

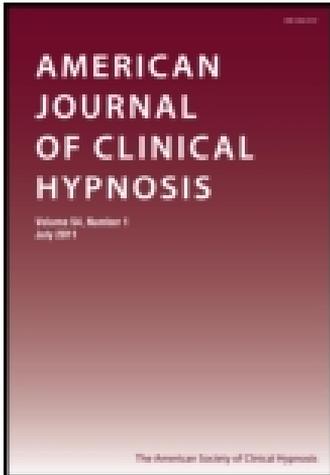
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ECEM (Eye Closure Eye Movements): Integrating Aspects of EMDR with Hypnosis for Treatment of Trauma

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The paper addresses distinctions between hypnotic interventions and Eye Movement Desensitizing and Reprocessing (EMDR) and discusses their effect on persons who have symptoms of Posttraumatic Stress Disorder (PTSD). Eye movements in hypnosis and EMDR are considered in terms of the different ways they may affect responses in treatment. A treatment intervention within hypnosis called ECEM (Eye Closure, Eye Movements) is described. ECEM can be used for patients with histories of trauma who did not benefit adequately from either interventions in hypnosis or the EMDR treatment protocol used separately. In ECEM the eye movement variable of EMDR is integrated *within* a hypnosis protocol to enhance benefits of hypnosis and reduce certain risks of EMDR.

Introduction

Posttraumatic Stress Disorder (PTSD) is a particular psychiatric disorder that describes the reaction to horror and helplessness of events that threaten life or physical integrity. The brain's normal processing modes for memory (Squire, 1991) are disrupted by trauma and can result in a failure to successfully integrate traumatic memories (Shapiro, 1995; Levin et al., 1999) and in fragmentation of traumatic experiences (Braun, 1986; van der Kolk & Fisler, 1995).

Symptoms of PTSD include anxiety and hyper-arousal. Patients report intrusive imagery in the form of flashbacks and nightmares. They exhibit exaggerated startle, phobic avoidance of trauma related cues, and emotional numbness. They may also have dissociative symptoms. One out of four persons who experience trauma will develop PTSD (Yehuda, 1998).

Trauma is registered both physiologically and psychologically. Trauma and chronic stress can affect limbic and cortical development in children (Teicher et al., 1993), lower the

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threshold for auditory startle (McFarlane et al., (1993), and impact immune function (Wilson et al.,1999). Neuroimaging studies indicate that trauma affects specific structures, e.g. the amygdala, corpus callosum, anterior cingulate and pre-frontal cortex. These are critical to working memory and to the ability to interpret the meaning of incoming stimuli (McFarlane, 1993; van der Kolk, 1997). Stress sensitization and the failure to make suitable discriminations about the meaning of events underlies the tendency of persons with PTSD to overreact to seemingly neutral stimuli as if they were a threat. Yehuda (1998) has outlined the process by which trauma affects brain functioning. Traumatic events signal the amygdala which responds to the perception of threat. The amygdala triggers activation of the sympathetic nervous system (SNS). Activation of the SNS leads to an experience of fear associated with an increase in heart frequency and breathing rate. This process involves an initial rise in glucocorticoids, which through the process of feedback also terminates the SNS response to extremely stressful events (Yehuda, 1998). Cells in the hippocampus, essential for the normal processing of memory, can be lost or damaged by abnormal concentrations of cortisol and glucocorticoids released under extreme stress (van der Kolk, 1997; Sapolsky,1996).

Prolonged stress leads to lowered cortisol and glucocorticoid levels. As part of a negative feedback loop affecting the hypothalamic-pituitary-adrenal (HPA) axis, lowered levels of cortisol and glucocorticoids results in a failure to shut down SNS reactivity. (DeBellis et al.,1993; Yehuda et al., 1996). A lowered ability to shut down SNS activity results in high anxiety, symptoms of PTSD and vulnerability to retraumatization.

One can hypothesize that altered neurophysiology accounts for the heightened arousal states, exaggerated startle response, generalized anxiety, intrusive imagery, avoidance, emotional numbness and other persistent psychological and behavioral symptoms which make it hard to achieve symptom remission in persons who have been traumatized.

Trauma also has a psychological impact on language. Clinically, trauma victims often seem as if speech fails them when they try to report terrifying events. They seem to revisualize the experience they want to describe but struggle in trying to produce a factual narrative of it. According to van der Kolk (1997), activity in Broca's area, the language area, is reduced during attempts to recall extremely stressful events. Traumatic effects on language may even diminish the ability of persons to respond to conventional psychotherapy. Anxiety management in psychodynamic psychotherapy is heavily dependent on language to impart insight, restructure cognitive distortions, and provide psychoeducation.

Hypnotic interventions and EMDR do involve verbal interaction between patient and therapist. However, hypnotic states and EMDR focus more on eliciting direct experience and imagery than on the translation of experience into language. This reduced dependence on language makes these treatment approaches especially suited to the task of re-processing distressing sensory and affective aspects of PTSD and persistent, intrusive perceptual imagery and memories.

Hypnosis

The hypnotic response can be conceptualized as an altered state of consciousness (Erickson, 1980b; Hilgard, 1965). The ability to respond hypnotically is part of our biological repertoire. Hypnotic states can be tracked through neuro-imaging, are associated with measurable physiological alterations, and can be identified by behavioral responses.

Brain changes

Hypnosis is associated with activation of cortical centers involved in sustained attentional processing (Crawford, 1994; Crawford, et al., 1998). In highly hypnotizable subjects,

depending on the nature of the hypnotic task, there are changes in cerebral blood flow, relative changes in brain asymmetry and in activation levels of alpha, beta and theta waves as measured by the EEG. (Crawford, et al., 1993; De Pascalis & Perrone, 1996).

Neurophysiological changes

Humphreys and Egan (2000a, b) view trance, in general, as a temporary marked dominance of either the sympathetic or parasympathetic branch of the autonomic nervous system. Sympathetic trances are characterized by excitement or dysfunctionally, by the fight-flight reactions to trauma, by panic states, and agitation of psychotic states. There is an increase in heart rate, blood pressure and respiration.

Parasympathetic trances are characterized by the familiar soothing, calm states, associated with therapeutic hypnosis and meditation (Humphreys & Egan, 2000a, b). In parasympathetic trances blood pressure is lowered and respiration becomes slower and more even.

Behavioral changes

Observable behavioral changes occur such as a peculiar economy of movement, modification of tension in muscle tone, absence of startle reflex, and even alteration of response to auditory stimuli (Erickson, 1980b). Ideomotor signaling, catalepsy, and dissociated arm levitation occur in the hypnotic state.

Hypnosis as a treatment intervention

Therapy in a hypnotic state makes use of hypnotic phenomena, recognizing individual differences in responsiveness to hypnosis (hypnotizability) and in perceptual style. Commonly utilized hypnotic phenomena include changes in level of hypnotic absorption. In hypnosis consciousness can be divided. Multiple levels of awareness can be activated.

Hypnosis facilitates subjective hypermnesia and amnesia, dissociation and integration, the accessing of safety as well as state-dependent experiences of stress and trauma. Hypnosis heightens sensory imagery. A hypnotic experience can encompass hypnotic dreaming and symbolism, age regression and abreaction, perceptual reframing through self-suggestion and posthypnotic suggestion.

Hypnotizability

Hilgard (1965) found that a history of stress was associated with high hypnotizability. Patients with PTSD tend to be more hypnotizable than those persons who have endured trauma without developing PTSD (Spiegel, 1990a, b). Hypnotizability, operationally measured with the Stanford Scale of Hypnotizability (Hilgard, 1965) plays a role in treatment outcome (Frischholz et al., 1981) but so do motivation and treatment context (Alman & Carney, 1980; Barber, 1980; Hollander et al., 1988; Weitzenhoffer, 1989).

Divided Consciousness, absorption, multiple levels of awareness

Weitzenhoffer (1989) regards hypnosis as a form of dissociation. Subjects in hypnosis develop a singular focus on their inner experience and can lose relative awareness of their surroundings. Levels of absorption vary within trance and between individuals. Erickson (1980) considered that multiple levels of therapeutic response occur at different levels of awareness or dissociation. Hilgard and Hilgard (1994) describe a hidden observer that has different perceptions than a person recognizes at levels of more conscious awareness.

Safety

Dividing consciousness in hypnosis can be utilized to enhance safety. When subjects dissociate by voluntarily dividing consciousness, or by deepening their absorption in hypnosis

in response to a therapist's suggestion, they may feel a greater sense of control than with the kind of dissociation that occurs involuntarily in trauma.

When consciousness is divided during hypnosis one aspect of the subject's awareness can attend to safety, while another aspect of awareness revisits the trauma. A subject may be aware of the therapeutic safety of the consulting room, while simultaneously giving attention to events of the past. Rossi (1996, 1997) divides consciousness by utilizing a bilateral arm levitation. When he elicits this "automatism" or dissociated action, he suggests that the individual compare personal resources (safety) with the "problem" and then let them "go along together." The complex intervention can facilitate association of dissociated experiences with a sense of an integrated self. Subjects who can divide consciousness can usually learn to imagine viewing trauma at a distance. At another level of awareness they can then discover they are able to re-view trauma without having to feel it.

Heightened sensory imagery

Subjects may re-experience a trauma while in hypnosis. Deeply absorbed, they may have the global experience of subjectively reliving a situation. Forgotten details may suddenly stand out. The hypnotic state can be utilized therapeutically at such times because it provides an opportunity for retrieval of non-traumatic sensory imagery. Thus, the client with PTSD can access visual, auditory, and kinesthetic images that are alternatives to hyper-arousal, intrusive flashbacks and emotional numbing.

Hypermnesia

Subjects in hypnosis typically will respond to heightened, sensory imagery as representations of memories their minds have recorded. Highly hypnotizable persons create hypnotic experiences which are new to the person's history. However, some persons create delusional memories about their hypnotic experiences, which go beyond the reality of their traumatic experiences. As far back as the turn of the century, Freud (Freud & Breuer, 1966) prohibited dissociated and delusional patients from engaging in self-induced hypnoid states. Fortunately, extensive scientific research shows that most people correctly preserve the gist of historic trauma (Williams, 1994; Kluft, 1996; Brown et al., 1998). However, if patients have existing delusional beliefs or suffer from dissociative disorders with memory disturbances, therapy utilizing hypnosis may be counter-indicated.

Dreaming and symbolization

In hypnosis, a patient can practice re-dreaming or managing nightmares, which often successfully reduces their frequency and intensity. The patient, after adequate therapeutic preparation, is invited to have a hypnotic dream or develop a suggestion for lucid dreaming, the awareness that a dream is in fact a dream, not reality. Utilizing hypnotically recovered awareness of survival details the patient can practice changing the ending of the nightmare, or develop posthypnotic suggestions to cope with nightmares.

Patients can be encouraged to find their own way to symbolically process trauma without directly reliving it. A patient who had been molested as a child did not want to recall the details of that experience. She hypnotically reprocessed her experiences while showering and reported that she had an awareness that, within hypnosis, she was washing away the sensations and emotions of her molestation while preserving her amnesia for it.

Abreaction

Emotional release or abreaction often occurs in the hypnotic state when trauma is reviewed. Emotional release relieves the emotional numbness induced by trauma. Horror, hopelessness, anxiety and grief can be tolerated if the therapist directs attention to the state of physiological calm that is the larger context for the hypnotic experience.

When patients in hypnosis go back in time to revisit a traumatic event they exhibit the phenomenon of hypnotic age regression. They may experience blocking, which represents the dissociation that occurred during the traumatic event. This kind of blocking was described by Janet (1925) and recognized by Freud (1956a, 1956b) as primary repression.

Ego strengthening and therapeutic suggestions to recover fragmented, compartmentalized aspects of trauma can be given at this stage of hypnotic experience. Therapists may direct a deeply absorbed subject to recover forgotten, dissociated, details of trauma, particularly those associated with survival.

Altered perceptions, problem reframing, restructuring of self-perceptions

Hypnotic suggestions can be used to alter perceptions, reframe problems and restructure beliefs. Distorted perceptions of the present as full of threat can be reframed as the patient recognizes that he or she survived the dangerous past. Self-perceptions can be altered as the patient imagines self-protective ways, not available at the time of the trauma, for responding to problems in the present.

Hypnotic suggestions gently invite the patient to restructure negative self-attributions, blame and shame. Suggestions may take the form of asking a patient, "how they would prefer to feel." Erickson (1980c) advised that when resistance appeared in hypnosis it signaled anxiety and provided an opportunity to reframe perceptions and strengthen positive self-imagery.

Posthypnotic suggestion

The rehearsal of anticipated situations and feelings of comfort is called crystal gazing or future pacing (Erickson 1980c) and is a form of posthypnotic suggestion. Once the patient identifies comfortable feelings they would like to experience they can construct hypnotic scenes in which these changes are taking place.

Therapists can give posthypnotic suggestions to maintain new hypnotic learnings or, more permissively, suggestions can be given for the patient to develop personal posthypnotic suggestions for change.

Destabilization risks in hypnosis

A presumed advantage of providing a corrective emotional experience during hypnosis is that hypnotic dissociation reflects some of the experience of dissociation that occurs during trauma. Hypnotic experiences can provide a foundation of stability, safety and ego strengthening and an opportunity to reintegrate compartmentalized and fragmented aspects of trauma.

However, clinical experience suggests that despite treatment with hypnosis, certain images representing trauma can remain persistent or recur. While abreactive work relieves emotional constriction resulting from trauma, repeated abreactions to rework trauma can lead to excessive emotionality, which can be overwhelming and destabilizing (Hammond, et al., 1994).

When EMDR was developed as a treatment model it appeared to offer a way for persons to rapidly process imagery representing trauma without being subjected to repeated abreactive work.

EMDR

Shapiro (1995) views the EMDR model as an accelerated information model which reprocesses dysfunctional information stored in "state dependent form". EMDR targets mental representation of trauma which reprocesses it through bilateral stimulation using eye movements, tonals or tapping.

Neuroimaging

The neurophysiological basis of EMDR is still uncharted. In explaining the therapeutic effects of EMDR, Shapiro (1995) draws on current theories of memory. Squire (1991), whose work is basic to current theory, demonstrated that normal processing of information involves transmission from short-term storage in the medial temporal lobe — involving the hippocampus, entorhinal, perirhinal and parahippocampal cortices — to long-term cortical storage. In contrast to normal memory, trauma memories persist vividly, painfully, and dysfunctionally, often for decades.

Critics argue that the effects of EMDR are due to repeated exposure to trauma imagery (Foa & Rothbaum, 1998; Pitman et al., 1996) and not to the effects of bilateral stimulation. Yet recent research suggests that after effective treatment with EMDR, subjects show increased activity in the anterior cingulate gyrus and left frontal lobe as well as in changes in scales measuring PTSD symptoms (Levin et al., 1999).

EMDR as a treatment model

EMDR is an eight stage treatment model which utilizes cognitive and psychodynamic perspectives as well as suggestions for safety based on and for hypnotherapeutic interventions for trauma. (Rossi, 1986; Spiegel & Cardena, 1990b; Watkins & Watkins, 1991; Watkins, 1992; Fine, 1991; Kluft & Fine, 1993).

EMDR reprocessing

The treatment model of EMDR begins with screening, establishing rapport and history taking. The patient learns stabilization techniques. These may include hypnotic-like images of safety. The patient then identifies target imagery representing trauma and identifies beliefs, emotions and body sensations associated with that imagery.

Rhythmic stimulation using bilateral eye movements, auditory tones or taps are carried out to reprocess trauma imagery. An installation phase incorporates positive cognition that the patient has identified as a replacement for the original negative one. A body scan is utilized to identify and reprocess remaining body tension.

Sessions may close with safety-oriented, hypnotic-like imagery, often consisting of a calm, soothing, diffused, white light to insure a state of emotional equilibrium. A re-evaluation phase is implemented at the beginning of each new session and includes additional targeting and review to insure optimal treatment effects (Shapiro, 1995, 1998).

Therapeutic change with EMDR

During EMDR reprocessing, the patient often experiences a rapid and significant reduction in anxiety. Blocking and resistance are addressed by altering the speed of delivery of bilateral stimulation or the direction of eye movements.

Distorted cognitive beliefs about responsibility for trauma and abuse and negative affects of guilt and shame shift to more positive self-affirmations. Therapeutic comments, given as part of an intervention called the cognitive interweave, assist this process and also help manage resistance and blocking.

Distress levels undergo change and are monitored with a Subjective Unit of Distress Scale (SUDS) Another self-report scale tracks how close patients feel to achievement of a desirable state of comfort, or achieving positive cognitions. These subjectively quantifiable changes in distress level and movement towards a goal of comfort serve as clear indicators to the patient and to the therapist of treatment progression and effectiveness.

Dissociation and destabilization with EMDR

Global reports by patients indicate they often experience profound relief from intrusive, persistent imagery representing trauma, particularly single incident trauma, following a relatively rapid processing of trauma memories. However, EMDR may elicit destabilization and dissociation in patients with an extensive history of trauma. The recommendation to assess patients for dissociation during screening (Shapiro, 1995) does not completely remedy the situation. Dissociative Disorders occur with PTSD (Putnam, 1989, 1990; Kluft & Fine, 1993) but they may be masked by depression or anxiety and often escape evaluation even with the use of instruments such as the SCID-D (Steinberg, 1985) or DES (Carlson & Putnam, 1986).

Concerns raised by the destabilization and dissociation in patients treated with EMDR redirected the authors' attention to interest in stabilization and safety features elicited by hypnotic techniques. Could the advantages of hypnotic treatment be combined with the advantages of EMDR reprocessing?

Attempts to combine a hypnotic experience within EMDR can produce negative effects in some patients. The second author treated a patient who dissociated after spontaneously entering an altered state during EMDR, although the patient was experienced with both treatment modalities. Similar findings have been reported by other therapists. Patients undergoing EMDR who seem to be skating on the edge of hypnosis, characterized by eye fixation, are directed to continue reprocessing with eye movements. Would the reverse be true? Could bilateral eye movements be incorporated within hypnosis without bringing about destabilization and dissociation effects?

ECEM (Eye Closure Eye Movements): Combining Hypnosis and EMDR

Hypnosis and EMDR are dissimilar and are experienced as different by patients. A key distinction is that they are carried out in different states of awareness. Relaxation effects may occur during EMDR but Nicosia (1995) suggests that it is basically a treatment modality carried out in a state of conscious awareness. Bi-lateral eye movements occur in hypnosis. Shapiro (1995), who recognized their significance in reprocessing trauma imagery, made them a central feature of EMDR. Bi-lateral eye movements in hypnosis are usually ignored although they were a standard feature of hypnotic inductions at the end of the nineteenth century (Bramwell, 1905). Dement (1997) identifies them with theta waves. Patients associate these bi-lateral eye movements with scanning of visual scenes or the exploration of discrepancies in feelings or ideas.

In order to utilize both the impressive effects of successive trials of bi-lateral eye movements on trauma imagery and the stabilizing effects of the hypnotic state and hypnotherapeutic interventions, the first author experimented with incorporating a truncated version of EMDR into the hypnotic experience of patients. The procedure is called Eye Closure, Eye Movements (ECEM).

In ECEM, a hypnotic state is induced and various hypnotic phenomena are utilized. Emphasis is given to stability, safety and ego strengthening. Specific interventions to modify trauma are offered. One intervention is ECEM. Within the hypnotic experience, while subjects have their eyes closed, they can indicate verbally or with ideomotor signaling, when they are experiencing images of trauma. Successful interventions are reinforced with bi-lateral eye movements and with posthypnotic suggestions.

Procedure

ECEM begins while the patient is in a conscious, awake state. Symptoms or troubling images that are part of the traumatic experience are discussed. The patient must have had hypnotic preparation over a number of sessions with accessing safety and inner resources. Often the patient will have worked on hypnotic approaches to manage sleep interruption and curtail nightmares. The therapist encourages the patient to develop a hypnotic state and ascertains the establishment of safety. A hypnotic probe may involve ideomotor signaling to indicate to patient and therapist whether or not the “inner mind” considers hypnotic exploration to be safe. If hypnotic exploration is not safe, the mind’s ability to be protective is affirmed. If appropriate, hypnotic interventions for stabilization are continued. If conditions for safety can be ascertained, the trauma can be accessed.

If the patient, in hypnosis, indicates readiness to process trauma, then, while the patient’s eyes remain closed, the therapist asks if the patient is ready to focus on the trauma-related symptom or image. The nature of the target imagery must be rechecked with the patient and not assumed because frequently the preselected imagery changes once the patient is in an altered state.

While the patient fixes on a particular image or symptom, directions are given for a succession of brief trials of about six bilateral sweeps of continuous eye movements. These trials continue until the subject reports some discernible affective or sensory change although no more than three to seven trials should be given. Following ECEM, hypnotic suggestions are given for rest. This permits nonverbal consolidation of the reprocessing experience.

After a moment or so of rest, and after the subject signals readiness, hypnotic interventions are resumed. Ego strengthening suggestions are offered. Choice is provided and resistance is paced. Before the subject is reoriented, the patient is encouraged to develop self-suggestions. The instructions are for the mind to suggest, on its own, new imagery and/or desirable emotional states that might occur in the future.

Steps for ECEM follow:

1. Identify trauma-associated symptoms such as intrusive imagery, hyperarousal, avoidance patterns, or emotional numbing.
2. Induce trance.
3. Explore safety after trance is induced to see if patient is still ready to work on trauma.
4. Check mental imagery. Hypnotic imagery may differ from the preselected imagery.
5. Suggest that patient carry out between three and seven trials of eye movements consisting of about six bilateral eye sweeps while focused on an aspect of trauma that has been troubling.
6. When patient reports change, suggest rest and hypnotic deepening.
7. After the patient rests, continue with hypnotic processing (accessing of personal resources, future orientation and other ego strengthening interventions).
8. Give choices for amnesia (patient can remember what will be consciously useful; forget what is unsafe).
9. Suggest development of personal posthypnotic suggestions.

10. Reorient.

Case example

The following case is reported with patient consent. Details have been altered to prevent patient identification and have been drawn from other patients who also gave consent.

Symptoms of PTSD and dissociation

A policeman had been a victim of gunfire and was only saved by the bulletproof vest he wore. He developed symptoms of Posttraumatic Stress Disorder. He slept poorly, had nightmares, flashbacks, and exaggerated startle. He suffered from intrusive thoughts, withdrawal from his family, and agoraphobia. He became unable to complete his regular tour if he had to drive past the point where the attack took place. He reported that he occasionally felt somewhat dissociated. Sometimes he felt as if another person were taking over his behavior. He had obsessive thoughts of using his gun preemptively as he envisioned new incidents in which he might be endangered.

Safety, through hypnosis utilizing eye closure, redreaming

The dissociative symptoms were of sufficient magnitude to rule out use of formal EMDR. Hypnosis was utilized in the first phase of treatment to stabilize the patient. Like many trauma victims he was initially unable to close his eyes to experience an altered state. Tolerance for eye closure was a metaphor for regaining safety in sleep. Over two months he developed enough safety anchors to experience hypnosis with eyes closed. His sleep status improved. With hypnotic instruction, he mastered lucid dreaming and the ability to re-dream and shift the endings of his nightmares.

He had achieved a degree of stabilization but he still felt emotionally numb towards his family members. He was both unwilling and unable to connect emotionally. Insight into his fear of trusting that emotional investment would lead to loss and grief had not changed his sense of being numb. In this phase of therapy he now asked to review in hypnosis the event in which he encountered unexpected gunfire. First, safety was established by asking the patient to review his current comfort with hypnosis as a tool for symptom reduction. He reviewed recent gains in venturing out of the home without fear. He was told that if his mind was willing he could recall the assault. ECEM was used to impact the most intense moments of that recall.

Hypermnnesia to revivify trauma, dissociative watching

PT: I can see everything so clearly in my mind. As if I'm watching TV. I can see all the details.

TH: Tell me what you are seeing.

PT: I get out of the car. Suddenly they are shooting at me. I can hear the bullets. I dive back into the car. They are shooting and shooting. It's like slow motion.

TH: And then what happens? Something happened next.

PT: The patrol cars are coming. They are coming to rescue us. Thirty of them. But I can't hear the sirens. I can't hear them.

ECEM to undo amnesia for loss of auditory memory, details of trauma, and to facilitate integration of fragmentation of experience

TH: Now let your eyes move back and forth. You know how. Six or seven times. Then do it again. And again. Until you hear the sirens

PT: (Carries out ECEM and then releases his breath.) I can hear them. I can hear them. The sounds are there. It's coming back (He is excited and pleased because he has retrieved auditory sensation that had been dissociated. He remains in trance).

Hypnotic suggestion for reframing

TH: Yes. They came to rescue you. And the sound is back. You needed that piece. That sensory piece of being able to hear. How do you feel?

PT: Better. I don't know why I lost the sound. I have it back now. Having the sound back changes something. I feel better.

Hypnotic suggestion to recall details related to survival during trauma (state dependent reestablishment of memory)

TH: There is something more. Please close your eyes now. Perhaps you can see more about the rescue. You remember the rescue. See it. How did you recognize that you had survived?

PT: (The hypnotic experience appears to deepen although he is still able to speak.) I see myself standing there alone. I'm touching myself. All over. Saying I'm alive. I'm not injured. I'm not dead.

Hypnotic suggestion for multiple levels of awareness in order to reintegrate dissociated sensory modalities

TH: Please be in touch with that "touching." Let yourself feel it. Know it. Believe it. You have been numb. Can you begin to get your feelings back? Knowing you survived?

PT: Patient appears to be reliving the moment and repeats over and over, "I survived."

Hypnotic suggestion for utilization of personal resources, rebalance sense of past, present and future distorted by trauma

TH: (Fosters sense of continuous self linking past, present, and future.) Connect that with how you used to be when you were able to feel. When you are ready, let yourself imagine having feelings....for anyone you care about.

PT: I can get that. Not all of it, not altogether. That's hard.

Hypnotic suggestion to address resistance and anxiety raised by revisiting trauma

TH: (Utilizes resistance to loss of defensive numbing by suggesting rest.) You can rest. Is that what you need now?

PT: Yes. (Goes into a relatively prolonged, image-free hypnotic state.)

TH: (Reframes patient's lack of readiness.) When you are ready, would you please give yourself approval for your progress? It was work, wasn't it?

PT: (Nods.) Yes.

TH: (Pacing and leading.) But effortless, in a way?

TH: (Invites "yes set" to bypass resistance and suggests future success.) Would you like to give yourself a suggestion . . . for imagining a situation . . . in which you will be able to let yourself feel more?

Hypnotic suggestions for self-directed posthypnotic suggestions and future orientation followed by ECEM

PT: (Nods.) Yes. (Appears to go deeper.)

TH: (Suggests ECEM to consolidate self-suggestions.) Use eye movements when you have achieved what you wanted to. Let go what you choose. Give yourself suggestions to keep what you wish to keep from this experience. Then reorient.

Changes at multiple levels of awareness

The patient's hypnotic self-suggestions were to allow feelings to return. The following week he reported with relief that his emotional numbness had begun to lift. He felt genuine enjoyment when he took his child to a petting zoo in the park. There were brief moments when he recaptured a sense of his former self. He felt some connection to his dissociated experience during crises as "his actions while on automatic pilot." He also reported a change in auditory startle. He no longer tensed when he heard police sirens. His sleep continued to be generally restful.

Discussion

ECEM is a novel clinical intervention for the treatment of trauma. The assumptions of ECEM are that bilateral reprocessing of trauma imagery with eye movements can be incorporated within a hypnotic state in which therapeutic suggestions provide for safety, ego strengthening and an opportunity for mastering involuntary dissociation in an altered state are similar to that of trauma experience.

Combining eye movements from the EMDR protocol with hypnosis implies a difference in the therapeutic effects of processing dissociation in a conscious state vs. an altered state and a difference in the way hypnosis and EMDR manage safety and resistance.

Dissociation

Dissociation that occurred at the time of a traumatic event can subsequently reappear according to Janet (1925). Freud (1956a, 1956b), distinguished between involuntary dissociation which he called primary repression and secondary, defensive repression which involves defensive, motivated forgetting. Secondary repression can become habitual or involuntary (Erdelyi, 1990).

Does EMDR reprocess secondary repression (negative cognitions and affects) but fail to reprocess primary repression or involuntary dissociation. Does bypassed dissociation of traumatic event(s) subsequently reappear in persons who dissociated at the time of trauma? If so, is it more effective to reprocess dissociation in an altered state, similar to dissociation experienced during trauma than during a state of conscious awareness?

Safety

Both EMDR and hypnotic protocols emphasize safety but perhaps there are differences in processing safety in an altered state rather than during a state of conscious awareness. Hypnotic approaches can give primacy to eliciting safety imagery and protecting the personality of the subject through a wide array of interventions utilizing phenomena particular to hypnosis (Erickson, 1980a, 1980c). Examples include introducing protective figures into age regression experiences to master trauma (Erickson & Rossi, 1979; Watkins & Watkins, 1980), and turning hypermnesia into its opposite, amnesia as the patient remembers "how to forget." Time distortion in hypnosis helps a patient rework a painful past by revisiting it while utilizing a patient's present, adaptive resources.

Techniques for preventing decompensation in hypnosis have been elaborated by Kluft (1989) and for ego strengthening by Phillips and Frederick (1995; Spiegel, 1990b; Fine, 1991; Watkins & Watkins, 1992). Rather than rapid reprocessing, hypnosis provides suggestions for the slow leak of unconscious, traumatic, material into conscious awareness (Erickson,

1980c; Kluff, 1989).

EMDR, focuses on “unsafe” imagery buffered by therapeutic safety. Subjects are directed to access images of safety and EMDR is not carried out unless safety imagery can be established. Reprocessing trials are discontinued if safety is compromised. Intuitively, EMDR has come to utilize altered states of awareness for safety. Hypnotic imagery, such as a calming, white light is utilized to terminate an EMDR session and can be used for self-soothing between sessions (Shapiro, 1995).

EMDR practitioners are exploring new approaches to provide ego strengthening for severely compromised trauma victims as preparation for bilateral processing. Positive cognitions are installed to support an enhanced sense of self. Leeds (1999) uses EMDR to install personal resources as a foundation for ego stabilization. His approach utilizes many of the contributions of an Ericksonian approach to therapy and hypnotherapy.

Summary

ECEM (Eye Movement, Eye Closure) is described as a clinical intervention, which combines the eye movement aspect of EMDR within hypnosis for the treatment of trauma. The procedure is designed to utilize ego strengthening and reprocessing in an altered state while incorporating the effects of bilateral eye movements adapted from the EMDR treatment modality. Distinctions between EMDR and hypnosis are discussed in terms of neurophysiology and neurobiology and the way safety, resistance, and eye movements are managed.

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