EMDR TREATMENT OF PHOBIC SYMPTOMS IN MULTIPLE PERSONALITY DISORDER

Walter C. Young, M.D.

Walter C. Young, M.D., is Medical Director of the National Treatment Center for Traumatic and Dissociative Disorders at Del Amo Hospital, 23700 Camino del Sol, Torrance, California 90505

For reprints write Walter C. Young, M.D., Medical Director, National Treatment Center for Traumatic and Dissociative Disorders, Del Amo Hospital, 23700 Camino del Sol, Torrance, CA 90505.

ABSTRACT

Two multiple personality disorder patients with severe, persistent phobias were treated using Eye Movement Desensitization/Reprocessing (EMDR). Both patients achieved significantly beneficial results with a single session in one patient and two sessions in another. Each patient confronted the previously phobic object successfully showing an objective measure of success and results were maintained at six months follow-up. Caution should be exercised from generalizing the use of EMDR for specific target symptoms to using it as a total treatment technique. Further research is needed to determine the efficacy of EMDR as a treatment procedure in general and its role in the overall treatment of dissociative conditions.

INTRODUCTION

In recent years a new treatment technique known as Eye Movement Desensitization/Reprocessing (EMDR) has emerged following two reports of the successful treatment of traumatic memories in brief therapeutic interventions (Shapiro 1989a, 1989b). Since that time additional and sometimes contradictory reports have been published regarding the effectiveness of this technique. Despite some negative reports, sufficient positive anecdotal literature and verbal reports of treatment successes suggest the need for further evaluation of EMDR with traumatic disorders. Due to the regular and extreme nature of traumatic reports by patients with dissociative disorders, especially those with Multiple Personality Disorder (MPD), a trial of EMDR was used in treating resistant phobic symptoms in two patients diagnosed with MPD.

REVIEW

Shapiro (1989a, 1989b) originally described dramatic change in 22 patients with PTSD symptoms. Results occurred in one to two sessions which coupled imaging of the traumatic memory with saccadic eye movements guided by the therapist. A control group narrated their traumatic memories and were subsequently treated with EMDR, with similar results.

The mechanism of EMDR is not understood, and all postulated hypotheses are admittedly speculative. For example, the role of the eye movements has been compared to REM sleep processing. Shapiro (in press) postulates accelerated information processing (AIP) occurs that may be facilitated by saccadic eye movements among other possible mechanisms.

A number of clinicians have described favorable results with EMDR. Page and Crino (1993) reported success in treating the victim of an armed robbery. Pellicer (1993) described its successful use in the recurrent nightmares of a ten-year-old girl. Puk (1991) reported success in two patients. Wolpe and Abrams (1991) used EMDR with traditional desensitization techniques and achieved good results. Marquis (1991) used EMDR on 78 subjects, but their use of a variety of other therapies makes the interpretation of the role of EMDR difficult. McCann (1992) successfully treated recurrent intrusive memories in a severe burn patient with bilateral above the elbow amputations, deafness, and severe scarring. Boudewyns, Stwertka, Hyer, Albrecht and Sperre (1993) reported success when comparing EMDR to simple imaging of the traumatic event. Wernick (1993) suggested that combining EMDR with other techniques may be effective in sex therapy. Spector and Huthwaite (1993) achieved relief in a patient who had suffered a severe automobile accident.

On the other hand, others using EMDR have not replicated such optimistic reports. Lipke and Botkin (1992) suggested that positive results may require longer treatment among veterans with chronic character pathology. This was echoed by Boudewyns, Stwertke, Hyer, Albrecht, and Sperre (1993), who compared positive verbal reports to more limited documented gains in situations where disability may involve a secondary gain that overrides overall improvement. They also questioned the role of placebo effects.

Pitman, Orr, Altman, Longpre, Poire, and Lasko (1993) used a crossover design in 17 patients where patients maintained eye fixation, and failed to show that the eye movements were essential. They found that global improvement of PTSD in general did not occur. Lohr et al. (1992) criticized methodologic flaws in Shapiro's study. Herbert and Mueser (1992) also raise methodologic concerns including a lack of baseline measures, and the use of subjective self-assessment ratings. They also questioned whether Shapiro

was treating subjects with subclinical syndromes.

Metter and Michelson (1993) found no benefits from EMDR and urged caution against over-zealous reporting. They questioned whether the eye movements may serve as a negative reinforcer leading subjects to report lowered distress levels. They also suggest EMDR may be related to sequence disruption techniques described by O'Hanlon (1987). In this regard fractionated abreaction facilitated by hypnosis has been employed by Kluft (1988) and Fine (1991) to allow patients to more easily move into and out of traumatic material to contain and control abreactions. Lytle (1992) compared EMDR to two control groups, one a non-eye movement desensitization group, and the second a non-directive therapy control group, and found EMDR possibly the least effective technique. Sanderson and Carpenter (1992) studied 58 subjects with a crossover design, comparing EMDR with image confrontation, encouraging imaging for a month after treatment. They report no significant differences EMDR in MPD in the procedures. Their study is substantially flawed by a number of variances from standard EMDR application. The most significant was that EMDR was applied for only seven sets of eye movements for twenty seconds each. This is far less than would be given in EMDR treatment, and is not sufficient to obtain optimum benefits.

In most of the studies, especially in those where negative findings are reported, there are significant limitations in methodology, making a truly accurate comparison very difficult. Limitations include length of treatment, use of ancillary treatments, and failure to use the same measures of outcome. Even with the variations in favorable reports, negative replications need to adhere to a standardized protocol for the results to have meaning.

In the present report both patients responded to treatment by actually confronting the phobic situation thereby objectively demonstrating a positive outcome, even though the procedure itself used the subjective measures in Shapiro's reports (1989a, 1989b).

METHOD

As part of a larger pilot study of EMDR treatment in dissociative disorders, two female dissociative disorder patients reporting severe phobias were studied. Talking about underlying issues had not helped either patient reduce the target symptoms. The subjects were selected in part because their phobic symptoms appeared somewhat isolated from the bulk of their traumatic material and because their responses could be assessed by their ability to address the phobic stimuli in vivo.

Each patient's phobic symptom was used as the target for treatment, together with her accompanying feelings, body sensations, and the negative beliefs stemming from her fear. A positive self statement (PSS) or belief was selected that the patient wanted to believe. Informed consent regarding the procedure was obtained. The patients were then given EMDR treatment according to Shapiro's protocol (1989a, 1989b) and her revised protocols (in press). A subjective unit of distress scale (SUDS) (Wolpe, 1982) was used to measure distress where 0 was no distress and 10 was the maximum distress created when an image of the phobic event was recalled. A validity of cognition (VOC) scale was used to assess the patients' level of confidence that they could believe in their PSS. The VOC scale rates the patient's confidence from one (the patient has no confidence in the PSS), to seven (the patient has total confidence he or she believes or will believe a new PSS). Believing the PSS is understood to indicate that the patient has replaced a negative belief with a positive one. SUDS and VOC measures were reported at the beginning and end of the EMDR treatment and intermittently in between.

After initial assessment, each patient was asked to bring to mind the target symptoms while the author instructed the patient to track a moving finger or object with her eyes, thereby initiating rhythmic saccadic eye movement. The patients were instructed to let images, thoughts, sensations or feelings occur. Periodically the author paused to inquire what was in the patient's mind. No interpretations were made by the author and the patient was not asked to give an ongoing narrative of their her experience. The EMDR sessions lasted from one to one and one-half hours. At the end, SUDS and VOC levels were obtained and the patient was debriefed to determine what the procedure felt like, how it compared to her standard work, what problems there may have encountered, and any other observations she wished to make.

Before beginning, each patient was asked to assure that she could maintain safety during the procedure, that her alter personalities would not obstruct eye movements, and that she would raise a hand to indicate if she wanted or needed to stop the procedure.

CASE REPORTS

Patient #1

Ms. A is a 35-year-old single woman with a terror of snakes. She had jumped on people's backs when seeing a snake. She recalled a snake had been thrown on her when she was eight or nine years old. After eleven years of treatment and despite improvement in other areas, this symptom remained still refractory. Ms. A was seen in consultation to address several issues, one of which was her severe phobia of snakes. She described feeling paralyzed, and unable to breathe just picturing a snake. Her belief was that she was powerless to face her fear and wished to believe she could feel in control and feel safe around snakes. Her distress level (SUDS) was rated at 10 and her confidence (VOC) she could stay in control and be safe around snakes was 2.

Ms. A was informed about the use of EMDR and gave consent to the procedure. She was asked to picture herself with a snake with the associated feelings of terror and helplessness. Her associations moved from exposure to snakes as a child, being chased by a snake, and then she reported a new incestuous awareness of her father by stating, "My father has a snake — it's his penis!" This was a new connection. She continued during the session to feel a dramatic reduction in her anxiety. She eventually smiled and stated she was not afraid of snakes anymore. She reported a SUDS

level of 0 and a VOC level of seven. Ms. A felt her processing of this material was rapid and far superior to her traditional efforts.

The following day Ms. A went to a pet shop where she handled a snake without anxiety. She remained asymptomatic with respect to the snake phobia six months later.

In one session Ms. A patient had a dramatic outcome, resulting in her seeking out the phobic object to test herself. She remained dissociative in those areas not addressed.

Patient #2

Mrs. B is a 39-year-old married mother of three children who had been in treatment for Multiple Personality for seven years. Her clinical course had been stormy. There were many hospitalizations for suicide attempts, depression, severe headaches, and self-induced injurious behavior consisting mostly of self-lacerations following pressure from hostile inner states. There was a history of severe child abuse by father, confirmed by her mother, and she had alleged multi-perpetrator sadistic acts which could not be verified. These factors contributed to a tumultuous course in which intrusive memories and disruptive symptoms often resulted in head-banging behavior, abreactions, or self-destructive acting out.

Mrs. B was highly motivated. She was moving gradually toward integration and had already experienced the fusion of a number of personality states when EMDR was suggested. EMDR was proposed as a means of therapy that might provide her a quicker and safer approach to working through painful material. The patient agreed to try EMDR with two symptoms of paralyzing phobic fear. Informed consent was obtained after extensive explanation and discussion. The patient had been requested to read Shapiro's original articles (1989a, 1989b) as part of this process.

Mrs. B described a fear of moths, especially in her home. She would lose all emotional control, literally screaming and running out of the room if a moth appeared. She recalled having been molested by her father in the garage when she was a child. She remembered moths flickering by an overhead light and occasionally diving toward her while the assault occurred. She would see them afterward when she was left in the garage. Mrs. B believed that she was powerless to control moths, and lived in terror of them. She was further distressed that her daughter was also becoming frightened of moths. Her second phobia was of seeing a full moon outdoors. This irrationally frightened her, but to a lesser extent than did the moths. She believed she would never enjoy a moonlit night outside.

The patient rated her first phobia at a SUDS level of 10 with only a VOC level of two out of seven that she could control moths in her home. Her second phobic symptom of seeing a full moon had a SUDS level of eight and a VOC level of three that she would enjoy moonlit nights safely.

The patient began EMDR with the moth fear for two sessions, then decided to wait two months until moths were "in season." After two sessions her SUDS level was only mildly reduced (to eight) but she felt increasingly confident that she could manage moths without becoming hysterical despite her fear (VOC 5). Her associations moved from images of her assault in the garage to moths in the night flying around the light, and eventually to the spots on their wings that reminded her of eyes looking at her. While she never overtly switched during the procedure, she was aware of experiencing a variety of feelings (such as fear, guilt, and being ugly and bad) which were affects associated with alter personalities she had encountered. The patient used part of a third session to use EMDR on her fear of the moon. She recalled the garage light had been suspended beneath a white metal shield that diffused the lighting in the garage, and that it had seemed moon-like to her. There were further associations to moths under the light from the first two sessions.

Treatment had to be suspended for several weeks when Mrs. B was called out of town. When she returned, moths were out in large numbers, and she requested EMDR to desensitize herself to them. Halfway into this session Mrs. B suddenly exclaimed she was no longer afraid of the moon. She had recalled an assault during a moonlit night in a field on her childhood farm home. She felt dramatic relief and was confident she could manage to be outside at night. Recall of the target full moon was not distressing (SUDS 0) and her confidence she was through the fear was high (VOC 6-7). Further work on the target symptom of moths resulted in only a modest reduction in fear (SUDS 8) but a VOC level of 6 that she could manage with moths.

The following week the patient announced proudly that when she saw moths at home she had remained calm and placed a flat dish of soapy water under a light on the table as she had seen her mother do when she was a child. The moths flitted about the light and its reflection, and would bounce into the soapy water where they got stuck. Then she threw them out. Due to other concerns, work proceeded in another direction. Mrs. B commented she felt the procedure was very helpful, much faster than our previous work, and that somehow her work on the material treated with EMDR seemed more finished than her work with other memories. She felt it was not like hypnotic work, and was pleased it had not resulted in abreactions or destructive impulses. She described an awareness of feeling states characteristic of some of her other alter personalities giving her an increased sense of her own range of reactions. Her work also demonstrated a generalization effect when work with her memory involving moths spilled over to a related memory of the moon and relieved her distress there as well. While her target symptom remained high for moths, she felt successful with both fears. If further work had been attempted she might well have lowered her SUDS level to moths. At six months she continued to feel confident in her progress on these two areas.

RESULTS

Both Ms. A and Mrs. B demonstrated rapid reduction in distress levels that persisted at six months follow-up. The second patient's distress over moths was reduced less, but her confidence that she could take effective action resulted in a sense of mastery with regard to the moths. She enjoyed

the additional benefit of her second phobic symptom (the full moon) spontaneously dissipating remitting during treatment for the first.

Little narrative or interpretation was made by the author. Still the patients improved. During the EMDR treatments each patient reported seeing material rapidly passing through her mind that appeared related through associations to the target symptom. In Mrs. A there was an awareness of incest and a teenage sexual assault. Mrs. B recalled the circular spots on the moths' wings and the overhead light in her garage where insects gathered as she recalled being molested. These and other associations were related to symptom relief. This factor suggests that improvement was not simply a matter of systematic desensitization or the hierarchical ordering of anxiety producing elements. This more closely fits Shapiro's (in press) concept that EMDR induces accelerated information processing (AIP). It further would seem to contradict the thesis put forward by Metter and Michelson (1993) that results occur secondary to sequence disruption or negative reinforcement from the eye movements.

On the other hand this report does not establish that the eye movements themselves constitutes the mechanism by which AIP occurs (or, indeed, that AIP occurs). What does seem clear is there was rapid relief of symptoms related to reduced fears of the target phobias, and that this relief occurred while traumatic material was being internally processed. More was occurring through simple desensitization or relaxation. Both patients demonstrated early distress when focusing on the target symptom initially; it was rapidly reduced as the EMDR progressed.

It should be noted that the successful results claimed for the patients relates to their phobic target symptoms alone. No effort was made to measure global functioning in other areas. Much of their clinical pictures deriving from chronic traumatization needed ongoing work. Based on their successful use of EMDR for the symptoms under discussion it is possible that their therapies may include the judicious use of additional EMDR treatments in the future. Chronic trauma patients may turn out to require more intervention for target symptoms than the single session treatment of episodes of trauma described in Shapiro's early work (1989a, 1989b). In some, the impact of characterologic overlay or chronic disability may impede the effectiveness of any therapeutic efforts, including EMDR, because of the secondary gain involved (Boudewyns et al., 1993, Lipke & Botkin 1992). The potential for generalizing from relief of a specific trauma by EMDR to relief of other traumatic materials has been suggested, and may find support in Mrs. B's sudden relief of her fear of the moon. The issues raised here will need further study.

DISCUSSION

While this report describes a positive outcome with EMDR in two patients with dissociative disorders, it is still necessary to be aware of the limitation of case reports in evaluating EMDR and all psychotherapy in general. Adequate standardized, baseline assessments, follow-up assessments and control studies are clearly indicated.

EMDR is still new. Both its potential applications and the cautions and complications that may surface as it enjoys wider usage need further study. The author is aware of potential pitfalls in the use of EMDR, such as premature flooding, increased escalation of angry impulses, and the failure to mobilize affect. He also is aware that its benefits need further study if accurate assessment of EMDR is to occur, and clear indications for the use of EMDR are to be defined. Further, the role of the eye movement itself remains to be clarified.

A number of limitations in this case report study need to be acknowledged. The two patients came to the author expecting positive results despite low confidence levels. This was partly due to an informed consent process during which Shapiro's articles were provided, partly because the author was seen in consultation for this procedure (implying positive expectancy), and partly because these patients were on an inpatient unit where other patients had discussed positive results coming from another EMDR pilot study in progress. Expectancy may prove to have exerted a more positive impact than did the EMDR itself.

The potential for contamination by hypnosis is important. Dissociative patients may bring their own autohypnotic talents to bear, augmenting the impact of the EMDR. Recent articles have described fractionated abreactions, using a hypnotic technique of moving in and out of trance states to pace the intensity of abreactive work (Fine, 1991; Kluft, 1988). If EMDR is, in fact, related to hypnotic processes, one would expect to find highly positive response patterns in a highly hypnotizable populations and poor responsitivity in low hypnotizable populations. This has not been seen to be the case in the author's experience with anecdotal reports in which EMDR outcomes are discussed. In this study, neither patient felt that the impact of the procedure was similar to formal hypnosis. They did feel subjectively that information was processed more quickly, more completely, and differently in EMDR as compared to hypnosis.

Clearly, controlled studies are going to be required to address many of the above concerns, and these studies will need to address more than single symptom interventions. They will also need to see whether EMDR as a major treatment modality can demonstrably shorten treatment in chronically traumatized individuals with dissociative conditions, or whether EMDR, if shown to be effective, can and should be introduced at judicious, clinically defined points in treatment. Controlled studies also need to study patients treated with more traditional therapeutic interventions, EMDR, and other "special" techniques designed to clarify the role of eye movement itself, in addition to the other factors that confound treatment outcome. The use of raters other than the treating clinician will be essential.

A current problem in evaluating reports on the efficacy of EMDR relates to the variety of different treatment protocols that are being described by the term EMDR. Many of these formats not only fail to adhere to Shapiro's (1989a, 1989b) protocol but often are used in conjunction with other treatment techniques. Baseline measures to standardize treatment protocols, outcome, and provide consistent criteria for positive results have to be applied in future study.

Despite the present problems assessing the efficacy and underlying mechanisms of EMDR, results to date suggest enough clinicians are finding positive outcomes in their work with this technique to warrant further study. The rapid response to EMDR of the two dissociative patients reported here support the need for further study of EMDR in dissociative populations to see whether this modality can contribute to the development of an effective, less painful, and more controlled and cost-efficient treatment technique for dissociative disorder patients. ■

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