Integrative Psychotherapy:
Combining Ego-State Therapy, Clinical Hypnosis, and Eye Movement Desensitization and Reprocessing (EMDR) in a Psychosocial Developmental Context

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The principles of this conceptual framework are: (1) personality organization is dissociative as well as associative, consisting of ego states, and progresses through stages of psychosocial development; (2) inappropriately activated ego states cause dysfunction, which is habitual or due to the intense affect of disrupted development or unresolved grief or trauma; (3) completely overcoming dysfunction requires therapy with both individual ego states and the personality system; (4) clinical hypnosis provides techniques to enhance accessing ego states; and (5) EMDR combines ego-state therapy with eye movements (EMs) to produce a powerful psychotherapy method. During assessment, ego states responsible for dysfunctional emotional reactions and behavior are identified together with those that could be appropriate instead. Included in the treatment protocol, EMs and clinical hypnosis promote: (1) corrective developmental experiences; (2) resolution of grief and trauma; (3) acquisition of skills and abilities; (4) co-consciousness; and (5) negotiation among ego states. The outcome is an integrated “family of self” that has effectively overcome developmental crises, grief, and trauma, is aware of essential inner resources, and can consciously activate appropriate ego states.

Introduction

This integrative psychotherapy combines psychodynamic ego-state therapy (e.g., Watkins & Watkins, 1979, 1991, 1997), clinical hypnosis (e.g., Brown & Fromm, 1986; Hammond, 1990), and eye movement desensitization and reprocessing (EMDR; e.g., Shapiro, 1989a, 1989b, 1995, 1996) in a psychosocial developmental context (e.g., Erikson, 1950, 1982). The principles of the conceptual framework are: (1) personality organization is dissociative as well as associative in the sense that ego states can be identified according to distinct emotions, behaviors, memories, and beliefs about the self (which provides a clinically useful metaphor for targeting interventions), where the degree of dissociation ranges from normal differentiation among ego states when there is minimal psychosocial developmental disruption to distinct personality states when disruption is severe because of repetitive traumas.

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or attachment failures in early childhood; (2) the predominant cause of dysfunction is the activation of situationally inappropriate ego states, which is habitual or due to the intense affect of disrupted development or unresolved grief or trauma that overwhelms the cognitive processing capacity of the nervous system and prevents access to more appropriate ego states; (3) surmounting dysfunction requires psychotherapy with both individual ego states and the personality system and must provide for habit change and corrective developmental experiences (e.g., trusting without being abused, exposing vulnerabilities without being shamed, succeeding at work, etc.), as well as resolution of grief and trauma; and (4) EMDR combines ego-state therapy with eye movements (EMs; bilateral stimulation, including tones and taps, that accelerates information processing) by activating ego states that cause dysfunction or that need to develop appropriate alternative responses and the client is simultaneously guided in EMs. Thus, this approach combines a variety of treatment techniques, based on different underlying models of psychological and behavioral functioning, that can be used in conjunction with one another.

This application of hypnosis and EMDR was developed from work with traumatized and dissociative clients, and then extended to anxiety and mood disorders, and even personality disorders, whenever emotionally distressed or developmentally disrupted ego states can be identified and worked with. Deep trance inductions are unnecessary when working with ego states, whereas light trances that increase internal awareness are helpful, especially during assessment as a basis for observing changes specific to different ego states. Expertise in treating the particular disorder a client has is a prerequisite to applying this approach, and preliminary issues of safety, stability, and support need to be addressed beforehand. Clients whose condition involves inability to control switching or to distinguish the past from present circumstances will first need help developing resources, while clients who are abusing substances or taking psychiatric drugs may be unable to access crucial ego states and will need help in coping with the issues that the chemicals suppress.

During assessment, the ego states in the personality system are identified, with particular attention to those responsible for dysfunctional emotional reactions and behavior and those that could be appropriate in the problematic situations instead. Included in the treatment protocol, EMs and clinical hypnosis promote: (1) corrective developmental experiences; (2) resolution of grief and trauma; (3) acquisition of skills and abilities in appropriate ego states to enhance their capacity to maintain their activation; (4) co-consciousness in problematic situations where a more functional ego state previously could not be accessed; and (5) negotiation among ego states in the interest of the personality system to insure needs are met in functional ways and to habitually activate appropriate ego states.

The therapeutic outcome is an integrated and functional “family of self” (cf. Watkins & Watkins, 1991) that has effectively overcome developmental crises, grief, and trauma, is aware of the essential skills and abilities of the “family members,” and is able to consciously activate ego states appropriate to life’s demands. This psychotherapy is thus termed “integrative” because: (1) its conceptualization unites widely applicable theories of personality organization (i.e., Watkins & Watkins) and psychosocial development (i.e., Erikson); (2) its purpose is to make individuals whole and complete by bringing together their parts, eliminating their impairments, and developing their capabilities; and (3) its applications combine powerful psychotherapy methods.

**Conceptual Framework**

**Ego-State Therapy**

Watkins and Watkins (1979) expanded Federn’s (1952) conceptual framework to develop ego-state therapy, in which personality organization is viewed as consisting of ego states
that vary in dissociation along a continuum ranging from normal differentiation to multiple personality disorder. H. H. Watkins (1993) recently proposed:

An ego state may be defined as an organized system of behavior and experience whose elements are bound together by some common principle. When one of these states is invested with ego energy, it becomes “the self” in the here and now. We say it is “executive,” and it experiences the other states (if it is aware of them at all) as “he,” “she,” or “it,” because they are then currently invested with object energy.

Ego states may be large and include all the various behaviors and experiences activated in one’s occupation. Or they may be small, like the behaviors and feelings elicited in school at the age of 6. They may represent current modes of behavior and experience or, as with hypnotic regression, include many memories, postures, feelings, etc. that were apparently learned at an earlier age. They may be organized in different dimensions... Behaviors to accomplish a similar goal may be uniquely different from one ego state to another, especially in true multiple personalities. (p. 233)

Watkins and Watkins (1991) defined ego-state therapy as “the use of group and family therapeutic techniques for the resolution of conflicts between the various ego states that constitute a ‘family of self’ within a single individual” (p. 29). H. H. Watkins (1993) noted “It is a kind of internal negotiation that may employ any of the directive, behavioral, abreactive, or analytical techniques of treatment, usually under hypnosis” (emphasis added, p. 236). In fact, J. G. Watkins (1993) stated “ego states become manifest only under hypnosis” (emphasis added, p. 230).

However, H. H. Watkins (1978) earlier described a method of overtly accessing ego states without formal hypnosis, a modified version of which we often employ (e.g., D. K. Wade, 1994a). Whereas she proposed resolution comes when the client experiences each ego state as both “I” (subject) and “it” (object), we find more intensive psychotherapy is necessary for many ego states because they are produced by disrupted development and trauma. Likewise, H. H. Watkins (1993) concluded, “The development of ego states seems to spring primarily from three sources, normal differentiation, introjection of significant others, and reactions to trauma” (p. 234). In contrast, we conceptualize dysfunctional ego states as resulting primarily from a fourth source: Disrupted psychosocial development (e.g., D. K. Wade, 1994b; T. C. Wade, 1994b; Wade & Wade, 1995a, 1996a, 1996b). Correlating “pathology” with psychosocial stages directs attention to corrective experiences necessary to develop the corresponding “strengths” (cf. Erikson, 1950, 1982).

**Psychosocial Development**

Watkins and Watkins (1993) proposed, “therapy can be more efficiently accomplished if the clinician first determines in which dimensions, areas, or personality segments the maladaptiveness appears to be centered” (p. 277). They extended Alexander and French’s (1946) “emotional corrective experience” to behavioral, perceptual, and cognitive dimensions of personality functioning. We add to “corrective experience” a developmental context derived from Erikson (e.g., 1950, 1982), focusing on ego states that embody disrupted development.

In Erikson’s epigenetic theory, psychosocial development is comprised of stages that begin in infancy and extend to old age. Each stage constitutes a “crisis” that must be resolved to acquire particular “strengths” or result in “pathology” that disrupts all subsequent stages. If
the failure to resolve a crisis occurs in earlier stages, the pathology is worse, but strengths developed early require elaboration in later stages or become sources of pathology if that does not occur.

Erikson’s theory alone cannot explain common observations that even very early developmental disruptions do not preclude progress through subsequent stages. With the addition of dissociation, however, one ego state can embody the disrupted psychosocial development of one stage while other ego states acquire the following strengths. Nevertheless, ego states that embody pathology impose continuing vulnerabilities on the personality system because they activate and cause dysfunction when present circumstances require developmental strengths the client lacks.

Eye Movement Desensitization and Reprocessing
To alter habitual behavior, correct disrupted development, and resolve grief and trauma, we incorporate Shapiro’s (1989a, 1989b, 1995) eye movement desensitization and reprocessing (EMDR). The standard EMDR protocol was originally applied to specific traumatic memories, for which eye movements (EMs) typically produce rapid resolution (see, also, e.g., Shapiro, 1996; Wilson, Becker, & Tinker, 1995). (In more recent applications, bilateral stimulation has been extended to include tones and taps on hands, shoulders, or knees, all of which are referred to here as EMs. During hypnosis, clients can momentarily open their eyes and be guided in eye movements, or keep their eyes closed and be subjected to auditory or kinesthetic stimulation.)

In assessment during the standard EMDR protocol, the client identifies the original traumatic event (which may require employing what Watkins termed a “hypnoanalytic” affect or somatic bridge technique, J.G. Watkins, 1971, 1990). The client next pictures that event, reports the body sensations and emotions that accompany it (rated on a Subjective Units of Disturbance scale, SUD, where 0 = “none at all” and 10 = “the most disturbed you can imagine”), and specifies the present meaning for the self (e.g., “I am powerless,” “I am unworthy,” etc.), termed a “negative cognition.” The client then specifies a desired belief (e.g., “I am strong,” “I am worthy,” etc.) (rated on a Validity of Cognition scale, VoC, where 1 = “completely false” and 7 = “completely true”), termed a “positive cognition.” As the client pictures the event, focuses on his or her reactions, and holds the negative cognition in mind, the client is guided in EMs, which is repeated until the trauma is desensitized (SUD 0) and the desired belief feels completely true (VoC 7).

We conceptualize the standard EMDR protocol as combining ego-state therapy with EMs, which involves: (1) identifying both traumatized and functional alternative ego states (i.e., the ego state that becomes disturbed when picturing the traumatic event and an ego state that has resources that can be used to cope with that disturbance, such as relaxation, self-confidence, assertiveness, etc.); (2) activating the traumatized ego state through recall of the traumatic event with its characteristic negative self-statement (i.e., asking the client to picture the event, think the negative cognition, and notice the emotions and body sensations); (3) guiding the client in EMs to desensitize the emotional disturbance of the traumatized ego state; (4) activating the functional ego state with its characteristic positive self-statements while recalling the traumatic event (i.e., asking the client to experience the qualities of the functional ego state and think the positive cognition); and (5) guiding the client in EMs to strengthen that ego state in that context (i.e., “install” the functional ego state’s resources). When EMs desensitize the traumatized ego state’s disturbance, and the functional ego state can be accessed instead with positive beliefs that feel entirely true, treatment of the trauma is complete.

However, the standard EMDR protocol cannot resolve dysfunction caused by disrupted
psychosocial development (e.g., lack of “basic trust” due to early attachment failures or deficient skills for “industry” or “intimacy,” etc.). Indeed, early childhood traumas, as well as developmental pathologies, are often unresponsive because no ego states are capable of coping with the problematic situations, appropriate ego states cannot be accessed, or multiple ego states contribute to the dysfunction (e.g., T. C. Wade, 1994a). The extreme dissociative disorder of dissociative identity disorder (DID) provides a dramatic example that applies to all degrees of dissociation when the standard protocol is ineffective because dissociated ego states that embody disrupted development and carry separate components of traumatic experiences are inadequately engaged in treatment. For EMDR to work with DID, ego states embody disrupted development and carry trauma must engage in appropriate interventions, and mature and capable alters must be supportive. We deviate from the standard EMDR protocol to access appropriate ego states, include multiple ego states, and engage ego states in treatment. Likewise, we employ EMs in many ways that are not EMDR (e.g., ego strengthening, promoting co-consciousness, etc.).

Purpose

Watkins and Watkins (1993) noted “in hypnoanalysis the well-conducted abreaction involving revivication, release of affect, interpretation, and often repetition constitutes the prototype for resolving emotional blockage” (emphasis added, p. 282). Indeed, reexperiencing trauma by itself has limited benefit (van der Kolk & Greenberg, 1987). However, combining ego-state therapy with EMDR for “corrective experience” in a developmental context constitutes a more powerful “prototype.”

When EMDR is applied to ego states distressed by specific traumas, “repetition” is typically not required as it is when using hypnosis as described by Watkins and Watkins (1993). In addition, corrective developmental experiences may be constructed according to the “family of self” (Watkins & Watkins, 1991) (e.g., a client in trance may visualize a mature ego state showing affection and verbalizing a commitment to protect an ego state that embodies a lack of basic trust), to which the application of EMs transforms pathologies into strengths by simultaneously eliminating the emotional disturbance and establishing a “template” to guide desired functioning, which includes behavior, affect, and physical sensations. EMs enhance negotiation, cooperation, and co-consciousness within the personality system (e.g., a client in trance visualizes such interactions among ego states and is guided in EMs). Repeated activation of appropriate ego states makes effective functioning relatively automatic, with the most frequently activated ego state experienced as the usual “self” and others serving specific functions as needed by the “internal family.”

Treatment Protocol Applications

During assessment, functional and dysfunctional ego states are identified. Functional refers to ego states that have behavioral skills that could attain realistic goals with affect that is appropriate to present circumstances, while dysfunctional refers to ego states that are emotionally distressed or engage in inappropriate behavior. After a dysfunctional ego state is first activated, in response to questions about how they feel as they describe a problem and what they do when the problem occurs, we insure that other ego states can “contain” the disturbance and carry on daily activities (i.e., part of the initial interview addresses whether the client is able to become physically relaxed and mentally calm, i.e., invest ego energy into, or “switch” into, an ego state that has that capability, and whether the client can “switch” into other situationally appropriate ego states during child care, work, etc.). Otherwise, “ego strengthening” is typically the first intervention, to which EMs are applied (e.g., the client is taught to relax and imagine a “special place,” then with eyes open the client is guided in
EMs). When a client’s presenting complaint can be connected to a specific traumatized ego state, and another ego state appropriate to the problematic situation can be accessed, the standard EMDR protocol can be employed.

If a client resists using EMDR to resolve trauma, or the standard protocol does not provide the rapid resolution expected, we explore the personality system’s reactions to EMDR and identify the ego states related to the presenting complaint (cf. H. H. Watkins, 1978). We determine needs for corrective psychosocial developmental experiences (cf. Erikson, 1950, 1982) by identifying the “ages” of dysfunctional ego states (i.e., how old they feel and their earliest memories) (cf. J. G. Watkins, 1971, 1990), or by inferring the nature of their developmental pathology from what they say about the “self” and “objects” (i.e., their characteristic self-statements, perceptions of other ego states and other people, and external involvements). If no functional ego state can be accessed in relation to the client’s problems, we examine other life domains (e.g., when are they motivated or when were they happy).

Once the ego states are identified, we use “family therapy” (cf. Watkins & Watkins, 1991) to describe dysfunctional dynamics and negotiate solutions. We then use EMs to resolve distress in particular ego states and increase access and utilization of appropriate ego states in problematic situations. Age progression (e.g., Phillips & Frederick, 1992) enables ego states to conceptualize the experiences necessary to correct developmental failures, which are then promoted using EMs (T. C. Wade, 1995a). We access “inner strength” (Frederick & McNeal, 1993; McNeal & Frederick, 1991) to empower deficient ego states, and then apply EMs as they visualize their new capabilities (D. K. Wade, 1995).

When inappropriate ego states without trauma or disrupted development habitually activate, we negotiate for appropriate activation and alternative behaviors that serve comparable intentions. We promote co-consciousness between the habitually activated inappropriate ego state and a functional alternative ego state through imagined interactions and guided EMs. We then negotiate for the “family” to consciously activate functional ego states until that becomes automatic.

Case Examples

These cases vary from nearly normal differentiation with disruption at a later developmental stage caused by a specific traumatic event in which overt ego states were easily identified, to early trauma with dissociation and covert ego states. These abbreviated examples illustrate our integrative psychotherapy, with applications of EMDR that extend from the standard protocol with hypnosis used for ego strengthening, to the inclusion of specialized hypnotic methods, and with a variety of corrective developmental strategies.

Case 1: The Extended Standard EMDR Protocol as Ego State Therapy with EMs

A 35-year-old female complained of distress during intercourse that caused marital conflict. Using an affect bridge, she connected her distress to a “date rape” at 15. The traumatized ego state was activated by asking her to picture what happened, notice her feelings and body sensations, and what that made her think about herself. She pictured being forcefully embraced, her pants pulled down, and penetrated. She felt 15, frightened (SUD 9), and physically rigid, with thoughts of “It was my fault” and “I’m not safe.” Asked what she wanted to believe, a mature ego state said, “I know it wasn’t my fault,” “I learned from it,” and “I’m safe now.” Because the 15-year-old ego state was still activated by the memory, those beliefs did not feel true (VoC 2-3). In her daily life, she was able to stop such disturbing thoughts and feelings by activating another ego state that engaged in bodybuilding and imagined competing.
Activating the traumatized ego state and guiding her in EMs provided resolution in one session. Following a light relaxation trance induction, she readily visualized the mature ego state explaining appropriate responsibility, what was learned, and how to be safe to the 15-year-old, and EMs were again applied. She pictured these ego states together dealing effectively with a range of sexual situations, with EMs applied. At the end of the session, when recalling the rape, she was not disturbed (SUD 0) and the positive beliefs felt true (VoC 7). She likewise reported no distress when imagining herself in sexual situations in the future. She had identical reactions in subsequent sessions when recalling the trauma and imagining sexual situations. She reported her marital relationship improved and sex was no longer distressing.

Case 2: Overt Ego State Assessment and Corrective Psychosocial Development Without Trauma

A 24-year-old, unemployed, recovering female alcoholic complained of low self-esteem, lack of motivation, and poor relationships, about which she respectively remarked, “I’m not good enough,” “I’ll never accomplish anything,” and “I’ll never find a man to love me.” Her childhood was unremarkable other than her father being severely critical, which she recalled with anger (SUD 5), but without pictures of specific incidents. She wanted to believe the exact opposites of her negative beliefs (VoC 2-3). EMs while picturing her critical father, with the disturbing emotions and beliefs, simply made her depressed. She was asked to write a letter to her critical ego state between sessions (cf. Torem, 1993), ask what it wanted, and allow it to respond.

At the next session, she stated that she had gone to an art exhibit, which at first seemed unrelated to the issues she was dealing with in therapy. She then presented a letter she attributed to the critical ego state, which said, “I want you to die because you’re a loser.” Overt ego state assessment (cf. H. H. Watkins, 1978) identified that ego state as originating in early childhood, wanting to “be good,” “do things right,” and “get love.” In addition, a 4-year-old ego state wished to be dead because she was unlovable, an 8-year-old was immobilized by fear of failure, and a teenager with no sense of identity wanted a man to take care of her.

The client said no positive ego states were present, but focusing on the art exhibit activated a creative and lively ego state. Other positive ego states were then accessed that interacted with people and participated in recovery. Asked to portray the relationships among the ego states, the client grouped the positive and negative ego states separately, with the critical ego state in between “with all the power.” However, a “family discussion” revealed that criticism did nothing other than switch her from the positive to the negative. Observing that criticism damages self-esteem rather than motivates, the ego states agreed to listen only when the critical ego state was encouraging. They supplied scripts for the critical ego state to use, during which that ego state was guided in EMs, after which the criticism virtually stopped. Similarly, functional ways other ego states could express their intentions were devised and rehearsed imaginarily in a light trance during which they were guided in EMs.

Also in a light trance, as part of negotiating as a “family,” the ego states committed themselves to support one another and cooperate, and imagined getting training, seeking employment, and working, each of which was accompanied by EMs. A similar approach was taken with relationships, in which ego states were involved who became anxious and other ego states who imagined themselves developing needed skills were guided in EMs.

Subsequently, the client no longer reported any anger at her father (SUD 0) and her positive beliefs felt true (VoC 6-7). She enrolled in vocational training and sought employment, and gained a sense of identity and reasonable expectations regarding relationships with men.
Case 3. Age Regression to Access Appropriate Ego States in Chronic Depression

A 27-year-old chronically depressed male reported no specific events associated with his dysphoria (SUD 6). He believed he was normal in childhood, but couldn't picture himself being like that. He only wanted to believe “I’m okay as I am” (VoC 4). He was guided in EMs as he focused on his depression, lack of relationships, thoughts about childhood, and desired belief, but he reported no changes.

To access a functional ego state, an eye closure induction was followed by age regression “to a time when you felt enthusiastic about life.” He pictured himself walking in the woods with his grandfather, a craftsman who loved people and nature, who taught him to construct toys and explore. He was guided in accessing details and feelings to fully activate the ego states involved. Suggestions were offered that his grandfather represented a model of industry and identity, who was expansively involved in the world. Previously unexpressed sadness over his grandfather’s death emerged. Suggestions were that he was emotionally connected to others, his early capacities evolved as he completed each successive developmental stage, and he now had strengths extending back to childhood.

During the trance, recalling walks with his grandfather accessed the enthusiastic ego state and he was guided in EMs. Imagining himself designing and producing things activated other ego states with experiences of purpose and competence. EMs while recalling his attachment to his grandfather and expressing grief provided experiences of fidelity, love, and care, which were then focused on expressing feelings to others in the future. Optimism about work and relationships replaced his dysphoric mood (SUD 1 and VoC 7).

Case 4: Habit Change and Corrective Developmental Experiences in Substance Use Disorder

A 36-year-old male repeatedly lost jobs, families, and friends as consequences of smoking crystal methamphetamine. As is often the case in substance use disorders, he had both an ego state whose substance use was “functionally autonomous” (i.e., no longer connected to any initial function) and an ego state that used substances for a specific intent (e.g., T. C. Wade, 1992, 1994b, 1995c; Wade & Wade, 1995b, 1997). In this case, the intent was to alleviate the pain of betrayed trust beginning in early childhood. When others seemed untrustworthy, he became distraught, “felt small,” and wanted to use drugs. He readily pictured himself as an infant sitting outside his house, with his parents inside screaming at each other. EMDR with that memory, a belief of “I can’t trust,” feeling hurt (SUD 9), and a desired belief of “I can choose when to trust” (VoC 1) produced intense affect but no resolution.

Overt ego state assessment accessed a hurt infant, a hopeless 4-year-old, and a repudiating teenager, each of whom then activated a substance user. Separate ego states were identified that worked, had relationships, parented children, and engaged in recovery. Following a light trance, EMs were applied to the “inner family” as they discussed the substance use and its impact, and negotiated to meet needs appropriately. EMs were used with the immature ego states as they imagined developing new skills while being supported by the mature ego states, which developed hope and fidelity (SUD 1 and VoC 6). EMs promoted activation of the recovering ego state and co-consciousness with the substance using ego states. Urges to use ceased as recovery became habitual, and he subsequently maintained employment and relationships.

Case 5: The “Center Core” Technique to Identify a Covert Ego State

A 37-year-old male recurrently felt his hands grasped, a hand on the back of his head, and his jaws clenching in intense fear (SUD 10), which he described as “I’m out of control” but wanting to believe “I have control” (VoC 1). Attempts to connect these experiences to their origin using affect and somatic bridge techniques were unproductive. EMs focused on the
affect and sensations with the negative cognition produced a prolonged abreaction, with grimacing and clenched teeth, but no picture or resolution.

Ego states were identified that worked, raised children, and competed in sports, but remained distant from the distressed ego state, unable to even observe it as “object.” Neither overt (H. H. Watkins, 1978) nor covert methods (Fraser, 1991) identified the ego state responsible for the distress. Following a relaxation induction, the “center core” technique (Gainer & Torem, 1993), which uses an “inner adviser” to promote the client’s objective and self-reflective thinking, identified the distressed ego state, described objectively as “a terrified 9-year-old boy with clenched jaws.” “Talking through” (Ross, 1989), in which it was assumed that other ego states heard statements made to the client while in the “center core” ego state, suggested that adults are responsible when they hurt a child and his reactions were normal. The mature ego states made commitments to provide support and safety and to accompany the child during therapy, to which EMs were applied.

Between sessions, the client visualized the child to enable him to trust the adults and accept their support. EMs then resolved the trauma as the adults served as intermediaries, the symptoms vanished (SUD 0), and the client felt “in control” (VoC 7).

Conclusions

H. H. Watkins (1993) proposed that “the nurturance that heals comes from the inside of the client as internal needs are satisfied and conflicts resolved. When the internal family is happy, the whole person is well adjusted” (p. 238). Accordingly, this integrative psychotherapy is conducted with the “internal family,” to correct disrupted psychosocial development and resolve grief and traumas that affect individual “family members,” and to negotiate functional patterns of ego state activation so needs are met in ways that benefit the entire “family.”

The standard EMDR protocol is appropriate when an ego state with all elements of a traumatic memory can be activated together with another ego state that could respond appropriately if the intense emotions of the traumatized ego state did not cause inappropriate switching. The use of ego state therapy insures that EMs are applied to an appropriate target, and that another ego state is available with sufficient ego strength to contain distress. Otherwise, ego strengthening is the first priority.

When traumatic elements are dissociated among ego states, or client problems involve ego states with dysfunctional habitual behavior, grief, or psychosocial developmental pathologies, the standard EMDR protocol does not apply. Then, ego state therapy and clinical hypnosis combined with EMs reduce distress and strengthen skills, facilitate negotiation among ego states and promote co-consciousness to produce new habits of functional switching into appropriate ego states. Acquisition of psychosocial developmental strengths is promoted internally by arranging corrective experiences (e.g., an ego state visualizes developing skills for work or intimate relationships, a mature ego state expresses commitment for protection and affection to immature ego states, etc.) during which the client engages in EMs.

This conceptual framework applies all along the dissociative continuum whenever ego states can be identified that cause inappropriate switching due to intense emotions, habitual behavior, or lack of needed skills. Conceptualizing certain disorders as lateral departures from the dissociative continuum may also prove useful. For example, chronic depression might be viewed at one extreme as unremitting activation of a single ego state, unresponsive to the demands of changing circumstances, for which increasing activation of appropriate ego states would be a therapeutic goal. Unresolved grief and trauma combined with lack of
skills and developmental strengths could be addressed together with the depressed ego state’s intentions for maintaining its depressed state in the context of the needs of the other ego states in the internal “family.”

At the opposite extreme, it is possible to conceptualize psychosis as including some inability to activate only a single ego state, such that multiple disturbed ego states are simultaneously activated and overwhelm the system. Interventions could then aim at increasing the capacity to activate one ego state at a time and strengthen ego states that are functional (e.g., T. C. Wade, 1993). Insofar as schizophrenic symptoms are due to organic problems, an increased ability of functional ego states to remain activated despite the symptoms may be desirable.

This integrative psychotherapy also has applications to substance use disorders, where all other issues apply together with ego states that habitually switch because of their intent to correct disturbances caused by other ego states, but active substance use, including psychiatric drugs, “represses” access to dysfunctional ego states, rendering essential change impossible (cf. Breggin, 1991; T. C. Wade, 1992b; Wade & Wade, 1995c). Conversely, precautions should be taken in using EMDR whenever “retrieving” memories is involved (T. C. Wade, 1994e), particularly if hypnosis is also employed (cf. Brown et al., 1997; Hammond et al., 1994). However, EMDR practitioners who do not use formal trance inductions but do employ techniques used in hypnosis for trauma work (e.g., Watkins’ hypnoanalytic affect and somatic bridge techniques) should likewise take appropriate precautions.

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