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Eye Movement Desensitization and Reprocessing: A New Therapy for the Treatment of Dissociative Identity Disorder

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ABSTRACT *Eye movement desensitization and reprocessing (EMDR) is a new type of therapy that has been shown to be helpful in the treatment of various psychological disorders. Some of these include body dysmorphic disorder, phobias, low self-esteem, and chronic phantom limb pain (Brown, McGoldrick, & Buchanan, 1997; Jongh1 & Broeke, 1998; Maxwell 2003; Schneider, Hofmann, Rost, & Shapiro, 2008). In addition, because EMDR has been found to be specifically helpful in the treatment of anxiety based disorders like post-traumatic stress disorder (PTSD), it could also aid in the treatment of dissociative identity disorder (DID). EMDR may help to quickly integrate disturbing memories that cause personality fragmentation; however, further research should be conducted in order to fully establish this hypothesis.*

Formerly known as multiple personality disorder (MPD), dissociative identity disorder (DID) is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM- IV- TR; 4th ed., text revision, American Psychiatric Association, 2000) as a disorder

characterized by the presence of two or more distinct identities or personality states [alters] that recurrently take control of the individual's behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. (p. 484)

Dissociative identity disorder is regarded as one of the more severe dissociative disorders (Cardeña, 2000). While many people believe the client to be plagued by a different number of separate personalities within his self, the client is actually unable to integrate a single consistent identity. Therefore, alternate personalities are not separate individuals, but rather separate psychological structures (Kluft, 1996).

The different personalities, or alters, in DID are known to behave dramatically different than the host (dominant) personality. They can have different personality affect, handwriting, speaking accent, likes and dislikes, physical

characteristics like facial expressions and posture, and even Electroencephalogram (EEG) recordings (Bowman & Coons, 2000; Braun 1986; Cardeña, 2000; Kluft, 1996; Pais, 2009). The different alters may also call themselves by another name than the host, and be a different age, gender, and/or different sexual orientation (Braun, 1986). The host, on the other hand, is generally subdued, depressed, and more quiet than the alters (Kluft, 1985).

Research has shown that DID can result from disturbing experiences during childhood. These can include but are not limited to extreme stress, inadequate nurturing, and childhood sexual, emotional, or physical abuse (Pais, 2009). Furthermore, symptoms of DID can be intrusive in a person's daily life. These symptoms can include amnesia for any amount of time, and the dissociative symptoms of depersonalization and derealization. Depersonalization is characterized by a detachment from the body during which the patient may experience the feeling of watching a movie of himself or being in a dream (Hunter, Sierra & David, 2004). Derealization, on the other hand, is detachment from the surrounding environment. The patient can experience this as if his or her surroundings are fake, changing size or shape, or as if he or she is on a stage (American Psychiatric Association, 2000; Hunter et al., 2004; Spiegel & Cardeña, 1991).

Although many articles and studies have corroborated the existence of DID as a true disorder, there have been many critics of its concept. These debates have sparked a controversy that many psychologists and psychiatrists alike have contributed to. For example, Piper and Merskey (2004a, 2004b) argue that the diagnosis of DID is not reliable and that much of its supporting evidence is illogical. Despite these arguments, DID has been shown to meet all criteria for its inclusion in the DSM- IV- TR (2000) and none for its exclusion (Gleaves, May, & Cardeña, 2001).

Treatment of DID

There are different options when treating DID; however, the main goal of all treatments should be personality integration. Although psychotherapy is intensive and can last from five to seven years, it is the most used method to treat patients with DID (McGreggor, 1986). In most cases, the following treatment procedures are used in combination with psychotherapy instead of being the sole treatment for DID.

Hypnosis is a commonly used technique in most, if not all, stages of the treatment of DID. Kluft (1982) suggests that hypnosis can be useful for integrating personalities, contacting alters, reducing anxiety, and creating 'safe places', among others (Kluft, 1999; as cited in McGregor, 1986). Another treatment is pharmacotherapy. Kluft (1999) addresses the issue that many DID patients have co-morbid disorders, therefore pharmacotherapy is a successful supplement to treatment. When prescribing medicine, the doctor should have the goal to treat the common symptoms found among alters (e.g. depression; Hart, Kolk, & Boon, 1998, p. 272; Loewenstein, 2005). In addition, EMDR is a new type of treatment that has shown promising results when treating DID.

EMDR

Eye movement desensitization and reprocessing (EMDR) is a relatively new type of treatment used primarily to treat anxiety-based psychological disorders. While the most common type of disorder treated with EMDR is post-traumatic stress disorder (PTSD; Boudewyns & Hyer, 1996; Ironson, Freund, Strauss, & Williams, 2002; Korn & Leeds, 2002; Yehuda, 2002), it has been suggested that this new treatment may also work for DID (Sieks & Sikes, 2003). Regardless of what disorder EMDR is applied to, a standard protocol must be followed in order to achieve the best results. This protocol can be slightly modified, however, to account for differences across disorders (Twombly, 2005, p. 88).

Eye movement desensitization and reprocessing is a treatment that, perhaps because of its complexity, has been shown to not only be useful for PTSD, but also for other disorders as well. This type treatment was first discovered by Francine Shapiro in 1987 when she noticed that quick

movements of the eyes decreased the intense emotions that came about at the thought of disturbing images or memories (Maxfield, 2007). Because of its ability to lessen the intensity of the emotions that these memories cause, EMDR has been established as an efficient treatment for PTSD (Cahill, 1999; Korn & Leeds, 2002; Yehuda, 2002). It is a complex therapy that involves different aspects of various therapeutic orientations, for example, cognitive behavioral, interpersonal, experiential, psychodynamic, and physiological therapies (Shapiro, 2001, 2002; Shapiro & Maxfield, 2002; as cited in Maxfield, 2007, p. 6). Perhaps because EMDR involves all of these schools of thought, research has suggested that this treatment is at least somewhat successful when treating anxiety disorders such as body dysmorphic disorder, phobias, low self-esteem, and chronic phantom limb pain, among others (Brown, McGoldrick, & Buchanan, 1997; Jongh1 & Broeke, 1998; Maxwell 2003; Schneider, Hofmann, Rost, & Shapiro, 2008). However, only a relatively small amount of studies have been directed at studying the effect of EMDR as a treatment option for DID (Lazrove & Fine, 1996; Powell & Howell, 1998; Young, 1994).

To successfully employ EMDR and avoid overstimulating the patient (which can further deteriorate his condition), the therapist must understand all phases of treatment (Kluft, 1999). Shapiro describes these eight phases of the standard EMDR protocol: 1) client history and treatment planning, 2) preparation, 3) assessment, 4) desensitization, 5) installation, 6) body scan, 7) closure, and 8) reevaluation. Briefly stated, the standard EMDR protocol for the treatment of PTSD requires the therapist to encourage the client to recall a traumatic memory and remember the negative feelings felt while focusing on the therapist's hand as it moves across the client's field of vision. The client must then rate the memory a 0-1 (lowest rating of distress) on Wolpe's (1973; as cited in Cahill, Carrigan, & Frueh, 1999) Subjective Units of Discomfort Scale (SUDS), which may require more than one set of eye movements. Once the memories are less aggravating to the patient, the installation of positive beliefs about oneself can begin. This is done by again instructing the client to remember the traumatic memory, but this time to think of a positive belief about himself or about the memory (e.g. 'I am strong', or 'It wasn't my fault'; Shapiro, 2001). Shapiro suggested that every client will need a different number of phases and sessions per phase before completing treatment. If the clinician

feels that the client is still plagued by previous disturbing thoughts, they must be addressed fully before therapy can be ended. While this is true for patients with PTSD, clients with DID may need even more modifications from the original protocol.

Although EMDR has been useful for some patients, many critics do not accept it as a new form of therapy, instead they regard it as a variant of regular exposure therapy. In a meta-analysis, Davidson and Parker (2001) found that EMDR was more effective than no treatment and than therapies not using exposure techniques. However, they did not find it to be more effective than other exposure-based treatments. Namely, it is argued that the eye-movements are of no additional necessity during therapy. However, Lee, Taylor, and Drummond (2006) found that the process of 'distancing from the trauma' during EMDR, which may be partly assisted by the eye-movements, was associated with more improvement. Even still, EMDR may be promising if, without the eye-movements, it still is more efficacious than regular exposure treatments (Rogers & Silver, 2002, p. 56). Further research is needed to explore this claim.

EMDR for the Treatment of DID

In addition to EMDR's success for PTSD and other disorders, it may also be successful for DID because DID can "best be understood as [an] extreme variant of complex post-traumatic stress disorder" (Herman, 1992, p. 126). Dissociative identity disorder is thought to be a variant of PTSD because both disorders are caused by extreme traumatic events in a person's past that significantly interfere with their present daily life. In addition, EMDR is effective in processing and integrating memories, and because alters in DID come about from traumatic memories that are not integrated, EMDR can help in the treatment of DID (Lazrove & Fine, 1996).

While EMDR has been shown to be a successful treatment for PTSD (Cahill, 1999; Korn & Leeds, 2002; Yehuda, 2002), its use for treating DID is not well established. There are only a few journal articles (Lazrove and Fine, 1996; Paulsen, 1995; Twombly, 2000; Young, 1994) that discuss the use of EMDR as a treatment for DID. When EMDR has been used, however, it has been combined with other procedures (e.g., hypnosis or medicine), which prevent the researcher from fully

understanding what treatment accounted for the effects on the patient. Furthermore, protocols have been deviated so far from Shapiro's (2001) original protocol, that some argue that these cannot be called EMDR sessions (Young, 1994). The development of a standard EMDR protocol for treating DID is needed in order to fully research the impact that this promising treatment option has on the healing of the patient with DID.

Modifications to the PTSD protocol have been made, however, that may prove beneficial in the treatment of DID. Paulsen (1995) has suggested some modifications to the PTSD protocol in order to treat DID with EMDR. Her theoretical modifications still need more empirical studies to test whether they can be fully successful in therapy. These modifications first start with the therapist informing the patient and the alters of the procedure. Consent to use this type of treatment is also inquired of the alters (Lazrove & Fine, 1996; Paulsen, 1995). Because the patient and his alters will reexperience traumatic memories and emotions, it is useful to start the work of processing these memories with older alters and not children, as well as starting out with memories that are least traumatic (Lazrove & Fine, 1996). If child alters exist, it is useful to work with older alters first because they can show the child alters that treatment is safe and can also coach and encourage them when they are working through memories themselves (Paulsen, 1995). Alters can either work through traumatic memories one by one, or, if a few alters are relevant to the memory being worked through, they can also all look through the eyes of the patient and work through the memory together (Paulsen, 1995). Lazrove and Fine (1996) disagree with the latter process of having many alters work through memories at the same time, however, because it may cause too much emotion and further re-traumatize the patient. Further research is needed to verify this claim. When all traumatic memories have been worked through, the possibility of fusion of alters into one whole personality is explored, and in most cases alters will cooperate in this goal (Paulsen, 1995). When using EMDR for fusion, the personalities are instructed to all look through the eyes of the patient and attend to the therapist's hand moving while repeating positive statements about themselves as one unit (Paulsen, 1995).

Eye-movement desensitization and reprocessing is a relatively new therapy that has been shown to be helpful in the treatment of a variety of disorders (Brown,

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McGoldrick, & Buchanan, 1997; Jongh1 & Broeke, 1998; Maxwell 2003; Schneider, Hofmann, Rost, & Shapiro, 2008). Specifically, EMDR is helpful in the treatment of anxiety based disorders like PTSD and DID (Boudewyns & Hyer, 1996; Ironson, Freund, Strauss, & Williams, 2002; Korn & Leeds, 2002; Sieks & Sikes, 2003; Yehuda, 2002). Although EMDR shows promise in the treatment of people with DID, further research needs to be conducted in order to establish a standard protocol to use with this disorder.

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