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Eye Movement Desensitization And Reprocessing (EMDR): The Making of a Psychotherapy

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Abstract

Eye Movement Desensitization Reprocessing (EMDR) therapy has burst upon the psychotherapeutic scene as a time-limited, cost-contained, and efficacious treatment for anxiety, stress, and psychological trauma. Although this therapy has been pronounced as revolutionary by its inventor, Francine Shapiro, it has distinct historical precedents. The explanatory models of pathogenic memory and dissociation theory, and the reliance on mechanical inference for objectivity make EMDR therapy familiar and salient. Notions of suggestion and hypnosis, and the eye-movement component of therapy are presented as discontinuous with clinical and theoretical practice, in order to free them from the tainting associations of pseudo-science and quackery. By connecting the current EMDR movement with the conceptual and practical history of traumatic memory, dissociation, and suggestion, I argue that EMDR is not revolutionary. It is a powerful technology of the self, normalizing and valourizing certain ways of behaving and thinking. Shapiro's implicit assumptions that psychological suffering is pathological, and that early traumatic events are indelibly encoded, stored and dissociated in the brain are problematized. A brief commentary on the moral, political, and psychotherapeutic implications of EMDR therapy is provided.

Résumé

La nouvelle thérapie Eye Movement Desensitization and Reprocessing (EMDR) se passe pour une thérapeutique peu coûteuse, courte et efficace dans le traitement de l'anxiété, le stress at le trauma psychologique. Bien qu'elle soit présentée comme étant révolutionnaire par son inventeur, Francine Shapiro, cette thérapie connaît d'importants précédents historiques. Par l'usage qu'elle fait de modèles explicatifs tels que la dissociation et la mémoire pathogénique et par son dépendance sur une mode inductive méchanique d'objectivité, l'EMDR et du déjà vu. Les concepts de suggestion et d'hypnose, et l'élément thérapeutique des mouvements oculaires sont présentés comme étant dissocié de la pratique clinique et théoretique afin de les nettoyer de toutes taches de pseudo-science et de charlatanisme. En lient le mouvement EMDR contemporain avec l'histoire pratique et conceptuel de la mémoire traumatique, avec la dissociation at la suggestion, j'affirme que l'EMDR n'est nullement révolutionnaire. Elle est une puissante technologie du sujet qui normalise et valorise certains façon d'agir et de penser plutôt que d'autres. Les suppositions que la souffrance psychologique est pathologique et que les événements traumatiques sont dissociés, codés at enregistrés de façon indélébile dans le cerveau sont problematisées. Un bref commentaire sur les implications morales, politiques et psychothérapeutiques est donné à la fin.

"How do we stand to the rival projects of clarification and explanation in general? We must avoid two complementary errors, that of seeking to resolve by reflection what can only be resolved by investigation, and that of seeking explanation when even its successful consummation could not give us what we anticipate from it."

—Frank Cioffi (1998: 301)

1. Introduction

In the late 1980's a new psychotherapy, called Eye Movement Desensitization and Reprocessing (EMDR) therapy was presented as a treatment of post-traumatic stress disorder (PTSD). This psychotherapy has situated itself within, as well as generated, much debate on the genesis and nature of traumatic memories, treatment strategies, and the production, reproduction, validation, and reliability of scientific knowledge in the mental health disciplines.

It is a useful starting point to speak of psychotherapy by its relation to suffering. The relief and easing of suffering, whether physical or existential, is most often the implicit motive driving the production and engagement of myriad psychotherapeutic interventions. Suffering has no intrinsic, timeless meaning. It is provided meaning by systems and institutions, most prominently biomedicine. The common explanation provides us with an etiological event, leading to alterations in brain chemistry, which the scientific community is slowly unraveling in its attempts to end this scourge of pain. It is a moral argument in which suffering is the evil against which can rally our resources together in opposition. Less often, however, are the historical, political, legal, economic, and philosophical dimensions brought into this discourse.

In this thesis, I plan to situate EMDR therapy in the debates through which a particular type of experience of suffering is circumscribed and given meaning. I rely upon an ethnographic stance in characterizing psychology and the scientific principles it purports to uphold. My goal is not to speak toward the truth and falsity of claims made by one group or another, on whether memories are fallible and cultivated by therapists or not, whether EMDR therapy *works* or not. I

will instead speak on the way in which the very idea of cause, proof, and conviction are formed. As Ian Hacking (1986) observes when considering the manifold ways in which science and technology "make up" people, the very diversity of human life means that a general theory bent on explanations and predictions will make little headway. Consequently, historians, philosophers, sociologists and anthropologists alike must attend carefully to the origin of our ideas and their evolution.

In this introduction, I will provide a brief internal account of EMDR therapy, using language consistent with the prescribed treatment theory and practice, quoting heavily to minimize interpretive distortion. I will further outline the implications for such a genealogy.

1.1 Background

In 1979, Francine Shapiro was undertaking a PhD programme in English literature at New York University when she was diagnosed with cancer. Unsatisfied with biomedical approaches to treatment, she left New York "in search of workshops and seminars on mind, body, and psychological methods to enhance physical and mental well being" (1995:vi). Shapiro's new-age investigative odyssey eventually led her to enrol in a doctoral programme in clinical psychology at the Professional School for Psychological Studies in San Diego.[1] It was in 1987, at age 39, while strolling through a park, that she noticed that her disturbing thoughts began to dissipate, as she instinctively moved her eyes from side to side. For her dissertation, she put together a study of 22 people diagnosed with PTSD (both sexual abuse and combat-related), to be treated with what was then called Eye Movement Desensitization therapy (1989a; 1989b).

[1] Shapiro's doctorate is from an "authorized" school of psychology, which rates below of "approved" and "accredited." The Professional School for Psychology Studies is now defunct.

A comprehensive account of its practice and theory can be found in the book *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (1995; hereafter referred to as *Principles*), written by its inventor Francine Shapiro. She proposes a conceptual framework in which psychological trauma is located in the brain, through a mechanism of dysfunctional memory storage.

What follows is an internal account of the relationship between the characterization of various mental ailments, the professionals privileged to treat these conditions, and their arsenal of psychotherapeutic techniques. This description is crucial to keep in mind while reading the second (historical) section of this paper; it provides the necessary reference-frame of EMDR. Afterwards I will unpack many of the implicit assumptions of EMDR as presented by Shapiro, focusing on the unproblematized nature of traumatic memory, dissociation, objectivity, suggestion, and patient-therapist relationship.

1.2 Francine Shapiro's EMDR: An Internal Account

In *Principles*, EMDR is divided into eight phases. Phases One and Two involve history taking and client preparation.[2] The former is described as an evaluation of the client's dysfunctional behaviours, stimulating triggers, and the determination of "the traumatic memories which are directly responsible for the present dysfunction and therefore should be processed with EMDR, and which are incidental to the crisis, and can be set aside... [to be] remediated by education, problem solving, or stress management techniques" (Shapiro 1995:93,102,116). The second phase, entitled "preparation," outlines goals toward explaining the EMDR process and

[2] Shapiro uses the term "client" throughout this book, and I have retained it for consistency. I do not mean to draw any attention towards its distinction with the term "sick person" or "patient."

putative effects to the client, addressing concerns, familiarizing the client with safety and relaxation procedures, and establishing a "therapeutic alliance" (Shapiro 1995: 68-69). This term is used interchangeably with rapport to indicate a general sense of bonding and trust between the therapist and patient.

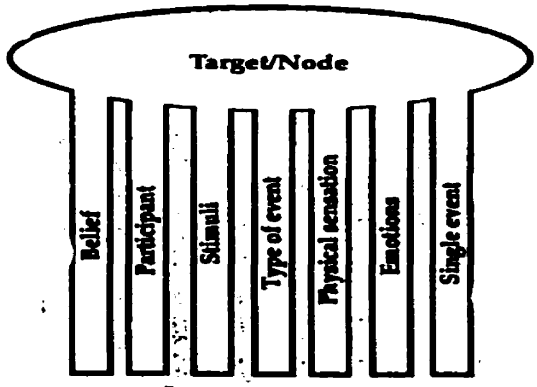
Phase Three, the assessment phase, produces positive and negative statements (cognitions) that will be used in the EMDR sessions, and provide baseline values for subjective reporting of emotional states. While the image of a specific past event is held 'in mind' with a negative statement such as "I'm powerless" or "I cannot succeed," the client is asked to name an emotion, and choose a number from 0-10 indicating their Subjective Units of Distress (SUD) level, and to then locate this distress in some "bodily sensation." Following, a positive cognition such as "I can control my actions" or "I can succeed" is rated by the client as to its perceived truthfulness on a 1-7 Validity of Cognition (VoC) scale. It is assumed that this "convergence of the image and negative cognition will generally stimulate the dysfunctional material to a greater intensity than either of the two alone" (ibid. 135). For the initial event, "the client is instructed to locate the earliest available memory to which the negative cognition applies....Clinical skill is necessary, however, because the original negative cognition designated by the client may not actually be the one linked to the earlier memory" (ibid. 187).

The first three phases are carried out in 50 minute sessions, and are not completed until an appropriate rapport has been established, even if this takes months (ibid. 119). Subsequent sessions are 90 minutes in duration.

Phases Four to Six are named Desensitization, Installation, and Body Scan, and are described as operating under the principle of Accelerated Information Processing. Shapiro's sample phrase for this phase is "Bring up the picture and the words [clinician repeats the

negative cognition] and notice where you feel it in your body. Now, follow my fingers with your eyes" (ibid. 142). Sets of saccadic eye movement, approximately 24 forward and backward motions of the therapist's fingers, tracked by the client across his or her field of vision, is the most unique aspect of this EMDR therapy. "It's purpose is to merely serve as an initial focal point for entering the memory network" (ibid. 142). Organized around terms like *neuro network* (see figure below; ibid. 77), Shapiro has developed a new language with which to identify and explain traumatic memory. In her words:

> For desensitization to occur, it is necessary to process the dysfunctional material that is stored in all of the channels associated with the target event. When an event is reprocessed, a variety of channels of associations may be revealed in consciousness. Each initial target is considered a physiological node to which other past experiences are linked. It is assumed that the disturbance inherent within any target node is fueled by the various channels of association.... As each channel is accessed, there emerges a set of lawfully linked associations (ibid. 147).



Target/Node and Possible Types of Associative Channels

Shapiro maintains that there appears to be a "neurological balance in a distinct physiological system that allows information to be processed to an 'adaptive resolution'." This resolution, also called "digesting" and "metabolizing," is the body's natural tendency to heal, citing the analogy of the body's tendency to heal after a laceration, by connecting dysfunctionally stored information to "appropriate associations...integrated into a positive emotional and cognitive schema" (ibid. 29).

EMDR therapy thus proceeds with the identification of troublesome memories or ideas followed by sets of eye movements (and other bilateral stimulation; see Section Three) while keeping in mind both this memory and the bodily sensation that it incurs. Following each set, the client is instructed to "Rest/let it go/blank it out, and take a deep breath," and asked "What do you get now?" Using shifts in awareness and beliefs, body sensation locations or intensity, and new images, emotions and insights, the therapy continues until the SUD level is reported at 0-1.

At this point the installation phase begins. The clinician instructs the client to "'Think of the event, and hold it together with the words [clinician repeats the positive cognition]', and then leads the client in a new set." Shapiro's instructions are very simple: The clinician checks the VoC and the sets are repeated, with the event and positive cognition linked, "until the VoC reaches a seven, or 'completely true'" (ibid. 158).

The body scan, phase six, rests on the assumption that, within the Accelerated Information Processing model, dysfunctional material has a physical resonance (tension, tightness, unusual sensation) that corresponds (again, "lawfully") to the blocked cognitive process, which must also be "cleared." The client mentally scans their body for any sensations while holding the memory of the event and positive cognition in mind. If found, they are targeted with future sets of eye movements, focusing on this sensation together with a positive cognition. If a positive bodily sensation is found, Shapiro recommends that "sets are done to strengthen it" (ibid. 160).

Each session is followed by the Closure Phase, ensuring that the client ends the (recommended) ninety-minute session at a low level of anxiety and a positive frame of mind. If the client is showing any signs of abreaction (strong emotional release) or dissociation (not defined), he or she should be lead through "safe-place" exercises: guided visualization or

hypnosis. Whether part of the exercise or not, closure includes a "complete debriefing" and instructions to keep a detailed log of any future dreams, memories, thoughts, or emotions related to the event or session. Like the eye movements, this activity is said to allow cognitive distancing from the event. The client is instructed to "notice it from a distance, like the view from a train" or "take a snapshot," and is encouraged to see emotions such as fear, shame, and anger as primary physical sensations that can be described and changed (ibid. 163).

The proper application of eye movements causes a consistent reprocessing of dysfunctional material in 40% of cases (ibid. 146).[3] Others, called "blocked" or "challenging" patients, do not report a decrease in SUD level after 15 minutes. Reasons cited for this are "looping" (the repetitive negative thoughts), insufficient information (such as insufficient education or experience from which do draw "the appropriate data to progress cognitively or behaviourally," lack of generalization (the processing of one target does not generalize positively with associated targets), and time pressures (a complex target cannot be fully processed in the time remaining in the session" (1995: 245, 270). For these patients, Shapiro advocates a proactive strategy called the "cognitive interweave." New Information is offered by the clinician to "therapeutically weave together the appropriate neuro networks and associations.... [toward] the adult or adaptive perspective" (1995: 244, 247). Owing to deficits in education, parenting, cognitive capacities, these patients do not have the appropriate neuro networks that can be favourably connected to the dysfunctional information, and must therefore be "introduced." By recommending adjustments to positive cognitions, or providing one, appropriate responsibility, safety, and beneficial choices will be available to the client. The feelings of safety must be

[3] Shapiro writes in a subsequent chapter that the cognitive interweave is "necessary with most most clients suffering from multiple sexual abuse, combat veterans, and clients with dissociative disorders" (1995: 272, 307), while a "client with a single trauma may require only one reprocessing session..." (196).

"ecologically valid" before they are able to generalize with distressing memories, relieving them of their negative affect quality.[4]

> For instance, to enable the client to express feelings of violation to an authority figure, the clinician might say 'Let's pretend. If you could say something to him, what would it be?' If the client answers in a way that reveals the appropriate attribution of responsibility, the clinician responds, 'Good. Now just imagine it and pretend you are saying it,' and then initiates another set.

Sessions are not complete until "the client can re-access the original traumatic material without disturbance" (ibid. 260). Phase Eight, Reevaluation, is used both at the beginning of every session to ensure that the previous session's reprocessed memories are still reported as a 0-1 SUD rating, and as a final review of all targets when psychotherapy ends. "Each target must be individually circumscribed and fully processed" (ibid. 56). These reportings are on specific memories, as well as the ability of the client "to feel at peace with the past, empowered in the present, and able to make choices for the future.... in a healthy social system." Concerning the treatment of a cancer patient, she writes:

> EMDR should be used to address not only the fear, but all of the ongoing traumatizing experiences related to the cancer, including feelings of body betrayal; real or perceived callousness or indifference of medical personnel, family, and friends; and negative emotions related to hospital stays, medical tests, operations, and so forth (1995: 235).

While this can take one to two sessions for single-event traumas, Shapiro states that multiple-event and long-term trauma survivors might require months of sessions (ibid. 197-199).

2.3 Applications and Variations

EMDR began as a therapy specifically intended for the treatment of people with PTSD, Shapiro maintains (ibid. 18). Separate protocols are outlined by Shapiro which distinguish between recent, single-event, and multiple-event trauma, general anxiety, phobias, excessive

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4 The term "ecologically valid" is used throughout the book, interchangeably with "appropriate," "adult," "consensus-reality validity," and "adaptive." In one case Shapiro writes "inappropriate (i.e., not ecologically valid)" (1995: 257).

grief, anxiety caused by illness and somatic disorders, and children as young as two years old (1995: Ch. 9, 307).[5] As well, EMDR has been used to treat panic disorders, body dysmorphic disorders, sexual dysfunction, crime victims, accident and burn victims, drug addictions, and persons with dissociative disorders (1995: 10-11, Chap. 9; see Cusack and Spates 1999: 88). More recently, EMDR has been used as a general performance enhancement tool. Shapiro writes, "The use of EMDR to give the client healthy 'templates' for appropriate future action has proved [sic] so successful that many EMDR clinicians are now working as 'coaches' with athletes, musicians, and executive officers of major corporations to achieve peak performance" (1997: 241). The therapeutic value of transforming "dysfunctional" into "functional" seems to have been extended to transforming "functional" to "exceptional."

To determine if EMDR is suitable for a particular case, "one simply observes the level of processing that has (or has not) occurred" (1995: 306). EMDR is deemed by Shapiro to be inappropriate for some clients. She writes: "Clinicians must determine which problems should be remediated by education, problem solving, or stress management techniques and which are based on dysfunctional material that needs processing" (1995:102). In addition, clients who cannot tolerate high levels of emotional disturbance, clients with whom the clinician cannot establish an appropriate therapeutic relationship, and clients with chemically or organically based disorders (Shapiro 1995: 47,75; 1997: 29), should not be treated with EMDR. As well, Shapiro notes that "whether there are corroborating data or not, the primary emphasis must be on client safety and appropriate support during the therapeutic process...whether the event is true, symbolic, or due to vicarious traumatization" (ibid. 295).

[5] See Lohr at al. for a review of other recent "novel" treatments for anxiety and stress (1999: 186).

2.4 EMDR as a Style of Reasoning

All of Shapiro's claims for EMDR therapy are derived from two basic, implicit assumptions. The first is that existential suffering (and its cognates, anxiety, stress and distress, psychological pain and trauma) are scourges that should be alleviated toward a better quality of life. Her second postulate[6] is that there is an innate, largely unconscious mechanism by which certain events cause biological responses, triggering trauma and suffering.

There are four corollaries which necessarily follow from these two postulates: 1) The body (including the brain and its properties) is universal; 2) Knowledge of the body (ailments, symptoms) is uncovered, making them ahistorical; 3) Our memories are linear and associative, thus allowing any distortions to be observable and measurable; 4) Observations and measurement of bodies can be objectively made; representation is not affected by intervention. The symptoms, through which this suffering is recognized and characterized are understood by, and suitable for, scientific inquiry; the science of suffering is the domain of the psy disciplines (psychiatry, psychology, and psychoneurology). That is, the symptoms are meaningful, and thus amenable, to interpretation and intervention.

These assumptions are not without historical precedent. Indeed, what we now call hardship and suffering have characterized the human condition probably since its inception, and this sentiment provides the backdrop against which this paper is made possible and relevant. The intellectual history of a certain type of suffering—psychic trauma—begins in the mid-nineteenth-century with notions of physical versus psychological trauma and distress. I intend to place EMDR therapy within such a historical dialogue, whereby the notion of psychological trauma has co-evolved with the discourse produced by those who have claimed authority in its

characterization and treatment. Contrary to the claim of EMDR's producer that it is a "breakthrough" and "revolutionary" therapy, I will show how it has been crafted and made possible by drawing upon popular and academic conventions which have characterized mental healing for hundreds of years.

In this task, I will use Ian Hacking's notion of *Styles of Reasoning* to discuss the large issues involved in the production, reproduction, and validation of ways of scientific knowing.[7] A style of reasoning is indistinguishable from the ideas, practices, materials technologies, and objects (memories, populations, symptoms) within which it has its existence and assumptions. They connect effect with its antecedent cause, while embedding such connections in metaphysical and ideological frameworks (normative accounts). Each style of reasoning produces its own standards and tests by which outcomes are proven true or false.

All styles of reasoning are maintained (self-stabilized or made consistent by circularity) by reasoning which is self-authenticating and self-validating. Self-authenticating styles of reasoning generate their own truth conditions (validity) for the propositions they produce (1992c: 51). Certain perceptions qualify as relevant "observations," "data," and even "outcomes," while others are artifacts, noise, or unworthy of comment. "The truth of a sentence (of a kind induced by a style of reasoning) is what we find out by reasoning using that style. Styles become standards of objectivity because they get at the truth. But a sentence of that kind is a candidate for truth or falsehood only in the context of style. Thus styles are in a certain sense 'self-authenticating'" (Hacking 1992a: 13).

Self-vindication is a material concept pertaining to the way in which ideas (concepts, classifications), practice (regulations, standards), things (instruments, materials), and marks

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[6] I use this term to mark an assumption or position assumed without proof, and therefore is self-evident.

(statements, calculations) are mutually adjusted (1992c: 51). If a style of reasoning is challenged by a contradictory or anomalous (unexpected) result, it is adjusted through a process of revising, tinkering, and manipulating the theory and practice to accommodate (and often include) the errant finding. The following sentence provides a characteristic example:

> I simply kept altering the procedure through trial and error to improve the results. Because the changes in a person's images, thoughts, and feelings came about—or didn't—so rapidly (usually within one session), it was relatively straightforward to fine-tune it into a comprehensive approach....Of course there were glitches, but even these turned out to be useful because they told me more about how EMDR worked (Shapiro 1997: 10, 19).

The historical component of this thesis has been written to show how ideas of science and objectivity have shaped our understandings of madness, by talking in specific ways about suffering, memories, bodies, abnormalities and treatments. I will show how the notion of psychogenic trauma—the object of EMDR—has arisen consensually with psychiatric diagnoses (hysteria, dissociation), etiological assumptions (psychogenic shocks, pathogenic secrets, phylogenetic memories, suggestion), the characterizing of these conditions (psychometrics, nosologies), and the ways of treating such conditions (abreaction, free association, hypnosis).

[7] He cites A.C Crombie as his influence in his project, although Hacking's focus is "on how we find out, not on what we find out" (1992a: 1). He is not arbitering truth, but examining paths, claims and proofs of truth.

2. The Historical Construction of Madness

Until the second half of the nineteenth century, persons who claimed to be sick, but could not convince a physician that their suffering was due to a known malady, were generally regarded as faking their illness, and were labeled malingerers. And those who claimed to heal the sick without recognition from the medical establishment were labeled quacks or charlatans. This perspective, both medical and lay, on suffering and healing, was remarkably transformed as result of the influence of Charcot, Janet, and Freud.[8] Their object of study was hysteria, around which concepts of patient and physician, disease and illness, psychiatry and quackery, and diagnosis and treatment revolved. "One could say" wrote Ellenberger, "that modern dynamic psychiatry emerged entirely from the study of hysteria" (1961 republished in Micale 1993: 242).

The word "hysteria" is derived from the Greek word for uterus, which is taken from the older Sanskrit word for stomach or belly. It was first noted in the written record in 1900 B.C.E., referring to a series of curious behavioural disturbances in adult women. Various descriptions and interpretations of hysterical symptoms cycle among gynaecological, demonological and neurological models, identified by irregularities in gestation or birth, anaesthesias, mutisms, or convulsions in demon possessions, and treated, in turn, by regimens of marital fornicatio, legal punishments involving confession, torture and execution, and medical ministrations of purges, powders and rest-cures (Micale 1995: 19-24; Freud [1923]1959: 436-472). By the early eighteenth century, the ties between female anatomy and hysteria were reintroduced within a

[8] This historical relationship and influence of these three figures is well documented by some great works of scholarship. These works focus on the history of the dynamic unconscious: Ellenberger's *The History of the Unconscious* (1970); psycho-legal issues: Laurence and Perry's *Hypnosis, Will, and Memory* (1988); Crabtree's

physical model, and etiological models involving animal magnetism, suggestion, and the intimate rapport between patient and physician gained popularity.

Hysteria was considered a great synthesis of various conditions, that included lethargy, catalepsy, ecstasies, hallucinations, somnambulism and personality changes. All of these conditions frequently occurred in the same person, and could be provoked and treated by hypnosis (Ellenberger 1970: 141-145). Having become associated with suggestion and hypnosis, a diagnosis of hysteria was a stigmatizing label. It connoted poor breeding and congenital weaknesses, usually met with punishment rather than treatment. Describing the period between 1860 and 1880, Ellenberger writes, "magnetism and hypnosis had fallen into such disrepute that a physician working with these methods would irretrievably have compromised his scientific career and lost his medical practice" (ibid. 85). It was Jean Martin Charcot, the director of the famous Salpêtrière neurology clinic, who made the first synthesis between these two traditions, bringing hysteria and hypnosis back within the realm of an official, scientific psychiatry (Chertok 1984: 111; Gauld 1992: 306, 311; Makari 1994; Binet and Féré [1890] cited in Crabtree 1993: 167). Freud, who had studied with Charcot for the winter months of 1885-1886, and attended many of Charcot's famous *leçons du mardi* from 1887-1888, wrote of this transition: "The general opinion was that anything may happen in hysteria; hysterics found no credit whatsoever. First of all Charcot's work restored dignity to the subject; gradually the sneering attitude, which the hysteric could reckon on meeting when she told her story, was given up; she was no longer a malingerer, since Charcot had thrown the whole weight of his authority on the side of the reality and objectivity of hysterical phenomenon" (1893: 18-19, 23).[9]

From Mesmer to Freud (1993) and *Animal Magnetism, Early Hypnotism, and Psychical Research, 1766-1925: an annotated bibliography* (1998); and Gauld's *A History of Hypnotism* (1992).

[9] This liberation was perhaps a smaller, but similar act consistent with the Salpetriere hospital. It had previously been used as a lunatic asylum where "incurable" women were chained to the walls. During the French Revolution

In doing so, Charcot took a large part in the birth of mental illness as the object of modern "psychiatric science." Hysteria became an illness which was not discovered by some physical alteration, but was invented by expanding the criterion of disease. Hysteria was *declared* to be a disease: a functional or conversion disorder understood in relation to organic pathologies, but with no identifiable physical cause (cf. Szasz 1960).

Charcot's hysteria was hereditary, and thus betrayed a physiological degeneration patterning itself with gender, social and personal characteristics, leaving the patient highly suggestible, and thus susceptible to hypnotic induction (a pathological process). There was, thus, no need for an emphasis on treatment in this model, only anatomical and behavioural description. It was a disease of the nervous system akin to epilepsy and syphilis.

Ultimately, Charcot lost this battle, and hysteria dropped out of favour as a diagnosis, and eventually as a medical entity altogether. In her 1965 study, Veith marvels at the "nearly total disappearance of the disorder" (pp. 273-274). And in 1990, Slavney writes: "This could well be the last book with *hysteria* in its title....*Hysteria, hysteric, and hysterical* are on the verge of becoming anachronisms" (p. 190). This was not to be the case. In 1997, Showalter proposed that "hysteria not only survives in the nineties, it is more contagious than in the past" (p. 5). We are, she contends, right in the middle of an "epidemic" or "plague" of hysterical disorders and imaginary illnesses. What is most distinct, and should be thought of in light of the following text, is the *definition* that Showalter gives to hysteria. It is a "universal human response to everyday human conflict," and is said to be part of everyday life, as we convert feelings of shame, guilt, and helplessness into symptoms when we are unable to speak. Hysteria is now identified with any negative self-feeling, and underlies the most general anxiety and strain.

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its superintendent, Philippe Pinel, who was one of the first to advocate humane treatment for mental patients, had the chains removed (Valenstein 1986: 9).

Shapiro's EMDR therapy has aligned itself with this view of suffering, and her therapy can only be understood with this in mind. She writes: "EMDR's success is not limited to people who have experienced a diagnosable trauma....Almost every type of suffering that we define and label a *disorder*—almost every type of psychological complaint—can be traced to earlier life experiences, which can also be healed" (1997: 11).

Charcot had no such luxury. As a rigorous academic, he was only willing to endorse a hysteria that was clearly pathological, hereditary, and that followed symptomatic stages which confirmed their biological base. One of his tasks, however, was to account for the number of persons who succumbed to hysterical symptoms following some type of severe physical or psychological shock, and suffered from what was termed "traumatic hysteria." It was well known that hysteria often followed stressful life events (van der Hart and Horst 1989: 398). But "stressful" and "traumatic" are terms which require further unpacking.

2.1 Railway-Spine and Psychogenic Trauma

Trauma, in the psychological sense of the word, has only existed since the mid 1860s. It was at this time that the physical sense of the word (such as a contusion or injury) was extended to include psychological or existential suffering. Most historical accounts locate this history with John Erichsen's article on "railway spine" (1866). Erichsen was a surgeon employed by the railway company, and it was his job to distinguish between those patients whose medical complaints were spurious, and those whose complaints were authentic, though they often lacked an identifiable physical cause. The proposed mechanism was that a shock to the system "through the medium of the brain" suspends volition and sense, while acting as a powerful sedative on the

heart and prostrating the nervous system. Such intense fear could cause a weak and fluttering pulse, cold sweat, relaxed sphincter muscles, shallow breathing, deep depression, incoherent speech, etc., which was a known cause of certain physical injuries to the nervous system (Young 1996a: 90).

Erichsen did not indicate the causal mechanism of such symptom development, referring only to states of helplessness and perturbation which might intensify the physical injuries. Herbert Page, another consulting surgeon for a railway company, criticized Erichsen for not considering neuromimesis as a possibility for his diagnoses. This theory conjectures that through a wholly unconscious desire for compensation, a person might mimic hysterical symptoms (Young 1996b: 250). Unlike Erichsen, who proposed that actual damage, albeit too microscopic to be physically detected, had taken place, Page disavowed any analogy with physical trauma.

Charcot's account of hystero-traumatic paralyses provided the needed theoretical mechanism: "A man predisposed to hysteria has received a blow on the shoulder... in consequence the idea arises in the patient's mind that he might become paralyzed; in one word, through autosuggestion, the rudimentary process becomes real (Charcot and Marie 1892: 633 cited in Gauld 1992: 313; see Ellenberger 1965: 142). This is perhaps the earliest *psychological* account of the syndrome then called 'railway spine', according to Young (1995: 19). The nervous shock following the trauma was assumed to be analogous to a hypnoid state, enabling autosuggestion. What had to then be accounted for, however, is some mechanism by which the person experiences some extreme shock or fright, causing certain symptoms, but no memory of the event. It is important to note that this idea could only come from within (autosuggestion), as opposed to implanted by a hypnotist or therapist (heterosuggestion).

The theory of psychogenic trauma, paradoxically identified by hidden memories, became an underlying principle in the identification and treatment of hysterics. It was assumed that these aversive memories underlying psychopathological conditions resided in a fixed and stable form in the brain. When a trauma occurs, Shapiro maintains, the information taken in at the time of the event becomes "'locked in the brain' in its original form (1999: 39). This type of language is consistent with her previous writings in which the traumatic scene is consistently referred to as some type of touchstone event, as the initial cause or genesis of the "dysfunctional information" that is stuck, blocked, in stasis, frozen in time, and in a state-dependent form in the nervous system, "isolated in the brain."

> When someone experiences a severe trauma, it appears that an imbalance may occur in the nervous system, caused by changes in neurotransmitters, adrenaline, and so forth. Due to this imbalance, the system is unable to function and the information acquired at the time of the event, including images, sounds, affect, and physical sensations is maintained neurologically in its disturbing state (Shapiro 1995: 30; see 3, 14, 40, 65, 101-104, 140, 147, 247).

The traumatic event is clearly the cause of presenting symptomatology. In EMDR, the patient is directed to locate the earliest possible memory to which the negative feelings apply (1995: 187), which then forms the "hub" from which other traumatic memories are identified.

The patient's reaction, however, is not only dependent on ontogenic (lived) experience, but is also encoded genetically. According to Shapiro, certain stimulus-response patterns have developed through evolution, providing us with instinctual reactions, such as fear or fright, to help avoid harmful circumstances (1995: 42-43; 1997: 274-275 fn 1). This mechanism is natural and beneficial, and although Shapiro does not endorse a diathesis model of genetic vulnerability, it is in degenerationist models of human physiology that we find this kind of "bodily memory" of past fear and pain.

2.2 Instincts and Organic Memory

The idea of degenerative heredity was a powerful etiological theory of neurosis at the turn of the nineteenth century. Through its diagnostic, prognostic, and therapeutic procedures, medical discourse intertwined etiologies of nervous diseases with political concerns by associating issues of race, nationality, and geographical location with bodily symptoms and complaints (see Brunner 1995: Ch. 1; Pick 1994). Action, motivation, and deficits thereof were to be understood in light of lived (ontogenic) experiences as well as ancestral (phyletic or phylogenetic) experience, mediated by memories, with the former in the sense that we use the term today, and the latter as a phylogenetic, or organic memory. Freud believed throughout his life that the individual contained both lived and phyletic histories, with the latter recapitulated over the course of the former (Sulloway 1979:156). According to this view, the individual is the product of an ongoing teleological process of absorption and accumulation, making history available through the subject, rather than solely an explanatory context. Like the archaeological law of superposition, older memories are buried in the brain, unconsciously affecting the higher, more complex and recently added strata. A devout recapitulationist, Freud believed that the cohabitation of this repressed core, and the bodily desires or instincts it engendered, conflicts with societal prohibitions, leading to psychological trauma. Neuroses were but phases in prior human conditions, the extent of psychological distress marked by the amount of "dissolution" that the patient had undergone (Grubrich-Simitis 1987[1925]: 79; Sulloway 1979: 271-272).

Freud's concept of psychological trauma did not develop by analogy from the centuries-old definition of "physical injury," but rather in connection with this latter notion of an organic, phylogenetic memory (Young 1995: 292 fn. 2; 1996a: 89; 1996b: 246). The history of this

memory is relevant here as it illuminates the origins of Shapiro's second basic assumption: that there is an innate, largely unconscious mechanism by which "traumatic" events cause lasting symptoms; and that these symptoms are available to scientific inquiry by the psy-disciplines.

Consonant with Lamarck's Law of Acquired Characteristics (heritability of ontogenically developed characteristics), Lorenz Oken, a comparative anatomist, proposed that human development proceeds according to a single tendency: "all development begins with a primal zero and progresses to complexity by the successive *addition* of organs in a determined sequence" (1847: 123 quoted in Gould 1977: 40; italics in original). Thus when humans pass through an embryonic stage in which gill slits seem present, this corresponds to the stage (although reduced greatly in duration) of their crustacean ancestry.[10] In *The Origin of Species* (1959), Darwin notes that "community in embryonic structure reveals community of descent (p. 427). He could not, however, explain the genesis of phenotypic variation among species, nor the mechanism through which favourable variation was inherited.

Herbert Spencer, a philosopher, proposed a definition of "evolution" as an organic change dependent on external forces (Gould 1977: 30). When Darwin noted in *The Expression of Emotions in Man and Animals* that fear is acquired phylogenetically as a memory of pain, he cited Spencer as the source of these ideas (Young 1996b: 253).[11] In *The Principles of Psychology* (1855), Spencer examined the origin of instincts, shifting from a localizationist view

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[10] Oken suggested laws of "successive addition" and "timing alteration" which influenced Ernst Haekel's laws of "terminal addition" and "condensation." Terminal addition predicts that the acquired characteristics of the adult form are added on to the end of an unaltered ancestral ontogeny (Gould 1977: 81). Condensation explains how ontogenic life can recapitulate the evolutionary additions of a time period spanning, as was held in the latter half of the nineteenth century, millions of years (ibid. 480). With the resurrection of Mendel's studies on genetic heritibility in the year 1900, this conceptual space closed, although Freud refused to abandon it, to the dismay of his peers (Sulloway 1979: 440).

[11] See Dawkins (1986, 1989) for current reiterations of this theory.

of the mind, toward an associationist one.[12] Introducing the term "phylogenetic memory," he proposed that all memories are marked by neurological traces. Whenever the memory is recalled, the same pathways are used in its recovery, increasing the ease and speed of recollection. Eventually, there is no resistance to the recall process, and once the pathway is initiated, it travels to the end, whether or not the individual is conscious of the stimulus. This was, for Spencer, the developmental path of an instinct: a heritable neurological etching that predicts unconscious acts.

In 1870, two young German physiologists, Gustav Theodor Fritch and Eduard Hitzig, produced "irrefutable evidence that functional parcellation of the cortex existed and that in principle Gall had been correct" (Clarke and Jacyna 1987: 214).[13] Armed with Spencer's philosophy and these classical experiments, John Hughlings-Jackson, one of the most influential neurologists of the nineteenth century, developed the notion of "dissolution" as the regression to a state of mental operation somewhere along the stage of development of the phylogenetic line (ibid. 306).[14]

In 1881, Théodule Ribot, the French philosopher/psychologist who held the fist chair of exprimental psychology at the Collège de France, wrote *Les Maladies de la mémoire*, which was the most cited book on this subject in the decade. He proposed, in the tradition of Jackson, that

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[12] The mind is represented as a blank slate, upon which simple ideas and perceptions are organized through relations of resemblance, contiguity in time and space (cause and effect), and sensations (notably pleasure and pain).

[13] Their experiments on the motor cortex of dogs showed that some areas of the brain controlled the motor functions of different parts of the dog. In 1873, David Ferrier presented compelling evidence that electrical stimulation to a pidgeon's brain produced distinct functional inhibitions. Paul Broca, around this time, had also proven to the satisfaction of the scientific community, that the faculty of speech was governed in a localized area of the cerebral cortex.

[14] Jackson's model of the nervous system was a series of biological layers, the deepest sediments being the most ancient and least voluntary, while the newest and uppermost neocortical layers were more complicated and voluntary. This was a double hierarchy of control and inhibition. The old centers were both superceded spatially and temporally by the new ones, but were also inhibited by them. A psychological neurosis, such as hysteria, was suggested by Jackson to result not from a defect of the upper centers reflecting a dysfunctional set of behaviours, but rather from damage to the upper centers allowing the lower centers under their control to be "disinhibited." He named this phenomenon "dissolusion," the same word used by Spencer (1879: 339 in Sulloway 1977: fn270).

memory required "*dynamic associations* that, through repetition, become as stable as primitive anatomical connections...which tend to follow the line of least resistance" (16, 118 cited in Otis 1994: 15, 24). Amnesia victims lost those memories that they had acquired more recently, and were thus more unstable, disorganized, conscious, and complex. The automatic and organic memories were the last to break down.

Ways of knowing ourselves (our souls, suggests Hacking) were secularized by the burgeoning sciences of memory. Between 1874-1886, psychology took over what had once been the domain of philosophy and theosophy. Brain localizationism had initiated the anatomical science of memory; experimental psychology studies on recall marked the start of the statistical science of memory; and Ribot's studies on the diseases of memory, the will, and personality were published (Hacking 1995: 5, 203-205). The notion that pathology held the potential to reveal the mind's history and development became scientific orthodoxy, and remains with us today through the rhetoric of memory associations, neural networks, instincts, conditioned responses, and involuntary action.

The theories of Darwin and Pavlov have been drawn upon explicitly to suggest a mechanism for EMDR's efficacy. MacCulloch and Feldman have drawn upon historical notions of fear and associated pain as an unconscious, involuntary response to certain events. "The basic condition for the formation of conditioned reflex is a single or repeated coincidence in time of indifferent stimuli with unconditioned reflexes" (Pavlov 1995: 273 cited in MaCulloch and Feldman 1996: 572). This is, they hold, the origin of the diagnosis for PTSD. But there are two trajectories of memory here. The first is the phylogenetic memory: a remembrance of past pain physiologically encoded resulting in a current sensitivity to potentially painful situations, marked by instinctual fear or fright. The eye movements are proposed as a natural activation of the

investigatory reflex. The patient scans the environment of the therapy session, notices no danger, and thus new meanings can "over-ride previously existing negative responses or emotions associated with the memory (ibid. 577). The second is the notion that highly aroused emotional states will affect the way memories are *stored.* They are described as separated and inaccessible to normal recall and reflection.[15]

Freud speculated that the reversion to a previous "state of being" was called "repression," which acted through mechanisms of disrupting previous associations, as well as disabling certain experiences from assimilating with older ones. The core of pathology was the internal impression of a traumatic memory that, because of its unbearable nature, was *sealed off* from the rest of the personality.

This concept, called "dissociation," was the primary mode of psychological defense against feelings or memories related to traumatic experiences, and was first studied systematically by Pierre Janet (van der Kolk and van der Hart 1989: 1530; van der Hart and Horst 1989: 397).

2.3 Dissociation and Pathogenic Secrets

Janet studied at the new *Institut Psychologique* at the Salpêtrière hospital in Paris, from 1893 to 1902. By the turn of the century he had become an eminent psychiatrist, succeeding Ribot in 1901 at the Collège de France. Although Janet believed that this reduced capacity to integrate information depends on innate disposition, the novelty of the situation, speed of events, and the physiological state of the person, such as illness, intoxication, fatigue depression, or the

[15] See Leys (1996) for a discussion of the developing theories on the effect of emotional state in the development and treatment of shell-shock and traumatic memories.

violent emotions precipitated at the time of the event were also considered (van der Kolk and van der Hart 1989: 1533). He emphasized most forcefully, however, the role of vehement emotions such as terror in response to traumatic events (van der Hart and Horst 1989: 407-408). Under ordinary conditions, awareness of emotions, thoughts, and sensations related to any particular experience is united in a single consciousness and is under voluntary control. Frightening or novel experiences, according to Janet, may not fit into existing cognitive schemes, causing memories of these experiences to split off, or *dissociate*, from conscious awareness and voluntary control, and fragments of unintegrated events may later show up as pathological automatisms.[16] Using the technique of automatic writing,[17] he found that a patient in a somnambulic state exhibited a second intelligence which is separated from and inaccessible to the ordinary waking consciousness.

The term dissociation is slightly misleading. There is no *dis*-association going on at all. There was, for Janet, an event which caused ideas to be *associated* in a "complex" that does not connect with the other "complex" made up of affect and episodic memories in a normal, waking state (Ellenberger 1970: 359-361).[18] The hysteric is constituted, paradoxically, by her own division.

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[16] The term "dissociation" is traced back to a collection of men writing on the specifics of this second state, around the same time as Janet. A lucid analysis of this concept can be found in Gauld (1992: 591-595), and his main points are as follows: 1) The term itself is not clearly explicated, as it has taken many meanings, even in the same period. 2) The phenomenon of automatic writing, a person confused or lost in one's surroundings or thought, or subliminal perception, have all been used at one time of another as proof of dissociation. 3) The only explanation of the major hypnotic phenomena "involves the coexistence in connection with the same organism of two separate streams of consciousness... which are, at least potentially, co-active and which pursue their courses not necessarily without mutual interference, but with limited mutual cognizance and a large measure of independence." 4) The evidence given as proof for this phenomena is inadequate and flawed.

[17] When in a somnambulic (hypnotic) state, a patient is distracted by a third person in a conversation, while the therapist comes up from behind, for example, and asks questions to which the answers were to be written on a pad of paper. Whether by the method of distraction or post-hypnotic suggestion, the patient had no recollection of the instruction of action, yet the tasks exhibited, to Janet's satisfaction, an indication of the workings of intelligence in a partial state (Gauld 1992: 371-372; see Ellenberger 1970: 120-121 for historical precedents to this technique).

[18] Like Janet, Freud held that the memory of a traumatic event, and its strong affect component, could be unassimilable with other memories. The unassociated affect acts as an attractor for ideas which would otherwise

Dissociation has not left us. Currently Ernest Hilgard has championed a model of neo-dissociationism (Hilgard 1994: 32-49). Most notably, dissociation is viewed by Hilgard as occurring naturally, albeit to different extents in all individuals, and is therefore not pathological in itself. The concept of dissociation has become relatively unchallenged in mainstream psychology, and I will present a further discussion on this subject in the next section.

I want to emphasize two things. The first is the reliance of dissociationist theories on an associationist model of the mind—one in which memories are accumulated, connected, and arranged into webs or networks. The second is that there are memories of experiences which are stored in the brain in a *place* that is dependent on the way in which it was stored. A memory can be isolated, and therefore inaccessible, from normal recall. Janet's goal was to re-access this information, and either reintegrate, pacify, or destroy it such that it was no longer pathological.

In Shapiro's EMDR therapy, there is also a memory network, which associates information along nodes and channels (see Figure 1). At the time of a traumatic incident, material is stored "dysfunctionally," blocking associative channels. In Shapiro's words,

> Essentially, the hypothesis states that the targeted information is metabolized and transmuted along associated memory channels through the progressive stages of self-healing. Transmutation is seen in all elements of the information—images, sensations, and beliefs. As the information moves from dysfunctional to functional form, the negative manifestations of the target become diffuse and the positive manifestations become more vivid (1995: 53).

The patient should be instructed as follows:

> Disturbing events can be stored in the brain in an isolated memory network. This prevents learning from taking place. The old material just keeps getting triggered over and over again. In another part of your brain, in a separate network, is most of the information you need to resolve it. It's just prevented from linking up to the old stuff. Once we start processing with EMDR, the two networks can link up. New information can come to the mind and resolve the old problems" (ibid. 124-125).

Memory alteration and consolidation is at the heart of the therapeutic projects of the turn-of-the-century psychiatric models, and provides EMDR therapy with a ready-made explanatory

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be recognized as a false idea. These associations were called *false connections*, and accounted for phobias, obsessions, and transference phenomena (S.E. 1895: 2: 17; cf. Makari 1994: 563-565).

framework. It is the idiom in which discussions of therapy and prognosis, and etiology and epistemology, took form. Thus the mechanism of the traumatic neurosis was dependent on a new type of memory—a traumatic memory—which enabled harmful secrets to be kept from oneself—a pathogenic secret.[19] The traumatic memory therefore was created at the intersection of two developments in the history of psychiatry: the medicalization of the past, and the normalization of pathology. It became accepted by the medical community, and by their patients, that traumatic neuroses are caused by my memories of events rather than by the events themselves, that these memories are pathogenic secrets, and that medical men have privileged access to these secrets and their meanings.

2.4 Freud and Fantasy

A letter written by Freud in 1897 to a close friend, marks the first break with the seduction theory of the neuroses:[20] "It seems once again arguable that only later experiences give the impetus to fantasies, which [then] hark back to childhood, and with this the factor of a hereditary disposition regains a sphere of influence from which I had made it my task to dislodge it—in the interests of illuminating neurosis." (Freud/Fliess 1985: 265).

Such illumination opened up new conceptual spaces by shifting from a diathesis paradigm toward a fantasy paradigm of nervous disease etiology. It was no longer necessary to

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[19] Ellenberger's essay, *The Pathogenic Secret and its Therapeutics* (1966 republished in Micale 1993: 341-360), augments the analysis in *The Discovery of the Unconscious* (1970: 44-66). Also see Young's *The Harmony of Illusions: Inventing Post-traumatic Stress Disorder* (1995) for a rich conceptual history of traumatic memory.

[20] The seduction theory states that hysteria and other neurotic states originated in early sexual assaults, occurring before the oedipal stage. The memory of such events was "repressed" into the unconscious, and thus not available to the patient. Later events trigger this memory and produce the symptoms that were ascribed by others as originating by hereditary deficiency. See Nov 21 1897: 264 and 6 December 1897: 212, S. Freud, *The Complete Letters of Sigmund Freud to Wilhelm Fliess, 1887-1904*, Trans. J.M. Masson; hereafter referred to as Freud/Fliess. The reasons that Freud gave for this break can be found in Freud/Fliess p.280-281; cf. Sulloway 1979: 206-207.

find an account of sexual abuse and associated traumatic memories and triggers, triggering deficiencies in the nerves. Freud located symptom production in the mind, postulating that this occurred beyond the realm of his patients' volitional control—as a result of a *dynamic, unconscious process.* The therapist was no longer an interrogator, constantly on guard against being a naïve believer of seduction tales, nor the proponent of a theory which either denied sexual abuse incidents or implicated (usually) fathers as perpetrators of incestuous acts (see Masson 1985: 390-391; the words "paternal etiology" are used in Freud/Fliess: 237, 286). He was free now to anchor his patient's reality in a fantasy world, influenced by ontogenic experience as much as it was by phylogenetic memories, and the oedipus complex.

> I have often had a suspicion that something organic plays a part in repression; I was able once before to to tell you that it was a question of the abandonment of former sexual zones.... Now the zones which no longer produce a release of sexuality in normal and mature human beings must be the regions of the anus and of the mouth and the throat....A release of sexuality (as you know, I have in mind a kind of secretion which is rightly felt as the internal state of the libido) comes about, then, not only (1) through a peripheral stimulus upon the sexual organs, or (2) through the internal excitations arising from those organs, but also (3) from ideas—that is, from memory traces—therefore also by a path of deferred action....To put it crudely, the memory actually stinks just as in the present the object stinks; and in the same manner as we turn away our sense organ (the head and the nose) in disgust, the preconscious and the sense of consciousness turn away from the memory. This is *repression* (Freud/Fliess 1897: 279-280; italics in original).

Repression must be understood in light of Freud's notion of deferred action. It has generally been interpreted as a retrospective resignification or changed meaning, later interpreted or constructed to produce a "fresh trauma." It has also been viewed as an attempt by Freud to reconcile intrapsychic fantasy and actual trauma (Blum 1996: 1152; cf. Thoma and Cheshire 1991). Best exemplified by the Wolf Man study, Freud proposed that a sexual seduction at age 18 months was not, at the time traumatic for the infant, but later was "traumatized" by activation by a dream at age 4, transforming a non-traumatic preoedipal memory into a new trauma. The *memory traces* were reinterpreted—activated—to become traumatic.

Pathological states are seen to "flank" normal states, outside of a threshold at whose margins we distinguish acceptable actions, conditions, and description.

> The psychosocial definition of the normal in terms of adaptedness implies a concept of society which surreptitiously and wrongly assimilates it to an environment, that is, to a system of constraints which, already and before relations between it and the environment, contains collective norms for evaluating the quality of these relations. To define abnormality in terms of social maladaptation is more or less to accept the idea that the individual must subscribe to the fact of such a society, hence must accommodate himself to it as to a reality which is at the same time a good (Canguilhem 1989: 282-283).

> Pathology is denied uniqueness and separateness, and is now either a loss or displacement of normal functions, followed by the release of lower level functions...or an exaggeration or extension of normal functions, resulting in a disequilibrium or depletion of functions and vital energies (Young 1995: 39).

Here Freud differed most notably from Janet. Although he too viewed outlying physical states as a means of studying the commonplace, Freud was perhaps the psychiatrist of greatest influence who denounced the diathesis model of mental illness, moving away from Charcot's diathesis model of hereditary and inchoate weaknesses.[21] He was able, however, to locate etiology in previous sexual abuse (then called seduction), leading to distinct neuroses with characteristic symptomatologies, and thus distinct treatments. At the same time as maintaining a theory of degeneration, he vindicated the degenerate. Writing at a time when, in Germany and Austria, the scientific community saw psychiatry as maintaining its institutional respect by applying rigorous experimental and observational methods, borrowed from the hard sciences (which has recently won great success in the prevailing germ theory of disease). "Obsessed with demarcation from philosophy, [psychiatry] remained on guard against what it perceived as contamination by

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[21] He did not move away entirely, though. In his footnotes to his translations of Charcot's Tuesday Lectures, Freud wrote of pathology lying "not in heredity but in abnormalities of sexual life...naturally they occur more intensely, with the same etiology, in individuals with a hereditary disposition" (S.E. 1887-1888 6: 138-139). He further admonished Charcot for not drawing a boundary between the neuroses which are acquired versus the organic nervous diseases. By 1892, he was well distancing himself from Charcot, writing the "the core of a hysterical attack, in whatever form it may appear, is a *memory*, the hallucinatory reliving of a scene which is significant for the onset of the illness....the *content of the memory* is as a rule a psychical *trauma* which is qualified by its intensity to provoke the outbreak of hysteria in the patient or is the event which, owing to its occurrence at a particular moment, has become a trauma" (S.E. 1892 1: 137). All citations of Freud's writings in English will be from the *Standard Edition of the Complete Psychological Works of Sigmund Freud*, translated by James Strachey et al. (1953-1974). Each reference will use the abbreviation "S.E." followed by the year of first appearance, volume, and page number(s).

speculation, which, psychiatrists feared, could throw the new science back into its prescientific stage" (Brunner 1995: 33; cf. Porter 1993: 236-239).

> By 1917, Freud wrote in *Introductory Lectures on Psychoanalysis*:
> I believe that these primal phantasies, as I should like to call them, and no doubt a few others as well, are a phylogenetic endowment. In them the individual reaches beyond his own experience into primaeval experience at points where his own experience has been too rudimentary. It seems to me quite possible that all the things that are told to us to-day in analysis as phantasy—the seduction of children, the inflaming of sexual excitement by observing parental intercourse, the threat of castration (or rather castration itself)—were once real occurrences in the primaeval times of the human family, and that children in their phantasies are simply filling in the gap in individual truth with prehistoric truth" (1916-1917 S.E. 16: 370-371).

From his Lamarckian-phylogenetic presuppositions, Freud was able to attribute to "pure phantasy" a degree of traumatic force that was otherwise missing from his general etiological framework.

What puzzled Freud was the cause of certain classes of neurotic symptoms (flashbacks, dreams, tremors, pains, paralyses, etc.) that were reminiscent of some traumatic event that become fixated upon and compulsively repeated. Confronted with the return of veterans from the First World War, he found a wide variety of sensory/motor disturbances in the absence of any organic injuries, generally after having suffered a traumatic brush with death. In an attempt to subsume these observations into the explanatory framework of psychoanalytic theory, Freud produced *Beyond the Pleasure Principle* in 1920. In it, he discussed a death instinct that could override the pleasure principle in certain neurotic disorders. The repetition-compulsion was actually a "regression" compulsion: "*an instinct is an urge inherent in organic life to restore an earlier state of things* which the living entity has been obliged to abandon under the pressure of external disturbing forces..." (S.E. 1920 18: 36). Placed in this biogenetic story of life, trauma became increasingly recognized as a major source of neurotic symptoms. Though Freud did not exclude reality from the causal chain leading to symptoms, it was not necessary to distinguish fantasy from reality for "as far as the neurosis was concerned psychical reality was more

important than material reality" (S.E. 1925 20: 34), and "hysterical symptoms had derived from phantasies and not from real occurrances" (S.E. 1933 7: 120).[22]

If Freud moved away from a unitary theory of pathogenesis in the seduction thesis, would this not seem to be a move away from the scientific model from which his legitimacy as a theorist of mental illness derived? The answer is a resounding no, as he was now able, in theory at least, to loosen the shackles of suggestion (which had plagued psychotherapeutic intervention from the time of Mesmer, a point to which I will return shortly), maintaining an organic idiom of explanation. As we have seen, hysteria was viewed as unscientific because of its being indistinguishable from the effects of suggestion. Classified as malingerers and deviants, such labeled persons were met with punishment rather than treatment. Charcot wrestled hysteria from the negativity associated with suggestion and hypnotic phenomenon, only to biologize and pathologize all three. It was Freud who reintroduced the notion of suggestion, in the form of auto-suggestion and fantasy, as a function of a dynamic unconscious, which was at once separate from the influencing interventions of the psychoanalyst and amenable to its study. Through free association, parapraxis (known as Freudian slips), and dream analysis, he offered a new view of a patient, to be understood in organic, phylogenetic, and psychological languages of unconscious mental drives and energies, and warring instincts and societal pressures to conform, all taking place outside of the awareness and lived history of the patient. In short, by the end of 1897 psychoanalysis had become a psychology of the id.

Free association consists of a client on a couch, facing away from the analyst, answering vague questions from the therapist. The first rule of free association is to say whatever comes to

[22] It was this movement which allowed therapists to take their patients' traumatic stories at their words. For Shapiro, it is the subjective suffering which validates their rightful claim to therapy. "We all feel fear, pain, despair, guilt, or unrelenting anger when certain experiences and pressures converge. The message here is that we do not need to be trapped by these feelings" (1997: 11).

mind. Given Freud's conviction that all vital phenomena, including psychical ones both true and fantasy, are rigidly and lawfully determined by the principle of cause and effect, he was poised to identify the thoughts which came from the preconscious, as well as those from the unconscious which affected the patient's words tellingly, especially in their resistances.[23] Resistance was an important marker for psychical conflict, as it located the areas of repression. It further exculpated the analyst from accusations of suggestion—the last thing that the therapist wants is to be resisted. "In rejecting a psychologic fundamentally interpsychic theory of suggestion, and by firmly reaffirming the boundary between the rational physician and illusional, suggestible patient, Freud undercut accusations of bad science, fakery, and fears of interpsychic contagion" (Makari 1994: 562). The degree to which free association was really free has been appropriately questioned.[24] What is more important, however, is why Freud, and his contemporaries, felt the need to alter theory, practice, language and etiologies of mental illness in large part to distance them from the "defiling" association with suggestion.

2.5 Suggestion, Hypnosis and Rapport

In 1775, Frans Anton Mesmer, an Austrian philosopher and physician well known for his curing abilities, clashed with the exorcist Father Gassner. Mesmer claimed that he could cure ailments, assumed to result from evil incarnate, without addressing any "supernatural forces," and thus replicable by his own practices and theories (Ellenberger 1970: 53-57). Proposing the discovery of a superfine fluid permeating and surrounding all bodies, he claimed "animal

[23] Florid and varied symptoms were not necessarily interpreted by Freud as markers for a severe neurosis. Quite the opposite, patients who were presenting symptoms were actively dealing with their internal conflicts, and were on the right path. Shapiro has also iterated such an idea: "An abreaction during EMDR is a sign that the dysfunctional material is being metabolized...and should therefore be viwed as a sign of emerging health" (1995: 170).

magnetism" to be the cause of universal gravitation and all bodily properties in the most intimate way. The age of enlightenment was fascinated by the discovery of invisible fluids, and amid excitement about Newton's gravity, Franklin and Galvani's electricity (made intelligible by Voltaire), and mineral magnetism, Mesmer's fluidic theory was uncritically accepted by many (Darnton 1976: 9-10, 23). Mesmer is credited by many as founding the first form of psychotherapy (Crabtree 1993, 1998; Ellenberger 1970; Gauld 1992; Mora 1980.[25] The force was mechanical and ubiquitous, able to be stored in objects and bodies, could be channeled by humans, and was specifically responsible for causing and curing all illnesses (Mesmer [1779] 1980: 46, 68-69). Arguing for a scientific, lawfully acting phenomenon, Mesmer felt that he was a magnet of a special kind, able to channel magnetic fluid into the body of a sick person, "curing nervous disorders directly and other disorders indirectly (ibid. 68-69).

This represents a remarkable power shift in the history of psychotherapy: the victory of science over theology, the aristocracy over the clergy, the recognition of illness as a bodily imbalance over demonological possessions of one sort or another, and the value of an intimate rapport, emphasizing talking and touching, over violent exorcisms, the latter often involving blood-letting and powerful emetics and purgatives.

Mesmer "would sit in front of his patient with his knees touching the patient's knees, pressing his patient's thumbs into his own hands, looking fiercely into his eyes, then touching the hypochondria and making passes over the limbs and face. Many patients felt peculiar sensations

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[24] See Macmillan 1997: 563-570 and Crews 1998: 76-84, 76-84 for examples of this, as well as general Freud-bashing—what seems to have become a popular academic trend.

[25] Zilboorg (1941) has traced the history of medical psychology to the work of Agrippa, Vives, and Weyer in the sixteenth century. Accounts of the treatment of mental illness before Mesmer have been collected by Simon Mialle 1826; Bernheim [1891] 1980: Lesson 1; Ellenberger 1970: Chap 1; and Ehrenwald 1976.

or fell into crisis" (Crabtree 1993: 14).[26] The patient would be *en rapport* with either Mesmer, others in the room, or a *baquet* (a large oak tub). Mesmer's popularity grew, and he began to treat large numbers of people using bacquets of "mesmeric water," around which as many as 200 people stood, in concentric circles attached with ropes around their wastes. Some members of the innermost circle held metal rods that came out of, and placed them *en rapport* with, the baquet. The room was darkened, and music would accompany Mesmer as he entered wearing a lilac silk robe, brandishing a metal wand, with which he would pass over (mesmeric passes) the limbs or bodies of his patients. He would continue this "until the patient was filled with the mesmeric fluid, and was transported with pleasure or pain, both sensations being equally salutary" (Binet and Féré 1888: 10-11; Laurence and Perry 1988: 57, 64).

Magnetizers ascribed tremendous attention to this rapport, paying particular attention to the sensitivity of the magnetized toward the magnetizer and his ability to perceive the latter's thoughts and bodily sensations. At the height of his fame, Mesmer moved to Paris to spread his theories and practice. Although his prestige grew quickly among popular movements, the medical community was less enthusiastic. Mesmer encroached upon their domain, and made it seem that anyone could be a healer, even those who were not lengthily and expensively trained.[27] Citing a growing concern for the moral deprivation of the patient, two commissions (called for by the king of France) were to investigate the merits of animal magnetism. Both returned unfavourable reports. Although Mesmer argued vehemently against any association with occult forces, coercion or suggestion, the scientific academies were not convinced:

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[26] A patient was said to experience "crisis" with the onset of any number of symptoms, including convulsions, fever, or a quiet, uncritical state. A "beneficial crisis" was the cure of all ailments, and was a physiological state in which "man experiences his connections with all of nature" (Mesmer [1799] 1980: 103-105, 123-124).

[27] EMDR therapists have invoked similar responses here. One journalist has written: "EMDR exposes a large and expanding rift separating the science of psychology and the practice of psychotherapy, an emerging struggle between the research-literate and the practically trained" (Marano 1994: 23). EMDR is "embarrassing" for the

> Examining subjects who had been blindfolded, we discovered we could influence them ourselves so that their answers were the same, whether they had been magnetized or not. This means we were dealing now with the power of imagination....We succeeded in manipulating the imagination. Without being touched or signaled, the subjects who thought themselves magnetized felt pain, felt heat, a very great heat...we were struck by the power of two of our most astonishing faculties: imitation and imagination. Here are the seeds of a new science, that of the influence of the spiritual over the physical (cited in Lopez 1994: 329).

A secret report written for the king, entitled "Love, Sexuality, and the Magnetic Rapport," further emphasized the potential dangers to moral character through the misuse of magnetic techniques. The magnetizers (usually men) were said to have a "natural empire" over the magnetized (usually women). Reference to prolonged touch, communicated heat, and parallels made between orgasm and crisis supported claims that "[t]he magnetic treatment cannot be but dangerous for morals....Exposed to this danger, strong women will move away, but weak women can lose their morals and health" (cited in Crabtree 1993: 93-94).

Couched in a language of sexual impropriety, spirituality, and domination, the phenomena in question were reproduced, yet still dismissed. It is not enough to cure the ill. One must explain it in with a theory that is accepted by the community. Mesmer fell out of favour with orthodox science, with "mesmerism," and "magnetic sleep"[28] polluted by associations with imagination and suggestion.[29]

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former category, as it is being praised lavishly in the absence of any "acceptable" proof—it exposes psychology to the potential for ridicule.

[28] The term "magnetic sleep" was invented by Mesmer's protégé, Armand Marie Jaques de Chastenet, the Marquis de Puységur. He dispensed with the mysterious magnetic fluids, instead placing emphasis on the psychologizing force between the magnetist and magnetizer, based on the power of *will*. The influence of Puységur has been well documented: in the history of Multiple Personality Disorder (Hacking 1995: 149-150), post-hypnotic suggestion and auto suggestion (Crabtree 1993: 104; Gauld 1992: 58-64) and further waves of research into areas of medicine, psychology, and psychical phenomena (Crabtree 1998). It is not to be taken for granted that magnetic sleep is a simple precurser to hypnotism, as Gauld has done (1992: 441). Such whig history strips words of their contextual, contemporary meaning, which make such "lineal descents" simplistic and worthless. Similarly, Ellenberger is guilty of anachronism when he states that "resistance" and "transference" had been known to magnetizers and hypnotists (1970: 490, 521, 538-539). Makari argues that the hypnotic rapport, as well as Janet's "somnambulistic influence," are not continuous with the notion of false connections (1984: 559-560).

[29] The term "suggestion" emerges as a psychological term around the year 1820, often used as a cognate of imagination. Perhaps the first to use "suggestion" in this sense was Abbé Jose-Custodio de Faria. He claimed that there was no external force acting on the patient. In public demonstrations, he would declare that he possessed no secret powers, and relied on nothing but suggestion. Healing was, for Faria, a contest of wills alone. Faria believed in a diathesis model of suggestion, claiming that women, the lower classes, and the infirm were more "suggestible."

It was not until a full century later with the work of Charcot that suggestion (this time named hypnosis[30]) was presented once again as amenable to scientific inquiry and characterization. In the last quarter of the nineteenth century, debate concerning the validity and mechanism of hypnotic phenomena in the treatment of mental illness continued in Paris between the Salpêtrière School and the Nancy School, headed by Hippolyte Bernheim. It was a time when the collective accomplishments in the history of somnambulic phenomenon, exorcists, priests, doctors, philosophers, novelists, poets, magnetizers, spiritists, psychologists and psychiatrists came together to form the discipline known presently as medical psychology. It was privileged as a "university psychiatry," situated in the major academic centers, dependent for clinical material on new university clinics, and pursued in specialized journals (Micale 1993: 25).[31]

Charcot's position has been discussed. But as I have noted, information is not produced in an intellectual vacuum. His position is made comprehensible when put into historical and intellectual dialogues, and there was no greater contemporary, academic rival than Hippolyte Bernheim.

Bernheim, a professor at the University of Nancy in Paris, argued that hypnosis was not a discrete physiological state. Suggestion, he claimed, is the acting force behind cures by honey pills, hydrogen peroxide, metallotherapy, suspension, etc., and among these adjuvants, hypnosis is the most effective. I will call this the "non-state" position, in contrast to Charcot's "state"

See Crabtree (1993: 103, 122-126) and Gauld (1992: 274, 278, 424-428) for a discussion of suggestion and suggestibility from 1820 to the turn of the nineteenth century.

[30] James Braid, a British physician, became interested in the study of nervous sleep around the time of the publication of the fourth commissioned report on the subject. In 1843, he published "Neurypnology, or the Rationale of Nervous Sleep." In 1843, he coined the term "hypnosis," and found that in such a state his patients could be shielded from pain. He further observed that a rapport does not develop unless directly or indirectly suggested, is always apparent, rather than real (Braid: [1843] 1960:137-141, 216).

[31] There was still a deep-seated fear from about 1870-1910 that innocent people could be hypnotized into committing heinous crimes in response to a signal by the hypnotist. This sentiment permeated psychiatric journals and popular press in this time frame (Laurence and Perry 1988: 217-219).

position, in which hypnosis is a physiologically *discrete* state. The non-state position of Bernheim is as follows:

> We have defined hypnosis as follows: a particular psychic state, capable of being induced, which activates or heightens, to various degrees, suggestibility (the capacity to be influenced by an idea and to realize it). The hypnotic state is nothing more than a state of heightened suggestibility....We have already described the various methods used to artificially obtain this heightened sense of suggestibility or hypnotic state, and we have concluded that all of them can really be reduced to one factor alone—suggestion (Bernheim [1891] 1980: 177, see 42-43).

These various methods involve establishing a rapport between the subject and the therapist, by using techniques, such as comfortable surroundings, long waiting periods, relaxing music, and heightening the sense of medical authority, which incline the patient to the idea that "falling asleep is to their best advantage, holding as it does the promise of cure" (cited in Ehrenwald 1976: 252; cf. Bramwell 1909: 133-134). Like Faria, Bernheim viewed the *conviction* of rapport as being both the cause of suggestion, and the source of its power. The Nancy school taught that all people were suggestible, and although some people were more prone to hypnotic induction, this was not a pathological tendency. If hypnosis is not incorporated into a diathesis-model, rapport becomes one of the central concerns of the therapist. Whether he or she believes or not, the successful treatment becomes a contest of wills, a collusion, or a *folie a deux*.[32]

Bernheim's accusations that Charcot's view of hypnosis underestimated the degree to which his own experiments were affected by suggestion were not met kindly (Crabtree 1993: 165; Ellenberger 1965 reprinted in Micale 1993: 150). Charcot's organic position held no place for such importance or rapport, and as such he portrayed it as some hypnotically generated illusion.[33]

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[32] This term was used by Delboeuf, a Belgian philosopher, claiming not that both parties were crazy, but rather that the first patient hypnotized leaves an imprint on the hypnotist: a method and expectation of certain results, which then lays the pattern for future subjects (Ellenberger 1970: 172).

[33] The subject of rapport was also engaged by Albert Moll's *Der Rapport in der Hypnose* (1892) and Janet's *L'influence somnambulique et le Direction* (1897). Moll claimed that an isolated rapport is not possible—a third person is acknowledged by the hypnotized person—and that this rapport can be passed on to another person. Janet

Charcot has been portrayed as an ominous figure, by virtue of his extraordinary intelligence, his fierce egotism, despotic treatment of students, and world-wide fame. Whether this is true or not can be questioned, although he certainly managed to incur the wrath of his prized student, Joseph Babinski.[34] In 1901, in true oedipal fashion, Babinski suggested a new definition of hysteria: "the sum total of the symptoms that can be called forth by suggestion and dispelled by counter-suggestion" (which he called persuasion; and hysteria was renamed "pithiatism", after the Greek word *peitho*, meaning "to persuade"). His model was accepted by most French Neurologists, and by the first World War, this model became became the most widely accepted (Ellenberger 1970: 785-786; Young 1995: 136).

Despite the various reasons given for Freud's abandonment of hypnosis in favour of free association and psychoanalysis proper, it was the language of sexual incontinence which provided the moral necessity for its removal: the possible psycho-sexual dependence of the subject on the hypnotist (Chertok 1984: 112-113; Gauld 1992: 564-566). Transference and countertransference[35] accounted for these developed (misplaced) feelings in the patient to therapist and therapist to patient directions respectively. Freud assures his audience that although he is well aware of the possibility for suggestion, it is *not* the cause of "intense feelings" within the therapeutic alliance.[36] He writes: "The cause of the disturbance is that the patient has transferred onto the doctor intense feelings of affection which are justified neither by

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also noted this close bond, stating that there were always feelings of love, whether erotic, filial, or maternal. It was so strong that the patient had to be weaned off the therapeutic relationship.

[34] See Ellenberger (1965 reprinted in Micale 1993: 142-144; 1970: 95-96).

[35] Countertransference has been described as the therapist's reaction to the patient's transference, and more generally a neurotic reaction of the analyst to the patient (Blum and Goldman 1995). Freud thought that it was rare (S.E. 1910 11: 144-145), again minimizing the suggestive influences involved in the therapeutic alliance.

[36] The therapeutic alliance must be distinguished from rapport in two important ways. First, it frames the relationship between the patient and therapist in such a way as to mechanize emotional connection, while rapport is more a cognate of empathy and connection in a loose sense. Second, in any Freudian framework post 1897, modes of influence and communication in any alliance are doubled by the presence of a dynamic unconscious. In *The Dynamics of Transference* (1911), Freud wrote that "it remains a puzzle why in analysis transference emerges as *the*

the doctor's behaviour nor by the situation that has developed during the treatment" (S.E 1917 16: 441). He does concede, though, that "it must dawn on us in our technique we have abandoned hypnosis only to rediscover suggestion in the shape of transference" (ibid. 446).

The association between suggestion and hypnotism, and the importance of rapport, was broadcast by the invigorating debate between the Nancy and Salpetriere schools in the 1880's and early 1890's. The twenty year infatuation with hypnotism among medical men was followed by a swift decline (Ellenberger 1970: 171). The skeptical and moral arguments against hypnosis were similar to those made against animal magnetists: farce, mimesis, suggestion, leading to the potential for seduction, exploitation, and domination. The skeptical arguments laid by such non-state theorists (such as Bernheim), implied that there is nothing unique happening when a subject is 'hypnotized'. While some thought that the possibility of being hypnotized is proof of the existence in a patient of some scale of suggestibility, others saw increased suggestibility as proof of the state of hypnosis. Debates about who was mistaking cause for consequence continued, and in the absence of a resolution, the medical community refused to embrace any therapeutic model that could not be proven dissociable from the effects of suggestion.

The neuroses were left in a lurch. Emil Kraepelin, probably the foremost authority in psychiatry during the first half of the twentieth century, believed that although some neuroses—the less severe ones—could be caused by everyday life experiences, he was convinced, along with most psychiatrists, that the psychoses—the more severe disorders—have biological causes, which are genetic in origin and essentially incurable. Among medical men in the 1920's, "clinical perceptions of hysteria were shaped by the growing acceptance that it is the product of suggestion" (Young 1995: 63; see pp. 66, 71-74).

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most powerful resistance to the treatment... " (S.E. 7: 101). He clearly attributes the transference to the neurosis, and not the psychoanalytic enterprise.

The moral arguments against hypnosis centered around the possible abuses that the patient could be left vulnerable to, at the hands of the therapist. Since the king's secret report in 1784, no explanation of hypnosis has enjoyed widespread popular approval. Will, intentionality, and freedom were all compromised, in one form or another, with the patient drawn as a transient slave. Although the psychoanalysts gained great sway in the mid-twentieth century,[37] by the 1960's the pendulum had begun to move again towards the biologization of psychiatry.

Compared to the rise of positivism in the 1850s, this re-biologization was characterized by 1) a de-emphasis on the hereditary factors of mental illness, 2) the development of powerful technologies to both diagnose and treat ailments, and 3) the increasing scope and sophistication of the census and other social databases as instruments of social policy. Once this population of mental health sufferers is made *visible*, the psychoactive drugs, imaging technologies, and standardized nosologies helped to firmly place psychiatry within a medical tradition (Young 1995: 170-172).[38] The philosophical domain once occupied by psychiatrists—doctors of the mind—are now the domain of the social worker, psychologist, and spiritist. Psychiatry has adopted the "scientific methods" of the biological sciences, as well as its spirit of biological reductionism: specific etiologies, symptomatic criteria, and strict protocols outlining treatment and prognosis.

Hysteria is still with us, though, as the prototypical neurosis. It has been relabeled and dispersed among such classifications as dissociative disorders, PTSD, personality disorders,

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[37] By 1950, more than half of the chairs of psychiatric departments in the United States were members of psychoanalytic societies.

[38] Orlinsky and Russell's *Tradition and Change in Psychotherapy Research* (1994: 185-214) presents a recent history of psychotherapy research which states that it is becoming more "scientific" until the period ending 1984. From 1984 (recall: four years after the publishing of DSM-III) to the present, there is a shift away from the positivist-empirical model, toward verification of theory through narrative, non-quantitative, and non-objectivist methods, "given the proliferation of the philosophies of science and the cultural and scientific embrace of pluralism in its many forms." Contrast this with a recent article in the *American Journal of Psychiatry* calling for a

anxiety disorders, etc., all distinguished and listed in a new nosology: The Diagnostics and Statistical Manual (DSM) for mental disorders.

2.6 Neuroses and Nosologies

In 1917, the Committee on Statistics of the American Medico-Psychological Association (the forerunner of the American Psychiatric Association) noted that "the present condition with respect to the classification of mental diseases is chaotic. This condition of affairs discredits the science of psychiatry and reflects unfavourably on our association" (Salmon et al., 1917:255). The first *Statistical Manual for the Use of Institutions for the Insane* was drawn up in 1918, and following nine revisions, laid the foundation for the first edition of the current psychiatric nosology: The DSM (American Psychiatric Association 1952, 1968, 1980, 1987, 1994).

The first edition of DSM was largely influenced by the psychoanalytic perspective on mental illness as influenced by WW II. The number of psychiatrists had increased dramatically, and many were practicing in private practice and community clinics, rather than psychiatric hospital wards (Grob 1991). Both dissociative and conversion disorders were attributed to the repression of anxiety evoking impulses. Shaped by its famous editor, Adolph Meyer, the mental illnesses were at one end of a continuum, with "normal health" at the other. In contrast to a Kraepelinian approach, diagnostic groups were labeled quantitatively as representing groups defined by differential behavioural response to similar causes: psychological, social, biological. Large numbers of psychiatrists did not adopt this language, as it was less amenable to a research-based science of mental illness (Young 1995: 98). DSM II was an attempt, along the same

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redefinition of psychiatric training and practice, to avoid an 'untenable' position if being ill-defined, and vulnerable to economic and political marginalization (Lieberman and Rush 1996: 11-1388-1397).

psychodynamic lines, to develop concordance with the World Health Organization's nosology: *The International Classification of Diseases* (ICD-8). The term neurosis was maintained, but the criticism remained that formal diagnostic criteria were not available with which to determine the boundaries of their diagnoses. A remarkable shift occurred from DSM II to DSM III, as the pendulum changed direction, taking its "intellectual roots in St. Louis instead of Vienna, and...intellectual inspiration from Kraepelin, not Freud (Spitzer 1985: 188 cited in Young 1995: 99).

This edition marked a transformation in American psychiatry, specifically, a return to Kraepelinian descriptive diagnosis, and a shift from the psychodynamic, psychosocial, and biopsychosocial models of mental illness to a more strictly biological view. A theory-neutral description was revived, emphasizing the patient's phenomenology and behaviour over clinical speculations about etiology and underlying mechanisms (Wilson 1993). Gerald Klerman, the highest ranking psychiatrist in the federal government at the time, asserted:

> In my opinion, the development of DSM-III represents a fateful point in the history of the psychiatric profession....The decision of the APA first to develop DSM-II and then to promulgate its use represents a significant reaffirmation on the part of American Psychiatry to its medical identity and its commitment to scientific medicine....[Concluding] that the judgement is in; DSM-III has already been declared a victory. There is not a textbook of psychology or psychiatry that does not use DSM as the organizing principle for its table of contents and for classification of psychopathology (Klerman 1984: 539, 542 cited in Kirk and Hutchins 1992: 6).

By emphasizing correlated rather than defining features, categorization by family resemblance, and within-category heterogeneity, the DSM-III implicitly acknowledged that the fuzzy-set[39] view of categorization applied to psychiatric diagnosis.

The term "hysteria" was completely eliminated, along with theoretical statements about the unconscious expression of anxiety in dissociative and conversion symptoms. Hysteria was not dead, though, as the diagnoses of dissociative disorder, conversion disorder, somatization

disorder, and Post-traumatic Stress Disorder invoke, or at least imply, a specific etiological mechanism: a traumatic event, represented by a traumatic memory, causing post-traumatic symptoms (1995: 4, 292).

PTSD is thought to have been discluded from the DSM-II because it was printed in 1968, in the relatively tranquil period after WW II and before the Vietnam War. It was brought into the DSM-III mainly to address veteran issues from this latter conflict. Scientific research on DSM was mainly sponsored by the Veterans Administration (VA), and were performed on war veterans (ibid. 108-114). Psychiatry boasted its effectiveness in containing war neurosis and returning troubled soldiers quickly to the battlefield. The DSM-III and DSM-III-R editions were tailored to capture the exceptional experiences/memories of an exceptional period of war. The problem is that it simply did not correspond with many cases that are currently diagnosed with PTSD (Young 1995: 288). With the publication of the DSM-IV, the inclusion criteria were made more general. The two features (reflective of the nature of the etiological event: the "stressor criterion") of inclusion are:

> *Feature 1:* The [traumatized] person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. [To be "confronted" with traumatic events would include] "learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates." *Feature 2:* The [traumatized] person's response involved intense fear, helplessness, or horror (Amer. Psychia. Assoc. 1994: 424, 427-428).

The definition of what constitutes a "realistic" threat has been made more subjective, vicarious traumatization (in contrast to direct encounters) are sufficient stressors, and there is still no time limit as to how long after an event it can be discovered as traumatic. The DSM-IV was trumpeted as the first well-documented psychiatric nosology, claiming that the "major methodological innovation of DSM-IV will be its effort to move beyond expert consensus by

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[39] Fuzzy-set refers to a model of diagnosis which is represented by sets of exemplars or prototypes (see Hacking 1995: 24, 33-35).

placing greater emphasis on the careful, objective accumulation of empirical evidence" (Frances et al 1990: 1146 cited in Kirk and Hutchins 1992: 211). It actually makes the stressor criterion consistent with ongoing practices, without excluding anyone who had been previously diagnosed with PTSD. In addition, and perhaps most notably, it increases the scope of interpretation of what constitutes a distressing etiological event. If hysteria is still with us, and necessitates the expansion of diagnostic criteria to fit its varied symptomatologies, it has found a partial home in PTSD and the traumatic memory.

3. Sociology, Science, and EMDR Therapy

3.1 Revolutions and the Boundary Object

The concept of science is inescapable for an anthropologist interested in medical matters. Speaking specifically of biomedicine, the medical knowledge generated in this field was at one time felt to have no epistemology. That is, it was authoritative knowledge in direct concordance with the natural laws, and could be empirically observed and objectively described. Biomedicine distinguished itself by such claims to a strict reliance on scientific reasoning, and the technologies that produced and engendered such an approach.[40] Many ethnographies have highlighted the trend in the past 30 or so years to re-question the ontology of science and its claims.[41] They serve to illustrate the myriad social influences on knowledge production and validation. Once the political, economic, philosophical, popular, legal (et cetera) realms are shown to affect science, it becomes "science," available to analysis and critique like any other cultural phenomenon.

The discipline of medical sociology has made its object the politicizing discourses which have tended to medicalize, and thus normalize, the body and our way of representing it in various

[40] Robert Merton pioneered an approach to sociology that placed scientific knowledge outside of its research scope. Anthropologists studied cultures around the globe *if* they did not adhere to the systems of Western science (versus religious and spiritual) for ways of knowing things medical (see Shapin 1988). Ludwig Fleck ([1935] 1979) wrote *Genesis and Development of a Scientific Fact*, in which he clearly states that Merton (and Lévy-Bruhl, and Durkheim) were mistaken in this view of sociology. Best known for anticipating Thomas Kuhn, Fleck situated scientific epistemology within a historical, collective framework, rather than as individual one. "Thought styles" are constructed to allow certain types of thought and restrict others, producing a closed yet harmonious system in which evidence of the origins of ideas can no longer be traced (1979: 38). Hacking's scope is wider than Fleck's, gazing across centuries and epistemes (cf. Foucault 1988) rather than fields or disciplines.

[41] For examples, see Paul Rabinow's *Making PCR: A Story of Biotechnology* (1996), Emily Martin's *Flexible Bodies: Tracking Immunity in American Culture from the days of Polio to the Age of AIDS* (1994), Allan Young's *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (1995), Arthur Kleinman's *"Social Origins of Disease and Distress* (1986), and Ian Hacking's *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (1995; also see Hacking 1983: 66).

forms. This section is an analysis of the construction of a EMDR therapy—its theory and practice, using conceptual tools created by sociologists of medicine: *styles of reasoning* (which I have already introduced), and *boundary objects* (Star and Griesemer 1989; Fujimura 1992). It is my position that this therapy, invented by Francine Shapiro, is not a "revolutionary" or "breakthrough" theory, as it has been called. Rather, it is made intelligible and manageable by historical precedents in the notions of traumatic memory, dissociation, objectivity, suggestion, and rapport. By claiming a model as a revolution, one must necessarily cut ties with the past, proving little historical precedent. Shapiro has, in this sense, presented a castle in the sky, and my aim is to illuminate its foundations.

The development and dissemination of scientific ideas requires cooperation. The information upon which any new theory is based, and the knowledge that it produces, must be "useful" if the theory is to enjoy widespread approval. Ideas and practices generated in one area must be made intelligible, reliable, and desirable in others. The integrity of such a system, such as EMDR, requires that its practices retain their integrity of coherence and outcome across time, space, and local contingency. *Boundary Objects* can be concepts (trauma, efficacy, patients, outcomes, eye movements, cost-efficiency, emotional intensity), or a standardized tool (nosologies, publications, statistical tests, diagnostic language).

> *Boundary Objects* are objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use, and become strongly structured in individual-site use (Star and Griesemer 1989: 393).

Whether abstract or concrete, they are modes of translation: interfaces by which coherence across fields is maintained and developed. A good example of a boundary object explicitly stated is Shapiro's use of her term "neuro networks":

> I use psychophysiological concepts by employing the term neurophysiological or *neuro networks*. This construct will subsume the way the way the term *neural networks* is currently being used by neuropsychologists and extends it to an additional strata of cognitive/emotional processing (1995: 28).

There is a second usage of *boundary objects* which has not been discussed by the developers of this concept. They can be used strategically to *break* ties of coherence and translatability. That is, new objects are constructed in an attempt to create distance, even incommensurability, with some historical or contemporary concept or tool.

Francine Shapiro has two necessary tasks to ensure that EMDR is accepted. First, she must make it *desirable.* That is, therapists and patients will find it indispensable for doing something more easily, cheaper, and faster. Second, she must ensure that her theory and practices are coherent to other researchers, clinicians, funding agencies, clients, etc. In this section, I intend to use the examples of psychogenic trauma, mechanical inference (statistics, diagnostic tests), eye movements, and suggestion, to show how EMDR has been created to accomplish both of these tasks.

Shapiro has maintained that EMDR is not derived from a theoretical position (1989b: 216; 1994: 155; 1995: 216; 1999: 45). Her 1994 article was entitled "EMDR: In the Eye of a Paradigm Shift," and in *Principles*, EMDR is referred to as a "shift in paradigm and perspective" (1995: 10, 12-13). Further, on the cover of her recent book (1997), the words "breakthrough," "amazing," "extraordinary," "profound," and "miracle" can be found. The opening line in *Principles* (her monograph intended for researchers and clinicians), starts off with: "We went from Kitty Hawk to a man on the moon in little more than 50 years, yet we have not had a major paradigm shift in psychology since Freud, nearly a century ago" (1995: v).

This creates for Shapiro both an exciting and open field in which to cultivate new ideas, as well as the unenviable task of proving extraordinary claims with the demand for extraordinary proof. Part of her struggle is to both appeal to a research-oriented community as well as a more mystical, popular-psychology audience. As such, there are two distinct lines of argument that run

through the extant literature on EMDR, that mirror many of the tensions involved in the treatment of mental distress. The first line comes from Shapiro-the-researcher, basing her texts in the language of probability, control-groups and placebo-matching, pathology and dysfunction, brains and neural pathways. She publishes in journals and texts which are meant to appeal to clinicians and psychiatrists with similar empiricist approaches to knowledge production. The second persona is Shapiro-the-healer, building a fortress made of anecdotes, appeals to the horrors of suffering, the need for a more holistic, spiritual approach to the mind. The rhetoric of easing pain provides the backdrop against which evidence is deemed valuable.

I have stated that Shapiro's two basic assumptions are that suffering is a scourge, always to be alleviated toward a better quality of life; and that innate, unconscious mechanisms cause trauma and suffering. I further elaborated four corollery necessities to holding these positions: that the body is universal; knowledge of the body is ahistorical; memory is linear, associative, and thus distortions are observable and measurable; and measurement is objective.

These assumptions and corollaries shape Shapiro's definitions of trauma, stated motivations for treatments, and the styles of reasoning followed in these tasks.

3.2 Psychogenic Trauma and the Universal Body

Any claims of novelty rest on the ability to produce a new element, and Shapiro offers four:

(1) The possibility of direct, non-intrusive, physiological engagement with the stored pathological elements;
(2) The information processing system is hard-wired and adaptive
(3) The transmutation of embedded information shifts identity constructs, and
(4) A release from temporal mandates (1994: 153-154; see 1995: 15-17).

The 'stored pathological elements' are traumatic memories. In the EMDR paper trail, the presence of these memories are uncontested, and are common parlance.[42] The traumatic memory has become so embedded in the psychologizing style of reasoning, that it is immediately recognizable, tangible, and applicable to various disciplines of study. In short, it is a prime example of a *boundary object.* EMDR's use is obvious; it has no trouble getting into the psychological journals which discuss anxiety and distress. Although familiar, this phenomenon is further restricted by local definition—a traumatic memory in one place is not a traumatic memory in another (see Young 1995: Ch 7). For Shapiro, it is encoded at one time, and remains in that place in the brain isolated and unchanged until psychotherapeutic intervention. This intervention deals with the information in a 'direct' way: "the focus of EMDR is on the *memory* itself" (Shapiro 1994: 153; italics in original). "There is little doubt that something about trauma causes information processing to be blocked..." (1995: 321). We are further told that "EMDR seems to have a direct biological effect on the nervous system, and because we all share the same nervous system, the results of certain experiences are fairly predictable" (1997: 7). This is not representative of most of the current climate of psychological and psychotherapeutic models of memory, which liken an individual's recall to a reconstruction influenced by suggestion, prejudice, and other environmental factors (see Schacter 1996a, b; Loftus 1993; Pope 1996).

Conversely, in a section marked "'Time-Free' Psychotherapy", Shapiro writes: "Traditional psychotherapy has been time-bound in the sense that its effects occur only after a protracted period of time. This probably occurs because conventional therapy uses verbal (rather than physiologically based) procedures to shift information that is dysfunctionally locked in the nervous system" (1995: 46).

[42] Muris and Merckelbach (1999) have been the only notable exception to this. They offer this observation in order to discredit EMDR, yet suggest no implications for the logical effect of this critique on other psychotherapies.

The body is clearly represented as universal in both physical composition and response to 'certain experiences'. Traumatic incidents, and their causes, are assumed to be "natural kinds," whereby talk (even disputes) over the etiology and intervention strategies is already to assume the authority of a physiological mechanism of post-trauma distress. There is only disagreement within a shared taxonomy. The concepts of trauma needs to be further problematized, as well as the notion that memories are stored indelibly in a dissociated form until EMDR therapy arrives.

The full title of Shapiro's most recent book is "EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma" (1997). It starts by introducing us to an unsuspecting woman in her apartment who was injured by the recent bomb blast in Oklahoma city (April 1995). The glass splinters and twisted metal are described in vivid detail, as they embedded into her skin and made her bleed from hundreds of tiny lacerations. We are told of her inability to recall the event, in fact how adamantly she denied it. She could not eat, ground her teeth until worn to the gums, woke up screaming and scared, and so on. Her story is contrasted a few pages later with a soldier in Vietnam who made a joke about a dead body, and was horrified to find out that the deceased man's son overheard the quip. His grief and shame are chronicled.

Shapiro asks the questions: "What do we mean by the word *trauma*?" She attributes the common technical definition to be inadequate, as it assumes that an event would have to be upsetting to everyone before it is deemed traumatic. Her definition is much more broad, in that it validates subjective experience. Events such as overhearing a passing remark that you are unattractive, getting a failing grade, having a pet run away, being angry at a boss, are called little "t" traumas, while rape, kidnapping, assault, natural disasters, and war events are called big "T" traumas. This separation is irrelevant in EMDR, Shapiro holds, as EMDR validates personal experience over clinician suppositions.

Her first study using EMDR therapy (1989a, 1989b) used twenty-two volunteers who were reported to have been diagnosed with PTSD. Associated symptoms such as nightmares and intrusive thoughts were reported as eliminated or substantially reduced. Truly spectacular results. The first criticism, however, was that subjects were not tested with a standardized clinical interview (Acierno et al., 1994; DeBell and Jones 1997; Herbert and Meuser 1992; Lohr et al. 1995, 1998). Subject's could claim to have been traumatized, without actually having been. In a rather negative appraisal of Shapiro's theory and claims, sympathy is still extended: "Perhaps this quick acceptance [of EMDR] reflects many therapists' frustrations with the difficult and time-consuming process of uncovering traumatic associations and the feeling of helplessness that comes along with seeing clients in pain" (Metter and Michelson 1993: 415). What I want to stress from this account is the association between trauma and suffering, and the moral solidarity shown by researchers in the common goal of eradicating such pain. The diagnosis of PTSD has served as a prototype for this type of thinking.

Patients in the EMDR literature are most often described as *victims* or *survivors*. They are terms that emphasize the passivity and vulnerability of persons, rather than modes of adaptation and agency. A distress-free existence is idealized, and any intrusion of psychological discomfort is pathologized and set out to be removed. Perhaps again Freud is to be implicated by his discussions of the psychopathology of everyday life (see S.E. 1901 V.6). A recent book on psychological trauma by Judith Herman, a psychiatrist, asserts that "everyone is a prisoner of the past" (1996: 235). In Shapiro's collection of case studies, her introduction states, "In these pages you may see yourself, a neighbour, a family member, or a friend. We all feel fear, pain, despair, guilt, or unrelenting anger when certain experiences and pressures converge....As we observe the process of healing that takes place in one person's mind, we see the reflection of our own

potential for healing. Perhaps we can also see a ripple effect that might lead to the eventual healing of us all" (1997: 11, 242).

When she uses the word heal, Shapiro is speaking of the verbal tests (recall SUD and VoC) which are administered to patients prior to, during, and months after the incident. The assumption that reported emotions are a guide to well being is refuted by Bowman, citing historical, cultural and research-oriented work (1997: Ch 12).[43] The assumption of a traumatic experience has been shown to underlie Shapiro's therapeutic intervention. The four paradigmatic points listed above are all conceptual. None refers to any action whether verbal or spatial. They are ways of describing *why*, rather than *how*. The postulate that there is an information processing system, which is hard-wired and necessarily adaptive, allows Shapiro to make further claims about the nature of trauma: they are divisible, generalizable, and available to the therapist.

> It is important to determine which traumatic memories are directly responsible for present dysfunction, and therefore should be processed with EMDR, and which are incidental to the present crisis, and can be set aside....Of course, clinicians will have to determine whether the earlier traumas are indeed unrelated to the client's present life conditions (Shapiro 1995:93).
>
> When [dissociation] happens during EMDR processing, the clinician should be able to discern the true nature of the apparent dissociation as one of the following possibilities: (a) the old feeling of dissociation that arises from the target memory and that will be metabolized by the sets, (b) a new dissociation that is being triggered because the client has been pushed too far, or (c) a dissociation that is the product of an undiagnosed dissociative disorder (ibid. 174).

[43] One well documented incident has provided more direct comparisons of the contributions of trauma exposure and individual differences variables. In the studies of the Australian bush fires of 1983 which were very well documented by McFarlane and others, fire exposure and other life events accounted for a reported nine percent of symptom reports after four months (McFarlane 1988). The long-term psychiatric morbidity seen in a small proportion of men after the fires was predicted better by pre-event individual differences than by exposure to the fire, or losses from them (McFarlane 1990). In particular, family histories of psychiatric illness and neuroticism accounted for the progression from acute distress to psychiatric disorder in two thirds of the cases (McFarlane 1992). Bowman's central argument, however, is anecdotal, arguing that emotional displays have become more validated in the trend away from universalism and objectivity, toward particularities and subjectivity, most recently represented by the post-modern movements in the humanities and social sciences, themselves a residual of Freudian quasi-scientific attempts to bring emotionality within a discipline governed by cause and effect (ibid. 103, 116). This critique appeals to the common-sense faculties upon which the SUD and VoC tests are based, and is a symptom of the disease that Bowman is trying to cure.

A mechanism for identifying the cause (whether direct or indirect) of dissociation is not provided. They are, it seems, simply available to the psychotherapist. Separate protocols for single and multiple traumatic events, anxiety, recent traumatic events, and for illness and somatic disorders are provided (ibid. 218-229), which provide clues for the reader. In the treatment of current anxiety, the initial target to keep in mind while performing a set of saccades, is the "initial memory," rather than the "memory or image of the actual traumatic event." Again, no mechanism for distinguishing physiological versus organic origins of distress are noted, other than that EMDR can only be used to treat the former. We are paradoxically told that:

> For many clients with somatic complaints, addressing the psychological dimensions will cause partial or complete remission of the physical symptoms. When primary organic processes are involved, the psychological issues may be viewed as exacerbating the physical condition" (ibid. 229).

The meanings of psychogenic symptoms, then, are located in the body. They are veridical, in the sense that they are a direct result of the trauma that occurred, and is still lodged, in state-specific form in the brain; and such meanings are available to the trained eye of the psychotherapist. They are not the product of interpretation, but are attached to them. The somatogenic symptoms, however, are products of pathophysiology, and have no meaning other than chemical or organic dysfunction. They might mimic known organic disease symptoms, but are not, in themselves, meaningful. There are at least three other ways, though not mutually exclusive, of speaking about psychogenic symptom formations that can be found in lay and expert discourses (Young 1999: 412-413).

The first is that symptoms are *psychosomatic*, whereby perception, mental conflict, and cognitive and/or emotional state cause pathophysiological processes. This explanation is the basis for psychoneuroimmunological theories that connect symptom formation or alleviation to stressful life events. Psychosomatic symptoms are differentiated from "psychogenic" in that psychosomatic symptoms encode or express no necessary meaning. Symptoms can also be

modified through *amplification*, whereby indistinct or ambiguous bodily sensations are focused upon and invested with meaning and emotions that a physician would deem illogical or untenable. These symptoms too do not correspond to the etiological event, and derive no meaning from its associations. The last method of symptom identification is a simple human propensity for embedding bodily organs, physiology and pathology within a daily *idiom* for communicating mental and physical states, and more general phenomena. They are employed *metaphorically* both unknowingly or knowingly, and the latter category can be further divided into a way of managing interpersonal relations, and as a means of eliciting attention, versus a means of acquiring certain possessions or status.

Within the EMDR style of reasoning, bodily sensations are both necessary and meaningful. "When a memory is being processed, most clients experience some manifestation of the information on a somatic level...since the physical sensations present during the trauma are also locked in the nervous system." The sensations are related or perceived as a "non-specific physical resonance... [and] the clinician should merely direct the client to think of the new location without attempting to ascertain what the sensation feels like or ascribe meaning to it" (Shapiro 1995: 84-85).

Psychotherapists, understandably tempted, sometimes claim a privileged position from which to find meaning in their patients' efforts to reveal and conceal, express and manage, his or her own 'true' feelings and sensations. Behavior is guided by belief, so for humans, beliefs *can* be causes. Shapiro's insistence on the presence of physical markers, their implicit and available encoding of traumatic associations, is misguided. We are told that "When a new negative idea or statement emerges, the clinician should ask the client where she feels it in her body...and the sequence of question and set should be repeated" (ibid. 151). And that:

> No matter how small a change the client notices, this body sensation should be targeted....The clinician should stay alert to any response by the client that denies body awareness while simultaneously revealing a physical sensation. For instance, when a client says 'I feel numb', 'I feel blocked', or 'I feel separated', this indicates a specific set of sensations that have taken on a particular emotional connotation mistakenly indicating a lack of feeling (ibid. 137).

In a provided script, a patient points to her neck and says that it is sore, saying "I hate them. And its not my fault," about her sexually abusive uncle and father. Without focussing on the physical sensation, the client states after two sets of eye movements, that she feels "more flexibility in her neck." Shapiro's margin notes read: "[The flexibility indicates a somatic shift, a release of state-dependent sensations that accompanied the original event, during which her head was pinned down]" (ibid. 253).

The trauma is simultaneously made visible and meaningful by physical alterations. Within Shapiro's schema, there are only somatogenic and psychogenic symptom formations, and by logic of exclusion, if it is not the former, then knowledge of the body is uncovered by the clinician, and not attributed to it. Shapiro's epistemology is based on conviction, and this mystifies the origins of knowledge by confining it to a private interior. Her rational explanation begins with the 'facts' of biomedical theory, with a rhetorical style of medical authority, toward an imperative for action. The patient's rationality is evidenced by his ability to grasp the clinician's argument and accept the physiological premises toward their natural conclusion (Kirmayer 1996: 325-326). Shapiro ignores the way in which her biologizing language, training and practices embedded in the creation and adoption of a theory, actually create the order in which she discovers and situates the patient's "real" problems. Within this narrow epistemological framework, the client's view of the world depends entirely on the empirical truth of his beliefs as judged against this clinical standard, and disagreement is viewed at best as irrational or uneducated, and at worst pathological.

> The clinician may need to supplement the client's understanding of the personality and interpersonal systems dynamics with education about the effects of psychological modeling or physiological imperatives

(Shapiro 1995: 258). "...avoidance behavior is considered both part of the pathology and the reason is maintained" (ibid. 119).

By this point, I have shown that the symptom, through which suffering is made visible and characterized, necessitates professional inquiry by the psy-disciplines; that the body is assumed universal; knowledge about it is uncovered, and therefore ahistorical; and the memories of experiences are linear and associative, enabling distortions in behavior and cognition to be both observable, meaningful, and altered methodically.

By incorporating traumatic memories, and the dissociative phenomenon of symptom formations unknown to the patients themselves, Shapiro has situated herself into a psychological history which makes her therapy immediately understandable. *Trauma* and *dissociation*, though themselves often vague and ambiguous terms, allow her to manipulate and incorporate accepted objects of study into her pervue, and enrol others in her research: they are ideal *boundary objects*.

I have left to prove the fourth corollery to Shapiro's two basic assumptions, namely, that observations and measurements of bodies can be objectively made; representation is not affected by intervention. In addition, "objectiveness" is another example of a boundary object.

3.3 Objectivity, Standardization, and Mechanical Inference

The adoption of DSM-III was part of a sweeping transformation in psychiatric knowledge-making that had begun in the 1950s. Clinical psychiatry in North America was profoundly altered, as it adopted research technologies from medicine (experimentation), epidemiology (biostatistics), and psychology (psychometrics). If captured in a moment, it was Hans Eysenck's pragmatic critique of psychoanalysis that provided the foundation on which the

behavior-therapy movement was erected. Methodological lessons were learned regularly for two decades on matters of internal and external reliability, psychometric measurement, subject selection, experiment demand effects, and ecological validation (for a few examples, see Bandura 1978; Lick and Unger 1977; O'Leary and Borkovec 1978). These procedures almost always entail statistical techniques: a probabilistic style of reasoning (1992c: 140).[44] The quantification of phenomena became necessary for recognition in psychological research. Similar conventions both defined one's position as a serious researcher, and allowed translation of results from one area into the quasi-labs of another. Enabling standardization by mobility through space, time, and application, mechanical inference became an obligatory passage point (Cohen 1994: 998; Sohn 1993: 1165-1168).

Like truth, beauty, and virtue, objectivity is a normative notion. It is a confirmation *on balance*, which means that the strongest and simplest relevant beliefs that are consistent with as many as one's prior epistemic commitments as possible are met. "Whereas probability once aimed to describe judgement, statistical inference now aims to replace it, in the name of objectivity (Gigerenzer et al. 1988: 288 cited in Young 1995: 265).

Perhaps the conversion of the neuroses, identified within the psychoanalytic (or environmental) model by etiology, into diagnoses which are to a affirm a 'commitment to scientific medicine', provides one of the best examples of the medicalization of human behavior. If there is a language which attempts to observe and measure behavioural phenomena, and make

[44] For a history of the development of probabilistic styles of reasoning, see Hacking's *The Taming of Chance* (1990) and L. Daston's *Classical Probability in the Enlightenment* (1988), and D. Mender's Chapter on *Neuropsychiatry and Numbers* (1994: 47-57). Accepted on probability means the possibility of accepting a "wrong" hypothesis is .05 percent; or, that there is a 95 percent chance that what is determined is correct. If this arbitrary threshold of .05 is reached, then the value is said to be statistically significant—it can be trusted as objective due to the reliance on mechanized inference. Critics of significance testing have maintained that statistical significance may not be taken as a sign of the truth of the research hypothesis, and that statistical significance tests to not generate verifiable predictions or replicable events (see Carver 1978: 368; Falk and Greenbaum 1995).

them amenable to—even seem driven by—standardized and systematic scientific principles, there is no better place to start than reliability and validity.

Reliability determines whether the same person will produce a similar value on multiple occasions (test-retest reliability) or whether two different testers, administering the test to the same subject on two different occasions (inter-rater reliability), will again reproduce this dissociability coefficient. Validity is more abstract. It is a judge of whether a test is measuring the construct that is in fact claiming to measure. Like any moral concept, it reflects the convictions about the nature of the interface of 'what's really out there' and our corresponding values and labels attach to these entities. Again, a number is generated, making such concepts like dissociation visible and amenable to statistical manipulation. Practically speaking, construct validity (also called face validity) is attributed to a test if its criterial features are *consistent with the clinical impressions and experience of experts.* As expert consensus varies greatly with theoretical and training socialization, Robert Spitzer, the senior architect of the DSM-III once quipped that face validity "was directly proportional to the growing number of approving faces and the wisdom of people behind those faces" (cited in Kirk and Hutchins 1992: 29).[45]

Dissociation is primarily a functional disturbance in the normal encoding, storage, and retrieval of memories, affecting our sense of consciousness, focus, and identity. What must be proven to satisfy a recognized diagnosis is to register above a threshold numerical value on a dissociability test. A subject fills in values, on a scale of stronger or lesser agreement or disagreement with certain statements, which are then summed and matched against this threshold value, and determines whether this person falls within or without the range of normality.

[45] See Kline's *The New Science of Psychometrics* (1998: 29-41) for a good review of issues involving the use of reliability and validity in psychological testing.

In a section entitled "Dissociative Disorders,"[46] Shapiro writes:

> EMDR specialists regard DID as a complex form of PTSD...in which the victimization was so great that, for survival, the global memory was compartmentalized to hold different aspects of the pain and disturbance; the alter personalities are conceptualized as neuro network configurations that serve as memory compartments. When EMDR (or other treatments such as hypnotic abreaction) has successfully resolved the traumatic material, the need for compartmentalization lessens, amnestic barriers between the alters dissolve, and 'co-consciousness' emerges (ibid. 101).
>
> The overwhelming sensations and emotional reactions experienced as the event is accessed are indicators that the information has been held in dysfunctional form" (Shapiro 1995: 50-51).

Dissociation is a fact; it is not contested in the literature on EMDR. The diagnosis of PTSD, for example, is bolstered by the argument that people have varying capacities toward dissociation. The re-assessment of all 'sensation and emotional reaction' experienced during therapy as proof of its efficacy, is another example of a self-validating style of reasoning. While arguing above that dissociation can be due to a single versus multiple traumatogenic memories, she writes:

> EMDR researchers should use measurement tools that are capable of assessing change when a single memory has been successfully processed. Unfortunately, practically no psychometrics have been developed for this purpose (ibid. 325).

Shapiro incorporates into her theory the implicit assumption that dissociation is a *continuum*, on which all can be assigned a value. The evidence for this is that there is a varied response by different individuals to the similar events, and that we measure dissociability on a *scale*. As I mentioned, the results are compared to experts in the field and thus calibrated for accuracy. The problem is that there is no body of experts in this field who consistently agree on what dissociation is. Hacking writes:

> Many leading psychiatrists say there is no such field. What we are observing is not the calibration of dissociative scales to judgements shared by students of the human mind and its pathologies. Instead, the scales are calibrated to the judgements of a movement within psychiatry...presented as objective scientific results like any other (1995:100).

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[46] Appendix B, Sec I (1995: 365-369) is devoted to issues involving EMDR and dissociation. It describes how all clients must be screened for DID using Dissociative Experiences Scale (DES), or the Mental Status Examination for Dissociative Disorders. If the index of suspicion is high after a screening, the therapist should conduct further 'diagnostic clarification' with further clinical interview tests. "No clinician should use EMDR with a client suffering from dissociative disorder unless he is educated and experienced in working with this population and has been trained in the use of the cognitive interweave....The lack of adequate screening for this population can have literally fatal consequences for this population...exacerbate the dysfunction for a number of DID 'alters' and result in suicide attempts, other injury, or the need for emergency medical services" (ibid. 303).

Associations and dis-associations of memories are, as shown above, linear and ahistorical; Shapiro even uses the words "lawfully linked" (1995: 147) and "ecologically valid" (ibid. 257) to describe the organization of the neuro networks. This language offers Shapiro the guise of working with a biological framework of the mind. The tests of reliability and validity were notions borrowed from the natural sciences, where the values being measured are *external*: length weight, force, etc. In psychology, personal characteristics such as stress, guilt, pain, and shame are *internal*, and are difficult to define validly, much less measure reliably.

Shapiro is a strong advocate of the need for measurement and standardization, and consistently calls for "greater methodological rigor and higher clinical standards" (1996b: 313), stating that "measurement is at the heart of all scientific research" (1997: 16). Discussing the VoC test, she writes, "This measure, which was created by the author...was assumed on the basis of its face validity to provide a rapid assessment of cognitive structure" (1989a 203). Not surprisingly, this 'assumption' was not well received, drawing such criticism as "The VoC, developed by Shapiro, does not appear to have been tested for reliability or validity" (DeBell and Jones 1977: 154). As well, the second subjective measure, the SUD, was claimed to be correlated with "objective physiological indicators of stress" (1989a: 203), although the search for *significant* results have been reported not to have been found (Boudewyns et al. 1993). Although the measures of self-reported anxiety, depression, intrusive thoughts and disturbing dreams *were* significantly reduced in one study (Montgomery and Ayllon 1994), the *physiological* measures were reported to have failed to corroborate these findings. This prompted DeBell and Jones to write, "Unless additional research finds a relationship between the SUDs and physiological indicators, the validity of the SUDs must then be questioned" (DeBell

and Jones 1997: 158). Most critiques of EMDR invoke issues of appropriate use of statistical tests and methodological neutral protocols.

> "No objective or standardized measures of psychopathology were used to assess changes as a function of treatment" (Forbes 1994: 118). "The method lacks both a theoretical foundation (Wolpe and Abrams 1991) and empirical support" (Vaughan et al. 1994: 284). "At this writing there is no scientifically credible evidence that any EMD package reliably produces demonstrably specific influences on predictively valid measures of adaptively significant naturalistic performances..." (McGlynn 1999: 604).

I have shown that dissociated memories arise from discrete causes, all of which are visible to the therapist, and thus distinguishable. The fourth and last corollery that I have left to show is that these observations and measurements of bodies can be objectively made, such that representation is not affected by intervention. This assumption is held by Shapiro and others working in the field of experimental psychology, yet it is the battleground upon which the accusations of inappropriate symptom recording, statistical analysis, type of control group, treatment fidelity checks, etc. are fought. It is this postulate of universality which is *tested* in the literature. We move in front of the curtain, in which science is no longer theorized in abstract thought. This is where patients perform tasks, questions are answered, actions are recorded, and numbers are tallied.

In one example, Renfrey and Spates performed an F-test to determine if there was a statistically significant effect for mean number of sessions and treatment effects (1994: 238). The "degree of freedom" coefficient used was, for 23 subjects, 2 and 18 degrees. Shapiro rails against both Renfrey and Spates and Lohr et al. (1995) for mistakenly using these values instead of the correct value of 2 and 20 degrees which "should have been used for this test" (1996b: 314). What lies in the balance of the 2 degrees of freedom is the all-powerful .05 significance rating. It would allow Shapiro to say that eye movements *are* statistically more significant than a fixed-eye condition, something she very much wants to do. "Although the errors found in the Lohr et al. (1995a) article are too numerous to list exhaustively," Shapiro writes, "it is clear even

from those noted that it is quite possible for readers to be seriously misled." A later article by Cahill, Carrigan and Frueh discuss this disagreement, concluding that no mistake was made in the original reporting, and it is Shapiro's assumption which was inappropriate (1999: 20).

Arguments like this do not merely clutter the paper trail, they constitute it. While the data produced in one area are meant to be both powerful and applicable in other spaces and times, they are, when seen in action, only *locally universal*: the protocols themselves are in constant flux, and only emerge in therapist offices to crystallize into an objective tool (Timmermans and Berg 1997). Social research, no less than experimental work in physics or chemistry, depends on standardization and on a kind of calibration that is more demanding in the social field than in the natural. Society and the individual subject must be remade before they can be the objects of quantification.

The appearance of objectivity, or at least value neutrality, is crucial for Shapiro. This is what identifies her with a community or researchers rather than a movement of activists, perhaps her most difficult task. For in the desire for objectivity we see Shapiro-the-researcher desperately trying to straddle the chasm between her involvement here and in the spiritual healing movement.

The examples above, of dissociation and dissociability, the SUD and VoC scales, and of statistical application, have concerned issues of validity. The next section will focus on issues of reliability. It also marks a shift in the style of reasoning. While trauma, dissociation, and statistics have been tacitly assumed and necessarily employed to ensure membership in the scientific enterprise, eye movements and suggestion have the opposite task. For reasons of novelty and scientific sterility respectively, they must be shown to be *unconnected* to EMDR's theory and practice. This allows them to function as *boundary markers*, calling attention to

discontinuity of time, space, and causality in conceptual and practical work-spaces. By avoidance, aversion, or ridicule, boundary markers function as signposts indicating the inappropriateness of incorporating a *theoretical* connection with impure or infecting associations. While boundary objects can be objects of practice and theory, boundary markers lie in secondary explanation, reinterpretation and spin-doctoring old ideas to look like new, incommensurable ones.

3.4 Eye Movements and Reliability

Eye movements have been associated with hypnosis and suggestibility for a long time. A playground parody of hypnotic induction pictures a pocket-watch being swung back and forth in front of the eyes of the subject to be hypnotized, with some instruction to relax in a smooth voice. In a crude eighteenth century sketch mocking a mesmerist charlatan, we see a woman being put into a state of somnambulism, her eyes fixed on the finger of the mesmerist (illustration in Darnton 1976: 53). And James Braid, writing in the mid nineteenth century on his new studies in hypnosis, opined:

> A patient may be hypnotized by keeping the eyes fixed in any direction. It occurs most slowly and feebly when the eyes are directed straight forward, and most rapidly and intensely when they can be maintained in the position of a double internal and upward squint. It is pretty generally known, that during the effort to look at a very near object, there is produced, according to the direction of the object, a double internal squint. (Braid [1843] 1960: 115-116).

Hypnotic treatments enjoying a brief resurgence in popularity around 1880-1910. Having become strongly associated with suggestion and suggestibility (taken as evidence of congenital weaknesses) in this time, however, it was marginalized in orthodox medical psychiatry. Later, in the 1970s, the link between eye movements and hypnotizability were broadcast again.

> Low amplitude, slowly varying eye movements (SEM) have been observed in a number of hypnotized subjects during periods of responsiveness and overt activity....and those who produce SEM are exhibiting much suggestibility in the presence of an altered state of awareness, otherwise identified as 'hypnosis'. (Weitzenhoffer 1969: 221, 227; see Dunwoody and Edmonston 1974; Etaugh 1972; Hiscock 1977).

Willingness and ability to maintain a non-analytic mode of attending was found to be common to hypnotic responsivity, meditating, and imaginal activities (Spanos, Rivers, and Gottlieb 1978: 586). The mysterious leap from the somatic to the psychic is still, in the words of Hacking, a *marvel.* And science abhors a marvel. The taboo on hypnosis, temporarily lifted by Charcot, is still felt today.[47] Within the language of "placebo effects," there is a desire to circumscribe and *remove* whatever percentage of therapeutic change is attributable to suggestion.

> Although considered outmoded at the turn of the century, there has been a recent upsurge of interest in the phenomenon of suggestion. There has been considerable interest in its relationship not only to psychotherapy, but to therapeutic change in general. *This involves the problem of separating suggestive influences from what might be considered specific therapeutic effects* (Winkelman and Saul 1972: 231; my emphasis).

If the eye movement component of EMDR therapy is to be accepted by the research-oriented community, it must be proven 1) necessary, 2) replicable, and 3) distinguishable from hypnotic induction techniques (placing the boundary marker; constructing novelty).

"The primary component of the EMD procedure is the generation of rhythmic, multi-saccadic eye movements while the client concentrates on the memory to be desensitized" (Shapiro 1989a: 201). Her study reported a 100 percent success rate and remarked that "enough information has been given here to achieve complete desensitization of 75-80% of any

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[47] While there is still research in the field of clinical and experimental medicine, it does not demand the attention of most orthodox medicine. The major theories of hypnosis, drawing from the intellectual heritage of Bernheim, Charcot, Janet, and Freud are still represented by the positivists, the neo-dissociationists, the social psychologists, and neo-Freudians. The positivist movement, founded by T.X Barber in the 1960s, holds that hypnosis cannot be indexed as a rise in suggestibility (its alleged antecedent) and attempts to prove that the hypnotic phenomena can be accounted for by independent and mediating variables, especially attitudes, motivations and expectancies (Gauld 1992: 581-568). The debate between the neo-dissociationists and the social psychologists, spearheaded by E.R. Hilgard and N.P. Spanos respectively, lead to a revival in interest in suggestion and hypnotic phenomenon in the 1960s and 1970s. In contrast to the neo-dissociationists, which I have commented upon above, the social psychologists emphasize the rôle of the hypnotized patient, as acted by their reception of culturally held beliefs about hypnosis and the (intended or intentional) cue from the hypnotist. Hypnosis is, for Spanos, a social behaviour

individually treated trauma-related memory in a single 50-min session" (ibid. 221). There is little wonder why this article produced much interest. The story changes, however, as readers, when presented with the same data and a few added case reports, are told in her next articles that "the present description contains enough information to desensitize approximately 60-70% of PTSD-related traumatic memories..." (1989b: 217), later becoming "and in 50% of the cases, this information is sufficient" (1992: 114). Moreover, studies have come out indicating that the eye movements are not more effective than fixed-eye or no-focus conditions (Pitman et al. 1996; Renfrey and Spates 1994; Sanderson and Carpenter). As Rosen has stated, "These findings, of course, presented a problem for EMDR, a relatively new and novel method that had proclaimed a critical role of eye movements. After all, without the "E" and the "M," one is left with already established components, namely "D" for desensitization and "R" for cognitive reprocessing" (1999: 179).[48] Where has the efficiency gone? As I have said before, EMDR, as well as the object of its study are both moving targets. Both the protocol has changed, along with the justification and explanations for its application and efficacy. EMD became EMD/R and eye movements could be substituted with finger taps and other auditory bilateral cues (Shapiro 1991; Shapiro 1993: 420; cf. Lohr 1995: 286).

In a series of point-counterpoint articles by Greenwald and Ommeren, the discrepant results in the EMDR controversy were presented by Greenwald as issues of treatment fidelity: those who have been trained formally by the EMDR institute, and are thus efficient in its application *are* able to practice EMDR as it is meant to be practiced, while those who have not undertaken this training cannot (1996). Ommeren counters this statement by introducing

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(ibid. 596-597). Spiegel and Cardeña have proposed a model by which hypnosis is explained by effects on memory, in a tripartite system of absorption, dissociation, and suggestibility (1991: Ch 4; Spiegel 1996: Ch 4).

concerns surrounding treatment fidelity assessor impartiality. He claims that an assessor who is has written favourably about EMDR, and is a paid instructor of the entry-level courses, might be an unsuitable judge. Ommeren misses the most surprising of Greenwald's claims, when speaking about the comparison of fixed-eye to eye-movement techniques. Greenwald writes that such a comparison is inappropriate "...as an example of EMDR's failure to outperform an alternate treatment, when in fact only variants of EMDR itself were compared" (1996: 91). This argument echoes Shapiro's very comments made two years earlier, also in response to concern over the necessity of eye movements versus fixed-eye conditions (Steketee and Goldstein 1994: 156): "Component analyses have compared eye movements and other forms of stimulation or 'forced focus' which sheds no light on treatment efficacy because all of the other EMDR components are included and alternate forms of stimulation have been used clinically for years" (Shapiro 1994b: 158: cf. 1995: 334).

The standardization of eye movements into a new psychotherapeutic tool was coextensive with the regulation of its use and the redefinition of its characteristics. This is a characteristic example of self-vindication, as a style of reasoning, whereby through a process of tinkering with the original protocol, it was *adjusted* to accommodate the findings which would otherwise have invalidated its claims to efficacy. EMDR is made stronger by incorporating this finding; the value of consistency is not nearly as high as making it work.

> The inaugural study (Shapiro 1989a) did indeed stress directed eye movements as the primary component of the therapy. This incorrect and unfortunate interpretation of the method can be explained by the author's concentration on the concrete actions in which she was engaged during therapy, rather than on the attendant complexity of the methodology actually employed and the underlying processes thought to be engendered by it (Shapiro 1999: 37).

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[48] In an article entitled *EMDR Minus Eye Movements Equals Good Psychotherapy* (1997), Lee and Brandsma argue that the treatment is effective in the absence of eye movements, as it applies common and general principles of psychotherapy, of which they offer ten.

The complexity was there all along by Shapiro's account, and she was simply unaware of the complexity of her actions. The process 'actually employed'—clinical knowledge rather than the recent spate of component analysis experiments questioning the role of eye movements—did in fact reflect the procedure as we know it today, Shapiro maintains, we just all missed it. Unable to maintain this position in light of much academic criticism, the story changed in 1995. After stating her support for the connection between the eye movements in EMDR and the Rapid Eye Movement (REM) action in dreams, she states: "In fact, even without the eye movements, EMDR has shown itself to be an efficient and structured approach to pathology that offers positive therapeutic effect" (25-26), stressing the complex nature of the eight-staged EMDR protocol. And the efficacy rate, which has dropped to 50 percent in 1993, has risen back to 80-90 percent.

> Clinical observation suggests that therapists trained formally or through supervision by experienced EMDR clinicians can expect a high success rate (perhaps as much as 80-90%) for appropriately selected clients. If this level is not being achieved, the clinician should take responsibility for becoming more skilled in the method (ibid. 339).
>
> Clinician's who fail to get positive treatment effects with EMDR may simply be those who cannot incorporate it into their therapeutic style (ibid. 338).

Her critics have questioned this circular, self-vindicating argument. "At the same time, treatment fidelity is an issue that can be abused and misused to defend against negative findings: in the case of EMDR, it appears that this has happened. Clinicians are dealing with a slippery slope, one where the rules keep changing, and data can never catch up" (Rosen 1999: 183).

In attempting to prove the eye movement component of EMDR therapy necessary and replicable, some EMDR theorists have tinkered with the treatment protocol to incorporate findings which were not predicted, and discredit unfavourable findings. I will now show how eye movements have been deliberately dissociated from notions of suggestion and hypnosis, in an effort to avoid the taint of subjectivity.

3.5 Suggestion, Hypnosis, and Rapport Revisited

When the object of a discipline is an internal state, not only are errors of reliability and validity common, understandable, and inevitable problems, but indigenous aspects indirectly or directly promote them, such as the establishment of a close rapport between the patient and therapist.[49] "EMDR is never implemented in the absence of an adequate client history, a clinical relationship that includes rapport and client comfort, and a treatment plan" (Shapiro 1995: 116).

In Charcot's neurological model of hysteria, the hypnotic state was a pathophysiological one: "the mental inertia [in the patient] is so absolute that in general it is impossible to enter into relation with the hypnotized subject or communicate any idea to him by any process whatsoever" (Charcot 1889 cited in Ehrenwald 1976: 256). The patient was thus a prop—an example of a natural type—to be presented as part of his famous lectures, and behaviours to be understood in light of degenerative heredity and organic dysfunction, rather than expectation, mimesis, and suggestion. If the disorder is biological, how could he interfere, much less affect his patient? This reasoning, of course, serves to justify the premise that it follows. That is, to maintain a position consistent with the separation of therapist and patient, it would strengthen such a position to assume a biological origin of the malady to be treated. Compare this with Shapiro's conception of therapist influence, stating that "EMDR studies...are strengthened by the

[49] Two articles have directly compared EMDR with Mesmerism (Ellard 1993; McNally 1999). Ellard's paper merely points out that eye-movements are distractors that might play a similar role in EMDR as in hypnosis. McNally's article does not necessarily compare EMDR with hypnosis as it does the mesmerist and EMDR movements. Although both writers are familiar with the extant psychological literature, neither is conversant with the history of mesmerism. Ellard offers no citations, and McNally relies on a single source. Non-critically, McNally states that although the parallels are stark, EMDR is not hypnosis, and then cites Shapiro as evidence! (1999: 226).

incorporation of more standardized diagnostic criteria and measures of symptomatology, as well as by a separation between the therapist and the measurement of effects" (1995: 328).

> Inherent in the Accelerated Information Processing model is the concept of psychological self-healing, *a construct based on the body's healing response to physical injury*....The notion of activating the adaptive information-processing mechanism is central to EMDR treatment and has been critical in its application to a variety of pathologies (1995: 31; my emphasis).

> If EMDR is properly applied (without major demand characteristics) and if the information offered by the clinician is accurate, a new perspective will be assimilated. If the information is not accurate, it will be rejected....It is mandatory for this intervention, and for all subsequent variations, that the clinician make the statement "Just think of it" in a suggestive, non-directive, tone of voice....Because EMDR does not appear to allow anything to be assimilated that is not appropriate for the client, the clinician must be willing to accept the possibility of being wrong. [But recall that] "owing to deficits in education, parenting, or modeling...the clinician may need to supplement the client's understanding of personality and interpersonal systems dynamics with education about the effects of modeling or physiological imperatives" (ibid. 256-258).

The body heals psychic injury as it would a physical injury, and no 'inaccurate' information can be assimilated into the patient's.cognitive schema. In addition to being an example of self-vindicating style of reasoning, what is most interesting is the bracketed words 'without major demand characteristics'.[50] How is a therapist meant to be simultaneously 'suggestive' and 'non-directive'? And how are we to tell which client-rejected suggestions are due to their inherent falsity rather than due to client deficits? It would be a mistake to think that the EMDR procedure acts towards decreasing demand characteristics. The argument that Shapiro and those trained by the EMDR institute can identify 'accurate' information by monitoring its rejection by the client is similarly specious.

Demand characteristics cannot be eliminated from any psychotherapeutic setting, and the EMDR protocol, in fact, explicitly states that they are crucial, and should be maximized.

> Sometimes—because of insufficient trust, a high susceptibility to demand characteristics, or a desire to avoid further painful material—a client inaccurately reports a low level of distress and inappropriately or prematurely end the session. (ibid. 91). The clinician's job is to facilitate the client's self-healing process. Any non-specific aids to this end (including ways to facilitate therapeutic bonding and unconditional support and regard) will increase therapeutic effectiveness (ibid. 120).

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[50] The term "demand characteristics" was first used by Martin Orne to refer to the sum total of experimental cues which convey an experimental hypothesis to the subject, and were predicted to be significant determinants of subjects' behaviour (1962: 779).

Clearly there are overt demand characteristics which are being down-played in some respect due to their connection with suggestive influence.[51] While Shapiro is interested in linking her theory to the established rhetorics of psychotherapy, she does so only insofar as they illuminate "theoretical convergences" (ibid. 17). Her revisionist histories clearly serve to support her present credibility. Yet not only are demand characteristics necessary to insure sufficient patient self-reports and to increase therapeutic efficiency, they are suggested as the underlying thread of efficacy in all psychotherapies.

> I believe that staying fully present—that is, being compassionate, aware, and sensitive—with a client during an EMDR session allows the clinician to rediscover the wisdom of every major current psychological modality. Clearly, these modalities all have something to offer therapeutically or they would not have stood the test of time (ibid. 268).

> What we find in EMDR is an interweaving of much of what appears to be valid in traditional psychotherapy, because whatever is true must dovetail. Essentially, regardless of the terms used, what all psychological modalities have in common is that information is stored physiologically in the brain....For instance, if EMDR is defined simply as hypnosis, its usefulness will be limited to those effects already available to the hypnotist. If it is viewed solely as desensitization, essential dynamics and applications may be ignored by the therapist....EMDR may best be described as an interactive, intrapsychic, cognitive, behavioral, body-oriented therapy (ibid. 51-53).

The argument against comparison between EMDR and hypnosis seem to rest solely on the fact that such a parallel would constrict the way patient and therapists *think* about EMDR, namely conferring to it their preconceived limitations of speed, causality, potential efficacy of the other

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[51] Janet's approach to treatment endeavored to remove the symptoms by any way possible: to bring the dissociated memories to primary consciousness, or eradicate or transform them so that they were no longer pathogenic. He openly used and advocated suggestion and coercion. "He dealt with traumatically called neuroses by convincing the patient that the trauma had never happened. He would do this by suggestion and hypnosis whenever he could. Take, for example, his early patient who at the age of six had been made to sleep beside a girl terribly suffering from impetigo on one side of the face. His patient would break out in hysterical marks, and would experience loss of sensibility, even blindness, on that side of her face. So Janet used hypnosis to suggest to his patient that she was caressing the soft beautiful face of the girl she had lain beside at age six. All symptoms, including the partial blindness, disappeared. Janet cured his patient by telling her a lie, and getting her to believe it. He did this over and over and over again with his patients—got them to believe what he himself knew was a lie" (Hacking 1995; see Janet 1889: 440). Janet did not believe that patients could be treated without a detailed understanding of their past, and took very careful personal histories, often interviewing the patient's family members and acquaintances. Psychotherapy only started after the patient had become less symptomatic, and had gained voluntary control of his or her actions. His goal was to take the patient back to the same state of consciousness as that produced by the traumatic incident itself, once there using hypnotic and non-hypnotic instructions to consolidate psychological improvement and to put newfound insights into action. This involved actively planting neutral or positive images for the traumatic memory (van der Kolk and van der Hart 1989: 1537-1538).

therapeutic modalities. Further, the eye movements themselves are claimed not only dissimilar to the hypnosis-like induction protocols, but also to *prevent* dissociation which betrays hypnotic induction, according to Shapiro: "the use of eye movements gives the clinician a good indication of the client attention to the task, which may be an important benefit when the treatment is carried out with highly traumatized clients who might otherwise dissociate into the material and stare fixedly into space" (ibid. 138); and "...unlike hypnosis, the EMDR abreaction does not continue moment by moment in a "real time" reliving of the event. (Even in cases of induced time distortion the hypnosis client will generally go through each instant of the event sequentially.)" (ibid. 168).

Again, this argument rests on the assumption that memory encoding, storage, processing, and retrieval do not effect the veridical nature of the memory with the original experience. Human experience as a varied, contingent form of expression—a process—is reduced again to a set of physical cues which are transparent to the clinician. The internal state is decoded into causes, triggers, and symptoms, reworded into universal mechanistic terms. With such a rational and self-vindicating style of reasoning, placing the clinician in a position where he cannot possibly do wrong, the search for some individual meaning intrinsic to the metaphoric gesture is unnecessary.

The eye movements are being used as boundary objects. Their connection with hypnosis is well established, and preferably avoided both to further claims of novelty, as well as loosen the association with suggestion. What was once an argument against similarity is now proof of difference. The eye movements stand sentry, in the aid of the clinician, against dissociation.[52]

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[52] Though clearly precluding comparison through boundary marking, eye movements *are* in practice used similarly to the powerful suggestive techniques assigned to hypnosis: "The clinician must be careful to maintain a supportive and encouraging demeanor, regardless of the client's words....the clinician should act as a cheering squad for the verbalization....If the client verbalizes between sets, her statements should be mentally rehearsed during the next

> However, the mechanisms that underlie this information processing are unknown and will probably remain so for years to come, owing to a lack of neurophysiological knowledge and appropriate measuring devices (340)..."However, the lack of definitive explanation of the underlying mechanisms of EMDR in no way detract from the demonstrated effectiveness of the method (1995: 309; see 1997: 26).

This is an example of an argument from a vacuum. It is reflective of Shapiro's positivist view of science as progressing gradually and inevitably toward a full explanation of the true roots of psychological phenomenon in 'neurophysiological' terms. She consistently misrepresents science as an exercise in logic following a path of induction. This tends to authorize only purposive or instrumental notions of rationality, and to delegitimate (as unresolvable or subjective) genuinely practical or political questions—the meaning is in the mechanism. There is no need to look to the historical record for inspiration or advice. The past is a repository of errors—at best a source of moral instruction in pitfalls along the path of progress. I do agree, though, that there is no necessary relationship between the correctness of a theory and the therapeutic results derived from its application (cf. Frank 1973).

Philosophical positioning has not changed in the last sesquicentennial as dramatically as the idiom. Rather, the language has been made more amenable to a "scientific method": scales and indices, phylogenetics, immune effects, physiological markers, and randomly assigned control-grouped double-blind trials are emphasized. The same state-nonstate debate—over the existence of a discrete hypnotic phenomenon—is cloaked a new imagery of differential diagnosis, psychometric tools and mechanical inference. Around the turn of the eighteenth century, Mesmer and Puységur lived in a time dominated by clerical ideologies, and criticism was directed toward sexual indiscretion and unwitting intimacy. Now, with the adolescence of pharmacological and genetic sciences, the patient's rights are protected by the morals of society under the banners of medical ethics, cost-effectiveness, and legal culpability.

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set. They should be repeated with successive sets until...the client feels both justification and conviction without fear or self-blame (Shapiro 1995: 179).

4. Conclusion

4.1 Implications for a Moral Economy

The ideological claim that science embodies progress is one dimension of how science reflects and constitutes a moral ordering. A subsequent claim holds that certain feelings and bodily states are to be identified and remedied by an 'authorized' practitioner. These claims are usually tacitly shared among Westerners (North Americans, at least). Our bodies and minds are normalized and idealized toward a model that is set by the medical establishment, as well as the mass media.[53] It is the scientific rhetoric which carries the day, however: "Although moral economies draw routinely and liberally upon the values and affects of the ambient culture, the reworking that results becomes the particular property of scientists" (Daston 1995: 7). And it is the prestige of science that leads us to understand ourselves in specific ways, casting all our complexities into a sanctioned explanatory model.

Distress is expressed in culturally sanctioned ways. If television (often a professional on a talk show) dictates that traumatic memories are acceptable medical diagnosis, a person might begin to interpret and reinterpret experience within this framework. We learn *how* to be sick, tired, and anxious. "The limits of my language mean the limits of my world," Wittgenstein once wrote. As we learn to reflect on our bodies, cognitions, and even causes in a language of suffering in the idiom of trauma, our world expands. Yet it is also constricted such that although

[53] See Wahl's *Media Madness* (1995) for a comprehensive listing and analysis of the images of mental health in various forms of media. He notes that those with psychiatric disorders are the only group for whom unchecked media defamation continues to occur (p. 165).

we have more *options* (epistemological spaces), language of trauma becomes privileged, allowing selective access to medical care, compensation, legal defense, and empathy.

By the patient's tacit belief in the therapist's expertise, he conspires to occupy the very space (diagnostic pocket) that his conviction empowers the therapist to create. The patient accepts the diagnosis as real, because it explains their suffering. He has undergone a battery of psychometric (and sometimes physiological) tests, and has symptoms which are both consistent with what the therapist expects, and the reason that he is interesting to the therapist at all. The patient is also told that the condition is reversible, giving the patient hope, in relieving anxiety, stress, and pain toward a new future. The patient is further told that *he* is responsible for the cure, thus bolstering a feeling of self-efficacy.

Within EMDR's explanatory framework, causes are biological. In this genetic fallacy, the cause and origin of a phenomenon (bodily state, cognition) and its eventual utility lie worlds apart. Yet whatever exists is repeatedly reinterpreted to new ends, redirected by some power superior to it. The trauma stories become the symbolic currency in which exchanges between patients and therapists takes place. The essential movement which makes EMDR a necessity is the obsession with psychological trauma: a mix of fascination, revulsion, anger, and fear. All human experience is reduced to an endless stream of connection making and connection breaking in the brain. If it is true, this is still not very satisfying when we ask the existential questions: Why me? Who am I? and What does this mean to me?

By eliminating these questions toward a genetic resolve, culture becomes irrelevant. Our differences are merely held as an example of the wonderful plasticity that our anatomy allows. "As cases pour in from all over the globe, it has become clear that there are many more common denominators among people and societies than there are differences...cross-culturally we share

physiological responses that can offer a window into the human mind and potential" (Shapiro 1997: 223). Cultural imperialism is now conducted by psychiatrists instead of missionaries. To date, the EMDR Humanitarian Assistance Program have provided services and training for therapists in Zagreb and Sarajevo, Northern Ireland, Kenya, The Ukraine, Colombia, El Salvador, Serbia, and Hungary (EMDR website; June 1999).

Although some forms of anxiety have been suggested to have some cross-cultural validity (see Kleinman 1988: 40), the field of transcultural psychiatry has raised many questions concerning the cultural variations in the experience of emotional distress (see Kirmayer 1989; Kleinman 1995; Littlewood 1990; Summerfield 1999 for examples). It is a conceit of those who share this genetic fallacy that the world exists to provides metaphors for the irreducibility of brain physiology: the plateau of information, the channel of a memory, the neuro network.

We should be clear that when examining the impact of EMDR on any mental state, we are not witnessing the affect of one tool on a social process, but rather one social process on another. EMDR is a moral tool of the first order, as it creates and regulates an ideal self. It is, like the psychological discipline, an intellectual technology, a way of making visible and intelligible certain features of persons, their conducts, and their relations with one another. Claims to understand the inner determinants of such actions and cognitions allow a delocalized expertise, enabling those empowered to speak of the morality of another.

4.2 Implications for a Political Economy

> In 1989, the director of the American Psychiatric Society recalled:
> ...that [by the 1970s] psychiatry was perceived by the federal government and by private insurance companies as a 'bottomless pit"—a voracious consumer of resources and insurance dollars—because its methods of assessment and treatment were too fluid and unstandardized (Wilson 1995: 1993: 403).

A recent article in the New York Times re-addresses this concern for late twentieth-century America, where 10 percent ($80 billion) of the health budget is earmarked for mental health research and treatment (Sharkey 1999). One of the selling points of EMDR therapy has been its time-limited nature, reducing symptoms without the use of expensive drugs, and complicated physiological testing. A study at the Kaiser Permanente health maintenance organization compared EMDR to its standard method of care for its clients. Shapiro reports that "in the wake of that study, it has been estimated that having EMDR available throughout the region where the study took place would save the institution 2.8 million dollars per year" (Shapiro 1997: 262 fn 5). Another study analysed the expense of EMDR against the standard treatments for PTSD, in an HMO setting (Marcus, Marquis, and Sakai 1997). More recently, Shapiro has written that "It is clear that the substantially reduced time required to produce observable therapeutic results with EMDR bring benefit to the client in terms of both reduced suffering and cost, advantages especially appreciated in this age of managed care" (Shapiro 1999: 61). When a maverick psychotherapy starts addressing issues such as cost containment for the benefit of insurance carriers, we know that it has established itself.

It should not go unnoted that almost all of the positive accounts of EMDR therapy have come from researchers and clinicians who are either members of the 'independent' regulating bodies (Dissociative Disorders Task Force, Professional Issues Committee, EMDR International Organization), EMDR Instructors, or directors of Veterans Associations (see Shapiro 1995 Appendices B and C for memberships: 365-375). One journalist has suggested that EMDR offers VA therapists a tool which is helping them do a better job treating PTSD, combatting a negative image of their previous track record (Marano 1994: 24).

EMDR is also a business.[54] The fee for the first level of training is in excess of $500, and again for the second level. Conferences will be held in 1999 in Utrecht, Nevada, and Copenhagen, and there are 21 training sessions offered across North America, and 15 courses around the world (Tokyo, Helsinki, Cologne, Buenos Aires, Johannesburg, Sydney, Adelaide, Denmark, London, Milan, Paris, Rio de Janeiro, Brasilia) for the level II course alone (EMDR web-site; June 1999). To counter claims that EMDR is business-oriented, Shapiro has written: "While the writers' emphasis may be on finances, mine is on training people to assist in alleviating a massive amount of suffering" (1992: 112).

4.3 Implications for Psychotherapy

In 1987, *The Journal of Anxiety Disorders* was founded, and only one year later *Anxiety Research* published its first edition. The 1980s were labeled "the decade of anxiety" by the former, citing the proliferation of books, articles, grant applications, and other funding opportunities in the field.

EMDR was not simply a *treatment* of mental illness, it is a technology by which we are able to talk of anxiety, make it visible. EMDR has been constructed with the specific aims made to intersect with many styles of reasoning—statistical, experimental, psychogenic trauma, dissociation, and so forth—and been made discontinuous with others (suggestion, hypnosis). If EMDR therapy is with us in 10 years, it is not because it accesses a place in the brain where traumatic memories are stored. Rather, it will be largely due to the efforts of Francine Shapiro. She has relentlessly toured lecture and conference circuits, published articles, chapters, and

[54] Although indicative of very little, EMDR has been listed in the National Council Against Health Fraud Newsletter, in an article written by Lohr and Rosen, two well-known dissenters (www.ncahf.org: Jan-Feb 1997).

books, taught courses around the world, and set up programmes ensuring that EMDR is familiar, accessible, and valuable.

EMDR supports the 'life as catastrophe' model of mental illness, eroding away the concept of trauma until the event sounds suspiciously like everyday experience.[55] That is, it has high sensitivity to human suffering, and zero specificity—everyone is suffering in some way or another. In the absence a systemic integration of notions of psychological suffering, Prozac, and what has been called its "behavioural equivalent," EMDR, are prescribed. EMDR is more than any of its specific uses, however, as it has the distinct quality of continuing to produce events.

> Can the treatment of traumatic memories in crime prevention programs demonstrate a significant impact on the incidence of violence and criminality? One of the goals of EMDR researchers is to inaugurate large-scale studies to *investigate the possibility* of using EMDR in the prison systems and crime prevention programs in inner cities. This is a special project under the auspices of the EMDR Humanitarian Assistance Programs, a non-profit organization dedicated to providing EMDR relief services globally (Shapiro 1997: 276; my emphasis).

If you are unwell, it will make you well, and if you are well, it will make you better, all the while defining what these states are. It creates new ways to be a person, new choices to make, for good and evil. The "neuro network" is one example of many models produced by EMDR. Rather than illuminate, it serves to proliferate meaning and confusion; it is an endless quasi-poetical variation on the same theoretical assumption, a variation that does not produce anything anew.

In 1995, the American Psychiatric Association (Division 12: Clinical Psychology) initiated a project to determine the degree to which the extant therapies were supported by empirical evidence. EMDR therapy was placed on a list of "empirically validated treatments," as "probably efficacious for civilian PTSD" (cited in Shapiro 1999: 36). The future of EMDR therapy lies in the ability of its proponents to make it so common that institutions and therapists run the risk of *not* using it.

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[55] See Singer and Lalich (1996: 187).

If we are to engage such a discourse without needless acrimony and confusion, we must at least have an appreciation for historical development of the ideas we propose, and the courage of our parochialism. We must recognize that only those with whom we share implicit and explicit knowledge derived from common preoccupations and epistemic temperaments will see the point of our communications, and we must relinquish any claim on those who do not.

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