Incorporating EMDR in ego-state therapy with health symptoms

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The purpose of this paper is to explore how EMDR (Eye Movement Desensitization and Reprocessing) can potentiate the use of ego-state therapy in the treatment of health symptoms. When such symptoms are the result of inner conflicts, an ego-state approach is often the treatment of choice to bring harmony to the personality states that are struggling over differing needs, and more integrative functioning to the individual as a whole. EMDR as a brief, rapid approach can be used to speed up ego-state therapy procedures. A clinical example of this approach to resolve complex migraine headaches is featured to support this position.

Ego-state therapy: An overview

The understanding that human personality is naturally divided or segmented has been commonly held since the 19th century (Phillips & Frederick, 1995). Janet (1907) pioneered the use of the word "subconscious" to describe aspects of personality that held patterns of feeling and cognition and could only be activated by hypnosis. Freud proposed a theory of tripartite personality development, consisting of the id, ego, and superego. This conceptualization was extended by several of his colleagues, including Carl Jung, who viewed personality as a multiplicity with different components that shifted between conscious and unconscious activity.

Paul Federn (1952) was the first of Freud's followers to suggest that the experience of self can vary depending upon which state a person is in at a given moment. His concept of ego state was adapted both by Eric Berne and John Watkins. Berne stayed close to Freud's model of personality to delineate three main ego states, parent, adult, and child, which formed the framework of his transactional analysis theory. Watkins, on the other hand, has viewed the personality as being comprised of innumerable ego states which do not fit neatly into Berne's three categories.

ciation. Because of this separation, they have not been able to participate with the rest of the ego states in experiences that would have likely contributed to their growth, maturation, and healing (Phillips & Frederick, 1995).

Goals of ego-state therapy

One of the main goals of ego-state therapy is to promote internal cooperation and harmony in the ego state system, which comprises the inner family of self. This process begins with forming a strong positive therapeutic alliance with the whole personality of the client. Once this is established, the next task is to form therapeutic alliances with each ego state related to the clinical issues under consideration as well as ego states activated for ego strengthening or self-nurturing purposes.

Once this step is achieved, the therapist may promote inner cooperation through a series of steps (Phillips & Frederick, 1995):

- Help ego states become aware of other ego states.
- Encourage or amplify communication among ego states.
- Help ego states develop empathy for one another.
- Suggest to ego states ways that they can learn from each other, work together, help and comfort each other.
- Acknowledge increased co-consciousness and co-presence as positive signs of increased personality integration.
- Present integration as a situation where ego states have the growth and maturity to direct their collective energies toward placing the needs of the whole personality before their own.

In order to achieve these goals, the successful mobilization of inner resources through a variety of approaches is essential. Since any approach which can be used with an individual client can be used with ego states, every effective therapy technique can be considered, depending on the goals of therapy and the client's readiness and preferences.

Although there are many hypnotic techniques which have demonstrated effectiveness in potentiating the goals of ego-state therapy (Phillips & Frederick, 1995; Phillips, in press), other therapeutic techniques also deserve contemplation. "Power therapies" such as EMDR and Thought Field Therapy (TFT) nead special consideration since they offer ways of speeding up certain learning processes and provide links to cognitive, emotional, and somatic experience that some clients may not achieve through hypnosis.

EMDR

Originally developed as a technique to resolve trauma and its related anxieties, recently EMDR has been applied successfully to a wide variety of clinical issues including phobias, grief, illness, somatic disorders, and dissociative disorders (Shapiro, 1995; Shapiro & Forrest, 1997).

As it has evolved over a number of years, EMDR methodology has added an emphasis on strengthening patients. However, clinicians continue to report incidences where some clients are overwhelmed by the rapidity and intensity with which traumatic material surfaces for reprocessing. In other situations, some clients are too fragmented or too dissociated from their inner experience to make good use of the EMDR approach.

More challenging clients who present with multiple complexities, such as personality disorders, major depression, or chronic health problems, in addition to post-traumatic difficulties, may need additional attention beyond the reprocessing model. It is the thesis of this paper that these types of patients might especially benefit from an incorporation of EMDR into ego-state work.

How EMDR works

In a typical EMDR session, following initial sessions that include appropriate history-taking and preparation, therapist and client work together to identify a target image and negative cognition related to the presenting symptom or difficulty. Clients are then asked to formulate a positive cognition, defined as what they would like to believe about the event or about themselves. Usually, movement toward this positive cognition is measured following the reprocessing of traumatic material. Frequently, clients report a shift that increases their belief in the validity of the positive cognition they have identified.

Sometimes, as a result of experiences during the desensitization phase of EMDR, clients will substitute, or can be encouraged to substitute, even more appropriate positive cognitions. For example, a client might progress from "I did the best I could" to "I am a strong and worthwhile person." In this event, the positive cognition is strengthened and integrated by having the client focus on the positive cognitive statement along with the target traumatic image during subsequent bilateral stimulation of eye movements (Shapiro, 1995), using sweeping movements of the therapist's fingers, tapping on the client's knees, or alternating auditory tones.

The general EMDR protocol calls for the targeting of early memories that underly current dysfunction, current stimuli that elicit the dysfunction, and a positive template, or "specific incorporation of an alternative behavioral response pattern" (Shapiro, 1995, p. 208), which is used to guide future action. Installation of the positive template is attempted only after the dysfunctional material of the past and the eliciting current triggers have been thoroughly reprocessed. To install and integrate the positive template, the client is asked to visualize specific, optimum future behaviors during successive eye movement sets.

Perhaps one of the most valuable tools of the EMDR method is the use of positive cognitions and other resources that can be interwoven throughout the processing phase. The interweave in EMDR is the use of questions, examples, or other positive statements that provide new information currently unavailable to traumatized clients, This lack of information is attributed to "freezing" of informational processing systems due to the psychological protection of dissociation as well as to neurobiological mechanisms (van der Kolk et al,1996).

Interweaves are recommended: 1) when clients "loop" with repetitive negative reactions, 2) when clients are not able to generalize EMDR results to situations related to specific targets, 3) when clients do not seem to possess adequate information to engage in productive reprocessing, or 4) when there is time pressure because clients are not approaching resolution near the end of a session (Shapiro, 1995).

In these cases, the therapist can offer a cognitive statement or image that serves to link memory networks and associations that which may be blocked or dissociated. Interweaves may be used to suggest new perspectives and introduce new information that would have emerged spontaneously in the person's growth process if they could access it freely (Shapiro, 1999). For example, if a sexually abused female client is stuck because she believes she is "bad" or worthless, and this cognition cannot be shifted, the therapist can ask whether she would feel this way if her own child or a child in her life were molested. From this new perspective, more functional cognitions can be constructed and installed.

Clinical case example

Jeannie (Phillips, 2000), age 49, presented a fairly complex health history. Migraine headaches had started about 6 years before, coinciding with the onset of menopause. MRI's and CAT scans were clear of organic damage. She rotated the use of several medications, including cafergot, fiorinol, and emetrex, on an almost daily basis. She had been diagnosed with Graves disease about ten years ago; when that problem went into remission, the headaches began. She had also been diagnosed with PTU, a condition involving a hyperenlarged thyroid gland, which had resolved with the help of medication, acupuncture, and herbs. Both of her parents had died within the last two years and her brother the year before that. Supportive therapy had helped her through those losses but the headaches lingered on. Although her doctors believed the migraines were linked to hormonal changes, everyone agreed Jeannie was not a good candidate for hormone replacement therapy because there was a strong history of breast cancer in the women on both sides of her family.

When she was seven, Jeannie sustained a severe head trauma when a truck suddenly backed out of a driveway and hit the bicycle she was riding. She was unconscious for more than 72 hours and convalesced at home for several months. She recalled being very worried during that time that her parents were going to be killed and fabricated illnesses so that her mother would come home from work. When she returned to school, Jeannie was far behind her classmates and struggled with learning new skills. Whereas prior to the accident, she had been a happy, self-assured student, her self-confidence after the injury seemed shattered, and was never fully restored throughout her school life.

Jeannie's goals were to manage her headaches without medication and to interrupt the negative internal dialogue related to writing deadlines so that she could enjoy her work and lower her stress. In discussing several options for treatment, Jeannie wanted

to try hypnosis first. She had read several articles on various uses of hypnosis in clinical settings, including a study where hypnosis was applied successfully to different kinds of headaches. Her reading gave us a chance to discuss different types of hypnotic approaches, including direct and Ericksonian hypnosis as well as ego-state therapy techniques.

Because her procrastination and writing stresses seemed clearly related to some type of ongoing inner conflict, I theorized that the headaches could be connected to that conflict, depending on what we learned about its nature. I believed that ego-state therapy might be useful, and perhaps necessary, to identify and resolve the inner battle that seemed to underlie her symptoms.

It also seemed likely that her current difficulties were fueled by self-doubts stemming from the aftermath of her head injury. If that were true, ego-state therapy could also help us explore and repair some of the psychological damage from that past traumatic event, with our ultimate objective to reintegrate parts of her personality and their diverse reactions to that challenging time in her life. As with the use of any hypnotic technique, however, we would begin with an introduction to hypnosis that would help Jeannie experience a sense of relaxation and safety, both in the therapy setting as well as internally.

Using hypnosis to promote safety and stabilization

Jeannie responded well to general hypnotic suggestions for mental and physical relaxation. She was able to surmount her acute sensitivity to traffic noises outside my office and learned quickly to clear headaches that she brought into the session. This was accomplished using ideomotor signals to bring in inner resources that allowed her to release tension and reduce discomfort following a brief hypnotic induction.

Hypnosis for gradual pain reduction

MP: "Since you've signaled that you are relatively comfortable, Jeannie, I'd like you to focus on your headache and let a number come to mind on a scale of 1-10, with 10 representing excruciating pain and 1 representing a very small amount."

J: "It's about an 8 right now."

MP: "OK. Let's ask your unconscious mind through your finger signals if it is permissible to lower your discomfort to a 7 on your scale."

J: [Yes finger moves]

MP: "Good. Now let's ask your unconscious whether there is an internal resource that might help with this change."

J: [Yes finger moves slightly]

MP: "Just take a few moments and let that resource come into the front of your mind, Jeannie. It might be an image, a thought, a body sensation, a memory, a symbol, an inner voice, or some combination of these...When you have something in mind, let me knowwhat it is."

J: [Long pause] On the right side of my head it feels like there's a knife across my right

eye and across the top of my forehead...I'm finding that when I imagine pulling out the knife, the pain goes down."

MP: "Fine. Just let your yes finger move when you're at a 7 on the scale."

J: [Yes finger moves]

MP: "Let's ask your unconscious if it's permissible now to go down to a 6 on the scale."

J: [Yes finger moves again]

MP: "OK, Jeannie, continue to let that inner resource help you by imagining that you can pull out a little more of the knife. And when you're down to a 6, your yes finger will move again to let me know."

J: [Yes finger moves again]

MP: "Good. Can we go down to a 5?"

J: [Yes finger moves]

Through this process, called *calibration*, she was able to move all the way down a SUD scale to a zero where Jeannie was completely free of headache pain.

Although pleased by her progress during our meetings, Jeannie was concerned that she could not reproduce this effect on her own. She had listened to audio tapes of our sessions and had tried to use finger signals to no avail. "After all," she said, "I don't want to come here forever. I need to learn how to do this on my own. But each time I try, it's like some voice pops up inside and shuts everything down."

Hypnotic ego-state therapy

Jeannie was letting me know that we now needed to deal with the problem of conflicting parts within her personality because the conflicts were interfering with the necessary task of generalizing headache management beyond our sessions and into her everyday life. We then discussed the ego-state therapy model and made our plans for proceeding.

Once Jeannie understood the basic process of ego-state therapy, she was ready to begin identifying and working with her ego states. To continue with ego strengthening and further stabilization, we began by activating helper ego states. Jeannie told me she felt she needed to connect with a part of herself who knew how to feel more confident. With this mission clearly in mind, our next step was to find and activate an ego state related to confidence.

Although any number of direct and indirect hypnotic and nonhypnotic techniques can be used to find ego states, because Jeannie was already comfortable with ideomotor signals, we decided to stay with that approach. The steps we took were:

1) Using a basic hypnotic induction to achieve relaxation.
2) Setting up the ideomotor signals.
3) Asking the unconscious if there were a part of Jeannie that knew how to feel very confident.
4) When her "yes" finger moved, asking that part of her to come forward inside in a way that she could recognize. Jeannie immediately felt a rush of energy and excitement in her chest.
5) Asking whether that part would communicate with us through the finger signals.
6) When there was a "yes" response, asking several general questions about the ego state's age and willingness to cooperate.
7) With this positive "yes set"foundation, asking whether the ego state would tell us in words what she knew about confidence. We found out that this part of Jeannie enjoyed playing touch football with her brother and other neighborhood friends. She felt carefree, strong, and completely confident.
8) We asked for and received agreement for full cooperation with our future work. Specifically, this part agreed to be present when Jeannie was writing and to lend her confidence as deadlines approached.

Activating ego states related to inner conflict

Jeannie found that the ego state connected to confidence, a 12 year old tomboy part, did not solve her headache problem. However, "it was like her voice was overwhelmed. I could sense that a more positive attitude was trying to take root, but it just got blown away by the negativity that I'm always aware of when I sit down to write."

For further strengthening, we explored Jeannie's safe place image of a gently curved river which she floated down into a deep state of relaxation. We also invoked "Inner Strength" (Frederick & McNeal, 1999). These efforts seemed to shore up Jeannie's resolve and she was able to replicate the state of relaxation and strength by listening to audiotapes before each writing session. Her headaches seemed to improve slightly but returned in full force just prior to biweekly deadlines.

Beginning to resolve ego-state conflicts

During the meetings that followed, we worked diligently to find the ego states that were entangled in the inner war that impacted the headaches. One set of ego states seemed to be associated with the time of Jeannie's head trauma. In a poignant exchange that took place after a brief hypnotic induction, a 7 year old ego state shared the dark fears that surfaced during her early recovery:

MP: "You must have been very scared after the accident."

7 yr. old state: "Yes. I'm scared that my parents are going to die in a car accident, that they won't come back when they leave me. So I make up things to get them to stay with me. I know I'm bad but I can't help it."

MP: "Are you able to move around much on your own? In addition to being scared, it must be very hard to stay at home for so long."

7 yr. old: "The doctor told me I have to stay still. I lie on the couch all day and Daddy takes me upstairs at night to bed. I can't go outside so I just lie here."

MP: "And then the scary thoughts come?"

7 yr old: "Yes, and they won't go away."

MP: "Did anyone tell you that you are much better now? That you can go outside and play?"

7 yr. old: "Oh, no. I'd better not. I don't want to get in any more trouble."
MP: "Jeannie, I'm a different kind of doctor. And you're here to find out that many things have changed since you've been injured. You need to be brought up to date. You're well enough to go outside now. If you want to test it out while I'm right here, go ahead. Take it slowly at first until you get used to the idea, but I think you're going to find out that you're fine. Do you want to try?"
7 yr. old: "OK.... (Long Pause) I'm back now."
MP: "How was it to be outside?"
7 yr. old: "It was great. You're right. I must be better!"

This is a good example of how traumatized ego states can be frozen in time, blocked from new information by inner walls of dissociation that separate them from the mainstream of conscious experience. Reconnecting these split off personality parts and providing them with corrective learning is an important part of ego-state work.

Repairing developmental vulnerability in ego states

Over time, we found that the unresolved issues of other child ego states were linked to stresses in Jeannie's adult writer life. As deadlines approached, these self-parts would feel as if they were being "hit out of the blue" by an overwhelming force. As they reenacted the collision with the truck, they described falling into a dark abyss where they believed they were going to die.

We probed the possible comparisons between the coma state Jeannie was in for several days and the state of death. We provided information about how the medical treatment of head trauma in children is different today, especially in terms of convalescence. We asked the ego states to reenvision what it would be like to go through recovery at the present time. And we engineered several escape routes out of the abyss image that menaced as deadlines loomed. These included a human chain that connected the frightened personality parts to older, physically stronger ego states who could pull them to safety.

These interventions resulted in a more mature attitude toward deadlines. Jeannie also initiated a writing schedule of two uninterrupted hours every morning, as well as other intervals during the day, which provided a more secure structure for the inner parts who were vulnerable to unpredictability. Her anxiety decreased and headaches improved further. We worked out a plan where she would calibrate beginning headache sensations on a 10 point scale. If scores were four or less, she would take an aspirin and 1/2 excedrin and use some of the imagery she had developed, including "Inner Strength" and the flowing river. Jeannie reported that about 70% of the time, this was sufficient to clear her symptoms.

Using more mature ego states to aid younger ones

As Jeannie became stronger, she decided to leave the magazine and actualize a long-standing dream of establishing her own business. Predictably, during this stressful transition, her headaches escalated again. We framed this as an opportunity to learn about

any unfinished inner business that might still be triggering these symptoms so that we could achieve full resolution.

We worked with another seven year old ego state who had struggled to learn cursive writing when she returned to school following her head injury. We learned that her classmates were three months ahead of her, her teacher provided no extra support, and she was plagued with post-concussive symptoms that made it difficult for her to concentrate. Jeannie's recollection of this time was that the devastation and loss of confidence she suffered were so great that she had never fully recovered her self-esteem.

To design a corrective strategy, we speculated that many resources would be available today to school children in this situation. We found a mature ego state who could serve as a special tutor, sitting beside Jeannie in the classroom during writing lessons to help her make progress. With the help of the inner tutor, we were able to confront and calm "little Jeannie's" fears, build on small successes, and reach writing goals that soon helped her reconnect with her classmates and with more self-confidence about writing.

Using EMDR with ego states

To facilitate Jeannie's integration of these experiences, I introduced her to EMDR, explaining that I thought this approach might help us complete our work more rapidly, as finances were now becoming an issue in her therapy. Jeannie was agreeable to this change, and I explained that we could use the technique with individual ego states, if needed, as well as with the whole personality.

Issues in adding EMDR

I had actually considered introducing EMDR much earlier in my work with Jeannie. When we began the ego-state work, which proved to be enormously helpful in determining the extent of post-traumatic fragmentation and helping her to begin to unify her personality functioning, the need for constancy for the younger self parts became obvious. Jeannie was hypersensitive to my absences and to any changes in our therapy routines. We addressed this need by keeping our hypnotic induction the same each session, by reinforcing positive imagery repeatedly, and by beginning and ending our meetings in the same way each time. When we first discussed using EMDR, we both agreed that this might upset the balance created by hard-won inner trust and decided to stay with ego-state therapy.

At this later juncture, however, we had explored the head trauma and related childhood experiences that appeared to underlie the headache symptoms. Developmental interventions had helped to establish a much greater level of inner constancy and trust with a significantly lower level of fragmentation. Both Jeannie and I felt she was ready for a change and were hopeful that EMDR would help us move from the stage of actively exploring the past into stages of fuller resolution and integration.

Our first step with EMDR was to install a conflict-free image of the river which we had found during hypnotic work, along with "Inner Strength." This provided a sense of

continuity for the younger ego states and provided an easy transition for the introduction of a new tool.

During the second session, we began with a target image of the onset of a headache as she was pushing her writing toward a deadline. Jeannie found herself feeling very small, grieving the loss of her brother who had been her childhood protector, and recalling some scenes related to her father's harsh discipline and criticism at the dinner table. Spontaneously, she brought in "True Self" and "Spirit," as well as other ego states we had worked with previously:

J: "I saw an image of True Self. She is such a grounding presence inside. And then I saw Inner Strength, another source of safety for me...connected to the life force and afraid of nothing. They are never going to leave me. I've learned that here."

J: "I was suddenly at the dinner table in the apartment where I grew up. That was my last glimpse of True Self until we found her again here. Dad's presence is so stern, disciplining me in such a harsh way. It's all mixed up with the accident. Mother was trying to comfort me. I feel sad because she got pushed away for so long, encouraged by him to leave me alone for so many years. And after awhile, I probably pushed her away too."

M: "Will this inner comforting mother leave you?"

J: "No (sobbing). She's like Spirit (another ego state)... I went to my inner room where all the parts meet. They're all there loving me without any judgement. I feel joyous and terribly sad. I welcome them all yet realize how hard it's been that they had to be apart until we found them and gave them a place to come together inside."

Jeannie felt moved by the flow of feelings and awarenesses that occurred during EMDR. Her writing seemed to move more easily but she still complained of many "false starts," times when she would sit to write and felt paralyzed inside. We continued on during a third session, encountering scenes of physical abuse by Dad and various struggles in recovering from the head injury. Jeannie spontaneously added many of the resource images and suggestions we had used in our ego-state work and felt good after each session. She continued to struggle, however, with her writing and headaches.

Alternating EMDR and ego-state therapy

Because we were not obtaining a clear resolution of the headache symptoms, using standard EMDR protocols and adding resource interweaves, I decided to check with her about her current use of medications. I was surprised to learn that even though the headaches had not worsened, she had intensified the frequency of pain medications . When we discussed this development, Jeannie was unsure how this had happened. "I think I was hoping that the EMDR would bring faster results. When it didn't, I guess I went back to my old reliance on my medicines."

Ideomotor signals in hypnosis indicated that Jeannie's recent return to drug dependency was related to two trauma-related ego states who called themselves "Fear" and "Panic". Although "Fear" had begun to feel more positive about writing and managing

the headaches, her remaining difficulty was to stand up to old critical messages of doubt and blame that originated from Jeannie's father. "It helps to hear True Self's voice inside now," she said, "but something more is needed and I don't know what." "Panic" added, "The headaches are so scary when they come out of the blue. The medication always works so I went back to that."

I explained to Jeannie, and to these individual ego states, that in order for us to obtain a true test of her own inner resources, she would need to taper off her medications, resuming our past plan of using non prescribed medications for primary management. Because this change was so threatening, we agreed in consultation with her prescribing doctor to have two transition weeks where Jeannie was allowed two doses of Fiorinol during a seven day period. She could decide at what point to use them when her pain rose above 4 on her subjective discomfort (SUD) scale.

When we next used hypnosis, various ego states reported that the first week of the medication plan had been challenging but that they felt good about being able to stay within the medication limits. I suggested that we use EMDR to detect and resolve any remaining anxieties for Jeannie or any of her ego states about continuing to rely on inner resources for pain management.

During the first few sets of eye movements, "Panic" appeared and admitted that it was hard to trust the other parts inside as firmly as she could trust the effects of the fiorinol. We then did some individual EMDR work directly with "Panic" while Jeannie was in a hypnotic state.

"P": "I'm feeling that it's just too hard without the medication. I can't find anything else that helps... I want to trust you that we can figure things out but I'm really scared."

"P": "That time I felt really bad. Everything looked really black. It reminded me of the abyss...I can't stand to go there and that's how it feels every time there's a headache coming on."

"P": (Shaking and sobbing) Why do I have to go through this? You're supposed to help me!"

MP: "I guess this is how you feel a lot of the time, that there's nobody to help you. Let's see if we can find another part inside who understands what you need and is willing to help right now. OK? [nod yes] During the next set of eye movements, let's see who comes to help you." Who came, Panic?"

"P": "It's 'Anger'. I think she is angry with me."

MP: "Let's ask her what she's angry about during this next set."

"P": "Anger's mad that I'm having such a hard time. She thinks maybe we ought to try a yoga class to help me relax. Jeannie's friend is going to one every day and it's helping her. I guess I could try it. Anger says it isn't easy for her either but we all have to be willing to try new things."

"P": "I was in the yoga class. I felt a little weird twisting into different shapes but I'm calmer inside."

Jeannie and I discussed the idea of a daily yoga class. She decided to try going with her friend while lowering her medication limits. When I saw her the following week, she sounded excited. "I think we're on the right track. The yoga is great for me. I'm sore but it's a good activity to build into my day and I had no headaches, just the beginning of one which stopped with the aspirin. I'm finding a daily structure that really works. I start with my two hours of writing, then I answer phone calls and emails. I write for a few more hours and I finish the day with yoga. I hope I can stick with this plan."

As Jeannie moved toward termination, our final two meetings, after about 60 hours of therapy, were spent clearing remaining concerns about letting go of the security of medication and installing positive future images. Jeannie decided she was ready to stop therapy with me and test out all the tools we had developed. As we parted, it was clear that she felt best about relying on the strengths she continued to find inside her family of self.

At six months follow-up, Jeannie was continuing to feel good about the work we had done. Her writing was going well. She used the audiotapes we had made to start and end most days and reported that her headaches were infrequent. She was continuing to enjoy the benefits of yoga and grateful that she had ended her dependency on the medications.

Conclusions

There are numerous ways of incorporating EMDR into hypnotic Ego-State Therapy. In some cases, ego state work may be indicated from the beginning of therapy in the way clinical issues are presented. As with Jeannie, clients may use the language of parts or indicate their symptoms are related to inner struggles or conflicts. EMDR can be introduced at any point in this process to potentiate ego strengthening for an individual part or the whole personality, to facilitate reprocessing of past traumatic events, or to help move the client toward integration of therapeutic change and personality functioning.

In other cases, EMDR may be the first intervention used in therapy, either at the request of the client or because this method is better suited to clinical or practical needs. Ego states often appear spontaneously during eye movement sets (eg. "I hear an inner voice telling me..." or "I see this image of a little girl self..."). Indications of ego state issues may emerge in many other ways as the therapy unfolds.

A third way of combining these approaches can occur when there is a more intensive focus on the body. For example, in my collaboration with a bodyworker, we work with somatic ego states linked to body issues using healing touch. Therapy progress can be intensified using RAS (rhythmic alternating stimulation) with eyes closed or by incorporating standard eye movement sets (Phillips, 2000).

In short, there are many possibilities for synthesis which may expand therapeutic possibilities for many clients who cannot make significant progress using either approach alone. Hopefully, further clinical research will establish the validity of specific models for combining these two powerful methods. Practitioners need be limited

only by client needs and readiness, by their own skills and experience, and by the co-creative processes that emerge in the therapy relationship. Appropriate training and consultation is recommended to build the confidence for therapist experimentation.

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