The Method of Constant Installation of Present Orientation and Safety

by Jim Knipe

The Method of Constant Installation of Present Orientation and Safety (CIPOS) can be used to extend the healing power of EMDR to many clients who are potentially vulnerable to dissociative abreaction because of a dissociative personality structure, and/or because of the client's intense fear of their own memory material. With CIPOS, the client is first helped to experience a full orientation to the present safety of the therapist's office (as assessed and verified through the Back of the Head Scale (BHS) procedure), and then is assisted very briefly to access the disturbing material in a highly controlled and predictable way. Through alternating between safety, and carefully titrated exposure to trauma, back and forth, the client can learn, often very quickly, the valuable skill of emerging from a traumatized ego state back to a safe orientation to the present. Bilateral stimulation (BLS) is used to constantly strengthen or *install* in the client's awareness a clear subjective sense of *being present* in the immediate *real life* situation (i.e. the therapy office). This method is described to clients during the *Preparation Phase*, prior to the *Desensitization* work, and then may be used during the actual *Desensitization* of a particular highly disturbing traumatic memory. By constantly strengthening the person's present orientation through BLS, and carefully controlling the amount of exposure to the trauma memory, the individual is more easily able to maintain dual attention. Through the use of the CIPOS procedure, processing of the memory can proceed more safely, that is, with much less danger of unproductive, dissociated *reliving* of the traumatic event.

With the CIPOS procedure, BLS is paired initially only with images and statements that express present orientation and safety. At the start of the procedure, when the client is most vulnerable to being overwhelmed by disturbance, BLS is not paired with information directly related to the traumatic disturbance. After the procedure continues successfully, usually within a single session, the client will be increasingly able to simultaneously be aware of both present safety and trauma, and, at that point, the usual pairing of BLS with trauma-related information can be safely initiated.

THE METHOD OF CONSTANT INSTALLATION OF PRESENT ORIENTATION AND SAFETY SCRIPT
The CIPOS steps are as follows:

Permission.

1. Obtain full permission from the client to work on the highly disturbing memory in a gradual and safe way, with ample time in the therapy session to complete the work regardless of whatever unexpected traumatic material may emerge during processing. With clients who have dissociated ego states, it is necessary to also ask for and obtain permission *from any other parts that are involved in this memory.* If some parts of the system do not wish to participate, that is fine, but there should be a commitment from the whole system to allow processing of the memory.

Since the way to ask the system for permission can be quite variable, with the words for one not necessarily appropriate for another, the following is only a suggestion to give you an idea of what to say. These words can be modified according to the needs of your client.

Say, "*I would like to ask all parts of the mind who are involved in this memory for permission to work on this today. Is this okay with all of you?*"

Safety.

2. As with any therapy intervention, it is important that the client be aware of the *objective* safety of the therapist's office. If the client seems unsure of the physical or interpersonal safety of the present situation, this issue should be addressed directly. Sometimes it is necessary, through observations, questions, and discussion, to help the client see that the fears that are being experienced in the present actually are the direct result of a past event, one which ended long ago and, often, took place far away. This cognitive orientation to present reality does not necessarily have to be accompanied by feelings of safety, but it should be clearly established in the client's intellectual understanding.

If the client is uncertain about the actual safety of your office, fears and concerns, including transference and counter-transference issues, should be explored and resolved before attempting trauma work. If, on the other hand, the therapist is simply unsure about the client's degree of contact with the reality of the safe office, the questions in step 3 can be asked to clarify the situation.

Strengthening Present Orientation.

3. To assess and further strengthen the person's sense of present orientation, the therapist may ask a series of simple questions relating to the client's present reality in your office, with each client answer followed by a short set of eye movements. When the client responds to these *simple questions*, the therapist says, "*Think of that,*" and initiates a short set of EM.

The therapist can chose questions that are appropriate to the client and/or make ones that are suitable for the same goal of grounding the client in the office. Sample questions are the following:

Say questions such as, "***Where are you right now, in actual fact?***"

Say, "***Think of that***" and do a short set of BLS.

Say, "***What do you think of that picture over there?***"

Say, "***Think of that***" and do a short set of BLS

Say, "***Can you hear the cars going by outside?***"

Say, "***Think of that***" and do a short set of BLS

Say, "***Can you find the flaw in the design in this rug?***"

Say, "***Think of that***" and do a short set of BLS

Say, "***How many tissue boxes do I have in this room?***"

Say, "***Think of that***" and do a short set of BLS.

The therapist can use the above questions or add relevant questions for the client. In this way, the client's subjective sense of being present is strengthened.

Say, "***What's good about being here right now, instead of somewhere else***?"

Of course, it is much better to be in the relatively safe present than to be reliving a traumatic event, so (usually without much direction) the client is able to say something like, "*I am comfortable here.*" Or, *"I know I am safe here,"* and this positive information can then be strengthened with additional BLS.

Say, "***Go with that.***"

If the client is confused about why the therapist is asking these simple questions, the purpose can be explained.

Say, "***A firm grounding in present reality is an essential precondition for the use of EMDR to resolve old disturbing memories. The way EMDR works is, 'One foot in the present; one foot in the past'.***"

One particularly useful method of assisting the client in orienting to present time is to engage in a game of "catch" with a pillow or a tissue.

Say, ***"Can you catch this pillow?"***

Say, ***"Good. Now toss it back. That's right*** (repeated 1-10 times, as necessary)."

Say, ***"Where are you on the line now*** (Back of the Head Scale)**?"**

Or, ask the client to "***Take a drink of water.***"

Or, "***Hold this drop of water/ice cube in your hand.***"

Or, "***Hum a song and then count to ten***", etc.

The game of *catch*, in particular, seems to quickly and reliably reverse the *derealization* experience in many clients. The action of tossing an object back and forth pulls the person back to the present. Playing catch is an easily performed task, and seems to require the individual to neurologically activate the orienting response (OR) in order to follow the trajectory of the tossed object. We can speculate that this procedure reciprocally inhibits (Wolpe, 1958) the activation of excessive traumatic material, which in turn allows the client to be more aware of the actual safety of your office. Other similar procedures are taking a drink of water, holding a drop of water or an ice cube in the hand, or alternately humming a song and counting to ten. Each of these procedures can bring about a *state change* back to orientation to present safety, which then empowers the client to be able to proceed with processing trauma material.

The Back of the Head (BHS) scale and CIPOS.

4. Through the use of the BHS, the therapist is able to assess the effectiveness of the CIPOS interventions. In this way, it can be insured that the client is remaining sufficiently grounded in emotional safety, so that reprocessing of the trauma can occur. The BHS is a way of making

sure the client remains safely in the zone of *dual attention*: continuing connection with present safety while accessing traumatic memory information.

An example of how to use BHS to assess the effectiveness of the CIPOS intervention occurred in Step 3:

Say, ***"Can you catch this pillow?"***

Say, ***"Good. Now toss it back. That's right*** (repeated 1-10 times, as necessary)."

Say, ***"Where are you on the line now*** (Back of the Head Scale)**?"**

By engaging the client in a CIPOS question and action, then asking the client to bring into awareness where she is in present time, according to the BHS as above, the therapist and the client are able to know if the client is sufficiently present to begin or to continue trauma processing. Seen from another angle, this procedure allows both therapist and client to monitor whether the client is experiencing derealization due to high levels of intrusive, post-traumatic disturbance in present time, if the client is beginning to move into a state of *derealization* and if the client has *derealized*. . This information informs the next step of the therapy. If the client is in a state of *derealization* or going into one, the therapist works to engage the client back into present time. If the client is experiencing sufficient orientation to in present time, for a sufficient amount of time based on the therapist's judgment, and the agreement of the client, they can proceed to do some trauma work.

Beginning trauma-work slowly.

5. When present orientation is sufficiently established,

Say "***Are you willing to go into your memory image for a very brief period of time*** (e.g. perhaps only two to ten seconds)."

Say, ***"Good. Go ahead and do this for*** _____(state how many seconds) ***seconds."***

Keep track of the time. This is essentially a carefully controlled dissociative process. Immediately following the end of this period of seconds, use soothing but repetitive and emphatic words as in the following:

Say, "***Come back into the room now, OK, now come back here, just open your eyes, find your way back here now, that's right, just open your eyes."***

Importance of encouragement.

6. At this point, give encouragement:

Say, "***Good,***" or "***That's right.***"

Then resume the CIPOS interventions,

Say, "***Where are you right now, in actual fact??"***

Say, ***"Go with that*** (do a short set of BLS)."

The CIPOS interventions are continued until the client is able to report, using the BHS, that she is oriented once again towards the present reality of your office. At this point, Step 5 (Trauma-work) can be repeated. The idea is to go back and forth between pairing *Present Safety* with BLS and then experiencing the trauma for 2-10 seconds with no BLS.

7. As this process continues, the client develops increasing ability to "stay present" as well as greater confidence and a sense of emotional control in confronting the disturbing memory. This opens the door to the use of *the 11-Step Standard Procedure* and directly pairing bilateral stimulation with traumatic material. The *Figure*, below, illustrates the sequence of steps in this procedure.

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EMDR European Conference, Istanbul, June, 2006;

EMDR Denmark Conference, Copenhagen, February, 2007;

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R-TEP Cheat Sheet

Overview

Phase 1: History – brief history to be able to evaluate Severity of trauma, Motivation to do the work, Strengths and resources

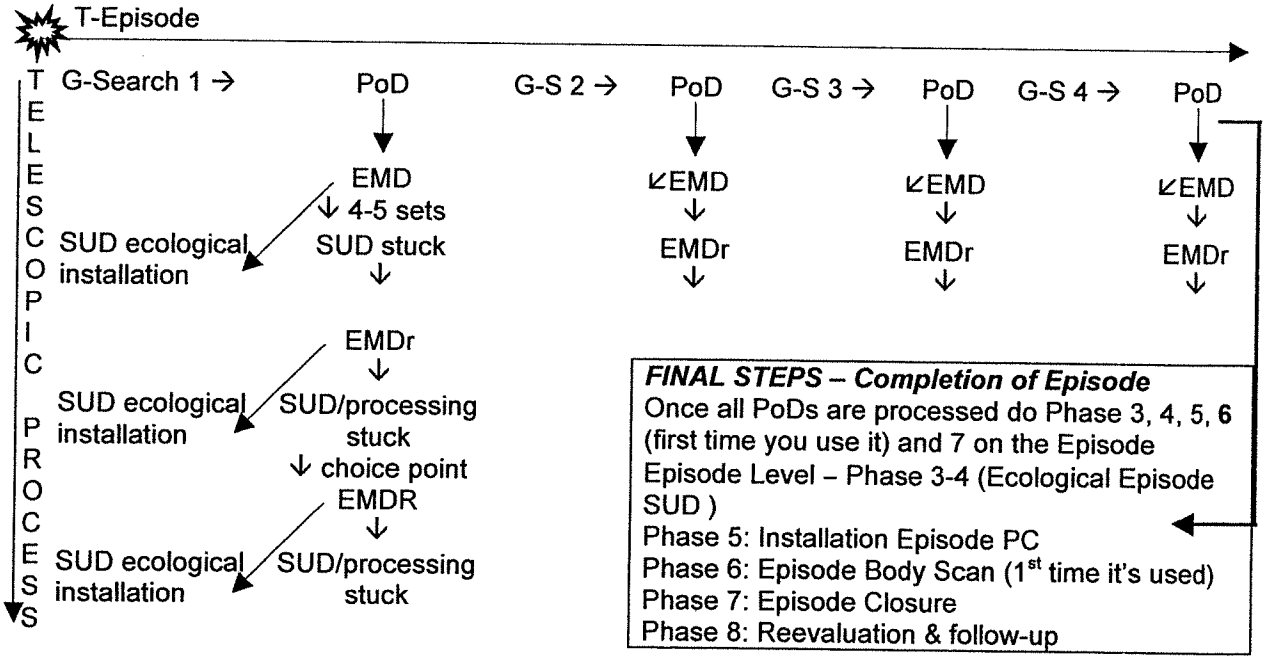
Phase 2: Preparation – establish sufficient safety & containment. Teach self-soothing skills such as Container, Calm/Safe Place, 4 Elements

Multi-target identification and processing within the Traumatic Episode (T-Episode)

1. T-Episode Narrative + slow, continuous BLS – telling the story aloud with BLS (use both tactile & EMs throughout by tapping hands at appropriate distance and asking them to follow with eyes)
2. Episode Google Search (G-Search) + slow BLS → identifying first Point of Disturbance (PoD) relating to T-Episode (doesn't have to be in chronological order)
3. Do Telescopic Processing with (Phase 3-5) 3-stage strategy: EMD → EMDr → EMDR (if necessary)
   - Phase 3: Assessment of PoD identified from G-Search
   - Phase 4: Desensitization – Telescopic Processing: 3 strategies staged approach (EMD → EMDR → EMDR)
   - Phase 5: Installation – ***NO PHASE 6: BODY SCAN YET***
   - Phase 7: Closure – extended closure exercises at end of session
4. Continue G-Searches and processing each PoD (as above) as it is identified until all PoDs are processed, THEN proceed to processing at Episode level using Standard Protocol (Phases 3-7). This will be the first time Phase 6: Body Scan is used.

Episode Level vs PoD Level

5. Check Episode SUD
6. What have you learned (re Episode)?
7. Phase 5: Installation of Episode PC
8. Phase 6: Body Scan of Episode ***(first time Body Scan is performed)***
9. Phase 7: Closure
10. Phase 8: Reevaluation – follow-up



Explanation: *"This EMDR protocol is especially suited for early intervention. Its aim is to help your natural system digest the disturbing fragments of the traumatic episode so that you can regain your balance. Let whatever comes to mind come up. Sometimes I will ask you to go back to a certain part of the memory: it's like zooming in or out. This can help you focus, observe, and process your memories and experiences so that past and present aren't confused and you can begin feeling calmer, safer and more in control. I am going to ask you to watch the whole T-Episode like a movie, beginning some time before it started until today. Feel your feet on the ground. The safety of this room, and tell the story out loud."*

1. Have client do Episode Narrative (telling the story aloud of what happened from the incident up to today + slow CONTINUOUS tactile + EM BLS)
2. Do the G-Search + slow BLS (tactile + EM) to identify the first PoD (doesn't have to be in order)

"Now, without talking, scan the whole episode for anything that's disturbing, like a "Google Search" on the computer. Just notice what comes up as you search the whole episode, in no particular order. Scan the whole episode from the original event up to today and stop and tell me when you find the first disturbance."

3. When a PoD is identified in the G-Search, STOP and use it as a target (Phase 3: Assessment – Phase 5: Installation)
4. Telescopic processing: begin Desensitization with the narrow EMD strategy – only go with associations that directly relate to the PoD or are adaptive. If associations depart from PoD, go to target (original PoD) and check SUD
5. When SUD reduces to ecological level do Phase 5: Installation of PC as usual
6. If SUD not reducing after a few sets expand naturally into EMDr strategy and go with associative chains relating to the T-Episode
   - Use client's ability to remain within affective window of tolerance to inform choice of which strategy to use (EMD vs. EMDr vs. EMDR)
   - If association departs from T-Episode (new issue from past) then acknowledge it, go to target and check SUD
   - When SUD reduces to ecological level proceed to Phase 5: Installation of PC as usual
7. Repeat steps 2-6 above until all PoDs are accessed and processed
8. Process the T-Episode (Phases 3-5) NOW do Phase 6: Body Scan and Phase 7: Closure

1st PoD identified with G-Search

Phase 3: Assessment

1. *"What picture represents disturbance?"*
2. *"What words go best with that picture that express your negative belief about yourself now?"*
3. *"When you look at the picture, what would you like to believe about yourself now?"*
4. *"When you look at the picture, how true do those words (PC) feel to you now on a scale of 1-7, where 1 feels completely false and 7 feels completely true?"*
5. *"When you bring up that picture and those words (NC), what emotions do you feel now?"*
6. *"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now?"*
7. *"Where do you feel it in your body?"*

Phase 4: Desensitization

- If association directly related to 1st PoD or is positive/adaptive, then continue, if not, go to target. *"What do you get?"* and check SUD.
- Continue processing until 0 SUD or ecologically valid (ability to think of the PoD calmly)

CHOICE POINT: Telescope to EMDr strategy

If association directly related to T-Episode or positive/adaptive then continue BLS, if not go to target. Return to target after 2-3 positive/adaptive associations

Phase 5: Installation for 1st PoD

NO PHASE 6: BODY SCAN yet!!!!

REPEAT UNTIL ALL PoDS ARE PROCESSED (may require several extended sessions)

Finally, process The T-Episode using Phases 3-7 (Standard Protocol). *"Now, as you think about the entire episode, what picture represents the worst part.....* (Phases 3-7 – this is the first time for Phase 6: Body Scan)

Phase 7: Closure – if at the end of session → incomplete or complete. Do strong closure.

Glossary

3-Staged Strategy – processing strategy that starts with most narrow focus and expands focus for experiences beyond the identified PoD. It is designed for minimal intervention and contained boundaries. "When the roof leaks, fix the roof!" The transition between strategies is a clinical choice point based on flexibility and attunement with client.

BLS – Bilateral stimulation. In R-TEP use EMs (eye movements) and tactile (tapping or pulsers) simultaneously (to ground, contain and orient) throughout the entire process. BLS is continuous during T-Episode narrative and G-Search. Once Phase 4: Desensitization begins, use standard BLS approach throughout processing.

EEI – Early EMDR Intervention: EMD, EMDR, EMDR

EMD – Eye Movement Desensitization protocol: focuses on intrusive image and frequently returning to it, checking SUD to limit accessing associative chains. Narrow focus on associations relating to PoD only. Return to target (PoD) and check SUD frequently. Particularly effective with intrusive image/sensation fragments.

EMDr – zooming out to a wider focus on associations relating to the T-Episode, if appropriate. Return to target when association departs from T-Episode. This is the main strategy in R-TEP.

EMDR – Zoom out to broad focus on associations relating to entire life with no limitations, if appropriate. Determine by client's ability to stay within affective window of tolerance and informed consent/contract with client.

ERP – Emergency Response Protocol, Gary Quinn

Episode – the entire traumatic experience

Episode Narrative – telling the story of the Traumatic Episode aloud with continuous BLS (tapping & eyes). This helps ground the client and contain affect while beginning to bridge the gaps of the story as the client begins processing. Avoid telling of narrative in Phases 1 & 2 to avoid premature activation.

G-Search – Google Search: a non-sequential attuned scanning mechanism for identifying multiple PoDs within the T-Episode. It is repeated after each PoD is processed until there is no disturbance. Use continuous BLS during G-Search

PoD – Points of Disturbance within the T-Episode. Composed of intrusive image/sensation/thought, or any other fragment/experience. Target and process each PoD, using standard Phase 3 Assessment (use clinical judgment to assess appropriateness) before doing G-Search for the next PoD

RE – Recent Event protocol, Francine Shapiro: conceptualizes traumatic event as unconsolidated fragmented experience so that no single image can represent the entire event.

R-TEP – Recent Traumatic Episode Protocol, Elan Shapiro & Brurit Laub

T-Episode – the original event + aftermath: includes all experiences, thoughts, and future concerns relating to the critical event up to today. It is seen as a trauma continuum. T-Episode may have several PoDs so G-Search is usually repeated until no more disturbance is found.

Telescopic processing – involves using a staged approach in EEI. Three optional strategies of expanding focus of associations which adjusts to the level at which the information processing may be sticking by "zooming in and out"

Window of Tolerance – client's ability to remain in an optimum affective zone during processing. You do not want the client to over-access (use containment strategies) or under-access (use strategies that amplify activation)

Negative Cognitions	Positive Cognitions
Self-Defectiveness	
I am not good enough	I am good enough
I am a bad person	I am a good person
I don't deserve love	I deserve love
I am not lovable	I am lovable
I am inadequate	I am adequate
I am worthless	I have value
I am weak	I am strong
I am permanently damaged	I am healthy (or can be)
I am shameful	I have honor
Responsibility	
I should have done something	I did the best I could
I should have known better	I do the best I can
I should have done more	I did my best
I did something wrong	I learned from it
It is my fault	I did my best

With responsibility beliefs you can often ask:
"If that were true, what would it say about you?"

Safety / Vulnerability	
I am not safe	I am safe now
I can't trust anyone	I can choose who to trust
I am in danger	It's over, I am safe now
I can't protect myself	I can (learn to) take care of myself
I am going to die	I am safe now, I am alive
It is not ok to feel or show my emotions	I can safely feel and show my emotions
Control / Choice	
I am not in control	I am in control now
I am powerless	I have choices now
I am helpless	I control my destiny
I am weak	I am strong
I cannot be trusted	I can be trusted
I cannot trust myself	I can trust myself (or learn to)

Processing Comparison Chart

EMD^

Phase 3: Access and Activate
1. Incident's worst part
2. Negative Belief
3. Positive Belief
4. VoC: 1, 2, 3, 4, 5, 6, 7
5. Emotions
6. SUD: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
7. Stop signal

Phase 4: Desensitization
- BLS: 5-10 round-trips
- *Breathe.*
- *Think of the incident.*
- *SUD: 0-10?*
- *Go with that.*
- 4th BLS:
  - *What's changed?*
  - *SUD: 0-10*
  - *Go with that.*
- End of desensitization
  - SUD=/>0?

Target specific desensitization

Phase 5: Installation
- *Think of the incident and the positive belief.*
- *Hold the two together.*
- VoC: 1, 2, 3, 4, 5, 6, 7
- BLS: 5-10 round-trips
- VoC<7?

Phase 7: Closure
- Stabilize
- Debrief
- Integrate
  - Extending Resourcing?

EMDr

Phase 3: Access and Activate
1. Incident's worst part
2. Negative Belief
3. Positive Belief
4. VoC: 1, 2, 3, 4, 5, 6, 7
5. Emotions
6. SUD: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
7. Body Location
8. Stop signal

Phase 4: Desensitization
- BLS: 10-15 seconds
- *Breathe.*
- *Think of the incident.*
- *What do you notice now?*
- *Go with that.*
- Repeat until no change
- *SUD: 0-10. Go with that.*
- End of desensitization
  - SUD=/>0?

Processing the incident with insights as well as desensitization

Phase 5: Installation
- *Think of the incident and the positive belief.*
- *Hold the two together.*
- VoC: 1, 2, 3, 4, 5, 6, 7
- BLS: 5-10 seconds

Phase 6: Body Scan
- Hold incident and positive belief.
- Scan your body.
- BLS: 5-10 seconds with any sensation
- Goal: calm or neutral sensations

Phase 7: Closure
- Stabilize
- Debrief
- Integrate
  - Extending Resourcing?

EMDR

Phase 3: Access and Activate
1. Incident's worst part
2. Negative Belief
3. Positive Belief
4. VoC: 1, 2, 3, 4, 5, 6, 7
5. Emotions
6. SUD: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
7. Body Location
8. Stop signal

Phase 4: Desensitization
- BLS: 15-30 seconds
- Paced: client non-verbals
- *Breathe.*
- *What do you notice now?*
- *Go with that.*
- Repeat until no change
- *SUD: 0-10. Go with that.*
- End of desensitization
  - SUD=0

Desensitization of entire neural network, not just a specific incident
May take multiple sessions

Phase 5: Installation
- *Think of the incident and the positive belief.*
- *Hold the two together.*
- VoC: 1, 2, 3, 4, 5, 6, 7
- BLS: 5-10 seconds

Phase 6: Body Scan
- Hold incident and positive belief.
- Scan your body.
- BLS: 5-10 seconds with any sensation
- Goal: calm or neutral sensations

Phase 7: Closure
- Stabilize (especially with SUD>0)
- Debrief
- Integrate
  - Extending Resourcing?