

Internal Conference Room Ego-State Therapy and the Resolution of Double Binds: Preparing clients for EMDR trauma processing

**By Shirley Jean Schmidt, MA, LPC
EMDRIA-Approved Consultant**

Since its inception EMDR has grown to work with an ever-increasing variety of therapeutic methods in the mental health community and ego-state therapy is no exception. Ego-state therapy has roots in hypnoanalytic therapy and the treatment of dissociative disorders (DD). Even without hypnosis, and with non-DD clients, ego-state therapy can be an important companion to EMDR therapy. It has great diagnostic value, can aid in screening and preparing EMDR candidates, and can help unblock stuck processing during EMDR. This article focuses specifically on one ego-strengthening method that can be very useful to EMDR therapists when preparing clients for trauma processing.

I recently realized the power of ego-state therapy while working with a client with many chronic illnesses and too little ego strength for processing her significant childhood trauma. Our initial sessions focused on learning about and addressing her paralyzing double binds, and on strengthening inner resources. I was surprised to learn that after a short time she experienced a dramatic reduction in symptoms. Her story is summarized at the end.

There are many whose concepts have led the way to understanding consciousness as "parts" or ego-states. Ellenberger (1970) noted that St. Augustine in his "Confessions" pondered whether personality was a unity, and that "divided personality" was known by the end of the eighteenth century. Janet (1907, 1925) described this phenomenon in his work with dissociative disorders patients. John Watkins was greatly influenced by Paul Federn's (1952), and his disciple Edoardo Weiss' (1960), concepts of psychic energy and ego-states and began his formulation of Ego-states theory in the early 1970's. During that time Roberto Assagioli (1973, 1965/1975) published his ideas about the multiplicity of the mind as subpersonalities. In addition to these subpersonalities, Jung (1963, 1968, 1969) and Assagioli talked about the Self or Center that is different from the parts. Schwartz (1995) elaborated on these concepts and applied his family systems training to conceiving and working with a person as a system of parts and a Self. Learning from his clients, Schwartz focused on the relationships among the parts and the Self and defined the Internal Family Systems (IFS) therapy. From the work of Watkins and Schwartz, the parts concepts can be applied far beyond the treatment of dissociation, to a broad spectrum of other psychogenic disorders, as well as normal problems of adjustment (Watkins, 1997).

Parts models assumes an individual is a conglomeration of different ego-states (a.k.a. parts, or inner selves). It may be helpful to think of ego-states as specialized neural networks that hold specific packages of information related to behavior, affect, sensations, and knowledge of our life experiences (Braun, 1988). For example, a corporate executive may have one neural network for behaving in the boardroom, another to interacting with his/her spouse, and yet another for playing with his/her small children.

All is well when ego-states communicate, cooperate, and appreciate each other. However, problems may occur for the individual who grows up in a dysfunction family or chaotic household, which leads to diametrically opposing neural networks for storing different traumatic experiences. For example, one neural network may hold evidence that it is dangerous to be passive, while another may hold evidence it is dangerous to be assertive. When this traumatized person is grown, and has to decide whether it is better (safer) to approach a particular problem by being passive or assertive, these parts may go to war with each other. This double bind may not resolve easily, because there is "good evidence," from personal experience, to support each opposing view.

Fraser (1991) wrote about the internal conference room as an important tool for communicating with alters in his treatment of dissociative disorders. In brief, it is a guided imagery technique which involves asking the client to imagine a safe meeting place such as a conference room, and invite all ego-states (parts) to enter the room and take a seat at a conference table for the purpose of personal growth. Fraser found this approach helped gain access to the inner ego system of his dissociative identity disorder clients. Many clinicians have found this true for non-DD clients too.

The conference table approach offers a great climate for working through double binds. "Double bind" refers to a type of internal conflict between parts holding diametrically opposing views. For example: One part may believe that safety comes from being in relationships, while another believes safety comes from being alone; One part may believe that safety comes from being sick, while another believes safety comes from being healthy. In my opinion, it is best to learn about and resolve these conflicts as much as possible, before processing trauma, for two reasons, (1) addressing these conflicts increases ego strength, and (2) EMDR may be ineffective when opposing ego states are working at cross purposes. Ego-state therapy helps the inner ego system pull together as a team to work towards the same goals.

Below is a simplified example of using ego-state therapy to address a double bind. Client, Betty, wrestles with confusion about how to react to her abusive husband. Part of her favors being assertive and standing up for herself, even leaving the marriage if necessary. This part gets angry at the husband and believes self-protection comes from pushing back aggressors. Another part of her favors being passive, giving in to the abuser's demands, and soothing him when he is upset. This part feels sorry for the husband and believes self-protection comes from caving in. To work through this dilemma it may be helpful to take Betty through a series of steps:

1. Starting to get the parts connected

Say to Betty, "Close your eyes and imagine these two parts of you (passive part & assertive part) sitting across a table from each other, and describe what you see." Do not be surprised to hear of images of great conflict, like two monsters fighting, or a little girl crying and an angry woman yelling, and so forth. Sometimes conflict is not evident from the images and it is necessary to ask, "Would you describe their relationship as more 'friendly' or more 'hostile'?" If the double bind is significant the answer will likely be 'hostile.'

2. Acknowledge common interests/goals

"What goals do you suppose both of you (parts) have in common?" If an answer is not forthcoming say, "I'll bet you're both interested in helping Betty feel safer. The only problem is you don't agree on how to do it. Does that sound right?" Expect agreement.

3. Acknowledge survival intentions

"Betty, would it be okay if I talked with the 'passive' part?" (Do so only with permission.) "I would like you (passive part) to know how much I appreciate your being here now, and that I understand and honor the hard work you have been doing for so long to protect Betty. When I consider your history it makes perfect sense to me that you believe safety comes from giving in to abusers. I suspect you would not be here if you did not believe there was a real need for your services now. Does this sound right to you?" Expect agreement.

4. Hint that the desired safety may be possible through other means

"Do you (passive part) ever find there are disadvantages to protecting Betty this way? For example, does it require a lot of energy?" Parts will typically name one or more disadvantages. Follow up with, "If it were possible to ensure the same level of protection and safety you get from being passive, without the disadvantages, would you be interested?" Expect a "yes" answer.

5. Check for uncomfortable body sensations

"Betty, what do you notice in your body now?" If this part is open to new possibilities for safety the body will likely release tension, if this part is fearful the body will suddenly feel uncomfortable. If discomfort comes up talk to the discomfort, as if it were a part, and say, "Thank you very much for expressing your feelings. There must be a very good reason for feeling this way, will you help me understand it?" Depending on the answer I may go back to Step 3 and honor the intention of the fear in promoting survival.

6. Acknowledge survival intentions of the next relevant part

Once the 'passive' part is open to new possibilities, ask for permission to talk with the 'assertive' part, and attend to the same questions from Steps 3 to 5, honoring the belief that safety comes from standing up to abusers.

7. Can parts agree to work as a team? / Assessing EMDR readiness

Once all relevant parts and body sensations have been heard, validated, honored, and respected, ask Betty about how the picture of the two parts at the table has changed. Expect the parts to appear less threatening to each other. Ask, "If it were possible for you (addressing both parts) to get more safety by working together, as a team, would you be interested?" It might be helpful to add, "If this other part had an important contribution to make to your safety and well being, would you be interested?" This is a very important moment in client screening and preparation. If the idea is frightening, Betty is not yet a good trauma processing candidate, however, if the notion of a team approach feels hopeful and if it releases tension in the body, Betty is fast becoming a good EMDR candidate.

8. Strengthening the team / Assessing EMDR readiness

"What might be required to make it safe enough for you (two parts) to begin working together?" The answer to this may lead to other necessary resource installations, cognitive interweaves, and/or psycho-educational interventions. This may also be a good time to help the parts respectfully exchange views – point and counterpoint – to gain a deeper appreciation of each others' intentions to protect. The willingness of parts to work cooperatively may or may not be easy to accomplish, depending on the nature of the trauma history and the level of dissociative defenses. This step could take minutes, sessions, or months.

9. Install the team spirit and associated positive cognition

Finally, when Betty reports that all relevant parts are feeling friendly towards each other, willing to learn from each other and work together, AND the body feels relaxed and hopeful, strengthen this bond by installing it with bilateral stimulation. If it feels true to the client, use a PC like, "We can learn to work together as a team for Betty's safety and well being," using the clients own words. Strengthen the PC with bilateral stimulation.

10. Testing ego strength / Assessing EMDR readiness

If this is Betty's first time with bilateral stimulation begin with a short set and check if it is helping or not. A client's initial response to bilateral stimulation may be an important indicator of ego-strength. If she reports little to no change with the bilateral stimulation, one may need to go slowly – using minimal bilateral stimulation in the beginning and only to strengthen positives, where appropriate. If the PC strengthens a lot, with more insights arising, and client returns to the next session with reports of positive change in her life, it may be appropriate to do future ego-state processing with continuous bilateral stimulation. As with EMDR trauma processing, the bilateral stimulation seems to help the opposing neural networks exchange information more readily as if these neuro-segments are connecting to form a continuous neuro-path. This seems to lead to a more rapid integration of adaptive information between ego states.

The steps outlined above are rather directive and as such may be counter to the working style of some therapists. In my experience these steps are highly validating and reassuring to clients who, generally, have never before considered that there may be "benefits" to their reactive parts and shadow sides. The dialogue proposed provides a model clients can use for approaching their inner conflicts. Over time they internalize these dialogues and learn to validate, honor and respect the survival intention of their dissenting parts. While this example describes working with two parts in conflict, sometimes several parts are relevant to a double bind. The same steps can be used with two or more parts.

Working with parts and the relationships among parts is more than merely following a suggested protocol. John and Helen Watkins offer extensive workshops on the fundamentals of ego-state therapy and Dick Schwartz offers a two-year training program at the Family Institute, Northwestern University. The use of this protocol may uncover previously undiagnosed DD. Clinicians who are not trained in treating DD should not attempt to do so without proper supervision.

Case study

My experience working with a 54-year-old female I'll call Georgia, illustrates the value of this approach. Last fall I began working with Georgia, who was living with her abusive husband of 34 years. She presented with several chronic health problems, including fibromyalgia, osteoarthritis, endolymphatic hydrops, borderline hypercalcemia, hyperparathyroidism, heat intolerance, sleep disorder, and Crohn's disease. Over a 20 year period she has had all but 1/4th of her bowel surgically removed. She used a walker and often wore a headband with ice cubes because if her brain became too warm she would suffer temporary neurological distortions. Her energy level was chronically low and she was in constant pain.

Georgia had been in psychotherapy on and off for 25 years. When she came to me she was afraid to work on her childhood traumas directly, which included chronic sexual abuse, because she feared she would become flooded and overwhelmed, as she had in past therapy. She agreed to work with me when I told her we would do nothing but ego strengthening until she felt ready to address the trauma, which she believed to be the root of her many problems. I even postponed taking her history because she said it would be too stressful.

This was the first time she had experienced ego-state therapy. She reported many ego states, and two were much like the passive and assertive parts of Betty, but with a twist. There was also an ego state that believed she had to stay married to her abusive husband because otherwise she'd have no medical insurance. Because her chronic illnesses (and her husband) had kept her out of the work force, she feared she would have to stay married to keep the medical care she needed. Fortunately, she had several wonderful, loving resource ego states, and a remarkable capacity to quickly get in touch with an unconditional higher power loving kindness. The focus of our work has been three fold: (1) addressing multiple double binds (with the steps listed above, often with bilateral tactile stimulation), (2) connecting the loving resources (internal and higher power) with ego states that needed love and understanding (strengthened with bilateral tactile stimulation), and (3) learning how to have a more loving relationship with her chronically ill body.

Just a few weeks after resolving many of her paralyzing double binds she began to report significant improvement in her health, her outlook on life, her self-esteem, and she continues to improve on all fronts. She has since filed for divorce, something she has wanted to do for over 20 years. Six months later we are just beginning to process childhood traumas with EMDR. She is handling the requisite emotional disturbances very well and connects quickly to her inner resources as needed. She describes her own progress by saying:

"Since I began (ego-state) therapy in November '97, there have been several significant changes in my physical, mental, and emotional well-being. For several years, I had been almost homebound at times. I had/have (?) endolymphatic hydrops which resulted in problems with my balance to the extent that I had been using a walker when I went out to do almost anything. I haven't used my walker since January 1. I still experience brief periods of feeling "tilty," but I am able to compensate by using techniques I have learned as a side benefit of the therapy we have been doing. Because of the fibromyalgia, I experienced a great deal of pain at times. When the weather was beginning to change, not only would the pain level increase, but I would also have greater difficulty concentrating and processing information, along with difficulty with word retrieval. I now am much less sensitive to changes in the weather and no longer anticipate having problems when the weather changes. I seldom have problems with word retrieval now and have made a correlation between sleep deprivation and the "mental fog" I often experienced in the past several years. My sleep patterns have improved, and except in periods of unresolved and unusual stress, I am sleeping longer at night with fewer times of waking up. Overall, I am much less sensitive to changes in my environment. I had been using a frozen headband on my head to keep me cool, in order to deal with an over-sensitivity to heat. I even had a special vest used by firemen to handle periods of extreme heat. So far this year, even with temperatures in the 90s, I have not used any of these products. I am still sensitive to heat, but I am able to calm down that hyper-reaction most of the time. I recently noticed I have recovered my ability to sweat, which had been gone for 10 years. The fatigue that I experienced most of the time for many years has lessened and it is my anticipation that I will gradually be able to return to work. I no longer view myself as a chronically ill person but as someone with physical difficulties that are manageable. I have been able to decrease the medication I take for pain management to a very low dose, at times even discontinuing it entirely. I am on more or less the same level of antidepressant. I also still take medication every night to help me sleep but anticipate being able to reduce and hopefully discontinue that medication within the next 6 months. I still have an ileostomy and short gut syndrome due to Crohn's disease, and I still have osteoarthritis, fibromyalgia, etc. There are some things that I will continue to deal with every day that I cannot change, but how I deal with them has changed. The therapy we have been doing has changed my life. My outlook has improved to the point that I now am caught off-guard if I revert to my old habits of feeling like there is no hope and my life is over. I feel hopeful, excited about the possibilities of my present and future, in control of my own life, and able to handle whatever comes. I've never felt more alive and centered."

Special thanks to James A. Kowal, MA and Andrew Leeds, PhD for reviewing my drafts and providing valuable feedback and encouragement.

References & Resources:

- Assagioli, R. (1973). *The act of will*. New York: Penguin Books.
- Assagioli, R. (1975). *Psychosynthesis: A manual of principles and techniques*. London: Turnstone Press. (Original work published in 1965.)
- Braun, B.G. (1988). The BASK model of dissociation. *DISSOCIATION*, 1, 4-23.
- Ellenberger, H. (1970). *The discovery of the unconscious*. New York: Basic.
- Federn, P. (1952). In E. Weiss (Ed.), *Ego psychology and the psychoses*. New York: Basic.
- Fraser, G.A. (1991). The dissociative table technique: A strategy for working with ego states in dissociative disorders and ego-state therapy. *DISSOCIATION*, 4, 205-213.
- Frederick, C. and M. Phillips (1995). *Healing the Divided Self*. New York: Norton.
- Goulding R. and R.C. Schwartz (1995). *Mosaic Minds*. New York: Norton.
- Janet, P. (1907). *The major symptoms of hysteria*. New York: Macmillan.
- Janet, P. (1925). *Psychological healing: A historical and clinical study*. New York: Macmillan.
- Jung, C.G. (1963). *Memories, dreams, reflections* (A. Jaffè, Ed.; R. Winston & C. Winston, Trans.). New York: Pantheon Books.

- Jung, C.G. (1968). *The collected works of C.G. Jung (2nd ed.): Vol. 9, Part 1. The archetypes and the collective unconscious* (H. Read, M Fordham, & G. Adler, Eds.; R.F.C. Hull, Trans.). Princeton, NJ: Princeton University Press.
- Jung, C.G. (1969). *The collected works of C.G. Jung (2nd ed.): Vol. 8. The structure and dynamics of the psyche* (H. Read, M Fordham, & G. Adler, Eds.; R.F.C. Hull, Trans.). Princeton, NJ: Princeton University Press.
- Leeds, A. (1997). Case formulation and resource installation in complex PTSD and attachment related disorders. *Presentation at the 1997 EMDR Conference.*
- Paulsen, S. (1994). Ego State Disorders: Dissociative but not multiple. *Presentation at the 1994 EMDR Conference.*
- Paulsen, S. (1996) Using Internal Dialogue to Achieve Maximum EMDR Results. *Presentation at the 1996 EMDR Conference.*
- Paulsen, S. (1995). Eye movement desensitization and reprocessing: Its cautious use in the dissociative disorders. *DISSOCIATION, Vol. 8, No. 1, 32-44.*
- Schwartz, R.C. (1995). *Internal family systems therapy*. New York: Guilford.
- Watkins, J.G. and H.H. Watkins (1997). *Ego states: Theory and therapy*. New York: Norton.
- Weiss, E. (1960). *The structure and dynamics of the human mind*. New York: Grune & Stratton.