ECEM (Eye Closure, Eye Movements): Application to Depersonalization Disorder

Harriet E. Hollander
Princeton, New Jersey

Abstract

Eye Closure, Eye Movements (ECEM) is a hypnotically-based approach to treatment that incorporates eye movements adapted from the Eye Movement Desensitization and Reprocessing (EMDR) protocol in conjunction with hypnosis for the treatment of depersonalization disorder. Depersonalization Disorder has been differentiated from post-traumatic stress disorders and has recently been conceptualized as a subtype of panic disorder (Baker et al., 2003; David, Phillips, Medford, & Sierra, 2004; Segui et al., 2000). During ECEM, while remaining in a hypnotic state, clients self-generated six to seven trials of eye movements to reduce anticipatory anxiety associated with depersonalization disorder. Eye movements were also used to process triggers that elicited breath holding, often followed by episodes of depersonalization. Hypnotic suggestions were used to reverse core symptoms of depersonalization, subjectively described as “feeling unreal” (Simeon et al., 1997).

Keywords: ECEM (Eye closure, eye movements) hypnosis, treatment depersonalization disorder, panic.

Researchers, taking a fresh look at depersonalization disorder, defined as a chronic dissociative disorder, have recently re-conceptualized it as a subtype of panic disorder. Episodes, occurring intermittently and unpredictably, are subjectively described as “feeling unreal” (Simeon, Gross, Guralnik, Stein, Schmeidler, & Hollander, 1997). Symptoms include poorly controlled attentional focus, sensory and cognitive numbing, dissociation, body detachment, and loss of “familiar self” (Hunter, Phillips, Chalder, Sierra, & David, 2003). Those affected say they cannot think (David, 2004). Onset is between the ages 16 and 23 years of age. Both
genders are equally affected (Simeon, Knutelska, Nelson, & Guralnik, 2003a; Baker et al., 2003).

Precipitants include negative affects, stress, threatening social interactions, and unfamiliar environments. Depersonalization disorder may emerge after panic attacks (Simeon, Knutelska, Nelson, & Guralnik, 2003a), or illicit drug use (Medford et al., 2003). Derealization, a feeling that the environment is unreal (Steinberg, 2005), is experienced by 73% of persons with depersonalization disorder (Baker et al., 2003).

**Depersonalization Symptoms in Post-traumatic Stress Disorder, Panic, Depression and Stress**

Symptoms of depersonalization and dissociation figure prominently in post-traumatic stress disorder (American Psychiatric Association, DSM-IV, 1994); in complex post-traumatic stress disorder with bipolar features (DSM-IV, 1994; Steinberg, 2005); in disorders of extreme stress (DESNOS) linked to childhood abuse (Van der Hart, Nijenhuis, & Steele, 2005), in dissociative identity disorder (DSM-IV, 1994; Steinberg, 2005) and in panic disorder (Segui et al., 2000). Administration of THC or psilocybin can induce depersonalization in persons without the disorder (Simeon et al., 2000). De-realization can occur in normal persons under stress (Simeon et al., 1997).

Simeon, Guralnik, Schmeidler, Sirof & Knutelska (2001) found emotional abuse in childhood predictive of depersonalization disorder. Baker et al., (2003) however, found that depression was the highest co-morbid diagnosis; in his sample only 14 percent reported traumatic history as a precipitant. Most persons with depersonalization disorder do not struggle with post-traumatic flashbacks, intrusive thoughts, and recurrent nightmares; bipolar features of complex post-traumatic stress disorder, guilt, shame, and loss typical of DESNOS (Baker et al., 2003; Simeon, Schmeidler, Sirof & Knutelska, 2001). In addition, they don’t suffer from memory disruptions, and identity shifts characterizing dissociative identity disorder (Simeon, Hwu, & Knutelska, 2007; van der Hart, Nijenhuis, & Steele, 2005), although most report derealization (Baker et al., 2003) and episodes of panic involving hyperventilation and breathing distress.

**Treatment Implications of Differential Diagnosis**

Differential diagnosis among post-traumatic stress disorders, panic disorder, and depersonalization disorder is crucial to treatment planning. Treatment of trauma, where memories pervade the present, focuses on reliving, avoidance, and emotional numbing. Treatment of panic focuses on breathing distress, anxiety related cues, and anticipatory anxiety. Treatment of depersonalization disorder focuses on respiratory stabilization, anxiety, and anticipatory anxiety, and further addresses unique symptoms of sensory and cognitive numbing, derealization, body detachment, and loss of familiar self.

**Neurophysiology of Depersonalization**

Whether the neurophysiology of depersonalization disorder and depersonalization in post-traumatic stress disorder is similar or different is unknown (Simeon, Guralnik, Knutelska, Yehuda, & Schmeidler, 2000b). Lanius, et al. (2005) and Frewen & Lanius (2006) studied depersonalization symptoms in post-traumatic stress disorder, defined as a condition of emotional dysregulation. As subjects listened to readings of personal trauma accounts (Rauch et al., 1996), neuroimaging identified two patterns and shifts between them—hyper-arousal (flashbacks, fear, heightened cardiac and sympathetic activity) and hypo-arousal (depersonalization, dissociation, and freezing of thought and affect).
Hyperarousal, viewed as a top-down failure to regulate aversive arousal, reflected dysregulation between the medial prefrontal cortex (MPFC) and limbic sites, notably the amygdala which processes signals associated with fear and danger. Relative slowing in the medial prefrontal cortex (MPFC) occurred in concert with intensified activity in the amygdala. Activity was reduced in the left anterior cingulate cortex (regulatory control over emotional arousal) and increased in the right anterior cingulate cortex, consistent with recall of negative, non-verbal imagery (Frewen & Lanius, 2006; Lanius et al., 2005).

Hypo-arousal - depersonalization and dissociation - was linked to oversuppression by the MPFC and by the anterior cingulate, inhibiting thalamic activity. Inhibited thalamic activity resulted in less robust heart rate, respiratory disturbances, inadequate affective arousal, and activation of the anterior insula of the right hemisphere. The right hemisphere anterior insula processes negative affect (Frewen & Lanius, 2006; Critchley, Melmed, Featherstone, Mathias, & Dolan, 2002). However, neuroimaging explorations of the interaction of the prefrontal cortex, amygdala and anterior cingulate in depersonalization disorder yielded contradictory results Sierra & Berrios (1998), Simeon, Guralnik, Hazlet, Spiegel-Cohen, Hollander, & Buchsbaum (2000).

Simeon, Guralnik, Knutelska, Yehuda & Schmeidler (2003b) compared HPA axis function in both post-traumatic stress and depersonalization disorders. Suppression to low-dose dexamethasone administration occurred in post-traumatic stress disorder; hypo-suppression occurred in depersonalization disorder. Hypo-suppression was interpreted as a failed reaction to stress, secondary to dissociation and depersonalization.

Neurophysiology of Depersonalization Disorder and Panic Disorder

Behavioral symptoms distinguish persons with depersonalization disorder. More than those with panic, they report trembling, sweating, chills, hot flushes, drug histories, and fear that drug use has altered their brains (Segui et al., 2000). Unlike persons with panic disorder they complain of sensory and autonomic blunting, being unable to think, avoidance of social situations, and fear of relationships. They believe they are strange (David, 2004).

Despite some differences, clinical studies support categorization of depersonalization disorder as related to or a subtype of panic. Although primary complaints are of depersonalization symptoms, the author has observed dysfunctional breathing patterns, primarily breath-holding, which can trigger panic. Studies find 25% to 67% percent of diagnosed persons have a panic attack history (Segui et al., 2000). Even without hyperventilation, during a depersonalization episode they may have rapid heartbeat, restlessness, and anxious hyper-arousal, as in panic attacks.

Persons with both panic disorder and depersonalization disorder express fears of “going crazy,” self-monitor excessively for signs of onset of an episode, feel powerless to control symptoms, and have hyper-emotional profiles (Gorman, Kent, Sullivan & Coplan, 2000). Attacks in both disorders are unexpected, and frequently described as “coming out of the blue.” In both panic disorder and depersonalization disorder there is avoidance and agoraphobia. These defenses contribute to maintaining the disorders (Gorman, Liebowitz & Klein, 1984; Hunter, Phillips, Chalder, Sierra, & David, 2003).

Neural distinctions between panic and depersonalization disorders

Researchers have explored neurophysiological distinctions between depersonalization and panic disorders (Segui et al., 2000; Simeon, Guralnik, Knutelska, Yehuda & Schmeidler, 2003b; Baker et al., 2003; David, 2004; Guralnik, Schmeidler, Simeon & Gross, 2000). Findings are that clinical distinctions in panic and depersonalization depend on different
levels of activity in the locus ceruleus, the primary site for production of norepinephrine. Overactivity of the locus ceruleus results in heightened noradrenergic tone and hyper-arousal symptoms associated with panic attacks. Hyper-arousal includes increased activity of the sympathetic nervous system, rapid heart beat, rapid respiration, and anxiety.

Underactivity of the locus ceruleus results in low basal norepinephrine. Underactivity of the locus ceruleus is expressed in autonomic blunting and other symptoms of depersonalization (Simeon, Guraulnik, Knutelska, Yehuda & Schmeidler, 2003b). Failure to release adequate norepinephrine is interpreted as a failure to meet the demands of stressful situations.

Other research by Simeon, et al., (2000) analyzed brain glucose metabolism with PET in people with depersonalization disorder. They discovered abnormalities in visual, somatosensory, and auditory processing pathways. Abnormalities were also found at sites responsible for an integrated body schema, consistent with the failure to integrate perception with sense of self.

Acute Respiratory Distress: Key to Differential Diagnosis

Whether fear or breathing dysfunction is central to panic (Vickers & McNally, 2005; Klein, 1993, 2000; Sinha et al., 1999) has been controversial, with implications for evaluating the role of breathing in depersonalization disorder. Fear-based panic attacks can occur during exposure to trauma. For example, soldiers during combat may hyperventilate, have chest pain, choking, faintness, and even dissociation and depersonalization, but panic symptoms remit once a combatant is returned to safety (Klein, 2000). Abrams, Rassovsky, & Kushner (2006) believe fear-based attacks are a subtype of panic disorder, different from typical symptoms of panic disorder characterized by episodes of acute respiratory distress.

Klein (1993, 2000) proposed that while fear is central to panic in post-traumatic stress disorder, persons who have panic disorder have a genetically-based carbon dioxide hypersensitivity that sets off a “deranged suffocation alarm” in the brain. People with panic can induce panic attacks through hyperventilation and/or breath-holding (Gorman, Kent, Sullivan & Coplan, 2000; Nardi et al., 2004). They have significant respiratory variability (Martinez et al., 2001), breathing dysregulation, and “suffocation sensitivity” (Sinha et al., 1999; Goetz & Klein, 2001). Nardi et al. (2006) found both breath-holding and CO₂ inhalation induced panic.

Hyperventilation, following respiratory challenge with CO₂ is associated with variable respiratory rate, increased heart rate, and reduced heart rate variability (Gararakani, Martinez, Voustianiouk, Kaufman & Gorman, 2009). First-degree relatives are hypersensitive to CO₂ inhalation (Asmundson & Stein, 1994; Coryell, Pine, Fyer, & Klein, 2006).

The interdependence between fear and respiration resolves opposing viewpoints on the relative importance of anxiety and respiration. Higher neural centers subserving emotion, influence changes in respiration outside of awareness (Brannan et al., 2001). Anxiety can set in motion psychological defense patterns involving maladaptive respiratory habits that in turn trigger carbon dioxide sensitivity reactions, eventuating in panic (Klein, 1993, Nardi et al., 2004).

Persons with panic disorder have an abnormally sensitive fear network (Gorman, Kent, Sullivan, & Coplan, 2000). Experimental triggering of a panic attack creates a conditioned fear reaction (Gorman, Kent, Sullivan, & Coplan, 2000, Gorman et al., 2001) analogous to real-life anticipatory anxiety that develops after a panic experience.

Although no experimental studies were found on the specific role of breathing dysfunction in depersonalization disorder, existing research, described above, supports the rationale for treating dysfunctional breathing patterns in depersonalization disorder as a subtype of panic disorder.
Challenges of Treating Depersonalization Disorder

Appraising various treatments efforts, Simeon, Guralnik, Schmeidler and Knuteska (2004) found that depersonalization disorder is unresponsive to treatment with pharmacotherapy and refractory to most psychotherapies. Therapies that succeed with post-traumatic stress disorder or panic disorder have not been successful with depersonalization disorder. Simeon, Knuteska, Nelson, & Guralnik (2003a) have called for the development of innovative treatments.

Cognitive and Supportive Approaches

David (2004), using Cognitive Behavior Therapy (CBT), advises patients against interpreting episodes catastrophically and encourages a view of depersonalization disorder as a chronic, uncomfortable, temporary, failed physiological response to stress. He directs people to “tough it out” and “get through.” Cognitive Behavior Therapy does not target core symptoms involving numbing and an altered relation to sense of self. Relaxation and emotional and physical stimulation can be supportive (Simeon, Knuteska, Nelson, & Guralnik, 2003a), but fail to address core symptoms of depersonalization disorder.

EMDR and Depersonalization Disorder

EMDR, a psychotherapeutic model with a component that makes use of bilateral processing - typically the use of bilateral eye movements, has been demonstrably effective in treating post-traumatic stress disorder (Shapiro, 1995, 2002; Wilson, Silver, Covi & Foster, 1996; Boudewyns & Hyer, 1996; Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Levin, Laziove, & van der Kolk, 1999; Andrade, Kavanagh & Baddeley 1997; Rothbaum, Astin & Marsteller, 2005). In 10 clients treated with EMDR, heart rate decreased, and heart rate variability increased, indicating de-arousal. (Sack, Lempa, Steinmetz, Lamprecht & Hoffmann (2008).

Eye movement effects in EMDR, as opposed to effects of exposure and habituation, have been challenged (Foa & McNally, 1996; Devilly & Spence, 1999). Yet, dismantling studies showed statistically significant effects attributable to eye movements (Kavanaugh, Freese, Andrade & May, 2001; Rothbaum, Astin, & Marsteller, 2005).

EMDR is contraindicated, however, as a stand-alone treatment for depersonalization disorder. Without extensive preparation and stabilization, conscious, rapid bilateral processing can elicit panic, agitation, dissociation, and/or depersonalization, destabilizing persons vulnerable to dissociation disorders (Shapiro, 1995, p. 381; Shapiro, 2005 pp. 366-367). Feske and Goldstein (1997) found EMDR ineffective with panic disorder.

When depersonalization disorder is conceptualized as a subtype of panic, treatment limitations of EMDR become apparent. EMDR is not designed to address maladaptive breathing, sensory and affective blunting or feelings of alienation from self. However, the inclusion of the eye movement component of EMDR during a hypnotic experience (ECEM) held promise as a means to desensitize anxiety-laden imagery, cues for maladaptive breathing and anticipatory fear of depersonalization episodes.

ECEM: Application to Treatment of Depersonalization Disorder

ECEM, used in conjunction with hypnosis, (Hollander & Bender, 2001) in this author’s experience, facilitates treatment of symptoms of depersonalization disorder. People with the disorder are typically breath-holders, acknowledging their breath-holding habit, and verifying that others have observed their habit. They can identify a temporal connection between breath-holding and onset of a depersonalization episode.
ECEM

Treatment with ECEM begins with induction and maintenance of a hypnotic state to stabilize breathing, presented as a technique to terminate a depersonalization episode. Hypnosis stabilizes respiration (Erickson, 1980) an effect monitored with neuroimaging by Meuret, Wilhelm, and Roth (2001) during biofeedback, which has similarities to the hypnotic state. Sebastiani, D’Alessandro, Menicucci, Ghelarducci, and Satarcangelo (2007), gave hypnotic suggestion to high hypnotizables, without formal induction, to reduce respiratory frequency and heart rate and increase heart rate variability and emotional numbing to a fear stimulus.

Respiratory stabilization is achieved by some clients with yoga or Zen breathing, described by Weil (1995). Wilson (2009) recommends meditation or deep muscle relaxation to elicit naturalistic or diaphragmatic breathing to manage anxiety attacks. Hollander (1989) used hypnosis for respiratory stabilization as a method to rapidly manage acute panic episodes and the approach is now incorporated in ECEM.

Once respiration is stabilized, ECEM addresses core symptoms of depersonalization. Reframing the hypnotic experience as a normal template for tolerating dissociation (Singer & Sincoff, 1990), persons are assisted in recovering a sense of familiar self through suggestions to reverse sensory and cognitive numbing, derealization, and dissociation. Suggestions given are the same as those given to subjects to reverse dissociation phenomena occurring naturally during a hypnotic experience.

Using hypnotic suggestions to encourage a person to intensify sensation, and reverse dissociation, numbness, detached body experiences and cognitive freezing, is consistent with the view of Damasio (1999, p. 226). He has pointed out that awareness of body sensations and experiences, transmitted to cortical centers, are biologically necessary for feeling that one’s experiences are happening to a personal self.

ECEM, utilizing the hypnotic state, is used to suggest an inner search for situations, thoughts, places, and sensations temporally associated with breath-holding. When the client is hypnotically engaged, trials of eye movements are introduced both to desensitize anxiety-laden cues associated with breath-holding and to reduce anticipatory fears of depersonalization episodes.

Clients Treated with ECEM

Eight clients, meeting full DSM-IVR criteria for depersonalization disorder have been treated. Two persons had a primary diagnosis of depersonalization disorder, were exposed to trauma, but did not meet criteria for post-traumatic stress disorder or panic disorder though they reported unexplained episodes of dizziness. Of the remaining six, one had experienced depersonalization since childhood, reported being on the “verge of panic” but did not have full-blown attacks. Three had frequent depersonalization episodes and periods of depression and anxiety, reported “chest tightness” without meeting full criteria for depression, or panic disorder. Two persons had histories of panic attacks prior to developing depersonalization disorder. Four persons terminated treatment for depersonalization within 20 sessions. Four continued for 12 to 18 months for management of marital or job issues and of depersonalization symptoms.

Treating Disorder with ECEM

Treatment of depersonalization disorder takes place in phases and focuses on: (1) differential diagnosis and identification of breathing patterns, (2) management of breathing dysregulation, (3) treatment of specific symptoms of depersonalization, (4) identification and desensitization of cues that elicit breath-holding reactions, and (5) desensitization of anticipatory anxiety. Therapy sessions may include or repeat interventions from other treatment phases.
Phase 1. Differential Diagnosis, Identification of Breathing Patterns

Exposure to trauma or history of panic attacks is explored in the initial interview to differentiate diagnostically among post-traumatic stress disorder, panic disorder and depersonalization disorder. The client’s breathing pattern while listening and speaking is observed. Psycho-education is conducted, explaining depersonalization disorder as a transient reaction to temporary fluctuations in brain activity, aggravated by habitual maladaptive breathing patterns, triggered by unrecognized cues and anticipatory fears. Permission for ECEM is obtained and explained as a hypnotic approach to stabilize breathing, utilizing eye movements to desensitize anxiety.

Phase 2. Management of Breathing Dysregulation

Clients are asked to describe a recent episode of depersonalization, to bring that experience into immediate focus for reprocessing. If the therapist has observed inhibited breathing, clients are asked to place a hand on the chest to become aware of breath-holding. Hypnotic induction follows. Suggestions are given to access safety to distract clients from attempting volitionally to control their now normalized breathing. For example:

You may notice that your breathing becomes naturally regulated as soon as your eyes close. Notice that you are getting comfortable, nothing you have to do, just concentrate on whatever your mind presents. As your eyes remain closed, and your breathing stabilizes, you will need to distract your conscious mind from interfering with that stabilization...you can be interested in something pleasant...a place...a time...a memory. Stay focused on that. You may take a little breath if you need to, but notice—your mind manages breathing independently while you concentrate on your personal imagery. Lift a finger, or nod, when you are focusing on that imagery.

Suggestions are given to use eye movements to block intruding negative imagery.

If unpleasant imagery intrudes, notice it. Then, move your eyes six or seven times back and forth from wall to wall, keeping your eyes closed. When there is a change—suggest to yourself a return to pleasant imagery.

Prior to re-orientation, suggestions are given for deepening, resting, and maintaining awareness of respiratory comfort. A post-hypnotic suggestion is given for development of self-suggestions to practice ECEM to manage respiration and anticipatory anxiety:

What do you need to review about this experience? Would you like to keep what you learned? How can you do that? Can you imagine using ECEM to normalize breathing, to breathe comfortably? Use eye movements as appropriate? Looking ahead, when, and where, would you practice?

Phase 3. Treating Symptoms of Depersonalization Disorder

Following normalization of breathing, ECEM addresses “inability to sustain attentional focus.” Clients provide ideomotor signals indicating arrival of the desired change. Confidence that concentration and attention will improve derives from research showing that the hypnotic experience involves activation of attentional centers (Crawford, H. J., Guru, R.C., Skolnick, B., Gur, E.R., & Benson, D. M., 1993).
Please signal when you become aware of being able to concentrate on pleasant imagery. Notice the return of your normal ability to concentrate; you can concentrate more and more deeply, as you are now doing. Soon, as you continue to concentrate successfully, you will find yourself recovering other aspects of your familiar self.

**Sensory Numbness**

You say you are numb. Numb is a feeling. Numb can change. Would you like to learn to change numbness? Is numbness everywhere, or is it like tiredness, a deep tiredness to rest, to recover your energy? Is there tension? Where is it? In your chest? Can you make the tension stronger? Does the sensation of tension change if you put your hand there? Would you be willing to check for any other kind of sensations? You can check for sensations of warmth, coolness, tingling, an ache or itch, or just normal feeling. Check your arms, hands, fingers, neck, torso, pelvic area, thighs, legs, toes, etc.

You can strengthen other imagery. You can ask yourself: What details do I notice? What am I wearing? What are the colors in my clothes? You may discover how to recall your favorite food, or even one you dislike—the taste, the smell. Can you bring to mind the sensation of touch? Can you sense your hand on your thigh, on your clothes? Can you direct your attention to your feet, your shoes, their color, their size? Think about your feet connected to your legs, etc. Are you more aware of sensation now? As you begin to notice sensations, you will be getting back to your familiar self. Can you review this technique to use on your own?

**Changing Unfamiliar/Spectator Self by Accessing Remembrance of Things Past**

As sensation returns, ECEM addresses “feeling unreal.” Suggestions are given to retrieve autobiographical memories, including affect. An affect bridge (Watkins, 1971) connects past feelings to the ability to feel in the moment. Self-suggestions for post-hypnotic maintenance of retrieved feelings are linked to an imagined future situation in which sense of self will be preserved.

Can you recall a time or memory in which you experienced feelings and were your “self,” the self familiar to you? Would you be willing to fully relive that experience now? Perhaps you would be willing to imagine a future situation when you want your familiar self to be there, the way you want to be? Would you like to rehearse how you can keep your ability to access your feelings…at that time in the future?

**Cognitive Freezing**

During depersonalization episodes, clients report they cannot think. Paradoxical suggestions are given to “think about the thinking that is ‘blocked’.” You say, you can’t think. If you could think, what would you think about? What’s on the list of what you think you need to think about? Can you picture, imagine, a list? To help clear your fogginess you may want to experiment with letting your eyes move back and forth quickly a few times.
Phase 4. Identification and Desensitization of Cues That Elicit Breath-Holding Reactions

In Phase 4, conditioned cues that trigger maladaptive breathing patterns are identified and reprocessed with eye movements. Breath-holding triggers may include anxiety-laden work, or interpersonal situations, deadline pressures, or interpretation of chest tightness, as forewarning an attack.

Can you think of, or remember some situation that brings on your breathing-holding pattern—a pressure to meet a deadline, a problem at work or home, a physical sensation? Use eye movements to reduce that distress. Become aware of how you continue to keep that easy breathing pattern. Let your eyes move back and forth, six or seven times, from wall to wall. You can repeat that. Nod, or let a finger lift, when there is a change of any kind.

Phase 5. Desensitization of Anticipatory Anxiety

Clients are asked to retrieve anticipatory fear of depersonalization, focusing on associated sensations and thoughts. Just as pain can be blocked by self-suggestion in hypnosis, a person can ask the inner mind to block anticipatory fear. Past competencies (resources) are accessed; images of supportive persons (introjects) are conjured up; and attention is paid to the physical relaxation, part of being in a hypnotic state, as a contrast to feeling “fear.” Reminders are given to notice how well breathing, regulated in the hypnotic state, can continue during processing of anticipatory anxiety. Suggestions to self-generate eye movement reprocessing are also utilized during ECEM to manage anticipatory fears.

Would you be willing to ask your inner mind to block fear of having an episode? Think of a stress or internal sensation that you associate with an impending attack, that makes you hold your breath. Imagine your mind blocking sensations of fear or negative thoughts. Imagine an action you might take, thoughts that might help in that future situation. Then add eye movements, moving your eyes from wall to wall, six to seven times, repeating that sequence until you are satisfied with the results. Notice the “easy” breathing.

ECEM to treat depersonalization disorder is illustrated in the following excerpt.

Case of Mr. W.

Mr. W., born in a third-world country, was the eldest of eleven children. In early adolescence he enrolled in a religious boarding school. Unable to tolerate the dawn-to-midnight study regimen, or the separation from home, he developed panic attacks. Diagnosed as suffering from stress, he was sent home. A homeopath prescribed pills. Mr. W took them for a year, finally discontinuing them because they caused terrifying visual hallucinations, vivid color experiences, disorientation, depersonalization, and derealization. In retrospect, he wondered if he had taken LSD.

At age 20, he immigrated to the United States, began a business and started a family. He was a chronic breath holder. Depersonalization episodes occurred in addition to panic attacks. Antidepressants elicited hypomania. He sought psychotherapy instead.

Explanations about the relationship among breathing patterns, panic, and depersonalization were given. Permission was obtained for ECEM. Panic attacks were quickly managed with hypnotic breathing. Management of depersonalization episodes began. The following excerpt is from a telephone call from Japan, made while he was in a taxi returning to the airport. Acute depersonalization, breathing dysregulation, feelings of...
unreality, and chest tightness, without hyperventilation or panic are described. Mr. W. successfully reinstates his training in ECEM to contain symptoms.

*Stabilizing Breathing Patterns and Accessing Safety*

**Therapist:** Check your breathing. Place a hand on your chest.

**Mr. W.:** Breathing is not too good. I’m holding the breath in.

**Therapist:** Close your eyes. You know how to do this. Rest and wait. Breathing regulation takes a few moments. You may be tempted to open your eyes or force deep breaths.

You can take a few deep breaths if you need them, but it’s preferable to distract from that urge and shift to comforting imagery. You might think of being safely at home...that you are going home.

**Mr. W.:** OK, I’m trying to concentrate.

**Therapist:** Focus, concentrate on the idea of home.

**Mr. W.:** Ok, I’m thinking about my house. The new furniture will be there. My wife took care of all the delivery problems.

**Therapist:** Breathing?

**Mr. W.:** Better. I’m not holding it in. But the weird stuff is happening. I don’t feel like myself.

*Support and Suggestions for Reversing Symptoms of Depersonalization/Derealization*

**Therapist:** Ok, your breathing is better. Now you can concentrate on those ‘weird’ symptoms. You’ve had a lot of stress. You were probably holding your breath throughout very difficult business negotiations, worrying about the translation, worrying about being taken advantage of. In unfamiliar surroundings, when you concentrate, you do hold your breath, do you not?

**Mr. W.:** Yes. I think I was—holding my breath—all the time. It was very hard.

**Therapist:** Shift, to your imagery of “home.” How is that now?

**Mr. W.:** Ok.

*Recovering Sensation, Affect, Cognition, Sense of Reality*

**Therapist:** Now you want to get back your sense of self, your sense of reality, do you not?

**Mr. W.:** Yes.

**Therapist:** With your eyes closed, review what happened during your meeting. Recall Mr. Z’s facial expressions. Think how he tried to “get over.” Remember details, the cups of tea in front of you. Remember what you said; how well you managed to think, even with your fear. You got most of what you wanted, did you not?
Mr. W.: Yes.

Therapist: Are you willing to tell yourself, I did the best that I could?

Mr. W.: Ok. It’s over now … until the next trip.

**Reversing Derealization and Strengthening Recovery of Sense of Self**

Therapist: *(Suggests refractionation)* Stay in trance but open your eyes. Look around. What do you notice about the taxi? Is there music, and a TV? You’ve been here before. What looks familiar outside?

Mr. W.: It’s a little better. I recognize some parts of the trip, not all.

Therapist: So close your eyes again and start thinking about what’s familiar to you now. What are you wearing? Become familiar again with your body — your eyes, your nose, your lips, the hair on your head, your shoulders, the right upper arm, the elbow, the wrist, the fingers, the left arm, elbow, wrist, fingers, the sensations in your stomach. Is your breathing Ok? Move parts of your body until you feel connected with yourself.

**Treatment of Anticipatory Fear, Future Oriented Rehearsal to Install Safety, and Eye Movements to Block Anticipatory Anxiety**

Mr. W.: I’m better now. But I don’t know what will happen in the airport.

Therapist: Can you think?

Mr. W.: Yes.

Therapist: To keep the worry away, why not make a picture of what will take place at the airport. You have been there before. Picture it. Rehearse going through security…waiting in the lounge. Rehearse what you can do if the weird feelings come back. Practice eye closure to regulate your breathing, keeping a focus on images being at home. Use the eye movements. Move your eyes back and forth rapidly, from side to side, six or seven times and then again, with your eyes closed, just like in the office.

Mr. W.: The eye movements calm me down.

**Further Suggestions to Strengthen Sensory Imagery, Heighten Sense of Self**

Therapist: When did you eat last? What will you eat in the business lounge? Will you read? Watch TV? Call home?

Mr. W.: OK, I can think about all those things. I’m calmer. More like myself. I won’t really know until I do it but I think I’m OK.

**Summary and Discussion**

Depersonalization, considered to be a dissociative disorder, is currently viewed as a sub-type of panic disorder. The disorder is considered unresponsive to existing therapies. An initial group of clients has been responsive to treatment of depersonalization disorder with ECEM in which hypnotic interventions provide respiratory stabilization and reversal of
core symptoms, while eye movements, adapted from the EMDR protocol, self-generated in
the hypnotic state, are utilized to reduce anxiety laden cues linked to breath-holding and to
reduce anticipatory fear of depersonalization episodes. Self-practice is encouraged.

ECEM, utilizing hypnosis, has several advantages over other therapeutic
approaches. Hypnosis is experienced implicitly as a normal template for the experience of
dissociation. In a hypnotic state, other depersonalization symptoms—sensory and cognitive
numbing, loss of familiar self, and feeling like a spectator—are reframed as non-catastrophic,
time limited, reversible phenomena, similar to naturally occurring hypnotic phenomena.

In the author’s clinical experience, ECEM does not appear to elicit destabilization,
as may occur in EMDR processing. One possible explanation is that depersonalization disorder
differs from post-traumatic stress disorder in which flashbacks and reliving create risks for re-
traumatization. Another explanation is that the use of self-generated eye movements within
hypnosis utilizes, rather than bypasses, dissociation and is less intense than reprocessing
with formal EMDR. However, hypnotic therapists, who use ECEM, should be trained in EMDR,
and evaluate risks to fragile ego defenses, before suggesting eye movements.

References

Psychiatric Press.

subtypes in panic disorder. Depression & Anxiety, 23, 474-481.

working memory approach to the treatment of post-traumatic stress disorder. British

parasympathetic nervous system function and subjective reactivity to respiratory
manipulations. Psychosomatic Medicine, 56, 187-193.

Depersonalization disorder: Features of 204 cases. British Journal of Psychiatry,
182, 428-433.

(EMDR) as treatment for post-traumatic stress disorder. Clinical Psychology
and Psychotherapy, 3, 185-195.

Brannan, S., Liotti, M., Egan, G, Shade, R., Madden, L., Robillard, R. et al. (2001). Neuorimag-
ing of cerebral activations and deactivations associated with hypercapnia and hunger
for air. PNAS, 98 (4), 2029-2034.


subjects at high-risk for panic disorder. Journal of Affective Disorder, 92, 3-70.

on regional cerebral blood flow during ischemic pain with and without suggested

control of autonomic arousal: A functional magnetic resonance study. Neuroimage,
16, 909-919.
Hollander


Hollander


