Integrating EMDR and Ego State Therapy in a Collaborative Treatment Model: A Practical Guide to Building a Referral-Based Practice

Carol Forgash, CSW
Carol Forgash, CSW, BCD, is a psychotherapist in private practice in Smithtown, New York, specializing in the treatment of dissociative disorders, trauma (especially sexual abuse), affective disorders, phobias, panic disorders, and performance issues. She is a Board-Certified Diplomate in Social Work and a member of the EMDR Humanitarian Assistance Program's Board of Directors. She has extensive training and experience in EMDR. Certified in EMDR training by the EMDR Institute in 1995, she is a faculty member of EMDR Institute and an EMDR International Association Approved Consultant. She provides instruction in ego state therapy integrated with EMDR at EMDR Institute Level II trainings and international conferences, including EMDRIA and the International Society for the Study of Dissociation. She presents two-day advanced EMDR workshops in the United States and Europe. She is the author of several articles on the treatment of trauma and the coeditor, with Margaret Copeley, of a forthcoming book on the integration of EMDR and ego state therapy.

Contact Carol Forgash at 353 North Country Road, Smithtown, NY 11787, or e-mail: c forgash@optonline.net.

This publication was edited by Margaret Copeley, M.Ed., a New Hampshire writer and editor who specializes in the mental health fields. She provides writing and editing services to graduate students, academic faculty, and clinicians writing dissertations, articles, and books. She may be contacted at editor@worldpath.net.
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Introduction:
What Is Collaborative Therapy?

Most therapists are familiar with the frustrating phenomena of stalled treatments, impasses, and apparent negative therapeutic effects. Therapists who are vigilant of their clients' progress and well-being are alert to changes in the client's emotional and functional status that arise as the therapy unfolds. Those changes may indicate new needs that need to be accommodated in new ways. This is particularly the case in the treatment of trauma, where the client's growing awareness of past traumas may produce new symptoms that can be unsettling for both client and therapist. If not addressed effectively, these can undermine the therapeutic relationship itself.

A therapist who lacks specific training in trauma treatment may feel inadequate to the task of dealing with the symptoms and destabilization associated with trauma. This challenge to a therapist's insight and technical skills may be expected to occur frequently, given the ubiquity of trauma in our contemporary society.

It is under these circumstances that a therapist may consider using collaborative therapy to meet the client's specialized needs that lie beyond the therapist's expertise. Collaborative therapy is the concurrent treatment of a client by two therapists: the primary therapist, and a specialist who provides adjunct treatment of specific conditions. The adjunct therapy is time limited and the client continues to work with the primary therapist during and after the adjunct therapy.

This article will describe the application of the collaborative treatment model to clients who undergo EMDR and ego state therapy with a specialist in addition to their regular therapy. EMDR/ego state therapy specialists are uniquely positioned to assist primary therapists in resolving stalled therapies and enhancing the treatment provided by the primary therapist. Collaborative treatment provides an opportunity for EMDR and ego state therapists to expand their practices by coming to the aid of colleagues who lack specialized training.

We will explore in this article the issues that become problematic over time in a course of therapy, which clients are good candidates for concurrent EMDR and ego state treatment, how to develop an effective working relationship with the primary therapist, and how to avoid problems that may arise out of this dual relationship. A detailed case study will illustrate each step of the treatment, from the initial contact with the primary therapist through the conclusion of the adjunct therapy.
The Initial Contact with the Primary Therapist

This introduction to our case study illustrates how difficulties in a treatment may lead a therapist to contact a specialist in EMDR and ego state therapy for collaborative treatment.

Laurel Roberts, a psychotherapist in Suffolk County, Long Island, specializing in substance abuse and depression, found herself at an impasse in her treatment of Sara, a 35-year-old physician diagnosed with depression. After a year and a half of successful work with Laurel, Sara had begun to lose ground. Her depression and anxiety had worsened; she was experiencing nightmares that contained vivid memories of childhood trauma; and she felt unable to cope with the demands of her roles as physician, wife, and mother. Laurel felt herself at a loss to understand the dramatic decline in her client's functioning or to identify strategies to reverse it. Having been introduced to EMDR at a conference, Laurel contacted me to discuss whether EMDR treatment could be helpful to Sara and provided me with a brief history of her background and progress in therapy.

Sara was a married mother of three daughters ages 6, 3, and 18 months. Shortly after the birth of her last child Sara had entered therapy for treatment of her postpartum depression and generalized anxiety. For over a year she appeared to make good progress in therapy but in the three months prior to her referral for EMDR treatment she experienced a recurrence of the symptoms that had led her to seek therapy. She appeared to be in a fatigued and numb state, with little affect—a significant change from her energetic demeanor prior to this setback.

Sara had grown up in a chaotic family environment in which she had witnessed her parents' frequent verbal and physical altercations. Their confrontations were lengthy and dramatic and Sara herself was also subjected to her father's anger and his demeaning criticism. Sara had been troubled by memories of these events periodically throughout her adult life, but she did not accord great significance to them, nor was she aware of their relation to her current difficulties, though the connection was unmistakable. Her nightmares revolved around images of the family violence that had deeply frightened her as a child. Her disturbed sleep was leaving her exhausted. The nightmares intruded into her daytime thoughts as well, preventing her from focusing on her work.

As the nightmares continued Laurel also noted a change in Sara's self-concept. She expressed feelings of worthlessness and a return to a childlike state: "I feel very small," she told her therapist, "sometimes like a little kid." I hypothesized that Sara was reexperiencing the fears, helplessness, and loss of self-worth associated with her abusive father and her parents' violent relationship that were held as traumatic memories by a child ego state. Lacking resources to neutralize and integrate those feelings and memories in the present (as had been the case in childhood as well), Sara was possibly experiencing dissociation along with other symptoms characteristic of chronic posttraumatic stress disorder. She was overwhelmed by the flashbacks in her nightmares and was shutting down emotionally. She expressed a fear of collapse that in fact seemed well grounded.
Laurel Roberts lacked experience working with posttraumatic stress disorder related to childhood trauma and felt unable to assist Sara. She was unfamiliar with affect containment techniques and stress management strategies that her client would need prior to working with traumatic material. She was unable to recognize the range of dissociative phenomena and had no awareness of ego states or how to respond to them.

Laurel feared that Sara would remain in this regressed state unless she received treatment to help her resolve these major past traumas. She contacted me to discuss whether her client could benefit from a collaborative treatment model that would allow Sara to continue working with Laurel as her primary therapist while undergoing EMDR/ego state treatment with me to address her trauma issues.

Offering Specialized EMDR Treatment through Collaborative Therapy

Sara had a well-established therapeutic relationship with Laurel, and their work had proven successful over a period of fifteen months. Clearly Laurel had been working effectively with Sara in some respects and was deeply committed to the welfare of her client, and yet Sara encountered difficulties that required specialized treatment beyond the training of her primary therapist. In a case such as this, collaborative treatment can be a powerful tool for making specialized treatment like EMDR available to the client. The client is able to continue working with the primary therapist, with whom there is an established, secure relationship, while at the same time receiving treatment from an EMDR practitioner.

Collaborative treatment has long been used by psychotherapists who refer clients to psychiatrists for evaluations, to specific types of group therapy, or for couples counseling (Bradley, 1990; Lustig et al., 2000). While a relatively new treatment approach, concurrent EMDR therapy has been supported by recent research (Lovett, 1999; Grand, 1999; Forgash, 1997).

As a clinician trained in EMDR and ego state therapy, and with over 20 years of experience treating clients with PTSD and dissociative and Axis II disorders, I frequently receive referrals for clients such as Sara for consultation and possible concurrent treatment. Clinicians are most likely to refer clients who are not making gains in conventional treatment or who are presenting symptoms outside the therapist's area of expertise. Primary therapists seek assistance from EMDR specialists in treating a wide variety of conditions that they find problematic, including panic disorder, early or current trauma, child abuse, substance abuse and other compulsive disorders, long-standing depression, psychosomatic disorders, personality disorders, PTSD, dissociative disorders, performance anxiety, and phobias. Many therapists also lack training in treating clients
with serious medical illnesses such as cancer, AIDS, lupus, and Parkinson's disease and terminal illnesses. These illnesses are traumatic for the client, who needs assistance in therapy to learn to cope with the illness and to work through fears of limitations imposed by the illness or even fears of death.

The field of traumatology has shed light on the deep impact of events such as childhood sexual abuse, war, natural disasters such as fires and tornadoes, early losses of primary caregivers, and accidents. These major traumas, which have been termed "big T" traumas (Shapiro, 1995; 2001), are likely causes of PTSD and dissociative disorders (Shapiro & Forrest, 1997; van der Kolk & van der Hart, 1991; Herman, 1992). It has also become evident in clinical practice that a large segment of the population suffers from aggregates of lesser traumas, termed "small t" traumas (Shapiro, 1995; 2001), that hamper current functioning. These include sporadic emotional neglect or abuse in childhood, negative experiences in school such as peer bullying, chronic employment problems, and ongoing financial stresses. Like big T traumas, these lesser traumas are stored as negative memories and have negative emotional and physical associations.

The number of clinicians trained in EMDR and ego state therapy is relatively small compared to the large number of clients who require treatment for trauma. The concurrent therapy model allows the limited resources of this EMDR-trained group of clinicians to be used most effectively to reach the greatest number of clients. While the primary clinician may be effective in treating part of the client's presenting issues, the addition of EMDR and ego state therapy results in successful resolution of trauma that may not be obtained, or that takes longer to achieve, through conventional therapy. As clients treated with EMDR learn better affect management and the frequency of overwhelming flashbacks and other distressing phenomena is reduced, their response to conventional therapy is enhanced while the length of treatment may be reduced.

**Expected Benefits and Outcomes of Collaborative Treatment**

Many of the approximately twenty clients I have treated with integrated EMDR and ego state therapy in a collaborative treatment model have reported that this approach was a new experience for them, significantly different from what they had experienced in prior therapy and resulting in changed perceptions, beliefs, and conceptions of relationships.

Many of the changed perceptions result from seeing the primary therapist in a new light. The therapist is humanized when it is recognized that not all of the needs of the client can be met by a single individual and that the therapist is not invested in being the client's only resource. Rather than feeling abandoned by the therapist, the client comes to
realize that the proposal for additional, specialized treatment is being made out of a
genuine concern for the client's needs, a degree of attunement that most likely has not
been experienced by the client who grew up in a dysfunctional family. The therapeutic
triad models for the client a collaborative relationship based on open communication
without secrets, power sharing, and concern for the client. This can be a new experience
that is very different from the dysfunctionally triangulated relationships in the client's
family of origin. A lack of trust in authority figures, often developed as a result of the
abuse of parental power, evolves into a new view of relationships as productive and
satisfying encounters that meet the participants' needs and goals.

Many clients with a history of trauma have attachment and abandonment issues.
These may be aggravated when the primary therapy arrives at an impasse and the client
feels that the therapeutic relationship is in jeopardy. The therapist clarifies that the
purpose of the referral to a collaborative EMDR therapist is for the purpose of furthering
the client's progress and that the primary relationship will continue during and after the
specialized treatment. The client is thus able to experience the continuity of a relationship
in spite of difficulties: the therapist is not giving up on the client but in fact proposing a
way to improve and continue the treatment.

The double format of the concurrent therapy model appeals to many clients. As
targeted issues are resolved through EMDR and ego state therapy, the client has the
opportunity to practice new skills in both treatment settings. The two treatment
modalities complement and reinforce each other, allowing the client to focus on specific
targeted problems and ego state issues in the specialized treatment setting while
continuing to explore the feelings, dreams, and so on that are the essence of their work
with the primary therapist; those in turn may provide further targets for EMDR work.
New issues, memories, and body sensations are likely to emerge from the EMDR/ego
state work, resulting in increased concerns that can be addressed by both therapists.
Clients appreciate the ongoing safety of the familiar primary therapy while undertaking
the new EMDR and ego state work. This continuing safety and the additional level of
support and encouragement are especially important for clients with security issues.

The concurrent therapy approach offers a new model for personal empowerment.
As a client-centered approach, the EMDR protocol provides many opportunities for the
client to exert significant control regarding the length of the sets of eye movements, audio
tones, or tactile stimulation and to choose traumatic events or situations to work on as
targets. The interest that the primary therapist expresses in the EMDR experiences and
the therapist's support of those experiences is empowering for the client as well. The
success of the experiences results in feelings of mastery and inner security for the ego
state system.

In addition to these changes in perceptions, beliefs, and ways of conceiving
relationships, which are apparent to the client, EMDR and ego state integrated treatment
leads to deeper internal changes to the ego state system and response to trauma. The
family systems approach (a reference to both the treatment triad and the internal family
system) used in ego state therapy results in the evolution of the internal system from a
conflicted, noncooperative model to one that is functionally adapted to present
experience. Extensive preparation for the trauma processing phases of the EMDR
protocol is necessary for dissociative clients. This preparation involves ego state work,
affect management, and bilateral stimulation (also known as Dual Attention Stimuli, or
This phase also includes individualized psychoeducational work such as information about EMDR, trauma, and PTSD. These stabilizing interventions and new information all help the client to cope more effectively with traumatic material. EMDR itself emphasizes reprocessing body sensations (such as pain, tension, and muscle spasms), normalizing them for the adult client and the ego states; the client subsequently becomes less fearful of processing these sensations and the memories to which they are tied.

Identifying Clients Who May Benefit from EMDR and Ego State Therapy

Combined EMDR and ego state therapy may be used to treat a varied group of trauma survivors.

- **Untreated survivors of childhood sexual abuse:** These clients, like Sara, have undiagnosed symptoms of posttraumatic stress disorder. When these individuals are subject to further trauma in adulthood—assaults, illness, accidents, and so on—they are particularly vulnerable to developing acute complex PTSD and dissociative disorders. Conventional treatment may not be sufficient to help them restabilize.

- **Clients who grew up in family environments with conditions of chronic instability and violence:** Again, these clients have preexisting PTSD and developmental deficits that compromise their ability to deal successfully with crises in adulthood such as sexual assault, marital issues, job loss, or children leaving home. A family that abounds in violence and instability fails to provide the sequential experiences that children and adolescents require in order to develop productive stress response skills, thus setting the stage for chronic PTSD in adulthood.

- **Clients with somatic problems that may be psychogenic in origin:** Somatic problems may be symbolic representations of body memories of trauma. These problems are manifested in a variety of ways, including muscle spasms, chronic pain, and sleep disorders. Many sexual abuse survivors experience severe and painful menstrual cycles. An individual who was subjected to chronic stress in a chaotic household may develop digestive tract problems such as colitis. Other somatic problems arise from injuries suffered as a result of physical or sexual abuse, risk-taking behaviors subsequent to the abuse, or severe medical problems in childhood. Often these clients are misdiagnosed as the trauma origin of their somatic symptoms is not recognized. They may have spent years seeking relief through unsuccessful medical treatment, stress reduction training, or pain management treatment. While at times the symptoms of these clients are minimized by medical practitioners and psychotherapists, they are distressing and interfere with functioning.
• **Clients who have experienced a large number of small traumas:** The failure of these clients to make progress in conventional therapy may not be recognized as stemming from an accumulation of lesser traumas, entrenched negative core beliefs, cognitive distortions, and chronic anxiety. These and other symptoms of PTSD may be present, even though the client does not meet all of the DSM IV criteria for the PTSD diagnosis. These problems can make the client resistant to change, blocking progress.

**The Challenge of Treating Trauma Survivors**

Trauma survivors bring with them a complex array of treatment challenges that require the therapist to be well versed in the dynamics of the ego state system and the manifestations of PTSD, including its dissociative aspects. These challenges often perplex the primary therapist, but they must be anticipated by the EMDR/ego state therapist.

The ego state system (also called the "internal family system") includes many parts that have developed throughout the lifespan in response to life experiences, both negative and positive. Some of the states developed long ago in response to the original traumas or crises. Since they are oriented toward conditions that existed in the past, they are likely to be particularly maladaptive in the present; in fact they may not be oriented at all to present time and place. Other states that have not been subjected to trauma may be better adapted to functioning in the present. It is particularly characteristic of chronic PTSD that ego states of varying capacity and maturity coexist in the same client, resulting in an uneven pattern of development, achievement, and coping skills.

All of the ego states, whether adaptive or maladaptive, are important to the client: each plays a specific role in the system as a whole and seeks to be preserved. The states perceive that to give up that role would result in their annihilation—this is especially true of states that developed initially as system protectors. The ego state system of the trauma survivor is troubled by conflicts among them as they compete for recognition and preservation and each one, with its individual needs and characteristics, strives to be recognized and maintained.

In addition to the challenge presented by the complexity of the ego state system and its conflicts, clients with chronic PTSD experience problematic responses to treatment ranging from impasses to dissociative episodes and destabilization. The primary therapist often experiences these responses as a frustrating resistance to treatment but may not recognize their true nature and their origin in trauma. For example, the therapist may find the client reluctant to discuss past events, but may not realize that underlying this apparent resistance are one or more ego states that fear exposure or are unable to violate family taboos against telling the truth. Clients who have been subjected
to abuse or other family trauma often have experienced threatened or actual punishment for disclosure of family secrets; they anticipate that disclosure in therapy will also result in punishment. The feared or actual punishment may have included abandonment by parents, siblings, or relatives and is extrapolated to abandonment or rejection by the therapist. In fact an ego state that discloses abuse may even come under attack or be abandoned by another state that has a stake in maintaining the family secrecy. A further consequence of childhood abuse is overwhelming shame, guilt, and distrust, all of which intrude on the therapy and the therapeutic relationship.

Clients may be aware, either partially or acutely, of their past trauma, but not anxious to explore it in therapy. They realize that difficult work lies ahead, and they fear reexperiencing their traumas. They are particularly fearful of being flooded by memories and the associated feelings, which they believe will result in a loss of control and ability to function similar to the lack of control associated with the original trauma.

At times trauma survivors take comfort in familiar responses to emotional overload. Memories, flashbacks, and nightmares may produce dissociative freezing, a state of immobilization and emotional withdrawal or numbness designed to protect the individual from further harm. This return to a survivor mode that was utilized at the moment of trauma may feel familiar and therefore comforting to the client, providing a sense of pseudosafety. It becomes an obstacle to treatment if symptoms persist or escalate to higher levels of distress, resulting in increased frustration, feelings of defeat, depression, anxiety, and loss of faith in the efficacy of treatment.

Developing a Successful Collaborative Therapy Relationship

The objective of the collaborative treatment model is to create a cooperative triad of client, primary therapist, and EMDR therapist. The transition to a triadic relationship presents a number of challenges that do not arise in the typical dyadic relationship. An awareness of these issues prior to making the decision to enter into a collaborative agreement along with careful planning and preparation of the client will help to minimize difficulties (Bradley, 1990; Lustig et al. 2000). While a relatively new treatment approach, concurrent EMDR therapy has been supported by recent research (Lovett, 1999; Grand, 1999; Forgash, 1997).

The best working team is composed of two practitioners who trust each other’s professional skills, judgment, and working methods. Clear communication between the two therapists as well as with the client is the cornerstone of the collaborative approach.

Before the decision to implement concurrent treatment is made, its advisability must be assessed by way of a risk-benefit analysis of EMDR for the client. The client’s
present functioning and readiness for trauma work are evaluated, allowing the purpose of the work—whether for restabilization or resolving trauma—to be defined.

Consideration must be given to how the client is likely to respond to a major change in the current dyadic team. Above all, the client needs to be reassured of the continuity of the relationship with the primary therapist. Clients may feel rejected and anxious if they believe they are being referred away from the primary therapist because they are in some way defective or inadequate or because the therapist no longer has interest in them or time to work with them. Although the work pattern of concurrent therapy is individually determined for each case, it is important for the client to know that continuity of treatment with the primary therapist will be maintained.

Primary therapists may also need reassurance if they express feelings of inadequacy or helplessness in their inability to meet all the client's needs. Once the therapist's self-doubts are recognized and assurance is given that the decision to seek consultation and specialized help is a mark of competence and concern for the welfare of the client, the primary therapist will likely feel relief that help is at hand. Thus, both actual and potential transference and countertransference issues between the therapists need to be addressed to smooth the way for collaborative treatment.

The first step in the assessment process is for the EMDR and ego state therapist to elucidate the course of the client's therapy to date, including success that has been achieved and problems that remain, and the reason for the referral at this point in the treatment. I inquire about the primary therapist's knowledge and expectations of EMDR and how the client feels about the referral as well. I explain how EMDR and ego state therapy will fit in with the work already in progress.

If the client is found suitable for EMDR work, the specific goals and nature of the concurrent treatment arrangement and how it will be implemented are established. A treatment contract will clarify the presenting problems to be addressed, the approximate length of the treatment, a schedule for formal case conferencing, and provisions for informal discussions for clarification and problem solving. At this point it is time for the first meeting between the EMDR therapist and the client.

Before bringing Sara into our discussion, I needed to address Laurel's unresolved feelings of inadequacy at having to ask for assistance from another therapist. I congratulated her for being able to transcend those feelings and act in the best interest of her client by seeking additional treatment for her. I emphasized the progress that Sara had made in her work with Laurel, and the trust in her that Sara showed when revealing to her the traumatic nightmares and their connection to childhood events. Laurel, as well as Sara, needed to know that their working relationship was solid and would continue after the EMDR treatment. When reassurance of her skills and Sara's attachment to her were provided, Laurel was able to release some of the stress she had been experiencing in her work with Sara.

Sara expressed some initial anxiety when Laurel first proposed concurrent therapy to her. She was concerned that working with me would be disloyal to Laurel. When in a later session she realized that she was not being sent away and would continue working with Laurel, she began to cry with relief, revealing for the first time the depth of her attachment to Laurel.
I met once with Sara to discuss the work I proposed to do with her and to allow her to ask questions. Subsequently Sara decided to proceed with the concurrent therapy.

Once Sara's agreement to participate in EMDR therapy was obtained, Laurel and I set the parameters of our work. Sara would see each of us during alternate weeks. We contracted for ten sessions, meaning that the EMDR/ego state component of Sara's therapy would be time limited although it could be extended by mutual agreement. Sara signed releases to allow us to discuss her case by telephone. As the primary therapist, Laurel would retain decision-making responsibility but would discuss with me in advance any major decisions such as recommending medication. These parameters were discussed with Sara as well.

Laurel and I agreed that Sara was not ready to begin the trauma work immediately because she was so easily overwhelmed by her nightmares and other triggers; she would need to stabilize first and learn techniques for affect regulation and stress reduction. We discussed some of the potential challenges that might arise in Sara's trauma treatment, including her perception that she could be punished for revealing what had occurred in her family, the legacy of the excessive secrecy imposed by her parents.

The remainder of this article will describe the actual collaborative work carried out with Sara.

Case Study

Session 1: History Taking

In the initial interview Sara was able to recall a great deal about her childhood and told me in detail about the "horror house," as she termed it, that she lived in. She believed that her gestation and birth were normal, although there was a family myth that her mother was very stressed by the pregnancy, possibly reflecting her mother's ambivalence about womanhood and motherhood. Her mother often complained about being restricted because she was a woman—she greatly disliked being confined at home and felt that she could have been productive and successful in the work world. She professed to not want children, but eventually she produced three daughters, of whom Sara was the oldest. Her maternal limitations and resentments were apparent soon after Sara was born: she refused to nurse her infant daughter after feeling ineffective on her first attempt. "I even failed as a newborn to get her to love me," Sara lamented.

Sara's mother also resented her marriage into an uneducated family when she herself came from an educated family. The rivalry between the parents, centering on their competition to establish superiority, was expressed in violent altercations from as early as Sara could remember. Although she scorned her husband, Sara's mother feared his volatile temper. From the age of 6 Sara took on the role of peacemaker in order to protect her mother from injury. (I noted that Sara's oldest daughter was also now 6 years old and
wondered if that played a role in triggering her nightmares at this particular time in her life.)

Sara painted a picture of narcissistic parents whose only focus was their thwarted need for recognition from each other. They appeared disinterested in their children and had no involvement in their education.

Sara's parents were strict disciplinarians who used verbal and sometimes physical abuse and harsh punishments to exact obedience from their children. Both parents were very controlling. Sara became socially isolated as a result of her father's excessive screening of her friendships and his demeaning treatment of her in front of friends. She had no experience with relationships with the opposite sex as dating was not allowed. Her father permitted no moments of relaxation such as reading or daydreaming. The atmosphere in the home under his control was one of constant tension; Sara always felt anxious and on guard when her father was at home. Her mother, well aware of her husband's temper, exhorted Sara to be quiet and avoid upsetting him when he came home from work. Sara had no actual or perceived safety at home and, as might be expected, became a poor sleeper.

Sara's mother micromanaged all aspects of her daughters' lives to such an extent that their individuality was lost to her preferences in decorating their bedrooms and choosing their clothing until they went to college. Her refusal to allow them to wear the same clothing as their peers further deepened their social isolation. Not surprisingly, Sara's mother was unable to show genuine warmth and caring toward her children unless they were injured or ill, the only times when she would cuddle them and read to them.

The control that Sara's parents exerted over their children extended even to the children's emotional lives. The parents were unable to tolerate any expression of anger or other negative emotions other than their own, which dominated the family dynamic. Such an overwhelmingly negative family environment inevitably impacted the relationships among the siblings as well. They were unable to develop a supportive or protective bond among themselves, instead retreating into self-protective individual isolation and loneliness. Their lack of closeness continued in adulthood such that when Sara came to work with me she had no close relationship with any family member. The sense of lack of belonging, of being outsiders, that began in childhood as a result of both abuse within the family and intentional social isolation imposed by the parents continued in adulthood.

Sara's one haven away from home where she was able to receive some nurturing was school, where she excelled and was well liked by her teachers. In spite of her success in school, she had no internal sense of her worth and abilities and felt like a fraud. The encouragement she received from her teachers was not enough to compensate for the disinterest of her parents and their deliberate efforts to undermine her individuality, sense of self, and self-esteem.

As a child Sara was very anxious to grow up and move away from her controlling mother and her violent father. She found relief in the present in her fantasies about the future and in reading. Her opportunity to make good on her resolve to escape from her parents came when she was accepted at an Ivy League college. She graduated in the top 10% of her class and was accepted into medical school, where she also received high honors. In spite of this sure evidence of her abilities and worth, Sara was still troubled by her feeling of fraudulence, that she wasn't really good enough to be in medical school. To
compensate for her feelings of inadequacy she overapplied herself in college and medical school, avoiding social activities and dating as had been required in her adolescence.

It was not until she became a physician that Sara began to establish a secure identity for herself, and she reported that she loved her work. During her residency she met her husband, who was also a physician. This was her first extended relationship. Her husband came from a family background that was very different from Sara's and she described him as a warm and loving father. She herself however felt inadequate to the task of raising her three daughters because she feared being unnurturing and controlling like her own mother.

Session 2: Assessment and Introduction to EMDR and Ego States

At the second session I learned more about Sara's work with Laurel Roberts. After the birth of her third child Sara began to experience depression, worry, anxiety, dissociation, and loss of libido. She started treatment with Laurel almost immediately after the birth. She reported that she had an excellent relationship with Laurel and that they had been making good progress in their work together until she started to feel like a small child and to "trance out," as she expressed it, in session and sometimes in moments of relaxation. Along with these experiences, which she understood as dissociation, she found herself withdrawing emotionally in her marriage and in her work with Laurel.

The symptoms that Sara reported to me at the beginning of our work included depression, anxiety, hypervigilence, loss of concentration, a lack of spontaneity and enjoyment of life, inability to relax, and disturbed sleep. She expressed concern about her ability to parent her new daughter due to her emotional state and fear of what was happening to her. Sara had little insight into the cause of her dissociation and was confused by the turn of events.

I noted several strong personal qualities in Sara, including her sense of humor, intelligence, and motivation. She applied her intelligence to the task of learning about the sequelae of chronic stress and trauma and EMDR from books that I recommended to her. This helped her to realize that her symptoms were an expectable response to her early trauma and that we would be able to resolve them through our EMDR work.

In this session Sara was able to make a connection between her family of origin and her current family. Like her parents, she had three daughters. She recognized that it was when she was six years old, the current age of her own oldest daughter, that she began to intervene in her parents' arguments to protect her mother. She began to cry as she realized that her nightmares were flashbacks to early traumatic experiences triggered by this association between her former and current families. She stated her resolve that although her parents had ruined her childhood, she would not allow them to sabotage the rest of her life or her children's lives.

Sara was now able to identify more clearly her goals for herself: to be able to feel contentment again; to be rid of anxiety and be able to relax; to regain her libido; to be free of the nightmares; to have conscious control over dissociation; to end her parents' cruel reign over her self-esteem so she would no longer fear criticism and scrutiny of her actions; to end her own negative self-criticism; and to be able to enjoy her children and offer them the nurturing she had never received herself.
Some of Sara's core beliefs about herself, primarily negative, emerged in this session: "I'm not safe." "I'm worthless." "I'm not lovable." "I'm just a fraud." "I'm an appendage." "I'm useless in relationships." To help her understand the origin of these beliefs, I introduced her to the idea of ego states, describing them as parts of our emotional selves that we all possess, like an internal family. The concept made intuitive sense to her and helped her to understand that her recent feelings of smallness were an expression of a child ego state and that getting in touch with that state was a positive development. The idea of ego states helped Sara to understand the relationship between her early traumas and her dissociative experiences.

Despite her intellectual understanding of these concepts, Sara needed further preparation for our trauma-related work in order to attenuate the emotional flooding that overwhelmed her at times. I explained to her that we would be working with the parts of her ego state system and would teach them to deal with stress, learn to relax, and identify their own needs so that they could learn to understand and interact with one another.

Given that Sara was already experiencing flashbacks and nightmares, at this point in our work I did not want to subject her internal family system to any further stress and I also hoped to avoid having to have recourse to medication; my plan therefore was to begin with some relatively easy relaxation work to give Sara the time to get to know me in a nonthreatening setting.

Session 3: Stabilization Phase

A series of sequential readiness activities is used to help the client create stable internal structures, learn to manage stress and affect in therapy and in daily life, and become acquainted with the ego state system in a safe environment. The therapist begins by identifying the client's preferred learning style as visual, auditory, or tactile. Sara was a visual learner, which would prove very helpful in our work. She began this phase by visualizing safe and relaxing spaces to which she could retreat should she feel overwhelmed during the trauma work.

Once the client has established a safe place of retreat, DAS is explained and introduced in very short sets. This trial serves an important diagnostic function as an indicator of the client's tolerance for DAS, that is, whether DAS is likely to be a positive experience or whether it might cause the client to dissociate or become flooded. I asked Sara to visualize her safe place and I began short sets of DAS. She tolerated these initial sets very well and she noted that they increased the positive emotions and body sensations such as warmth and muscle relaxation associated with the scene of her safe place. I then asked her to practice going to her safe place without the aid of the DAS. She again experienced pleasant relaxation. I recommended that she take a few minutes each day to practice safe space work between the sessions.

When the client has the ability to return to the internal safe space in times of distress and has been successfully introduced to DAS, it is time to begin accessing the ego state system. Being a visual learner, Sara wanted to "see" her ego state system; she was in fact able to visualize a few shadowy figures. Despite their lack of clarity at this stage, Sara was comfortable with the idea of their existence and was willing to work with them. She referred to the states as "parts"; other clients are more comfortable with the
terms "states of mind" or "selves." Sara chose my office as a safe workplace for the system, holding the image of the office in her mind when she wanted to think about her ego states or speak to them in session. I used DAS to help her strengthen the image.

We then worked to create a metaphorical home base for Sara's ego state system. She visualized a cabin on the shores of a lake in the mountains, with a large front porch with gliders and rocking chairs, and she introduced her ego states to their new home. This image was also reinforced with DAS.

When Sara expressed interest in the trauma processing phases of EMDR I explained that we would not start that portion of our work until her ego state system felt safe enough. This was an appropriate time, however, to describe to her the standard EMDR protocol in preparation for the work to come. I told Sara that she would describe a problem or troubling event that she had already selected, visualize a target (a component such as an image, thought, feeling, or memory related to that traumatic event), and describe her initial beliefs and feelings about the target. She would also develop both a negative cognition that best described her belief about herself in regard to that trauma (for example, "I'm not good enough") and a positive cognition identifying what she would prefer to believe about herself ("I'm okay"), even though this traumatic event had occurred. She would use the Validity of Cognition Scale (VOC) to rate the positive cognition from 1 (not at all true) to 7 (completely true). Then, using the Subjective Units of Distress Scale (SUD), she would describe the emotions she felt while viewing the target scene and rate the distress associated with the scene from 0 (no distress at all) to 10 (maximum possible distress). Finally she would identify any body sensations she noticed as we went through the above steps. I explained to Sara that DAS would be used to help her process the target scene, negative cognitions, emotions, and body sensations associated with the trauma until the SUD reached 0, and then to enhance the positive cognition.

We discussed the concept of present orientation. I asked whether Sara's ego states knew what year it was, who Sara was, where she lived, and that she was a doctor, wife, and mother. It emerged that some of the states were indeed aware of all of these present phenomena, while others were unaware of them. Some of the states expressed anxiety when questioned in this way; they preferred not to know that anything had changed in Sara's life because they felt anxious about potential future changes. Sara, however, responded with her belief that life is all about change; she reassured her ego states that she would try to negotiate change at a pace that would be comfortable for everyone. I explained that present orientation and change were difficult concepts for the ego states and that they would need time to come to terms with them.

Finally, Sara agreed to use a hand signal and the word stop to indicate moments when the EMDR protocol felt too overwhelming.

Session 4: Beginning to Work with the Ego State System

By the fourth session, Sara was able to look inside herself and invite individual ego states to join her and get acquainted. She discovered a very rich internal world and was pleased with the complexity and variety of the states she found. While these ranged from infants to adults, she often referred to all of them as "kids." Different parts—some
that she could see and some that she could only sense—appeared at each session. They included a terrified child, a competent problem-solving adult, an efficient worker, a popular, attractive girl, a compassionate physician and healer, a stubborn and rigid perfectionist, an awkward girl, an excellent doctor, and a peacemaker. The emotions and personalities of these parts varied greatly; they were approval seeking, creative, very critical of themselves and others, thorough and detail oriented, emotionally distant, angry and defiant, self-hating, defensive, and unintelligent. Sara realized that some of her ego states resembled her parents and expressed discomfort with those parts.

Sara demonstrated increasing ability to work with her ego state system. In our work we employed the metaphorical language that is used in the treatment of Dissociative Identity Disorder. Using this metaphorical language Sara was able to admit her states into consciousness and give them a voice in communicating with both her and me. I explained to her that all of the states could be present and listening to our conversation even if they were not visible to her, reinforcing the concept of the individual states constituting a whole. To avoid overwhelming Sara I encouraged her to focus on only a few states at a time while reassuring her that the others continued to be present.

Before beginning any exploratory work, it is necessary to obtain the consent of the states (parts). The states should be reassured that they will retain control over their participation in the work. I always tell the ego state system that no state is obligated to participate in each session. They can stay at the home base, listen in, choose not to speak, and so forth. Most importantly, whether they participate or not, they need to agree not to sabotage the work. This may take many sessions in order to work out a consensus. In Sara's case her ego states were most anxious about making errors.

At this point Sara expressed some negative thoughts about Laurel. A part of her that idealized Laurel felt that Laurel should have been able to "make everything better by now"; her nightmares were seen as evidence that Laurel was not entirely competent and undermined Sara's trust in Laurel. Now, however, she was able to recognize that her idealization and expectations were not realistic.

It must be kept in mind that some ego states play an important role in keeping the client safe. While they may carry out this task in a manner that is maladaptive, their function must be honored by the therapist.

To further enhance her ability to manage stress and affect, Sara was participating in a breathwork class. She was including positive affirmations ("I have self-worth"); "I deserve self-care") in the breathing exercises practiced in the class. As she told me about this class, she reported soreness in her head and neck. To understand the cause of this discomfort, she "consulted" with her ego states and found that they were experiencing a mixture of fear and anger toward both her and me.

I was unable to foresee the response of the protective states—which in Sara's case were the child states that protected her from her parents—to our relaxation work. In their role as protectors it was necessary for them to be on guard at all times, although their primary belief was "I'm not safe even when I'm on guard." The goal of our relaxation work was to diminish this anxiety, which left the protectors feeling threatened—they believed that if they let their guard down they could be harmed.

In fact some of Sara's ego states perceived me to be dangerous and pressured Sara to end her work with me. They further expressed their loyalty to Sara's parents, their resistance to change and new ideas, and even their discomfort with Sara's positive
affirmations. All of these aspects of Sara's work with me were experienced as threatening to the status quo of the ego state system, which did not want to be deprived of its parts, functions, and manifestations, no matter how maladaptive. The system blamed not only me but also Sara for not being mindful of the existence and needs of the protectors.

I realized my error in not taking care to obtain the permission of these ego states before beginning our relaxation work. I apologized for not including the protectors in our visualization work that created safe places and a home base for the system and promised to include them in our future work and to make sure they understood the nature and purpose of the work.

With those reassurances we were able to continue developing specific relaxation strategies, including sensory awareness. Sara learned to locate and focus on the most relaxed part of her body. As she held onto her awareness of the physical sense of relaxation, the feeling would spread to the rest of her body, resulting in a relaxed state throughout the body. We then worked to teach this strategy of finding the positive, stress-free part of the body to the ego states. When some anxiety about returning to full alertness arose, I reminded Sara that as the mother of young children she always awoke from sleep if she heard the sound of a child and would go to locate the source of the sound. I asked her to reassure the anxious ego states that she would also be able to "awaken" from her relaxed state if they sensed that her full alertness was required. To demonstrate that relaxation does not diminish present orientation, we practiced the exercise again and Sara noted that the ego states were aware of a clock ticking and cars passing by my office.

Finally in this session I introduced the concept of containment to Sara so that she could manage her anxiety at home. I reassured her that I was not asking her or any ego state to repress important feelings, as had been necessary in childhood, but that sometimes, in order to remain calm and be able to work or be an effective parent, it was important to be able to put feelings or thoughts away until they could be examined safely. I proposed journaling and drawing as ways of externalizing feelings and using an imaginary object to contain negative affect. Sara chose to visualize a piggy bank into which she could deposit upsetting feelings; the feelings would be held safely in the bank until she could process them in our work and empty the bank.

Session 5: Reprocessing Parental Anger and Control

At the beginning of the fifth session Sara reported that she had been successful in practicing at home the relaxation strategies she had learned with me and that she had been able, through internal dialogue, to reassure her ego state system of the benefits and safety of relaxation. However, as she described her successful experiences with relaxation to me, she once again experienced soreness in her neck. Continuing to use our metaphorical language, Sara summoned her ego states to the meeting room to discuss what was distressing them. She discovered that her relaxation work was bringing back memories of her tense and chaotic childhood home, where relaxation was impossible, and of her father, who insisted that she be continually engaged in productive work. There was no quiet, relaxed refuge away from his control and his anger.
Continuing to explore this theme, Sara discovered that some of her ego states held her responsible for failing to protect them from her father. They believed that since Sara's mother was ineffectual in protecting them, Sara herself should have taken on the protective role, in effect becoming a parent to her own ego states. In her present adult state Sara was stunned by this illogic. I asked her to explain to her younger ego states why she could not have protected them from her father. She told them that she could not have been there for them because she (the adult) did not exist at that time. She explained that she was now their grown-up self. She said she wished she could have been there to protect them, adding, "But I'm your protector now." As she cried she was able to release some tension in her body. I noted during this conversation with her ego states Sara's shift from a negative cognition ("I'm a wimp for not protecting myself in the past") to a positive cognition ("I can protect myself now").

I felt that this was an opportune moment to focus on the disturbing memory of her father's anger and control that Sara was currently experiencing. This became our first target. Sara agreed to try to work with the target but cautioned me that her ego states did not want to get too close to her father. I offered Sara a visualization strategy that would allow her to control the image of her father shouting at her. I asked her to imagine herself sitting in a screening room similar to a theater with very comfortable seats. I directed her to project the image onto the screen at a comfortable distance. She practiced using an imaginary remote control to turn the image on and off, make it fade from dark to light, and change from color to black and white.

Before we could begin working with the target it was necessary to reassure a 6-year-old child ego state that what we were about to do would not be upsetting to Laurel and would not cause Laurel to reject Sara or terminate their work. This ambivalent child was simultaneously angry at Laurel for not having referred Sara for further treatment a long time ago, when she first started having nightmares. A 13-year-old ego state supported this child, and both expressed not feeling strong enough to participate in the EMDR. I invited them to join us as observers, telling them that the work we were about to do might make them stronger.

We continued by reviewing the target (Sara's father shouting at her) and the negative cognition, "I'm a wimp." Sara rated her belief in the positive cognition "I'm a protector" as a 4 out of 7 on the VOC Scale. She reported that a preschool-age part was very upset because they had to go through the horrible shouting sessions with Sara's father all alone, with no one to protect them. Sara felt upset, fearful, and angry. She rated her distress as a 6 out of 10 on the SUD Scale. I asked about her body sensations and she reported that her shoulder hurt and her chest was tight, but there was no discomfort in her neck. I asked her to focus on the image of her father shouting at her when she was alone with him, and to be aware of the negative beliefs, emotions, and body sensations she felt.

Sara wanted to reassure her ego states who felt unprotected. She told them, "It's okay with me if you're angry. I'm not angry with you and I'm right here if you need me." As we had practiced during our preparatory sessions, she was able to provide a safe container for her own strong affect and the shoulder pain receded. Her affect management was an indication that she was ready to provide the empathy and soothing needed by the ego states who had been subjected to her angry father. Though no one had protected and soothed her in childhood, she could provide this for herself now with therapeutic assistance.
In session 3 I had presented Sara with the modalities she could choose from for our EMDR work: a light bar or tracking my fingers for eye movements, music with alternating tones, or a tactile device to be held in each hand. She expressed a preference for bilateral music and in this session she chose a CD track that mixed music with ocean sounds and put on the headphones.

Very quickly Sara felt a fear of being angry that she recognized as stemming from her family dynamic, in which she was not allowed to express any discontent and there was room only for her parents' anger and control. She identified her fear as being expressed by the preschooler. She turned the music off and said, "One part says I want to be angry and tell. Another says if you're angry, someone big will be angry at you." I wondered to myself whether she was referring to her father or to me.

As Sara noticed her feeling of dread and verbalized it, it first grew stronger and then receded. She turned the music on again and found that her fear again intensified. Keeping the headphones on, she said that the preschooler, who earlier in the session had angrily rebuked Sara for not protecting her, wanted to know how I felt about her protestations. I replied that I understood how upset she was and that I was comfortable with strong feelings. I said I hoped the preschooler would allow Sara to help her work through her feelings of anger.

Although her feeling of dread continued to intensify, I encouraged Sara to stay focused and to continue the auditory stimulation as I felt it would help her move through her fears more quickly. As she had learned during the preparatory phase of our work, I asked her to go to the most relaxed part of her body. Initially she said she was too frightened to do this, indicating again her fear of letting go of her self-protective tension, of letting her guard down. But then she said that as a result of our relaxation work she had come to realize that her relaxed body could act as a cradle for the frightened young child. She imagined holding this child in her arms and soon felt calmer, reporting that the child now knew that Sara loved her and would protect her. Clearly Sara had gained significant skills in affect management and self-soothing since the beginning of our work and I felt she was progressing well.

Sara now reported a SUD of 0 for the previously angry preschool child and 6 for the cynical thirteen-year-old, who still didn't trust adults. We agreed that this teenager would be the focus of our next session. To end the session we reviewed the affect management strategies that Sara could use if troubling thoughts or feelings from this session should arise during the coming week, including containment images, journaling, and her safe space. Sara said that she felt remarkably relaxed and calm at the end of this session in spite of the upsetting images and feelings to which she had been exposed and attributed her calm to the musical stimulation that had continued through most of the session.

Session 6: Reprocessing Feelings of Defectiveness

Returning two weeks later for her sixth session, Sara appeared even more relaxed than previously. She described a successful session with Laurel during which she was able to express, through her child ego states, her anger that Laurel had not referred her
earlier for EMDR treatment to relieve the distress of her nightmares and traumatic memories. In childhood she would have been subjected to further abuse if she had voiced such feelings of discontent. With Laurel she was able to experience expressing anger and resentment and having those feelings accepted and validated by Laurel in a supportive and nondefensive manner. At the same time she learned that relationships endure through conflict; both she and the therapeutic relationship survived her expression of genuine feelings. She found the act of giving voice to her feelings empowering and attributed her success in this to our work, which validated the existence and needs of her ego states.

Reflecting further on the previous session, Sara said that both the 6-year-old who had been angry with Laurel and the 13-year-old now seemed less distressed since that session and the next session with Laurel. The 13-year-old now felt that at least three adults (Laurel, me, and Sara herself in her adult ego state) were trustworthy.

We returned to the target of our previous session, the image of Sara's father shouting at her angrily. Sara reported a shift in her feelings from feeling alone and unprotected to being able to provide self-protection. The 6-year-old and the 13-year-old reported an anxiety rating of 0 on the SUD Scale. In this session Sara chose visual rather than auditory stimulation and I reinforced her feelings of internal security with some short sets of eye movements (Ems).

Sara asked to change her positive cognition from "I'm a protector" to "I'm a strong protector." Holding those words in her mind, she gave them a VOC rating of 5 and the 6-year-old and 13-year-old ego states concurred. She said that the target image was beginning to fade. After more eye movements she gave the image a VOC rating of 7 and then reported that the image had disappeared entirely. We did several more sets of eye movements to enhance the positive cognition and Sara confirmed that the VOC remained at a firm 7.

I asked Sara to scan her body and focus on the positive cognition, "I'm a strong protector" while I did more Ems. She reported that to her surprise her body felt warm and relaxed. I reinforced those comfortable sensations with several short sets of Ems. Showing that she was truly internalizing the positive cognition, she said that she wanted us to work further on self-esteem and meeting her needs more effectively, including the needs of her internal family.

Sara was not yet finished working with the target image of her father. She expressed her resentment of her father's controlling and narcissistic personality: "He would never spend time with me just for fun or because I was worthy of his attention. He just wanted to impart his lofty, bullying rules." Referring to her school-age part she said, "No one ever met her needs. She would just have to shut up, stuff her feelings, and meet everyone else's needs."

With these memories Sara began to feel nauseous and couldn't breathe. She was able to relieve these feelings through deep breathing. She described an internal split between her younger and older parts. As she had grown older, Sara's father had intensified his verbal abuse. Her youngest ego states were unaware of the severe abuse reported by the older states. That caused the youngest states to doubt the older states' reports of her father's cruelty, setting up a conflict among them. This split was further intensified by Sara's lack of a sense of belonging in the family as a teenager. She felt awkward, an embarrassment to the family. She now felt sad and disgusted with herself. As she expressed those feelings, her stomach began to hurt and she said, "I'm garbage."
Sara now became entangled in the war among her ego states and became confused by the multiple conflicting messages she was receiving from them. One ego state said that her parents were going to abandon her because she was bad and an embarrassment. An older child pointed out that her parents needed to turn their anger and criticism on her and avoid addressing their own defects in order to preserve their dysfunctional union; therefore her imperfections served to maintain the cohesion of the family. While recognizing that these perceptions of her ego states lacked validity in the present, she still professed to believing them emotionally. They were quite distressing to her, making her feel inadequate and childish. She made a series of self-disparaging remarks, reflecting the internalization by her child ego states of her parents' perception of her as defective.

I asked Sara what she would like to believe about herself now, as an adult. She said she wanted to believe that she was not defective, that she was okay, and that she was not responsible for her parents' troubled marriage. She wanted to achieve internal calm in spite of the disparate sets of beliefs held by her ego states; that is, she wanted to validate those beliefs initially while working to resolve them. The first step was to be able to tolerate the anxiety that they caused.

We established a new target: Sara's father shaking his finger at her menacingly while berating her for her shortcomings. We identified her negative cognition, "I'm garbage." To the positive cognition "I'm okay" she gave a VOC rating of 4 out of 7. The feelings associated with the target image were anger, disgust, alienation, and sadness. Her SUD rating was 6 and she identified body sensations of tightness and soreness in her stomach.

Sara chose to return to using bilateral music at this point. As she projected the image of her father onto the imaginary movie screen she expressed discomfort with the closeness of the image, saying her child ego states felt anxious at that distance. I asked her what would help to see if she could take the initiative of making an adjustment to manage her anxiety. She decided to add more seats to the projection room so that the child ego states could sit farther from the screen.

Refocusing on the target image, Sara began to cry and said, "They were terrible parents. They thought life was hard and their job was to toughen us up at home so we could survive. They wanted to show us at home just how bad life can be. That's what they thought parenting was. That's ridiculous!" Sara stopped crying and her sadness changed to anger as she contemplated this bleak scenario. She continued, "They were so dysfunctional in their marriage. They had absolutely no parenting skills and they used me to make sure no one noticed how inept and crazy they were. They made it look like I was the defective one and the cause of that mess."

Sara now expressed a more realistic perception of herself as a child: "I wasn't bad. I was a good child, but I wasn't really allowed to be a child most of the time. I want to allow my parts to be children, the way we couldn't do with my parents." A playful image came into her mind of taking her ego states to the park, but then she began to cry again when that image made her realize how many important nurturing experiences she had missed out on. Her next thought, though, was that she could provide herself with that nurturing care now in adulthood while also providing it to her own children. "I wish I had had more caring parents," she said. "I'll take the child parts to the park when I go with my daughters and I'll include them in my relaxation every night."
Sara next contemplated telling her parents how angry she was about their abusive parenting style. She quickly rejected that idea as too frightening but realized she could achieve the same objective by confronting the target image of her father. After a long silence she said that she had told her father what a poor parent he had been and that she was a much better parent to her own children. When she next focused on the target image, it had changed. Instead of intimidating her verbally and physically, her father stood impotently in front of her looking very surprised and dazed, amazed that his daughter had the audacity to criticize him. He was no longer moving or speaking at all, but frozen in space. Sara seemed very satisfied with this image and began to laugh. She told me that "the spell was broken" because her father now looked so ridiculous and pathetic.

Sara now reported a SUD of 0 for the negative cognition "I'm garbage" and a VOC of 6 for the positive cognition "I'm okay"; in fact she upgraded that belief to "We're just fine!" which is a stronger positive cognition. I used a few sets of Ems to enhance the new belief and it rose to a rating of 7. To reinforce the positive cognition herself, Sara visualized writing a letter to her parents to tell them about her new beliefs about herself. She said she wouldn't mail the letter because "it would be a waste of time," indicating her understanding that the important transformation was taking place within herself and that validation from her parents was not necessary. Sara confirmed that her child ego states had participated in this transformation and were in agreement with her new positive cognitions. What was more, they all agreed that secrecy about her past abuse was no longer required and that she could share this experience with her husband and Laurel.

A body scan revealed Sara's feeling of physical well-being and we ended the session with a deep relaxation exercise.

Session 7: Closure

Sara's happy and relaxed demeanor when she arrived for her final session was remarkably altered from the initial anxiety, confusion, and depression she manifested at the beginning of our work. During my vacation she had had two very productive sessions with Laurel that reinforced the work she had done with me. She reported that she was no longer experiencing nightmares or flashbacks. She was no longer anxious about her parenting skills and was confident that she could raise her children in a nurturing manner that would be significantly different from how her abusive parents had raised her. Her libido had returned and overall she was feeling more at ease. Laurel had noted these positive changes and was pleased with the effectiveness of Sara's EMDR and ego state work. They had agreed that Sara could end her work with me when she felt ready. In our consultation Laurel informed me that she had been researching ego state work and believed she would be able to continue working with Sara and her internal family.

In our seventh session Sara and I consulted her ego states about their readiness to terminate our work. It seemed that the internal family members were reassured by Laurel's newfound understanding of their existence and needs and her willingness to work them and thus were in agreement to end their work with me. We agreed that Sara could return for further EMDR work if Laurel advised it.
We used this session for closure of our relationship. At Sara's request we both listened to the bilateral music that she had enjoyed in the sessions. She and her ego state system chose to say goodbye to me at their home base, the lakeside cabin in the mountains. There she communicated messages to me from her ego states. Several younger states wanted me to know that Sara was much more playful and fun to be with. The adolescent affirmed her acceptance and appreciation of me as a trustworthy adult but was glad I approved of her returning to work only with Laurel. Ego states that had formerly felt defective and inadequate were grateful to me for my acceptance of them and for restoring their self-acceptance. I told them how courageous they had been to make themselves known to me so that I could be of help to Sara.

At this point, Sara reported that all the child states had "gone back inside." She expressed that they were in her heart now, just like her own daughters.

In evaluating her experience with EMDR and ego state therapy, Sara said that her current emotional functioning was significantly better even than her status prior to the birth of her last child, that is, better than what she previously considered to be her normal, functional state. She said that our team approach to her treatment had provided her with a model that she and her husband could now apply to their teamwork as parents. Clearly her ego state system had been functioning as a conflicted and disunited group much like her family of origin. I pointed out to Sara that her internal family members were also now able to coexist peacefully as a team.

To end our final session we used eye movements to practice the sensory and visual relaxation strategies that Sara would continue to apply in her daily life to manage stress and affect.

Summary

Although it would have been impossible to deal with all of Sara's emotional difficulties in such a short course of integrated EMDR and ego state therapy, our seven sessions had a significant impact on Sara’s presenting symptoms such that she was able to return to work effectively with her primary therapist after only seven of the ten sessions in our contract. Several factors coalesced to ensure that our work would be successful. The primary therapist realized that conventional treatment was not working with her client and that the client was regressing. The therapist was able to recognize her limitations in working with a trauma survivor with chronic PTSD and, being invested in her client's welfare, referred the client for specialized integrated EMDR and ego state therapy that she could not provide herself. Despite the worsening symptoms, the therapist had established a strong working relationship with the client; this relationship provided a secure basis that allowed the client to transition to a triadic treatment relationship. My
assessment of the client's history and current symptoms revealed that she was an excellent candidate for EMDR and ego state work. Finally, the primary therapist and I were able to establish clear and effective parameters for our collaboration. The information provided by the primary therapist allowed me to formulate an effective short-term treatment plan.

The client herself brought several qualities and strengths to our work that resulted in positive resolution. She was highly motivated to work to be free of her symptoms. She was self-reflective and analytically minded and showed a great deal of curiosity about her psychological functioning. She was courageous in her willingness to try a new therapist and a new therapeutic approach.

Once our work began there were further signs in the client's response to the preparatory phase of our work that she could be assisted by EMDR. This phase consisted of training in stress and affect management and ego state work, during which the client learned to know, accept, and work with her internal family. The client showed increasing ability to master her anxiety and overwhelming feelings of instability. The EMDR work ahead aimed to effect major changes in the client's perceptions of past events, in her self-image as conveyed by her abusive parents, and in her present self-image. During the preparatory stage it was necessary to work directly with individual ego states to reassure them that the coming work did not pose a threat to their existence and well-being, that the client and I would support their right to existence and validate their needs. We worked to establish trust among the child ego states, the client in her adult ego state, and myself as the therapist who would be guiding the ego states through the work of revisiting their trauma. Additionally the internal system needed to learn that the dual treatment team would not become the negative parent figures that were so feared in the past. The concurrent therapy model provided ongoing reality testing by allowing the client to review her experiences with both of her therapists.

The client's increasing ability to tolerate strong affect and understanding of her internal ego state system signaled that she was ready to undertake the standard EMDR protocol. At this stage I was alert to negative sequelae but detected none; the client was subsequently able to proceed through the protocol to resolution of her symptoms. Our EMDR work allowed the client to reprocess powerful negative feelings and memories associated with childhood trauma and to transform negative cognitions about her lack of self-worth and safety into forceful new positive beliefs about her worth, skills, ability to function in her current adult roles as a mother, wife, and professional, and her ability to provide self-protection and self-soothing.

In effect the client was able to neutralize negative feelings associated with abusive parenting in childhood and learned to become a parent to her own internal family, resulting in greater confidence and skill in her adult relationships. The collaborative therapy model allowed the client to access specialized treatment that would not otherwise have been available to her and was freed from the limitations of childhood trauma.
References