

Most people who choose EMDR therapy have already learned to leave, in one way or another. Dissociation is not a failure, it is a survival strategy that once kept the nervous system afloat. The task in EMDR is not to bulldoze through it, but to help the person return to the present often enough, long enough, and safely enough for the brain to complete what it started years ago. That is a delicate craft. It calls for patience, precise pacing, and a shared language for what presence actually feels like.

What dissociation looks like in the room

Dissociation arrives in more than one outfit. Some clients feel woozy or far away. Others watch themselves from across the room. Words evaporate. Time warps. A client's eyes glaze as if they took a long blink and never quite opened it. I have seen dissociation present as a tiny cough that starts with harder material, a foot that begins to rock, a stare to the left corner where a window once was in a different apartment. It can be subtle, and by the time it is obvious, the client is already partly gone.

Language gives us shorthand. Depersonalization, the sense I am not real. Derealization, the world is not real. Absorption, lost in a thought or image. Time loss, I missed a few minutes and do not know where they went. For clients with complex trauma, dissociation can include parts of self that hold specific roles, like the part who performs at work, the one who stays small to avoid harm, the one who carries rage. None of these are pathologies in themselves. They are adaptations. Our job in trauma therapy is to invite enough connection between parts and enough regulation in the body that processing can proceed without flooding or numbing.

How EMDR engages a dissociative system

EMDR therapy uses bilateral stimulation, typically eye movements, taps, or tones, to activate the brain's natural information processing system. The method tracks three channels, images or sensations, negative belief, and emotion, while adding dual attention. One foot remains in the present, sensations of the chair, therapist's voice, breath in the belly. One foot touches the past, a memory or the felt sense of a longstanding pattern. When dissociation is active, dual attention collapses. The past floods the present or the present disappears. To keep a client engaged, we widen the window of tolerance through preparation and tailor the speed and intensity of processing.



Empower U Bilingual EMDR Therapy
69R3+GW Ladera Ranch, California, USA

Many clients think EMDR will look like a movie montage of terrible scenes. In practice, we rarely start there, especially when dissociation is part of the picture. We begin by building resources, testing anchors, and mapping what presence and absence look like and feel like for this person. The aim is not to eliminate dissociation on day one, it is to increase voluntary control over state shifts, so that the client can notice, name, and nudge their arousal back toward midline.

Why dissociation shows up during processing

Dissociation is a threat management tactic. When arousal or emotion spikes beyond what the nervous system can meet, the system reduces awareness, sensation, and sometimes even memory formation. In EMDR, the combination of activating a target and adding bilateral stimulation can push arousal unpredictably. If we go too fast, the client may float **Counselor** away. If we go too slow, we can get stuck in rumination. Pacing matters as much as method.

Three threads often drive dissociation during EMDR. First, overwhelming affect without enough regulation skills in place. Second, functional dissociation learned over years, for example in high-performing adults who cut off from body signals to keep going at work, which can generalize into therapy. Third, structural dissociation, where parts of the personality have limited access to each other's memories, beliefs, and sensations. The more parts are split off, the more careful we must be about target selection and the more frequently we might shift from processing to stabilization.

I track three metrics in session to catch dissociation early. Eyes, breath, and speech. Eyes that stop tracking and lose saccadic movement, breath that becomes shallow or irregular, and speech that thins out or shifts tone. These are not perfect markers, but paired with a client's own signs, like numb hands, a metallic taste, or a sudden headache, we can often intervene before the client leaves the room.

Preparation is not optional

Clients who dissociate need preparation that is concrete, practiced, and portable. If I ask someone to slow their breath, I need to know they can find and feel their diaphragm at home, on a bus, or while on hold with the insurance company. I expect to spend anywhere from two to ten sessions in preparation, sometimes longer for those with complex PTSD or active self harm urges. That is time well spent.

Resource installation, in EMDR terms, often includes Safe or Calm Place work, nurturing, protective, and wise figures, and a future template for handling triggers. With dissociation, I prefer to build a Present Place first. Where in your body do you feel right now, even if it is not pleasant. What means you are here. Can we turn up a little more color in the room, notice edges of objects, count vertical lines. This is not distraction. It is orientation. When orientation becomes a practiced pathway, it is easier to return to it when activation rises.

I also use brief interweaves borrowed from approaches like CIPOS, constant installation of present orientation and safety. For example, a client might hold a tactile anchor, like a cool stone or a textured band, while tracking eye movements. Between each short set, they scan the room and name three blue objects. It looks simple. The effect is not. Over several sessions, the brain learns, I can visit the past a little and still know it is the past.

Assessment tools have a place, but they are not the work. A screening like the DES-II can highlight dissociative tendencies, and the MID can clarify patterns for those trained to use it. The richer data come from collaborative mapping. What happens in your body right before you go blank. What pulls you back. What counts as too much. We write down a shared language. Sometimes we borrow the client's own phrases. One person called their pre dissociative state the elevator. The elevator doors are starting to close. That image let us intervene five seconds earlier than before.

Five core practices that help clients stay present

- Establish shared stop and slow signals, then actually use them. A raised palm or the word pause ends the set immediately. A small wave or a single tap on the chair slows the pace, longer pauses, shorter sets. Rehearse this twice before the first processing set. Clients who dissociate often doubt their right to ask for changes. Practicing the signals primes action under stress.
- Anchor in sensory details that travel well. Sight and touch are most reliable. Keep a textured object in hand, feel your back against the chair, name a color you can see without moving your eyes. Weave these elements into the sets, not only before and after. If eye movements feel too floaty, switch to alternating taps on the knees or handheld tappers. Many dissociative clients tolerate tactile stimulation better at first.
- Titrate activation with micro targets. Instead of running the full memory, select a slice, the sound of the door, the feeling in the throat, the belief I am trapped. Run sets for 10 to 15 seconds, then orient. If SUDS jumps more than 2 points, downshift to preparation, orient to present, drink a sip of water, or swap to a benign target like the sensation of bare feet on a warm deck to re establish dual attention.
- Keep a visible here and now anchor in the visual field. A printed card on the wall that reads You are in my office on Tuesday, 3 p.m. Can cut through fog without requiring the client to find words. Some clients choose a photo from a current safe place. When dissociation hits, simple factual orientation outperforms interpretive language.
- Pre plan a friendly disruption if trance deepens. Agree that if the client's eyes lock or they stop responding for more than ten seconds, the therapist will switch to a present focused prompt, call the client's name, invite a stretch, or ask for a temperature check of hands. Tiny motor tasks often bring back the frontal networks we need for dual attention.

These practices are ordinary, which is precisely the point. Presence is muscle memory, not magic.

A case vignette, with the edges left on

A software engineer in her thirties, an immigrant who had navigated three countries in a decade, came for anxiety therapy that flared during code reviews. She described freeze and a sense that her hands were rubber. Childhood had included long stretches of caregiver absence and periods of community violence. She was articulate and charming, and also spent much of the first session looking at the corner of the ceiling.

We spent four sessions in preparation. We found that tactile stimulation worked, tones did not, and eye movements were tolerable only when paired with a cool stone in her palm. We built a Present Place anchored [Depression therapy](#) to her new kitchen floor, patterned tiles, cool under bare feet. We set stop and slow signals, and I insisted we practice them until they felt slightly silly.

On the first processing day, we selected a micro target, the moment a manager shut the door behind her during a review, sound of latch, pressure in throat, belief I have no escape. Sets lasted 12 to 15 seconds. After the third set, speech thinned and her pupils drifted. I named the present, you are in my office, the plant is to your right, feel the chair at your back, and asked for her hands to rub together, briskly. She returned with a deep sigh, that was close. We stayed on the edge of the target for eight short sets, then closed with future template work, picturing her standing to open the office door a few inches at the start of reviews.

Across six processing sessions, dissociation still arrived, but later and with less force. SUDS peaks ranged from 6 to 8 at first, then capped at 5. She began to notice early cues in daily life, a small drift right before she froze. She started scheduling reviews in a room with glass walls. A month later, she described feeling present 70 to 80

percent of the time in meetings. The remaining work moved to attachment themes and the part of her that believed visibility meant danger. None of this was linear. It was human.

Adjusting EMDR without losing EMDR

Purists worry that too much modification turns EMDR into something else. I share the concern in the abstract. In practice, you can adjust a great deal while remaining faithful to the model.

Set length and speed matter. For clients who dissociate, I often use slower, shorter sets. I track the eyes deliberately rather than chasing rapid movement. If eye movements produce a floaty feeling, I pivot to alternating tactile taps. If a client has migraines or seizures, I coordinate with medical providers and select the gentlest form of bilateral stimulation, often the lightest knee taps with generous pauses.

Target selection matters more. Start with present day triggers that are annoying but not annihilating. Let the brain rehearse success. Then step back to feeder memories. If you find attachment targets that carry global beliefs like I am unlovable or I cannot trust anyone, expect more dissociation and build more scaffolding.

Interweaves are a tool, not a crutch. When a client is stuck looping, I offer contextual facts that orient to time, you are 34, you live in Washington Heights, the year is 2026. Or I ask a parts informed question, is the part who is here old enough to drive. If no, we invite an adult self to hold the hand of the younger one. This is not analysis. It is a small bridge that allows the processing to continue.

Session length matters too. Ninety minutes allows room to titrate and still close well. If insurance or schedules limit you to 50 minutes, respect that boundary and plan accordingly. One target slice per session can be plenty.

When depression and anxiety complicate presence

Depression can flatten sensation so completely that dissociation hides in plain sight. A client reports feeling nothing, not numb, just gray. In depression therapy, I move more intentionally through activation. We bring online any sensation that carries even a hint of aliveness, the warmth of tea in the mouth, the weight of the body in the hips. I also keep a closer eye on sleep and medication side effects, particularly anything that blunts arousal, because those can reduce the vividness of present moment anchors.

With anxiety therapy, dissociation often follows panic. The body overshoots, fear whites out, and the client goes away to escape. Here, the work is to lower the ceiling without dropping through the floor. Grounding that focuses on exteroception, sight and sound in the room, helps more than breath work alone. Breath can be a trigger for some panic clients because it draws attention inside. Cold water on the wrists, naming street names between the office and the subway, **Psychotherapist** and a brief walk after session can reduce post processing spin.

Medication is not the enemy of EMDR, but timing matters. If a client takes benzodiazepines before sessions, arousal may drop so low that processing stalls. If they are starting an SSRI, the early weeks can bring jitter or brain fog. Name these factors openly. Adjust pace. It is better to spend three extra sessions preparing than to force processing and watch the client leave the room in more ways than one.

Cultural and immigration considerations

Therapy for immigrants involves more than translation. Dissociation often carries cultural meanings. In some communities, dissociative experiences are framed as spiritual visitations or moral weakness. If a client sees their episodes through a spiritual lens, I honor that language and work alongside it. Orientation to present time and place does not conflict with faith. It protects the nervous system enough for meaning making to deepen rather than collapse.

Language matters. Many bilingual clients describe different emotional textures in different languages. I invite clients to process in the language that matches the memory, then orient in the language of the present. That switch itself can act as dual attention. When working with interpreters, we slow way down and agree on consistent terms for body sensations and parts of self. We also discuss safety planning that reflects immigration specific stressors, like asylum **Trauma therapy** hearings, family separation, or the unpredictability of work permits. Trauma therapy that ignores these realities risks pathologizing survival strategies that are still needed outside the office.

Logistics matter too. For clients who travel long distances for work or who share crowded housing, home practice must be compact and quiet. A single anchor card in a wallet, a small smooth bead, a one minute orientation script recorded on a phone in their first language, these details make presence more portable.

Telehealth without the drift

Virtual EMDR is possible with dissociative clients, but you need a few extra rails. I ask clients to set their camera at eye level, light their face, and clear the space behind them. If they tend to look away to dissociate, we name that early and agree on whether that is acceptable or a sign to pause. I often use self taps on the shoulders or upper legs on video, paired with present orientation prompts. We also plan for reconnection if the signal drops, including a backup phone call and a protocol for how to re ground before resuming.

The biggest risk in telehealth is the softening of the frame. Set a visible clock if needed. Use a closing ritual that marks the end of work, stand up, stretch, look out a window, drink water. Clients who leave video sessions and

walk directly into a kitchen full of family need a bridge. I often ask them to schedule a 10 minute walk or a shower right after.

Measuring progress when dissociation is part of the picture

Progress shows up in many small ways. A client notices early cues and uses a skill within 30 seconds instead of 5 minutes. They can maintain eye contact during a short set without floating. SUDS rise in a controlled way and settle within the session. They catch themselves before they go to the elevator, to borrow my client's metaphor. Time loss shrinks from 10 minutes to 30 seconds. They leave sessions tired but not obliterated, and sleep reasonably well that night.

I rely on both numbers and narratives. SUDS changes matter, but so does the client's language. If they say, I felt scared but knew I was here, that is a sizeable win. If they can hold contradictory truths, my father was dangerous and I am safe now, that suggests integration between parts is growing. We also track post session functioning. Can the client drive home safely. Can they attend to work later the same day. If not, we downshift pace.

A short between session checklist for clients who dissociate

- Rehearse your present orientation script once daily. Keep it to 60 to 90 seconds, speak it out loud, today is Tuesday, I am in my apartment in Queens, the plant is on the shelf, my feet are on the rug.
- Carry one portable anchor. A small textured item you can touch without drawing attention. Pair it with one breath that emphasizes the exhale.
- Limit high intensity trauma content after sessions. No documentaries or long news scrolls that feature your triggers on the same day as processing.
- Move your body gently. A 10 to 20 minute walk, light stretching, or a warm shower helps the nervous system settle and prevents late evening spikes.
- Log two early cues and one successful intervention. Write a single sentence each. I noticed my hands went numb in the meeting, I rubbed my fingers and looked for the color blue.

These practices are not homework for gold stars. They are the scaffolding that makes in session work viable.

When to pause or change course

There are times to slow or suspend EMDR. If dissociation increases significantly between sessions, if self harm urges rise, if nightmares proliferate beyond what the client can tolerate, or if daily functioning drops under a threshold the client sets as essential. The threshold is individual. For one person, it may be attending classes. For another, caring for a child safely. When those lines are crossed, stabilization becomes the treatment, not the warm up. That may mean more skills work, consultation with a psychiatrist, or coordination with a higher level of care.

Clients with diagnosed dissociative disorders can benefit from EMDR, but only with clinicians trained in that territory and only within a phase oriented approach. Safety and stabilization first, then careful processing, then integration. The presence we seek is not a trick we pull in one session. It is a relationship we build with the self.

Final thoughts from the chair

Staying present during EMDR processing is a shared practice. The therapist learns the minute geography of a client's nervous system, where the cliffs are and where the footholds lie. The client learns that presence is not passive. It is the active work of sensing, naming, and choosing. The two of you build a map that includes detours and rest stops, not just a single straight arrow through the dragon's lair.

Along the way, you will notice that work on dissociation tends to lift other symptoms. Anxiety therapy begins to stick because the client can face arousal without exiting. Depression therapy gains traction because the body can feel and care again. For immigrants carrying multi layered stress, presence becomes a resource that travels across borders and interview rooms and new apartments. Each of these changes is small on its own. Stacked together, they create a kind of freedom that does not rely on forgetting. It relies on remembering, while staying here.

Empower U Bilingual EMDR Therapy

Name: Empower U Bilingual EMDR Therapy

Address: 12 Tarleton Lane, Ladera Ranch, CA 92694

Phone: (949) 629-4616

Website: <https://empoweruemdr.com/>

Email: cristina@empoweruemdr.com

Hours:

Sunday: Closed

Monday: 8:00 AM – 7:00 PM
Tuesday: 8:00 AM – 7:00 PM
Wednesday: 8:00 AM – 7:00 PM
Thursday: 8:00 AM – 7:00 PM
Friday: 8:00 AM – 5:00 PM
Saturday: Closed

Open-location code / plus code: G9R3+GW Ladera Ranch, California, USA

Coordinates: 33.5413483,-117.6452347

Map/listing URL:

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Empower U Bilingual EMDR Therapy provides online psychotherapy for bicultural individuals, immigrants, and adult children of immigrants in California.

The practice is led by Cristina Deneve, MA, LMFT #132306, an EMDRIA Certified therapist licensed in California.

The official website emphasizes online therapy in Irvine and throughout California, while the matching public listing shows a Ladera Ranch address for local reference.

Listed services include EMDR therapy, trauma therapy, anxiety therapy, depression therapy, therapy for immigrants, terapia en español, parenting support for immigrants, IFS therapy, CBT, and DBT.

The practice focuses on transgenerational trauma, complex trauma, cultural identity stress, guilt, self-doubt, anxiety, depression, and the pressure of living between cultures.

Empower U Bilingual EMDR Therapy may be relevant for clients seeking therapy in English or Spanish with a culturally responsive, trauma-informed approach.

The official contact page states that therapy is currently online only, so prospective clients should confirm appointment format and California eligibility before scheduling.

To contact the practice, call (949) 629-4616, email cristina@empoweruemdr.com, or visit <https://empoweruemdr.com/>.

The public map listing for Empower U Bilingual EMDR Therapy can help clients verify the Ladera Ranch listing while the official site provides the most direct scheduling and service information.

Popular Questions About Empower U Bilingual EMDR Therapy

What is Empower U Bilingual EMDR Therapy?

Empower U Bilingual EMDR Therapy is a California psychotherapy practice focused on online trauma therapy, EMDR therapy, and culturally responsive support for bicultural individuals, immigrants, and adult children of immigrants.

Who is the therapist at Empower U Bilingual EMDR Therapy?

The official site lists Cristina Deneve, MA, LMFT #132306, as the therapist. She is listed as EMDRIA Certified and licensed in California.

Where is Empower U Bilingual EMDR Therapy located?

The matching public listing shows 12 Tarleton Lane, Ladera Ranch, CA 92694. The official website emphasizes online therapy only and uses Irvine / California service-area language, so clients should confirm before planning any in-person visit.

Does Empower U Bilingual EMDR Therapy offer online therapy?

Yes. The official contact page states that the practice currently provides online therapy only, and the site says services are available in Irvine and throughout California.

Does Empower U Bilingual EMDR Therapy offer therapy in Spanish?

Yes. The official site includes terapia en español and describes Cristina Deneve as bilingual in Spanish and English.

What services are listed by Empower U Bilingual EMDR Therapy?

Listed services include EMDR therapy, trauma therapy, anxiety therapy, depression therapy, therapy for immigrants, terapia en español, parenting support for immigrants, IFS therapy, CBT, and DBT.

What does Empower U Bilingual EMDR Therapy specialize in?

The official site describes specialties in transgenerational trauma, complex trauma, bicultural identity stress, anxiety, self-doubt, guilt, and challenges faced by immigrants and adult children of immigrants.

What are the listed hours for Empower U Bilingual EMDR Therapy?

The matching public listing shows Monday through Thursday from 8:00 AM to 7:00 PM, Friday from 8:00 AM to 5:00 PM, and Saturday and Sunday closed. Appointment availability should be confirmed directly with the practice.

Does Empower U Bilingual EMDR Therapy accept insurance?

The official site says the practice accepts Aetna, UnitedHealthcare, Oxford, and Quest Behavioral Health insurance plans, and may provide superbills for clients with out-of-network benefits. Clients should confirm current coverage before scheduling.

How can I contact Empower U Bilingual EMDR Therapy?

Call (949) 629-4616, email cristina@empoweruemdr.com, visit <https://empoweruemdr.com/>, or use the listed social profiles: <https://www.facebook.com/profile.php?id=61572414157928>, <https://www.instagram.com/empoweru.emdr/>, <https://www.tiktok.com/@empowerubilingual>, <https://x.com/empoweruemdr>, and <https://www.youtube.com/@EmpowerUBilingual>.

Landmarks Near Ladera Ranch, CA

Empower U Bilingual EMDR Therapy is listed in Ladera Ranch, while the official website states that therapy is currently online only for California clients. Clients near these landmarks can call [\(949\) 629-4616](tel:9496294616) or visit <https://empoweruemdr.com/> to confirm appointment format, service fit, and availability.

- [12 Tarleton Lane](#) — The public listing address area for Empower U Bilingual EMDR Therapy; clients should confirm details before visiting because the official site states online therapy only.
- [Ladera Ranch](#) — The clearest local reference point for the public business listing in south Orange County.
- [Ladera Ranch Town Green](#) — A recognizable community landmark for residents orienting around the Ladera Ranch area.
- [Mercantile West](#) — A local shopping and service area that helps identify the broader Ladera Ranch community.
- [Antonio Parkway](#) — A major local route through Ladera Ranch and nearby south Orange County neighborhoods.
- [Crown Valley Parkway](#) — A familiar Orange County corridor connecting Ladera Ranch with nearby communities.
- [Rancho Mission Viejo](#) — A nearby master-planned community south of Ladera Ranch; California clients can ask about online therapy access.
- [Mission Viejo](#) — A nearby city often used as a regional reference point for south Orange County therapy searches.
- [San Juan Capistrano](#) — A well-known nearby Orange County city and landmark area for clients orienting around the region.
- [Laguna Niguel](#) — A nearby south Orange County community; clients can visit the website to confirm online therapy eligibility.
- [Irvine](#) — The official site uses Irvine service-area language, making it an important local search reference for the practice.
- [Orange County](#) — The broader county context for Ladera Ranch, Irvine, and surrounding communities served through California online therapy.