EMDR: AN EFFECTIVE THERAPEUTIC TECHNIQUE FOR PSYCHIATRIC DISORDERS

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INTRODUCTION

Treating symptoms without knowing the real cause is not recommended in medical practice. We present this case to highlight this important aspect of medical practice and to show the effectiveness of Eye Movement Desensitization and Reprocessing (EMDR), a newly introduced non-pharmacological therapeutic intervention for Psycho trauma and other psychiatric disorders in Pakistan.

CASE REPORT

A 25 year old final year medical student was under psychiatric care for Mixed Anxiety and Depression. She was not showing significant improvement to the pharmacological treatment which she was getting for the last three months. Her condition had rather deteriorated gradually. She started missing her classes, failed in the final professional exam and was reluctant to rejoin college for preparation of supplementary exams. The treating psychiatrists referred her to a psychologist to add on non-pharmacological interventions for her anxiety and depression. During assessment, patient shared with the female psychologist an incident of sexual harassment by one of her class fellows as precipitating factor of her psychiatric disorder. She then revealed symptoms of flash backs of her trauma in the form of images and thoughts. To avoid all cues which triggered those flashbacks, she stopped going to the college and consequently failed in her final professional exams. On reassessment she fulfilled the criteria of Post Traumatic Stress Disorder (PTSD) on Diagnostic and Statistical Manual-IV. The Psychologist tried to help her through counseling using the principles of CBT. The combination of this psychotherapeutic technique and medicines was somehow not producing satisfactory results. Considering her psycho-trauma as major etiological factor of her illness, she was referred for EMDR therapy. As the patient was reluctant to share details of her trauma with any male therapist, the EMDR therapist gave her the option that she might not share the details of the event but would let whatever happens happen in her imagination during the therapy and should not deliberately stop or discard any thing coming into her mind. As the rapport built in the subsequent sessions, she developed confidence and started sharing the details.

In accordance with the standard eight stages of EMDR protocol, sessions started with detailed history to understand one patient and her problems. She showed marked Anxiety and depression on Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI). There was no significant dissociation on Dissociative Experience Scale.

She was explained the theoretical model of EMDR: Adaptive Information Processing (AIP). Safe Place Exercise was taught as a resource to self manage anxiety when required. The selected target image to work on was 'The perpetrator holding her arm and she shouting for help with no response from the class fellows standing around them'. Her negative cognition at the time of assessment was 'I am a BAD GIRL' and preferred Positive Cognition, 'I am a GREAT GIRL'. Validity of her positive Cognition(VOC) at a scale of 1-7 where 1 is completely false and 7 completely true was 2. Subjective Unit of Disturbance (SUDs) at a scale of 0-10 where 0 means no disturbance and 10 highest level of disturbance, she assessed as 10. She felt discomfort in her chest and neck.

In the next phase of the protocol, patient was desensitized by helping her to reprocess her trauma memory using bilateral eye movements. She was very disturbed during the sets and often moved to tears and expressed feeling of shame, guilt, fear and helplessness. She was encouraged to let it go. The level of

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SUDs gradually decreased to zero and validity of her Positive Cognition 'I am a Great Girl' was 5 which improved to 7 after 2 sets. She had no discomfort in her body and session was closed.

In the next session patient shared another trauma memory of similar nature which had been triggered and disturbing her since last session. This trauma memory was reprocessed by using 8 phase Protocol of EMDR as done for the previous trauma.

After seven sessions of EMDR she felt relaxed, developed confidence, could focus on her studies, took exam and qualified MBBS. Her scores on BDI and BAI showed marked improvement. She however had some anxiety as she might have to face her class fellows during her internship. Future Template technique of EMDR helped her to manage this anxiety as well.

DISCUSSION

Old disturbing memories can be stored in the brain in isolation; they get locked into the nervous system with the original images, sounds, thoughts, and feelings involved. The old distressing materials just keep getting triggered over and over again. This prevents learning/healing from taking place. In another part of our brain we already have most of the information we need to resolve this problem; the two just cannot connect[1]. This is what was happening with our patient. The environment of her college and sight of her class fellows triggered flash backs of her sexual trauma. She developed avoidance and stopped going to the college. Once EMDR started, a linkage between two parts of the brain took place which helped resolve the old trauma memory. This is analogous to what happens spontaneously in REM sleep where eye movements help to process unconscious material.

In a short span of 25 years, 'EMDR has evolved from a simple technique to a leading Psychotherapeutic approach with a theoretical model attempting to explain the psychopathology through the brain's Information Processing System'[2]. The current treatment guidelines of the American Psychiatric Association and the International Society for Traumatic Stress Studies designates EMDR as an effective treatment for PTSD[3]. It has been observed that the symptoms of PTSD reduce by 25% after four sessions of EMDR and the gains have been maintained at 3 and 12 months follow up supporting the use of EMDR for treating the symptoms of PTSD[4].

EMDR is an experiential therapy and does not require language proficiency which is a huge advantage in our culture where literacy rate is very low and people are not comfortable to share their personal experiences as was observed in this case.

REFERENCES

1. Farrell D P, The Practice of EMDR in the Management of Psychological Trauma, University of Birmingham, Training Manual Nov 2011: 2.2
2. Shapiro F, EMDR: Adaptive Information Processing and case Conceptualization, Journal of EMDR Practice and Research 2007; Vol 1 no 2: 68-87
3. Havelka J, EMDR: Method of psychotherapy for the treatment of trauma. Psychiatria Hungarica 2010; 25(3):243-250
4. Kemp M, Drummond P, McDermott B. A wait-list controlled pilot study of EMDR for children with PTSD symptoms from motor vehicle accidents. Clinical Child Psychology and Psychiatry. 2010 Jan; 15(1):5-25. Epub 2009 Nov 18.