

THE USE OF EMDR IN PATIENTS WITH DISSOCIATIVE IDENTITY DISORDER

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ABSTRACT

Hyperarousal during trauma inhibits the integration of memory. In DID, memory is further disrupted when alter personalities coalesce around individual memory fragments and either reenact conflicts or disown them. Eye Movement Desensitization and Reprocessing (EMDR) is an innovative psychotherapeutic method which accelerates information processing and facilitates the integration of fragmented traumatic memories. Following a successful EMDR session, patients report that the nature of the traumatic memory has changed and that the event is now less upsetting and "feels over." A strategy for using EMDR to integrate traumatic memories in patients with dissociative identity disorder (DID) is presented and technical considerations for its implementation are discussed. To the extent that alter personalities often are based on memory fragments, integration of traumatic memory facilitates personality integration. EMDR may be a superior method for working with traumatic memories in that it appears to enhance memory integration and reformulate cognitions concomitantly.

INTRODUCTION

Trauma is an etiologic factor in a number of psychological disorders, including dissociative identity disorder (DID) (Bliss, 1980; Boor, 1982; Braun, 1986; Coons, 1986; Greaves, 1980; Kluft, 1984; Putnam, Guroff, Silberman, Barban, & Post, 1986; Rosenbaum, 1980; Ross, Norton, & Wozney, 1989; Saxe, van der Kolk, Berkowitz et al., 1993; Schultz, Braun, & Kluft, 1989; Spiegel, 1984; Wilbur, 1984). As such, the treatment of DID incorporates many of the psychotherapeutic principles and techniques developed for treating other forms of post-traumatic stress. One important

principle in trauma therapy is that of stage-oriented treatment, as first described by Pierre Janet (1919; cf. van der Hart, Brown, & van der Kolk, 1989). Janet identified three treatment stages: 1) stabilization and symptom reduction, 2) treatment of traumatic memories, and 3) reintegration and rehabilitation. Recently, a number of modern authors have endorsed the stage-oriented approach to the treatment of trauma (Braun, 1986; Brown & Fromm, 1986; Herman, 1992; Fine, 1991; Kluft, 1986, 1987, 1988, 1989, 1993a, 1993b; McCann & Pearlman, 1990; Putnam, 1989; Ross et al., 1989; Ross, et al., 1991; van der Hart, Steel, Boon, & Brown, 1993). Although the suggested number and names of the stages may vary, in general, preparation precedes trauma work, and integration of the knowledge and feelings gained from trauma work is the goal during the later stages of therapy.

The integration of traumatic memories in patients with DID has been endorsed as one of the essential goals of therapy and is a precursor to the integration of the person as a whole (Braun, 1986; Kluft, 1984, 1986; Putnam, 1989; Ross et al., 1989; van der Hart et al. 1993). This strategy has been labeled "integrationalism" by Kluft (1993a, 1994) and Fine (1991, 1993), while van der Hart et al. (1993) have referred to it as "synthesis." Braun (1988) has endorsed this philosophy in his BASK model, wherein the integration of the components of memory (i.e., behavior, affect, sensation and knowledge) is an essential task of therapy.

Fine's (1991) tactical integrationist model incorporates both cognitive grounding, a necessary precursor to mastery and control over disabling symptoms, and the resorption of the BASK elements of memory in a structured and playful way. This cognitively based, ordered approach dovetails naturally with the highly structured methodology of EMDR. Paulsen (1995) begins to address some of the benefits of EMDR in the treatment of DID, and her contribution is a welcome addition to trauma therapy. However, Paulsen's approach appears derived from the perspective of an EMDR therapist who discovered patients with dissociative disorders among her clients rather than that of a DID therapist who incorporates EMDR into the treatment plan. Therefore, a careful review and evaluation of EMDR therapy in patients with DID, based on the published literature and current standards of care in the treatment of DID, is in order.

Eye Movement Desensitization and Reprocessing

(EMDR) is an innovative method of psychotherapy which has been shown to be effective in the treatment of post-traumatic stress disorder (Shapiro, 1989a, 1989b, 1991, 1995; Vaughan, Armstrong, Gold, O'Connor, Jenneke, & Tarrier 1994a; Vaughan, Weiss, Gold, & Tarrier, 1994b; Wilson, Becker, & Tinker, 1995). EMDR initially was based on Shapiro's personal observation that the intensity of a disturbing thought diminished when she moved her eyes from side-to-side. Left-right cues in sensory modalities other than vision, such as auditory tones or hand taps, subsequently were found to produce a similar effect. Shapiro hypothesized that alternating attention induces a physiologic effect that facilitates and accelerates the processing of information. EMDR protocols allow a person to resume the productive processing of a traumatic memory, transforming it into a less disturbing and more adaptive form (Shapiro, 1995). While the physiologic basis for this effect is unknown, EMDR appears to be distinct from hypnosis (Nicosia, 1995).

The authors' clinical experience incorporating EMDR into the psychotherapy of patients with DID has been extremely positive. Processing traumatic memories in patients with DID using EMDR seems to provide more rapid emotional relief than non-EMDR-informed therapies and to facilitate integration. This report offers one strategy for using EMDR to facilitate the integration of traumatic memories in patients with DID and presents a clinical example. A theoretic basis for understanding the effect of EMDR is proposed based on the van der Hart, Brown, and van der Kolk's (1989) expansion of Janet's (1919) dissociation-integration model of trauma.

A discrepancy exists between the original use of the term *abreaction*, meaning an "emotional release or discharge after recalling a painful experience that has been repressed because it was consciously intolerable" (American Psychiatric Association, 1984), and the current use of the term in the literature on dissociation, which stresses reexperiencing the traumatic experience without reference to repression (Comstock, 1991; Steele, 1989; van der Hart & Brown, 1992; van der Hart et al., 1993). This paper does not attempt to resolve this discrepancy. Instead, the use of the term "abreaction" will be avoided in favor of other descriptors. "Trauma work" refers generally to therapeutic focus on specific traumatic experiences; "reengagement" is reconnection with a traumatic event; and "reexperiencing" is the subjective consequence of reactivating traumatic material following reengagement.

A THERAPEUTIC STRATEGY

Overview

The use of EMDR to process the traumatic memories of patients with DID is based on the dual assumptions that traumatic memories need to be detoxified for personality integration to proceed and that the patient must be protected

from becoming overwhelmed during memory processing. To achieve this goal, "fractionated abreaction" was developed by Kluft (1989b) and expanded upon by Fine (1991). In "fractionated abreaction," here called, "fractionated trauma work," the therapist-patient dyad deconstruct the traumatic memory into constituent components with manageable amounts of affect and sensations. Individual fragments then serve as discrete targets for separate sessions during which the fragments are reengaged and reexperienced. An outcome is successful when the memory becomes less affectively laden. This processed memory is then incorporated into the ongoing therapeutic work. The piecemeal nature of this work means that complete processing of an extremely disturbing traumatic memory usually requires multiple sessions, with separate sessions focusing on distinct aspects of the traumatic event.

The present approach is a modified version of the eight-phase model developed by Shapiro (1995). Her eight stages are: client history and treatment planning, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation. The primary difference between the standard EMDR protocol and the protocol for DID is that whereas the standard protocol tries to identify and desensitize whatever associations to the trauma exist, the EMDR protocol for DID takes great care not to overwhelm the patient with affectively laden material. This is discussed in some detail below.

It is important to understand that EMDR facilitates reengagement of traumatic memories, so it is expected that the patient will reexperience the trauma during an EMDR session. For this reason, EMDR should be considered a form of trauma work and should not be conducted until the initial stages of psychotherapy have been completed and the patient is ready for such work (Fine, 1991; Herman, 1992; Kluft, 1993a, 1994; Putnam, 1991; van der Hart et al., 1993). In the tactical integrationist model (Pise, 1991), EMDR would be attempted cautiously in the dilution of affect phase of therapy once some of the personalities have surfaced, their distortions have been identified, and cognitive restructuring has commenced. Debilitating waves of affect must be attenuated before introducing therapeutic trauma work (Fine, 1991, 1994a).

EMDR is sufficiently different from other psychotherapeutic methods to require special training. It is essential that clinicians receive formal training and be comfortable applying EMDR's advanced techniques before attempting to use them with patients who have a dissociative disorder. Conversely, experienced EMDR clinicians should not attempt to use EMDR with patients who have a dissociative disorder unless they already have been trained to work with dissociative disorders and have experience treating this population.

The following is a brief description of the standard EMDR trauma protocol. It is presented as background for the discussion of the modification used in patients with DID. Once the determination has been made that the patient is a can-

didate for EMDR, the patient identifies the aspect of the traumatic memory, the scene or image, that represents the most disturbing part of the event. The negative self-belief associated with that scene (e.g., "I'm dirty," for a woman who had been raped) is elicited in addition to an alternative positive cognition representing what he or she would like to believe now ("I did the best I could"). The validity of the positive cognition (VoC; Shapiro, 1989b) is rated on a scale from 1 (completely false), to 7 (completely true). The patient is asked for the emotions associated with the event and rates the level of disturbance from 0 (not disturbing at all), to 10 (the worst experience imaginable) (subjective units of disturbance scale, SUDS; Wolpe, 1956). As the final step in the setup, the patient does a body scan, an imaginal scanning of the entire body to notice what physical sensations are associated with the target memory at the end of the session. Residual discomfort often indicates unprocessed material. Physical sensations can be used as targets for additional sets of eye movements. Thus, the setup can be conceived as an attempt to collect the BASK elements necessary to integrate the trauma. The therapist begins sets of left-to-right hand motions that the patient follows with his or her eyes. During the sets of eye movements (saccades), the patient is instructed to "just notice" what comes to mind. Between sets, the patient describes what he or she is "just noticing," after which another set of eye movements is begun to resume processing. Ideally, sets of eye movements are repeated until the SUDS decreases to 0 or 1 and the VoC is 6 or 7. The session is closed by having the patient pair the original image with the positive cognition, and another set of eye movements is performed to enhance this association (installation). In the event of an incomplete processing, a standard safety assessment must be performed. Any residual discomfort can be dealt with using grounding and relaxation techniques, as well as safe place imagery. A debriefing is performed to explain that processing may continue in between sessions, and that the patient should keep a log of all memories, thoughts, and dreams that relate to the target memory for use in subsequent sessions. Patients are encouraged to use relaxation techniques on their own as needed.

History, Preparation, and Assessment (Shapiro Stages 1 to 3)

EMDR must be used within the context of an established psychotherapeutic relationship in patients who have DID. Many patients initially will not be familiar with EMDR. Therefore, the therapist must provide an explanation of what EMDR is and what it is not, as well as describe its role in the treatment. This discussion should include a candid description of both the importance and the difficulties of reengaging traumatic memories. Patients should be given ample time to have their questions answered before undergoing an EMDR session. The oral consent of personalities associated with the target memory fragment and/or the consent of system-based personalities is requested, with the understanding that out-

of-awareness personalities and personalities who are intentionally hiding may emerge with unexpected material. Once the subject of EMDR has been broached, the interval between the initial discussion and the first session may be anywhere from several days to several weeks or longer depending upon the clinical situation.

The therapist should try to structure the trauma work around a specific aspect of a discrete traumatic event. This approach has two advantages. First, the more precisely the target is identified, the less likely it is that spontaneous affect bridging (Brown & Fromm, 1986) will interfere with processing. Second, work focusing on discrete, rather than complex, targets is more amenable to complete resolution, and thus is more "rewarding" (positively reinforcing) to the patient. Concomitantly, it is important to keep in mind that because the memory is by definition a fragment, processing the memory usually will not resolve the entire event for the patient or the alter. It is helpful to state this explicitly during the preparation for EMDR to avoid the unrealistic expectation of a dramatic, all-encompassing cure.

Initially using targets with a low affective valence gives the patient first-hand knowledge of EMDR without excessive distress and produces confidence in the procedure. The memory should be suggested by the patient and be disturbing but not "the worst." For instance, particularly cruel acts by a chronically abusive father are likely to have extensive associations that almost guarantee more material will emerge than can be managed initially by the patient. A reasonable target is a situation which impacts on day-to-day functioning and may be a derivative of the original trauma. It is preferable to begin work with "older," as opposed to child, alters, as this may afford better protection against overwhelming affect. Nevertheless, regardless of how safe a target seems, it is important to poll as many alters as possible to determine whether it really is safe to proceed.

Example: A woman with DID came to an individual psychotherapy session very upset. She had become angry during group therapy that day when the group leader had failed to come to the main point of her talk on procrastination. The patient saw this event as evidence that she was bad because she had lost control. During the EMDR session, she realized that her anger had been justified in this case and that becoming angry did not constitute losing, but taking control, an insight that made her feel proud. She was able to recall that other group members had thanked her later for speaking up, and she felt validated. The session was concluded as soon as the target issue was resolved and before affect bridging to other traumatic memories occurred.

Ninety minutes is the recommended length for an EMDR session, and sessions with patients who have DID generally should fit into this time frame. Fine's multimodal therapy for DID continues with 45 minute sessions in which EMDR may be one of the methodologies used in the course of the session. Adherence to Kluft's "Rule of Thirds" will increase

the likelihood that the therapist will accomplish this goal successfully (Kluft, 1993a). Lazrove's experience is that some sessions may last longer than 90 minutes, especially when EMDR is first introduced into therapy and when first confronting core issues. Sessions which consistently last longer than 90 minutes suggest that the EMDR targets were too broad, that preparation has not been adequate or that resistance to treatment has been too great. In such instances, the therapist should re-explore what is occurring in trauma work without using EMDR, attempt to understand the road blocks, and try to identify more manageable targets that the patient can approach without undue distress.

EMDR requires greater physical proximity between the therapist and the patient than standard "talking" psychotherapy. The therapist must pay attention to the patient's conscious concerns regarding physical safety as well as to the intensification of transference-countertransference material (Loewenstein, 1993; Kluft, 1994). Demonstrating the arrangement of the chairs prior to sitting down and explicitly obtaining permission to sit closer than is customary conveys the message that the patient retains the locus of control, and may alleviate some overt fears.

Safe Place

It is very important that the therapist help the patient develop competence in the use of grounding techniques prior to reengaging a traumatic memory. One particularly useful technique is the creation of a "safe place." This traditionally has been done using formal hypnosis (Brown & Fromm, 1986), and EMDR offers an alternative methodology.

One protocol for constructing a safe place using EMDR is offered as an illustration: The patient is asked to close his or her eyes and visualize a safe place. The safe place may be imagined or real, a place that exists in the present or the past. Once an image is held clearly in mind, the patient is instructed to open his or her eyes and follow the therapist's fingers. The therapist does one set of eye movements, lasting 30 to 60 seconds, to install this safe place. During the eye movements, the therapist helps the patient to strengthen associations to the safe place, saying, "Notice what it is that makes this place safe," the therapist inquires about sensory input: "Look around, what do you see?" "Listen, what do you hear?" "What do you smell?" Finally, the therapist asks, "Notice what it is like to feel safe."

Once the set of eye movements is complete, the patient is not told, "Let it go," as in the standard EMDR protocol, but is asked how he or she feels. If the patient feels comfortable and relaxed, the patient is told, "This is your safe place, and you can go back to it whenever you want."

Once a safe place is established, the therapist would proceed to the trauma work. However, if the patient does not yet feel safe, the therapist may ask, "What would make this place feel safe?" and this new information is installed. If the

patient is unable to make this place feel safe, then he or she is asked if there might be another place, real or imagined, which would feel safer, and this new place is installed. If the patient is unable to remember or image any place that feels safe, alternative grounding techniques should be used. If there is no safe place and the patient is unable to use a grounding technique, the therapist should reevaluate whether the patient is ready for trauma work.

The formal EMDR setup accesses the memory network associated with the targeted memory fragment. The therapist should attempt to complete the full setup, but in clinical practice this may not be practical. Patients can become overwhelmed while describing an extremely traumatic event and be unable to engage in cognitive tasks, such as rating how upset they are. This may be an indication that there is more work to do in the suppression of affect stage (Fine, 1991); more cognitive work may be required prior to reengaging the traumatic material, or a grounding technique may be indicated. Once the patient has been adequately prepared for extreme affective intensity and is likely to work productively, the therapist should begin desensitization even if the negative cognition has not been elicited during the setup. The positive cognition can be obtained once the patient has processed some of the traumatic material and is feeling less overwhelmed. The VoC still can be used without a negative cognition, however, because it is based on how true the positive statement feels.

Desensitization (Shapiro Stage 4)

The session is structured so that, in EMDR terminology, channels associated with the target are cleaned out one-by-one. In other words, the networks of memories associated with the trauma are systematically processed to completion. As with non-dissociative patients, the risk of "looping" (non-productive processing) is greater in multiply than in singly-traumatized patients. When looping occurs, the therapist should intervene first by using basic EMDR techniques, such as changing the axis of the eye movements. If this is not successful, the therapist should proceed to advanced EMDR techniques, such as the cognitive interweave, to address fears, blocking beliefs (negative beliefs that block processing) and feeder memories (untapped earlier memories that block processing) (Shapiro, 1995). Cognitive interweave is the brief and judicious introduction of new material by the therapist to unmask cognitive distortions, whereby the therapist deliberately interlaces statements using an adaptive, more adult, perspective to catalyze, or facilitate, the processing. Typically, the cognitive interweave is useful in modifying dysfunctional beliefs related to issues of responsibility, safety, and choices that have stalled the information processing. Though the cognitive interweave is sometimes necessary to further the patient's healing trajectory, it is always preferable for the processing to center around the patient's own spontaneous associations.

The number of eye movements included in each set is a clinical decision. The more eye movements per set, the greater the opportunity to process traumatic material. The obvious advantage is that the work may go more rapidly when the processing is therapeutic; the disadvantage is that the abundance of associations that emerge in longer sets increases the risk of overwhelming the patient. Short sets of eye movements (5 or 6 saccades) may be indicated in the patient who is able to tolerate only small doses of affect at a time. Longer sets of eye movements (100+) may be necessary to detoxify extremely powerful traumatic events or when an uncooperative alter personality actively resists the EMDR process. An additional complication with longer sets of eye movements is that some DID patients will lapse into spontaneous trance and disengage from the process altogether.

The existence of alter personalities impacts on EMDR patients with DID in three ways: 1) An alter personality may be owner of a specific memory. In this case the session can be conducted directly with the alter (Kluft, 1982; Putnam, 1989). EMDR with an alter personality follows the same format as sessions conducted with the host personality; 2) Portions of the traumatic memory may be held by alter personalities that are dissociated from the accessed part of the system. This situation precludes full integration of the memory. The therapist must respect this boundary as a sign that conditions exist which make the system unprepared to process all aspects of the memory at the present time. Additional preparation in non-EMDR sessions is necessary before the memory can be fully accessed and metabolized; 3) Switching may occur during the eye movement processing for several reasons. On the one hand, the affective, cognitive or sensory theme may carry over and be passed through to like personalities within a cluster. If this is the case, and the patient is not becoming overwhelmed, the processing may continue with caution. On the other hand, switching may draw attention away from the target. When switching occurs, likely there is a change in the core belief system, the cognitive schema, and probably the active traumatic memory fragment. Switching during EMDR sessions is handled as it would be during any trauma work with a patient who has DID.

Obstacles

There are three obstacles to traumatic memory integration anticipated in EMDR: 1) uncontrolled affect bridging, 2) resistance to cognitive restructuring, and 3) the intensity of trauma work.

Uncontrolled Affect Bridging

The term "affect bridging" originally was developed to describe a hypnotic technique for connecting two memory networks sharing similar affect (Watkins, 1971). The therapist uses the affect to guide the patient over a "bridge" that connects two feelings, identifying new material and reinforcing their association. Currently this term often is used

to reflect the spontaneous association of memory fragments having the same or similar affect, and as such, it is an important part of the therapeutic work (Fine, 1991; Fine 1993). In DID, bridging may link alters who share similar cognitions, affects, sensations, and behaviors, who may have participated in the same events, or who may perceive similarities between events which occurred at different times. Bridging is constructive when it intentionally targets a new memory fragment after the original target has been processed completely or identifies a blocking belief or feeder memory which is impeding the processing of the original target. Affect bridging is non-therapeutic when it distracts the patient from productive work by shifting attention rapidly and frequently, and it is destructive when it produces such an abundance of associations that the patient becomes affectively overwhelmed. Despite the therapist's best efforts to prevent uncontrolled affect bridging, it may, nevertheless, occur occasionally.

When spontaneous affect bridging occurs, the therapist must make a determination as to whether it is therapeutic or uncontrolled. The therapist first should inquire what the patient believes is happening. When processing is therapeutic, the patient should be encouraged to continue processing without intervention by the therapist, as with standard EMDR. When the affect bridging is uncontrolled, the therapist should first attempt to refocus the patient on the original trauma, by returning to the target and asking, "When you think of the original trauma now, how does it seem?" Any change in the original target should be noted and chosen as the revised target. When refocusing is not successful, the therapist should check whether the patient is working on a feeder memory or blocking belief, and if so, the therapist should encourage the patient to "go with it," and process that particular association. On the other hand, if the patient is becoming affectively overwhelmed to the point where he or she is no longer able to process effectively, the therapist should help stabilize the patient using the "return to safe place" or other grounding techniques.

Resistance to Cognitive Restructuring

The fixity of the core negative belief system associated with a traumatic memory, a belief such as, "it is all my fault," or "I'm evil," may be substantial and arrest the progress of the EMDR session. Deeply rooted negative cognitions are likely to have an extensive network of associations, making it difficult to establish cognitive dissonance as a precursor to cognitive restructuring (Fine, 1991). In this case, direct work on core issues is best delayed until the network of associations has been "pruned" by processing some of the less intense associations. Initially avoiding targets with high affective valence will reduce the risk of encountering the most deeply rooted negative cognitions prematurely; (i.e., before effective processing can be undertaken). Therefore working with older alters first, alters who are less immediately connected to the target and who have reached the stage of formal oper-

ations) (Piaget, 1977), is recommended (Fine, 1990, 1991). By working with older alters initially, the patient gains an increased sense of control and mastery over traumatic material and learns through personal experience that one does not die when doing trauma work (Fine, 1990).

Once the main trauma work has begun, instances of ineffective processing invariably will occur. Standard EMDR techniques should be tried first to interrupt the looping (Shapiro, 1995). The cognitive interweave using Shapiro's hierarchy of responsibility, safety, and choices, is an extremely helpful intervention when working with virulent trauma. Additionally, uncovering and processing irrational fears, such as punishment by a dead perpetrator, can restart stalled processing. In many instances, a blocking belief or feeder memory can be identified and processed effectively. When the therapist is unable to interrupt the looping, then intrapsychic conditions may exist which make it impossible to complete the processing of that particular memory fragment. The session should be closed down, and the memory explored further without EMDR.

Intensity of Trauma Work Using EMDR

Performing EMDR when the patient is experiencing intense affect presents an additional technical problem. Intense affect per se is not an indication to interrupt EMDR. However, visual tracking is difficult when the patient is crying or sobbing intensely. Therapists should use their voice to help ground the patient, reassuring that "It is old stuff," and "It isn't happening now," while reminding the patient, "Follow my fingers." If the patient still is not able to track visually, a different sensory cue may be used, such as hand taps or alternating auditory tones. If the DID patient cannot follow the direct prescriptions of the therapist when affect is intense, it is best to close down the EMDR session and shift to a more traditional "talk therapy" to explore the difficulties that are emerging.

Installation, Body Scan, Closure, and Reevaluation (Shapiro Stages 5 to 8)

Because the framework of the EMDR session in DID is predicated upon fractionated trauma work, the assumption is that complete processing of the trauma will *not* occur in a particular session. This approach differs markedly from the standard protocol (Shapiro, 1995) which actively seeks out unprocessed fragments and associations and brings the EMDR session to an end only when the original target and all associated elements are detoxified completely. The DID therapist must accept that the SUDS will not decrease to 0 in most cases, nor will the positive cognition be "completely true." (The SUDS may be 0 and the VoC 7, however, if the memory fragment is sufficiently isolated from other memory fragments). A more realistic goal is to expect that both the patient and the therapist will come away with the sense that something has been accomplished. Perhaps one channel, one frag-

ment, has been processed fully, so that the original target is no longer as overwhelming, or the scene is not as disturbing, or, the patient feels good about saying, "Hey, at least I tried." For installation, the patient should be asked if the original positive cognition (if one had been elicited) still fits, or if there is another positive statement that seems more suitable. However, as the session is incomplete, the therapist may need to assist the patient in coming up with a statement for installation. A useful question to ask is, "Based on what happened today, what is the most positive statement that you can make about yourself?" and the installation is performed. A final VoC may be obtained, but the patient is not asked, "What stops that statement from being completely true?" because the therapist does not want to trigger additional associations at this point.

The body scan also should be modified to account for the fact that processing is incomplete. While checking for physical comfort, "How are you feeling now," is useful in assessing whether a safe end-point has been reached; the therapist does not inquire about specific areas of tension or discomfort since these are assumed to represent unprocessed material which will be addressed in subsequent sessions. Statements representative of a safe stopping place are, "Things are better now," and "A weight has been lifted." The clinician should also do his or her own assessment of the patient's level of disturbance, focusing on whether it is safe for the patient to leave the session. The patient is debriefed and instructed to keep a log, as per the standard EMDR protocol.

The patient should be prepared for the likelihood that processing may continue to occur following a session and be informed that such processing moves therapy along more rapidly. Extra-session processing becomes destructive when the intensity of the emerging material overwhelms the patient, such as occurs with ongoing persistent flashbacks. Therefore, the therapist must assess the balance between ego strength and the patient's affective tolerance in an ongoing manner (Fine, 1994). The use of standard grounding techniques is essential to maintain patient safety and to contain emerging material (Fine, 1993; Kluff, 1991, 1993, 1994; Shapiro, 1995).

Material covered during an EMDR session is debriefed during the next psychotherapy session. This is a continuation of the realization/integration phase of trauma work (van der Hart et al. 1993). Residual areas of distress may be targeted during subsequent EMDR sessions at a rate dictated by the patient's tolerance for trauma work.

Case Report

The following clinical material is drawn from the given history of a patient treated by the senior author (S.L.). It is not known whether the material produced by this patient and addressed in the course of treatment reflects historical events, mental constructions of unspecified origins that do

not depict actual historical events, or a combination of historical and mentally constructed sources. They are presented, despite their sensational nature and their uncertain veracity, because they illustrate the successful resolution of severe subjective experiences of traumatization with the application of EMDR methodologies.

A 27-year-old gay man presented with a given history of DID secondary to extensive childhood physical and sexual abuse. Meeting the dominant, protector alter personality and mapping out the basic system of personalities were accomplished rapidly. The patient was extremely motivated and attended sessions three times a week without fail. The first EMDR session was performed about two months into therapy.

The possibility of using EMDR had been discussed the week prior to the initial EMDR session, and the patient indicated his desire to work on one specific troubling memory. The therapist (S.L.) was concerned that questioning the patient about the memory prior to the actual EMDR session would reengage the memory and thus did not explore the nature of the memory prior to the EMDR session. The actual memory was much different and more traumatic than expected.

As a child, the patient had been sodomized frequently by his uncle. One day, a neighbor discovered the two, and the uncle killed the man when he tried to intervene to protect the child. The patient was forced to eat the dead man's penis and hide the decapitated head. (The unexplained disappearance of this man subsequently was attested to by other family members.) For the patient, these two fragments (eating the penis and carrying the head) were distinct and autonomous.

Memory Fragment 1: Eating the Penis

The negative cognition associated with the first fragment, eating the penis, was that he, the patient, was bad. During the course of a 90-minute EMDR session, the original event was re-engaged, and the patient re-experienced the memory intensely, biting his fingers and chewing the insides of his lips. He cried over and over, "I'm bad, I'm bad. God is going to punish me." Then, during one set of eye movements, he changed to, "Why did he do that to me? He's bad, he's bad. He's really bad." This represented a cognitive shift on the theme of responsibility, with ownership changing from the patient to the uncle. At this point, a protective alter emerged and demanded that the procedure be stopped and the patient "taken out of the pain." I explained that if he (the alter), too, could participate, then he might benefit as well. The alter said that he and other alters were suffering with the memory, too and agreed to cooperate. Almost immediately, there was a change in the way the event was perceived by the protective alter and remembered by the patient. While still upsetting, the event now was seen as though it were "a little video" in the sense of having less affective charge, even

though what happened still was remembered clearly. The scene remained "disgusting," but the patient no longer felt as though it was still occurring. The realization that eating the dead man's penis was not his fault changed the quality of the memory. This change was reinforced (installed) using EMDR. A short time later, the protective personality that had emerged during the session announced that he intended to integrate with the host and did so spontaneously several weeks later.

Memory Fragment 2: Carrying the Head

The second memory fragment, carrying the head, was not processed during the initial EMDR session and remained an intrusive thought and a source of nightmares. While other trauma work was done, and several other personalities integrated, the patient was not ready to resume work on the murder directly until approximately one year later. The female personality who carried the head was Emperatriz, Empress in Spanish. Emperatriz agreed to undergo EMDR to work on the memory because the other alters convinced her that this memory was disturbing the rest of the system.

Although the second memory fragment was based on the same event as the first memory fragment, the core conflict was completely different. In this second fragment, the negative cognition involved betrayal by men in general, and by the male personalities in particular. According to Emperatriz, the male alters were supposed to carry the head and hide it. However, it became Emperatriz's responsibility to hide the head when the male alters became frightened and dropped it. During EMDR-facilitated trauma work, Emperatriz re-experienced the events of that day. The eye movements were interrupted while she re-enacted the scene of hiding the head, seeming to carry it by the hair and place it down. Following this, the affect intensity decreased dramatically. However, Emperatriz's resentment of men and her determination not to be dominated by any man was strengthened, and she resolved to kill the patient's male partner. To resolve this potential crisis, a male internal helper (Comstock, 1991) noted that the Empress still believed in the stereotypes of 20 years ago and needed to understand that, "This is the 90's. Men and women are the same." Emperatriz returned, and another set of eye movements was performed with Emperatriz while the internal helper assisted the processing from within. The two alters had an internal dialog during the next set of eye movements. The outcome was that Emperatriz was able to accept that different people have different abilities, and while hers was determination, other people's abilities also were valid, even complementary. At the end of the session, the patient reported that the memory fragment of carrying the head now resembled the memory of the first fragment: while remembered clearly, it was less overwhelming emotionally. This perception has remained stable over 60 months.

Comment: This report illustrates both the strengths and

the dangers of EMDR-facilitated trauma work in a patient with DID. On the positive side, this case demonstrates how a single traumatic event can remain fragmented in memory, with individual fragments having their own unique core belief and associated affect. It also illustrates how individual fragments may become associated with specific alter personalities whose characteristics may be derived from the qualities of the memory fragment. Finally, it shows how EMDR can be used to work with traumatic memory fragments sequentially to an adaptive resolution based on the principle of divide and conquer.

On the other hand, this case highlights the importance of adequate preparation when using EMDR in patients with DID. Despite the felicitous outcome, more affectively charged material emerged during the initial session than the patient was prepared to handle, and disaster was avoided because the therapeutic relationship served as the container while a solution was worked out. In retrospect, it is clear that the patient would have been better served by delaying EMDR until the memory had been dissected, fractionated and processed via a carefully planned approach.

DISCUSSION

Trauma Work

Over a century ago, Janet proposed that hyperarousal during trauma inhibits the integration of memory. A normal (non-traumatic) memory is transformed by integration, and as a result, feels "once removed" from the event. This is why bringing a happy occasion to mind may be pleasing, but it is not as joyful as the original experience. In trauma, information processing is disrupted so that an integrated, coherent memory is not created. The disrupted information processing spawns unintegrated memory fragments which contain components of the original, incompletely processed experience (Braun, 1988). When activated, these memories create the feeling of re-experiencing, rather than remembering. The intensity of the original experience is preserved in the fragment. Contrast the difficulty in remembering a pleasant experience clearly with the memories of a trauma survivor who trembles at the mention of her assault. These unintegrated individual fragments may form associations to unrelated events sharing similar affect or having similar personal meaning. Thus, a relatively stable memory network of powerful intensity can be created by linking together elements of upsetting experiences containing fear, for example, or a negative self-belief, such as, "I'm bad." Under some conditions an individual network may serve as the nidus for the elaboration of an alter personality, though the process by which this occurs is not currently understood.

One important goal of trauma work, then, is to reengage the memory fragments and resume processing of the memory to create an integrated, coherent form, using the pathways for processing "normal" memory. This objective is

distinct from Freud's concept of abreaction, "release of repressed affect" (van der Hart & Brown, 1992). Many current writers on the treatment of DID have returned to Janet's original prescription for treating traumatic memories and have developed techniques for integrating the dissociated components of a traumatic memory (Braun, 1988; Fine, 1991, 1993; Kluft, 1991, 1993; Putnam, 1989; van der Hart et al., 1989, 1993; van der Kolk & van der Hart, 1991).

Dissociation and Integration

Integration of traumatic memory and integration of alter personalities can be conceptualized as two parallel processes, even though for some alters the processes are virtually identical. However, the term "dissociation" also encompasses two phenomena: 1) A passive dissociative process in which the brain fails to generate an integrated, coherent memory of a traumatic event (Janet, 1919; van der Hart, et al., 1989; van der Kolk, 1994). This integration failure likely is a consequence of the physiologic conditions in the central nervous system which exist during trauma. 2) An active dissociative process which facilitates the creation of alter personalities, then distributes and partitions information and experience among the alter personalities (Braun, 1986; Kluft 1984, 1986; Putnam, 1989; Ross et al., 1989; van der Hart et al. 1993).

In trauma work, the patient reengages a traumatic memory under non-threatening conditions, reactivates it, re-experiences it, and processes it to a less disturbing and more adaptive outcome; thus passive dissociation is addressed directly by memory integration. In the sense that the alter personalities are connected to traumata, traumatic memory integration lowers dissociative barriers by relieving distress. The resolution of traumatic memories does impact on the structure of the personality system. However, only an overarching therapeutic strategy will address the complexity of that internal state of being which maintains the system of alter personalities.

EMDR-Facilitated Trauma Work in DID

Two articles on the use of EMDR in patients with DID have been published so far. Young (1994) describes the successful treatment of phobic symptoms in two women with DID. In both cases, the phobic symptom was related to childhood trauma, and anxiety was reduced when the original traumatic memories were processed. The second paper, by Paulsen (1995), is more ambitious and attempts to develop a theoretical model for incorporating EMDR into the treatment of dissociative disorders as well as to provide guidelines for its use.

Paulsen (1995) elaborates a theory of dissociation based on the concept of "neural networks" in which different networks of neurons hold different information. This model hypothesizes that EMDR "re-associates dissociated material" held in different neural networks thereby integrating mem-

ory and personalities. Normal ego states and poly-fragmented DID exist on a continuum depending on the degree of integration of the different neural networks. While intuitively appealing, this model is problematic. First, it is at variance with the idea, presented in this report, that there is a difference between the failure to integrate experience during trauma (integration failure) and the active partitioning of information and experience (active dissociation). Second, the term, "neural network" is ambiguous. In some instances, Paulsen uses the term to represent the BASK elements, and in dissociative disorders, she uses it to represent ego states or alter personalities. Before the true value of this formulation can be determined, the term "neural network" will have to be defined more succinctly and a relationship to a specific neurologic substrate hypothesized.

Paulsen (1995) does make several important clinical contributions. Paulsen was the first to report EMDR's ability to unmask dissociative disorders; and she emphasized the need to screen patients for dissociative disorders prior to using EMDR. Her case reports suggest useful methods for treating less severe dissociative disorders. These methods, however, need to be modified for more complex dissociative syndromes such as DID. Most importantly, the suggestion that all the alters "look through the eyes" during an EMDR session is not consistent with the principle of fractionated trauma work and easily might produce an overwhelming amount of affect should the alters actually cooperate.

EMDR-facilitated trauma work appears to be both qualitatively and quantitatively different from trauma work using other methods. It is qualitatively different in that cognitive restructuring is incorporated explicitly into the method. Concomitant with the integration of the memory fragments, the patient develops a cognitive reformulation which has personal meaning and begins to address the need to resolve the existential crisis associated with trauma-induced loss of meaning or loss of safety (Steele, 1989). Van der Hart et al.'s (1993) model for treating traumatic memories identifies three stages: 1) Preparation, which provides the preliminary groundwork for doing the trauma work; 2) Synthesis, the stage during which the actual trauma is re-experienced within a therapeutic setting; 3) Realization and integration, the stage in which meaning is attributed to the transformed memory and is incorporated into the person's life. In contrast to other techniques, which often are limited to synthesis, EMDR concomitantly addresses both the synthesis and realization/integration stages of the trauma work. Finally, the fact that a portion of the trauma can be resolved within a single EMDR session teaches the patient that there is a beginning, a middle, and an end to the trauma (Fine, 1994b), just as there is a beginning, middle and end to the EMDR session.

EMDR appears to be quantitatively different from other techniques for doing trauma work in that the patient often moves through the traumatic memory quite rapidly. This may be in part because synthesis and realization/integration occur simultaneously. However, it is equally likely that information

processing is accelerated by the physiologic effect produced by alternating attention (Shapiro, 1995).

CONCLUSION

EMDR is a powerful new method of psychotherapy that is effective treatment for trauma. EMDR facilitates the processing of traumatic memories to better-integrated forms that are less disturbing and more adaptive. When used in patients with DID, the standard EMDR protocol must be modified to conform to the principles of fractionated trauma work. However, EMDR complements existing strategies for treating DID by offering an alternative method for managing the processing of trauma. Clinical and controlled studies are needed to establish EMDR's role in the treatment of DID more precisely. ■

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