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EMDR as a Special Form of Ego State Psychotherapy: Part One

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Ego state therapy has become an increasingly recognized and utilized form of psychotherapy over the past 25 years, although it has been used primarily by hypnotherapists in the context of the treatment of dissociative disorders. The use of Eye Movement Desensitization and Reprocessing (EMDR) has also expanded extremely rapidly over the past ten years, primarily in the treatment of acute and chronic Post Traumatic Stress Disorder (PTSD). It is the thesis of this paper that EMDR can be conceptualized as a special form of ego state therapy. EMDR's unique contribution to the ego state therapy process is in its subtle, but profound, impact on the associative/dissociative process, and ego state therapy can be considered a meta model for informing EMDR therapeutic interventions, particularly with regard to impasses.

J. G. Watkins and H. H. Watkins (1997), basing their work on the writings of Paul Federn, have taken the lead in developing and teaching the basic ego state therapy concepts. They define an ego state as "an organized system of behavior and experience whose elements are bound together by some common principle." (H.H. Watkins, 1991, p. 233). Over the past 20 years, other writers (Edelstein, 1982; Fraser, 1991; Malmo, 1991; Newey, 1986; Phillips, 1993; Phillips & Frederick, 1995; Torem, 1987) have elaborated on the ego state therapy model. Most of them have approached the subject from a hypnotherapy perspective. Writers from other psychotherapeutic schools have also formulated models which can be seen as a reflection of ego state phenomenology, although the term "ego state" is not specifically used. Berne (1961, 1977), in his development of transactional analysis, talked about the parent, child, and adult parts of the self, as well as games that different parts play, all of which reflect the actions of different ego states. Assaglioli (1968), in his psychosynthesis writings, discussed the concept of subpersonalities, which can also be conceptualized as separate ego states. Schwartz (1995), coming from a family systems model, has written about "internal family systems," which is also a reflection of ego states or subpersonalities. Young (1994), with his cognitive therapy schema-oriented approach, talks about the schemas of patients in a way that is very close to that of an ego state model.

These are just a few examples of the many writers whose work might well be interpreted from an ego state model perspective. Similarly, EMDR can be conceptualized as a special form of ego state therapy.

This paper presents an abbreviated summary of an ego state theory of personality, psychopathology, and psychotherapy. This model is the author's personal formulation of ego state therapy and may not reflect the views of other ego state therapy practitioners. A brief overview of EMDR theory and technique follows. Finally, EMDR is conceptualized as a special form of ego state therapy, whereby the pre-therapy dissociative barriers between and within ego states are attenuated and new associative linkages are formed, such that a more integrated ego state structure emerges.

Ego State Therapy Model

The Development of Personality Structure

The fundamental basis for the structure of personality derives from the neuronal connections developed out of the state-dependent learning process. Rossi (1986) discusses how processes become "hard wired" together as a result of state-dependent learning processes. "Learning" in this context refers to the fact that biochemical and neuronal associations are made among components of a "state," linking them together. These interconnected components can be conceptualized as the simplest form of "ego state"—the totality of all that a person is in a single moment of time, incorporating all the components of the self. These components can be categorized according to Braun's BASC model -- Behavior, Affect, Sensation, Cognition (Braun, 1988). Or, they might be categorized according to the broader acronym proposed by Lazarus (1989) BASIC ID—Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal, and Drugs (which may be reformulated as Biology).

The *high intensity* of the terror of a traumatic experience tends to promote the creation of more enduring ego states. *Chronicity* or *repetitiveness* of an experience also tends to promote more enduring, strong ego states; hence, repetitive family patterns, including trauma, have a more powerful effect on the personality.

But associational linkages also develop among momentary ego states which occur sequentially in close proximity. These linkages are also stronger when associated with intense affect or regular repetition. Thus, for example, when we uncover the memory of an early childhood sexual trauma, the patient will experience a whole series of different affective ego states in close sequence, paralleling the initial experience, going from intense apprehension, to outright terror, to feelings of dejection and helplessness. These momentary ego states unfold one by one, as if played on a video tape.

As one might expect, these neuronal linkages through time can get increasingly complicated, such that elaborate combinations of affect, behavior, cognitions, etc., become interconnected in consistent, repetitive ways. These elaborate patterns may be called subpersonalities. It is this aspect of ego state phenomenology that is reflected in the definition of ego state by Helen Watkins (cited above). The common theme of an ego state (subpersonality) may consist of the person at a certain age, which would then include different affects; or it might include a common mood or affect, with different behaviors; or it might be a certain type of interpersonal strategy.

In summary, it is the biological sub-stratum underlying ego state phenomenology, based on state-dependent learning processes and their derivatives, that gives power to ego state phenomenology and to the therapeutic use of the ego state model in working with psychological symptomatology. Previous writers have not emphasized this biological underpinning of ego state phenomenology. It is this biological sub-stratum for ego state phenomenology that may ultimately lead us to understand how EMDR impacts on ego state pathology.

Most previous ego state conceptualization refers only to subpersonalities or parts. In this paper, the term "ego state" will be used to refer to all ego state phenomenology, including the subpersonality or part of the self, as well as the ego state as the state of the ego in one moment of time, as might happen in a flashback.

The role of dissociation and hypnosis

Although ego state phenomenology is derived directly from underlying biological linkages, these linkages are not consistently obvious because they are often overridden and hidden by the capacity of the mind to dissociate. Dissociation is the compartmentalization of consciousness, so that one part of the self is not aware of other aspects of the self. This compartmentalization may be between one component of an ego state and the other components of that ego state, such as remembering an event without affect or having a flashback of affect without any memory. Or the dissociation may be between ego states, such as in dissociative identity disorder (DID), where the dissociation is extensive. But all of us dissociate ego states to some degree; for example, when one is down in the dumps, it is often difficult to access a more optimistic ego state.

Now, because it is impossible for a person to maintain full consciousness of all components of all ego states at one moment in time, generally the energy and identity of the self tends to reside in only one ego state at a time, with the other ego states being more or less dissociated. The phrase "more or less" is critical, because the quantity and quality of dissociation among the ego states varies considerably from one personality structure to the next. The nature of the relationship between the currently dominant ego state and the other ego states that are temporarily less dominant will depend on two major types of variables —permeability and fluidity. Permeability is the ability of the primary ego state to access one or more of the components of other, temporarily more subordinate, ego states. Fluidity refers to the shift from one predominant ego state to another.

Psychopathology from an Ego State Perspective

One could view all psychopathology as the failure to maintain optimal dissociative barriers among the ego states, that is, to maintain optimal permeability and fluidity —in short, a failure of the psychological system to do an adequate job of time-sharing. Since all of the ego states have a certain energy or need for self-expression, if that energy or need is suppressed by the system, then that ego state that is suppressed will ultimately break through the suppression in the form of some sort of symptomatology. The symptomatic or problematic ego state is called the "hidden" ego state —hidden in the sense that it is unacknowledged or "disowned" by the predominant ego states. However, its presence is made known through the symptomatology. The ego state may be disowned because of an unbearable affect, such as anxiety or terror, or because of

some "undesirable" behavior. However, the symptomatology generally does not give an indication of the full nature of the ego state driving it, ultimately requiring that the rest of the ego state associated with the symptoms become fully amplified and developed for therapeutic relief to occur. So, for example, in PTSD, intrusive feelings or thoughts present themselves, often without the patient's awareness of where they come from. Similarly, phobias, compulsions, and impulsive behavior are reflections of one aspect of an otherwise hidden or disowned ego state.

Sometimes psychopathology derives not from the suppression of a hidden ego state by a predominant ruling group of ego states, but rather from a conflict between two or more major groups of ego states. In this case, an overt or guerrilla war exists between these warring camps. Each camp believes that it is right and that if it only fights harder, it can win. Unfortunately, this process tends to polarize the warring camps and never leads to a real resolution. Either the power simply shifts from one camp to another, without real resolution between them, or one camp may seem to predominate for long periods of time, while the other camp fights a guerrilla war from behind the scenes. For example, an overweight patient may identify with an ego state or a group of ego states that want to lose weight, but there may be one or more ego states with an investment in either eating or being overweight, and these other ego states persist in maintaining the weight problem, in spite of repeated brief periods of successful dieting.

However the balance of power among the various ego states plays out, it is the system's maladaptive use of dissociative processes that allows the conflict and the pathology to persist. First, there is either the dissociation by the predominant ego states of the hidden ego state, or the dissociation by each camp of ego states of the other camp of ego states. Second, there is the dissociation of the fact that this previous dissociative strategy isn't working in either maintaining stability or in achieving the specific goals of the various ego states. Hence, dissociation may be conceptualized as the primary mechanism for maintaining psychopathology, not just of "dissociative disorders," but virtually all psychiatric disorders. For example, defense mechanisms—repression, isolation of affect, splitting—are technically variations of dissociative phenomenology. It is extremely important to attend to the nature of the dissociative barriers in understanding and addressing all psychopathology.

Ego State Psychotherapy

The major principles of ego state psychotherapy derive directly from the above formulation of psychopathology. First, it is essential to undo the maladaptive dissociation in order to achieve optimal permeability and fluidity. Second, it is important to promote a cooperative, collaborative attitude among the ego states, rather than a competitive, polarized posture, thereby moving the system toward "consensual democracy," with all parts having a say and none dominating autocratically. When these goals are achieved, the psychological system is "integrated," meaning there is optimal interconnectedness among the ego states, and any ego state can easily access any other ego state that might be of use in a given moment. Integration does not imply fusion or merging of ego states. The biologically based ego state infrastructure developed initially still persists, even in an integrated personality. But ego state therapy diminishes the dissociative barriers within and among the ego states and develops new biological linkages among the ego states, so that one ego state can access the other ego states more readily and spontaneously. It is as if the dissociative barriers previously separating the various ego states were removed and replaced by new "highways" or "communication wires" so that ego states have the potential of being interconnected at any time, even though these connections may be temporarily switched off.

The ego state bridge

In 1971, the Watkins' formulated the concept of the affect bridge, a technique for amplifying an affect while the patient is in a hypnotic trance. The patient is then invited to take that affect back in time, as if going across a bridge, to find its origins (J.G. Watkins, 1971). They subsequently developed the somatic bridge technique, which works like the affect bridge, but uses somatic sensations as the starting point for hypnotic amplification and age regression (J.G. Watkins, 1990). Grove (1989) amplifies both somatic sensations and imagistic-metaphorical representations of those sensations to elucidate the meaning of symptoms. The Gouldings (1979) developed Redecision Therapy, which invites the patient to amplify a cognition or decision and take it back in time to when it was first made. It is clear that all of these techniques are based on the underlying bio-

logical ego state infrastructure. By accessing the here-and-now manifestation of affect, somatic sensation, image, behavior, or cognition, and then amplifying that ego state component, spontaneous associations to other dimensions of that ego state will unfold, due to the underlying biological connectedness of that ego state. Consequently, the earlier manifestations of the very same ego state will frequently unfold spontaneously, because they are associated biologically so closely to its present day manifestations.

This is the "ego state bridge" technique, with which any component of an ego state can be amplified and thus associated with its other components, including the historical and anamnestic pieces. Note that the bridge is a bridge in time, not a bridge to a different ego state. The technique amplifies whatever ego state components present themselves as much as possible, minimizes any anxiety driven dissociative barriers, usually through hypnotic techniques, and then allows the underlying ego state structure to unfold itself spontaneously. Generally, the affective and somatic components of the ego state provide the most powerful linkages to the rest of the ego state, but the imagistic component is the most powerful reflection of historical content. Working back and forth among all ego state components is the key to optimizing the amplification of the ego state associative process.

The ego state shift

While the ego state bridge allows one to understand the full dimensions of a problematic hidden ego state, this understanding by itself is generally not enough to produce a lasting therapeutic effect. That ego state was largely hidden through dissociation, usually for a purpose, and that purpose almost always is to protect the system from excessive anxiety. Usually the patient has been "stuck" in this problematic ego state because at the time the ego state developed, the patient had no way alleviate the anxiety associated with that ego state, except through dissociation. The therapeutic task is to facilitate a natural shift from the problematic ego state to some other ego state that can soothe or relieve the anxiety associated with the problematic ego state. That shift, which the patient could not do by himself at the time of the development of that ego state (either because of the biological limitations on information processing during a traumatic experience or because of developmental immaturity), can usually be conducted fairly easily with the facilitative assistance of the therapist.

This process can be facilitated through the use of imagery, simply by inviting the patient to let whatever needs to happen in the image to happen. Usually the patient will know exactly what needs to happen to get relief from the anxiety or other affective tension being experienced in the initial ego state. Sometimes, however, the patient may need encouragement to "let go of historical reality" in order to allow the image to unfold as necessary. Most patients are then able to shift from the problematic ego state to a new ego state and provide relief for themselves.

For example, a patient with PTSD who has associated to the early origins of the trauma can resolve the terror of that traumatized ego state by shifting to an ego state that would provide a sense of empowerment with anger, or to an ego state that provides protection, nurturance, or comfort. Those ego states may not have been in fact historically available, but the patient is free in the here and now to access these ego states, so that he need not remain stuck in the previously helpless one. The advantage of imagery is that it allows the patient to discover his own ego state needs, rather than it being prescribed by the therapist, as some hypnotherapists are inclined to do. For example, a patient who needs nurturance and soothing will not respond therapeutically to a therapist who exhorts him to make an ego state shift by angrily beating up his abuser.

It is important to note that, as with the amplification of an ego state during the ego state bridge, a shift from a stuck ego state to a more adaptive ego state should be facilitated through whatever ego state component is optimal for that particular patient, whether it be affective, cognitive, somatic, behavioral, or imagistic.

The internal dialogue

Sometimes the pathological dissociation in a system is not aimed at keeping a single ego state hidden, but rather reflects dissociation between two or more major groups of ego states. For example, when the therapist invites an ego state shift to occur, the patient may appear to be unable to make such a shift, regardless of what technique or ego state component the therapist attempts to utilize. Such a patient is often labeled as

"resistant." This resistance, however, simply reflects the presence of a protector ego state, which feels that it must protect the system by not allowing this ego state shift to occur. In other words, there are one or more ego states that are opposed to a change in the system, even though it means that the patient will not get symptomatic relief. It is now this protector ego state that is more or less covert, and this covert protector needs to be flushed out, explored, and engaged with in order to understand what its concerns and agenda are. Thus, whenever there is a significant therapeutic impasse, the therapist should suspect that there is a covert conflict, led by one or more covert protector ego states.

This therapeutic impasse is perpetuated by the maintenance of a dissociative barrier between the ego state(s) which hold the symptomatic pain, and the ego state(s) which are opposed to a change in the system. This dissociative barrier can be diminished by introducing an internal dialogue among these previously unconnected parts. The goal of the dialogue is to undo the dissociation between these parts and to foster a collaborative, cooperative attitude among them.

There is a great variety of specific techniques for facilitating such an inner dialogue, including imagery, the Gestalt empty chair, writing with the nondominant hand (Capacchione, 1991), psychodrama, voice dialogue (Stone & Windelman, 1989), the parts party (Satir, 1991), and internal family systems (Schwartz, 1995). Each of these techniques has certain advantages and disadvantages, but whatever the methodology, parts of the system will oppose the process, and these parts will need to be addressed. Regardless of the therapeutic modality used, it is important to appreciate that the process is intended to facilitate reduction of the dissociative barriers among the separate ego states and to enhance a collaborative attitude among the parts. All parts must accept the notion that each part is entitled to have its needs addressed in some way.

This process of connecting the ego states interactively and non-dissociatively develops a biological infrastructure among the ego states so that they are now more likely to flow back and forth spontaneously and freely, thus optimizing the patient's adaptive functioning in the future.

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