort	*Pain and discomfort frequently occur, but typically dissipate when the client merely notices them.*
Difficulty breathing	*Difficulty breathing is particularly associated with birth processing. If they stop breathing, reassure them that they will breathe spontaneously as soon as they are ready.*
Ear pain	*Ear pain often occurs. O'Shea hypothesizes that there may be some relationship to early ear infections.*
Falling asleep	*Falling asleep is quite common, and it is hypothesized that it may be associated with mother's drug use (prescriptive or not) or as the only way a prenate/infant can escape an inescapable situation. Let them know you will simply continue tapping until their system moves through whatever it is.* *Clients typically awaken quickly rather than gradually. Range: 5 minutes to 3-1 hour sessions (20 min; 40 min; 5 min) which was a 16 year old boy whose Mom had used drugs throughout his pregnancy; major behavior changes were reported by the Dad between these sessions. Most typical duration: 15-20 min*
VISUAL IMAGES	*Because information is primarily stored physically before age 3, images may be absent.*
Blank Images	*If the image is described as **"blank"** when you are focusing on the prenatal time period, don't assume there's nothing there, or that they aren't focused. Remember, it was pretty dark in the womb and the "blank" might also be "black". It's typical for people to mistrust their perceptions as they usually don't have experience with being able to access anything from this early time.*
Vivid Images	*Surprisingly vivid memories also occur. Clients tend to feel the images are valid if there is congruence with emotions, sensations, or other experiences or if validated by caretakers.*
Symbolic Processing	*Imagery may initially be symbolic, but will typically move to an experiential level (emotional distress) in order for experiences to be fully reprocessed.*
ASSIGNMENT OF RESPONSIBILITY	*Typically occurs during Review Stage.* *It is not difficult for people to see that the parent/caretaker should be responsible for the infant's well-being, so responsibility interweaves are not usually necessary. If so, the Interweaves taught in Part 1 of EMDR training work. Awareness they did not have before, such as, "that was my Mom's fear, not mine", is common.*
INTENSE EMOTION	*Typically occurs during Release Stage and leads to a feeling of safety.* *Intense emotion is more atypical than typical. When there is intense emotion (usually from life threatening events), a symbolic level of processing often occurs first and seems to act as a preparation, so that when it does occur, it's not overwhelming and typically less than distress they've felt their entire lives.* *They have been trapped in the traumatic experience, so they may imaginatively see themselves run away, get bigger and fight back, or have someone come to protect them. If it's not an adult part of themselves, I usually just stay with the processing and let them come to an awareness that someone else should have protected them*

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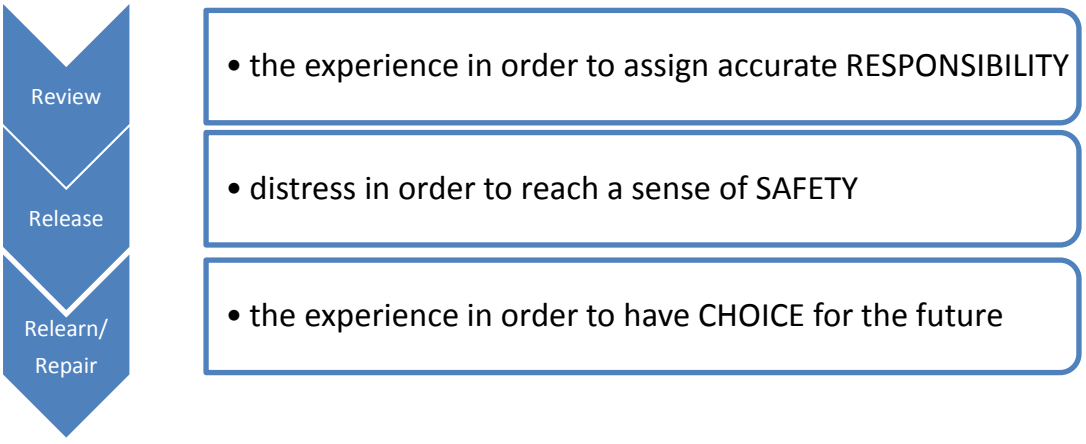
IMAGINAl RELEARNING	*Imaginative relearning helps them to have a felt sense of choices for the future.* *When they have completed the Review and Release stages, they will typically look back and imagine what they should have experienced during this early time. Imagining it gives them the behavioral capability to respond differently now and in the future. If it occurs spontaneously, their internal organization will have determined whether they are ready to group the experiences together e.g. pre- and peri-natal, or singly e.g. prenatal only. If it doesn't happen spontaneously, you'll need to stimulate this stage by saying, "Imagine what would have happened, if everything could have been the way it needed to be." Their life experiences create the way they need to be grouped, e.g. if there was a move at age one and significant change in the parent's functioning, the time after that will need to be imagined separately.* *Almost always, they can imagine their own parents changing the way they were treated, but I don't dictate who it should be. Sometimes they say,* ***"I have to go back and fix them first****." Just say,* ***"Imagine that".*** *Even when they are able to spontaneously imagine what should have happened, our culture has not typically provided all that little children needed, so you need to suggest they focus on that time again and* ***"see if there's anything else you needed"*** *until nothing more emerges.*
CONTINUED PROCESSING	*Often the processing will continue beyond the time period you are focused on, even up to the present or into the future. This is fine, as long as they do not get stuck or overwhelmed. It is an associative channel. When it Is complete, just go back to your target time period.*

NATURAL SEQUENCE OF LEARNING FROM TRAUMA – SHORT VERSION



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NATURAL SEQUENCE OF LEARNING FROM TRAUMA – LONG VERSION

WHAT HAPPENS AS EXPERIENCE PROGRESSES	EMOTIONS	NEG COGNITIONS & INTERWEAAVES
WAVE 1-TRAUMA/THREATENING EVENT OCCURS		
If it isn't safe to experience, we don't. May be threatening.	*ALARM*	
WAVE 2 - PROTECTIVE DISCONNECT		
Body remains on alert because not safe. Person doesn't assimilate and integrate experience, keeps it outside of themselves. Disowns the sensations, images, behaviors, affect, and/or meaning that are held in their raw unprocessed form. Doesn't process to adaptive resolution.	*NUMB, SHOCK, DISSOCIATION DISTRACTION*	"I can't believe it," "I couldn't cope if I believed it" "It couldn't happen" "It's not real" "That's not me"
WAVE 3 –REVIEW EXPERIENCE		
Only when safe to do so or more threatening not to (as in a therapeutic relationship or other safe state). Requires acceptance of inability (helplessness) to change our response or the situation plus validation from self and others. Experiences S-I-B-A-M (Sensation, Imagery, Behavior, Affect, Meaning). ***First shame release occurs when assign responsibility correctly.***	*HELPLESS GUILT/SHAME, PITY FOR SELF/ OTHER*	*"I'm helpless." "I'm (they're) going to die," "I can't help (X)," "I can't protect myself," "I'm bad," (X) is/are bad."*
WAVE 4 - RELEASE		
Escape, protection, fight flight. Survival circuits are activated. Imagination provides a safe way to escape/fight back/obtain needed protection, whatever was not possible or available at the time of the trauma. Trapped energy/emotion is released, which is necessary to escape from being trapped in the trauma and past, or may realize "I DID escape/survive.	*PANIC FEAR RAGE DISGUST*	*"I'm trapped," "I'm not safe," "I can't move" "I hate (X)," "I want to hurt" "Nobody will help me"* ***Imaginal Interweave: "Imagine what you needed or needed to do (to have a different outcome)"***
CREST OF THE HILL – NO LONGER TRAPPED-- HAS PERSECTIVE - & OBJECTIVITY		
Client releases a sense of safety, the trauma begins to be experienced in the past.	*RELIEF*	*"It's over," "It's in the past." "I'm safe now,"*
WAVE 5 - COMPASSION W PROTECTION		
Understanding expands. Beyond simple relaxation, there is sometimes a wave of spirituality or other sweeping and broader perspective, compassion for self and other(s). Some people call this forgiveness. Hebrew word for forgiveness means "moving on." ***Second release of shame comes with compassion***.	*COMPASSION CARE ACCEPTANCE*	*"They didn't know any better," "I can love you, hate what you did," "He/she/they didn't realize" "I deserve love/ protection" "I wonder what happened to them" "*
WAVE 6 - RELEARN/REPAIR		
Choices for the future. What can I do to protect self/others now/future, What should/could/would have happened if. Imagining it locks knowledge into behavior	*SEEKING CURIOUS SPARK OF INSIGHT*	*"I should/could/would have," (if x)* ***Imaginal Installation: Imagine getting what you needed, the way you needed it to be."***
Grief for what was lost, for what could have, should have been, awareness and appreciation of what was gained.	*GRIEF GRATITUDE*	
Integration with similar or related experiences, including present and future, often at high speed, with objectivity. **Third release of shame comes with objectivity**.	*WHOLENESS*	*"This IS me, this is my life."*
WAVE 7 - RETURN TO SAFETY		
Relaxed, aware state. Able to apply knowledge to better protect self and others in the present and future. Knowledge will be automatically	*EXCITEMENT*	*"It's over, I'm safe now."*

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HANDOUT FOR CLIENTS

Emotions are important sources of information that we need. They are like the dash-board gauges in our car, and are there to tell us when things are overheating, out of gas, and more. If we can't read those emotional gauges, we are missing important information. The following descriptions give an idea why emotions are there.

PROTECTIVE, LIFE-PRESERVING EMOTIONS
GUILT/SHAME
Healthy shame protects us from doing harm. The feeling tells us we've made a mistake. If we let ourselves feel the guilt, shame, or remorse, it will register in our system and we simply won't do what we did again. Instead, we'll correct the mistake (if we can). If we don't allow ourselves to feel it fully, we'll keep feeling bad, and we'll either continue to make the same mistake or over correct for it and make other mistakes. If we feel too much shame though, thinking "I'm bad" instead of "My behavior was bad", we'll either try to be too good or do things that prove we are bad, or use addictions to keep the bad feelings away. The words we use to describe the intensity of shameful feelings are: *Examples: regret, remorse, guilt, shame, humiliation*
SELF- PITY
When something harmful happens to us and we didn't do anything to make it happen, we need to feel sorry for ourselves. As soon as we let ourselves feel how much it hurt us, we'll get busy doing whatever we can to make things better. Even though people say, "Don't feel sorry for yourself," it really is necessary. If we don't, the feelings won't go away and we won't learn to protect ourselves and others from people and things that do harm. They'll just keep trying to let us know something hurt us and it wasn't fair. Remember, feelings only stay if we push them away. *Examples: sorry for yourself, self pity*
DISGUST
When something feels disgusting, we just want to spit it out and get away from it, like our body does if we eat something that's rotten or poisonous. We might say, "That's sick" or "He's sick". We feel like this when someone does something that's not OK, that seems kind of rotten, not anything we want to be around. This is a feeling we don't want to ignore. If we don't pay attention to it and keep hanging around someone or something that's disgusting, we'll become more like they are and people will start feeling that way around us. *Examples: disdain, disgust*

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FEAR

Fear protects us by letting us know danger is present and giving us the energy to respond in whatever way is best at the time, from freezing in place, to confronting the threat, to getting away (flight) as quickly as possible. Concern or worry push us to take whatever precautions are necessary to keep us safe in the future. Fear not only calls attention to immediate physical danger, but to anything that might hurt us emotionally, such as loss of an important relationship. Fearful feelings vary from concern to terror.

Examples: concern, worry, anxiety, fear terror

ANGER

We have anger to protect us from being harmed or hurt. It allows us to fight back when we need to defend ourselves (or others) from threat to our well-being, or to fight for something that's important to us. Once we've felt angry feelings and released the energy physically, verbally, or safely in our imaginations, we don't feel angry anymore. We just take firm action if that's possible. If nothing can be done, we accept it, instead of gritting our teeth and trying to tolerate the problem. Anger below a five rejects behavior; above five though, the person we're angry at feels rejected and can't look at their behavior, so we need to first imagine releasing it unless verbal or physical protection is actually necessary.

Examples: irritation, frustration, resentment, anger, hatred

SADNESS/GRIEF

Sad feelings let us know we've lost someone or something important to us. The more Important they were, the stronger the sadness is. Our body learned they were part of our lives, and it hurts to break the automatic connections between our bodies and our brains. Tears carry the hurt away. Then we remember the good times we had together. If we feel the sadness each time we lose someone or something, we'll know that can happen and won't hold back our love. We'll make sure we really love, enjoy and appreciate our friends and family and pets while we have them, knowing that someday they might not be with us. Sad feelings also tell us we need lots of things to be the same. That helps us know what will happen, so we'll be able to do things automatically without thinking about it. When we have too many changes, our brains and bodies need to keep making and breaking connections and that takes way too much energy!

Examples: disappointment, sadness, sorry, grief, anguish, hopelessness

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LIFE-ENHANCING, REGENERATING, CONNECTIVE EMOTIONS

PRIDE

When we do something that takes a lot of effort and turns out well, we need to feel proud of ourselves! We don't want to skip proud feelings because they give us the energy to use our talents and skills and knowledge to make ourselves and our world better. Of course, we don't want to just sit around and say how wonderful we are, but we don't need to worry about that happening. When we feel our feelings, they go away. The gas in a car gets used up while we're driving. If we fill up again, we can go even farther! Proud feelings fill us with energy so we can do even better. And if what we did was the best it could be, we'll find other things to work on.

Examples: pleased, proud, arrogant

GRATITUDE

When something good happens to us, that we weren't responsible for, we feel appreciation. Someone might say something nice about our talents or looks that we're just lucky to have, or they might give us a gift for our birthday or a holiday. We feel it when we get to see something beautiful like a sunset or go somewhere on a vacation, get to do something we like to do, or eat something we like, because someone else made that happen for us. We feel it when we see others who don't have what we have or aren't as fortunate as we are.

Examples: thankful, beholden

ENJOYMENT

Enjoyment calls our attention to experiences that are pleasurable in and of themselves. When we enjoy something, we take in energy and regenerate our minds, bodies and spirits. Beautiful sights, wonderful sounds, delicious tastes, pleasant touch and delightful smells attract us to pleasing experiences. The pleasurable feelings help us remember those experiences and make us want to do them again. And because the smallest division of humanity is the group, they're even more enjoyable when shared with others.

Examples: enjoyment, pleasure

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CURIOSITY

When our bodies and minds are working the way they were made to, we love to learn! In fact, we need to have a healthy balance between sameness (predictability), and new experiences. Recent brain research has shown that our brains make new cells (actually grow) whenever our environment is stimulating, which can be thinking, feeling, seeing, hearing, touching, smelling, tasting or doing something. The old belief that we don't make new brain cells seems to be the result of studying the brains of laboratory mice raised in boring environments. Making sure that we have a healthy dose of new experiences results in challenging ourselves to be all we can be and creatively improving our world!

Examples: interest, curiosity, excitement

LOVING

Loving feelings make us want to take care of other people, animals, even ourselves and our earth. We feel them because whoever or whatever it is, makes us feel good. Everything needs love. Even plants grow better when they're loved. Babies brains grow more neurons when they're given lots of love and the people doing the loving grow more neurons too! Remember, we can keep growing more brain cells all our lives, so loving not only feels good, but it makes us smarter too! It's not good to hold in love energy, just like it's not good to hold in scared or mad feelings. Loving touch makes us feel calm. Think of how good it feels to pet a dog or cat. When we're "in love" we can't think of anything else but being with the one we love. Just like the feelings that protect us, when we have really strong good feelings, we can't think of anything else. That's OK if it's a new baby or someone we might want to be with all of our life, but most of the time, we need to be able to take care of other responsibilities too.

Examples: like, love, in love,

LOVED

Feeling loved tells us how important we are, and helps us feel connected to others. And the more important we feel, the more energy we have to do all the things we want and need to do! Feeling loved also makes us feel connected to other people, so we want to be around them, spend time with them, have fun with them. When we feel loved, even things that are hard for us, don't seem so hard. Our bodies heal faster and we're healthier too. Skin is our largest sense organ, so, maybe, being able to feel loving touch is at least as important as being able to see beautiful sights or smell wonderful smells or taste something really delicious. Oxytocin is secreted when we feel love or are touched in a caring way, which facilitates a sense of connection. Loving touch is calming. Loving words and looks show us how loveable and loved, we are.

Examples: concern, cared for, loved, adored

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