EYE MOVEMENT DESENSITIZATION AND REPROCESSING: ITS CAUTIOUS USE IN THE DISSOCIATIVE DISORDERS

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ABSTRACT

Eye Movement Desensitization and Reprocessing (EMDR) is described in terms of clinical phenomena, the need for appropriate training in EMDR, and the consistency of neural network theory with BASK theory of dissociation. EMDR treatment failures occur in dissociative disorder patients when EMDR is used without making diagnosis of the underlying dissociative condition and without modifying the EMDR procedure to accommodate it. Careful informed consent and the use of the dissociative table technique can allow EMDR to move successfully to completion in a dissociative patient. Certain "red flags" contraindicate the use of EMDR for some dissociative patients. A protocol for EMDR with dissociative patients is offered, for crisis intervention (rarely appropriate), abreactive trauma work, and integration/fusion. The safety and effectiveness of EMDR's use in the dissociative disorders requires adequate preparation and skillful trouble-shooting during the EMDR.

INTRODUCTION

The Clinical Phenomenon of EMDR

Shapiro has detailed a clinical protocol for the Eye Movement Desensitization and Reprocessing (EMDR) process that emphasizes efficacy and safety. It has been evaluated in her original research (Shapiro, 1989) as well as in more recent studies (e.g., Wilson, Tinker, & Becker, 1994). That protocol elicits hypothesized traumatic neural networks, facilitates emotional processing of the contents of the neural networks, and enables safe completion of this process (Shapiro, 1995). Education in that protocol and its basic variations comprise the two levels of EMDR training workshops (Shapiro 1994a, 1994b).

When EMDR is conducted upon the experiential aspects of a traumatic memory, the clinical effect is of desensitization of affect, resolution of body sensations, and shifting of cognitions and imagery associated with the trauma. For a single trauma, this can often be achieved in a single long session, although related material may need subsequent processing. For example, motor vehicle accident trauma may require one EMDR session for the accident itself, and additional sessions address the medical, legal, and insurance company experiences subsequent to the event, as well as the patient's physical losses, changed identity due to physical disability, and effects on family roles.

The following is an extremely abbreviated version of Shapiro's more elaborate procedure. This summary is not intended to supplant the need for training in the procedure, but rather to offer the reader an idea of what occurs in EMDR. The reader should bear in mind that the underlying mechanism for the process of EMDR is unknown. In this article a hypothetical model widely regarded as plausible by EMDR theorists and practitioners will be used as an heuristic (Shapiro, 1995). Only time and further study will determine whether it is accurate, or merely a helpful metaphor.

The procedure begins with a set-up phase that precedes the eye movements. Set-up starts with a careful informed consent process. It is also necessary to screen for dissociation, because, as will be discussed later, the protocol for dissociative individuals differs from the usual protocol. Next a target image is selected that best typifies the traumatic event, with its affective, visual, and kinesthetic components and maladaptive cognitions associated with the event. A goal is also articulated that expresses how the patient would like to think and feel about the event. The therapist emphasizes safety precautions and the patient's ability to stop the process by using a stop signal.

Two measures are used to monitor process status against the goal when the target traumatic image is brought to mind. Subjective Units of Disturbance (SUD) (Wolpe, 1956) measures patient distress. Validity of Cognition (VOC) (Shapiro, 1989) measures how true the desired cognition is in the patient's view at any point in the process. These two measures are first taken before the eye movements begin.

The desensitization phase involves engaging the patient in lateral eye movements while the neural network containing the traumatic material is activated and the information processing is "catalyzed" (Shapiro, 1995). Neural network activation is thought to be achieved by evoking the visual, kinesthetic and affective components of the trauma in combination with the associated maladaptive cognitions. Once

the traumatic material is activated, the patient watches the therapist's fingers or a mechanical device move, usually laterally; this effort causes the patient's eyes to move. The eye movements seem to "push along" the processing of the memory of the traumatic event. Typically but not invariably, the patient will recall the event in apparent detail. It cannot, however, be assumed that images or information obtained in EMDR are exempt from the various sources of distortion that affect all memory processes (Johnson & Howell, 1993; Loftus, 1992; Sheehan & Statham, 1989). Typically, the patient also experiences a sequence of emotions about the event, which Shapiro refers to as "cleaning out the channels" associated with that neural network. When the SUD rating indicates that the trauma feels neutral when the patient brings it to mind, the desensitization phase is complete.

Although normally the optimal strategy during EMDR is for clinicians to remain silent and allow the patient's process to emerge, sometimes the processing stops. When the process is stuck or "loops," Shapiro recommends "cognitive interweave" to restimulate the process by bringing in adaptive information (Shapiro, 1994b). These interventions, when skillfully applied, involve very little talking during the EMDR on the therapist's part, and rather resemble a single Socratic question such as "whose responsibility was it?" or "what would you like to have done?" in the tradition of cognitive therapy (Beck, 1993) and cognitive behavior therapy (Meichenbaum, 1993).

The installation phase follows. It serves to close down the catalytic process and to "install" the goal cognition, facilitating the emergence of positive cognitive schema. These positive cognitions then become associated with the stimuli which previously had triggered PTSD activation. Conducted while the patients' eyes are moving, special installation procedures (such as imagining oneself in future situations fully experiencing the desired goal cognition) serve to maximize generalization of learning. If necessary, relaxation or imagery may be needed to assure containment of any residual affect in what is referred to as closure.

The final phase is a debriefing, which alerts the patient to the possibility of continued processing between sessions, plans for the unlikely event of needed emergency procedures, and explains that any residual distress should be logged for targeting in future EMDR sessions. At the next appointment, SUD and VOC levels are taken to determine whether EMDR effects have been maintained, which is usually the case. Customarily, patient's reports of experiences such as active dreaming about related themes for several days between sessions offers evidence that the processing has indeed continued following the formal EMDR. The therapist evaluates whether new target images have emerged as a result.

The EMDR process unfolds differently for the treatment of recent trauma than for work with trauma several months old (Shapiro, 1995). In older trauma, once stimulated, the memory tends to "play" sequentially. In recent trauma, the process is more piecemeal, with moment-by-moment fragments of memories needing to be continuously restimulated by taking the patient back to the target trauma incident and asking what comes up next. Processing recent traumatic memories with EMDR is more like groping for snapshots in the dark than playing a movie. Shapiro postulates that the brain has not yet consolidated the memory components in the recent memories (Shapiro, 1995).

As noted above, these observations, and indeed whether eye movements are themselves the critical catalyst, currently have the status of clinical observations. Much research remains to be done on the phenomenon of EMDR. In the meantime, the clinical use of EMDR is spreading widely. Worldwide, approximately 10,000 clinicians have been trained in its use.

The Need for Formal EMDR Training

The clinical procedure for conducting EMDR is complex and powerful. It can be risky if it is undertaken without the therapist having the skills in place to take the procedure to its completion. If the therapist does not have the requisite skills and the EMDR procedure is left incomplete and unclosed, patients may be left in a state of hyperarousal, which could be dangerous for those patients prone to suicidal, homicidal or self-destructive behavior. Shapiro has been criticized for her insistence on workshop training before clinicians use EMDR. Her insistence has been widely misunderstood as being entrepreneurially-motivated, or worse. However, due to the possibility of adverse outcomes if the procedure is not applied with appropriate safeguards, clinicians trained in and using the procedure find that the training is necessary (Lipke, 1992). The potential for harm to clients is real if clinicians are not appropriately trained in the procedure.

It is important for the reader to appreciate that this article does not suffice to replace supervised training. With the publication of a book explicating the details of the procedure (Shapiro, 1995), mental health professionals will have ready access to knowledge about EMDR, but it is still strongly recommended that clinicians acquire appropriate supervision in the procedure before adopting its use. The learning curve is substantial.

As noted, clinicians who use eye movements to treat traumatized clients without training in EMDR are putting their clients at serious risk for retraumatization, suicidal ideation, or other ill effects. The risk is even greater for dissociative patients, whose history of trauma, betrayal, and abuse of power is enormous. Even experienced clinicians must not contribute to their patients' trauma histories by being cavalier with this powerful procedure.

BASK THEORY AND NEURAL NETWORK THEORY

The BASK theory of dissociation (Braun, 1988a) and its treatment (Braun, 1988b) is supported by what is observed

clinically in EMDR as traumatic experience is accessed and resolved. In some EMDR sessions, the various BASK elements are reintegrated one element at a time; in other cases the processing of BASK elements occurs in a simultaneous manner.

Neural network theory is compatible with BASK theory as illustrated by such convergences as: 1) both theories conceptualize traumatic material as held separately from conscious awareness, which is adaptive at the time of trauma, but which, in chronic form, is related to psychopathology; 2) Both refer to the specific elements which may be held out of awareness. Whereas BASK theory refers to the elements of behavior, affect, sensation, and knowledge as elements which can be dissociated individually or in combination, (Braun, 1988a), neural network theory refers to visual, affective, cognitive, and kinesthetic, and any other elements that are considered avenues to accessing neural networks (Shapiro, 1995). The language used in BASK theory existed first. The language of neural network theory matches the clinical procedure of EMDR very closely, and enriches dissociative theory. Neural network theory therefore has a face validity that is supported by the EMDR clinician's daily experience. Procedurally, Shapiro cautions clinicians not to use EMDR to treat a formal dissociative disorder unless they are already experienced in the treatment of dissociative disorders (Shapiro, 1994a, 1994b, 1995).

Neural networks, hypothetically, are convenient functional structures that group aggregates of associated information for easy access. In post-traumatic stress disorder (PTSD), as Shapiro (1995) explains, the associated information is related to trauma and held in a neural network for purpose of containing the raw affect-laden material apart from conscious awareness until it can be processed and neutralized.

As in PTSD, the neural networks in dissociative disorders were also developed to contain traumatic material. The neural networks in dissociative disorders contain material from childhood involving trauma that was chronic, inescapable, and severe (Kluft, 1987; Braun, 1984, Loewenstein, 1992). As a result of the chronicity, the severity, and the stage of development of the self at the times of the traumas, the neural networks in dissociative disorders are more elaborated and more imbued with self and identity than are the neural networks of adult onset PTSD.

The neural networks in dissociative disorders are held apart more completely from conscious awareness, behind relatively less permeable or even amnesic barriers, than in normal neural networks. The contents of these neural networks may be construed as ego states (Watkins, 1992) or alter personalities. Although ego states and alter personalities are not synonymous (Kluft, 1990), they are here understood to have in common that they are situation-specific and state-specific ways of being that develop to serve specific functions. There is a hypothesized continuum from normal ego states to polyfragmented DID. Ego states are manifest in a normal population as different ways of being for specific situations, but without the discontinuity of self and/or of memory found in DID. Neural network theory can encompass the full continuum, in as much as neural networks can be postulated to contain normal state-specific learning as well as fully dissociated information in the form of alter personalities. In the latter case, those neural networks, because of the demands of surviving chronic, severe, and inescapable trauma, have developed highly elaborate, specific and in some cases complex solutions to the functions they serve within the self system.

Dissociation theory can inform neural network theory as well. Another way to construe EMDR's effects is that whether or not the patient has a formal dissociative disorder, the neural networks which EMDR access contain dissociated material. When EMDR resolves trauma, it may always be because it has reassociated dissociated material.

EMDR IN THE TREATMENT OF DISSOCIATIVE DISORDERS

EMDR has a special and intriguing relationship to the phenomenon of dissociation, in that EMDR seems to act as a dissociation finder, whether or not the practitioner has previously suspected dissociation in a given patient. This section will discuss: 1) EMDR treatment failures as a function of undiagnosed dissociative conditions, 2) current dissociative disorder screening practice, 3) minimizing false positives while still doing appropriate screening, and 4) interpreting the results of dissociative table interventions.

EMDR Treatment Failures

Although EMDR often produces good clinical results rapidly, there are occasional reports of EMDR treatment failures. For the first few years of EMDR's history, it was known was that some EMDR sessions failed to complete as expected. Rather, the affective material "looped," or "got stuck" without resolution and with high levels of affective arousal (Shapiro, 1989). Shapiro (1989) incorporated into her protocol "cognitive interweave" and special closure procedures to handle this occurrence, with patient safety paramount.

It has been found clinically that the most serious EMDR treatment failures often turn out to be cases of undiagnosed dissociative disorders. This section will describe why and how that phenomenon occurs, and re– commend solutions to this problem. The procedures suggested herein have been clinically derived, as have other suggested procedures for using EMDR in the dissociative disorders (Fine, 1994; Fine, Paulsen, Rouanzoin, Luber, Puk, & Young, 1995; Paulsen, Vogelmann-Sine, Lazrove, & Young, 1993; Marquist & Puk, 1994; Puk, 1994; Young, 1994). These protocols, when followed with skill and care, will often successfully and safely manage the use of EMDR with dissociative clients. Without such procedures, however, the likelihood of treatment fail-

ures with EMDR increases substantially. To lay the groundwork for the procedures, it is necessary to review some theoretical aspects of dissociation.

Dissociation has been described as occurring on a continuum, with an absence of dissociation on one end of the continuum and polyfragmented dissociative identity disorder (DID) on the other end (Braun, 1986; Putnam, 1989). Between the ends of the continuum are the degrees of dissociation that represent such trauma-related dissociative conditions as psychogenic amnesia, fugue states, post-traumatic stress disorder, atypical dissociative disorders, DID and poly-fragmented DID (Braun, 1986; Putnam, 1989). PTSD in this view is understood to be within the dissociative spectrum.

Highly dissociative individuals can be categorized in terms of some of the parameters of their self-system, such as degree of hostility between parts, internal and external cooperation across the parts, the parts' tendency toward dangerous behaviors, the permeability of amnesic barriers, and the degree of the parts' co-consciousness. These variables are important in determining whether to proceed with EMDR in a dissociative individual. A task force of EMDR therapists treating dissociative disorders has outlined a decision tree to determine which dissociative patients should not be treated with EMDR except under conditions of complete safety (Fine et al., 1995). EMDR should not be attempted with highly dissociative patients with problematic characteristics unless the clinician is already highly experienced with dissociative disorder populations and has a controlled setting in which to conduct the EMDR. Safety considerations must be taken very seriously.

Dissociation Screening Practices

Although Shapiro did not originally include screening for dissociation as a requisite part of her protocol, she now emphasizes it in order to avoid retraumatizing clients with undiagnosed dissociative conditions.

It is oversimplified to decide whether to proceed with EMDR based on the presence or absence of a formal dissociative disorder. Several considerations are relevant: 1) If EMDR is always reassociating dissociated material, and if dissociation occurs on a continuum from single dissociated BASK elements to polyfragmented DID, then the dichotomous variable of the presence or absence of a dissociative disorder is insufficient to characterize whether a patient will be at risk if EMDR is used. 2) EMDR may proceed well in a highly dissociative person if the patient's self-system is highly cooperative and internally in agreement with the use of the procedure, (whether or not the therapist knows he/she is treating a dissociative disorder). 3) Perhaps the largest category of dissociative disorders – Dissociative Disorder Not Otherwise Specified (DDNOS) – is essentially a waste-basket category, having so few defining criteria as to render it nearly useless in decision-making. 4) The easiest screening procedure for a dissociative disorder is the Dissociative Experiences Scale (Carlson et al., 1993), yet it can produce false negative, as well as false-positives. Recommended cutoff scores on the DES for suspecting dissociative disorders range from 25 (Saxe et al., 1993) to 40, (Frischholz, Braun, Sachs, & Hopkins, 1990). A score of 15 is the mean for psychiatric inpatients, and is well above the "normal" population, (Ross, Anderson, Fleisher, & Norton, 1992). Clinically, however, using even the lowest of these cutoffs does not insure that dissociation will not derail the EMDR. 5) Many EMDR-trained clinicians are untrained in dissociative disorders and some may not believe that dissociative conditions exist. 6) Many EMDR-trained clinicians are afraid to look for dissociation because of fear of being accused of creating dissociation, although it is highly unlikely that this could occur (Braun, 1989; Ross et al., 1989).

When EMDR-trained clinicians conduct EMDR without screening for dissociation, most of the time nothing untoward will occur, because most patients do not have an undiagnosed dissociative disorder. However, because of the prevalence of undiagnosed dissociation in many clinical practices (Kluft 1987), it will not be unusual for problems to be encountered. For an EMDR session in a dissociative individual to be completed normally, all or most of the relevant alters/ego states need to participate, in order to complete their portion of the trauma. By its very nature, however, dissociation keeps unknowable secrets from the patient and from the world, including the therapist, initially. Alters accomplish this goal by remaining out of one another's consciousness much of the time. Until the relevant alters participate in co-consciousness by "looking through the eyes," the EMDR cannot complete normally. This requirement of "looking through the eyes" is terminology which alters tend to grasp readily, and seems to be synonymous with being co-conscious with the host or other alters/ego states (Kluft, personal communication, November, 1994).

If neither the patient nor the therapist is aware that there are other alters/ego states that need to be involved, the therapist will fail to include the alters/ego-states in the necessary preparatory steps for EMDR. Therefore the relevant alters are unlikely to be cooperative, although they may be co-conscious and co-present. They may watch the EMDR from the sidelines without participating. Alters may learn about EMDR from watching, but the traumatic material they hold about the target trauma will not be resolved without their being actively engaged in the therapy.

Speaking metaphorically, EMDR seems to act like a divining rod for dissociation, and to pull the relevant alters/ego states forward in the sequence that they appeared (or were called into play) at the time of the original trauma. If the relevant alters have not been prepared for the EMDR, however, they are likely to resist. They resist for many reasons, including: 1) not understanding the purpose or the process of EMDR; 2) being willing to participate but being absorbed

in observing, and not realizing they need to "look through the eyes"; 3) remaining committed to their purpose of keeping away from the host and maintaining the secrecy of their purposes; 4) having other intentions than the part(s) of the self that consented to EMDR treatment, (e.g., needing to keep the pathology unresolved because it wishes to keep its current powerful role in the system); or 5) rapport not having been established between these alters and the therapist. For example, if an alter is awakened for the first time in years during and by an EMDR procedure to which it has not consented, and has never met the therapist before, therapeutic rapport cannot be assumed. Complications may ensue that set back the therapy. Should an awakening alter find itself reliving a trauma without knowing it is a reliving rather than a currently occurring trauma, the alter may confuse the therapist with the perpetrator of the trauma that it is reliving. This must be avoided to avoid retraumatizing the client and destroying therapeutic rapport.

To avoid EMDR treatment failures, the protocol for all patients undergoing EMDR needs to take into account the fact that undiagnosed dissociative conditions are not rare. Clinicians who treat dissociative disorders have received criticism from those who assert that screening for and talking to alters as separate entities encourages dissociation where it may not exist; that is, it creates false-positives. Failing to work with alters, however, means working with only the "front part" of the patient, delaying indefinitely appropriate diagnosis and treatment.

In addition to the above described risks from failing to screen for dissociation prior to conducting an EMDR procedure, there is an additional argument to be made for dealing with dissociation early on in the process. EMDR has the effect of shortening total treatment length, in part because of the relative tolerability of the abreactions it produces, and due in part to its tendency to increase co-consciousness and enable cognitive shifts, sometimes spontaneously. Especially in the milder dissociative conditions, where there are fewer traumas and greater system cooperation, the condition can sometimes be resolved in relatively few sessions. Therefore, the emphasis on the separate alters/ego states is for the time-limited purpose of establishing rapport and enlisting the entire patient in treatment. EMDR is a powerfully reintegrative tool, and so moves much more rapidly than do most therapeutic approaches. The criticism of encouraging dissociation by talking to alters is relatively easier for the EMDR clinician to defend, because of the relatively rapid movement toward healing and wholeness. The emphasis is on unity, but to achieve unity one must acknowledge the separateness.

EMDR therapists should always administer the DES or another appropriate screening device for dissociation before administering EMDR. Scores above 25 are clear indications that EMDR should not proceed without treating the dissociation present. For individuals scoring above 15, the therapist should examine any specific high-scoring items, and make appropriate additional inquiries.

If the patient's responses suggest dissociation is a prominent feature of his or her internal world, even though a formal dissociative disorder may not be present or readily apparent, the clinician should conduct preparation for EMDR by dealing with the dissociation that is present, without engaging in an inappropriate or premature diagnosis of a dissociative disorder. This can be accomplished by explaining that it is quite normal for people to be multifaceted and to have different ways of being in one situation than they do in another situation. At any point in the process, if the patient queries about being "schizophrenic," or "multiple," it is helpful to explain that having different ways of being or aspects to oneself certainly does not by itself prove that a person is either "schizophrenic," or "multiple," and to respond to the specific fears of the patient regarding those labels. One explains that the EMDR will not work well if part of the patient does not want to do it. It is useful to ask the patient's permission to see whether the entire self has consented to the procedure or whether the patient has mixed feelings. The dissociative table technique is a useful aid and will be explained below. It is helpful to ask the entire self to listen while the EMDR procedure is explained and to ask if any aspect of the self has concerns or questions. If parts do not wish to participate, the therapist should ask if the concerned part will permit the EMDR and watch until that part decides later if it wants to participate or not. The therapist may want to employ various methods to assist in the treatment of dissociation described elsewhere in the literature (Kluft, 1989).

Using the Dissociative Table Technique

The dissociative table technique (Fraser, 1992) is a straightforward method to gain access to a patient's inner world without engaging in formal hypnotic inductions. It is easily accomplished in the patient's normal waking state by asking a patient to imagine a pleasant internal "conference room" in which there is comfortable furniture for all aspects of the self. There may be various equipment (e.g., a microphone, spotlight, remote control, movie screen) and adjacent facilities as needed for any given patient (e.g., waiting room with or without speakers and a one-way mirror so others can hide but observe). These extra features are especially helpful for true dissociative disorders, because it supplants the need for either switching or formal hypnosis, and is therefore time-saving and enhances co-consciousness.

Once the internal conference room is established, the therapist invites the entire self, including parts known and unknown, to come into the "conference room" if they wish inclusion in the discussion. The therapist can invite the patient to "give a voice" (internally) to any aspect of the self that wishes to become known. The host communicates the internal messages to the therapist.

Interpreting Dissociative Table Results

Although this procedure is very useful for highly dissociative individuals, it is also readily engaged in by and very useful for non-dissociative individuals. It can be a good mechanism for enabling an internal dialogue on any issue about which a patient has mixed feelings, by giving a voice to the pros and cons of an idea (for example).

As a cautionary note, the therapist must realize that if parts come into the conference room, this may or may not correspond to the presence of alters. This procedure is not diagnostic for DID; non-dissociative individuals may readily image parts. If the patient seems to be surprised by what s/he sees or hears from the parts, this begins to raise an index of suspicion for dissociation, because it suggests that there might not be straightforward communication between aspects of the self. The therapist's index of suspicion for a formal dissociative disorder should go up if the procedure reveals: 1) intense hostility between parts, 2) amnesia between parts, 3) disbelief by some parts that they are in the same body, 4) and/or indications that the parts have existed separately long before the patient first talked to the therapist. If these or other clinical signs of dissociation are present, the therapist should not proceed to EMDR without conducting a thorough evaluation for a formal dissociative disorder using a more specialized clinical interview (Loewenstein, 1991) or a more complete assessment method, e.g., the SCID-D (Steinberg, Rounsaville, & Cicchetti, 1990). It is, of course, important to avoid the false positive diagnosis of a dissociative disorder, but it is not acceptable to fail to find one if one exists (Braun, 1989).

Red Flags Contraindicating Using EMDR With a Dissociative Patient

Because EMDR's safe and effective completion relies on the cooperation of the patient with the procedure, clinicians are discouraged from using EMDR with certain patients unless the environment can be secured for complete safety in the days following the EMDR procedure. Those "red flags" include: 1) ongoing self-mutilation, 2) active suicidal intent, 3) homicidal intent, 4) uncontrolled flashbacks, 5) rapid switching, 6) extreme age, 7) physical frailty, 8) terminal illness, 9) need for concurrent adjustment of medication, 10) ongoing abusive relationships, 11) alter personalities that are strongly opposed to the procedure, 12) extreme character pathology, especially severe narcissistic, sociopathic, borderline, or passive-aggressive disorders, 13) serious concomitant diagnoses such as schizophrenia or active substance abuse (Fine et al., 1995).

Therapists who are highly experienced with abreactive work with patients with the above characteristics may be able to proceed to use EMDR safely and with good results. However, the work is considerably more complex than using EMDR with a more cooperative dissociative patient, and therefore a careful risk-benefit analysis should be undertaken and appropriate preparation made before such use of EMDR when these red flags are present.

PROCEDURAL GUIDES FOR EMDR WITH DISSOCIATIVE PATIENTS

This section will discuss the use of EMDR in various stages of treatment including crisis intervention, trauma work, integration and fusion, and will offer procedures for conducting EMDR with dissociative patients.

Crisis Intervention

There is only a limited appropriate use for EMDR early in treatment of a dissociative disorder. This is because of the need to obtain a careful informed consent from the system; it may take months before rapport is established with the alters sufficient to obtain that consent. EMDR may, however, cautiously be used for crisis intervention (Vogelmann-Sine, 1993) to prevent hospitalization, but not for uncovering work, before the system is sufficiently mapped and rapport established. This approach distinguishes crisis intervention, which is stabilizing, from uncovering work, which is destabilizing. In crisis intervention, even though the system may be largely unknown, the distress level permeates enough of the system that the alters are likely to be motivated to participate in a truncated eye movement process in the hope of gaining relief. In uncovering work, however, the unknown parts of the system may not be distressed enough to participate in the EMDR. Attempting EMDR prematurely with alters that are not motivated to participate will result in at best incomplete processing and at worst escalation of distress levels with looping over traumatic scenes with no comfortable resolution. It is riskier to use EMDR in crisis intervention than in the later therapeutic stages of uncovering work, when rapport with the system is well established. EMDR should not be used for crisis intervention if the patient has a history of suicide attempts, self-mutilation or other acting-out (see "Red Flags" discussion).

If the dissociative patient is in acute distress and has no red flags contraindicating proceeding, the EMDR clinician may ask all alters, known or unknown, to listen to an explanation of EMDR through the host. Permission should be obtained from all known alters to proceed, explaining that silence/or no answer will be construed as permission. Any heard, felt, or observed internal "no" is a sign not to proceed with eye movements. Eye movements are used only briefly until distress acuity is reduced to a tolerable level, but not attempting to complete the EMDR per the usual EMDR procedure including the "body scan" (Shapiro, 1989) which would result in uncovering of new material, for which the patient has not been prepared. Careful installation and/or closure procedures, (e.g., through relaxation, imagery or formal hypnosis) are needed to complete the crisis intervention. Careful debriefing is needed to ensure safety, and the clinician or

other emergency backup, including options for hospitalization, should be available following such a crisis intervention. A no-suicide contract should be in place.

Trauma Work

For the dissociative disorders, uncovering and neutralizing specific traumatic material can proceed rapidly and safely using EMDR when properly conducted. Within the dissociative disorders, uncovering and neutralizing traumatic memories in milder dissociative states (i.e., DDNOS) is more straightforward than in true DID due to the relatively greater cooperation that is found in the milder cases, the relatively less narcissistic involvement in separateness in DDNOS, and relatively less frequent presence of persecutor alters. For the polyfragmented multiple, the number of needed EMDR sessions may be great. For some patients, an EMDR session can target more than one trauma, if the traumas are related by category, such as perpetrator, type of trauma, location, age, etc. A limiting factor can be the patient's ability to physically tolerate intense affect, so treatment needs to address managing the patient's comfort level (Kluft, 1989). By patient report and therapist observation, EMDR-produced abreactions are often less painful than hypnotically-produced abreactions, so affect tolerance is less of a problem. For some patients, a fractionated abreaction procedure should be used to dilute the intensity of the affect (Kluft, 1988; Fine, 1993).

EMDR Preparation

To prepare any patient for the destabilization associated with opening up traumatically induced neural networks in dissociative disorders, it is necessary to first establish the diagnosis using clinical screening as described above (e.g., Loewenstein, 1991),or by a structured interview (Ross, 1991; Steinberg, 1993). Communication with the system can be established via "talking through" the host (Kluft, 1982) to the other alters or by "dissociative table" (Fraser, 1992). In "talking through," the clinician asks the host to relay information back from internally perceived ego states. Information may be heard, seen, or felt by the patient. Next, via the dissociative table technique, the clinician invites any ego states or aspects of the self which may be listening to take seats at the table, stay in a corner until they feel safe, or even stand outside the door or in a waiting room with a viewing screen if they prefer, to keep needed distance from the therapist and the host self. Weeks or months may be needed for the clinician to establish rapport with the alters, learning their purpose, history, concerns and needs. To work with alters, it is usually necessary to have a handle by which to pull them out; a name serves this purpose. When possible, it is cautious to refer to the parts by their function (e.g., "sad part" for the ego state that keeps sadness away from conscious awareness), but some will prefer true names. It is necessary to establish concurrence that reducing pain internally is a desirable goal, but persecutor or other alters may not agree with this goal. Markedly conflicting goals should be addressed before undertaking EMDR treatment, to avoid aborted processing.

It may be necessary to demonstrate to some alters that they are in one body. This may be achieved by asking alters to "look through the eyes" and see the host's hand wiggling the fingers, and asking to whose body the hand is attached. Variously, the clinician may ask the doubting alter to remain in one chair while the host moves to another chair. These empirical results, though initially startling to some alters who consider themselves quite separate, can go far to educate the system that the alters succeed or fail *en masse.* Alters often need to be educated that what is good for whole system is likely to also address concerns of alters. In some DDNOS cases, the ego states have little influence over the host's behavior, and will appreciate the clinician negotiating on their behalf. A therapeutic alliance is therefore readily established between the therapist and the ego states. In DID, the alters may have sufficient power that they do not consider themselves to be in need of the clinician's services. Education about the consequences of trying to live separate lives may motivate the alters to a reluctant teamwork, thus preparing them for EMDR work.

The EMDR clinician explains EMDR according to the Shapiro protocol, as a means to reduce internal pain and resolve distress. Some alters readily agree because their pain is great. Some care little, but can be motivated to assist suffering parts if they construe those suffering parts as in the same body and part of the same self system. Internal communications and negotiations are needed generally, and specifically for obtaining informed consent from all parts to participate in the EMDR. An EMDR target is selected according to which alters are willing to abreact the trauma they hold and which are in the most distress from nightmares or flashbacks of traumas. Experience has taught that first EMDRs for highly dissociative individuals should target specific memories rather than categories of trauma in order to keep the amount of material manageable. It is helpful to establish internal assistants who will assist during the EMDR if needed, by comforting child parts, informing the clinician of problems developing, and to make sure the parts are "tucked in at the end of the session." This is needed to keep the host comfortable between sessions, and to ensure that the host is willing to keep coming to therapy. The clinician may need to explain this to the alters, who otherwise may not care about the host's comfort unless it is understood to be tied to their own goals or pain. Before the first eye movements of EMDR, all alters should have a special relaxation place to which to go to diminish distress, in case the session cannot be completed because an alter balks half-way through the EMDR. Other preparation for the EMDR session includes identifying the various alters' negative cognitions associated with the target traumatic memory as well as identifying, to the degree possible, desired positive cognitions. Realistically, time will not permit a complete list of negative cognitions, but

some should be identified as a starting point. The affect and kinesthetic sensations associated with the trauma are noted, as are levels of affective arousal.

The EMDR Session

The EMDR session itself proceeds with a variation on the Shapiro protocol. The following procedure does not sufficiently describe the Shapiro EMDR protocol to eliminate the need for EMDR training. The EMDR session begins by inviting all alters to assemble around the conference table. There should be a final check for "new alters" (previously existing but unknown to the clinician or the patient). If other alters emerge, EMDR should not proceed until their informed consent is obtained. If there are no emerging alters, a final informed consent check is still needed. The system is reminded to expect temporary discomfort in the name of long-term relief. A stop signal is established and the alters are reminded that they have authority to stop but that discomfort will likely continue for several days if they stop in the middle. All alters who were present at the time of the trauma or who have feelings about it are asked to assemble around the internal conference table. Others may watch the process without "looking through the eyes." The one suffering most can have the spotlight, the microphone, and control the memory using "remote control." Alters not present during the original event or having no concerns about the event can wait in the waiting room or elsewhere (e.g., child alters with no need to be exposed to an adult rape memory can be sent off on a "fluffy white cloud" until after the session). The clinician then asks all alters who were present during the trauma or who having feelings about it to "look through the eyes" during the eye movements. They should be reminded that the EMDR will not work if the relevant alters are not "looking through the eyes." Eye movements are conducted according to the Shapiro protocol. It is necessary to check periodically to be sure the alters are tolerating the affect and are still "looking through the eyes." They may need morale boosting during the procedure due to the intensity of affect. It should be understood that unlike the usual EMDR session, a zero SUD level is unlikely to be achieved. Some alters will process sequentially, instead of simultaneously with other alters. In sequential processing, the alters take their own turns in consciousness, engaging in eye movements for their own part of the traumatic material. As the next alter takes its turn, the other involved alters watch co-presently but not co-consciously. Kluft (personal communication, November 1994) prefers the more conservative stance of working with only one alter at a time.

Trouble Shooting

"Looping" or stuck EMDR processes are often a sign that some participating alters have withdrawn, "gone to sleep," or otherwise stopped the process. This may manifest as an alter's overt refusal to continue. Conversely, there may only be evidence that the EMDR is stuck with no alter taking responsibility for stopping the processing. In a DID patient's EMDR that has become stuck, the following problem-solving approach is recommended. The clinician should identify the alter that has dropped out and what his/her concerns are. If needed, a helper alter, in combination with the clinician, may be enlisted to explain advantages of continuing. The alters are reminded that they might remain uncomfortable for several days if the EMDR process stops in the middle, but the patient's wishes should be respected and should govern. As needed, other alters may be enlisted to lend power to weak alters, protection to child alters, leadership to uninspired alters, or to take other motivating steps to salvage the EMDR if possible.

"Looping" often occurs at the point of interface between two alters' portions in the sequential processing of a traumatic memory. The clinician can "jump-start" the process by asking, "the part of the self that comes up next" if it is "willing to look through the eyes now."

If the system refuses to complete the processing, the session should be carefully closed down per the Shapiro protocol, and with relaxation imagery or formal hypnosis. If headaches or sustained and intense pressure in the head begins during EMDR, this is likely a sign that a previously hidden alter is being pulled forward by the EMDR, but is unwilling or unable to participate in the process. The clinician should ask to speak to the alter behind the headache and determine his/her concerns. If it is a previously unknown alter, it is necessary to determine if it has been watching the EMDR and consents to the process. If it has not been watching and does not know what EMDR is or even who the clinician is, the EMDR should not proceed, but rather should be closed down carefully using a relaxation and closure procedure. If the system, including the newly disclosed alter, consents, the processing may be completed. The session should be closed down carefully using containment imagery (e.g., putting fragments of the memory or feeling back in the jar until next time). Additionally, the EMDR session should be carefully closed using installation procedures, per the Shapiro protocol. The clinician maintains rapport and cooperation by expressing appreciation to all participating alters or ego states, debriefing them about what to expect following the session, the possibility of continued processing, and clinician availability. Finally, for the host's comfort, the alters should be asked to return to the place they normally wait until the next time they are needed.

The above describes a single EMDR session, which is repeated as many times as needed to process the patient's reservoir of dissociated material, process cognitive distortions to an adaptive resolution, and meet various other therapeutic goals such as skills building and fusion. If a single traumatic incident requires repeat processing, the clinician will note that the content and affect are different with each processing, because different parts are participating in the EMDR. This indicates progress. If, however, the clinician notes that

precisely the same material is coming up in relation to the same target, this indicates that an alter, known or unknown, is hiding, and not "looking through the eyes" during EMDR. Repeating the same looped process will not succeed; rather, what is needed is to engage the reluctant alter in the process.

The treatment of a dissociative patient cannot be limited to only EMDR processing of trauma, however. Between EMDR sessions, psychoeducational, supportive relationship building and problem- solving sessions will be needed as the dissociative patient integrates into her/his general fund of knowledge the now freed-up and reassociated information formerly held apart in dissociated neural networks. The patient's life may change dramatically as the trauma is left behind and the patient becomes freer. Once alters have shared consciousness and released the old traumatic material, integration unfolds spontaneously. This does not obviate the need, however, for developing appropriate coping skills so that the patient is not forced to revert to dissociation when life takes negative turns.

Integration proceeds naturally with EMDR, as a normal outcome of conducting the procedure. As if the eye movements lance dissociative barriers and allow a reweaving or reassociation of information, the parts come to understand and appreciate each other, tolerate co-consciousness well, and no longer need to maintain amnesic or other barriers. This moves the entire self-system toward greater unity, from the time of the preparation for the first EMDR session.

FUSION

When all trauma work is complete for an alter(s), EMDR may be used to conduct a fusion if this is the desired goal of the self-system. Fusion refers to the removal of the hypothesized neural network walls, which served to keep the affect-laden material separate from consciousness. Once the traumatic material is processed and integrated into the patient's easily-accessed fund of information, amnesic barriers are no longer needed.

When the walls come down, the ego states lose their separateness, except to the degree that normal consciousness requires situation-specific ways of being. Conducting a fusion using EMDR takes these walls down, somehow, using a straightforward process that takes only a few minutes. It should not be undertaken unless an alter no longer needs to be separate to hold traumatic material.

Once the trauma is neutralized with EMDR, most moderately dissociative self-systems willingly embrace integration and fusion as a goal. For some individuals with DID, however, alters express reluctance to give up their separate identities, and reject fusion as a goal.

The fusion procedure using EMDR is preceded by an educational component about the nature of fusion that is directed to all alters, answering their questions about what will happen to them. They can expect to lose something, (i.e., their feeling of separateness) and to gain a sense of wholeness. The walls between them will disappear, but the essence of each alter's function will continue in the whole person. The clinician should be sure that the system has learned other coping skills instead of dissociation, or splitting off of alters may recur when the patient is under extreme stress. When consent is achieved and alternative coping skills are available, the EMDR for a fusion consists of surprisingly few eye movements conducted while all alters are present and "looking through the eyes." At the same time, the system's attentions are turned to positive schemata such as, "we feel clean and whole, we are one, we are I, walls falling away," etc. This process takes only one or two minutes, but may be extended by adding desired installations of imagery of future coping by using new skills, or self-esteem enhancing statements. After the fusion, the clinician should check for remaining dissociation using the dissociative table procedure. If no alters answer, the fusion is apparently successful. It is still necessary to conduct post-fusion follow-up, to ensure that assertion, communication, problem-solving, and other skills are used instead of dissociating anew. It is not rare, after a fusion, for previously unknown alters who were at a deeper layer to make their way to the surface. Both therapist and client must expect this possibility rather than construe it as failure, or both may become discouraged.

After fusion of parts, the consciousness achieves relative unity, or unity approximating the more normal condition of normal ego states for various situations. Metaphorically, the walls are replaced by screen doors, with easy access, cooperation, and permeability of information throughout the self.

ILLUSTRATIVE CASES

The following four cases are included to provide a sense of the use of EMDR with dissociative patients. They reveal the problems associated with failing to screen for dissociation prior to using EMDR with a patient presenting with such problems as phobias or PTSD. The first two cases should be considered examples of what *not* to do. They illustrate, however, EMDR's dissociation finding ability. EMDR should *not* be used to deliberately uncover dissociation, because there can be deleterious impact on therapeutic rapport, as well as unintended disruption of the self-system.

Case 1: DID Uncovered During EMDR Targeting a Rape

A 52-year-old married Caucasian female, formerly employed as a restaurant worker, presented with severe anxiety, nightmares, and stuttering with an onset two years prior, following a rape. No screening for dissociation was conducted because the therapist was not yet trained in dissociation. Although the therapist was trained in EMDR, the EMDR training at that time did not include emphasizing the necessity of screening for dissociation. After several weeks of initial

interviewing, clarifying the diagnosis of severe PTSD, and general establishing of rapport, the therapist introduced and explained EMDR. The patient, who was intelligent, educated, and apparently highly cooperative, willingly agreed. During the EMDR targeting the rape, the patient closed her eyes repeatedly, making EMDR impossible. When the therapist asked why the patient was closing her eyes, the patient appeared confused, denied that she was closing her eyes, and stated her willingness to continue. Continuing, the patient started chanting multiplication tables and, on therapist inquiry, denied that she was chanting. In a subsequent session, an angry alter personality emerged and warned the therapist to discontinue EMDR treatment. Subsequent to the therapist's acquiring needed training in dissociation, the patient's score on the DES was 69, strongly suggesting the presence of dissociative identity disorder. Various alter personalities were subsequently met. The patient relocated to another state due to her husband's job transfer and no follow-up is available.

Case 2: DID Uncovered During EMDR Targeting a Simple Phobia

A patient presented for treatment of a simple phobia related to small lizards, again before the author was trained in dissociation and before she customarily screened for dissociation. After initial interviewing established the phobia diagnosis and after rapport was well established, EMDR was explained and the patient consented. During the procedure the patient looked confused with rapid blinking, the onset of an intense headache, and did not recognize the therapist. The patient said, "Who are you, why am I here, and why are you waving your finger in my face?" The aspect of the patient accessed by the EMDR was an alter that understood herself to be 19 years old, was present at the time of the onset of the lizard phobia, and who wanted nothing to do with therapy. Although the host had amnesia for this portion of the EMDR session, another alter emerged to explain that the lizard phobia had begun during a molestation in childhood, when the child watched a lizard on the window sill during the molestation. Because EMDR was premature at this point in treatment, therapy continued without use of EMDR until the patient relocated out of the state. This is not the preferred sequence of events in the therapy of a dissociative patient. Through these cases and hearing other similar stories from other EMDR therapists the author became convinced that 1) graduate education often ill-prepares mental health professionals for treating dissociative patients, 2) the standard EMDR protocol needed to be modified to include screening for dissociation prior to conducting EMDR. The author both obtained the needed training and suggested the modification to Dr. Shapiro, who modified EMDR training to include screening for dissociation.

Case 3: DDNOS Uncovered in Screening Prior to a Brief Successful Treatment

A 37-year-old married Caucasian female, employed as a medical technician, presented in acute distress related to intrusive images and strong emotions that she felt were not her own. She had marital discord related to these symptoms. She reported low self-esteem and lack of assertiveness that interfered at home and at work. In the intake interview, screening for dissociation found a subclinical score on the DES (13), but on interview the patient admitted to various dissociative symptoms including made feelings, hearing voices in her head, and headaches that worsened in times of stress. Additionally, she had strong feelings that there had been trauma in her childhood, but she did not have specific memories of trauma. The dissociative table technique was used early in treatment to establish rapport with possible various ego states; and the patient fully cooperated with this procedure. The patient expressed surprise upon hearing the internal voice of a child ego state that cried, "help me, help me," addressed to the therapist. EMDR was explained to the entire patient, and the patient, including known ego states, consented to EMDR treatment. EMDR was conducted six times over the course of 14 sessions. Without the therapist ever suggesting specific trauma, the patient became aware of abuse memories related to molestation by neighbor boys. Of note, an early EMDR image was of the patient's father's face, while the patient was also re-experiencing somatic sensations associated with molestation. The patient inferred initially that her father may have been her perpetrator. These perceptions were fragmented and in flashes, and the EMDR became stuck at this point. After interviewing the ego states involved in the particular trauma being targeted, it became clear that the EMDR had become stuck because the child ego state felt too fragile and frightened to continue "looking through the eyes." The therapist negotiated for older and stronger ego states to stand with her and assist, and this blending of ego states enabled the involved child alter to be in consciousness (to "look through the eyes") so the EMDR could continue. Under this arrangement, the formerly fragmented perceptions became continuous and full, and the patient processed the trauma to completion. With the full information in consciousness because of the full participation of the ego states, the patient became aware that her father had not been the perpetrator but rather had interrupted a molestation by neighbor boys. By the end of the EMDR sessions, apparently all of the BASK elements associated with two molestation memories had been reintegrated and neutralized. During the EMDR, cognitive elements had emerged related to the young child's self-blame for the molestation, and internalization of a parent's statement that the child was dirty. These cognitions spontaneously shifted during the EMDR to adaptive adult understanding that the child-self was not to blame. The patient reported greatly reduced emotional distress, and better functioning at work. Self-esteem was improved by self report, and

the patient was able to assert herself for the first time, no longer feeling to blame or dirty. The patient's husband reported amazement that his wife had changed so dramatically and rapidly. Gains were maintained at one year follow-up.

Case 4: DID Uncovered in Screening Prior to a Relatively Brief and Successful Treatment Course

A 33-year-old black female attorney presented with the chief complaint of acute distress, with uncontrolled weeping and stuttering, following a confrontation with her supervisor at work. In initial interview, screening for dissociation was conducted, and the patient scored 45 on the DES. Additional diagnostic interviewing and the dissociative table technique was used to make acquaintance with several alter personalities. A child personality was responsible for the weeping, being reminding by the supervisor's behavior of childhood traumatic episodes with her mother. No red flags contraindicating the use of EMDR were present. The child alter was cooperative and willing to engage in EMDR for relief of acute distress. The use of eye movements was explained to the entire system by talking through the host, though the system was largely unknown to the therapist. Alters were given the opportunity to say no to the use of the procedure and none did. A brief course of eye movements reduced the child's distress. Eye movements were discontinued at that point, because to continue would probably have "awakened" other alters, due to the uncovering tendencies of EMDR. This successful experience was observed by other alters, who were willing to engage in EMDR as treatment progressed. The work-related issues were targeted in EMDR, and the EMDR sessions spontaneously referred back to early childhood traumas, which were then abreacted and neutralized. With each successful trauma or set of traumas neutralized through EMDR, alters tended toward integration spontaneously and each consented to fusion except one – hatred – who feared loss of power and death if she engaged in EMDR. Ultimately, she agreed to EMDR and the hatred was neutralizing, leaving an adaptive and powerful alter willing to integrate. After 36 sessions (of which 20 were EMDR sessions), the patient had complete resolution of not only her presenting complaints, but various other life-long problems of fugue states, lost time, hearing voices, and flashbacks or childhood trauma. Latter sessions worked on developing alternative coping strategies to use instead of dissociation. At the end of treatment, she continued to have narcissistic personality features, but was no longer dissociative. She discontinued treatment, and returned six months later because she felt as if she might have created an alter in a stressful situation related to a family member's terminal illness. The recently acquired alter was amenable to EMDR, and was reintegrated in a single session focusing on the family member's illness. In the installation phase of EMDR, the therapist installed the image of the patient using alternative coping skills successfully, and maintaining her continuity of identity and consciousness. On additional six months follow-up, there were no new alters found and the patient was maintaining her job and relationships well, without continuing dissociation.

DISCUSSION

EMDR, in the hands of clinicians trained in the treatment of dissociative disorders and in the formal and safe process of EMDR, can be a powerful clinical resource. Its emphasis on reintegration of dissociated material is the basis of its powerful healing potential. Like all forms of power, in the wrong hands it can be abused, and therein lies its risk to traumatized patients. EMDR clinicians need to learn about dissociation to provide safe and effective EMDR treatment. Conversely, clinicians familiar with working with dissociative disorders but new to EMDR will be greatly aided by obtaining appropriate training in this new procedure. It is hypothesized that EMDR potentiates the brain's own healing mechanisms as it produces a relatively rapid recovery from trauma.

This article has attempted to preliminarily integrate neural network theory, dissociative theory, EMDR practice and dissociative practice. It is based entirely on clinical findings. There is fertile ground for researchers to determine whether the theoretical postulates are true, and whether the procedure is as efficacious as it appears clinically. In the meantime, EMDR appears to offer promise as an important means to make the treatment of dissociative disorders more comfortable, rapid and cost-effective for patient and therapist. ■

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