A Case Study: The Integration of Intensive EMDR and Ego State Therapy to Treat Comorbid Posttraumatic Stress Disorder, Depression, and Anxiety

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This study used a quantitative, single-case study design to examine the effectiveness of the integration of intensive eye movement desensitization and reprocessing (EMDR) and ego state therapy for the treatment of an individual diagnosed with comorbid posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and generalized anxiety disorder (GAD). The participant received 25.5 hr of treatment in a 3-week period, followed with 12 hr of primarily supportive therapy over the next 6-week period. Clinical symptoms decreased as evidenced by reduction in scores from baseline to 6-week follow-up on the following scales: Beck Depression Inventory (BDI) from 46 (*severe depression*) to 15 (*mild mood disorder*), Beck Anxiety Inventory (BAI) from 37 (*severe anxiety*) to 25 (*moderate anxiety*), and Impact of Events Scale from 50 (*severe PTSD symptoms*) to 12 (*below PTSD cutoff*). Scores showed further reductions at 6-month follow-up. Results show the apparent effectiveness of the integration of intensive EMDR and ego state work.

Keywords: EMDR; ego state therapy; depression; anxiety; PTSD; evidence-based practice

This article describes the brief, intensive treatment of a college student using a combination of eye movement desensitization and reprocessing (EMDR) and ego state therapy. Initial assessments indicated that she had posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and generalized anxiety disorder (GAD), but no formal dissociative diagnosis. Nevertheless, the client's powerful co-conscious ego states had sunk her into a vegetative depression, which led to a psychiatric hospitalization. The client chose not to stay in the hospital. At the beginning of treatment, the client was on 200 mg of Zoloft, 12.5 mg of Seroquel, 150 mg of Lamictal, and 0.5 mg of Ativan as needed. She saw her psychiatrist regularly during this treatment. After a week of the successful combination of intensive EMDR and ego state therapies, the client was able to return to college part-time; and after 3 weeks of treatment, the client returned as a full-time student. Assessments showed that she no longer met the criteria for the disorders at follow-up. At the end of treatment, the client was taking only 200 mg of Zoloft and 0.5 mg of Ativan for sleep. Her own summary of the work also illustrated a profound shift in how she understood herself.

Eye Movement Desensitization and Reprocessing

EMDR therapy was created by Dr. Francine Shapiro as an integrated approach for the treatment of trauma and other adverse life experiences or psychological stressors. It incorporates many modalities including cognitive behavioral, psychodynamic, and body-centered therapies and organizes them in an eight-phase methodology (Shapiro, 2001). The eight phases of the EMDR process are as follows:

1. History taking and treatment planning (obtaining background information, assessing suitability of EMDR, identifying potential target memories for processing)

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2. Preparation (including preparing clients for EMDR and increasing their ability to switch to positive affect states)
3. Assessment (accessing specific targets and identifying the components of memories)
4. Desensitization (reprocessing experiences to resolution with procedures that include bilateral stimulation)
5. Installation (increasing connections to positive cognitions and emotional networks)
6. Body scan (bringing awareness to the body and processing any residual disturbance)
7. Closure (ensuring stability at the end of and in between sessions)
8. Reevaluation (at the subsequent session, revisiting the processed memory to see if any residual material requires processing; Shapiro, 2001).

Shapiro (2001) also developed the adaptive information processing (AIP) model, which is the conceptual basis of EMDR.

> [T]he model regards most pathologies as derived from earlier life experiences that set in motion a continued pattern of affect, behavior, cognitions, and consequent identity structures . . . pathology is viewed as configured by the impact of earlier experiences that are held in the nervous system in state-specific form. (pp. 16–17)

She asserts that there is an inherent information processing system in the brain, which processes the multiple elements of an individual's experiences in an adaptive manner. EMDR's eight-phase treatment methodology is used to access and treat the impact of disturbing life events and traumas, whether specific or recurring (Shapiro, 2001). It does this by targeting those past events, their impact in the present (referred to as triggers), and how they may be expected to affect the individual in the future. Some form of bilateral stimulation, such as back-and-forth eye movements, or alternating auditory or physical sensations, helps the client maintain present awareness while focusing on a past event, and also stimulates the brain's information processing system. After each brief period of bilateral stimulation, the client is invited to share what has come up, until that memory feels resolved or as resolved as possible given the circumstances.

Intensive Eye Movement Desensitization and Reprocessing

The typical format for EMDR treatment has been consistent with the traditionally accepted procedure of a weekly psychotherapy session. Recent research, however, suggests that using EMDR in a more intensive or concentrated format can be highly effective in symptom reduction (Abel, 2011; Grey, 2011; Wesson & Gould, 2009). Intensive EMDR, for example, may involve seeing the client 3–5 days a week for 60-, 90-, or 120-min sessions or for two separate 60-min sessions each day (E. C. Hurley, personal communication, July 1, 2011). Such treatment has also been described as consecutive day EMDR treatment (Grey, 2011) or concentrated EMDR treatment (Abel, 2011). The research on this model, albeit limited, supports its efficacy in reducing trauma symptoms. Grey (2011) successfully treated a woman with comorbid MDD with psychotic features and panic disorder with agoraphobia with three 90-min sessions per week for 4 weeks. After 3 months, she maintained subclinical scores on the Beck Depression Inventory (BDI)-II and the Beck Anxiety Inventory (BAI). Wesson and Gould (2009) treated a British medic in Iraq for an acute stress reaction to a land mine explosion. He was seen 2 weeks after the explosion and treated with the EMDR Recent Events Protocol on 4 consecutive days and was then immediately able to return to frontline duties. Treatment effects were maintained at 18-month follow-up. The promising results of these studies support the need for further research on an intensive model of EMDR.

Using EMDR to Treat Posttraumatic Stress Disorder

Several randomized clinical trials and meta-analyses support the efficacy of EMDR in reducing PTSD symptoms (Bisson & Andrew, 2007; Bradley, Greene, Russ, Dutra, & Westen, 2005; Davidson & Parker, 2001; Hogberg, 2008; Marcus, Marquis, & Sakai, 2004; Maxfield & Hyer, 2002; Seidler & Wagner, 2006; Van der Kolk et al., 2007). Neuroscience research also supports the efficacy of EMDR. In one study, the brains of 10 people with PTSD were assessed before and after EMDR treatment. Following EMDR therapy, there was a reduced arousal level, a reduced orienting to new stimuli, and a significant improvement in PTSD symptoms (Lamprecht, Kohnke, Martin, Matzke, & Munte, 2004). Most recently, the National Registry of Evidenced-Based Programs and Practices of the U.S. Department of Health and Human Services Substance Abuse and Mental Health Administration (EMDR International Association, 2011) listed EMDR as a treatment for PTSD, anxiety, and depressive symptoms along with general global mental health function.

Using EMDR to Treat Depression and Anxiety

MDD is diagnosed in 6.1% of the American adult population annually, whereas GAD is diagnosed in

approximately 3.1% of the American adult population annually (National Institute of Mental Health, 2011). Given the prevalence of trauma within the mental health population, EMDR would appear to be an appropriate method of addressing the life experiences that could contribute to the comorbidity of MDD, GAD, and PTSD (e.g., early trauma, attachment disruptions, and grief). Some preliminary research supports this assertion and shows that after treatment with EMDR, there may be a reduction of fear and other anxiety symptoms (Gauvreau & Bouchard, 2008) and a reduction of depressive symptoms both related to grief (Sprang, 2001) and to non–grief-specific depression (Bae, Kim, & Park, 2008).

Ego State Therapy

Federn, a colleague of Freud, was the first to use "ego state" as a way of clinically describing various parts of the personality. "He believed that each ego state has its own history, thoughts, feelings, sensations, and behaviors, and that each ego state contains personality energy that interacts with the energies of other ego states, somewhat like the members of a family" (Phillips, 2000, p. 86).

The two-energy theory derived by Federn consists of the ego (perceived as "me") and the object (perceived as "not me"), each having energy or cathexis when they are dominant (Forgash & Knipe, 2008). Paulsen (2009) further explains that *cathexis* refers to the investment of emotional energy in a particular point of view. More specifically,

> Ego-energy or ego-cathexis means that a part is executive, which means it would use the first person "I" to speak of its point of view. This contrasts with object-energy or object-cathexis which means that other parts would use the third person, he, she, it or they, to refer to parts "over there" which are in that moment experienced as "not me" (not in ego). (Paulsen, 2009, pp. 244–245)

For example, a student may have a very studious part of himself and a wilder and fun-seeking part of himself. His grades on a particular exam will be higher if the studious part is ego cathected in the days before the exam and will be lower if the fun-seeking part is ego cathected, which may lead the student to go skiing for the weekend rather than studying.

Watkins extensively developed ego state theory and made it a cornerstone of his psychoanalytic hypnotherapy, which he initially used to treat World War II veterans who had experienced shell shock (Watkins & Watkins, 1979). According to Watkins and Watkins (1997), ego states are defined "as an organized system of behavior and experience whose elements are bound together by some common principle, and which is separated from other such states by a boundary that is more or less permeable" (p. 25). Furthermore, because of the various ego states within an individual, the client can be viewed as a family of the self; as a result, ego state therapy involves individual, group, and family therapeutic techniques to resolve the internal conflicts among the various ego states.

Three major processes by which an ego state develops have been delineated. The first process is through "normal differentiation" where children develop healthy ego states with fluid and flexible boundaries that help them deal with parents, teachers, and playmates. The second process is through the "introjection of significant others," such as healthy or abusive parents. For example, if children introject two parents who are often at conflict as ego states, they are likely to experience frequent headaches later in life because these two introjected ego states may be warring internally. The third process is that of dissociation; if children experience severe trauma, they may dissociate (Watkins & Watkins, 1997).

Because the client described in this article did not meet the criteria for a dissociative disorder, this article did not discuss the use of ego state therapy with dissociated parts of self (or alters). However, it is helpful in the context of this article to understand a few aspects of dissociation. According to the structural theory of dissociation of the personality, people who are severely traumatized have an *apparently normal part of self* (ANP) that lives daily life and *emotional parts of self* (EPs) that live in trauma time in the past. People with dissociative identity disorder have two or more ANPs. Emotional parts have powerful stories to tell that are full of vehement emotion that the ANP cannot tolerate. Thus, the ANP develops a phobia of traumatic memories held by the EPs, whereas some EPs are also phobic of other EPs (Van der Hart, Nijenhuis, & Steele, 2006). Although Van der Hart et al. (2006) reject the term *ego state* as too limited, their concepts clarify some of the issues commonly confronted in ego state therapy. In this article, the terms ego states, parts, or parts of self will be used interchangeably.

Ego State Therapeutic Techniques

Paulsen's (2009) extensive work with ego states includes a technique where the client creates an image of a meeting place in the client's mind where the ego state work will be done. The part that wishes to speak,

or with whom the therapist would like to speak, is asked to *look through the eyes* of the client. The part that is looking through the eyes has ego cathexis. The other parts have object cathexis and may be referred to in the third person (Paulsen, 2009).

A more common way of working with ego states, and the one that was used in this treatment, is the Dissociative Table Technique developed by Fraser (1991, 2003). For a more detailed description of this technique, see Martin (2012). Forgash calls this a workplace (Forgash, 2004, 2005; Forgash & Knipe, 2008), whereas others call it a meeting place procedure (Gonzalez & Mosquera, 2012). It is also commonly called the conference room technique in which the therapist uses guided imagery to bring the client to a room with a conference table (Paulsen, 2009). The client's ego states (or those parts relevant to a particular issue) are then invited in the client's mind to come into the room and join the client at the table. A conversation ensues, which may involve mapping the internal system, negotiations with parts that are currently impinging on the client's well-being, meeting the needs of younger parts of self, and other work specific to a given client.

Although it is understandable to want to work with, protect, and try to rescue an abused child part, it is essential in ego state therapy to first honor and work with powerful protective ego states (Paulsen, 2009). These powerful parts originally served a protective purpose in childhood or adolescence, but in adulthood often lead the client to behave in self-destructive behaviors or in ways that prevent optimal growth. These protector parts are often introjects of abusive parents, other role models, or perpetrators. Paulsen (2009) calls them "honchos." In Internal Family Systems language, they may be "managers" or "firefighters" (Schwartz, 1995). The therapist acknowledges their many years of hard work that was initially helpful in some ways in childhood. Parts of self "typically seek to protect their existence and roles, even if those are counterproductive," so change involves strategic negotiations (Forgash, 2005, p. 6). Ego state therapy, like all therapy, is rooted in the belief that change is possible. And as parts of self change, accept new roles, and/or are brought into present awareness, the client's progress is often dramatically enhanced.

The therapist carefully explains to the client that parts cannot be extinguished, even ones that the client may hate. Then the therapist helps educate a protective part about how it is now unintentionally sabotaging the adult client's ability to grow and thrive in the present (Forgash, 2005; Forgash & Knipe, 2008; Paulsen, 2009). Negotiating with the protective part to step back and allow the client, who is no longer a child, to make decisions by himself or herself, even if he or she may make a mistake, is often a first step. A way for the protective part to express concerns, rather than take over, is agreed upon. Sometimes, protective parts are willing to take on a very different or even opposite role in the present.

In the treatment described in this case study, a negotiation with the client's powerful protector—what she termed the *perfectionist part of self*—was the essential first step to making change possible. The perfectionist part of self was intolerant of the client's emotional life and of her romantic relationships. (In structural language, it was phobic of some of the client's other EPs.) This had to be addressed for the client to accept all of herself and to be less internally embroiled.

Some writers emphasize the idea that underneath the costume of the often fearsome honcho is a frightened young child ego state that was forced to take on that protective role (Paulsen, 2009; Schmidt, 2006). Thus, after the honcho's power is acknowledged, that protective part is sometimes willing to take off the costume or mask and access the child ego state to meet early needs. That step was not used in this treatment.

Ego states may be defined by a particular age or by a function or trait. In this treatment, there were five parts of self: a 7-year-old, an adolescent, a perfectionist, an academic, and a nurturing mother, all of which were known by and readily accessible to the client. This previous accessibility made the work more efficient. Often in ego state therapy, protective parts are difficult to access, whereas child and adolescent parts come forward readily because they are eager to be heard and have their needs met. Protective parts may remain obscure and inaccessible because the client's ANP cannot tolerate acknowledging these protective EPs (Gonzalez & Mosquera, 2012). The practitioner has witnessed this in sessions with other nondissociatively disordered clients.

Integration of Ego State Therapy With EMDR

The standard EMDR protocol (Shapiro, 2001) works with remarkable proficiency for many clients and on many issues. When clients are temporarily stuck in a child memory involving self-blame, for example, it is often sufficient to ask the client a standard cognitive interweave such as "if this were your child, what would you want her to know?" (Shapiro, 2001, p. 264).

However, when clients have a known or undiagnosed dissociative disorder, the EMDR protocol may

not be sufficient and can actually be destabilizing if parts get triggered in ways that are difficult to contain with typical resource development or self-soothing techniques (Paulsen, 2009). Bilateral stimulation can break through dissociative barriers (Paulsen, 2009; Twombly, 2005). For instance, when a client has a known or undiagnosed dissociative disorder, EMDR processing may bring forth an ego state or alter that is not oriented to the present and whose violence or terror the client cannot contain. The resultant destabilization could lead to hospitalization (Paulsen, 2009). This illustrates the need for an enhanced dialogue about integrating ego state work with EMDR. See Appendix B in Shapiro's 2001 text for recommended guidelines for EMDR's use in the dissociative disorders (Shapiro, 2001).

It can be beneficial, and sometimes necessary, to use ego state therapy even when there is not a formal dissociative disorder. There are several reasons for this. First, PTSD itself is defined by dissociative aspects of reexperiencing the past in the present, including avoidance of stimuli, generalized numbing, and increased arousal (American Psychiatric Association, 2000). If ego states hold these memories and/or physiological processes, ego state therapy may become essential to full resolution of the traumatic memories. Second, clients with complex PTSD may experience blocked processing that does not resolve with standard EMDR interventions, such as a change in the length or direction of eye movements or a cognitive interweave (Shapiro, 2001). Blocked processing may include looping, a failure for subjective units of distress (SUD) level to drop to 0 (or to an ecologically acceptable level), or for the validity of cognition (VOC) of the positive cognition to rise to 7 (Shapiro, 2001). A potential cause of blocked processing can be ego states that are not ready for EMDR or protective parts that have not been consulted and have not agreed to allow the EMDR processing to occur (Forgash & Knipe, 2008; Paulsen, 2009).

Third, blocked processing may also include very strong abreactions, such as a reexperiencing of terror, in which the client becomes "lost" in a childhood trauma making it difficult to maintain dual awareness because an adult state living in present reality is not accessible to either the client or the therapist. Thus, the client cannot access his natural AIP capacity. Fourth, ego state therapy can take the work to a much deeper level. For instance, clients may process their targets to an SUD level of 0 and a VOC of 7, yet the presenting problem—such as the lack of a felt sense of safety, low self-esteem, fear of emotional or sexual intimacy, or anxiety—hardly shifts. The integration of ego state work can help the client achieve characterological trait change, a treatment goal of EMDR.

Fifth, initiating ego state therapy early in treatment, such as through the conference room, allows for a much more comprehensive understanding of the core issues and competing internal points of view, which can significantly reduce the length of EMDR treatment. Sixth, ego state therapy may decrease internal conflict and increase internal communication. This practitioner has worked with several nondissociative clients who report, "There's a committee in my head and they're always arguing." Combining ego state therapy with EMDR has been very helpful in quieting down those internal arguments.

Seventh, nondissociative clients may often have a "whiny" child part or a "scary" adolescent part and so forth. Often, a single session of conference room work, using a technique such as loving eyes, will enable clients to develop compassion and understanding for such parts (Knipe, 2008). Follow-up work with those parts has allowed their needs to be met, enabling these ego states to become happier child parts or to merge with the adult client. The adult client may then notice an increase in playfulness or energy.

However, it is also important to note that there are some potential limitations to consider when integrating these two modalities. For instance, it may prolong the treatment if there is no need for ego state treatment. Some clients cannot acknowledge the idea of parts of themselves and so will not be open to it.

The integration of EMDR and ego state therapy is often indicated for work with clients with childhood trauma and/or neglect or those who have complex PTSD; it is considered essential for clients with dissociative disorders (Forgash & Knipe, 2008; Paulsen, 2009; Twombly, 2005). On the other hand, it may be less useful for work with clients who do not have a history of trauma.

A resolution of the seven issues discussed earlier often comes through integrating ego state therapy with the EMDR process, as will be shown. For example, a client having an overwhelming abreaction may no longer have access to dual attention awareness or his or her AIP capacity. This may only resolve by speaking directly and actively with that child ego state, providing information that the child ego state does not know in that moment—that the abuse is over, that the child part grew up to be an adult (perhaps with children of her own), and that the child part is safe in the present space at the present time.

Several strategies can be used when integrating ego state therapy with EMDR to facilitate safety for the client and for the ego state(s) being worked with.

These include Knipe's (2002, 2010) Back of the Head Scale and Constant Installation of Present Orientation and Safety (CIPOS) and loving eyes procedure (Knipe, 2008). Other strategies include creating a home base where the ego states remain between sessions (Forgash, 2010; Forgash & Knipe, 2008), orientation to present reality (Forgash, 2005), and Twombly's (2005) picture in a picture technique where the client goes back and forth between his or her safe or calm place and the traumatic memory. In addition, although the safe or calm place may provide adequate safety for the adult part, the young ego states may need further comfort or security measures such as a blanket, playroom, and so forth. It can be useful to have an affect dial or dimmer switch in the workspace so that the level of disturbance during processing is carefully monitored (Paulsen, 2009). Finally, in setting up targets, Forgash (2005) explains, "Each ego state may require a separate VOC, SUD, NC, and PC . . . length of sets and type of stimuli are also selected by consensus, both between therapist and client and among the ego states" (p. 19). Although these strategies will not be described in detail here, it is recommended that clinicians interested in learning more about these techniques consult the respective sources.

The Present Case Study

Design

This study used a quantitative single-case study design to examine the efficacy of the integration of intensive EMDR treatment and ego state therapy with a client who met the criteria in the *Diagnostic and Statistical Manual of Mental Disorder*, Fourth Edition (*DSM-IV*) for the following diagnoses: PTSD, MDD, and GAD (American Psychiatric Association, 2000).

Participant

Throughout this study, the client's confidentiality was maintained and ethical procedures were followed for her protection. The client was a single, 21-year-old, White college student attending a major university in the Northeast. The first author (FL), herein referred to as "the practitioner," had treated her for a year during high school and now agreed to treat her intensively with EMDR and ego state therapy for symptoms of PTSD, depression, and anxiety as an alternative to a recommended hospitalization.

Treatment

This intensive treatment followed Shapiro's eight-phase EMDR standard protocol, with ego state work integrated throughout. The 25.5 hr of integrated EMDR and ego state therapy treatment were provided over 3 weeks. In Phase 1 (history taking and treatment planning), an updated history was taken, with attention given to how dysfunctional ego states were currently affecting her. In Phase 2 (preparation), grounding techniques were reviewed to prepare the client for EMDR treatment. Phase 2 also involved meeting ego state parts to establish communication and negotiate new roles for them that would allow the client to heal, also assuring that each part had a safe place or grounding technique to access. In Phase 3 (assessment), the client's negative cognitions were assessed and connections were made to her different ego states. During Phase 4 (desensitization), crucial interweaves and interventions in relation to her parts were employed. The integration of intensive EMDR and ego state therapy continued to be used during all EMDR phases, as will be shown in the following texts.

In Week 1, there were six sessions for 60, 90, or 120 min in length that totaled 9.0 hr. In Week 2, there were five sessions, four of which were 120 min and one was 60 min, totaling 9.0 hr. In Week 3, there were five sessions of 60, 90, or 120 min totaling 7.5 hr. Lateral eye movements were the primary form of bilateral stimulation during EMDR Phases 4 and 5 (processing and installation), although tactile stimulation was sometimes used instead.

Pretreatment Assessment

An interview grounded in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (*DSM-IV-TR*) diagnostic assessment procedures revealed that the client met the diagnostic criteria for PTSD, MDD, and GAD. The practitioner administered five quantitative assessment instruments: the BDI (Beck, Ward, & Mendelson, 1961), the BAI (Steer & Beck, 1997), the Impact of Events Scale (Weiss & Marmar, 1997) as a measure of PTSD symptoms, the Schwartz Outcome Scale (Blais et al., 1999) as a measure of self-satisfaction and confidence, and the Dissociative Experiences Scale (DES; Carlson & Putnam, 1993) as a measure of dissociation. The client's negative cognitions were also assessed (Shapiro, 2001). The practitioner relied on the clinical interview as well as the definitions provided by the aforementioned scales for the diagnoses.

At baseline, the client's BDI (Beck et al., 1961) score was 46, which is considered "severe." Her BAI (Steer & Beck, 1997) was 37, which falls in the "severe range." The Impact of Events Scale (Weiss & Marmar, 1997) indicated "severe PTSD," with a score of 50: 12

on the avoidance scale, 20 on the intrusion scale, and 18 on the hyperarousal scale. The Schwartz Outcome Scale is an assessment of perceived satisfaction with life (Blais et al., 1999); the client had a total score of only 8 out of a possible 60. Finally, her score of 15 on the DES (Carlson & Putnam, 1993) did not indicate a dissociative disorder.

On the EMDR Negative Cognition Checklist (Shapiro, 2001), which lists 37 of the most commonly held negative cognitions such as "I am not safe" or "It is my fault," the client checked a remarkably high 27 of 37 statements as true for her. Negative self-beliefs may be strongly connected to particular parts of self. The depth of what she described as her "self-hatred," evidenced by the very large number of negative beliefs about herself, contributed to the practitioner's conceptualization of the case, and determination that ego state therapy would be helpful, despite the absence of a dissociative disorder.

Ego State Assessment

The client was fully aware of several ego states, and she understood during this treatment that these had caused her hospitalization and/or prevented healing. It became evident almost immediately to the practitioner that intensive EMDR would yield only small gains if treatment did not address these parts of self and their related needs and concerns. The most powerful of these ego states was the perfectionist, which had an unremitting focus on superior achievement both in academics and in outside activities to the exclusion of all emotions. Other ego states, as mentioned, included a 7-year-old state, which was focused on a core traumatic memory. Guided imagery work, as will be shown later, in which the 7-year-old ego state was healed by a nurturing mother ego state part in a sacred space, produced a fundamental resolution of the client's self-hatred. Treatment also included negotiations with the perfectionist ego state and the academic ego state about completing the semester's work over the summer.

Client History and Presenting Problems

The client was the youngest of three daughters, born to middle class White parents. The first was 5 years older than the client and was born with severe neurological impairments, requiring intensive care. When the client was 8 years old, her eldest sister died. The client explained that she had been very close to this sister and the sudden loss was devastating for her. She also experienced more criticism from, and more conflict with, her mother. The client stated that this heightened conflict prematurely interrupted her grieving, as she withdrew to defend herself.

As a young child, the client experienced being left alone much of the time, with few memories of spending time with her parents. She reported feeling "unseen, unheard, and blamed." During this course of treatment, the client had supportive conversations with her father who corroborated much of her childhood and adolescent experiences.

At the time of this clinical treatment, the client presented with profound depression because of relational, academic, and familial pressures and her ego states' responses to those pressures. The intensity of the depression confined her to her dorm room for 10 days. Her therapist recommended voluntary hospitalization to treat her "vegetative depression," so she took a medical leave from the university. Once at the hospital, the client's perfectionist ego state pushed the client hard "to get out of here." The client found this internal pressure empowering at a time when she had been quite helpless. The client was able to reconnect with the practitioner who proposed an intensive level of work that might enable her to complete her semester. The client's short-term goals for treatment were to significantly decrease her symptoms to be able to complete her semester's coursework. The client's long-term goals were to feel proud of herself, to put less pressure on herself about her studies and her relationships, and to no longer feel burdened by an unrelenting sense of responsibility for others.

Case Conceptualization

The practitioner viewed the client's symptoms as related to traumatic familial experiences. He thought that her difficulty in forming attachments and her struggles to acknowledge her needs in intimate relationships, which she reported in Phase 1, and the development of her self-critical personality stemmed from her complex family history. The practitioner used the theoretical underpinnings of the AIP model to conceptualize the case and understand the client's presenting symptoms. The client's symptoms manifested in cognitive themes about a sense of worthlessness and a sense of responsibility. The negative cognitions that this treatment focused on were "I must be perfect" in relation to her sister, "I am a failure" in relation to academic work, and "I am a bad person" in relation to her mother.

When working with long-standing relational trauma, it is often necessary to expand Phase 2 (preparation) to develop stronger internal resources. The client was easily able to access her calm place as well as

her container in which to put away disturbing images and memories, which she had established during her initial work with the practitioner 3 years earlier, and further resourcing appeared unnecessary.

As was explained earlier, it is often very useful to use ego state therapy within the EMDR protocol to meet the competing needs of a client's ego states, parts, or alters that are preventing change or causing self-harming behaviors (Forgash, 2005; Forgash & Knipe, 2008; Gonzalez & Mosquera, 2012; Knipe, 2008, 2009; Paulsen, 2009; Twombly, 2005; Twombly & Schwartz, 2008). The practitioner hypothesized that as the client reprocessed her traumatic experiences, integration of these experiences and of her parts would occur and her symptoms would reduce, allowing for better functioning and improved well-being.

Course of Treatment

Week 1: Preparation and Her Sister. At the beginning of the first week of treatment, treatment focus was the first three phases of EMDR along with identifying problem-causing ego states. In Phase 1, the client's history was updated. In Phase 2, the client recreated her container and calm place, and created a new calm place combined with the light stream—a guided imagery technique that can relieve tension and create an internal state of calm (Shapiro, 2001).

In Phase 3, the client identified many negative cognitions and then labeled each one as being rooted in her experience of her eldest sister, and/or her mother, and/or school. Following the AIP model, the earliest relevant memory of her eldest sister and of her mother were targeted first. The negative cognition "I have to be perfect" was used for both memories related to her sister in Week 1.

The client had five co-conscious ego states. As mentioned earlier, she had a perfectionist, an academic, a 7-year-old child, an adolescent, and a nurturing mother part of self. The ego state that had the greatest impact on her daily life was her highly self-critical voice, which she called the perfectionist. The perfectionist demanded an unremitting focus on achievement both in academics and in outside activities to the exclusion of all emotions. The perfectionist was especially angry when the client was in turmoil about a boyfriend. The client believed that the perfectionist ego state's insistent demands on her had caused her hospitalization.

During therapeutic work with the Dissociative Table Technique, the client imagined a great room with a big table and chairs as well as a comfortable living room. This, then, was her conference room and it was a primary place where ego state therapy took place in this treatment. The practitioner would guide the client down a set of stairs to her great room. Once there, the practitioner would ask the client to invite the ego state(s) relevant to a particular issue to come into the room. The practitioner would then speak with the part(s) through the client.

Because the client believed that the perfectionist ego state's demands had led to her hospitalization, the first such meeting was with the perfectionist. The practitioner acknowledged its concerns and got this ego state to recognize that its unbending insistence on relentless academic achievement had landed the client in a psychiatric hospital. It then agreed to step back considerably and make room for change. This was the essential precondition of much of the progress that the client experienced in this intensive EMDR course of treatment. The practitioner used the conference room technique several times during the course of treatment, primarily to negotiate with the perfectionist and the academic ego states.

The first two EMDR memories that were targeted related to the client's eldest sister who was severely handicapped. The first, a vivid image at the age of 6 years of how she could do so many things her sister could not do made her want to use all of her capabilities to excel as a way of honoring her sister. The client's trait of perfectionism, she thus realized, had much earlier roots than she had ever recognized. Here, the client began to understand that it was only because of her "open heart" that she was able to be so close to her sister and to be a deeply loving presence in her life. The client was shocked to learn that these loving emotions were in fact the source of her wish to excel. She had always believed, because of the self-critical perfectionist ego state, that emotions were her nemesis. This false perception had created such a profound inner conflict that the client worked on this first memory of the 6-year-old's experience for 6 hr in the first week of therapy. This work ended with the client imagining a much better life in the future by keeping her open-hearted relationship with her sister in mind, a clear example of future template work (Shapiro, 2001). A paradigm shift was beginning to settle in.

The client targeted her "life of self-hatred" through a second, later memory around her sister. During EMDR reprocessing, the client realized that her sister had been "extraordinary" despite her handicaps because she had had the constant attention of their two parents and a team of caregivers. Through AIP, the client developed a new positive cognition about the child she was: "I deserved help and I wasn't a bad person if I needed help, even if I needed more help than some other people." It appeared that after this second target,

the client was beginning to integrate many of her early experiences related to her sister and the family's complex dynamics into a new, more positive understanding of herself. She was thus able to acknowledge the positive cognition above in the present tense.

Week 2: College Work. The second week of treatment began with a reevaluation (Phase 8) of the targets around her sister. There were no longer any negative irrational beliefs but rather an appropriate sense of loss. Because the client was already transitioning back to classes 1 day a week, the work shifted to target present triggers for reintegrating herself into school. The client's core negative cognition was, "I am not the person I thought I was. I am a failure." With the perfectionist's concurrence obtained in the conference room, the first 3 days significantly cleared away the blocks to getting her academic work done. Not surprisingly, because she hadn't attended classes for nearly 3 weeks, going back to classes was very difficult. On the second day of Week 2, after a particularly difficult time with classes, the client was very overwhelmed ("I'm in a big gray bag with no exit," she declared). Somatic interweaves—pushing against the practitioner with micromovements as she said, "Get off of me, depression . . . this is my life. I am going to live it . . . I want my life back"—proved to be a very powerful way to turn her helplessness around. The client was then able to evoke her eldest sister's presence again in response to a cognitive interweave from the practitioner ("If your sister were here in this moment, what would she tell you?"). The client realized, "She is telling me that if I love myself, even if I screw up, I can still do something and love myself and keep going." Although often challenged, the client continued to have increasing success at school from Week 2 forward.

Weeks 2 and 3: Her Mother. In the last 2 days of the second week and during the third and final week of intensive EMDR and ego state therapy, the client reported she was doing reasonably well commuting one day to classes, and that she was ready to target what she had experienced as her mother's emotionally abusive relationship. The negative cognition, "I am a bad person," was used for both memories processed related to her mother.

The client began with a vivid image of being brought as a 7-year-old by her mother to a child therapist; the treatment focused on the young client's rage issues. The client experienced her therapist and her mother as ridiculing her for loving her cat, which she felt was her only source of unconditional love. In her processing, the client repeated what she remembered believing as a child: "Everything I did was bad, but I didn't know how to stop being me."

There was a part of her that did not believe those thoughts even as a child. "I constantly struggled between being very angry with my mother for abusing me and angry with myself for being so flawed," she told the practitioner. "This internal conflict caused such anxiety that it was in some ways worse than my mother's endless blaming of me." During the processing of the first memory of being in the therapist's office, the client experienced herself as the frightened 7-year-old ego state. Extensive cognitive interweaves enabled her to develop greater distance from the power of the memory. The next day, the client's processing went back and forth between the experience of the 7-year-old ego state with that therapist and several experiences in high school, especially a confrontation with her parents "about how rageful and emotional I was." The client spontaneously ended the second week by imagining breaking into the child therapist's office as a 21-year-old and dramatically rescuing the 7-year-old ego state.

The third week of intensive therapy continued with the original target in the child therapist's office. The client felt like the 7-year-old again, wondering "why am I so terrible? I don't want to be a bad person. I hate myself so much." When the practitioner noted that these thoughts as a 7-year-old might have been the very beginning of her self-hatred, the client replied, this is "the strongest feeling and belief of all." The client then sobbed uncontrollably, visibly overwhelmed and shaken. She was unable to continue EMDR Phase 4 (processing). Because the practitioner experienced both the client and the 7-year-old ego state to be very distressed, simply using the safe/calm place seemed inadequate. Hence, the practitioner chose to shift to a more powerful form of guided imagery, leading the client and the 7-year-old ego state from her calm place to a sacred place in which the 7-year-old part was healed by a nurturing mother part of the client. This reengaged the client's access to AIP, and the EMDR processing of this target was successfully concluded. The client experienced a dramatic shift, understanding, for the very first time, that she had never done anything fundamentally wrong. The client's SUD was 0 and her positive cognition, "I deserve love not because of hard work but because I am human," was 7.

The client then targeted the second memory with her mother, which occurred at the age of 15 years. The client had been distraught about a big argument with her best friend. She was shaking with rage. Her mother entered and escalated the situation dramatically, ridiculing her for being so upset. "I could not

hate myself anymore than I did at that moment," the client reported. This target image had frozen her in terror; she was visibly pale. This was a memory the client and practitioner had targeted with EMDR 3 years earlier, and yet it overwhelmed her now; she experienced it viscerally as the adolescent ego state. It was necessary to ground her repeatedly for the target memory to be clear, so the practitioner used Twombly's (2005) picture in a picture technique (see the original source for more details on how to use this technique). This repeated process of titration enabled her to fully process the target. By the end of the session, the client's fear and self-hatred were gone, her righteous anger was high, and her positive cognition ("I am a stable, moral person") felt completely true (a VOC of 7).

In the following session, the client realized that her guilt and sadness about her mother had been the major cause of her vegetative depression. After processing these two memories at ages 7 and 15 years, and working with the corresponding ego states, she said, "There is no longer any guilty thought that I should do something [in the present] to take care of her." The third week of intensive EMDR ended with a conference room discussion with two ego states, the perfectionist and the academic. The practitioner got each to support her goals of returning to college, functioning effectively and completing her semester's work. After 3 weeks of intensive therapy, she returned to living on campus and attending classes full time. She came home each weekend on Friday, which enabled the practitioner to continue supportive therapy for 6 more weeks until she left for a summer job.

Weeks 4 Through 9: Adjusting to Being a Full-Time Student and Further Ego State Therapy. The practitioner continued to treat the client for 2 hr a week for 6 more weeks while she was back at the university full time. She commuted home for long weekends. Half of the work addressed her many challenges catching up with an intensive academic load. The client also came face-to-face with her profound challenges in her relationships with men because two men "who I shouldn't touch with a 10-foot pole" pursued her. She became mistrustful of everyone and felt hypervigilant. In the conference room, there were several conversations with a newly encountered lonely part, the perfectionist and the academic. The client became aware that the lonely part, who "looked 16," had actually been a part of the client's life since early childhood when she had first experienced the absence of a mother figure. Because of the earlier success taking the 7-year-old part to a sacred place where she was healed by a nurturing mother part of herself, it was agreed that the client would take the lonely part of herself to this same sacred place through guided imagery. This created another significant shift for the client.

The work ended when the client flew west to a summer internship. She was in a profoundly healthier place than when we began. Over the 6 weeks of follow-up treatment, her understanding of herself had changed significantly. And under the close supervision of her psychiatrist, before she left for her internship, she was now completely off Lamictal and Seroquel, only taking 200 mg of Zoloft plus 0.5 mg of Ativan for sleep.

Summary of the Work

The previous description of the intensive therapeutic work illustrates how the phases of EMDR were used, and how ego state therapy was integrated throughout these various phases. This successful integration of EMDR and ego state therapy resulted in the full reprocessing of each of the targeted memories, with the level of disturbance reduced to 0 and the VOC rising to 7. The practitioner's negotiations in the conference room with the client's perfectionist and academic ego states successfully modified their self-critical influence so that continued academic, social, and emotional well-being was much more likely. The ego state therapy with the 7-year-old and lonely part of self led to profound shifts in the client's self-acceptance.

Results

Psychometric Measures

In the first week of treatment, after 9 hr of EMDR, the client's score on the Impact of Events Scale had dropped from 50 to 27 (Figure 1). This indicated that her PTSD symptoms were now in the moderate range, whereas her score on the Schwartz Outcome Scale had doubled from 8 to 15, indicating greater self-satisfaction and confidence (Figure 2). Midway through the second week, after 14 hr of EMDR treatment, the client's score on the BDI dropped from 46 to 24, indicating a moderate level of depression (Figure 3). Early in the third week, after 22 hr of EMDR treatment, the client's score on the Impact of Events Scale had further dropped to 12 (see Figure 1). Each of these measureable changes indicates that the client had a major reduction in symptoms. At that point, the client also endorsed only 8 out of the 37 negative cognitions, significantly reduced from her initial endorsement of 27. Furthermore, all 8 negative cognitions that the client

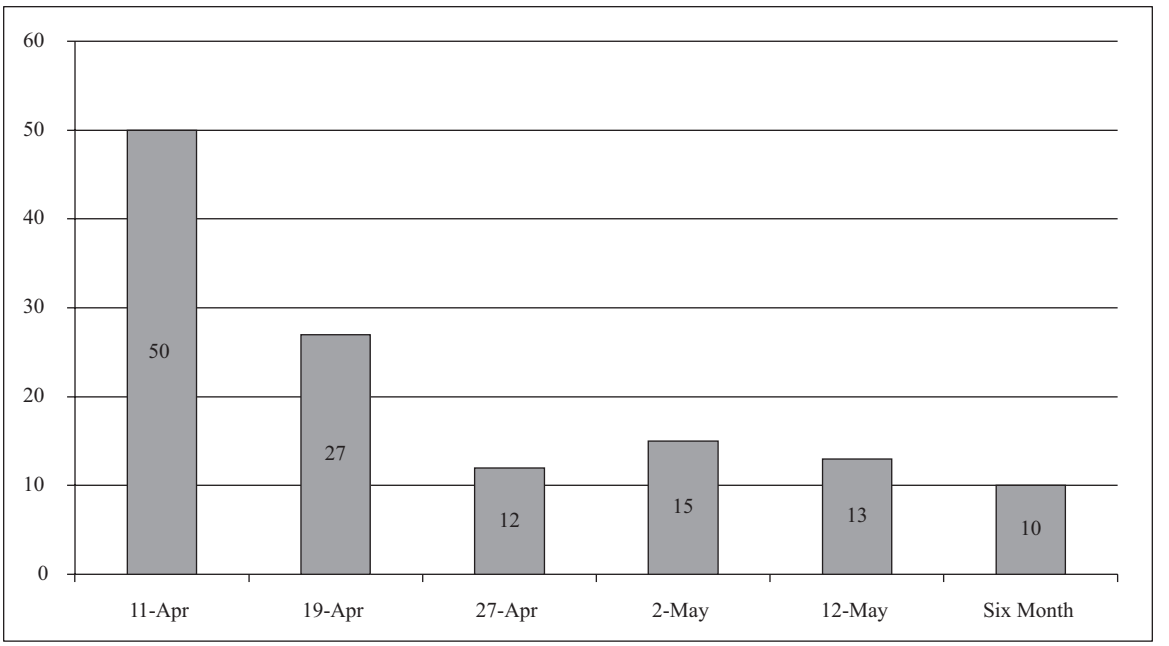

FIGURE 1. Scores on the Impact of Events Scale-Revised.

held to be true related only to being behind in schoolwork, further evidence of her profound shift.

In the fourth week, the client's Schwartz Outcome Scale rose to 25 (see Figure 2), triple the original score. Because the BAI addresses "the past month," 33 days after the client had begun the intensive treatment, it was readministered. Her score had dropped from 37 (described as "severely, it bothered me a lot") to 25 (described as "moderately, it wasn't pleasant at times"; Figure 4). Similarly, her score on the BDI had dropped to 15, indicating only a mild mood disorder (Figure 3). Ultimately, at the Week 4 reassessment, following the intensive 3-week treatment, the psychometric instruments indicated that the client no longer had any significant symptoms of PTSD, no longer met the criteria for MDD, and her GAD had

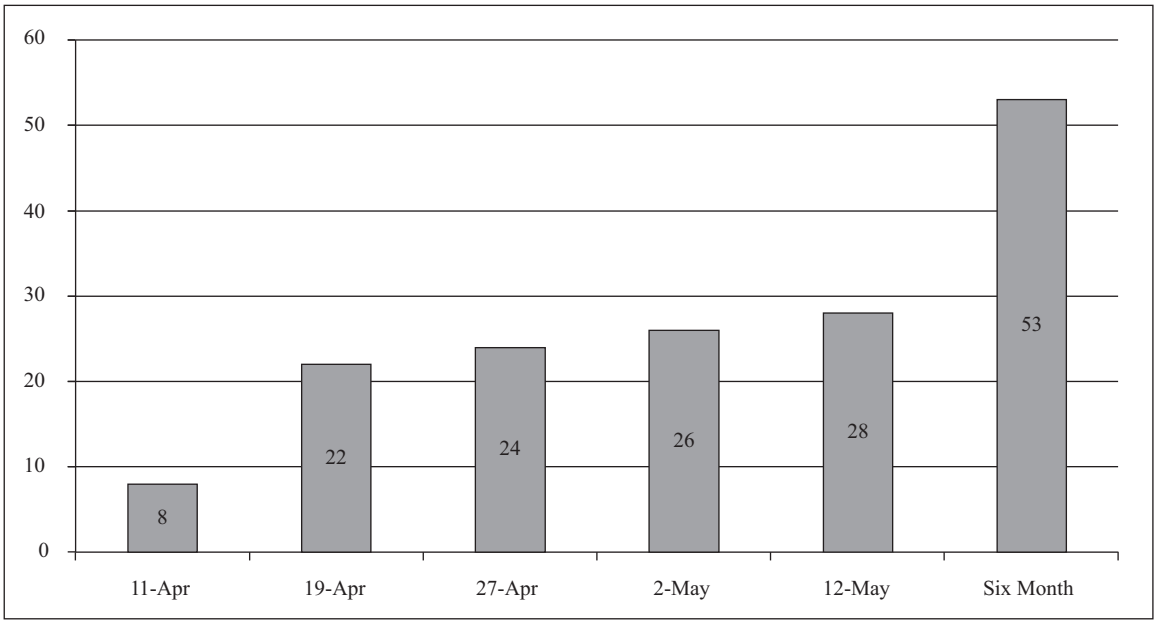

FIGURE 2. Scores on the Schwartz Outcome Scale.

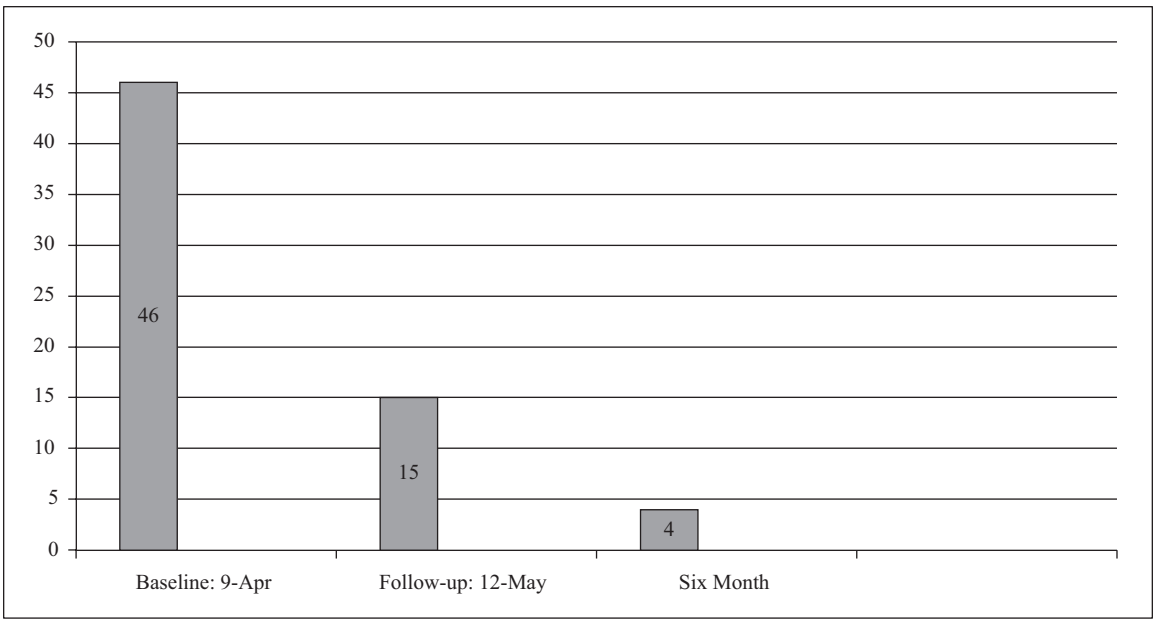

FIGURE 3. Scores on the Beck Depression Inventory.

decreased from severe to a moderate level. She also reported many fewer negative beliefs about herself and expressed greater self-satisfaction and confidence (see Figures 1–4). There were no further changes in her psychometric scores during the 6 weeks of follow-up therapy.

While home for a visit 6 months after her intensive treatment, the client met with the practitioner for a follow-up. During this meeting, the client's score on the BDI score was 4 (0–10 is considered "normal ups and downs") and her score on the BAI was 1 (1–21 indicates "very low anxiety"). The client's score on

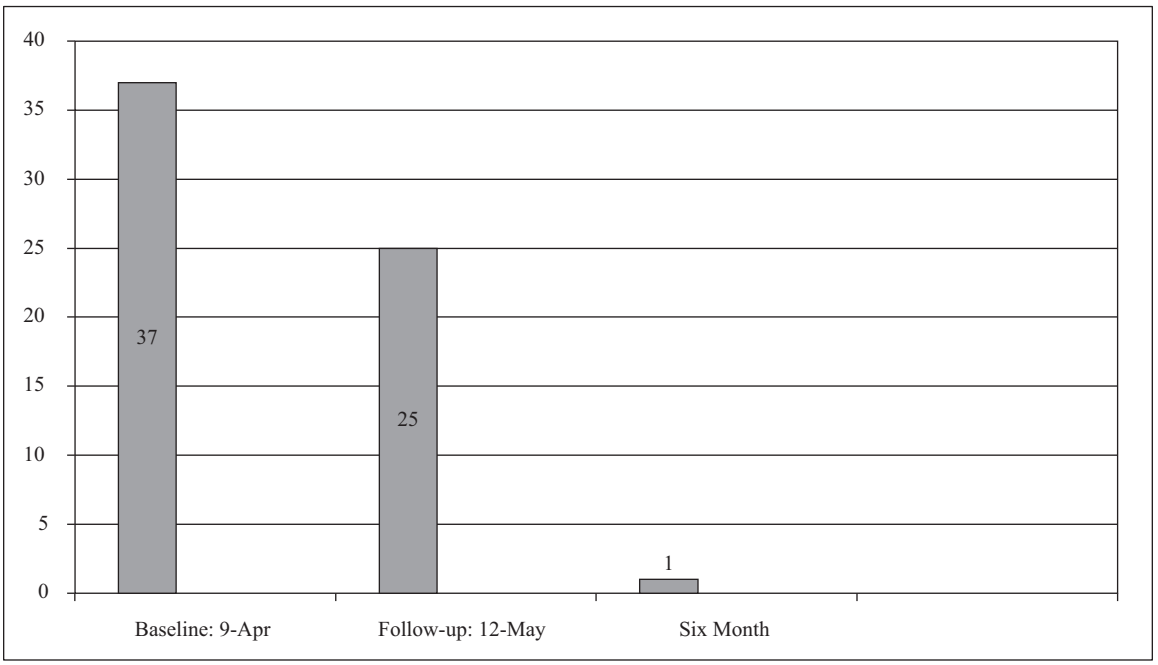

FIGURE 4. Scores on the Beck Anxiety Inventory.

the Impact of Events Scale score was 10, indicating the continued absence of any significant PTSD symptoms. The client's Schwartz Outcome Scale score had dramatically improved to 53 out of a possible 60 (see Figures 1–4). Finally, regarding negative cognitions, she ascribed to 6, but reported that none of them had a powerful influence on her daily life. These scores indicate sustained success from treatment after 6 months.

The practitioner spoke by phone to the client 18 months following the intensive treatment. The client was now studying abroad for the year, successfully handling a course load of engineering classes in Germany and adjusting well to living there. She had several German and American friends at the university where she was studying. Her mood was bright during the conversation.

Behavioral Changes

As mentioned earlier, after 3 weeks of intensive EMDR therapy, 25.5 hr, the client returned to live on campus and resumed classes full time. She commuted home for long weekends and the practitioner saw her for 2 hr a week for 6 more weeks until she left for a summer job out of the area. Psychometric scores did not shift further during this second stage of work. This may have been caused by the high level of stability she had reached. However, there were major functional shifts. She was able to face her challenges in an increasingly coherent way. The client's own evaluation at the end of the 9 weeks of treatment showed major insights about herself and her family. She had consolidated a new narrative about herself, evidence that the 3 weeks of intensive EMDR and ego state therapy had allowed for further integration of her painful experiences, resulting in both less chaos and less rigidity (Siegel, 2011).

Near the end of the work with this practitioner, the client said, "This has been one of the calmer periods of my life. I'm terribly behind in my schoolwork and I'm not crying every day." In her last session, the client reflected at length on what she had learned in these 9 weeks,

> The month after my sister died, I experienced disbelief, then anger, then knowing I would be really upset for years. Then I repressed my grief because the abuse from my mother began. So I see the emotions ahead as the grieving process that is completely normal. It's not PTSD or another psychological disorder. And there are a lot of different things to grieve.

She continued,

> The most obvious thing is the death of a family. It was believed to be stable. It wasn't. My parents divorced and it wasn't my fault . . . I need to grieve the absence of a mother . . . then when I'm a mother, I won't do it her way. I'll start from scratch." She added, "I've been dealt bad situations. I choose to honestly feel the pain and get over them. I couldn't do that while I was still living with my mother. My ending is not a fairy tale ending, but it's a good one. I am glad I can come to this point, even if it's painful.

At the 6-month follow-up, the client reported that she had completed her semester's assignments by the agreed date and had received excellent grades. The client excitedly described all she was learning at an internship in a Midwest aeronautical company. The client stated that she is increasingly excited about a career in "the real world" rather her original goal of academia.

Discussion

This single case study indicates that the integration of intensive EMDR and ego state work was successful in very quickly reducing severe symptoms of PTSD, depression, and anxiety for this client. In this situation, it was an effective alternative to psychiatric hospitalization. At the beginning of treatment, the client was experiencing intense distress and was severely symptomatic. She met the criteria for comorbid PTSD, MDD, and GAD. She appeared unstable and hospitalization was recommended, but it was determined that she was not at imminent risk for suicide. The value of the rapid work meant that she was able to target the sources of pain and suffering in a much shorter amount of time than would have been possible in traditional weekly psychotherapy, or in the inpatient hospital setting, where much less individual trauma-focused work would have been possible.

For her, the advantages of integrating EMDR with ego state therapy were clear: Early traumatic experiences that had deflected her normal developmental trajectory (Siegel, 2011) were thoroughly reprocessed, so they had much less impact on her present daily functioning. The combined work also allowed her ego states to integrate these experiences in a safer and more comprehensive way, adding to her recovery. Success was evident in multiple ways: her decreased scores on all psychometric measures; the fact that she

no longer met the criteria for two of her initial three diagnoses; her ability to return to college classes and begin working; and her ability to be significantly less self-critical and more self-compassionate. The positive outcomes allowed the client to create a more balanced life and find more joy in living.

Intensive Treatment

Future research is recommended to further evaluate the use and effectiveness of intensive treatment. If the results support the use of intensive treatment, it is hoped that programs will reevaluate policies and structure of treatment, and insurers will agree to pay for this apparently cost-effective treatment.

Recommendations for Future Research

This case study and the previously mentioned cases (Abel, 2011; Grey, 2011; E. C. Hurley, personal communication, 2011; Wesson & Gould, 2009) all indicate that rapid change occurred when intensive EMDR was used with several different diagnoses. This is an important clinical consideration for practitioners. Furthermore, for those involved in research, expanding this line of inquiry will help determine when, if, and with whom intensive therapy is most helpful. Future research questions should focus on (a) comparing the outcomes of intensive EMDR and weekly sessions of EMDR in a randomized controlled trial and (b) comparing the outcomes of standard EMDR to that of EMDR plus ego state therapy in a randomized clinical trial. Research could also evaluate the mechanisms involved in rapid change.

The client felt that she accomplished much more during 3 weeks of intensive work than she had in the year of weekly therapy with this same practitioner when she was a mistrustful teen and more than she had done in her often-interrupted therapy with an EMDR-trained therapist while at the university. Therefore, qualitative studies exploring clients' subjective experience of intensive EMDR versus weekly sessions would also be beneficial.

Limitations

A major limitation of this study is the case study design, which allows for limited generalizability because it only focuses on one individual. Another limitation of this study is that the primary researcher also functioned as the practitioner. Although this could be a threat to validity, the researcher used peer conferencing, following of EMDR fidelity protocols and objective psychometric measures to assure ethical procedures and to decrease this threat to validity. A complicating factor in this study was the inability to conduct an extensive follow-up with the participant because of her summer internship in the Midwest, transfer to a university across the country, and then her study abroad.

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