Recommendations and Illustrations for Combining Hypnosis and EMDR in the Treatment of Psychological Trauma

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Three experienced therapists, trained in hypnosis and EMDR, distilled some tentative hypotheses about the use of hypnosis in EMDR from fifteen cases, two presented here. When a therapist uses hypnosis with EMDR, it seems that the client is having difficulty or the therapist anticipates that the client will have difficulty managing the experiences processed with EMDR. Hypnosis initiated either during the introduction to EMDR or within a therapy session prior to the initiation of EMDR seems to have served two functions. The first function is to activate inner work that prepares the client to use EMDR successfully, and the second function is to facilitate overtly the processing of the traumatic experience. Clients might have two kinds of difficulties in managing affect or distress: (1) they may have a long-standing, irrational and strongly held belief that interferes with managing affect or distress, and (2) they may never have developed the capacity to tolerate intense affect, distress or pain. Should a therapist use hypnosis during the closing down phase of a session without preparing the client with hypnosis during the introduction to EMDR, the therapist should seriously reconsider the pace and focus of EMDR and the client’s resources to manage affect and distress.

The authors have used hypnosis and EMDR separately in the treatment of psychological trauma. They have used hypnosis to access traumatic material, to moderate the intensity of the working through, to pace the psychological work to accord with environmental and personal resources, to distance the traumatic material when needed, to provide alternative coping mechanisms and, when needed, to provide amnestic barriers to reduce distress. They have used EMDR to treat psychological trauma so that clients were no longer symptomatic. For a single trauma, EMDR has been quick (three sessions or less) and usually involves the experience and resolution of intense distress. The process seems to occur naturally, using the individual’s psychological resources without direct suggestions or guidance from the therapist. Of particular note are the distinct differences in effect the authors have discovered.

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between EMDR and hypnosis, a difference that emphasizes the unique outcomes of the two approaches, and has, on occasion, led the authors to combine these two treatment techniques. These distinctions will be discussed in a later section.

Shapiro (1995) has cautioned therapists to evaluate carefully combining these two therapeutic techniques. This paper provides some initial recommendations for this evaluation. What are the circumstances one might use hypnosis while doing EMDR? Does one use hypnosis before, during or after a completed EMDR session or series of sessions? This also raises the question of when to use EMDR during hypnosis, a question the current authors will not answer.

Recommendations for Combining Hypnosis and EMDR

The authors have a sample of approximately fifteen cases from which they have distilled commonalities and drawn tentative hypotheses that illustrate what might be at issue in combining hypnosis and EMDR. Hypnosis can be used effectively to address defensive processes in the client and to have the client work on issues blocking the effective use of EMDR, as well as shifting rigid beliefs and thought patterns. As a generalization from all cases, then, hypnosis, initiated either during the preparation for EMDR or in session pre-EMDR, seems to activate inner work that prepares the client to use EMDR successfully, and to facilitate overtly the processing of the traumatic experience. Although EMDR can reduce distressing affect, character traits (such as poor impulse control) remain unchanged. A prerequisite for a client to use EMDR successfully is the ability to tolerate distressing emotions and not diffuse them via acting out. Hypnosis can help a client cope with distressing affect.

Considering the context of the fifteen cases, when the authors have combined hypnosis into EMDR, almost all of the case contexts involved managing affect or distress. As a result, when a therapist uses hypnosis in EMDR, it seems to indicate that, in the therapist’s judgment, the client is or will have difficulty managing the experiences processed with EMDR. (Clearly, this is a narrow and delimited use of hypnosis; the conclusion is drawn in the context of using EMDR. Hypnosis can be used for many other reasons.)

The authors also recommend that before a therapist begins to engage in hypnosis with an EMDR client, the therapist seriously consider the coping abilities of the client and the appropriateness of EMDR. The intention to use hypnosis can function as a cue indicating a therapist’s possibly implicit concerns surrounding the client’s ability to cope. This should lead the therapist to consider the pacing and focus of EMDR and the client’s resources to manage affect. EMDR that uses shorter and fewer sets of eye movements or other bilateral stimulation might allow the development of affect tolerance and continued processing of traumatic material without emotional overload or acting out. In this regard, both EMDR and hypnosis can function as clinically useful tools to provide further assessment and understanding of the client. Alternatively, resource installation (Leeds, 1998) and hypnotic ego strengthening (Hammond, 1990) could be done until the client can manage the EMDR-elicted material.

One can differentiate two kinds of overall difficulties that clients might have in managing affect or distress. Although both might be labeled defensive, the origins are conceptualized differently and lead to different interventions. The first overall difficulty is a long-standing, irrational and strongly held belief that interferes with managing affect or distress. This might pertain to a belief in one’s inherent incompetence or to one’s inability to tolerate certain emotions. The operation of this belief could be labeled defensive or resistive. On occasion, usually with an individual who is characterological, EMDR processing will get
struck in a negative belief or experience and “cycles” over and over without leading to change. The belief or defensive pattern is amenable to hypnotic intervention prior to and then during EMDR so as to facilitate a change in that belief. The second overall difficulty is never having developed the capacity to tolerate intense affect, distress or pain. The second seems to contraindicate the use of EMDR or to modify significantly the pace and focus of EMDR.

The paper continues with a brief overview of EMDR, follows with a discussion pertaining to the efficacy of EMDR and then with a discussion of similarities and differences between hypnosis and EMDR, continues with two case examples and ends with a discussion of how the recommendations are apparent in the case examples. The authors selected these two cases from the sample of 15 to illustrate these points. Both cases focused on resolving traumatic issues using EMDR. As advised by Shapiro (1995), the use of EMDR in these two cases was integrated into regular therapy.

**Brief Overview of EMDR**

In brief, the experience of being an EMDR patient involves the following. (See Shapiro (1995) for a comprehensive presentation of EMDR.) Three facets of the traumatic incident (the target) are elicited: a visual image of the worst moment, a negative identity-related cognition, and emotional responses along with their bodily location. The patient is asked to bring to mind the three facets just described. This activates the trauma psychoneurophysiologically (to coin a new term). The patient is then told to “let happen whatever happens” and to attend to a bilateral, external stimulus, such as finger movements (visual), alternating finger taps (kinesthetic) or alternating tones (auditory). While the bilateral stimulation occurs, the patient no longer holds the three facets of the trauma in mind but attends to whatever comes into awareness. The experience of the patient “splits” in order to track the external stimulus while attending to inner experience. Awareness, therefore, is focused externally, on the therapist’s fingers (in the visual mode) as well as on what is happening internally.

After a set of bilateral stimulations (usually a minimum of 26 right-left pairs), the therapist asks for feedback about the patient’s experience, in particular being attentive to whether there has been any change from the beginning to the end of the set. If there is change, the patient is asked to note the last experience, and track the next set of bilateral stimulations, letting happen whatever happens while noticing whatever comes to attention. This procedure continues until the subjective distress evoked by the target is zero or minimal.

Following a patient’s report of minimal distress, a positive, identity-related cognition (developed before the EMDR intervention) is paired with the target while the patient attends to a shorter and slower set of bilateral stimulations. Treatment of this particular trauma is considered finished when the patient reports that the positive cognition is totally true and there are no body sensations in response to the target. In the authors’ clinical experience, when patients get to this point in treatment the trauma has been totally resolved. We have never seen remission after a patient reports no distress in response to the target and believes totally the truth of the positive cognition.

**Hypotheses for the Efficacy of EMDR**

Various hypotheses have been proposed to account for the efficacy of EMDR. Shapiro (1989) has suggested that EMDR may reverse pathological neural changes. The idea that neural changes maintain a traumatic incident in its original state was first introduced by Pavlov (1927) as an explanation for traumatic sequelae. Shapiro (1989) has also proposed
that the eye movements in EMDR may be linked to REM sleep and information processing in REM states. Greenwald (1995) suggested that the mechanism of action in EMDR is related to conscious dreams. Analogously, Shapiro (1989) hypothesized that EMDR activated REM-related neurological activity, which was hypothetically linked to resolving trauma in dreams by Greenwald (1995). While plausible, these explanations fall short in describing how EMDR functions using alternating kinesthetic sensations or auditory tones.

Macculloch and Feldman (1996) have offered a theoretical explanation of EMDR based on a combination of Pavlovian and Darwinian theory. The authors suggest that EMDR prompts an investigatory reflex, which causes the individual to reassess traumatic memories. This reassessment allows for the individual to perceive no current danger and also allows for a subsequent lowering of arousal as well as a decrease in avoidance behavior. This theory, while having face validity, does not account for processes noted during EMDR such as increases in arousal, increases in number of emotional mood states, and the frequent appearance of visual images of prior trauma.

Dyck (1993) has proposed that EMDR is a distraction/extinction procedure that breaks the links between conditioned and unconditioned stimuli by interrupting the link between the traumatic event and anxiety. This formulation explains EMDR as no different from other exposure methods that might employ distraction procedures. Such similarity needs to be established empirically.

Shapiro (1995) also explains how EMDR works with an accelerated information processing model. In this general model, EMDR activates and facilitates an accelerated processing of information, for example, linking isolated, possibly fragmentary memories with other, more adaptive information. During EMDR treatment, it is assumed that electrical pulses and organic systems, such as the limbic and cortical systems, are biochemically balanced. There are several levels or domains of explanation in this model: information, information processing, electrical pulses, biochemical states, and biochemical balance. The links between components and how they relate to PTSD and its resolution are complex and unspecified.

A simpler and more explicit model of EMDR’s efficacy is proposed by Armstrong and Vaughan (1996). In this model, an orienting response, generated by EMDR’s hand-tracking component, breaks the link between conditioned and unconditioned stimulus and leads to treatment effects. A problem with this model is that the orienting response ends once the new stimulus is perceived. It is difficult to discern how a slight stimulation, such as hand taps, would maintain an orienting response after their initiation. As well, given the sustained tracking of the fingers with the eyes, the response of the patient is more properly described as sustained, outer directed attention, and not orienting. This model also has difficulty accounting for changes in vividness of imagery and emotional intensity during EMDR treatment.

Although hypnosis has been considered an explanation for the efficacy of EMDR, the various theories that have been proposed do not focus on hypnotic-like responses. It would seem, therefore, that EMDR and hypnosis are different kinds of interventions—an observation that brings up the question of how hypnosis might be incorporated into EMDR. Shapiro (1995) has cautioned therapists to evaluate carefully combining these two approaches to therapy. “The efficacy of combining methods, such as EMDR and hypnosis, should be carefully assessed, rather than assumed, by the clinician” (p. 306).

Similarities and Differences between Hypnosis and EMDR

EMDR, Shapiro has cautioned, can release intense, unresolved trauma-linked experiences such as emotions, bodily sensations, nightmares, intrusive images or memories or various
symptomatic disruptions such as panic attacks or obsessive-compulsive symptoms. From a therapeutic point of view, these symptoms represent the fragmentary reexperience of an emerging trauma in the context of treatment. These reactions are not necessarily detrimental so long as the client continues to function adequately and stops avoiding the associated trauma in order to resolve it. The cases reported here support this view and indicate that EMDR requires some basic capacity for managing affect and distress by the client. This is consistent with the cautions set forth by Shapiro (1995). Hypnosis, amongst other methods, can help the client develop the capacity to cope. Selecting from many hypnotic interventions (see Hammond, 1990), the therapist can dilute the intensity of distressing affect, generate alternative and more functional behaviors, increase the effectiveness of defenses, and mobilize spontaneous problem solving and conflict resolution. EMDR can also be used to install “resources” and to strengthen the ego by activating relevant states (for example, past instances of coping or imaginary protectors) followed by a few, slow eye movements (see Leeds, 1998). A regular facet of EMDR is the teaching and practice of relaxation prior to EMDR and the establishment of a safe place that can reduce distress post-EMDR (Shapiro, 1995). Published material on EMDR (see Shapiro, 1995) emphasizes that during the eye movements the client should maintain an alert, present-time/current-situation awareness while concurrently tracking inner experience. The balance of this split attention between the inside and the outside shifts as the intensity of inner experience changes. In addition, there might well be individual differences in the capacity to split attention this way.

One hypothesized mechanism for the efficacy of EMDR is that EMDR is actually hypnosis, an explanation dismissed by many trained in EMDR, including the current authors. Supporting this position, Shapiro emphasizes that EMDR is not hypnosis (Shapiro & Forrest, 1997), pointing out that there are demonstrable differences between the two in EEG recordings, suggestibility and memory processing. The only study addressing the differences between EMDR and hypnosis is by Nicosia (1994). Even though the current authors take the position that EMDR and hypnosis are distinct, a single study (Nicosia, 1994) with a small number of subjects does not provide strong evidence supporting this difference. The authors are not aware of EEG studies designed to draw conclusions that differentiate hypnosis from EMDR. Future research will be needed to establish this distinction.

Considering hypnosis-like elements of the EMDR protocol, the instructions that frame EMDR might serve as suggestions. In this context, clients are asked to assume the inner perspective of the observing or receptive ego (Fromm, 1979; Fromm, 1992), observing whatever comes into awareness in a non-attached way, like watching scenery go by from a train or like watching TV or a movie (Shapiro, 1995). Clients are also told that anything that comes up is simply to be noticed and that there are no “shoulds.” Furthermore, clients are told that their feedback primarily is to make the distinction between change and no-change in their experience. Finally, creating a positive identity-related cognition preintervention, generates a subjectively defined goal and the expectation that it will be achieved. If no change occurs over several sets of eye movements, the direction of those movements is changed. One might argue that the pre-EMDR instructions serve to establish expectations, attitudes and set that can lead to hypnotic responding on the part of the client. The authors are aware of no research on this hypothesis.

Despite the observations made in the previous paragraph, once EMDR has begun the therapist refrains from making suggestions or interpretations, simply taking what the client most recently experienced as the focus for the next set of eye movements. In more complex cases, additional interventions are added. However, if EMDR is hypnosis or has hypnotic components, then that should be present during the least complex EMDR intervention. As a
result, it would seem that if hypnosis is an aspect of EMDR, it is during the preparation phase, when the attitude and expectations of the client are established. On the other hand, it must be pointed out that EMDR does not involve attempting to induce trance. In addition, the authors have clinical experience of EMDR being effective even when the patient actively doubts that the intervention will work. A way to test whether EMDR activates a hypnotic state would be to measure hypnotizability. If EMDR is hypnosis, then the highly hypnotizables should change while the non-hypnotizables should not.

The authors have found that adding hypnosis into EMDR is useful in particular kinds of clinical situations. In this regard, the authors have found in practice that EMDR alone is not adequate and that adding hypnosis to the interventions helps the client. In addition, the authors have observed that how clients experience and process abreactions seem different: in hypnosis a trauma can be re-lived and resolution derives from processing independent of that re-living; in EMDR, though possibly re-experienced, the trauma seems to be processed sensorially, emotionally and cognitively so it ceases to be bothersome. These distinctions in practice suggest that hypnosis and EMDR are different kinds of interventions.

**Case Examples**

**Case 1**
The client was a 34-year-old woman diagnosed with Posttraumatic Stress Disorder (PTSD). Her disorder developed following a car accident that resulted in two fatalities. The client was ruled to be at fault for the accident. Initial symptoms included hypervigilance, nightmares, flashbacks, sleep and appetite disturbance, intrusive thoughts about the accident, fatigue and lethargy, panic and anxiety, tearfulness and general depression.

The client was raised in an intact home and has two older sisters. She described her mother as quiet and submissive and her father as somewhat stern, controlling, and perfectionistic. She related that the other members of her family always described her as the clumsy one and she stated that she views herself as someone who works hard and means well but who “screws things up a lot.”

The client attended college, obtaining her bachelor of science degree a number of years before the accident. She had been employed by the same organization since that time. The client saw a psychologist for approximately three months immediately following the accident. She stopped going because her employer was paying for treatment and she was only allotted twelve sessions. PTSD symptoms continued. The client again sought treatment about four years later after meeting with the families of the victims. The families told the client they could never forgive her for the deaths. Symptoms of PTSD were exacerbated to such an extent following this meeting that they interfered with her work performance and her employer sent her to another psychologist. She, again, was in treatment for three months. Two more years passed before the client sought treatment yet again because the traumatic symptoms were once again interfering with her work performance. As before, she met with the therapist for approximately three months.

The client entered the current treatment because the symptoms had again become sufficiently overwhelming as to interfere significantly with her ability to do her work. Symptoms evident at work included frequent panic attacks, crying episodes, chronic shaking, poor work attendance, somatic complaints, fatigue, and inattentiveness. By this time, she had been symptomatic for approximately eight years. The client presented as physically and emotionally exhausted. She was visibly tense and anxious during the intake session and cried or was tearful throughout most of the initial interview. The client did not believe treatment would work for her; therapy had been disenfranchised because of past therapy
failures. She was very discouraged about the prospect of ever feeling normal, healthy, or happy.

The client stated that she viewed herself as a clumsy person and blamed the accident and death of two people on her clumsiness, a trait she saw as an inherent and irreparable flaw. This belief led the client to view herself as potentially dangerous. She believed she might inadvertently hurt or kill someone again. This belief made her fearful, indecisive and emotionally and behaviorally paralyzed. She could not risk getting better because that would lead her back into the world, where she might do more damage. Yet she could not continue living with the symptoms, which made her current existence almost intolerable.

An overwhelming sense of guilt strengthened the client’s resistance to therapeutic intervention. The client believed she deserved to continuously relive the accident and to feel worthless, afraid, and miserable all the time. Any time she would begin to feel better she would again be overcome with guilt over surviving when others died and for smiling, laughing, or feeling good after having taken two people’s lives. In essence, the client felt guilty for being alive. The PTSD symptoms left her basically unable to experience life as she had known it prior to the accident. The worse she felt and the more incapacitated she became, the less guilt she experienced. The better she felt, the more guilt she experienced. The symptoms served the dual purpose of keeping the world safe from her “clumsiness” and of keeping at bay a crippling sense of guilt.

A combination of relaxation techniques was used to address the multiple, complex factors involved in this client’s chronic anxiety. Progressive relaxation (alternately tightening and relaxing specific muscles) was used to address chronic muscle tension and shaking. Training in diaphragmatic breathing was used to lower heart rate and blood pressure, and to deepen relaxation. Guided imagery was used to deepen relaxation further, and to provide the client with a coping device to block intrusive thoughts and images of the accident.

The progressive relaxation involves consciously tightening followed by passively letting go, waiting and remaining aware of sensory changes. It can be considered a nonverbal, hypnotic metaphor for resisting change and maintaining psychopathology with the tightening followed by allowing change to take place automatically, effortlessly and unconsciously with letting go, waiting and remaining aware. The positive and relaxed state subsequent to progressive relaxation can be considered, in addition to reinforcing the process, evidence to the client of the potential, positive outcome of the “metaphorical” intervention.

Diaphragmatic breathing functions in a similar fashion. Despite the client’s active efforts to breathe deeply, the change in blood pressure and heart rate occur automatically, subsequent to conscious efforts and independent of the conscious will. Likewise, the positive results reinforce the “metaphorical” message about the change process. An additional, profound metaphorical message implicit in both relaxation techniques is that the potential for positive change is present in the client’s mind and body and the client needs only to allow “healing” to occur.

Guided imagery, described in more detail below, functions metaphorically to establish greater internal safety and control. The client feels vulnerable and out of control in relation to thoughts and images about the accident, a present-time experience that captures her state at the time of the accident itself. The guided imagery allows her to cope and diminish her distress. In addition, by involving herself in fantasy, she lets go of the Generalized Reality Orientation (GRO; Shor, 1959). Furthermore, her fantasizing facilitates the process of helping her get absorbed in her experience. These three techniques introduced hypnosis.
Hypnosis was chosen as an adjunct to the EMDR due to the chronicity of the symptomatology and the entrenched belief system of the client. Prior to beginning EMDR, the client was taught to visualize a safe place. She chose a wooded area, which she described as having trees, grass, a babbling brook, a wooden bridge, a path, and a clearing. It was important to get as many details as possible in terms of temperature, time of day, sights, sounds, smells, and tactile sensations so that the therapist would be better able to guide the client toward complete immersion in the fantasy. This detailing and the consequent vivification of the safe place for the client served to deepen her hypnotic state. In anticipation of the possible later need to help the client shut off distressing material as a result of EMDR, the “safe place” provided a posthypnotic cue to evoke the inner experience of safety.

The first three sessions were used to talk about the accident and to explore the client’s belief system in relation to the accident. The relaxation training and guided imagery just described were also provided during each of these sessions with instructions for the client to practice relaxation at home and to practice briefer exercises at work between therapy sessions. Hypnotic suggestions were put in place during these relaxation sessions as well. The key hypnotic suggestions, experientially linked to the preparatory relaxation, involved letting go of the past, living in the present, and looking toward the future. These suggestions were stated during periods of deep relaxation when the client was immersed in her wooded fantasy.

Two symbols, the bridge and the path, established hypnotic procedures designed to facilitate previously blocked growth. Crossing the bridge, she was told as a posthypnotic suggestion, would allow her to let go of the past, put it to rest, and begin to live in the present. To allow these suggestions to work would require her to resolve her self-blame, guilt and belief in her dangerousness. Then, prior to EMDR, the client was asked to visualize a path that would lead to the bridge. Once she could do this, she was asked to visualize any obstacles that might be in the way of her reaching the bridge. She visualized a large boulder that blocked the path and, as expected the boulder made it impossible for her to reach the bridge.

EMDR was introduced in the fourth and continued through the sixth session. The client selected a target picture and a related a negative cognition which was “I’m incompetent.” The positive cognition was “I am competent.” The picture dissipated in seconds following the onset of the eye movements and the level of distress went from a 10 to a 0. The client, however, reported no further shifts in imagery and no shifts in thoughts or feelings during the eye movement set. Instead she stated that she felt immediately distracted by having to follow the moving pen with her eyes and that she believed the distraction eliminated (at least temporarily) her subjective distress.

A second target picture was chosen. The negative cognition was “It is my fault.” The positive cognition was “It was an accident.” The client experienced the same effect as with the first target picture. A third and fourth target picture were processed with similar results. This was completed over the course of three sessions.

Following these EMDR sessions, the client could not bring the images back into her mind and did not become distressed when she thought about them. However, the client continued to have nightmares and to experience continued distress in relation to the accident. Her Impact of Events Score (IES; Weiss & Marmar, 1995) was 63 prior to the first EMDR session and was reduced to 31 by the end of the third EMDR session. This means that PTSD symptoms went from severe to moderate.

Sessions seven through ten involved hypnosis which was used to assist the client in accessing untapped resources to overcome the persistent obstacles impeding her ability to process the trauma. A deep state of relaxation was achieved and the client was asked once again to
visualize the safe place. She was taken back to the path and the boulder. She was asked to find what was needed to clear the boulder from the path, and was instructed not actually to clear the path, but simply to find what was needed. She was then instructed to take her favorite color (blue in this case) and shine it in the form of a bright, potent light into the center of the boulder and to infuse the boulder with this light very gradually. She was told that, once the boulder was completely infused with the blue light, it would dissolve. She was sent home to work on this.

During the next session the client was again relaxed and taken into the guided visualization. She reported that the boulder was gone, but that she could not cross the bridge. That the boulder was gone indicated she had begun the process of resolving her resistance. EMDR was used to help her visualize herself crossing the bridge. This was a direct suggestion during the eye movements, an intervention that is not part of the EMDR protocol. The therapist also used cognitive interweaves such as “It’s time to let go of the past” and “It’s time to live again, to live life, to feel alive.” Other verbal suggestions included restating positive cognitions developed during earlier sessions such as “I’m confident and competent,” “It was an accident and I choose to live,” “It’s time to let it be in the past and to embrace my life.” (The authors note that the cognitive interweaves are quite similar to direct suggestions.) The client was able to cross the bridge, but could not step from the bridge to the path that symbolized her own life, present and future.

The next session focused more on guided imagery, deepened the hypnotic state by including sensations (sights, sounds, smells, tactile senses such as the warmth of the sun, or a cool breeze) and incorporated observations about the path ahead without asking the client to walk it. The therapist’s descriptions of life along the path functioned as suggestions about future therapeutic change and addressed the client’s concerns about positive growth. Examples include birds chirping, leaves whispering softly in the wind, with chipmunks and squirrels scurrying. The therapist described life along the path as infused with quiet, peaceful life and reinforced safety with words like “serene” and “calm.” Other phrases suggested increased energy and motivation — “quiet energy,” “gentle exploration,” and “quiet curiosity.” Since the client did not traverse the path but vividly created it in experience, the fantasy served the transitional function of affording her the opportunity to anticipate a world that was safe, interesting and calm as well as to work through her resistance to experiencing it that way. In a paradoxical way, though she never walked the path, as soon as she could vividly imagine and experience the path as the therapist described it (peaceful, serene, safe, interesting), traversing it became a fait accompli.

During the last EMDR session the client was instructed to begin with the first image that came to her mind in relation to the accident and to let the accident and its aftermath unfold before her like a movie. She was to envision it from start to finish. The client was able to do this during one lengthy series of eye movements. She was then able to leave the bridge behind and begin walking slowly along the path that symbolized her present and future, exploring the wildlife along the way.

The client reported feeling relaxed and confident during the final session, one week after the last EMDR session. Her IES was reduced to a two, meaning she was sub-clinical for PTSD. She reported feeling more energetic, hopeful about the future, and happier than she had felt at any time since the accident. At one month follow-up, the client continued to report positive treatment effects. Her IES score was now a one. She did not think about the accident often, though she still felt sad, but not debilitated. Intrusive thoughts had decreased to approximately one every two to three weeks and her subjective level of distress was never higher than one. She reported no sleep disturbances, nightmares, or flashbacks of the event.
Case 2
A 16-year-old high school junior was being difficult at home and not functioning well at school both academically and socially. She came to therapy mostly on her own initiative. According to her mother, she had at age 6 witnessed her father sexually abuse a neighborhood child. Her parents divorced when she was 8. She decompensated immediately following the abuse incident and, diagnosed with PTSD, obtained play therapy and support in the school system from a social worker. She had been amnestic for this precipitating event until 11, when she withdrew massively from everyone, leading to a month-long hospitalization for depression. Subsequently she obtained therapy for about a year. The girl described the therapy as helpful, assisting her to accept herself and her emotional reactions. However, the end of therapy had been compromised because the therapist divulged to her mother confidential therapy information. Since age twelve she had not been disruptive or withdrawn, though she was interpersonally difficult and somewhat rebellious.

On beginning therapy this time, she stated that resolving the age 6 trauma, an event for which she still only had fragmentary memory, seemed to be the critical task. In addition, there were present day difficulties which she found distressing: she was socially phobic and felt like a misfit; she was beset by unspecified and “unrealistic” fears; suffered from low esteem; and engaged in “bizarre” and out-of-control thinking. Attempts by the current therapist to obtain clarifying details proved futile since, instead of clarifying, she quickly drifted off-topic and elaborated extensively on a different matter of her concern. She provided the therapist hints that many things were distressing her and did not communicate them directly. Her Dissociative Experiences Scale (Bernstein & Putnam, 1986) score was 35.6, and DES-T was 33.1, placing her in the Dissociative Disorders Not Otherwise Specified (DDNOS) range and possibly, Dissociative Identity Disorder (DID) if further information surfaced. After the first year of contact, DID had not become apparent, and by the end of the subsequent year, an Atypical Dissociative Disorder had become apparent without the overt operation of alters but with some activity of dissociated “states.” Her Beck Depression Inventory was 23, indicating moderate depression. The Penn Inventory (Hammarberg, 1992), a measure of PTSD, was 28 and did not reach the cut-off of 35. The therapist has extensive experience working with DID.

During several months of relationship establishment, she initially vented and then began to take risks letting the therapist know what she felt and thought; her behavior at home and school improved dramatically. Given her anxiety about many situations, the therapist attempted to teach her various relaxation techniques. She was not able to relax either by focusing on her body or by engaging in mental or fantasy activity. She would attempt to focus her attention for five or ten seconds and then overtly shift her posture while stating “This won’t work. I can’t do it.” Even when the therapist became somewhat forceful to establish external controls, she was unable to engage in even the preliminary actions involved in learning to relax. This suggested that she needed to engage in continual avoidance of intrusions associated with memories, impulses or emotions, not a positive prognostic sign in terms of her ability to manage her affect. On the other hand, the therapist discovered that Ericksonian-like hypnotic interventions (Erickson, Rossi & Rossi, 1976) worked. The following example demonstrates this. The therapist noted that she was not aware of how she became upset or tense. “Isn’t that right?” he asked; she nodded “Yes.” “So,” he continued, “you don’t need to be aware of how that tension leaves. Right?” After a pause, she nodded “Yes” in a slow, distracted, trance-like way. “And, will you let me know when your tension has left?” Again she nodded “Yes” and, a short while later, she was visibly more relaxed and calmer.
Four months later, the therapist engaged her in some pre-EMDR hypnotic work, obtaining hypnotic agreements to reduce tension and distress, and establishing that she could close down EMDR sessions and go to a safe place. EMDR seemed appropriate since her everyday functioning had improved, her affect tolerance increased and a series of concerns, all linked thematically to the initial abuse episode, had been the focus of four therapy sessions. The concerns had to do with “dirty old men” who were “disgusting” since they were interested in her sexually, and her repeated sense of being evil. In addition, during every one of these sessions, her mother was the target of anger, mostly because she did not listen. There were three EMDR sessions.

The initial EMDR session focused on her strong negative feelings about having her physical space invaded by her mother’s boyfriend. The “invasion” appeared benign in that he was trying to be friendly and she kept moving away so as not to be in the same room with him. As the sense of this “invasion” was explored prior to EMDR, she began to feel younger and frightened. Her negative cognition was “I’m stupid” and her positive cognition was “I’m ordinary.” (Although apparently unconnected, the negative cognition related to her sense of being a stupid fool who never fits in, whether in her family or her peer group. To be ordinary, by contrast, makes her like everyone else and, thus, she can fit in.) Current Subjective Unit of Distress (SUD; see Shapiro, 1995) rating was 7.5 on a 0 to 10 scale, highly distressing, and the Validity of Cognition (VoC; see Shapiro, 1995) for the positive cognition was 1 on a scale of 1 to 7, almost totally untrue of her. Attempts to clarify the positive cognition with a higher VoC were not successful. Shapiro (1995) indicates that such a low VoC implies that the positive cognition is not attainable. In the therapist’s clinical experience, inconsistent with the standard EMDR protocol, in some circumstances the positive cognition and/or a low VoC occasionally change so as to be attainable after a series of eye movements or sessions.

Within a few eye movement sets, her imagery had shifted to the trauma at age 6. The therapist continued with EMDR cautiously, being attentive to her level of distress and the quality of her verbalizations. Overtly, she experienced some distress and said that she had no difficulty with what was emerging. Although there was movement into the material, EMDR did not lead to a resolution. Her process seemed to move slowly. At the end of session, the client was able was able to close down readily, and, as a precaution initiated by the therapist, used a hypnotic “key” to lock the material in a “safe.”

At the start of the second session, the client reported acting out at home and at school. Connecting this to the emerging material stimulated by EMDR, the therapist inquired about any usual emotion experienced during the week. None was reported, but a dream of being threatened was reported. The therapist “heard that” as a continuation of the prior week’s processing and focused the EMDR on the dream since it was experienced as unusual and since the theme of threat reflected the prior week’s material. As suggested in the EMDR protocol, the most distressing dream image was targeted without engaging in the development of new positive and negative cognitions. EMDR effectively moved the material along the same associative channel started in the first session. The imagery continued elaborating various facets of the witnessed molestation. Once again, the client was somewhat distressed, but, as a precaution, the material was again “locked up” in a safe and the key was given to the therapist.

At the start of third session, the client reported increased acting out at school and at home, for example, consciously lying to her mother about not going to school and breaking other home “rules.” This concerned the therapist and he confronted the client about the behavior, asking for an overt agreement to stop the behavior. She readily agreed. Current life themes
consisted of feeling increasingly angry and breaking rules, as just described. The therapist
assumed that the acting out was a behavioral expression of the unresolved trauma; he also
hypothesized that dealing with the trauma directly should reduce the acting out. As a result,
he decided to continue with EMDR, which continued similarly to the prior two sessions.
Once the material was unlocked hypnotically, the imagery focused even more directly than
in previous sessions on the early trauma. Resolution (complete recall, no distress, and new
cognitions) was still not achieved, but the session was shut down readily with no apparent
distress persisting for the client. The client was reminded of and she reiterated her agreement
to go to school.

At the start of the fourth session, the client reported even more acting out, not only continuing
to skip school but masquerading as her mother. The therapist informed the client that they
would stop EMDR since it seemed to be creating more life difficulties rather than less. In
particular, the client had agreed to contain the acting out behavior and had not done so. The
character of her acting out (“being bad” and “breaking rules”) connected thematically to
the EMDR work. One might conjecture that, although the acting out helped her manage the
painful emotions generated by the EMDR, it also indicated difficulties with self-control.

Since, in the therapist’s experience, EMDR reduces negative affects such as anxiety, fear
and distress, he had anticipated that ongoing EMDR in the context of little overt distress
should nonetheless have begun to reduce the client’s hidden emotional turmoil. Over three
sessions there should have been marked change. In this situation, however, that had not
happened. In fact, using her acting out as a criterion, her distress was being expressed in
action rather than as experienced emotion. As a result, a change in approach was necessary
and required using hypnosis to shore up her self-control and therapy needed to shift toward
containment.

The client did not seem to be suffering, although she had withdrawn from family and friends
while continuing to function well at her part time job as a clerk at a local store. Hypnosis
was again used to keep the material amnestic and thereby eliminate intrusions. Her reports
indicated that the material was not intruding, even as dreams or nightmares. The therapist
again overtly confronted her acting out, making the observation that the acting out was a
way of avoiding what was at issue, and might have self-destructive outcomes, like being
expelled from high school.

Since the client responded well to conversational inductions, interventions were made to
help distance her from the witnessed molestation. As an example, the therapist said, “You
know that what happened in the past is in the past, don’t you?” After an affirmative nod, the
therapist added, “Then the past is past and you can pay attention to the present. Right?” To
this, after a pause, she nodded affirmatively. Another focus of the new intervention was
interpersonal. Allowing her to ventilate had yielded positive outcomes a few months earlier;
the therapist returned to that general approach. Soon her relationship with her mother
improved. Though very attractive, she had not had a single date and had no male friends.
Within a month, she had her first date.

Her actions led her to fail several classes, which made it impossible for her to graduate. She
dropped out of school, got a different part time job and committed herself to working through
her difficulties. EMDR was slowly reintroduced, beginning with short interventions, which
gradually increased in length. Hypnosis was no longer used. The material shifted from
witnessing sexual abuse to being sexually abused by her father. She struggled with being
“evil” and “bad,” like him, and by contrast being religious. Her resentment and rage primarily
at her father but also her mother was expressed with increasing frequency. She began to
function more effectively overall, relating to friends, co-workers and family more easily
and being in less conflict with them. She re-enrolled in high school and graduated a year late.

Some observations about the uses of hypnosis, possible ego states, the acting out, and her dropping out of school are warranted. The therapist has extensive experience working with DID and was concerned about her getting overwhelmed by the emerging material. The rationale for this concern had to do with her difficulty using relaxation techniques and shifting away from emotionally laden topics in the context of being amnestic and using other dissociative defenses. Attempts before the initial EMDR to discover and thus work with different ego states (possibly alters) were unsuccessful. This contributed to the therapist’s decision to use hypnosis as an aide in managing affect associated with and awareness of anticipated traumatic material.

The therapist was surprised she only experienced some distress and, initially assumed she had worked more through in previous therapies and/or that the hypnosis had attenuated the intensity of the material. Her acting out initially seemed a behavioral expression of the material, which, the therapist assumed, would drop out with increased EMDR processing. Before doing EMDR in the third session, the therapist probed for ego states, attempting to establish some kind of communicative connection with possible ego states associated with the acting out. Since no such states emerged, the therapist assumed that the emerging material was generating the acting out. In considering what arose after she dropped out of school, she was struggling with being sexually abused in addition to witnessing the sexual abuse of others. She felt like a complete misfit at school, just as she had felt in relation to family and friends during and after her abuse as a child.

In retrospect, her increased acting out was clearly multiply determined since, in addition to the previous observations, the EMDR processing did not evoke intense affect. It seems reasonable to conclude that, although she reported some distress, her acting out indicates she was feeling increasing distress associated with her work on this trauma. Even using hypnosis did not contain her acting out. This led to a reassessment of her clinical situation and a change in approach.

Discussion of the Cases

The two case examples serve as illustrations of the recommendations for combining hypnosis and EMDR.

Hypnosis can be used effectively to address defensive processes in the client and to have the client work on issues blocking the effective use of EMDR, as well as shifting rigid beliefs and thought patterns. As seen in the first case, hypnosis and EMDR, both integrated in the context of regular therapy, worked well both simultaneously and sequentially. That is, hypnosis was used to assist the client in working through resistance prior to EMDR (clearing away the boulder); and, then EMDR was used to help her cross the bridge with the simultaneous use of previously established posthypnotic suggestions and suggestions contemporaneous with trance (typical hypnotic strategy of leading and pacing); finally, hypnosis was used to assist her in exploring her new, safe life symbolized by the therapist’s descriptions of the path. As a generalization from all cases, then, hypnosis initiated either during the preparation for EMDR or in session pre-EMDR, seems to activate inner work that prepares the client to use EMDR successfully, and to facilitate overtly the processing of the traumatic experience.

As seen in the second case, although EMDR can reduce distressing affect, character traits (such as poor impulse control) remain unchanged. A prerequisite for a client to use EMDR
successfully is the ability to tolerate distressing emotions and not diffuse them via acting out. Though hypnosis can be used to reduce or suppress distress (as illustrated in the second case), the emerging traumatic material clearly had overt behavioral effects. Moreover, the client was not able to fulfill her agreement with the therapist, for example, agreeing to go to school on several occasions and then not doing so. The therapist had not previously been aware of this difficulty. In marked contrast, at an earlier point in therapy and in another context, she stated that she was motivated to please, a motivation that should have led her to meet her commitment.

In the second case, as in the first, the therapist used hypnosis to assist the client in coping with distressing affect. The intervention was less effective than with the first case, possibly because the second case is complex, chronic and involves an atypical dissociative disorder. On the other hand, the client’s response to EMDR and hypnosis led to a re-evaluation of the clinical situation and a deeper understanding of her functioning. In this regard, EMDR and hypnosis became clinically useful tools that provided further assessment and understanding of the client.

As seen in the second case, subsequent EMDR that used shorter and fewer sets of eye movements allowed her to continue processing the material without acting out. This work helped her develop additional affect tolerance.

References


