

SOME CONSIDERATIONS ABOUT EMDR AND PSYCHOSIS

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Abstract

The aim of this paper is to outline some considerations about the efficacy and applicability of Eye Movement Desensitization and Reprocessing (EMDR) approach on psychotic patients. EMDR is receiving great attention from different scholars and across different approaches. Several meta-analyses have shown the effectiveness of EMDR therapy in treating Post-Traumatic Stress Disorder (see Jonas et al. 2013; Chen et al. 2014, 2015). According to contemporary scientific literature it has been noticed that a diagnosis of psychotic disorder does not always represent an exclusion criterion for applying an EMDR intervention (van der Vleugem et al. 2015). A comorbidity exists between psychosis and Post-traumatic Stress Disorder (PTSD), and this could mean that a common landscape between these two dimensions may be explored (Kim and Lee 2016, Millan et al. 2017). PTSD patients that later develop psychotic symptoms have often a story of early abuse and they could probably benefit of an EMDR approach.

The authors of the present paper evaluate the existing scientific literature about the use of EMDR for psychotic patients, showing how the available data seem to indicate it as part of a more complex intervention, able not only to reduce the impact of explicit symptoms, but also to make a change of a pervasive imagery and core negative beliefs that maintain a kind of distortion in the inner and external world of the patient.

Also if no real evidence is still available about the use of EMDR in psychosis, there are a few promising studies regarding its applicability for the post-traumatic aspects often existing in psychotic disorders (Hardy and van den Berg 2017).

Key words: Eye Movement Desensitization and Reprocessing (EMDR), psychotic patients

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Treating PTSD and Psychosis with EMDR

The prevalence of PTSD diagnosis in psychotic patients is significant (12,4-29%) (Achim et al. 2011, van den Berg et al. 2015), when compared with general psychiatric population (less than 5%).

Psychotic disorders and PTSD can sometimes be difficult to be distinguished: they are characterized by intrusive experiences, avoiding behaviors and negative symptoms.

The causes of psychosis and PTSD can be traced back differently, or each of them can provoke the other.

Anyway, when they are present at the same time, delusion's intensity, pervasiveness, and general malfunction are worst.

The presence of severe psychopathologies induced by psychotic symptoms and PTSD could scare the most of psychotherapists, and lead them to ignore trauma related symptoms, to avoid the exacerbation of psychotic symptoms..

On the other hand, there's no scientific evidence about the fact that revealing a traumatic experiences could have negative impact in case of psychosis.

Emotional pain and psychic disorganization

that could accompany the act of becoming aware of traumatic event is usually temporary.

Generally, people with severe illness strongly want to talk about their traumatic experiences, because they need to experience the emphatic "mirroring function" embodied by the psychotherapist, fundamental for alleviate anguish experienced in solitude.

So, the "harm hypothesis" may be contradicted by more recent studies.

Since 2010, a few studies about EMDR and psychosis have been published (Kim et al. 2010; de Bont et al. 2013, 2016; van den Berg et al. 2015, 2016; van Minnen et al. 2016). For a review, see Valiente-Gomez et al. 2017.

Many clinicians, experts in EMDR treatment too, usually face with complex phases when they are asked to reassure a psychotic patient. In this case a structured supervision could represent a great support. A psychotic patient showing delusions and hallucinations or severe negative symptoms, may be reassured by this way:

"Unfortunately you experienced horrible things in your life, but now these things are only memories belonging to your past. However you're still experiencing intrusive memories about them. As you

may know memories could be very disturbing, but they cannot really hurt you. During this treatment, we will focus on your worst memories and we will work on it, and this will allow you to experience yourself as strong enough to face them. I trust in you” (Shapiro 2013).

By this first step and other similar statements, the therapist share his therapeutic procedure with his patient and create a climate of cooperation with.

By this way, the patient can experience himself as a fundamental and integral part of the therapeutic process, a feeling that significantly improves working alliance.

Any clinician should consider that as worst is the trauma, as worst will be the intensity of delusions and hallucinations.

We should consider that a trauma can directly establish a PTSD syndrome, as well as cognitive alterations and patient’s self-defeating believes can induce an hyper-sensibility for general events.

Negative believes about themselves and about other people could establish a cognitive link between traumatic experiences and psychosis.

Core assumptions can determine the nature of a delusion, as can be seen in a delusional disorder, in the cognitional form “poor me” or “bad me”.

By the same way it’s have been noticed that negative answers to critical voices are related to depression, negative self-esteem and early abuse.

Cognitively, psychotic patient’s imagery can represent a good *target* for EMDR process: it can influence deeply his present life, some mental images may turn into catastrophic landscapes, influencing the permanence of a delusion.

EMDR for psychotic patients become part of a more complex intervention, and the task is not only to reduce the impact of explicit symptoms, but also to make a change of a pervasive imagery and core negative believes that maintain a kind distortion in the inner and external world of the patient.

A well structured intervention, integrating EMDR approach, includes psycho-pharmacology, family training, individual cognitive-behavioral psychotherapy, family training and occupational therapy.

EMDR approach for psychotic patients can be offered in a modified form, combining some coping skills inspired by cognitive-behavioral approach, either in a psychosis provoked by an early traumatic experience, either when psychosis influence negatively present life, turning it into a series of traumatic events.

A clinician willing to offer an EMDR treatment of psychotic patients should consider the following obstacles:

- Core believes, especially when persecutory, may obstacle the construction of a good working alliance, they can turn into a controlling behavior that may complicate let-them-go eyes movement. This specific situation may require a preliminary cognitive psychotherapy focused on negative believes so patient may increase the sense of confidence related to the opportunity to trust in his therapist.
- Low learning and focusing ability could represent an obstacle in receiving instruction, the clinician could have to repeat instructions more than one time, auditory hallucinations could represent a distraction during the process. A good solution to face this problem is to repeat frequently instructions and work with shorter sessions to limit the interference of delusional convictions.
- Even if pharmacotherapy is an essential source, it could interfere with patient’s focusing ability and

with data integration by inhibiting cholinergic system, so clinicians could ask their patients not to assume drugs in the session day. Furthermore, it can be assumed that EMDR treatment stimulate cholinergic system in the brain (Elofsson et al. 2008). This system is related to the maintenance of cognitive functions just like memory, focusing and attention. Neuroleptic drugs can however block cholinergic receptors producing a long list of collateral effects by this way. To face them anti-cholinergic drugs are administered, that on the other side could obstacle the efficacy of EMDR approach.

- A reduced working memory spam: according to Baddeley’s memory model, when we challenge working memory with a double task the risk is saturation. If this happens, the traumatic memory move to long-term memory storage, losing its vividness and its emotional impact. To face the double task required by EMDR approach is essential to count on a well-working-enough working memory. Psychotic patients show greater difficulties in following fingers movements, so as the clinician must take great attention in tuning with his client, either in movement speed either in choosing the most adapt stimulation mode.

Clinical examples and intervention methodologies

In the following examples (De Bont et al. 2013), we will consider three different types of approach in using EMDR in the treatment of psychosis.

In the first case, traumatic experiences are directly related to psychotic symptoms, mainly to delusions and hallucinations.

Francis was an asylum seeker from Sierra Leone. He had been diagnosed with paranoid schizophrenia 8 years ago. During the evaluation, he said he heard voices threatening him with statements like “we’re going to cut off your hands” and “kill you”. He believed that these voices belonged to people who really wanted his skin and this made him very suspicious and anxious. He was nervous, had nightmares and met difficulties in concentrating. The voices began after seeing people burned alive with their hands cut by the rebels. Psychotic symptoms have been directly associated with these traumatic experiences.

Using the approach of the first method, we assumed that reworking these memories would have a positive effect on the psychotic symptoms. The therapist provided information to Francis about the consequences of a traumatic experience and described his hypothesis that the voices were directly related to the traumatic experiences in Sierra Leone explaining that he expected the treatment of the trauma to translate into a reduction of his suffering. Francis identified two very disturbing target memories:

- (a) seeing a person burned alive
- (b) seeing a person lose both hands.

The Negative Cognition (NC) that accompanied the two images was “*I am in danger*”. In this case the psychotherapist used a facilitative cognitive intervention, trying to reduce the impact that the voices were really those of the murderers. Making a cumulative probability calculation, Francis realized that a series of conditions had to be satisfied and that the odds in this case would have been low. In this way EMDR led the Subjective Unit of Disease (SUD) to progressively decrease. We can affirm that the integration of psychoeducation with cognitive

interventions and with the EMDR has helped Francis to modify his evaluation of the voices. The idea that the voices were actually very vivid flashbacks slowly gained credibility, and supported him in ignoring them. This reduced his concern for the voices.

This clinical example shows the importance of a cognitive reframing in those patients with a severe dysregulation, essential prerequisite before offering EMDR sessions.

The second type of intervention aim to reduce the impact of traumatic experiences related to psychotic interpretation of reality.

In this case the patient built interpretative models of reality based on stressful emotional experiences of his life, subsequently these models crystallize as core assumptions that influence the rise of present delusions.

Irene was a 49-year-old woman diagnosed with schizophrenia and major depressive disorder in her early twenties. She had several psychotic episodes and was admitted to hospital once a year. Irene has benefited from prolonged treatment and has lived in a support house. In his forties, Irene's situation began to improve. His psychotic episodes occurred less frequently, he had his apartment and eventually married a man he had met during one of his hospitalizations. In the last year Irene dealt with a very difficult situation, since her husband committed suicide while hospitalized. He had turned off the phone because he kept calling her.

During the same night, he committed suicide. This led to a long stay during which Irene tried to kill herself several times. She was discharged from the hospital after 10 months. Irene heard voices insulting her and accusing her for harming others. She was depressed and had many suicidal thoughts. Irene had strong negative beliefs about herself, others and the world. His most dysfunctional fundamental belief was "I am bad".

Many different experiences in her traumatic life have contributed to this central belief and the therapist presented the second type of approach so as to determine which target memories have to be identified. He asked Irene what life experiences still seemed to her as proof of her central belief. Irene told how when she was 7, a brother forced her to have sex several times. Irene was used to it and felt increasingly indifferent about it. The same brother died in a car accident when Irene was 12 years old. The day after his death, Irene began to hear voices. A few years later, Irene was stunned and unable to speak at her father's funeral. His mother said it was the worst time of the day and the starting point for his major depression that lasted 4 years. The most recent memory was linked to the situation when Irene had turned off her cell phone the night her husband committed suicide.

EMDR therapy focused on the following goals: do not talk on the phone when your husband was in a panic (NC: "I'm bad"); having sex with her brother (NC: "I am a big bitch"); and having listened to his mother's comments when he had to speak at his father's funeral (NC: "I'm not worth anything"). The objectives were outline done after the other and the positive knowledge installed. Together, positive beliefs have helped to reduce the intensity and credibility of the fundamental negative belief "I am bad". The voices intensified during the first weeks of treatment but Irene and her therapist together decided to continue the EMDR therapy. With the progress of the EMDR treatment, Irene began to question and contradict the rumors. He learned to consider them as "ghosts of his past" and became less reactive.

Even though guilt diminished, the fear of being overwhelmed by the voices remained strong. In order

to deal with that, the therapist and Irene designed an imaginary image of the future that they used as targets for the reworking of the EMDR. The image represented Irene, sitting in her room, surrounded by voices of her mother, her brother, her father. CN was "I am helpless". The S.U.D. dropped to 0 in two sessions. Positive Cognition (PC) ("I can do it") has been installed in two series of Eye Movements. At the end of the treatment, Irene still heard voices, but she paid less attention and was less overwhelmed by fear, her self-esteem improved and she felt less depressed.

The third type of EMDR intervention is related to intrusive images, so we have to pay attention to offer this third way only to those patients sufficiently aware about the hallucinatory nature of this images, in many cases this require a preliminary cognitive-behavioral psychotherapy to put the patient in contact with a sane reading of reality.

In the latter case, for example, in the case of voices or paranoia, a patient can construct a mental image of his "persecutors". The Reprocessing of this image can reduce emotional involvement and concern. A target can be, for example, the patient who is seen sitting on the bed with a man by his side who shouts unpleasant things through a microphone. EMDR is applied in the usual way.

Conclusions

The present considerations are intended only to offer some light on the use of the EMDR approach in psychotic patients with concomitant PTSD diagnosis.

In particular, it was noted that the doubts concerning the applicability of the method were largely linked to convictions about the undue overlap between psychosis and fragility, the fragility of a psychotic patients is related to their relationship with reality, compromised after all by a systematic invasion of traumatic mental images in their daily life.

The technical measures such as to make EMDR a valid aid tool are mainly linked to the cognitive difficulties of this type of patients, characterized by stories of long hospitalizations and protracted pharmacological regimens related to the state of cognitive decline.

Also if no real evidence is still available about the use of EMDR in psychosis (the available data are really a few and essentially reported by the same group of researchers), there are a few promising studies regarding its applicability for the post-traumatic aspects often existing in psychotic disorders (Hardy and van den Berg 2017). We hope that in the next future more data will be available to clarify the real effectiveness of the EMDR approach even in psychotic disorders.

In fact, very innovative preliminary studies investigate the use of Bilateral Stimulation and Eye Movements in order to directly address the psychotic symptoms, to reduce the cognitive dysfunctions and to promote the self-confidence in psychotic patients (van der Gaag 2016).

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