EMDR in bipolar disorders

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EMDR Europe Workshop Conference
28 - 30 June 2019 - Krakow, Poland
GROUP STRUCTURE

02/2017
DR. BENEDIKT L. AMANN
Head of the group
Senior researcher

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BRIDGET HOGG
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CARMEN MASFERRER HERRERA
Collaborating clinical researcher

SARA PORTA SATURIO
Collaborating clinical researcher

OSCAR ROYUELA PÉREZ
Collaborating clinical researcher

22 external EMDR psychologists, 12 students of master in psychology, 3 residents
“THEY ALWAYS ASK WHAT IS WRONG WITH YOU AND HARDLY EVER ASK WHAT HAPPENED TO YOU”
Idea of the workshop

Contents

• Phenomenology of bipolar disorder
• Problems in the management of bipolar disorder
• Role of trauma in bipolar disorder/severe mental disorders
• Parts of the EMDR Bipolar Manual
• Excercise, videos and cases
• If time: Evidence of EMDR in the treatment of unipolar and bipolar disorders

Schedule

• 9.30 – 10.30
• Break: 10.30 - 11.00 hs
• 11.00 – 12.30
phenomenology
BD is multidimensional

Mania

Depression

Mixed Phase

Subsyndromal Symptoms

Hypomania

Rapid Cycling (difficult to treat)

BD I

BD II

BD I

Concept of polarity

Predominant Polarity

Manic PP

Depressive PP (more)

UPP (undetermined PP)

Affective symptoms

**Mania**
- Psychotic symptoms
- Fast thoughts
- Restlessness
- Hostility
- Labile
- Delusional
- Suicidal ideas
- Euphoria
- Social interest
- Libido
- Verborrea
- Lack of insight
- Uncontrolled spendings

**Hypomania**
- Sleep
- Self-esteem

**Mixed episode**
- Irritability
- Hopelessness
- Psychomotor Retardation
- Physical pain
- Sleep alterations
- Changes in appetite

**Depression**
- Sadness, emptiness
- Anxiety
- Hopelessness
- Ideas of guilt and ruin
- Suicidal ideas

APA, 2002
Fig. 1. Modelling Mixed States using ACE. (a) Mood fluctuates and is defined as manic or depression. Mixed states are less clearly defined but span both phases of illness and individual symptoms provide no specificity. (b) By conceiving the overall changes in mood as being determined by a constituent of activity, cognition and emotion greater granularity is achieved and when symptoms from different domains alongside fluctuate in asynchrony then a mixed state occurs. In other words, a mixed state is asynchrony of symptoms of different domains.
Video Anna S

Affective symptoms
Etiology of bipolar disorder?
• Effect on cellular signalling, neurotransmission, molecular transporter, neuronal growth
• BD = a genetically heterogenous disorder (polygenetic)
• Numerous overlapping genes with other mental disorder

Figure 1. Manhattan plot for our primary genomewide association analysis of 20,352 cases and 31,358 controls. GWAS -log_{10}P-values are plotted for all SNPs across chromosomes 1-22 (diamonds, green for loci with lead SNP GWAS P < 10^{-8}). Combined GWAS+followup -log_{10}P-values for lead SNPs reaching genome-wide significance in either GWAS or combined analysis (triangles, inverted if GWAS+followup -log_{10}P > GWAS -log_{10}P). Labels correspond to gene symbols previously reported for published loci (black) and the nearest genes for novel loci (blue), at top if GWAS+followup P < 5x10^{-8}.

Stahl et al, 2017
This is why we use psychopharmacological medication in severe mental disorders
Mood-stabilizers for BD

- Lithium: Plenur®
- Valproate: Depakine / Depamide®
- Carbamazepine: Tegretol®
- Oxcarbazepine: Trileptal®
- Lamotrigine: Lamictal®
- Olanzapine: Zyprexa®
- Risperidone: Risperdal®
- Quetiapine: Seroquel®
- Aripiprazol: Abilify®
- Asenapine: Sycrest®
- Paliperidone: Invega®

- Plus antidepressants, benzodiazepines, biperidene etc...
- Mood-stabilizers help, they are the basis
- They can be considered as a further positive resource you should aim to benefit of
- If you are a psychotherapist, include a psychiatrist in the treatment plan
- Explain the psychiatrist what EMDR is
Video Victor V

Evaluation: What means bipolar disorder and how you live with this diagnosis?
Are psychiatric conditions really largely genetically determined or occur mainly out of the blue?

“The genetic risk for schizophrenia is widely distributed in human populations, so that we all carry some degree of risk.

The fact that so many genes are involved suggests it is unlikely that studying them will lead to therapeutic breakthroughs anytime soon.

Huntington’s disease is caused by a single dominant gene with a known biological function. Years after this gene was discovered there is still no sign of a medical therapy for this simplest of all the genetic conditions.”

Keneth Kendler, Guardian (2016)
Researcher in psychiatry genetics, h-index 2016: 126
**TABLE 2** Assessment across the six meta-analyses of risk factors for bipolar disorder

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Sample size (number of cases)</th>
<th>Significance threshold reached (under the random-effects model)</th>
<th>95% prediction interval rule</th>
<th>Estimate of heterogeneity$^a$</th>
<th>Small-study effects or excess significance bias</th>
<th>Random-effects summary effect size (95% CI)</th>
<th>Classification$^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma$^{35}$</td>
<td>&gt;1000</td>
<td>&lt;0.001</td>
<td>N/A</td>
<td>Small</td>
<td>N/A</td>
<td>2.12 (1.57-2.87)</td>
<td>III</td>
</tr>
<tr>
<td>Childhood adversity$^{36}$</td>
<td>&gt;1000</td>
<td>&lt;10$^{-6}$</td>
<td>Including the null value</td>
<td>Large</td>
<td>Neither</td>
<td>2.86 (2.03-4.04)</td>
<td>II</td>
</tr>
<tr>
<td>Exposure to obstetric complications$^{37}$</td>
<td>&lt;500</td>
<td>&gt;0.05</td>
<td>Including the null value</td>
<td>Small</td>
<td>Small-study effects</td>
<td>1.15 (0.62-2.11)</td>
<td>Non-significant</td>
</tr>
<tr>
<td>Head injury$^{38}$</td>
<td>&lt;500</td>
<td>&gt;0.001 but &lt; 0.05</td>
<td>Including the null value</td>
<td>Small</td>
<td>Neither</td>
<td>1.85 (1.17-2.94)</td>
<td>Weak</td>
</tr>
<tr>
<td>Irritable bowel syndrome$^{39}$</td>
<td>&gt;1000</td>
<td>&lt;10$^{-6}$</td>
<td>Excluding the null value</td>
<td>Small</td>
<td>Neither</td>
<td>2.48 (2.35-2.61)</td>
<td>I</td>
</tr>
<tr>
<td>Obesity$^{40}$</td>
<td>&gt;1000</td>
<td>&gt;10$^{-6}$ but &lt;0.001</td>
<td>Including the null value</td>
<td>Very large</td>
<td>Both</td>
<td>1.77 (1.40-2.23)</td>
<td>III</td>
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<tr>
<td>T. gondii infection$^{15}$</td>
<td>&gt;1000</td>
<td>&gt;0.001 but &lt; 0.05</td>
<td>Including the null value</td>
<td>Large</td>
<td>Neither</td>
<td>1.52 (1.05-2.19)</td>
<td>Weak</td>
</tr>
</tbody>
</table>

$^a$Heterogeneity was categorized as not large ($I^2$<50%), large ($I^2$=50% but $I^2$<75%), and very large ($I^2$≥75%).

$^b$Convincing evidence criteria (class I): >1000 cases, significant summary associations ($P$≤10$^{-6}$) per random-effects calculation, no evidence of small-study effects, no evidence of excess of significance bias, prediction intervals not including the null and heterogeneity not large ($I^2$<50%). Highly suggestive evidence criteria (class II): significant summary associations ($P$<10$^{-5}$) per random-effects calculation, >1000 cases, and the largest study with 95% CI excluding the null. Suggestive evidence criteria (class III): >1000 cases and significant summary associations ($P$<10$^{-3}$) per random-effects calculation. Weak evidence criteria: all other risk factors with $P$<.05. Non-significant associations: all associations with $P$>.05.
### Psychological Trauma and Functional Somatic Syndromes: A Systematic Review and Meta-Analysis

Niloofar Afari, Ph.D.1,2,3, Sandra M. Ahumada, B.A.4, Lisa Johnson Wright, Ph.D.5, Sheeva Mostoufi, M.S.1,2, Golnaz Golinari, M.D.3, Veronica Reis, Ph.D.6, and Jessica Gundy Cuneo, Ph.D.2

#### Associations of reported trauma and functional somatic syndromes presented separately by type of trauma and type of condition

<table>
<thead>
<tr>
<th>Trauma</th>
<th>OR</th>
<th>95% CI</th>
<th>z-Value</th>
<th>p-Value</th>
<th>k</th>
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</thead>
<tbody>
<tr>
<td>Emotional Abuse</td>
<td>2.11</td>
<td>1.58 – 2.82</td>
<td>5.06</td>
<td>&lt;0.001</td>
<td>23</td>
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<td>Physical Abuse</td>
<td>1.89</td>
<td>1.58 – 2.26</td>
<td>6.89</td>
<td>&lt;0.001</td>
<td>49</td>
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<td>Sexual Abuse</td>
<td>2.01</td>
<td>1.74 – 2.32</td>
<td>9.41</td>
<td>&lt;0.001</td>
<td>69</td>
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<tr>
<td>Combat/Deployment</td>
<td>3.06</td>
<td>1.72 – 5.47</td>
<td>3.79</td>
<td>&lt;0.001</td>
<td>9</td>
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<tr>
<td>PTSD*</td>
<td>2.93</td>
<td>2.38 – 3.61</td>
<td>10.13</td>
<td>&lt;0.001</td>
<td>20</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Functional Somatic Syndrome</th>
<th>OR</th>
<th>95% CI</th>
<th>z-Value</th>
<th>p-Value</th>
<th>k</th>
</tr>
</thead>
<tbody>
<tr>
<td>fibromyalgia (FM)</td>
<td>2.52</td>
<td>1.92 – 3.31</td>
<td>6.62</td>
<td>&lt;0.001</td>
<td>21</td>
</tr>
<tr>
<td>chronic widespread pain (CWP)</td>
<td>3.35</td>
<td>2.55 – 4.41</td>
<td>8.65</td>
<td>&lt;0.001</td>
<td>5</td>
</tr>
<tr>
<td>chronic fatigue syndrome (CFS)</td>
<td>4.06</td>
<td>3.18 – 5.18</td>
<td>11.20</td>
<td>&lt;0.001</td>
<td>14</td>
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<tr>
<td>temporomandibular disorder (TMD)</td>
<td>3.33</td>
<td>1.15 – 9.68</td>
<td>2.21</td>
<td>0.027</td>
<td>3</td>
</tr>
<tr>
<td>irritable bowel syndrome (IBS)</td>
<td>2.22</td>
<td>1.72 – 2.86</td>
<td>6.16</td>
<td>&lt;0.001</td>
<td>29</td>
</tr>
</tbody>
</table>
Childhood adversity causes severe mental disorders

- Emotional, psychological and physical neglect
- Emotional, physical and sexual abuse
- Bullying or exposure to bullying
- Separation from parents
- Family violence
- Family mental disorder
- Family substance use disorder
- Parental death
- Family economic adversity

Multiple refs
Fig. 2.6. A comparison between worldwide and European estimates of prevalence rates with 85% confidence intervals from self-report studies for sexual, physical and emotional abuse.
Fig. 3.1. Ecological model showing examples of risk factors for child maltreatment

- Socioeconomic disadvantage
- Poor social capital/social disorder
- Availability of alcohol
- Presence of drugs

- Young/single parenthood
- Mental health problems (perpetrator)
- Substance abuse (perpetrator)
- Childhood maltreatment (perpetrator)
- Externalizing problems (child)
- Child disability (child)

- Cultural norms supportive of violence
- Weak legislation preventing child abuse
- Economic stress
- Societal conflict

- Family conflict
- Domestic violence
- Poor parenting behaviours
- Large family size
- Low socioeconomic status
- Nonbiological parent in the home
The effects of childhood maltreatment on brain structure, function and connectivity

Martin H. Teicher1,2, Jacqueline A. Samson1,2, Carl M. Anderson1,2 and Kyoko Ohashi1,2

Figure 1 | Abuse type-specific effects on the developing brain. Images depicting the potential effects of exposure to specific types of childhood maltreatment on grey-matter volume (GMV) or thickness and fibre-tract integrity. Exposure to parental verbal abuse was associated with increased GMV in the auditory cortex portion of the left superior temporal gyrus25 (part a) and decreased integrity of the left arcuate fasciculus (AF) interconnecting Wernicke’s area and Broca’s area26 (part b). Visually witnessing multiple episodes of domestic violence was associated with reduced GMV in right lingual gyrus, left occipital pole and bilateral secondary visual cortex (V2)27 (part c) and decreased integrity of the left inferior longitudinal fasciculus (ILF), which serves as a visual–limbic pathway28 (part d). Adults reporting exposure to multiple episodes of childhood forced-contact sexual abuse were found to have reduced GMV in right and left primary visual cortex (V1) and visual association cortices, as well as reduced thickness in right lingual, left fusiform and left middle occipital gyri29 (part e) and portions of the somatosensory cortex representing the clitoris and surrounding genital area30 (part f).
Video Victor V

Evaluation: What about childhood adversity and bipolar disorder?
Video
Sandy, trauma history

bipolar spectrum
generalized anxiety disorder
fibromyalgia
M: escitalopram, trazadone, lamotrigine, diazepam
Time of interview in day hospital
RELAPSE
Patients are ill half of their life
Meta-Analysis of the Risk of Subsequent Mood Episodes in Bipolar Disorder

Joaquim Radua\*\^e-g, Heinz Grunze\^h, Benedikt L. Amann\*\^\=d-e

5837 bipolar I and II patients (12 studies)

-44% first year, 19% second year, 22% third year
Interaction of various risk factors

Lack of insight

Parcial or lack of adherence

Cognition and functioning

Late diagnosis

Subsyndromal symptoms

Comorbidities

More episodes

Psychological trauma

Complex pharmacological strategies
• Psychoeducation
• Family Interventions
• Interpersonal and Social Rhythm Therapy
• Schema-focused Therapy
• Mindfulness
• CBT

• Functional remediation

Objectives:
– Information disease and therapy
– Improve insight and acceptance of disease
– Improve observation of mood swings, sleep and prodromal symptoms
– Cope better with stress

Estimated to reduce recurrence by 15% (Yatham et al, 2018)

Problem: not integrated in a regular way
Environmental factors, life events, and trauma in the course of bipolar disorder

Fanny Aldinger, MD and Thomas G. Schulze, MD*
Institute of Psychiatric Pharmacology and Genomics, Ludwig-Maximilians-University, Munich, Germany

Figure 1. Impact on the course of bipolar disorder.

<table>
<thead>
<tr>
<th>Environmental factors</th>
<th>Kennedy et al.42</th>
<th>2002</th>
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<tr>
<td>clinical</td>
<td>Garne et al.43</td>
<td>2005</td>
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<td>infection</td>
<td>Kauert-SantAnna et al.44</td>
<td>2007</td>
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<td>maternal smoking</td>
<td>Quarantini et al.45</td>
<td>2009</td>
<td>140</td>
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<td>prenatal infections</td>
<td>Fisher et al.46</td>
<td>2010</td>
<td>Review</td>
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<td>birth complication</td>
<td>Daruy-Filho et al.47</td>
<td>2011</td>
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<td>job loss</td>
<td>Miller et al.48</td>
<td>2013</td>
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<td>bereavement</td>
<td>Aas et al.49</td>
<td>2014</td>
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<td>high expressed emotions</td>
<td>Gushkin et al.50</td>
<td>2014</td>
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<td>social zeitgeber</td>
<td>Benedetti et al.51</td>
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<td>Social support</td>
<td>Sala et al.52</td>
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<td>Baumeister et al.53</td>
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<td>Life events</td>
<td>Eisin et al.54</td>
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<td>Oliveira et al.55</td>
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<td>Benedetti et al.56</td>
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<td>Etincott et al.59</td>
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<td>Gniber et al.71</td>
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Risk factors

Psychological trauma such as sexual, emotional and physical abuse, bullying, death parents, separation parents
- at least 50% of all bipolar patients
- cause more manic symptoms, more rapid cycling, more suicide attempts and substance use disorders

Life events
Important changes in their personal lifes with social consequences
Positive events: more manic episodes
Negative events: more manic and depressive episodes
Loss of a beloved one: more manic episodes
Somatic illness: more depressive episodes
Before manic episodes often interpersonal, financial or labour problems

Psychological trauma in childhood is an etiological factor for the diagnosis of bipolar disorder. Psychological trauma and life events can worsen the course of the illness.

Aldinger and Schulze, 2016
A.M. 46 años
Trastorno Bipolar tipo 1

Mi padre intenta matar a mi madre con cuchillo
Muerte madre
Me voy de casa y no sé donde voy, luego me encontraron y me ingresaron...

Abusos sexuales por parte de tío y padre
Mi padre nos obligaba a pedir limosna
Maltratos físicos y psicológicos continuados por parte de mi padre y tío

Enfermedad de mi madre (Cáncer de mama)
Maltrato continuado de mi suegra
Intento de suicidio

22 años
39 años
44 años

Vicky Blanch, EMDR therapist
Video Paula K

Evaluation: What means bipolar disorder and how you live with this diagnosis?
How do we treat traumatized bipolar clients?
I inform them about this EMDR publication!

Messages:
- EMDR works also in mice
- We know how it works!
CS group
(conventional extinction)

ABS+CS group

The 1st extinction trial with CS only

The 2nd extinction trial with CS only

The 1st extinction trial with ABS-paired CS

The 2nd extinction trial with ABS-paired CS
We also know much more about the anatomy now!
Video Victor V

Resource installation
4 elements (E. Shapiro)

Very useful to activate the parasympathetic nervous system and decrease stress levels
Many patients are blocked
-Introverted irritability-
Olga,
58 years
Dx:
1. Mayor depressive disorder
2. Complex PTSD
3. Trauma due to bullying at work

Family history: Mother with SZ

Reason for consultation: Mobbing at work, medication

Revising her history: Complex trauma as parents were not present, boarding school, bullying
Recourses: married, one son
At start: Moderate depressive, labile, flashbacks, nightmares, insomnia, passive suicidal thoughts

Treatment:
1. Mirtazapine 15 mg, reducing alprazolam
2. 3 EMDR sessions
We need to address present and new occurring life events!
We reinforce whatever positive life event/experience since last visit

Video Ricardo
Coffee break
We take a good history of the client and can use hereby our EMDR bipolar protocol.
Grants
- Instituto Carlos III; FIS 2016
- Narsad (2016)
Index of the EPBD

• Short theoretic introduction of BD and the role of trauma, PTSD

  • Phase 1
    - Clinical history
    - Treatment plan

  • Phase 2
    - Client preparation
    - Positive resources, such as the 5 EMDR Bipolar Subprotocols
CLINICAL HISTORY

• Assess current patient status!
• EMDR **recommended**:  
  ➢ In clinical remission
  ➢ With subsyndromal symptoms (Novo et al, 2014)
• EMDR **possibly feasible**:  
  ➢ Mild depression
  ➢ Hypomanic episode
  ➢ Psychotic symptoms (Van den Berg et al, 2015).
• EMDR **not recommended**:  
  ➢ mania, mixed phase
  ➢ moderate to severe depression (even though consider protocol DeprEnd© by Hoffmann et al, 2015)
Assess suitability for EMDR reprocessing
Watch out if exists:

 ✓ Actual Substance abuse/dependency
 ✓ Bad adherence to treatment
 ✓ Lack of insight into their illness
 ✓ Weak support network
 ✓ High risk behaviors
CLINICAL HISTORY

Watch out:
• How the structural dissociation level is

• And if exists an axis II co-morbidity, following DSM-IV-TR criteria

• We are not scared but take this into account
Areas to be assessed

- Identify first, worst affective episode, age and type and subsequent episodes with age and type.
- Explore prior events of affective episodes.
- Collect hospital admissions and experiences.
- Evaluate impact of diagnosis.
- Impact of illness on functioning.
- Issues of attachment in childhood.
- Take the history of traumatic experiences.
- Significant (+ or -) life events (with helpful person).
TREATMENT PLAN

• Make a list of negative events with year and SUD.
• Consider the idea of a therapy focused on the symptom.
• Start with symptoms of the present which cause more discomfort to access those traumatic memories in the past associated with symptoms of the present.
• Then go to the past and begin with the most disturbing symptom, reprocess the group of distressing memories associated with this symptom.
• Past: Keep in mind the targets of the disease which we already registered at the history taking (first episode, impact of diagnosis, hospitalization etc).
TREATMENT PLAN

PRESENT:

• The memories of recent events and recent disturbing stimuli.
• Family, social and work related problems.
• Flashbacks and intrusive memories.
• Physical sensations and disturbing emotions.
Client preparation (Phase 2)

- Establish a good therapeutic relationship
- Coordinate with family members/psychiatrist
- Check whether received psychoeducation
- Explain how EMDR works
- Introduce bilateral stimulation
- Patient consents to EMDR treatment
- Foster conscious observation attitude
- Monitor mood (e.g. with App Moody Me)
The protocol is very systematic and client centred but too excessive at times.....
5 specific bipolar EMDR sub-protocols

- Moodstabilizer protocol
- Insight protocol
- Adherence protocol
- Prodromal protocol
- Deidealization of (hypo)manic symptoms
EMDR Mood-Stabilizing Protocol

• Aim: Positive enforcement/installation of a situation in the past with a stable mood and feeling of control of his/her life.
• Use it in every session.
• Idea is that this protocol is a psychotherapeutic mood-stabilizer.
EMDR Mood-Stabilizing Protocol

Say, “In bipolar patients the mood changes often from depression to an exaggerated, elevated mood. Furthermore, the daily stress and tensions provoke us to be at the mercy of matters that are happening around us. With this exercise we will determine memories and moments where you found yourself well and stable in your mood. Concentrating on this will stabilize your mood and increase the sensation of control in your life.”

Say, “Please describe a moment in your life in which you had the sensation of a stable mood, and where you were controlling your life. You can go as early in your life as you wish, you just have to feel the sensation of a stable mood and control.”

Say, “Which image represents this best situation?”

Say, “Which positive thought accompanies this situation?”

Say, “Which emotion accompanies this image and the positive thought?”
EMDR Mood-Stabilizing Protocol

Say, “In which part of the body do you feel this?”

Say, “Now concentrate on this image of your stable mood, control and __________ (state the positive words) and the body sensations, and ______ (state whatever type of bilateral stimulation you chose).”

Do 6-12 sets of BLS.

Say, “What do you feel in your body now?”

If the experience continues to be positive or even increases, reinforce with another 6-12 sets of BLS.

Say, “Concentrate on this and follow my fingers.”
EMDR Mood-Stabilizing Protocol

If the experience continues being positive or even increases, choose from the various possibilities:

- Reinforce as often as you think might be helpful.
  Say, “Go with that.”

- Concentrate on the positive cognition and the body sensation.
  Say, “Focus on the positive words _____ (state positive cognition) and the body sensation and go with that.”

- Do the same but intensify the body sensations
  Say, “Focus on the positive words _____ (state positive cognition) and really experience the body sensations and go with that.”

- Anchor/reinforce with a keyword
  Say, “When you think of that positive experience, what is the word or phrase that represents your positive experience?”
If a negative sensation or memory comes up, leave that and go on to another positive experience.

*Note:* It is recommended to repeat the procedure in a stable and constant form during the therapeutic process to support clients in stabilizing their mood.
Video Paula K

“Mood-stabilizer protocol”
(Amann et al, 2016)
Exercise
-try the mood-stabilizer protocol-
The other 4 subprotocols are currently under revision after our first experience in the RCT. But you will find them attached at the end!
Index of the EPBD

- Phase 3: Assessment
- Phase 4: Desensitization
- Phase 5: Installation
- Phase 6: Body scan
- Phase 7: Closure
- Phase 8: Reevaluation
Video
Victor phase 3 and 4
Video
Marta, phase 3 and 4

bipolar II disorder
alcohol dependence
generalized anxiety disorder
M: gabapentin, lamotrigine, escitalopram
Time of interview in day hospital
How do we address recent and past adverse events?

- Standard protocol by F. Shapiro
- Recent-Traumatic Event Protocol (R-TEP) by E. Shapiro
Video Paula K

Death mother
Conclusions

BD is a complex, multidimensional disorder with a often negative evolution

Childhood and recent traumatic events play a major role

It is important to evaluate the biography with regards to traumatic events

We take positive resources into account and use stabilization techniques

PR: safe place, moodstabilizer protocol, Nature article, use positive resources such as medication, reinforce positive life events with BLS

We can process traumatic events in bipolar clients

We have an EMDR bipolar Manual being tested in a RCT
“THEY ALWAYS ASK WHAT IS WRONG WITH YOU AND HARDLY EVER ASK WHAT HAPPENED TO YOU”

THANKS FOR THE ATTENTION

benedikt.amann@gmail.com
Scientific evidence of psychotherapy in severe mental disorder plus psychological trauma
25 years of EMDR: The EMDR therapy protocol, hypotheses of its mechanism of action and a systematic review of its efficacy in the treatment of post-traumatic stress disorder

Patricia Novo Navarro, Ramón Landín-Romero, Rocío Guardiola-Wanden-Berghe, Ana Moreno-Alcázar, Alicia Valiente-Gómez, Walter Lupo, Francisca García, Isabel Fernández, Víctor Pérez, y Benedikt L. Amann

Scientific evidence:
- >30 RCT in PTSD
- Underwent scrutiny of various independent meta-analysis
- Recommended by WHO (2013) as first-line treatment in PTSD
## EMDR beyond PTSD: A Systematic Literature Review

Alicia Valiente-Gómez, Ana Moreno-Alcayzar, Debi Traen, Carlos Cecron, Francisco Colom, Victoria Pérez, and Benedikt L. Amann

1 Centre Emili Mira, Institute of Neuropsychiatry and Addictions, Parc de Salut Mar, Barcelona, Spain. 2 Centre Forum Research Unit, Institute of Neuropsychiatry and Addictions, Parc de Salut Mar, Barcelona, Spain. 3 Institut Hospital del Mar d’Investigacions Mèdiques, Barcelona, Spain. 4 Department of Psychiatry, Autonomous University of Barcelona, Barcelona, Spain. 5 Institute of Neuropsychiatry and Addictions, Hospital del Mar, Parc de Salut Mar, Barcelona, Spain. 6 Centro de Investigación Biomédica en Red de Salud Mental, Madrid, Spain.

### TABLE 1 | RCT of EMDR in psychotic disorder.

<table>
<thead>
<tr>
<th>Title author, year</th>
<th>Sample (n)</th>
<th>EM/Full protocol</th>
<th>Control condition</th>
<th>Main findings</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim et al. 2013</td>
<td>10</td>
<td>EMDR</td>
<td>TAU</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 2 | RCTs of EMDR in affective disorder, substance use disorders and chronic pain.

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Diagnosis</th>
<th>Sample (n)</th>
<th>EM/Full protocol</th>
<th>Control condition</th>
<th>Main findings</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van M 2016 – de Bo 2016*</td>
<td>Bipolar disorder</td>
<td>20</td>
<td>EMDR</td>
<td>TAU</td>
<td>EMDR&gt;TAU in trauma, depressive and hypomanic symptoms.</td>
<td>EMDR can help to treat subsyndromal mood beyond trauma symptoms in bipolar patients.</td>
</tr>
<tr>
<td>Hase et al., 2015</td>
<td>Unipolar depression</td>
<td>16</td>
<td>EMDR+TAU</td>
<td>TAU</td>
<td>EMDR+TAU&gt;TAU</td>
<td>EMDR has positive effects in the treatment of depression.</td>
</tr>
<tr>
<td>Behnammoghadam et al., 2015</td>
<td>Depression after myocardial infarction</td>
<td>60</td>
<td>EMDR</td>
<td>WL</td>
<td>EMDR&gt;WL</td>
<td>EMDR is an efficient treatment to depression in patients with myocardial infarction.</td>
</tr>
<tr>
<td><strong>AFFECTIVE DISORDERS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SUBSTANCE USE DISORDERS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hase et al., 2008</td>
<td>Alcohol Dependence</td>
<td>34</td>
<td>EMDR+TAU</td>
<td>TAU</td>
<td>EMDR+TAU&gt;TAU</td>
<td>EMDR might be a useful approach for treating addiction memory and craving of alcohol.</td>
</tr>
<tr>
<td>Perez-Dandieu and Tapia, 2014</td>
<td>Alcohol and other substance use disorders</td>
<td>12</td>
<td>EMDR+TAU</td>
<td>TAU</td>
<td>EMDR+TAU&gt;TAU</td>
<td>PTSD symptoms can be successfully treated with EMDR in substance abuse patients.</td>
</tr>
</tbody>
</table>
What do we offer patients with SMD and traumatic events?

“Very few trials have investigated trauma-focused psychological interventions for individuals with SMI and PTSD. Results from trials of TF-CBT are limited and inconclusive regarding its effectiveness on PTSD, or on psychotic symptoms or other symptoms of psychological distress.”

3 RCT:
• 2008: Mueser et al, J Consult Clin Psychol
• 2013: Mueser et al, Br J Psychiatry
• 2015: van der Berg et al, JAMA Psychiatry
A Randomized Controlled Trial of Cognitive-Behavioral Treatment of Posttraumatic Stress Disorder in Severe Mental Illness

Mueser et al, 


Baseline Characteristics of the Sample

<table>
<thead>
<tr>
<th>Demographics</th>
<th>CBT (N = 54)</th>
<th>TAU (N = 54)</th>
<th>Total (N = 108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>13 (24.1%)</td>
<td>10 (18.5%)</td>
<td>23 (21.3%)</td>
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<tr>
<td>White</td>
<td>46 (85.2%)</td>
<td>45 (83.3%)</td>
<td>91 (84.8%)</td>
</tr>
<tr>
<td>Education (High School Grad.)</td>
<td>41 (75.0%)</td>
<td>36 (66.7%)</td>
<td>77 (71.3%)</td>
</tr>
<tr>
<td>Never Married</td>
<td>17 (31.5%)</td>
<td>21 (38.9%)</td>
<td>38 (35.2%)</td>
</tr>
<tr>
<td>Age, mean (SD), y</td>
<td>45.13 (9.83)</td>
<td>43.30 (11.1)</td>
<td>44.21 (10.64)</td>
</tr>
<tr>
<td>Currently Employed</td>
<td>3 (5.6%)</td>
<td>6 (11.1%)</td>
<td>9 (8.3%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>CBT (N = 54)</th>
<th>TAU (N = 54)</th>
<th>Total (N = 108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>5 (9.3%)</td>
<td>3 (5.6%)</td>
<td>8 (7.4%)</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>5 (9.3%)</td>
<td>4 (7.4%)</td>
<td>9 (8.3%)</td>
</tr>
<tr>
<td>Major Depression</td>
<td>30 (55.6%)</td>
<td>36 (66.7%)</td>
<td>66 (61.1%)</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>14 (25.9%)</td>
<td>11 (20.4%)</td>
<td>25 (23.1%)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Diagnoses</th>
<th>CBT (N = 54)</th>
<th>TAU (N = 54)</th>
<th>Total (N = 108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline Personality Disorder</td>
<td>15 (27.8%)</td>
<td>12 (22.2%)</td>
<td>27 (25.0%)</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>17 (31.5%)</td>
<td>27 (50.0%)</td>
<td>44 (40.7%)</td>
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</table>

<table>
<thead>
<tr>
<th>Psychiatric History</th>
<th>CBT (N = 54)</th>
<th>TAU (N = 54)</th>
<th>Total (N = 108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Psychiatric Hospitalization</td>
<td>46 (86.9%)</td>
<td>42 (81.8%)</td>
<td>88 (82.4%)</td>
</tr>
<tr>
<td># of Prior Hospitalizations, median (range)</td>
<td>4 (0-100)</td>
<td>5 (0-100)</td>
<td>4 (0-100)</td>
</tr>
<tr>
<td>Age at 1st hospitalization, mean (SD), y</td>
<td>27.85 (12.03)</td>
<td>22.98 (11.70)</td>
<td>25.49 (12.05)</td>
</tr>
<tr>
<td>Months since last hospitalization</td>
<td>49.11 (43.54)</td>
<td>31.95 (34.31)</td>
<td>41.01 (35.39)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continuous Variables*</th>
<th>Condition</th>
<th>Base</th>
<th>Post</th>
<th>3 Month</th>
<th>6 Month</th>
<th>df</th>
<th>F</th>
<th>P</th>
<th>ES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPS-Total</td>
<td>CBT</td>
<td>74.46 (17.56)</td>
<td>55.53 (27.92)</td>
<td>55.10 (25.96)</td>
<td>57.48 (25.34)</td>
<td>1.78</td>
<td>8.30</td>
<td>.005</td>
<td>.45</td>
</tr>
<tr>
<td></td>
<td>TAU</td>
<td>76.15 (17.97)</td>
<td>67.78 (26.84)</td>
<td>64.80 (28.25)</td>
<td>70.90 (24.15)</td>
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<tr>
<td>CAPS-Total (~65)</td>
<td>CBT</td>
<td>82.05 (14.46)</td>
<td>59.68 (29.12)</td>
<td>57.23 (26.92)</td>
<td>62.78 (25.01)</td>
<td>1.57</td>
<td>9.16</td>
<td>.004</td>
<td>.59</td>
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<tr>
<td></td>
<td>TAU</td>
<td>83.87 (12.45)</td>
<td>79.65 (18.41)</td>
<td>74.50 (22.17)</td>
<td>74.24 (23.54)</td>
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<tr>
<td>BDI-II</td>
<td>CBT</td>
<td>31.48 (13.24)</td>
<td>21.91 (11.52)</td>
<td>21.67 (13.32)</td>
<td>25.02 (12.85)</td>
<td>1.78</td>
<td>14.89</td>
<td>&lt;.001</td>
<td>.51</td>
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<tr>
<td></td>
<td>TAU</td>
<td>31.76 (13.79)</td>
<td>27.70 (14.75)</td>
<td>30.66 (15.26)</td>
<td>31.30 (13.50)</td>
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<tr>
<td>BPRS-Total</td>
<td>CBT</td>
<td>43.77 (7.42)</td>
<td>42.25 (7.59)</td>
<td>43.97 (10.37)</td>
<td>46.60 (11.56)</td>
<td>1.74</td>
<td>5.69</td>
<td>.02</td>
<td>.45</td>
</tr>
<tr>
<td></td>
<td>TAU</td>
<td>43.77 (7.42)</td>
<td>42.25 (7.59)</td>
<td>43.97 (10.37)</td>
<td>46.60 (11.56)</td>
<td></td>
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</tr>
</tbody>
</table>

2008: First RCT of CBT in patients with SMD and PTSD
N=201; 12 meses seguimiento
Prolonged Exposure vs Eye Movement Desensitization and Reprocessing vs Waiting List for Posttraumatic Stress Disorder in Patients With a Psychotic Disorder: A Randomized Clinical Trial

David P.G. van der Berg, MSc; Paul A.J.M. de Rond, MSc; Berber M. van der Vleugel, MSc; Carlijn de Roos, MSc; Ad de Jongh, PhD; Agnes Van Minnen, PhD; Mark van der Gaag, PhD

**Importance** The efficacy of posttraumatic stress disorder (PTSD) treatments in psychosis has not been examined in a randomized clinical trial to our knowledge. Psychosis is an exclusion criterion in most PTSD trials.

**Objective** To examine the efficacy and safety of prolonged exposure (PE) therapy and eye movement desensitization and reprocessing (EMDR) therapy in patients with psychotic disorders and comorbid PTSD.

**Design, Setting, and Participants** A single-blind randomized clinical trial with 3 arms (N = 155), including PE therapy, EMDR therapy, and waiting list (WL) of 13 outpatient mental health services among patients with a lifetime psychotic disorder and current chronic PTSD. Baseline, posttreatment, and 6-month follow-up assessments were made.

**Interventions** Participants were randomized to receive 8 weekly 90-minute sessions of PE (n = 53), EMDR (n = 55), or WL (n = 47). Standard protocols were used, and treatment was not preceded by stabilizing psychotherapeutic interventions.

**Main Outcomes and Measures** Clinician-rated severity of PTSD symptoms, PTSD diagnosis, and full remission (on the Clinician Administered PTSD Scale) were primary outcomes. Self-reported PTSD symptoms and posttraumatic cognitions were secondary outcomes.

**Results** Data were analyzed as intent to treat with linear mixed models and generalized estimating equations. Participants in the PE and EMDR conditions showed a greater reduction of PTSD symptoms than those in the WL condition. Between-group effect sizes were 0.78 (P < .001) in PE and 0.65 (P = .001) in EMDR. Participants in the PE condition (56.6%; odds ratio [OR] 3.41; P = .006) or the EMDR condition (50.0%; OR 3.92; P < .001) were significantly more likely to achieve full remission than those in the WL condition (27.7%). Participants in the PE condition (28.3%; OR, 5.79; P = .01), but not those in the EMDR condition (16.4%; OR, 2.87; P = 10), were more likely to gain full remission than those in the WL condition (6.4%). Treatment effects were maintained at the 6-month follow-up in PE and EMDR. Similar results were obtained regarding secondary outcomes. There were no differences in severe adverse events between conditions (2 in PE, 1 in EMDR, and 4 in WL). The PE therapy and EMDR therapy showed no difference in any of the outcomes and no difference in participant dropout (24.5% in PE and 20.0% in EMDR, P = .57).

**Conclusions and Relevance** Standard PE and EMDR protocols are effective, safe, and feasible in patients with PTSD and severe psychotic disorders, including current symptoms. A priori exclusion of individuals with psychosis from evidence-based PTSD treatments may not be justifiable.

**Trial Registration** isrctn.com identifier: ISRCTN79584912

JAMA Psychiatry. doi:10.1001/jamapsychiatry.2014.2637
Published online January 21, 2015.

**Author Affiliations** Author affiliations are listed at the end of this article.

**Corresponding Author:** David P.G. van der Berg, MSc, Parnassia Psychiatric Institute, Zoetersewegel 40, 2512 HI Den Haag, the Netherlands (dbergen@parnassia.nl).
Trauma-Focused Treatment in PTSD Patients With Psychosis: Symptom Exacerbation, Adverse Events, and Revictimization

David P. G. van den Berg, Paul A. J. M. de Bont, Berber M. van der Vleugel, Carlijn de Roos, Ad de Jongh, Agnes van Minnen, and Mark van der Gaag

Table 3. Session Ratings of Paranoid Ideation, Auditory Verbal Hallucinations, Dissociative Feelings, and Suicidal Ideation

<table>
<thead>
<tr>
<th></th>
<th>Before First TF Session (N = 96)</th>
<th>After First TF Session (N = 96)</th>
<th>P Value</th>
<th>Before Second TF Session (N = 94)</th>
<th>After Second TF Session (N = 90)</th>
<th>P Value</th>
<th>Week Before First TF Session (N = 98)</th>
<th>Week After First TF Session (N = 94)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid ideation</td>
<td>3.63 (3.4)</td>
<td>2.78 (3.4)</td>
<td>.001</td>
<td>2.98 (3.2)</td>
<td>2.49 (3.0)</td>
<td>.010</td>
<td>4.53 (3.3)</td>
<td>3.85 (3.4)</td>
<td>.003</td>
</tr>
<tr>
<td>Auditory verbal</td>
<td>1.89 (3.1)</td>
<td>1.56 (3.0)</td>
<td>.089</td>
<td>1.84 (3.2)</td>
<td>1.83 (3.2)</td>
<td>.901</td>
<td>2.71 (3.6)</td>
<td>2.62 (3.5)</td>
<td>.475</td>
</tr>
<tr>
<td>Hallucinations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociative feelings</td>
<td>3.53 (3.2)</td>
<td>2.92 (3.2)</td>
<td>.064</td>
<td>3.14 (3.2)</td>
<td>2.30 (3.0)</td>
<td>.005</td>
<td>4.34 (3.3)</td>
<td>4.22 (3.5)</td>
<td>.894</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>2.12 (2.8)</td>
<td>1.40 (2.6)</td>
<td>.001</td>
<td>1.80 (2.7)</td>
<td>1.59 (2.9)</td>
<td>.356</td>
<td>2.78 (3.3)</td>
<td>2.44 (3.1)</td>
<td>.206</td>
</tr>
</tbody>
</table>

Note. TF, trauma-focused.
*Data are expressed as mean (SD). Scores range from 0 (no, not at all) to 10 (yes, very much). P values are based on paired samples t tests.

Table 2. Observed Outcomes of Symptom Exacerbation

<table>
<thead>
<tr>
<th></th>
<th>Trauma-Focused Treatment</th>
<th>Waiting List</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ratio</td>
<td>%</td>
</tr>
<tr>
<td>Any symptom exacerbation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline to posttreatment</td>
<td>13/91</td>
<td>14.3</td>
</tr>
<tr>
<td>Baseline to follow-up</td>
<td>10/88</td>
<td>11.4</td>
</tr>
<tr>
<td>Clinician-rated PTSD symptoms (CAPS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline to posttreatment</td>
<td>3/91</td>
<td>3.3</td>
</tr>
<tr>
<td>Baseline to follow-up</td>
<td>2/88</td>
<td>2.3</td>
</tr>
<tr>
<td>Self-reported PTSD symptoms (PSS-SR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline to posttreatment</td>
<td>3/88</td>
<td>3.4</td>
</tr>
<tr>
<td>Baseline to follow-up</td>
<td>2/88</td>
<td>2.3</td>
</tr>
<tr>
<td>Paranoid ideation (GPTS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline to posttreatment</td>
<td>3/91</td>
<td>3.3</td>
</tr>
<tr>
<td>Baseline to follow-up</td>
<td>2/88</td>
<td>2.3</td>
</tr>
<tr>
<td>Depressive symptoms (BDI-II)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline to posttreatment</td>
<td>9/91</td>
<td>9.9</td>
</tr>
<tr>
<td>Baseline to follow-up</td>
<td>7/88</td>
<td>8.0</td>
</tr>
</tbody>
</table>
Prolonged exposure and EMDR for PTSD \textit{v}.
a PTSD waiting-list condition: effects on symptoms
of psychosis, depression and social functioning
in patients with chronic psychotic disorders

P. A. J. M. de Boni\textsuperscript{1,2}, D. P. G. van den Berg\textsuperscript{3}, B. M. van der Vleugel\textsuperscript{4}, C. de Rood\textsuperscript{5}, A. de Joung\textsuperscript{6,7}, M. van der Gag\textsuperscript{8} and A. M. van Minnen\textsuperscript{10,11}

\textbf{Fig. 1.} Observed outcomes trajectories as a function of treatment group. AHRS, Auditory Hallucination Rating Scale; BDI-II, Beck Depression Inventory – II; CAI, Clinician-Administered PTSD Scale; GPTS, Green Paranoid Thoughts Scale; SCI-SR-PANSS, Structured Clinical Interview for Symptoms of Remission for the Positive and Negative Syndrome Scale. \textsuperscript{a} Mean scores are based on individuals who were actively hallucinating at baseline and/or post-treatment and/or follow-up.
Effect of Eye Movement Desensitization and Reprocessing (EMDR) on Depression in Patients With Myocardial Infarction (MI)

Mohammad Behnammoghadam¹, Ali Karam Alamdari², Aziz Behnammoghadam³ & Fatemeh Darban⁴

Table 1. Comparison of distribution of qualitative demographic variable in experimental and control groups

<table>
<thead>
<tr>
<th></th>
<th>Experimental N(%)</th>
<th>Control N(%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25(83.3)</td>
<td>25(83.3)</td>
<td>0.635</td>
</tr>
<tr>
<td>Female</td>
<td>5(16.7)</td>
<td>5(16.7)</td>
<td>0.931</td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>15(50)</td>
<td>15(50)</td>
<td></td>
</tr>
<tr>
<td>Bachelor degree</td>
<td>9(30)</td>
<td>10(33.3)</td>
<td></td>
</tr>
<tr>
<td>Higher than Bachelor degree</td>
<td>6(20)</td>
<td>5(16.7)</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2(6.7)</td>
<td>3(10)</td>
<td>0.5</td>
</tr>
<tr>
<td>Married</td>
<td>28(93.3)</td>
<td>27(90)</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>20(66.7)</td>
<td>7(23.3)</td>
<td>0.001</td>
</tr>
<tr>
<td>No</td>
<td>10(33.3)</td>
<td>23(76.7)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Comparison of the mean scores of depression in experimental and control groups

<table>
<thead>
<tr>
<th></th>
<th>Experimental Mean(SD)</th>
<th>Control Mean(SD)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre treatment</td>
<td>27.26(6.41)</td>
<td>24.53(5.81)</td>
<td>0.001</td>
</tr>
<tr>
<td>Post treatment</td>
<td>11.76(3.71)</td>
<td>31.66(6.09)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Note: Significant at α=0.05.

3 EMDR sessions
Inpatients with mild to moderate depression
EMDR plus TAU vs TAU
TAU: psychodynamic individual sessions, psychoeducation, sport therapy, and relaxation therapy
4-5 EMDR sessions (focused on disturbing memories Related to onset and course of depression
Between 12-18 sessions in both groups
Eye movement desensitization and reprocessing therapy in subsyndromal bipolar patients with a history of traumatic events: A randomized, controlled pilot-study

Patricia Novo a,b, Ramon Landin-Romero a,c, Joaquim Radua a,c, Victor Vicens a,c, Isabel Fernandez d, Francisca Garcia e, Edith Pomarol-Clotet a,c, Peter J. McKenna a,c, Francine Shapiro f, Benedikt L. Amann a,c,g

Randomization:
20 patients
- age
- sex
- IQ
- traumas

TAU (n=10)

EMDR (n=10)

13-18 EMDR sessions following standard protocol

Screening
26 patients
HDRS: 8<X<14
YMRS: 7<X<14
Trauma scales (CAPS + IES-R)

2nd week: HDRS YMRS
5th week: HDRS YMRS
8th week: HDRS YMRS
12th week: HDRS YMRS Trauma scales (CAPS + IES-R)
24th week: HDRS YMRS Trauma scales (CAPS + IES-R)

EMDR: Eye movement desensitization and reprocessing therapy; TAU: Treatment as Usual Group; HDRS: Hamilton Depression Rating Scale; YMRS: Young Mania Rating Scale; CAPS: Clinician-Administered PTSD Scale; IES-R: Impact of Event Scale.
Aims Bipolar EMDR Trauma (BET) Study

Improvement trauma via processing trauma

Better functioning

Better mood

Safety check
BET-Study

**Inclusion criteria**
- DSM-IV BPD I or II
- Subsyndromal Symptoms
- No full blown affective episode in last 3 months
- Good adherence
- 3 traumatic life events (SUD>5)

**Exclusion criteria**
- Active drug use
- Neurological illness
- Suicidal ideas
- EMDR Therapy
- DES>25

<table>
<thead>
<tr>
<th>ISBD consensus criteria [2]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manic episode</td>
</tr>
<tr>
<td>Hypomania</td>
</tr>
<tr>
<td><strong>Subsyndromal hypomania</strong></td>
</tr>
<tr>
<td>Euthymia</td>
</tr>
<tr>
<td><strong>Subsyndromal depression</strong></td>
</tr>
<tr>
<td>Depressive episode</td>
</tr>
<tr>
<td>Mixed subsyndromal</td>
</tr>
<tr>
<td>Mixed episode</td>
</tr>
</tbody>
</table>
BET-Study – baseline data

Table 1. Socio-demographic and clinical baseline characteristics of the EMDR group (n=10) and the TAU group (n=10)

<table>
<thead>
<tr>
<th>Variable</th>
<th>EMDR (n = 10)</th>
<th>TAU (n = 10)</th>
<th>Statistic, p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD)</td>
<td>43.90 (6.87)</td>
<td>44.80 (6.86)</td>
<td>t = -0.29, p = 0.773</td>
</tr>
<tr>
<td>Gender, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>7 (70)</td>
<td>5 (50)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3 (30)</td>
<td>5 (50)</td>
<td></td>
</tr>
<tr>
<td>Estimated pre-morbid IQ (TAP)</td>
<td>25.40 (2.83)</td>
<td>26.44 (2.006)</td>
<td>t = -0.1916, p = 0.372</td>
</tr>
<tr>
<td>Estimated current IQ (WAIS III)</td>
<td>100.6 (10.90)</td>
<td>102 (15.70)</td>
<td>t = -0.228, p = 0.623</td>
</tr>
<tr>
<td>Marital Status, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single/divorced</td>
<td>3 (30)</td>
<td>3 (30)</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>7 (70)</td>
<td>7 (70)</td>
<td></td>
</tr>
<tr>
<td>Working status, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>2 (20)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>1 (10)</td>
<td>0 (0)</td>
<td>Fisher test, p = 0.033*</td>
</tr>
<tr>
<td>Sick leave/disability</td>
<td>7 (70)</td>
<td>10 (100)</td>
<td></td>
</tr>
<tr>
<td>Duration of illness (months), mean (SD)</td>
<td>18 (10.28)</td>
<td>23.3 (7.86)</td>
<td>t = -1.29, p = 0.212</td>
</tr>
<tr>
<td>Affective episodes, mean (SD)</td>
<td>12.80 (12.22)</td>
<td>27.85 (6.71)</td>
<td>t = -3.32, p = 0.004*</td>
</tr>
<tr>
<td>Hospital admissions, mean (SD)</td>
<td>0.9 (0.87)</td>
<td>6.10 (8.02)</td>
<td>t = -2.03, p = 0.056</td>
</tr>
<tr>
<td>Previous psychotherapy, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>5 (50)</td>
<td>7 (70)</td>
<td>Fisher test, p = 0.350</td>
</tr>
<tr>
<td>CBT†</td>
<td>5 (50)</td>
<td>2 (20)</td>
<td></td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>0 (0)</td>
<td>1 (10)</td>
<td></td>
</tr>
<tr>
<td>Seasonal affective cycle, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7 (70)</td>
<td>9 (90)</td>
<td>Fisher test, p = 0.582</td>
</tr>
<tr>
<td>No</td>
<td>3 (30)</td>
<td>1 (10)</td>
<td></td>
</tr>
<tr>
<td>Psychotic symptoms, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5 (50)</td>
<td>6 (60)</td>
<td>Fisher test, p = 0.656</td>
</tr>
<tr>
<td>No</td>
<td>5 (50)</td>
<td>4 (40)</td>
<td></td>
</tr>
<tr>
<td>Substance abuse, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3 (50)</td>
<td>6 (60)</td>
<td>Fisher test, p = 0.370</td>
</tr>
<tr>
<td>No</td>
<td>7 (50)</td>
<td>4 (40)</td>
<td></td>
</tr>
</tbody>
</table>
BET-Study

Traumas:
- Witness physical aggression
- Physical aggression
- Sexual abuse
- Kidnapping
- Robbery
- Sudden death of a beloved one
- Accident
- Psychological abuse
- Emotional neglect
- Conflicitive family environment
- Separation
- First episode
- Admission to hospital
- Mechanical restraint

EMDR:
All patients have been evaluated by all therapists to define targets.

Drop outs (3 after baseline/2 after visit 4):
1 DES > 25
2x withdrawal from written consent baseline
1 had to be withdrawn due to ethical reasons, new traumatic event
1 withdrawal con written consent after 4th visit
Figure 2. Evolution of clinical scores with LOCF intention-to-treat in the trauma symptoms were significant differences were found between the EMDR (n = 10) and TAU (n = 10) groups.

LOCF: Last Observation Carried Forward; EMDR: Eye Movement Desensitization Reprocessing; TAU: Treatment as Usual; CAPS: Clinician Administered PTSD Scale; IES-1: Impact of Event Scale 1; IES-2: Impact of Event Scale 2; IES-3: Impact of Event Scale 3; * Significant differences between groups, † Trend level statistical significance
Figure 1. Evolution of clinical scores with LOCF and intention-to-treat in the mood symptoms between the EMDR (n = 10) and TAU (n = 10) groups

LOCF: Last Observation Carried Forward; EMDR: Eye Movement Desensitization Reprocessing; TAU: Treatment as Usual; YMRS: Young Mania Rating Scale; HDRS: Hamilton Depression Rating Scale; CGI-m: Clinical Global Impression-mania; CGI-d: Clinical Global Impression-depression; * Significant differences between groups
Thanks for attention and discussion!

GROUP STRUCTURE

02/2017
DR. BENEDIKT L. AMANN
- Head of the group
- Senior researcher

DRA. ANA MORENO ALCÁZAR
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- Senior researcher

DRA. ALICIA VALIENTE GOMEZ
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WALTER LUPO TORRALBO
- Collaborating clinical researcher

01/2019
ITXASO GARDOKI SOUTO
- Predoctoral researcher

CARMEN MASFERRER HERRERA
- Collaborating clinical researcher

SARA PORTA SATURIO
- Collaborating clinical researcher

OSCAR ROYUELA PÉREZ
- Collaborating clinical researcher

22 external EMDR psychologists, 12 students of master in psychology, 3 residents

benedikt.amann@gmail.com
Add on: other four subprotocols, if needed in your praxis
EMDR Illness Awareness Protocol

• Background: Poor insight is mainly associated with medication compliance, prognosis, voluntary versus involuntary admission, and cultural concepts of disease.

• Few interventions are available to improve awareness in BD.

• Objective:
  1. To create more awareness into the disease.
  2. This improves adherence, alimentary and sleep habits, reduces risky behaviors and also facilitates asking for professional help when necessary.

(Ghaemi and Pope, 1994)
Structure of this protocol

- We revise whether or not the patient presented with affective symptoms in the past.
- We offer a list with positive believes which the patient might have experienced and helped him/her to manage better the disease.
- We search for the experience of insight into the disease with an image, PC, emotions and physical sensations.
- We use brief and slow BLS (6-15).
- We search for a anchoring word which helps to remember this experience as positive resource which we install.
This is a 48 y patients with a BD I, first manic episodes with 23 y. Afterwards multiple depressive and manic episodes with 5 admissions in psychiatric hospitals. In the last year he had 2 episodes with one admission.

He describes prior to all episodes previous stressfull life events: examens, start working, separation from partner, birth of his first daughter, close to birth of second child, doubts about his religious believes.

In treatment with the same psychiatrist since 5 y. He sowed difficulties in acceptance of his disease and pharmacological and psychological tretament.
2. EMDR ILLNESS AWARENESS PROTOCOL

As a first step, it is recommended that the therapist review with the client the presence of affective symptoms suggestive of bipolar disorder that the client experienced in the past.

Check symptoms of hypomania and mania.

Say, "Do or did you ever suffer from interrupted sleep?"

Say, "Have you ever experienced a decreased need for sleep, feeling refreshed with only 3 or 4 hours a night?"

Say, "Do you know the sensation that you feel when you have made too many plans, projects, and activities?"

Say, "Do you remember episodes of an uncontrollable need to spend money, have sex, shop, or eat?"

Say, "Did you have moments in your life when you felt tense or more conflictive?"

Say, "Did you live episodes with an increased vitality, energy, or strength?"
Say, “Did you ever notice that you have so many thoughts in your head and that you cannot pay adequate attention to each one of them?”

Say, “Have you ever been more talkative than usual?”

Say, “Did you ever feel the need to move around aimlessly and restlessly?”

Say, “Did you ever have difficulties in concentrating or maintaining attention when you read, worked, or you were talking to someone?”

Say, “Do you have a feeling of being watched or observed by others?”

Say, “Do you have a feeling that someone may be following you?”

Say, “Did you ever hear voices in your head?”

If so, “How many voices do or did you hear?”

Say, “Do they communicate amongst themselves?”
Check Symptoms of Depression

Say, “Does or did your mood ever feel low, melancholic, or very sad?”

Say, “Do or did you ever feel an excessive need to sleep?”

Say, “Do you ever have the experience that your thinking is slowed down?”

Say, “Have you ever thought about suicide?”

If so, “Do or did you have a plan?”

Say, “Do or did you ever lose your appetite or feel that you can’t stop eating?”

Say, “Do or did you ever suffer from anxiety?”

Say, “Do or did you ever experience a complete loss of sexual desire?”
Check Symptoms of a Mixed Episode

Say, “Do or did you ever feel excessive irritability and are or were you prone to argue excessively?”

Say, “Do or did you ever feel restless and agitated?”

Say, “Do or did you ever feel excitement and sadness at the same time?”

Say, “Do or did you go from being lively and cheerful to being sad for no apparent reason?”

Say, “Do or did you suffer from other symptoms we have not mentioned and you may think are part of bipolar disorder?”

Say, “We have collected a number of symptoms that might be typical of bipolar disorder. Next, I wonder if we can find any positive beliefs that are useful to better manage the disease.”
Checking bipolar symptoms in the past, confirms that he dahn manic/hypomaniac and depressive episodes.

In the positive beliefs list which I proposed he responds positively in many suggestions.

The next step is to find concrete experiences when he was conscious of his disorder and to reinforce them with positive beliefs.


List of Positive Beliefs

The therapist can propose positive beliefs that can help clients manage the symptoms that were worked on previously.

Say, "I wonder if any of the following beliefs could be useful to you to better manage your disease?" (Please make a cross where client responds positively)

Say, "Accepting my illness allows me to better regulate my leisure time." □ Yes □ No

Say, "Accepting my illness allows me to choose a better job and/or a better job schedule." □ Yes □ No

Say, "Accepting my illness allows me to have a better relationship." □ Yes □ No

Say, "Accepting my illness allows me to be in better control of my life." □ Yes □ No

Say, "I feel like I take care of myself if I accept my disease and take my medication." □ Yes □ No

Say, "I am able to call my therapist and ask for help if I feel unstable." □ Yes □ No

Say, "Being aware of the illness I have makes me less sick." □ Yes □ No

Say, "When I notice the first symptoms of my illness, I know that I have to contact _______ (name a person of trust) because he or she gives me a trustworthy and realistic point of view about my condition." □ Yes □ No

Say, "Please tell me if there are any other beliefs about yourself that we have not mentioned."
The next step is to reinforce illness awareness by using PCs so that the client is able to cope with it.

Say, “Now let’s talk about how the awareness of your symptoms allows you to take care of yourself and ask for help. During which life experiences have you been aware of your illness, and how has that been for you?”

sido eso para ti?” En la última crisis, mi mujer puso límites a todos los cambios que estaba haciendo en la casa y me autoimpuse aceptarlos.

Say, “What bodily sensations do you experience when remembering this experience?” “¿Qué sensaciones corporales experimentas al recordar esa experiencia?” Alivio de sentir estos frenos.

Say, “What image best represents this experience?” “¿Qué imagen representa mejor esa experiencia?” Puedo disfrutar jugando con mi hijo y la mirada de mi mujer reconociéndome como un buen padre.

Say, “What positive thought (of the previously presented PCs) goes along with this experience?” “¿Qué positiva asociación tienes con esa experiencia?” Aceptar mi enfermedad me permite tener una mejor relación con mi familia y me siento más responsable de mí mismo.

Say, “What emotion goes along with that image and positive thought?” Alegria, plenitud y paz.

Say, “Where do you feel it in your body?” En el pecho

Say, “Now, focus on that image of ________ (state the time when client was in control and aware of his or her illness), those positive words, and the body sensation, and follow my fingers.” (Use 6 to 12 sets of BLS).
“Ahora, centrate en esas imágenes de disfrutar jugando con su hijo y la mirada de reconocimiento de su mujer, las palabras positivas aceptar mi enfermedad me permiten tener una mejor relación con mi familia y me siento más responsable de mí mismo y en la sensación en el cuerpo, y sigue mis dedos” (Usar tanda de 6 o 12 movimientos de EBL).

Say, “What do you get now?” **Me dejo llevar, era algo necesario**

If the experience continues to be positive or becomes stronger, reinforce with a second set of 6 to 12 BLs.

Say, “No.

Say, “With... calma, paz y equilibrio.”

If it continues to be positive, reinforce with a new set of BLS.

Say, “Is there a word or phrase that can help you remember this as a resource?”

“¿Hay alguna palabra o frase que te ayude a recuperar eso como un recurso?” Sensatéz y simpleza

Say, “Connect it with the pleasant bodily sensations, and follow my fingers.”

(Do 5 to 12 sets of BLS.) **Quiero lograr ecuanimidad y control y esto me acerca a ello**

Say, “What do you notice now.”

Se mantiene y pienso en las causas y consecuencias de mis conductas

If there are any negative sensations or any negative memories that come up, leave this resource and move on to another positive experience.

You can repeat the EIAP in the same session or in different ones throughout the therapeutic process.
EMDR Adherence Enhancer Protocol

• Background:
  - The most important risk factor for relapse is poor adherence.
  - Poor adherence is caused by the feeling of being controlled by drugs, (hypo)manic episodes, lack of insight, a negative view on pharmacological treatment, substance abuse, lack of treatment response and side effects, such as weight gain and sedation.

• Objective: To identify and improve those issues and strengthen adherence to avoid further affective relapses.

Leclerce et al., 2013
The goal of this protocol is to strengthen adherence to drug treatment in clients with bipolar disorder, and to help them appreciate the positive aspects of taking their medication.

**Negative feelings about taking medication for bipolar disorder**
First, we have to find out what bothers the client most about receiving drug treatment.

Say, "What bothers you most about taking medication for your disease, bipolar disorder?"

**Positive feelings about taking medication for bipolar disorder**
The therapist acknowledges the client’s issue about taking medication but suggests some possible positive outcomes from taking medication and asks the following question:

Say, "I understand that [state the issue] bothers you. However, what would you say is good about taking medication?"

Say, "Have you ever thought that taking medication has been beneficial for you with regard to your family and social environment?"

Say, "Have you ever thought that taking medication has been beneficial for you with regard to developing your professional and intellectual activity?"

Say, "Have you ever thought that taking medication has been beneficial for you with regard to being better organized in daily life, in your daily tasks?"

Say, "What further issues do you remember in your life in which taking medication has been beneficial for you?"

Say, "After everything we’ve talked about, when you take the medication, what can you say that is positive about yourself now?"
Check for possible positive beliefs (make a cross if positive):

Say, "Do you feel that one of the following positive beliefs is correct for you now?"

I control my life. □ Yes □ No
I control my disease. □ Yes □ No
I control my medication. □ Yes □ No
I can take care of myself. □ Yes □ No
I am worth it. □ Yes □ No
I am able to ask for help. □ Yes □ No
I am strong. □ Yes □ No
I have options, I can choose. □ Yes □ No
I am responsible for my actions. □ Yes □ No

Say, "Do any further positive beliefs come into your mind when you think about taking medication and/or when you took medication?"

The next step is to identify each specific positive experience related to taking medication regularly, and to work on them one by one to strengthen treatment adherence with the following procedure.

Say, "What experiences or positive memories of your life come into your mind associated with taking medication regularly?"
Choose an experience that is vivid for the client.

Say, "What sensations do you have when you think of that particular experience?"

The therapist can help develop the sensory aspects related to that experience.

Say, "What image represents this experience best?"

Say, "What positive thought goes along with this experience?"

Say, "What emotion goes along with the image and the positive thought?"

Say, "Where do you feel it in your body?"

Say, "Now, focus on that image of control, those positive words, and the sensation in your body and follow my fingers." (Do 6 to 12 sets of BLS.)

Say, "What do you notice now?"
If the experience continues to be positive or becomes stronger, reinforce it with a second set of 6 to 12 BLS.

Say, “Focus on that and follow my fingers.”

Say, “What do you notice now?”

Say, “Now, while you focus on the pleasant bodily sensation, bring to mind the words ________ (repeat PC related to the memory), and follow my fingers.” (Do 6 to 12 sets of BLS.)

Say, “What happens now?”

If it continues to be positive, reinforce with a new set of BLS.

Say, “Is there a word or phrase that could help you remember this as a resource?”

Say, “Connect it with the pleasant bodily sensations, and follow my fingers.” (Do 6 to 12 sets of BLS).

If any negative feeling or negative memories come up, leave this resource and move on to another positive experience.

You can repeat the EAEP procedure in the same session or different ones throughout the therapeutic process.
Patient for the adherence protocol

- Patient 34 y with BD I.
- First depressive episode with 20 y after a first hypomanic episode.
- A few years later manic episode with psychotic symptoms and suicide attempt. Admission to the psychiatric hospital.
- Some large episodes in remission. Due to partial adherence to his pharmacological treatment also various admissions due to manic episodes with auditory and visual hallucinations, the last 2016.
- He is euthymic when we start 20 sessions EMDR therapy.
- Safe attachment in infancy which changed when he is 12 y old. The mother starts with dementia and admissions to hospitals. This is his first traumatic experience. With the father signs of an insecure, ambivalent attachment.
“¿Qué te molesta más de tomar la medicación para el trastorno bipolar? Ganar peso

“¿Cuáles son algunos de los resultados positivos de tomar medicación?”
Encontrarme bien. Dicen que además el litio tiene propiedades protectoras para la neurona, yo encantado de tomarlo.

“¿Alguna vez has pensado que tomar la medicación ha sido bueno para ti en cuanto a tu entorno familiar y social?” Sí, estar bien con todo el mundo.

“¿Alguna vez has pensado que tomar la medicación ha sido bueno para ti en relación a desarrollar tu actividad profesional e intelectual?” Sí, sobre todo poder hacer actividades diferentes.

Beneficios de la medicación en relación a organizarse mejor en la vida y tareas diarias. A veces me cuesta organizarme porque me hace despertar muy tarde.
“¿Qué otras cosas recuerdas de tu vida en la que tomar la medicación haya sido positivo para ti?” Empezar a tener hábitos de vida saludables, como salir a caminar.

“¿Después de todo lo que hemos comentado, cuando tomas la medicación ¿qué dirías de positivo de ti mismo ahora?” Bueno, todo lo que ha he dicho.

Responde que todas las creencias positivas que se le sugieren, son correctas y le pueden ser de ayuda.

“¿Qué experiencias o recuerdos positivos de tu vida te vienen a la mente asociados a tomar medicación con regularidad?” Vivir y trabajar en Londres durante 6 meses.

“¿Qué sensaciones tienes cuando piensas en esa experiencia”? Cuando fui a coger el avión para volver a BCN, paso por la cafetería donde trabajé, me encuentro con el jefe, me da un sándwich y se lo agradezco.
“¿Qué imagen representa mejor esa experiencia? Cuando yo le agradezco: “Thanks for everything”.

“¿Qué pensamiento positivo acompaña a esa experiencia?” He hecho cosas que no hace cualquiera. Soy capaz. Puedo conseguir más cosas.

“¿Qué emoción acompaña a esa imagen y ese pensamiento positivo?” Estoy contento.

“¿En qué parte del cuerpo lo sientes?” Paz y tranquilidad en todo el cuerpo.

EBL “¿Qué notas ahora?”. Paz

EBL “¿Qué notas ahora?” Mi madre sonriendo. (positivo y negativo a la vez). EBL. Ha vuelto la paz.

“¿Hay alguna palabra que te ayude a conectar esta experiencia como recurso?” Londres.
EMDR Prodromal Symptoms Protocol

• Background:
  - The recognition of prodromal symptoms is decisive for relapse prevention.
  - Most often reported prodromal symptoms: sleep disturbances, mood changes/lability, psychotic symptoms, agitation, restlessness, increased anxiety, changes in appetite or suicidal ideas

• Objective: To help to identify early prodromal symptoms which then facilitates that patients ask for a rapid therapeutic intervention to avoid an affective relapse.

Check for Prodromal Symptoms

First, the therapist will ask the client which prodromal symptoms usually occur before an affective episode.

Say, “What are the first symptoms you usually notice before a depressive episode starts?”

Say, “What are the first symptoms you usually notice before a hypomanic or manic episode starts?”

Say, “What are the first symptoms you usually notice before a mixed episode starts?”

In case you want to evaluate more affective symptoms as possible prodromal symptoms, please check with questions from the EIAP (see earlier).

Once the client can recognize his or her prodromal symptoms, the therapist can propose some positive beliefs that can help the client manage the symptoms previously identified and worked on.
List of Positive Beliefs

Say, “Could any of the following positive beliefs or suggestions be useful to you to avoid a possible full depressive, manic, or mixed episode?”

Mark useful positive beliefs with a check.

Say, “When I notice ___________ (state prodromal symptom), I know I have to ask for help.” □ Yes □ No

Say, “When I notice ___________ (state prodromal symptom), I recognize it is a symptom of my illness.” □ Yes □ No

Say, “When I notice ___________ (state prodromal symptom), I have to take and/or maintain my medication as prescribed.” □ Yes □ No

Say, “When I notice ___________ (state prodromal symptom), I am about to suffer from a new episode.” □ Yes □ No

Say, “When I notice ___________ (state prodromal symptom), I have to plan the following steps cautiously and calm down.” □ Yes □ No

Say, “When I notice ___________ (state prodromal symptom), I have to be aware of not getting into an argument.” □ Yes □ No

Say, “When I notice ___________ (state prodromal symptom), I have to avoid conflictual relationships.” □ Yes □ No

Say, “When I notice ___________ (state prodromal symptom), I have to communicate with a person I trust.” □ Yes □ No

Say, “When I notice ___________ (state prodromal symptom), I have to avoid the use of alcohol, coffee, Coca-Cola, Red Bull, amphetamines, and drugs.” □ Yes □ No

Say, “When I notice ___________ (state prodromal symptom), I should smoke less.” □ Yes □ No

Repeat the list of positive beliefs if necessary with every prodromal symptom.

Say, “Can you tell me if you have any other beliefs we have not mentioned related to the good part about recognizing the symptoms that precede an episode?”
Reinforce Prodromal Symptoms Awareness With PCs

The next step is to reinforce prodromal symptoms awareness with PCs, allowing the client to better cope with the crisis.

Say, “Now let's talk about how awareness of the symptoms that precede your episodes allows you to take care of yourself and ask for help. In what life experiences have you been aware of symptoms that precede your episodes and this has been good for you?”

List all experiences and start with the most vivid one:

1. ___________________________________________
2. ___________________________________________
3. ___________________________________________
4. ___________________________________________

Say, “What image represents this experience best?”

________________________________________________________________________

Say, “What positive thought __________ (of the previously presented positive beliefs) goes along with this experience?”

________________________________________________________________________

Say, “What emotion goes along with this image and the positive thought?”

________________________________________________________________________

Say, “Where do you feel this in your body?”

________________________________________________________________________

Say, “Now, focus on that image of __________ (state experience), those positive words __________ (state words), and the body sensation, and follow my fingers.” (Do 6 to 12 sets of BLS.)

Say, “What do you get now?”

________________________________________________________________________

If the experience continues to be positive or becomes stronger, reinforce with a second set of 6 to 12 BLS movements.
Say, "Focus on that and follow my fingers."

Say, "What do you get now?"

If it continues to be positive, reinforce with a new set of BLS.

Say, "Is there a word or phrase that can help you remember this as a resource?"

Say, "Connect it with the pleasant body sensations, and follow my fingers." (Do 6 to 12 sets of BLS.)

If there are any negative sensations or any negative memories that come up, leave this resource and move on to another positive experience.

You can repeat the EPSP procedure in the same session or in different ones throughout the therapeutic process.
The EMDR De-Idealization Manic Symptoms Protocol

• Background:
  - Bipolar patients are more focused on their depressive episodes and tend to idealize (hypo)manic episodes.
  - Pleasant aspects of euphoria frequently cause a negation of devastating high-risk behavior during manic episodes. The latter include severe conflictive behavior, engaging in unrestrained buying sprees, impulsive sex and sexual indiscretions, or foolish business investments.

• Objective: To use this protocol in patients with awareness of manic episodes but still idealize specific pleasant euphoric symptoms to avoid poor adherence and further affective relapses.
The steps for the EDMSP are the following:

- **Step 1:** Create a list with clients of the types of life experiences they have had while in a manic state that ended in disastrous consequences.
- **Step 2:** Activate the neural networks for each manic experience that contain those memories of manic symptoms and impulses, along with the associated consequences, feelings, and beliefs or thoughts.
- **Step 3:** Work with each one of the experiences to strengthen the client’s awareness that it is positive—in a preventive way—to connect the impulsivity and disastrous experiences with the manic state.

**Manic Symptoms or Impulses That Lead to Negative Consequences**

**Step 1:** Together with the client, create a list of manic-state life experiences that ended in disastrous consequences.

Say, *"Do or did you suffer from negative experiences as a consequence of manic symptoms and/or impulsivity? Can you give some examples of the impulses you have had and the types of experiences you had as a result of them?"*

<table>
<thead>
<tr>
<th>Manic symptoms or impulses</th>
<th>Negative consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience 1:</td>
<td></td>
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<tr>
<td>Experience 2:</td>
<td></td>
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<tr>
<td>Experience 3:</td>
<td></td>
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<tr>
<td>Experience 4:</td>
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<tr>
<td>Experience 5:</td>
<td></td>
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<tr>
<td>Experience 6:</td>
<td></td>
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</tbody>
</table>
Step 2: Connect each experience that occurs during a mixed or manic state with the corresponding impulse, action, sensation, belief, and thought.

Say, “When you felt such a strong impulse, how would you describe the impulse?”

Say, “What action followed the impulse?”

Say, “Do you remember the sensations you felt in that moment?”

Say, “What beliefs did you have in that moment?”

Say, “What was the result of the impulse and action? What consequences did it have?”

Step 3: Strengthen the client’s awareness that it is preventive to connect the mania and impulsivity with disastrous consequences.

Say, “When you think about the negative consequences of your experience _________ (state the experience), how important is it for you to know that they are a symptom of your illness, on a scale from 0 to 10, where 0 = not positive at all and 10 = being totally positive?”

Strengthen the positive awareness response with 6 to 12 sets of BLS.

Say, “What do you get now?”
Follow with BLS until 9/10 or 10/10 is reached.

Say, “How positive is this awareness for you now on a scale from 0 to 10, where 0 = being not positive at all and 10 = being totally positive?”

Strengthen the positive awareness response with 6 to 12 sets of BLS.

Say, “What do you get now?”

Follow with BLS until 9/10 or 10/10 is reached.

Continue and link all the client’s experiences of impulses and manic symptoms with negative consequences.

**Phase 3: Assessment**

Use the trauma targets established in the treatment plan with the EMDR Standard Protocol.

<table>
<thead>
<tr>
<th>Description</th>
<th>Year</th>
<th>SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma 1:</td>
<td></td>
<td></td>
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<tr>
<td>Trauma 2:</td>
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<td>Trauma 3:</td>
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<td>Trauma 4:</td>
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<tr>
<td>Trauma 5:</td>
<td></td>
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</tbody>
</table>

*Incident*

Say, “The memory that we will start with today is _________ (select the next incident to be targeted).”
Say, "What happens when you think of the ________ (state the issue)?" 

Or say, "When you think of ________ (state the issue), what do you get?"

---

**Picture**

Say, "What picture represents the entire ________ (state the issue)?"

---

If there are many choices or if the client becomes confused, the clinician assists by asking the following:

Say, "What picture represents the most traumatic part of ________ (state the issue)?"

---

Sometimes bipolar patients have difficulty accessing NCs; however, it is helpful to try the standard method first.
**Negative Cognition**

Say, "What words best go with the picture that express your negative belief about yourself now?"

Regarding negative beliefs, if clients do not access their disturbing emotions and can connect with a negative assessment, ask them the following (following Leed's, 2009):

Say, "In your worst moments, when you are remembering some aspect of the event, what thoughts or negative beliefs do you have about yourself?"

---

**Positive Cognition**

Say, "When you bring up that picture or _______, (state the issue), what would you like to believe about yourself now?"

---

**Validity of Cognition**

Say, "When you think of the incident (or picture), how true do those words _______ (repeat the PC) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>(completely false)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(completely true)</td>
</tr>
</tbody>
</table>

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**Emotions**

Say, "When you bring up the picture or _______, (state the issue) and those words _______, (state the NC), what emotion do you feel now?"

---

**Subjective Units of Disturbance**

Say, "On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>(no disturbance)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(highest disturbance)</td>
</tr>
</tbody>
</table>

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**Location of Body Sensation**

Say, "Where do you feel it (the disturbance) in your body?"
· “¿Has sufrido o sufres experiencias negativas como consecuencia de síntomas maniacos y/o impulsividad? ¿Puedes poner algunos ejemplos de los impulsos que has tenido y el tipo de experiencias que han resultado de ellos?”

· Enojo y reacción agresiva por negativa de mi madre a entregarme dinero para una inversión.

· “¿Cuando sentías aquellos impulsos tan fuertes, ¿cómo describirías el impulso?”

· Tenía el derecho de hacerlo y actuar de esa manera.

· “¿Qué acciones seguían al impulso?”

· Tiraba objetos contra el suelo y amenacé a mi madre de golpearla con una silla.

· “¿Recuerdas las sensaciones que sentías en esos momentos?”

· Indignación, encarcelado, injusticia, violencia.
“¿Qué creencias tenías en aquellos momentos?”

Me sentía sano, no aceptaba la negativa. Tenía mi libertad para hacer lo que quiero y era tratado injustamente por mi madre.

“¿Cuál era el resultado del impulso y la acción? ¿Qué consecuencias tenía?

Después me avergonzaba porque la violencia va en contra de mis valores. Es una de las cosas más terribles y locas que hice.

Fortalecer de que es preventivo conectar con la manía y la impulsividad con las consecuencias negativas

“¿ Cuando piensas en las consecuencias negativas de tu experiencia de amenazar a tu madre, ¿Cómo de importante es para ti saber que son un síntoma de tu enfermedad, en una escala de 0 a 10, siendo 0 nada positivo y 10 completamente positivo”.