Treatment of Dissociation With EMDR When War Interrupts the Process

The Integration of EMDR With E-Mail Therapy

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This article describes the integration of e-mail correspondence with EMDR treatment for a woman with a fear of driving and a diagnosis of dissociative disorder, not otherwise specified (DDNOS). When the client first presented for treatment, her diagnosis was unrecognized, and treatment showed limited success. With recognition of the DDNOS diagnosis, the treatment contract was renegotiated, with the focus of therapy shifting to addressing her dissociative experiences. Therapeutic progress was being made when the course of the treatment was interrupted by war in the north of Israel, and regular meetings became impossible. Communication was maintained by e-mail correspondence. When face-to-face sessions recommenced, the e-mail therapy continued because writing had become a powerful therapeutic tool. Therapy concluded with the successful treatment of both the dissociative disorder and the fear of driving. Cautions regarding the use of e-mail therapy are provided.

Keywords: dissociation; war; e-mail; writing; EMDR; dissociative disorder, not otherwise specified

Dissociation is a state in which certain thoughts, emotions, sensations, and/or memories are compartmentalized, "resulting in discontinuities in conscious awareness" (International Society for the Study of Trauma and Dissociation, 2008). Symptoms of dissociation are common in many disorders, such as posttraumatic stress disorder and acute stress disorder. In severe forms of dissociation, disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; American Psychiatric Association, 2000) specifies the following diagnostic criteria for dissociative identity disorder (DID): the presence of two or more distinct identities or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self with at least two of these identities or personality states recurrently taking control of the person's behavior. When there is no loss of memory between the different states, the diagnosis of dissociative disorder, not otherwise specified (DDNOS), can be made.

DID Treatment

The International Society for the Study of Trauma and Dissociation (2008) reported that the following components are usually included in DID treatment: "a strong therapeutic relationship, a safe therapeutic environment, appropriate boundaries, development of no self- or other-harm contracts, an understanding of the personality structures, working through traumatic and dissociated material, the development of more mature psychological defenses, and the integration of states of self." Peterson (1997) stated that wherever possible, treatment of DID clients should move the patient toward a sense of integrated functioning. Although the therapist often addresses the parts of the mind as if they were separate, the therapeutic work needs to bring about an increased sense of connectedness or relatedness among the different alternate personalities. Treatment of dissociative disorders may attempt to "reconnect" the identities of the disparate parts into a single functioning identity and/or may be symptomatic to relieve the distressing aspects of the

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condition and ensure the safety of the individual. Traditional treatment methods may include psychotherapy and medications for comorbid disorders. Some behavior therapists initially use behavioral treatments, such as responding only to a single identity and using more traditional therapy once a consistent response is established. In recent years, anecdotal reports suggest that eye movement desensitization and reprocessing (EMDR) may prove to be an effective approach to the treatment of dissociative disorders.

EMDR Treatment of Dissociation

Reports of EMDR's successful application in the treatment of DID have been provided by Twombly (2000, 2005), Fine and Berkowitz (2001), and Chefetz (2006). Fisher (2000) notes that some DID or DDNOS patients are unable to tolerate affect or associations to traumatic memories and that they cannot control switching, get grounded, or resolve internal struggles over power and control. EMDR can be very effective in increasing affect tolerance when it is used to enhance mindfulness, or the ability to notice a feeling or bodily sensation and "let it go by." For example, a 2-minute EMDR session within a session can be initiated each time a strong feeling comes up: the patient can be asked to stop for a moment, notice the feeling and where she feels it in the body, and then "let it go by" as the therapist provides two to six short sets of between 6 and 10 eye movements of bilateral stimulation. With dysregulated, destabilized dissociative disorder, patients some of the following modifications can be used. These strategies have been reported as helpful by Fisher (2000) but have yet to be empirically assessed.

- Ultrashort (5–15-minute) EMDR "sessions within a session"
- Use of tactile, auditory, and "standing" bilateral modalities, individually and in combination with each other or with eye movements
- Use of continuous bilateral stimulation throughout the whole session
- Installation of imagined internal resources rather than actual experiences of mastery or symbolic images
- Installation of actual experiences of safety rather than imagined safe places

Case Study

This is the case of a woman with a complex trauma history and a diagnosis of DDNOS. The presenting complaint had to do with anxiety around driving and initial EMDR focused on this. Limited progress was made until the author took a training course in dissociative disorders, realized that the client had many dissociative symptoms, and diagnosed her with DDNOS. The treatment was disrupted by war, but this had the serendipitous effect of making the client utilize her writing abilities to develop a dialogue among her ego states and formulate problems that helped prepare the ground for EMDR. The age of instantaneous communications has made it possible to add e-mail to the battery of therapeutic tools. In this case, e-mail assisted in the treatment of her dissociative disorder by providing a bridge to the therapist when war necessitated a break in treatment and in helping the client prepare for EMDR.

Presenting Problems

Sara (not her real name), a woman in her 50s, had recently passed her driving test but had found herself incapable of driving alone. Even when driving with her husband accompanying her as a passenger, she described herself as panic stricken and as having poor concentration. Sara explained that as she was totally lacking in orientation skills and was scared she would get lost. The panic would reach its peak on entering the car, and after a journey her legs would "turn to jelly" and stay that way for about 20 minutes. Sara also described herself as "living inside a bubble" and believed that if she came out of it, she would cause someone terrible damage, although she was unable to specify what kind of damage and to whom. Sara recalled that she first experienced this image of a bubble around the age of 4 and since that time also experienced fear of her father's (unexpressed) anger. Sara hypothesized that as a driver, she was liable to kill someone, which seemed to her to be connected to the guilt her father felt as a teenager for leaving his parents in Europe just before the Holocaust and thus being "responsible" for their deaths.

Client History

Sara is the older of two children born to parents who immigrated to Israel from central Europe in the late 1930s. While Sara's maternal grandmother had accompanied her mother to Israel, her father left his parents behind in Europe to their subsequent deaths, and her father felt great guilt about this. Sara's mother became a successful and award-winning academic, while her father, who was also gifted and intelligent, went into a more mundane career.

Sara learned to read at an early age and started school very successfully both academically and socially. However, at age 6, after the birth of her brother,

she experienced a severe decline in both areas. She gained excessive weight and had few close friends. Sara recalled obsessive-compulsive behavior throughout her adolescent years and being taken by her parents to a psychologist without any prior warning or explanation. She described treatment, the use of projective picture testing, as highly intrusive and totally unhelpful.

Like most 18-year-old Israelis, Sara enlisted in the army. However, after a year or so of regular service, she had a mental breakdown and was transferred to a different unit. She completed her service and reluctantly entered the university. She dropped out after 2 months, transferred to a different university, and dropped out of that one too.

Sara returned home, married, and worked in education. This union ended in a conflictual divorce 7 years later. Sara experienced another mental breakdown and returned to live with her parents. After 3 years, Sara remarried and completed a degree in literature. This marriage, although problematic, was successful and remains so to this day. Sara was unable to become pregnant, and after many grueling and frustrating attempts, the couple decided to adopt children. Much to her surprise, she found motherhood natural and rewarding. The family moved to the northern part of the country, and Sara became an expert in teaching college students with learning problems. At this stage, Sara returned to therapy and, with the help of a psychotherapist and a very patient driving instructor, overcame her anxiety about learning to drive and passed her test. Having achieved this, she finished therapy and expected to drive freely, at least over short distances. After a few unsuccessful months of trying to drive alone, she decided to seek help through EMDR.

Assessment

Sara presented as a competent, intelligent woman who had considerable awareness of her abilities and limitations. Her husband was fairly supportive and encouraged her to drive. Being able to drive freely would be a great advantage to her professional career. After years of therapy, both successful and unsuccessful, Sara possessed a great deal of self-awareness and knowledge of factors that helped and hindered her. She arrived for therapy with a clear goal and positive expectations about EMDR based on successful treatment of close family members.

Initial Case Conceptualization

Following usual procedures for driving phobias, the therapist began EMDR by identifying negative cognitions and keystone events in the past that may have contributed to the current situation. Finding negative cognitions appeared easy because Sara understood the concept well and had a good idea of what might be causing her anxiety about driving. There were events in the past where she had felt a lack of control, and it was surmised that these events may be contributing to her feeling a lack of control while driving. There were also instances of feeling incompetent in the past that could provide material for processing. Another possible direction of work was to focus on her "need to fulfill others' requirements" and the resultant anxiety if she failed to live up to these expectations. Although Sara could have decided that driving was "an impossible mission," she rejected this possibility, even though this would have relieved her of considerable anxiety and the consequences of another "failure."

Initial Course of Treatment, Including Assessment of Progress and Outcome

The total treatment took place over 3 years, with a break after the first year. During the first year of treatment, although Sara processed traumatic events from her past successfully, her anxiety around driving seemed resistant to change. She made progress in many other parts of her life. She applied and was accepted to a master's degree course, and the feeling of "living in a bubble" that she had experienced since age 4 disappeared. Sara became aware of the role that she had unconsciously adopted, as a receptacle for her father's unspoken, unspeakable suffering and guilt at having left his parents to die in Europe. At the end of the first year of treatment, Sara felt that she had progressed sufficiently enough to stop. Although she was driving only infrequently and only when accompanied by her husband, she reported that her emotional strain had decreased significantly. Her creative talents were coming out in her studies both in writing and in art, and she felt empowered.

Second Course of Treatment. Three months later, Sara returned to treatment reporting a familiar and uncomfortable sensation of not being present during lectures. She also became aware of becoming increasingly socially isolated to the point where she lost all but two of her friends on the course. She felt as if she were the only one unable to make friends within her group of close colleagues. All this reminded her once more of being a little girl.

This second stage of treatment began 1 year and 3 months after the original assessment. Since that time, the therapist had taken a course on diagnosis and treatment of dissociative disorders and now

realized that Sara had been exhibiting dissociative symptoms. In addition to her description of "not being present during lectures," some of her behavior during the first stage of treatment also indicated the possibility of dissociation. For example, in contrast to her usual open and engaged presentation in treatment sessions, she would occasionally sit curled up in her chair, with her arms tightly folded, avoiding eye contact, and sometimes would leave the room abruptly, citing sudden bladder pressure.

At the beginning of the second stage of treatment, the therapist proffered the explanation that Sara might have different "ego states" functioning within her at different times. Sara agreed that these states were very individual and that she appeared to be suffering from a dissociative disorder. With no gaps in her awareness or loss of time, Sara met the diagnostic criteria for DDNOS rather than DID. With the diagnosis and recognition of the necessity of working with Sara's ego states, treatment took a completely different turn, and progress commenced.

Therapy began by identifying and mapping the different ego states. Attempts were made to engage each state in dialogue both separately and as a group, and later EMDR was used to work on issues that troubled each part of the personality. Various strategies were applied to build a therapeutic alliance with each ego state (Forgash & Copeley, 2008). The dissociative table (Fraser, 2003) was used to identify individual ego states that were then named according to their dominant properties. These included "the functioning (host); the one who cuts off; the angry; the creative; the enjoyer." Each of these ego states had their own distinct age and traits and were evidently aware of each others' presence, although often one would dominate over the others in a particular activity.

Treatment focused on increasing dialogue among ego states in order to facilitate eventual integration. Putnam (1989) has recommended the use of journals and diaries for this purpose. "The one who cuts off" was identified as the ego state most akin to being "the host" and who was effectively responsible for Sara's anxiety in many circumstances, including driving. Progress was made initially through work with this ego state.

E-Mail Correspondence. However, it was at this stage that war broke out in the north of Israel, and thus office sessions were not possible. It was agreed that e-mail correspondence, which prior to this had been used mainly for scheduling, should be augmented. Sara started to correspond with the therapist by e-mail in detail, giving voice to each of the parts. The e-mails were dialogues, with each of the parts expressing their own opinions. This process served to clarify things for Sara and to keep the therapist updated. The therapist's e-mail responses were usually brief but encouraging. Occasionally he e-mailed Sara a summary of the content of her e-mails to assist with synthesis and integration. Over this period of almost 2 months during July and August 2006, there were more than 40 e-mails, and Sara got in touch with a new part, "the one who is humiliated."

After this period, it was possible to resume face-to-face weekly sessions. Sara had gained many new insights. She realized that all negative displays of emotion were forbidden to her as a child, that the 4-year-old ego state had taken control at various stages of her life, and that she had used eating as a means of controlling this ego state.

Even though regular treatment had resumed, Sarah continued in frequent e-mails to articulate her ongoing internal discussions and share these with the therapist. Material from e-mails often provided material for the weekly face-to-face sessions. As work with ego states progressed, it became possible to ask them to take the "driving seat" when working on EMDR with the different issues. It was necessary to emphasize that none of the parts would "disappear" during treatment; the ego states carrying the most negative emotions had initially been uncooperative because of concerns that the final goal of merging/integration meant that they would "disappear."

Over time, usually as the result of insight gained during EMDR processing, more ego states surfaced, including the paralyzed one, the one who wanted to die, the one who wanted to cry, the victim, and, finally, the transparent one. As the fears of each of these ego states were processed, for example, "I will cease to exist," they began to merge gradually into the "whole" Sara. As treatment progressed, Sara developed coconsciousness with the ego states and became more and more aware of ego state activity. She remained powerless to intervene with the ego states, which were contributing to the driving anxiety, but she developed coping skills that enabled her to drive. She was also able to inhibit her impulses to eat indiscriminately.

At one stage, the help of a drama therapist was enlisted to facilitate communication with several parts with whom Sara had not been able to establish a dialogue. This was accomplished by the use of masks and was a very positive step in the recovery process.

As targets were processed, it became clear that probably from birth on, Sara had been exposed to and picked up many of her father's fears. Neither parent allowed normal expression of feelings, so much so that even the natural need of a toddler to seek comfort from

her parents because of night fears was out of the question. The pervading message she received was that "you are alone" yet at the same time totally exposed to a dangerous world. To combat this and survive, Sara developed her protective bubble, dissociative symptoms, and, eventually, a series of adolescent rituals. It was this feeling of being totally alone that prevented her from driving comfortably out of town.

After almost 3 years of treatment, things came dramatically to a head while working on the image (future template) of being stranded in her car. Sara terminated the meeting by saying, "Enough, I'm fed up of being a victim," and left the room. The therapist perceived this to be a statement of frustration. However, Sara e-mailed 2 days later to say that this expression actually came from "the victim" herself and that she (the victim) had made a conscious decision to stop this behavior. From that decision on, Sara's driving anxiety diminished, and even a long, nighttime journey became possible.

Face-to-face sessions continued for a further year and a half until all the parts were identified and all their traumas and concerns were addressed. While many other issues arose, the frame of reference of this case was always around driving, and a significant stage in the treatment was achieved when Sara drove at night on her own for more than an hour with no sensation of panic or distress and without losing sleep the night before because of anticipatory anxiety.

Discussion

Treatment of Dissociation

This case shows that identification of dissociative symptoms, diagnosis, and ego state work can make the difference between a client's success or failure in treatment. Initial EMDR sessions resulted in only limited progress until the therapist recognized Sara's dissociative disorder and ego state work was begun. EMDR done within the ego state framework facilitated the treatment process. With dissociative clients, one can anticipate many surprises and setbacks along the way, so to expect the unexpected and "go with that" is a good rule of practice. It also helps to realize that although the client has a long and demanding mission in processing all traumas and the eventual merging of ego states, it is a treatment that can be successful.

In the treatment of dissociative disorders, building trust with all parts is an ongoing task. Mapping the full extent of the system of ego states cannot be assumed to be complete at the end of the preliminary conference table exercise. Working methodically through the EMDR protocol with each ego state will, with patience, bring results. As Sara had parts who protected her from instability, it was possible to apply the full protocol with the parts, including positive and negative cognitions and ratings of subjective disturbance, although sometimes the rating of the validity of positive cognition was skipped.

The presence of each distinct state adds an extra dimension to the treatment, and it is important to realize that one or more ego states can sabotage progress until their concerns about targets, goals, and/or integration are addressed. There were times when the therapist felt that he was drawn into excessive dialogue among ego states, although some of this concern could be related to his lack of experience in work with clients with dissociative disorders.

Integration of Writing With EMDR

It appeared that Sara's willingness and ability to use e-mail to write down internal conversations meant that more of the meeting time could focus on EMDR processing. For Sara, as small and large traumas were processed, many of the ego states naturally merged after internal discussions.

This case study illustrates the benefits for Sara in the process of internal dialogue. The issues for Sara were not only about driving but were also related to her studies, relationship with her parents and family, and behavior at work. For Sara, writing was a marvelous source of identifying cognitions for processing during treatment sessions and appeared to be an active ingredient in developing internal communication and cooperation and the eventual merging of ego states. Writing (Kluft, 1996) and, in particular, creative writing have proven an effective treatment tool (Lahad, 2002).

If appropriate, clients with dissociative disorders could be encouraged to keep a diary to facilitate developing and maintaining an ongoing dialogue with as many of the parts as possible, regarding all important issues. However, journaling is not advised when there are obsessive components to the client's behavior and regular writing is a cause rather than a relief of anxiety.

Use of E-Mail

E-mail was used both ways: by Sara to communicate to the therapist and by the therapist to communicate with the client. Occasionally, it was helpful for the therapist to provide a short e-mailed summary to remind all ego states of what came up during a session. The involvement of the therapist in receiving

and reading e-mail appeared to facilitate the healing process. This may have been due to the therapist's "being available to hear" the various voices, with subsequent validation. E-mail communication is not recommended when the client oversteps the guidelines agreed on (discussed later) or has unrealistic expectations of the therapist. There may be DID or DDNOS clients for whom writing alone at home would be triggering and counterproductive.

The scope of this article does not allow a thorough discussion of the ethics of e-mail therapy and its liabilities and benefits. The reader is referred to the guidelines of the American Psychological Association (Fisher & Fried, 2003, 2008).

It is recommended that a clear treatment contract regarding e-mails be developed prior to engaging in e-mail communication. This contract could specify the length and frequency of the client's e-mails that the therapist is prepared to read and relate to and the content of the e-mails. For example, is e-mail communication the best way for the client to communicate an "urgent cry for help" or suicidal intention?

Expectations of the therapist's response availability need to be clarified. Will the therapist respond by e-mail? If so, how and when will the responses be made? Will the therapist simply confirm receipt, or will the therapist respond to the client's material? Furthermore, the relationship of this correspondence must be considered: What is the arrangement concerning payment for the therapist's time? How will e-mail communication problems be resolved? A discussion regarding risks of privacy and confidentiality is also recommended.

Summary

In summary, Sara's case illustrates how a form of communication initially used for relaying messages became a tool for enhancing and facilitating progress in information processing and allowing parts that were more reticent in the clinic situation to give voice. This process, which was originally developed to cope with an interruption in treatment due to the war, developed into an effective therapeutic tool.

The use of e-mail facilitated Sara's internal dialogue and enhanced communication among the various ego states, increasing her self-awareness and insight. The therapist's role in reading, responding, and understanding appeared to be an invaluable component, as each part felt "heard" and validated. Use of e-mail was not time dependent; often, an idea was started or a problem stated, and the theme was developed over the day in short bursts. E-mail correspondence remained even if the thoughts were forgotten or held by a part reluctant to become involved in conversation during a session and the therapist could choose salient points for work at the next session for EMDR processing. Specific concerns became EMDR targets, usually in the form of future templates, and were processed according to the standard protocol. Integration itself did not happen during the EMDR sessions. It was a process in which Sara noticed that in different settings, she was able to report that more and more thoughts and actions were coming from Sara the host rather than from one or more of the parts.

The treatment produced a successful outcome for Sara. Dissociative symptoms were greatly reduced, with an integration of many of the ego states. Sara noticed that the dissociative bubble no longer encapsulated her, she was able to relate with more confidence to her superiors at work, her relationship with her elderly parents improved, and she made great progress in higher studies. Importantly, the driving anxiety, which had been a primary focus of therapy, was substantially reduced, with Sara able to drive alone to many places without anxiety, even at night.

Future research on the treatment of dissociative disorders with EMDR is strongly recommended, as is research on the use of e-mail communication during EMDR. With more input from EMDR clinicians treating dissociative disorders, more conclusions will be drawn and another tool honed in our therapeutic inventory.

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