Dr. Keith Sutton (00:00:22):

Welcome to therapy on the cutting edge podcast for therapists who want to be up to date on the latest advancements in the field of psychotherapy. I'm your host, Dr. Keith Sutton, a psychologist in the San Francisco bay area and the director of the Institute for the advancement of psychotherapy. Today, I'll be speaking with Rachel Walker, LMF T, who is a trauma informed psychotherapist and EMDR approved consultant practicing in Oakland, California. She is the winner of camps distinguished clinicians award for 2021 for her innovative contribution to the field of trauma treatment. She has created an in-depth trauma training for mental health professionals called at the crossroads of trauma therapy, which integrates theories and interventions for many of today's most effective trauma models. Rachel is also the founder and creator of the online platform, trauma recovery store.com, which provides simple tools for improving trauma related treatment and promoting the self healing process. She has written and designed numerous treatment tools for therapists and clients, including the trauma recovery guide book for therapists and the trauma recovery handbook for survivors in English, Spanish and Icelandic. Rachels therapeutic training began in the arts where she learned to apply, play metaphor, creativity, and spontaneity to the work. Her deepest and most heartfelt desire is to inspire trauma survivors and the therapists who treat them to hope with perseverance, patience, curiosity, and human to human contact. She believes that recovery is absolutely possible. Let's listen to the interview.

Dr. Keith Sutton (00:01:54):

Hi, Rachel. Welcome.

Rachel Walker, LMFT (00:01:56):

Hi Keith. It's nice to meet you.

Dr. Keith Sutton (00:01:59):

Well, thank you so much for joining us today. So I've heard about your work. A number of clinicians in our practice have been in consult groups. And I've done trainings with you, and I know you do a lot of work with trauma, and particularly you also do EMDR work and I know you integrate a lot of different approaches. So I wanted to learn a little bit more about, how you got to doing what you're doing and kind of areas that really interest you, and yeah. What you've been doing lately, or what's kinda interesting to you, but if we could start off first with, I'm always interested in kind of the evolution of thinking, how did you get to do what you're doing now?

Rachel Walker, LMFT (00:02:37):

Well, I started out in terms of the trauma lens, like, you know, really serious trauma lens, which is really all I do. I started out in EMDR. So when I first took my very first EMDR training, it like blew my mind. I think a lot of people have this experience coming out of a general education for psychotherapy. And then you go to an EMDR training. You're like, oh my God, this makes so much sense. And I could learn this and I could be good at it. It just feels so hopeful. And then also you get somebody really good who's teaching and they actually model it in the session, you know, in the training session and you see it work and it's super exciting. I was one of those people and it just totally, I did it with Phil Manfield.

Dr. Keith Sutton (00:03:34):

Oh yes, perfect. I've interviewed him for this podcast also, he was great.

Rachel Walker, LMFT (00:03:36):

I saw his name up there and he's my mentor. I studied with Phil for years and years. He's a master EMDR trainer and practitioner, and he's an innovator. He's given a lot to the field, which is fabulous. And I use his tools, his flash technique. And so anyway, I was one of his students and super excited and about the whole thing. And I just did a lot of the trainings. Not just level one and level two, but I went ahead and got certified and then I became a consultant and all those specialty trainings working with EMDR and addiction modifications for early childhood trauma, modifications for attachment, all kinds of innovations around resourcing use of EMDR with resourcing. And I feel, you know, pretty clear that I got to be a very educated and skilled EMDR practitioner.

Rachel Walker, LMFT (00:04:44):

But there were areas in my practice. I mean, one of the things that was driving me to continue learning is that I kept having these gaps, like where it wouldn't work or someone would get worse and on the one hand I would be like, well, I didn't understand why it was what wasn't working. And on the other hand, I thought maybe there was some gap in my own knowing about the technique. So I would continue getting all these trainings, but after a while, I would say, you know, as much as seven or eight years, the number and the volume and the quality of the kinds of ways in which EMDR was not working in my practice was unfulfilling mysterious and disheartening. And so I started to take trainings and started to read from models and theories that were outside of EMDR to try to figure out what it was that I wasn't getting.

Rachel Walker, LMFT (00:05:47):

And that was a hugely illuminating. I mean, EMDR is amazing and it has brought an incredible tool to the table, but there are other models and theories that have actually been around a lot longer. And they have a lot to contribute to our understanding about what trauma is, how the brain and body adapts to it and what the symptoms mean and how do engage with them. And so I studied structural dissociation, I studied attachment and I studied parts work in parts models. And I learned an enormous amount about areas that EMDR really only touches on lightly. You know, these models go in very deep to why it is that trying to access and process memories can go awry when you're working with somebody who has poor attachment or just a lot of traumas. And so I got here through my failures and then through learning and learning and learning, applying many more different kinds of tools.

Rachel Walker, LMFT (00:06:56):

And all of a sudden my success rates began to rise. My failure rates began to drop, but even more important. I mean, that's really exciting and fulfilling, but even more importantly than that, as a clinician, I felt more oriented. So I was less mystified when something didn't work or did work. And I was getting better at course, correcting and being able to apply the right lens and the right intervention for what was going on in front of me. So if I made a mistake, it was okay. I could tell what happened and I could make a correction and get us back on track. So the sense of being oriented was very grounding. And I think it conveyed to my clients. I think they felt a sense of my growing confidence in what we were doing.

Dr. Keith Sutton (00:07:46):

Yeah. Sometimes I think about it. It's like when you're feeling competent and you have a good roadmap, so you know where you are and where you're going. And even if it's a very hard session, it's in a tough spot. If you know where you are in the process, it can often help you as a therapist, feel grounded and

know this as part of where we are and where we're going rather than feeling like things are going wrong, or I don't have enough, or I don't know what to do here.

Rachel Walker, LMFT (00:08:10):

That's right. Yeah. So that's, that's definitely one way that it can show up, meaning that another way it can show up for example, is the client feels lost. Like, what are we doing? I'm not feeling better. We're doing this EMDR thing is not working. I mean, back in the old days, when all I knew was EMDR, it's not working. I would feel, you know, I would feel thrown off my seat. I would be like, I don't know why isn't that working? And so when the client loses sight of why they're feeling bad or why something didn't work, you know, so much more of the time is possible to contextualize what is happening within the map and the client goes, oh yeah, that, that is right. That's, that's true. And we're on the same page and suddenly the anxiety about not knowing where we are is lowered and we're back on track. And we can just enter in again with some, you know, with the work or interventions. Yeah. So that's been my, you know, how I got where I am. I like to say it's through the failures.

Dr. Keith Sutton (00:09:31):

Yeah. Our clients are oftentimes our best teachers, often times too, like you were saying, you know, I think that it's really important that when things aren't going well, looking towards what else can I learn or getting consultation or so on rather than just getting stuck in saying, oh, this is a difficult client or something like that, but more that there's, there's something that I'm probably missing.

Rachel Walker, LMFT (00:09:51):

Yes, yes, that's right. That's right. Yeah.

Dr. Keith Sutton (00:09:55):

So tell me a little bit about, maybe we can start off with the attachment piece and kind of what you learned there and what you integrated into that helps, or either one, any of those pieces, the parts work, the structural dissociation model. Whatever's most interesting for you or,

Rachel Walker, LMFT (00:10:14):

Okay. Well actually, if you want, maybe what I could do with that question is kind of weave them together in a quick, so you can kind of see which sort of speaks to your second question, what I'm known for. So what I learned from going into these different directions, off of the EMDR track, structural dissociation parts models, in general and attachment theory is that basically, as all of us know the brain, the brain body of human beings is enormously complex. And also that life is hard. It's hard coming into being birth and then dealing with life, there's just so many things that go wrong. You know, there's just a lot to adapt to and to survive through, and to overcome.

Rachel Walker, LMFT (00:11:25):

And what I learned was that, especially in the attachment research there's just volumes, I mean, decades and decades and decades of empirical research as well. Now, even more neuroscience is getting much more interested in attachment. I think of attachment therapy and therapists and researchers must be like singing for joy because finally they're getting the attention they deserve around with neuroscience, joining the ways in which positive attachment, the ways in which having a reliable and secure and protective, nurturing presence. That's good enough buffers, the entire nervous system, the entire physiology physiology of the body and the person buffers them from the experience of life. It just

buffers them. It gives them a resilience in dealing with the hardships. And so, and, and the absences of things you would otherwise want to be there. So what happens is when we lack that, or it's interrupted in some way, in a major way we are less equipped to work with what life throws at us, but we're even less equipped to deal with resetting after an event.

Rachel Walker, LMFT (00:12:53):

It's not really the events. It's the fact that our brain and body have to adapt to that event and whether or not they're able to reset once it's over or the adaptation continues on and on and on and on, and grows and grows and grows and grows over time. And the adaptation basically from my perspective is disassociation. So you're more and more developing ways to keep yourself distant from the full impact of what that experience was. And you're developing ways of not encountering another incident like that. And certainly you're developing lots of internal ways of staying away from your pain.

Dr. Keith Sutton (00:13:38):

So it never kinda gets processed.

Rachel Walker, LMFT (00:13:45):

So that it never gets processed right.

Dr. Keith Sutton (00:13:46):

Because the body Or the mind is kind of creating ways to

Rachel Walker, LMFT (00:13:49):

Stay away from, stay away from

Dr. Keith Sutton (00:13:51):

Not go there. But then those kind also make it hard to ever reset or kind of, you know, get back to baseline.

Rachel Walker, LMFT (00:13:59):

You don't get over it. Yeah. You don't get over. You don't ever have a time orienting experience that, oh my God, that was really horrible, but I survived it. Look at the things I did do to make that possible. Oh, I'm so glad, like the visceral feeling of it just being over, that you often get in and from the past, like you often get in a really successful EMDR processing of a concise target. You'll get someone feeling like, oh my God, I survived. It's over, you'll get a visceral feeling in the body of time orientation and you will install that. Right. But for people who don't have great attachment the ability to do that to get over things is compromised. And so the strategy they used in the moment to bear it, becomes a little locked in place. And then they develop all kinds of strategies to not have to revisit it. So going further and further away from that memory, don't want to think about it and, um, adopting a way strategies in order to handle the discomforts and the hurts of life.

Rachel Walker, LMFT (00:15:18):

Structural dissociation talks, inject something in here, which I think is incredibly important, which is that, a way they call it a phobia actually of pain kind of gets locked in. there is a really big stressor on human beings that has to do with developmental milestones, like keeping up with our peer groups basically.

And so in order to keep up with our peer groups, we end remain on track and be normal. We have to develop some part of our personality that is really good at making successful developmental leaps and milestones and going forward in life, even with the rest of us, trying not to listen to our pains and hurts. And with enough of these going on enough, hurts and pains enough strain to focus on developing and meeting developmental milestones and a lack of attachment underneath all that you can get, you know, basically the development of very distinct parts of self, some that are hyper functioning and others that are, you know, just way emotionally dysregulated and unable to cope. And then the person internally is straining to look and act normal on the outside, even though inside there's a massive amount of upset going on, and that becomes their strategy for being okay as they walk through life.

Dr. Keith Sutton (00:17:03):

So that's how they kind of ended up becoming functional is by, you know, kind of separating that part. That's, that's not functioning, that's stuck in is kind of stuck developmentally, but then bringing in another part that can show up and be functional and get through life and particularly even become hyper functional even, right.

Rachel Walker, LMFT (00:17:23):

Yes. They often do. Or, you know, kind of very, very high functioning in some area of life

Dr. Keith Sutton (00:17:31):

Because this actually is something that I've been curious about recently with my own clients and such that's been coming up, particularly with trauma, the black and white thinking, the all or none. The, if I'm, if I let my guard down, then I'm going to just fall apart and not do anything. I'm very functional at work, but then if I'm not so hyper functional, then it'll fall apart. Or if I show myself in any compassion, then I'm just going to not care about anything. I'm wondering if, you know, do you see that in that kind of parts aspect of that kind of extreme or sense of if I shift that position at all? I don't know if that makes sense.

Rachel Walker, LMFT (00:18:08):

Yes. Because the part that is managing life or doing everything they can to not fall apart, the part that's responsible for that genuinely feels and has an internal experience that if they don't keep doing that, they're going to fall apart because what they've left behind is going to sweep over them like a tsunami. And I take that very seriously. In fact, I tend to agree that, if all that's, you know, we don't want to get into an argument about that. We want to say, whoa, that sounds, if that's true and it very well could be it, if that's true, then we better go very slowly. And if we were going to try to do something that wasn't all or nothing, I wonder how much we could do that would leave you feeling safe. Like you would be able to keep it together and do a tiny bit of relaxing, you know, what would that, what would that take?

Rachel Walker, LMFT (00:19:12):

So that's a little bit of a cognitive exchange. I mean, probably the way I would actually do it in a session is with part work. So I would ask the part that's afraid of relaxing at all, to do a little bit of work, to have a visceral experience of relaxing some and having it remain safe and they would be in control of that process. Yeah. And then, you know, if I was doing, let's say integrative approach where I was interested in making sure that if that positive experience were actually able to happen, I would ask about some kind of new learning. What do they know about what we did that made it possible? And what has that taught them? And when they come up with that for themselves, I might install it with BLS.

Dr. Keith Sutton (00:20:09):

With EMDR.

Rachel Walker, LMFT (00:20:10):

I mean, right. So instructional dissociation, meaning this split between high functioning part or parts and parts that are left behind freaking out. We do a lot of helping the most functional part to grow up, meaning to realize, but little by little that they can learn the skills necessary to turn towards what's upsetting them and be able to handle it. But we do it very gradually. So we don't trigger their phobia of all those feelings. And so installing some new learning, like I did it, or I guess that was possible, even if it's reluctantly learned, we would install it because we want them to start grokking a little bit of a bigger reality than their defensive system, which has been all or nothing. Like I have to remain vigilant or I'm not going to be okay. Well actually, as we all know, the situation is over and it would be really good if we could begin softening that strategy, that adaptive, um, software system that's gotten sort of stuck there, but we do it little by little.

Dr. Keith Sutton (00:21:24):

So, so let me put this all together. So, so the experience happens and that the person kind of learns these the way strategies are. It makes me think of the acceptance commitment therapy term of like emotional avoidance or again, being able to manage these overwhelming emotions and it's unable to be processed and then basically developing strategies for not going there. And then even to the structural dissociation, dissociating and departs. So that there's a functional part that's moving forward developmentally while that other part is not doing well. And a particularly the attachment aspect and the presence of healthy attachment or so on are kind of what allow us to potentially go there and process that stuff when that's not there, then it, it just makes it more increasingly likelihood that the person's gonna, again, kind of develop some systems for continuing to maintain those away or avoidance or that kind of deal with that phobia of dealing with that, that unprocessed

Rachel Walker, LMFT (00:22:28):

You got it. Exactly. That's beautiful. You learned it, you learned it. That's fabulous. So attachment is the soil that we want really rich and nutrient rich under there. And if it's anemic or it was, you know, all dried up or there just wasn't, the person was born on a stone, there just isn't any anything there. Then it's just that these other therapeutic models and theories have seen over time that the thing that happens in response to that is this dissociative process, this moving away thing in order to help them regulate, stay within, you know, their window of tolerance, they have to figure out some way if they don't have a loving yum yum in there. Yeah. I have to learn some way to lower disturbance. And when a human being is left on their own to do that they have to figure, they figure out a way strategies and that can become extraordinarily extreme. You know, based on the intensity of the traumas and the how anemic the attachment environment is those two things together seem to create more or less reliance on dissociation.

Dr. Keith Sutton (00:23:55):

And can you say, well, I don't know if this is where you're going to go, or if it'll get in later about that goes into then kind of EMDR, or at least trauma work happening in a different way than traditional kind of just the EMDR. It sounds like, or when there's been more of this kind of, uh, associative kind of aspects or that, that makes it more complex, or, you know, also complex trauma. I really like Walker's work and kind of this idea too, and, and Phil is talking about this also how complex trauma is very

different than kind of single incident comma when using EMDR or other trauma techniques. And that's not the way you you're running into too, as you were bringing in these other kind of integrative approaches to go beyond what the EMDR on its own could do.

Rachel Walker, LMFT (00:24:42):

That's exactly right. So one thing that was, you know kind of a revelation to me when I finally sort of got out of the EMDR world to go look for other maps, basically I was looking for other maps because this one map wasn't doing it well enough was that there were many there were many EMDR people in those times and that, you know, in the EMDR world themselves itself, they do acknowledge the presence of dissociation, the importance of attachment in providing the brain and body what it needs to develop an adaptive information processing system that that system is actually reliant on good enough, some good enough attachment there. And if you don't have it you're going to have a very hard time processing because there's nowhere for it to be filed adaptively.

Rachel Walker, LMFT (00:25:38):

Right. So that's right.EMDR acknowledges this this very important environment in which it's trying to do its magic. And you do, you need to know about it. You need to know what is complex PTSD, and you also need to know the spectrum, you know, everything from, some spotty functioning that shouldn't be there too. I just never felt loved to all the way up to borderline personality disorder, trauma based, and D.I.D. There's a, there's a spectrum. And so that's right. So EMDR, the world of EMDR as you know, has totally grokked this. And they, they work with it in many, many creative ways. I just found that the folks who had been working in this with this stuff all the time, the whole time I was super turned on by their maps, I was like, whoa, this really speaks to me. And they so I took those maps as opposed to just staying in the EMDR world and I integrated them. Yeah. Myself.

Dr. Keith Sutton (00:26:59):

So you're using this model kind of with the mixing of attachment and parts and the structural dissociation. How did that lead to this kind of integrative approach that you're using in the map, the maps that you are using are, I don't know if it's too much for this amount of time, but can you describe the map of kind of the work that you're doing ?

Rachel Walker, LMFT (00:27:24):

Well, I think in some ways we, we kind of covered it, which is the map, the most important understanding is that it's not just about memories. People's symptoms are most of the time, you're not just looking at simple PTSD. Most of the time, you're not, and EMDR teaches you how to reprocess you know, a standout moment of, of trauma. But most of the symptoms you see in people are not rooted there. It's an amazingly important tool to have in your toolbox. You should, I think people should have it because it's so powerful and so efficient. But you need to be able to see when the symptoms you're looking at or the cluster of symptoms you're looking at, because usually people come with some cluster, you know, it's not just, I don't want to get in my car cause I had an accident last week.

Rachel Walker, LMFT (00:28:29):

It's, you know, it's going to be a whole thing. Oh. And my relationship is falling apart. And oh, by the way, I've been drinking more than I used to. You know, you you start seeing trauma in more and more areas of life, right? Not just from the accident two months ago or whatever. Anyway you need to be able to have a sense when you've got such a cluster of symptoms that there's a picture that explains that.

And it's not just going to be about misfiled memories. It's going to have something to do with potentially depending on where someone is on the spectrum, attachment deficits or ruptures lifelong adaptive strategies that have been growing over time, because when moving away phobic however, when you want to call it turning away, strategies do not get addressed in and of themselves.

Rachel Walker, LMFT (00:29:36):

It becomes habituated. the brain just begins doing it without person even noticing it just becomes their go-to method for calming down when something upsetting has happened. And so the places in one's life where they're dissociating begin to get bigger and bigger and wider and wider until it's just leaking out everywhere. And this is when someone comes into your office, basically what you're looking at is some kind of tipping point where they're most of the time, it's a tipping point, their strategy of turning away and muscling it through in order to function is beginning to break down.

Rachel Walker, LMFT (00:30:22):

So most of the time you're not looking at some misfiled memory, you're looking at a full strategy that is getting shaky and is stopped functioning well. And so this is my map. And so I focus on for the most part in any, in almost any therapy, unless it's super clear that it's just a simple PTSD thing, which it almost never is. I almost always begin focusing on addressing the moving away strategy because in one, to some degree or another, it is beginning to grow and take over a person's life. And there's a spectrum for that, but I just begin treating that right away because here's the other thing is that if you treat it well, the symptoms begin to stabilize right away. It's almost as quick as EMDR. Like you should begin to see results within three to five sessions, just like you would.

Rachel Walker, LMFT (00:31:24):

And you can tell your client that you could say, if we're looking at some kind of moving away strategy and we begin to treat that a little bit in a way that's not overwhelming you. That's not going to stop your ability to work. You reassure them. Then we'll know we're onto something. And so you just, just like with the MDR, you begin the simple techniques. And we just start seeing if they start feeling better, if they start having a little more resilience, some of their symptoms begin to lower. And the two of you together to say, okay, we're onto something.

Dr. Keith Sutton (00:31:58):

Say more about what you're using as these simple techniques.

Rachel Walker, LMFT (00:32:01):

Okay I will, but give me a second to just play this out. I was just going to, my thought was, what I wanted to articulate is that this process of decreasing the moving away, the amount the person is moving away internally and doing something productive with that is, most of the time in my work, is the beginning of the creation of the adaptive information processing network.

Rachel Walker, LMFT (00:32:31):

When we decrease the dissociation, eventually we also increase attachment neural networks. Those two things together begin spontaneously to create an adaptive adult. And suddenly you have what you need to begin processing traumas. And if you miscalculate, you think the person is doing well, you go for it. And if they backslide, you just return to treating the ability away process. You're like, oh, we just so sorry. You had a bad week. You know, let's get back on track. Um, and you begin stabilizing the away,

the away functioning. Again, you work more with the attachment system. You want them to get a little stronger before you try again, and then you can go back in.

Dr. Keith Sutton (00:33:22):

It's like you're building up the soil. Like you're assigned to kind of attatchment.

Rachel Walker, LMFT (00:33:25):

Nutrients, nutrients, nutrients, the human brain. Most of the time, it wants to grow up. It wants to be integrated. It wants to function. It wants to be able to deal with itself and with life. It wants that. So if you can give it a little bit of success at that in the sessions, uh, it starts to regulate the person. And I mean, ideally, you're looking for them to get a little hopeful, like, oh my God, I think this is starting to work for me. And then they get more motivated and maybe they'll start doing homework because you do tell them the more you practice this on your own, the faster your brain begins to develop a new way to regulate. And you can fill in some of the time that, you know, you were only in therapy one hour a week, but you could decide to do it 10 minutes a day. Sure. And, um, and then we could move a little faster, you know? So do you still want me to talk about interventions or do you want me to-

Dr. Keith Sutton (00:34:32):

Well, let's go. So it sounds like you were saying first that you're kind of addressing those away strategies, increasing more of that kind of attachment structure, which then you're moving into then doing some of the reprocessing. Is that kind of the, the map?

Rachel Walker, LMFT (00:34:50):

There is, although there's many, there are a number of different elements to treatment that helps reduce the turning away thing. There are a number of elements. So attachment is, is just, one is just one, but it turns out, you know, for adults, when you get their prefrontal cortex online in service of actually looking at what's going on and you in the session, you help them remain regulated while they're doing that. The prefrontal cortex gets a little stronger at that. And, and actually you want to recruit their most high functioning self or part to be the one that's getting smarter and more capable at looking internally and dealing with what upsets them. And so the interventions go very slowly. They start kind of cognitively with some education. Is this all this making sense to you? You give them some basic information about the map that I'm just describing.

Rachel Walker, LMFT (00:35:59):

So it's super transparent, very collaborative. Very, very, you know, one adult to another. And then typically what I'm doing is I'm moving from some education to saying, are you willing to try doing a little bit of looking at what's been going on? If we're able to keep it kind of low key, like you can walk out of here and go back to work. Are you willing to try it? Yes. I'm willing to try. And so then I do a kind of a guided mapping, what I call mapping. Many people have ways of mapping. And so I have a way myself, which I teach where you take one particular part or symptom and you draw it on a piece of paper. And then in a very methodical way, the client thinks through some questions that I log at them. Yeah. Where do you feel it in your body? St you know, very therapeutic questions, very simple. What does this symptom think about when it's really activated and, um, what are its emotions and just write those down. So you're keeping them task oriented while they're looking. That is the process of thinking and feeling at the same time. It's the definition of being in your window of tolerance. So basically you're just

holding their hand while you're helping their prefrontal cortex turn internally towards the symptom, remain regulated and begin to learn about it.

Dr. Keith Sutton (00:37:28):

So they're kind of staying grounded, like kind of in that concrete wall, making contact with it kind of connecting like that upstairs, downstairs brain?

Rachel Walker, LMFT (00:37:39):

I guess you could call it that in my language, I would say you're keeping one foot very much in the present by having them describe it without being swept up inside it.

Dr. Keith Sutton (00:37:55):

Not being in it.

Rachel Walker, LMFT (00:37:56):

That's right. So you ask them sort of character logical questions about it, and then you ask trauma oriented questions about it. Like if this symptom we're trying to help you in some way, how might it be working on your behalf? What would its mission be if you were just going to speculate about that?

Dr. Keith Sutton (00:38:21):

And is this influenced at all by internal family systems?

Rachel Walker, LMFT (00:38:24):

Yes.

Dr. Keith Sutton (00:38:26):

That concept that heart is trying to help you in some way, and that we need to understand it and get to know it and have compassion for it rather than just try to get rid of it.

Rachel Walker, LMFT (00:38:36):

So when you put it in that way, I guess I could ask you, what are you doing when that happens? Are you turning away from it or are you turning toward it? Are you developing attachment feelings towards your symptoms or are you hating on them and being terrified of them? So it in my way of working IFS, internal family systems, is an incredibly practical way to begin doing the muscle building. I could say of the prefrontal cortex to actually really turn towards and develop, understanding, acceptance, valuing, caring about the symptoms, extending that feeling towards the symptom, and then viscerally calming it down through care and love. That is a second stage in the treatment progression that I teach. I teach working on paper education, working on paper first, very cognitively, and then moving into something like IFS. And the reason for that is that for people who are very dissociated to feel their feelings triggers their phobia. And so I think about going into the waters of what their feeling of their vulnerability or what they've left behind very gradually starting out in shallow water and gradually deepening so that the most adult part of them is beginning to learn that they can handle it and they understand the steps, you know, they're feeling they're not going to be thrown in somewhere.

Dr. Keith Sutton (00:40:23):

So there, you know, sometimes with my clients, especially with trauma, is that, you know, you're the, you're the captain of the ship here and that, you know, really kind of making sure that they've got the agency. And I think, like you're saying with the transparency kind of knowing where they're walking rather than, but they're feeling like the therapist just going to toss them in the deep end.

Rachel Walker, LMFT (00:40:41):

Yes. So for people who do internal family systems, it's kind of the thing and you don't need anything else. I haven't found that, I have found that these ways of working inter modely, I don't want to say modely, I want to say modeling, meeting the models, bringing what the models do best and what they each have to teach us together to form the picture of what the map is has been. I become quite a believer in this, that the eyes of the many tell us much more than the eyes of just one person or two people, you know, not just Richard Schwartz and not just Francine Shapiro. Yeah. Not only own a Vander Hart, you know, he's structured association guy, right. We want to take what they see and saw and figured out. And we want to put all of that into a room together and start being able to grok more of the whole picture because each of the models gives us a slice of what it is that's happening. So people who do only IFS work with highly dissociated people, always in the same way. I don't, I work step-by-step and I merge the interventions in a kind of progression.

Dr. Keith Sutton (00:42:06):

In that Integrative way.

Rachel Walker, LMFT (00:42:07):

In that integrated way. That's right.

Dr. Keith Sutton (00:42:09):

Different from an eclectic where it's just doing different things, but more integrating these different into overall mapper direction.

Rachel Walker, LMFT (00:42:17):

That's right. There's one overall map. And then the interventions, well, and the map helps you case conceptualize. What is, what has happened that has given the elements I talked about before, what has happened via attachment and adaptation to not enough attachment traumas, adaptation, what has happened to create all of these symptoms? That's your conceptualization. And then how dissociated is the person on the spectrum? Where do I meet them, where they are, and begin moving forward towards decreasing the dissociation in preparation for trauma processing, we're building the adaptive information processing system, building that gradually through decreasing the dissociation and enhancing attachment circuitry until eventually the client is stable enough that they can go into the pain and have it be productive.

Dr. Keith Sutton (00:43:20):

So there's the first part where kind of decreasing the away behaviors and staying kind of a bit more cognitively psychoeducation and then mapping the parts. And again, kind of having that one foot in and then you're kind of moving into then kind of, did you say, I think the second stage of where then they're beginning to do more of that parts work and making more contact with those parts and the highly functional part is kind of beginning to build some confidence that they can kind of go into that. And what's the next stage I'm dying to know what comes next?

Rachel Walker, LMFT (00:43:58):

Well, once that gets started, typically speaking, I'm looking to go deeper into probably, well, it really depends on the client. It really depends on the client, like where things morph from there. But, I, at a certain juncture when the client is starting to get pretty some facility with being competent with their own symptoms, meaning they're able to experience them as parts of self extend care and compassion and acceptance and validation to them, and actually have that calm down the symptom. Like they're starting to get that little feedback loop at some juncture. I tend to introduce some more heavy duty attachment repair protocols, which are really big into bringing images and visceral feeling of attachment figures into the mind's eye and working through obstacles to positive attachment and developing more and more capacity to soak in positive attachment feelings through the imagination and getting better and better at feeling into that. This process tends to make their care for their own parts, you know, kind of go on steroids again, much, much better at it. The more their own internal attachment system begins to get stronger. They're more capable of tolerating, positive effect around relationship, basically. So I tend to begin in bringing that into the treatment too, is when they start getting the sense of how to work well with their parts. And so that's the next, usually the next stage.

Dr. Keith Sutton (00:45:49):

Can you give me an example of that? Is this with their actual attachment figure of a parent or someone who oftentimes was the traumatic one, or is this like a nurturing figure, like an EMDR where you're bringing in the imagination of somebody, or like a mother also thinking of like February man, Milton Erickson, kind of a hypnosis technique of kind of bringing in an imaginary person that the person almost installing a memory of an attachment, even though it wasn't there.

Rachel Walker, LMFT (00:46:14):

Yeah, that's right. That's right. Well, actually you just said it, installing the reality of an attachment figure because as long as the person is incredibly engaged in the imagery and they're feeling it through and through the brain, doesn't really know the difference. I mean, it knows some, maybe some of the difference, but the person can get much, much more engaged with an internal process with an attachment figure. Then you would imagine it is quite remarkable and along the way you trigger all of their attachment wounding, and this is the attachment figure is typically the resource they need to heal that.

Dr. Keith Sutton (00:47:02):

And are you bringing in just an imaginary? Or is it of somebody that-

Rachel Walker, LMFT (00:47:09):

These days I just bring in imaginary ones and there are so many creative ways.I think when you were just asking this question, you list in reference five people. You know, I don't even know all those people, but there are many, many ways and it's totally fine to use any of those. The one I got the most excited about this was maybe two or three years ago is called the ideal parent protocol. It was developed by two Seminole people in the attachment field. And I think it was kind of a culmination of their careers, an amazingly beautiful protocol and extraordinarily evocative. And I read about it when I was deep, deep diving into attachment and I just started using it right away. It's so triggering. It's wonderful.

Rachel Walker, LMFT (00:48:03):

It's so triggering. So when the client's ready and you're ready to start processing their attack, the paradox with attachment, which is that you long for it, you need it in order to survive and be okay. And yet for most of our clients, and maybe for us too, it evokes either, you know, terror or rage or, you know, feelings of betrayal, basically, it's just not safe. You cannot rely on that. So that's the paradox that has to be healed deep down, that is the, what did we call it? The nutrient rich soil that you need to get to in order to develop the adaptive information processing systems. So you have to go there at some juncture in my book, you have to be able to go there, but all I was saying is that, so I've been using the ideal parent protocol, but, I've also been into the comprehensive resource model CRM. They have a whole way of integrating these same attachment feelings, using animals, using elements from nature, using spiritual beings. They don't really care, you know, anything that the imagination conjures, they just lean into and bring attachment behaviors to that. And it's beautiful, you know, it's beautiful. So it's fine to be creative.

Dr. Keith Sutton (00:49:25):

Sure, sure. Definitely. Well, that's the wonderful thing about the integrative work is that if you have that kind of theoretical map and you can bring in different interventions, and kind of integrate what works best with your own even personality, too, if you're gonna bring art to bring kind of cognitive exercises or so on. Or oftentimes I do some of this, I also do family work and oftentimes I will bring in the parents if that appropriate into a situation. A young woman I was working with was in a abusive relationship during your late teen years or things like that, never talked to her parents about it. And then part of it was shoring up her attachment with the parents as an adult. And her parents were a great resource, but bringing in that resource in, in real time, integrated ways or moving from an individual or to bringing a partner in to do EFT. So then working on the attachment with the actual current partner and integrating that with the EMDR.

Rachel Walker, LMFT (00:50:26):

It's a lot easier when a traumatized, a person with attachment wounding, at the base of their complex PTSD symptoms. You know, it's so much easier when that person has done some attachment repair work just internally on their own. For the attachment to begin to be productive for them to be able to be working with the tools and the partnership or with their parents more effectively, you know, with a family or their partner more effectively, it's so much easier when the trauma survivor has been able to practice some of it on their own with a good guide. And so they have some of that positive affect tolerance already installed and worked on, and some of the obstacles have been smoothed out.

Dr. Keith Sutton (00:51:19):

So I'm mindful of time here and I want to make sure we get kind of the whole progression. And so then we get to the then the parts work, and then you're going deeper into the attachment piece and kind of building that foundation or those structures. Where's it going from there again, depending on clients response to the situation?

Rachel Walker, LMFT (00:51:41):

Well, what I found is that, maybe we won't have time for me to speak to where my learning edges now, what I'm really excited about, but what I find is that the process, well, we very well may begin moving into, or weaving in trauma processing at this juncture because they're basically feeling a lot better. They're less sort of terminally thrown off balance by life. They're dealing with stressors in the way you would want to see, and they are sticking less, you know, they're less floored by that interaction with

their boss. And they were at the beginning of the therapy, they've reset, eat more easily. So we might begin doing some EMDR processing just beginning to weave that in. And what I witnessed is that when the dissociation is being addressed, the need for attachment circuitry, getting activated and more and more robust is being addressed, the trauma processing is being addressed.

Rachel Walker, LMFT (00:52:55):

The brain and body of the human being begins to stitch itself together. Like we don't have to do everything, you know, with these elements in place, it begins to come together and they begin to have a sense of how to operate and within their own life. And at a certain juncture, you're looking at a massive amount of frustration and grief that it's taken so long to become functional in the way they actually feel like a whole person, right. They're all here. And yet it's been so taken them so long. Sorry, again, so many people, you know, cry about that, we cried together really sad. It took 50 years. I'm so sorry, you know, anyway, so there's some of that to contend with, but there is also the frustration and there is a sort of point at which they are just desperate to grow in the way they have been avoiding growing or the things they tried and that constantly got interrupted.

Rachel Walker, LMFT (00:53:59):

And so there's this sort of growth period in the therapy where you're really encouraging them to go out and try their wings, you know, go on, go out there and we're working on risk-taking and re-engaging with whatever, whatever it is dating or upleveling around your job or doing that thing, you always long to do that, what we're scared to do or failed at so many times you gave up like re-engaging with all these things. And im going to slip it in the last few minutes. The thing I'm most excited about right now is during that process, almost every person that I work with comes in at some juncture and says, you know, I think I have a problem with bad habits.

Rachel Walker, LMFT (00:54:51):

And I say, yes, yes, you do. Yes, you do. So the habit center of the brain, the basal ganglia is my newest, exciting edge. And it has everything to do with the period of therapy. Well it could be worked with all along for sure, but the way I see it in the progression, how I work, it sort of naturally emerges as the person is longing for post-traumatic growth. They're longing to move beyond their trauma into something that is more alive and real and integrated and feels like their whole being is involved in their life. And what they find is that this little basal ganglia guy was so important to everyday functioning has also encoded emotions from the past. Thoughts loops from the past and even behaviors from the past that have been outside of their ability to gain any traction with.

Rachel Walker, LMFT (00:55:59):

And this process of beginning to weave in habit work, which is its own thing, it's its own thing. Habits ingrained habits do not respond to just different thoughts and they don't respond to moving a memory. That's not going to change them. They don't respond to having a great attachment figure. They're just their own little thing in there. You know, you procedurally learned this thing and it is running of its own accord. But the cool thing is, is that there's a lot out there now about hacking habits and, slipping in new ones. And how the basal ganglia works. It's actually super simple, or part of the brain, I don't want to call it its own organ, but section of the brain, it's very simple. And they, the scientists, not therapists have just watched it work.

Rachel Walker, LMFT (00:56:59):

They've tracked it, they've mapped it out and they can teach you all that. There are all these hacks and books. And certainly Joe Dispenza is all about this. He's all about engaging with the habits of the mind in new ways through meditation and other people write about how to engage the habits directly through behavior. So anyway, there's a lot out there. And the cool thing is, is that once a lot of the trauma adaptation that we can affect through trauma therapy has been worked with working with the habits is really effective. And it's very exciting.

Dr. Keith Sutton (00:57:39):

Sure. Well, after doing all that work, it sounds like the person's really primed to make some of those changes. Where they go much harder to work on with all the other stuff going on, because it's hard to shift that and learn new procedural habits when things aren't safe, you need to kind of rely on what's worked before. And so changing it up and doing something different is, is kind of the lower on the hierarchy of needs at that point.

Rachel Walker, LMFT (00:58:07):

It triggers too much survival terror. You said it beautifully.

Dr. Keith Sutton (00:58:15):

Well, it's wonderful. This is so great to hear about your work. And it's just got my mind, I'm like interested in learning all these different kind of pieces that you're bringing in. There's so much depth here and I know you also do trainings, is that right? I think you also have a, is it a book or a handout on mapping the parts and so on and kind of your way of doing it? So there's a lot of really great resources and I know you run consultation groups and so on.

Rachel Walker, LMFT (00:58:41):

Yes I do. And yeah, the training is at the crossroads of trauma therapy and it lays it all out step-by-step and then there's a website, the tools for help give, bring this integrative approach directly into your sessions with clients like scripts and books and pictures is all there at the trauma recovery tools.

Dr. Keith Sutton (00:59:03):

Okay, perfect. Well, I'll link to that on our website where you can get all that information. And I really appreciate you taking the time today. This is wonderful. It's always great to hear about people doing innovative work and integrating, and it's really important because there's so much out there. And it sounds like again, that your, your work and your integrative work is driven by helping your clients and kind of going beyond places where you get stuck. And I think that's just so important for clients as well as for the field. Well, thank you so much. I appreciate you taking the time today.

Rachel Walker, LMFT (00:59:33):

So nice to meet you Keith.

Dr. Keith Sutton (00:59:34):

So nice to meet you too. Take care. Bye-bye.

Dr. Keith Sutton (00:59:41):

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Speaker 3 (01:00:45):

[inaudible].