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The Wreathing Protocol: The Imbrication of Hypnosis and EMDR in the Treatment of Dissociative Identity Disorder and Other Dissociative Responses

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Dissociative Identity Disorder (DID), a chronic childhood onset posttraumatic stress disorder, is currently recognized as a treatable condition. It is considered the paradigmatic dissociative condition and carries with it extreme posttraumatic symptomatology. Therapists skilled in the treatment of DID are typically fluent in the uses of hypnosis for stabilization, affect management, building a safe place and grounding to name of few. EMDR, which has come to the forefront of clinical awareness in the last ten years, seems aptly suited for the treatment of trauma, but can be destabilizing. This paper proposes a protocol, called Wreathing Protocol, for the imbricated use of EMDR and hypnosis in the treatment of not only DID (though this will be the primary focus of the paper), but also Dissociative Disorder Not Otherwise Specified (DDNOS) and chronic Posttraumatic Stress Disorder (PTSD). This protocol is useful to advanced clinicians skilled in both modalities independently. The sequential steps of the Wreathing Protocol will be described and illustrated by a clinical vignette on DID. The clinical implications of the use of the Wreathing Protocol will be discussed in DID as well as the chronic post traumatic spectrum.

> The thing that I am most aware of is my limits. And this is natural; for I never, or almost never, occupy the middle of my cage; my whole being surges toward the bars.
>
> Andre Gide, *Journals*
> August 4, 1930

Patients with Dissociative Identity Disorder (DID), better than any other, illustrate the phenomenon of living at the edge of their cage. For them, this cage is a psychological one built in childhood to keep outsiders out, but which now, as adults, keeps them captive. Their posttraumatic symptomatology holds them vigilantly looking through "the bars," while their startle response hurls them (or, at least, a personality within them) into an unsolicited retreat. DID patients represent the paradigmatic dissociative and posttraumatic

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condition. This particular diagnostic category will be the illustrative dissociative psychopathology for this paper and will be supraordinate to, as well as encompass, less trauma-based diagnoses such as Dissociative Disorder Not Otherwise Specified (DDNOS) and chronic Posttraumatic Stress Disorder (PTSD).

Therapists working with DID patients must be willing to work "on the edge" as they themselves stay grounded; they must meet the DID patients where the patients are, understand their defensive structure, provide a safe environment for exploring painful and disruptive conflicts and also be less fascinated by the patients' discourses than by their recovery. DID patients deserve as adults to "get a life" rather than live in the past. Therefore, it behooves DID therapists to both respect the ground rules of DID therapy, and to bring to their work the most thorough and expeditious strategies and techniques to help their patients heal. This paper will briefly review the treatment organization for DID and describe the role of hypnosis and EMDR in the therapy. The Wreathing Protocol, which is designed to more thoroughly and expeditiously negotiate fractionated abreactions, will be described in detail; it will be followed by a clinical vignette. Then, the clinical implications of the use of the Wreathing Protocol will be considered.

Current thinking recognizes that overwhelming childhood experiences are one of the etiological factors (Kluft, 1984) giving rise to dissociative states. DID represents the most severe dissociative pathology in which individuals' repetitive reliance on their dissociative skills fosters an automatic and fairly inflexible defensive structure. It is through the ongoing elaboration of this defensive structure that alternative and/or fragmentary identities develop. Rossel (1998) reports that the diagnosis of DID, a chronic, complex dissociative disorder characterized by problems of identity and memory (Kluft, 1991; Nehmiah,1991), or otherwise said, a childhood onset posttraumatic condition (Spiegel,1986), is increasingly acknowledged. A number of treatment strategies have evolved over the last twenty years (Kluft, 1988a) to help the patient with DID who struggles with multiple reality disorder (Kluft, 1995, 1998) deal with the influence of his/her various self-generated hypnotic realities.

Goal of therapy for DID patients

Treating DID patients involves a willingness on the part of the therapy dyad to be involved simultaneously in many brief structured problem solving modalities disseminated across dissociated personality structures, as well as to promote the dissolution of amnestic barriers which protect (albeit pathologically), the system of mind from "knowing" or "experiencing" current or past traumata. The complete integration of all dissociated parts of the mind and all dissociated experiences is the goal of treatment, irrespective of the therapist's preferred treatment mode.

Given that these experiences and conflicts are predominantly contained within segregated personalities, Kluft's (1984) formulation of the goal of treatment is that there needs to be a congruence of purpose and motivation among the various personalities. Fine (1990, 1991,1992), though agreeing with Kluft, prefers to concretize the treatment goal using Braun's (1988) BASK model of dissociation. She would state that the goal of treatment is that all personalities need to attain identical BASK experiences. This means that all personalities need to be congruent and similar in Behavior, Affect, Sensation and Knowledge. For Fine (1991, 1996a, 1999), the organization of the work of therapy is cognitive behavioral in nature, informed by the dynamics within and between the personalities, and arranged in such a way as to diminish abreactive work in the initial stabilization stages of the therapy (suppression of affect stage). She then recommends promoting fractionated and planful abreactions partitioned along the BASK dimensions of the various individual personalities and/or clusters of ego states (dilution of affect stage). Regard to the planful organization of

the work with DID patients is significant because the work with DID is permeated with trance-like, hypnosis-like phenomena. Indeed Bliss (1984) and Frischholz (1985) both report that DID patients are highly hypnotizable when they are measured by a standard hypnotizability test. Putnam (1991) prefers to comment on the DID patients' high dissociativity. There are numerous published articles in the dissociative literature which recount in detail the uses of formal hypnosis in the treatment of such patients (Braun, 1984; Kluft, 1982; 1992a; 1994). Putnam and Loewenstein (1993) report that 70% of the 305 therapists that they surveyed use formal hypnosis in their work with DID patients. The current Zeitgeist, driven as much by legal concerns as a need for further research on suggestibility, dictates the more cautious use of formal hypnosis in the treatment of DID; it however actively supports understanding and doing informed hypnotic interventions to escort a DID patient through a difficult and often confusing therapy.

Use of hypnotically informed psychotherapy with DID patients

Kluft (1992b) has suggested that DID patients' hypnotic proclivities may suffuse the treatment despite the therapist's intention; indeed, the therapy for DID could not be conducted without the intrusion of spontaneous trance states in the patient. Therefore, the intentional use of heterohypnosis helps patients gradually gain mastery over their dysfunctional autohypnotic states (Kluft, 1992b). The thoughtful use of formal heterohypnosis can provide repeated, controlled, deliberate and respectful access to dissociated material; it can foster a positive working alliance and promote ego-development. These heterohypnotic techniques which have been aptly delineated elsewhere (Kluft, 1982; Kluft, 1992a; Kluft, 1992b; Kluft, 1994; Phillips & Frederick, 1995) form the intervention arsenal of the dissociative disorder specialist. The question then becomes: are there other methodologies to further a secure and beneficial change for these patients?

Use of Eye Movement Desensitization and Reprocessing with DID

Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1995) is a relatively new clinical technology, which is a subset of Accelerated Information Processing (AIP) treatments (Ochs, 1993; Schmitt, Capo & Boyd, 1986). Shapiro (1995) likens the AIP model to Freud's (1919; 1955) and Pavlov's (1927) understanding of information processing. In EMDR, eye movements (EMs), hand taps and sounds/tones are used to provide alternating right-left hemispheric stimulation. A traumatic experience, which may only partially intrude in the mainstream of consciousness or, which may obtrude in a derivative manner through affect storms, somatic disruptions or seemingly confusing flashbacks, may be reinserted into the mainstream of consciousness by targeting it while doing EMDR. Once more accessible to the patients' awareness, the trauma can be recognized, described and metabolized; then and only then, can patients learn and make sense of their traumatic experience(s) and make meaning of their lives.

In other words, traumata and conflicts which are contained within the various personalities of the DID patient, and which through either passive influence or active intrusion disrupt the patient's life, can be accessed, understood, transformed and integrated. This integration is understood to require a thorough and complete abreactive process. For DID patients, however, premature abreactive work can promote regression, decompensation and uncontrolled affect bridges with potential re-emergence of posttraumatic symptoms. If premature or misaligned abreactive work occurs, the message to the DID patient is that past experiences contained within parts of the mind remain overwhelming and unmanageable, and that they should continue to be avoided at all cost. Therefore, because of the easy affective destabilization of the DID patient (Fine, 1991, 1992, 1993, 1996a), great caution should be exercised in the use of EMDR because it is such a powerful methodology (Fine, 1999;

Lazrove & Fine, 1996; Paulsen,1995).

Advantages and disadvantages of the separate and/or joint usages of EMDR and hypnosis with DID patients and with patients with chronic maladaptive dissociative responses

It becomes relevant to consider the perceived benefits and drawbacks of either substituting for, or complementing with EMDR, established hypnotic interventions in the treatment of DID patients; after all, these interventions have been understood as the foundational language and communication forum between the dissociative patient and the therapist. In addition, the misuses of EMDR in the treatment of DID have been a concern for years. Shapiro (1995) addresses this problem forthright by forming a task force to establish guidelines for the use of EMDR in the treatment of dissociative disorders… a task force which included one of the current authors (CGF). Five years after the task force guidelines for the treatment of DID, the following seems accurate:

Hypnotic fluency remains part of the infrastructure in the formation of DID; hypnotic phenomena are the communication module among the personalities, and between the personalities and the therapist; hypnosis, whether formal or not, remains crucial in the treatment of DID.

However, DID patients can use hypnosis as a resistance. They, or a part of them, can choose to use slow moving hypnotic phenomena as a distraction from the stated goal of the session. They can get lost in hypnotic reverie, take a hypnotic left turn, instead of a right turn. Meanwhile, the therapist can be unaware of the "road not traveled," perhaps because the therapist is not asking the right question, because the personality within the patient who is being questioned was unaware of the derailment, or because the patient/ personalities are intentionally disrupting the therapy.

Hypnosis, by its typical slow pace, can reward affect and sensation intolerance by unintentionally supporting the DID patient's belief that "it must be so terrible that I can only approach it slowly." Though sometimes slow is good, it is not always good. Why should a DID patient take months processing/avoiding data which if approached differently could be resolved/redirected in weeks? (The authors are aware of how a few hypnotic interventions can accelerate abreaction; they are neither common, nor numerous).

Additionally, hypnosis often involves a more elaborate intervention style on the part of the therapist; the therapist may structure most of the interventions; she may guide the patient through an affective minefield to only be told by the patient, once the minefield is clear, that she, the therapist, suggested the mines, that the field was always clear, and nothing really happened in the patient's life to explain the psychological problems...other than the therapist. There is much more of a presence of the therapist in a purely hypnotically informed DID therapy where transferences are turbocharged. EMDR informed DID therapies obviously need to be hypnotically informed as well; however, the material that emerges to be processed in the therapy comes, more directly and less controversially, from the mind of the patient.

The structured presentation and usage of EMDR methodology adapted to the DID patient allows for a more rapid, thorough access and processing of abreactive material with fewer content intrusions on the part of the therapist. The words, images, fantasies, thoughts and experiences which get targeted or which emerge in the course of the EMs are the DID patient's, not the therapist's. The adapted use of EMDR with DID patients therefore diminishes the likelihood of the patient feeling that the therapist "suggested" an experience.

With EMDR informed therapy, the DID patient is double bound in a helpful way: if the trauma material which emerges from the EMDR processing is not true and is a fantasy... the therapist does more EMDR to elucidate "why this type of fantasy?"; if the trauma material which emerges from the EMDR does reflect a previously experienced external reality, then it gets processed and should not reemerge. It is always the patient's material, one way or the other.

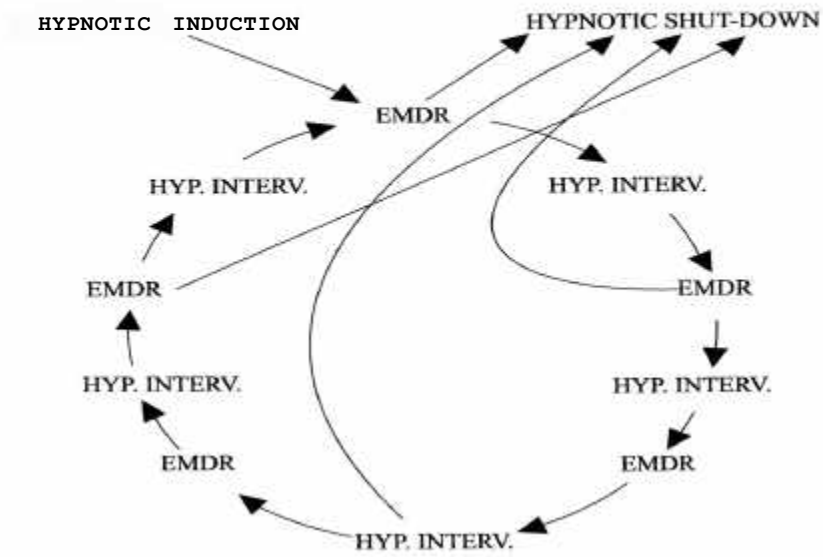
Also, EMDR is more helpful than hypnosis in making contact with preverbal and nonverbal ego states earlier in the therapy. These types of personalities/ego states are frequently important flashpoints of distress for the system of mind; they, with EMDR, can be given Better support to resolve therapeutic connundra.

In summary, hypnosis is an established tool in the treatment of DID, a posttraumatic condition. EMDR is a powerful methodology, which helps more rapidly and effectively resolve traumatic experiences. Therefore, it would seem natural to consider imbricating hypnosis and EMDR in a timely and cautious manner into a structured DID therapy. Herein is the premise of the Wreathing Protocol.

Purpose of the Wreathing Protocol

The Wreathing Protocol is designed to create an organizing scheme for planned fractionated abreactive work in the structured treatment of DID. The organization of the abreactive work will combine both hypnosis and EMDR methodologies. How each Wreathing Protocol evolves will naturally be dictated by the needs, deficiencies and ego strengths of the individual DID patient. The Wreathing Protocol represents a skeletal structure around which complex dissociated elements of personality can regroup, blend and integrate after detoxification and transformation of traumatic material.

Figure 1: The Wreathing Protocol



Structure of the Wreathing Protocol

1) Determine which BASK dimension has the highest level of reported distress or disturbance at the moment of questioning within the therapy session. Shapiro (1995) borrowing from Wolpe (1991) may ask the patient to report a Subjective Unit of Distress (SUD) level typically associated with a negative cognition. In the Wreathing Protocol, the therapist meets the patient/personality's distress at whatever BASK dimension seems significant and relevant to the patient, the personality or the cluster of personalities involved in the eventual abreactive work.

2) Hone in, as precisely as possible, on either the B, the A, the S or the K dimension of that experience in the moment. As with regular EMDR, the more accurately the relevant BASK dimension is targeted, the better access to the bound neural network. Unlike in the traditional protocol for PTSD, the therapists may not ask for a positive cognition (PC) until the SUDs level of the experience being processed has reached less than 40% of its original value. Because these patients are so demand characteristic sensitive, the PC initially reported is too often what they think or feel the therapist wants to hear or what they have read it should be, rather than genuinely their own. In the spirit of respecting the known dynamics of these patients, it is worth eliciting the PC later in the Wreathing Protocol and installing it in a timely manner then.

3) Determine whether EMDR should be initiated from the current level of disturbance or whether a hypnotic intervention to:

   a) diminish the valence of the experience at onset or whether the hypnotic intervention is needed to
   b) frame and contain the experience better.

   Though the purpose of the EMDR is to promote a revivification, and therefore an intensification of the experience, if the valence of the disturbance is too high or too uncontained, then uncontrolled affect or sensation bridges may occur among the various alters. Poorly contained abreactive sequences can too easily foster unmanageable flashbacks and encourage nightmares.

   The assessment for an acceptable disturbance valence must always take into consideration the particular alter, the system of alters and the patient's overall ego strength. For instance, someone who has already done abreactive work fluently is understood to be less at risk than someone for whom these are the initial attempts at controlled fragmented abreactions.

4) Initiate EMDR (EMs, taps, tones) while maintaining hypnotic duality among the personalities or the host during the Wreathing Protocol. There may be benefits to the obverse; loss of hypnotic duality (duality meaning that the patient/personality has simultaneous awareness and connection to past and present) may be tolerated when working with internalized abuser personalities or certain child personalities when other prespecified alters are configured for containment purposes.

5) Expect rapid shifting from one BASK dimension to another regardless of the initial targeted dimension. The abreactive process for the DID patient is potentially so disequilibrating that many truncated wreathing sessions are likely to be necessary before the entire BASK of the original target is metabolized. Therefore, true to the traditional work with these patients, many partially completed (uncompleted) Wreathing Protocols may remain suspended for days or months before the patient will be able to re-engage the original topic and finish the Wreath. When using the Wreathing Protocol for

abreactive purposes, truncated wreaths correspond to the usage of fractionated abreactions in the dilution of affect stage of the tactical integration model of therapy for DID patients (Fine, 1991, 1993). Hypnotic containment and hypnotic shut down techniques are clearly in order with the Wreathing Protocol.

The ongoing cyclic imbrication of hypnotic and EMDR interventions represents the wreathing effect where established hypnotic interventions for the treatment of DID are woven into an EMDR format; stated differently and perhaps more accurately, EMDR is introduced in a timely manner to an effective, planful hypnotically informed treatment for DID.

Description of the Wreathing Protocol with a DID patient through a clinical vignette

Patient descriptors
The example given represents a composite patient where no data presented in this paper could reveal the actual identity of a patient. The patient, Melissa, is an attractive 25-year-old married white female with no children. She is diagnosed with DID and is in the middle stages of her therapy. She has attended junior college and currently works at a day care center.

Therapeutic objectives and personalities involved in the work segment
The therapeutic objectives for the use of the Wreathing Protocol, in this instance, are the re-association and reprocessing of fragmented dissociated experiences which impinge on the patient's behaviors and affects. The therapy dyad is already fluent in the uses of heterohypnosis, of EMDR for decreasing and eliminating minor posttraumatic symptoms and of the controlled negotiation of fractionated abreactions without EMDR.

The alters (alternate personalities) which are included in the vignette are:

Melissa	Presenting host personality, identified with her Mother
Melissa Too	Angry alter identified with her Father
Lissy	identical twin, child alter created at the time of a car accident
Paige	identical twin, child alter also created time of the same car accident

Organization and description of the therapeutic segment
The therapeutic segment described in this paper takes place over a 4- week period of time; the patient meets, as usual, with the therapist for two single sessions each week, for each of the 4 weeks. During this time, the patient has occasional, but brief phone contact with the therapist to re-stabilize and re-ground; this proves necessary, even though, at session end, the therapist always actively and appropriately supports a secure hypnotic shut down.

The BASK sequence partially described in this example is detailed as follows:

Behavior	Head hitting as enactment of witnessed fatal injury (Paige) Head hitting (Paige and Lissy)
Affect*	Rage, terror, grief (Melissa Too, Lissy, Paige)
Sensation*	Somatic memories from car accident such as facial pain, severe headache, etc. (Lissy and Paige)
Knowledge	Voice in head based on guilt and self-loathing for helping actual twin sister climb in front seat of car (Lissy and Melissa Too)

However, for the sake of brevity, only two of the four BASK based Wreathing Protocol sessions will be described. Because Shapiro (1995) in her standard protocol very aptly illustrates how to initiate EMDR starting from a cognition (the K of the BASK), we felt that it would be helpful to portray the patient in a way that most commonly reflects how DID patients present. It is indeed fairly common for DID patients to "not know" what is going on for them. They commonly report that their mind is a "blank" or that there is so much noise in their heads that they cannot focus on only one cognition. However, they commonly experience vague "nameless" feelings (A of BASK) or "unknown" somatic problems (S of BASK). Therefore, our vignette will start the Wreathing Protocol first targeting the affective dimension of the BASK to be then followed with the description of a Wreathing Protocol session starting with a somatic memory.

The presenting symptoms at the initiation of the first Wreathing Protocol session involve enactments triggered by the patient getting lost on the way to therapy due to traffic being re-routed. The patient is verbally abusive to the therapist; she threatens the therapist and has obsessions about self-injury as a defense against hurting the therapist.

Working with Affect

The affect present at the beginning of the session is rage. Melissa enters the session 15 minutes late; she is seething. Her nonverbal behaviors reflect the passive influence of Melissa Too, an alter identified with her narcissistic and abusive father. Melissa, the host personality, is clearly struggling to contain Melissa Too. With the safety contract reaffirmed and because the therapeutic alliance between the therapist and this DID patient is excellent, the therapist feels comfortable exploring the connection between Melissa's current experiences and her past, using the Wreathing Protocol.

(N.B. To aid the reader in following the Wreathing Protocol across BASK dimensions, hypnotic interventions and EMDR targets, the authors put in italics the name of the hypnotic intervention and the word "target" to specify from whence EMDR is initiated).

Hypnotic Induction - Spiegel Eye Roll on Melissa

Hypnotic Intervention - Reconfiguration of personalities: Melissa Too comes to the forefront. Melissa Too says: "I'm so mad about getting lost. I should have gone home. I hate you. I want to hurt you. Really, I mean it. I want to hurt you. I'm pissed off at you."

*EMDR Intervention – Target***:** "I'm pissed off at you" and begin Eye Movements (EMs). After several passes, the patient reports feeling "just like my dad" as she remembers his narcissistic rages. *Target:* Feeling Dad's rage. After many passes, Melissa Too reports an incident when her father was driving with the whole family in the car and he got lost. Melissa Too recalls her father "blowing up" at her mother and physically attacking her Mother while he was still driving. As he erupted, the father also blamed the mother for getting lost; he was contemptuous towards her during the car ride.(This is a parallel to how the session began with the therapist). *Target:* Melissa Too's feeling of father's projections onto Mother. After many passes, Melissa Too reports feeling terrified of her father; she also reports feeling anxious about an impending calamity. The therapist notices that Melissa Too is having difficulty tracking; the EMs are more labored. A change in the direction of the EMs helps only little. The therapist learns, after verbal exploration, that Lissy is near and too terrified to allow Melissa Too to continue. Lissy fears what is going to happen next.

Hypnotic Intervention - A Reconfiguration of personalities occurs with Lissy stepping forward as Melissa Too steps back. Lissy after having been heard out by the therapist, now agrees to work on her terror.

EMDR Intervention - Target: Lissy's fear of impending calamity. EMs are initiated; after a number of passes, Lissy reports remembering her father's "driving like a wild man". She recalls her twin sister climbing into the front seat of the car, her Mother crying and the car seeming out of control." Everything is out of control." *Target:* Feeling that "everything is out of control." After several additional passes, Lissy reports that the car crashes into a tree and her twin sister seems severely injured. *Target:* Feeling of "My twin seems severely injured." After more passes, Lissy begins to wail and reports that she knows her sister was fatally injured. Lissy has increasing difficulty in tracking; the therapist changes the direction of the EMs and attempts a cognitive interweave. The EMs remain stuck. Continued verbal exploration reveals the passive influence presence of Paige.

Hypnotic Intervention- After further discussion the therapist, Lissy and Paige agree that Lissy and Paige are so overwhelmed that they would probably benefit by "formally" working together on the processing of these feelings. The therapist helps Paige and Lissy develop a *Safe Place* in which and from which they can process their grief and loss. The therapist decides to help modulate the intensity of the affect by doing a *Rheostat intervention* before initiating additional EMs. The *Rheostat intervention* is geared to lower the ceiling on the intensity of the affect *(modulation of affect)*. This intervention is designed to promote a sense of success and competence for these personalities in mastering their overwhelming feelings. The *Rheostat intervention* will be revisited in an ongoing manner to promote complete resolution of the affect in a titrated manner; this means that as affect tolerance increases in the patient, more and more affect can be released to be processed. In addition, because the crying of Lissy and Paige is so intense, the therapist shifts the EMDR from EMs to hand taps.

EMDR Intervention - Target: Overwhelming feelings of shock, terror and grief experienced by Lissy and Paige at sister's injury. Hand taps promote further distress, but also further processing. Hand taps are continued with suggestions to release little by little the affect modulated through the *Rheostat inervention*. Hand taps continue until Lissy and Paige have significantly reduced their crying and report an average level of distress. They also report shared somatic experiences. The processing of Lissy and Paige's terror and grief has clearly created a *Blending of personalities* between them.

At this point the therapy session is nearing its end and the therapist decides to shut down as best as possible further processing until the subsequent session.

Hypnotic Intervention - Lissy and Paige are asked to *Focus* very intently on their body experiences (*body memories*). They are asked to imagine that their body pain has a shape and a color (*Symptom substitution*); each could pick a different shape and color to their liking. These somatic modules are then placed in a *Vault* (Containment) with strong powerful doors, impenetrable to the world between sessions. The *Vault* is then receded far, far into the distance, very far away (*Distancing maneuver*) from Paige and Lissy. Then, the therapist suggests a *Reconfiguration of personalities* where Lissy and Paige are to step away from front and center, and where Melissa steps to the foreground. The therapist then empathizes with Lissy and Paige's job well done and recommends that they doze off into a *Dreamless Sleep* (to avoid posttraumatic nightmares) until the next abreactive session.

The session ends with a short debriefing with Melissa, the host personality with suggestions to her of *Permissive amnesia*. The subsequent two therapy sessions do not involve abreactive work but rather focus on discussing what was learned in the wreathing session. A phone call by Melissa to her Mother actually corroborated her recollections and additional details were added by her Mother.

The subsequent Wreathing Protocol session started by focusing on the Sensation dimension of the BASK experiences.

Working with Sensation
The sensation dimension of the BASK experience for this DID patient represents the "shared" somatic memories from the car accident; these are severe body pains, excruciating headaches and facial pain with a sensation of wetness. Melissa enters the session expressing concerns of not feeling very well. "My body hurts. I must be getting the flu. That's the problem with working in a day care setting. You always get sick." It is indeed noteworthy to appreciate how powerful Melissa's wish "not to know" about the trauma remains and how hypnotic interventions to distance the somatic complaints and the permissive amnesia are helpful, but not foolproof. These combine to promote for Melissa, a complete misattribution of cause to her symptoms, and therefore can foster a false sense of correct solution. (Some patients would have gone to their medical practitioner to remedy the perceived physical problem). However, a deeper examination of these symptoms reveal to Melissa the need to attend to what was locked in the Vault at the end of the last Wreathing Protocol session (i.e., the somatic module).

Hypnotic Induction - Spiegel Eye Roll with Melissa

Hypnotic Intervention - The therapist *Speaks* to Lissy and Paige *through the host personality*, Melissa. They confirm that their somatic pain is increasing and that the *Vault* may be leaking. The therapist suggests to Lissy and Paige that they let the *Vault* come closer to them (*Reverse the distancing maneuver*), that they open the *Vault*, take out one of the shapes, shut the *Vault* and let it recede into the distance again. The redistancing of the *Vault* is to discourage an affect or a sensation bridge. The therapist requests that Lissy and Paige come together front and center and go to their *Safe Place*, *Reconfiguring* the personality system such that Melissa and Melissa Too are in the background in their respective *Safe Place*, quietly observing. Once the reconfiguration is done, Lissy reports to the therapist that she has retrieved the "black and blue ball" out of the *Vault*. The ball is black and blue because it represents being bounced around and bruised in the car.

EMDR Intervention - Target: Sensations of being bounced around in the car. Lissy and Paige report the pain moving all over their body as EMs are initiated. The therapist chooses to do only 6 to 10 sweeps at a time, interrupting the EMs to make contact with the personalities and keep them on track as they build up tolerance to the pain. EMs are continued as the therapist tracks with Lissy and Paige how the pain moves across all parts of the body. The therapist persists in the short groupings of EMs until both Lissy and Paige are clear of body discomfort, as longer and longer passes of EMs are presented and tolerated.

Hypnotic Intervention: Lissy and Paige check for the black and blue ball. They locate it in their *Safe Place* and report that it is smaller.

EMDR Intervention- Target: Lissy and Paige stare at the black and blue ball and focus on the sensation in their body. EMs are initiated and continue until Lissy and Paige remain tranquil in their seat; they report that the ball is reduced to the size of a grape but... that their head is throbbing. *Target:* The head throbbing. The EMs targeting the head throbbing seem to stall. The therapist verifies through change in the direction of the EMs, through the use of cognitive interweave and through exploration of the possible presence of another, yet unknown, alter...the reason for the obstruction in the work. Then, the therapist inquires as to whether the headache is related to any other shape in the *Vault*. Lissy and Paige respond, "Yes."

Hypnotic Intervention - The therapist directs Lissy and/or Paige to *retrieve the next shape from the Vault*. Lissy takes the "dark board" (the patient never discussed the symbolic meaning of this object; the therapist suspects that it may be a representation of the dash board of the car) out of the *Vault*; she states that the pounding in her head is stronger. Paige's head hurts too. The therapist then suggests to Lissy that the smaller she makes the board, the less their head will pound (*Modified rheostat intervention*). Lissy remarks that, "The pounding is still there, but it is more tolerable."

EMDR Intervention - Target: the head pounding in Lissy's and Paige's head. EMs are initiated in sets of EMs until the pounding has significantly diminished to the point of being hard to notice.

Hypnotic Intervention - The therapist recommends to Lissy and Paige that they slowly *increase the size of the "dark board" (Rheostat maneuver)* and to notice what happens to the pounding in their heads. They then target the pounding for the next EMDR sequence; they are to continually alternate EMDR and board size changes until the EMDR elicits no further pounding in either Lissy's or Paige's heads. This alternating continues until the board is its original size. At that point, Lissy and Paige report that their only somatic concern is their newly blurred vision.

EMDR Intervention - Target: Blurred vision experienced by both Lissy and Paige. Only a few EMs are necessary to reduce this symptom such that both personalities recover their regular visual acuity.

Hypnotic Intervention - The therapist directs Lissy and Paige to recover the remaining shape from the *Vault*. Paige removes a yellow, jagged puzzle piece. Both alters will continue to work with this shape together, but this time, Paige will be the spokesperson rather than Lissy. While intently *Focusing* on the puzzle piece, Paige cries out: "My face hurts and it's all wet!"

EMDR Intervention - Target: Paige and Lissy focus on "my face hurts". Several EM passes later, Paige and Lissy report seeing Paige's face lacerated and Paige screams in pain. *Target:* The screams of pain. EMs continue with both personalities together; groups of passes with increasing number of passes per cluster are introduced as pain tolerance increases and pain resolution occurs. When the screaming subsides, Lissy and Paige start crying; they report "feeling blood on their face." *Target:* Bloody wetness on face and switch to hand taps rather than EMs to allow for the intensity of the crying. There is active switching of personalities between Lissy and Paige as their respective and distinctive characteristics increasingly merge. When their distress is average, by their report, their crying stops and they talk about the horror of their recollections.

Hypnotic Intervention: The therapist directs Lissy and Paige to check the *Vault* to see whether they find any other shapes therein. They only detect the grape sized ball, a small "dark board" and a now a very little, yellow jagged puzzle piece. The therapist understands that though the valence of these objects has clearly diminished, their meaning has not yet been fully understood or explored by the personalities. There is a reason why the objects neither dissolved completely in EMDR, nor hypnosis. The therapist again helps contain the affect or sensation associated with these objects by helping the personalities *seal the objects in the Vault*. A *Distancing Maneuver* recedes the *Vault* to the back of the mind where it will remain "until needed, some time in the future, face to face with me (the therapist) in session" (*Time Lock intervention*). Paige and Lissy ask to "*go to sleep*, like last time"; they are invited to drift off into a *Dreamless Sleep* (containment of posttraumatic nightmares) as they slowly float up, up, up... light and comfortable... breathing softly, regularly and

comfortably (*Directed Progressive Relaxation*)...onto a cloud (*Distancing Maneuver*) which they had imagined because unlike the car, the cloud was light, soft and the contours would fit their bodies without bruising them.

Hypnotic Stabilization - A Reconfiguration of personalities is requested. Melissa comes forward at the therapist's request while other personalities move further back. Because of the strenuous and still unfinished nature of the abreactive tasks of Paige and Lissy, the therapist brings Melissa back more slowly than usual (*Grounding Technique*) recommending that "Melissa, as you breath, in and out slowly (*Grounding Technique*), regularly, comfortably, you will feel increasingly refreshed, more and more alert and aware of very ordinary and natural sensations in your body" (*Permissive Amnesia*).

Again, in the case vignette above, the entire Wreathing Protocol for Melissa remains incompletely described. It remains unfinished for this experience until both the K and the B dimensions of the BASK are included. As stated earlier in this paper, because DID patients struggle with the issue of trust, it behooves the therapist to wait until the patient elicits a positive statement to install it. Prematurely honing in on a PC, which is elicited at the onset of the EMDR segment (as in the traditional EMDR protocol for PTSD) runs the risk of being based on the patient's wishes rather than on a truly meaningfully connected cognition. Additionally, DID patients have felt mocked by the therapist "who is asking them for what they can never achieve." The flow of the therapy can suffer from asking for a PC in the initial steps of the EMDR setup with some DID patients balking at the lack of empathic attunement of the therapist. Therefore, it is typically at the end of the Wreathing Protocol (or at the end of truncated segments of the Wreathing Protocol) that the DID patient will spontaneously elicit a PC or a positive feeling that can then be promptly installed by the therapist.

Clinical findings and treatment implications

The Wreathing Protocol for use in the treatment of DID is beneficial to the patient and therapist alike. It assures (1) the continued holding environment provided by a hypnotically informed and facilitated therapy for DID, (2) a more rapid processing of selected fragments of traumatic experience, and (3) a planful, consistent and predictable structure from which the patient can effect abreactions; this planful structure also allows the therapy dyad to monitor the completeness of the abreactive trajectories. Therefore, DID patients who implement the Wreathing Protocol actualize for themselves self-control, mastery and self-efficacy. These patients are necessarily active collaborators in the therapy process and must take responsibility (Fine, 1996b) for the content and process of the experiences evoked in the wreathing— though they may struggle to own them. The Wreathing Protocol, as it is presented here, works better than hypnosis alone and EMDR alone in the treatment of DID.

This methodology is equally helpful in dealing with DDNOS and chronic childhood onset PTSD, which unlike its adult onset variety carries numerous multifragmented and disjointed aspects of experience. Though fragmentation is present in standard PTSD it is understood that DID, DDNOS and childhood onset PTSD syndromes are multi-fragmented. The BASK elements which are formed in these latter cases typically represent smaller pieces of experience with additional affective and sensory loading. These fragments of experience are emotionally, cognitively, developmentally, morally, socially and psychologically less mature, and therefore less manageable and harder to reassemble. The realignment of very "young" fragmentary BASKs is like working with TNT (Thunderous aNd Tumultuous); the therapist cannot just plough on as if all PTSDs are alike. Disorganized fragmentation in the trauma response requires planful fragmentation in the therapeutic methodology whether the patients are diagnosed with DID, DDNOS or childhood onset PTSD.

The Wreathing Protocol grants safe access to therapy material that typically slows down a therapy. The avoided therapy data can be consciously withheld by the patient because the data is too shamed based; it can be sequestered in personalities that are nonverbal and that are not allowed to speak to an outsider (like the therapist); it can be segregated in personalities which are preverbal and/or where no words can be readily found to describe their experiences; or, it can be isolated in a particularly disowned and rejected personality such as an internal abuser. The Wreathing Protocol, because of its structure, predictability, explicitness as well as its ability to process an experience without immediately putting words to it, permits for the detoxification of therapy facts that are traditionally avoided by the patient and which require many clarifications and confrontations by the therapist.

In these strained moments in the therapy, DID patients are typically lost, ashamed and/or scared; they commonly attempt to deny the presence of the personalities associated with these disowned negative feelings. It is at these times that DID patients typically refute their diagnosis, and recant what, for them, is perceived as intolerable. It is understood that unacknowledged material of this nature can bring a potentially productive therapy to a halt, and recreate for the patient a sense of futility and future oriented hopelessness. Personalities, wedded to these anchors and stalemates, are often clueless about the process of therapy; they also tend to lack hypnotic duality. Commanding their presence in the therapy through verbal interaction often elicits a negative therapeutic response; the DID patient can feel under attack and traumatic transferences, with the activation of projections and projective identifications, can even take hold of the host personality. The authors do not claim that the Wreathing Protocol can always circumvent these standard patient reactions, but they do advance that the Wreathing Protocol can lessen their frequency and grip.

Therefore, though the Wreathing Protocol may not be a therapeutic panacea, it offers additional flexibility to the DID patient-therapist dyad as well as to those with other severe posttraumatic conditions. It is this kind of flexibility that is both its clinical strength and theoretical weakness. Indeed, the facile use of this protocol requires mastery in the therapy of DID, skill in the uses of hypnosis and EMDR and a willingness to meet patients where they are rather than be a staunch hypnosis or EMDR purist. The therapeutic position promoted by the Wreathing Protocol serves to deter impasses in the therapy, such as those defined by Nathanson (1992) as “interruptions of flow in the therapeutic process.” It both frames the therapy and accommodates the patient’s style and resistances. On the other hand, it must be acknowledged that the Wreathing Protocol runs the risk of displeasing everyone who is more married to form than to function. It is “nonstandard hypnosis,” combined with “nonstandard EMDR,” which gives birth to targeted, trackable, more rapid and complete metabolizing of traumatic material in a predictable format. Fine and Berkowitz (in preparation) are exploring its usages in other posttraumatic and dissociative conditions and examining the impact of specific micro-deviations to this protocol in the service of therapy reluctant personalities. In a separate, but complementary vein, Berkowitz and Fine (in preparation) are studying the implementation of the Wreathing Protocol in the management of multiple transferences. The thoughtful and cautious usage of the Wreathing Protocol in the treatment of DID patients and those with other severe posttraumatic conditions may, more rapidly, return the locus of self control to those who may choose to live in the middle rather than the edge of their cage...so that perhaps, some day, they may forgo the cage altogether.

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