EMDR therapy and the Treatment of Psychoses Including Schizophrenia

Introduction to the ICONN Model – including case information

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Schizophrenia is viewed as the most severe psychosis and it is characterised by core disturbances of thinking, perceptions and emotions and creates a heavy burden relating to legal problems, stigma and life expectancy\(^1\). After over 100-years experience with what we now know as schizophrenia, only a minority of sufferers could be said to make a full recovery.

The diagnostic boundaries of schizophrenia have expanded and contracted several times from the days of Kraepelin\(^2\), who first referred to the syndrome as *Dementia Praecox*, although most diagnostic systems agree on a ‘core’ group of symptoms. The genetic epidemiological study of schizophrenia by Professor K. Kendler’s (VCU) team looked at vulnerability to schizophrenia, which was transmitted within families and found that it was not limited to ‘core’ symptoms, rather it was a risk to non-affective psychosis. Much of this work was carried out with data from the people of the Island of Ireland: due largely to genetic homogeneity, which minimised the risk of false positives due to population stratification.

**The Case Who Started My Journey**

The seminal client who started my journey of exploration of the application of EMDR therapy to psychosis was Janus; a 40-year-old male referred by his General Practitioner because of problems at work. He gave a history of
emotional and physical abuse by a violent, alcoholic father. He also experienced child sexual abuse (CSA) as a 12-year-old. Janus witnessed his mother attempt to shoot his father during an argument and she also stabbed his father. Following initial assessment a diagnosis of ‘Severe Depression with psychosis’ was made [ICD-10: F32.3]. The patient later sent a letter describing undisclosed psychotic phenomena and a SCID (Structured Clinical Interview for DSM) was completed, which met the criteria for schizophrenia.

At the time of his initial presentation Janus described, “My thoughts hang out of my head in a balloon where everyone can see them, attached to my brain on a string. I try to cut the string with my hand but it doesn’t always work, so I don’t like going out of the house…” These phenomena had a significant functional impact on the patient.

Janus completed a Dissociative Experiences Scale, which is the tool used to screen for dissociative experiences; as recommended in current EMDR Institute trainings. DES scores above 30 are almost always associated with DSM-III-R diagnoses of MPD (Multiple Personality Disorder) or post-traumatic stress disorder. At the start of treatment Janus scored 33 and on completion: 3.

Janus participated in 9 EMDR therapy sessions; having formulated the case and treated him within an EMDR paradigm over a 10-month period. Three sessions were EMDR-reprocessing with the remainder consisting of an initial
assessment, history taking and psychoeducation, in keeping with the 8-phase model of EMDR therapy. EMDR therapy was introduced at the 8-month time-point in his treatment journey. He had been in receipt of the orthodox medication treatment with antipsychotics and other relevant psychoactive medications. The drug treatment plan included the selective serotonin reuptake inhibitor – paroxetine (initiated by his G.P.); this was increased to 60mgs daily, incrementally over 10-weeks and he remained on this dose for 18-months. A second-generation antipsychotic medication, quetiapine was started after initial assessment, increased to a maximum 300mgs twice daily over 3-months and maintained for just under 1-year, when it was then reduced over 3-months, after EMDR. The tetracyclic (noradrenergic) antidepressant, mirtazapine, was added at the 8-month time-point to assist with sleep and continued for 5-months, then stopped. These medications had no lasting beneficial effect on his ‘psychotic’/dissociative phenomena clinically.

Psychoeducation included a description of the EMDR paradigm; the Adaptive Information Processing model of Shapiro⁶ and McLean’s Tribrain Model⁷. There were 3 sequential targets in the EMDR reprocessing sessions:

1. The delusion that his neighbours could see his thoughts in balloons
2. An episode of overwhelming emotion, at work
3. His relationship with his abusive father
After the last EMDR reprocessing session he was no longer actively psychotic. Janus has been euthymic (normal mood) and free of psychotic phenomena for over 7 years. He has also been medication-free for the same period.

**Background**

Scharfetter and Moskowitz⁸ argue that Bleuler’s schizophrenia⁹ ¹⁰ has a stronger link with dissociation theory, paralleling the work of Janet and Paulhan⁸ rather than with Freud’s repression-based model. When Bleuler coined the term ‘the schizophrenias’ 4 other terms existed that all drew explicitly on the dissociation model⁸.

25 to 40% of those currently with a diagnosis of schizophrenia would meet criteria for, ‘Dissociative Schizophrenia’¹¹, which models an environmental aetiology for schizophrenia and presents the possibility of psychotherapeutic treatments. However, the current biological model means that treatment is focussed on medication. Although two thirds of Dissociative Identity Disorder (DID) cases meet structured interview criteria for schizophrenia they can achieve integration, at which stage their psychotic phenomena go into long-term remission¹¹; Janus is a case in point. Repatriating schizophrenia into the dissociative spectrum would facilitate research and the development of psychotherapy in schizophrenia. Janus demonstrates that EMDR therapy is effective for a case meeting DSM criteria for schizophrenia; Janus also met the criteria for dissociative schizophrenia¹¹ – as proposed by Colin Ross MD.
Jaspers\textsuperscript{12} described primary delusions as being psychologically irreducible and particularly characteristic of schizophrenia. This widely held belief that delusions and hallucinations in schizophrenia are meaningless is not only untrue; they hold the key to successful psychotherapy. Psychotic phenomena are an **ICONN - Indicating Cognitions of Negative Network** and like a computer icon, represent an underlying system; the ‘Dysfunctional Memory Network’ (DMN) of Shapiro’s ‘Adaptive Information Processing\textsuperscript{6}’ (AIP) model and recovery occurs at the level of the DMN, not ICONN content. Janus’ paranoia included, “everyone can see and read my thoughts as they float out of my head in balloons”, this ICONN led to the DMN that had a traumatic aetiology and when it was targeted with EMDR therapy his psychotic phenomena resolved. All psychotic phenomena may serve as an ICONN that the clinician tracks back to the underlying associated DMN, which can be processed within the 8-phase EMDR therapy paradigm. The link between childhood trauma and emerging psychotic symptoms has been demonstrated and recent research has replicated this association, which supports the logic for using EMDR to target the original traumatic material\textsuperscript{13}. Sometimes phenomena are more dynamic as with ‘voices’ and Ross advocates engaging ‘voices’ in dialogue\textsuperscript{11}, which is similar to ego-state work which Carol Forgash has championed in combination with EMDR therapy\textsuperscript{14}. In addition to this case in a chronic patient, a Korean study\textsuperscript{15} has shown that EMDR therapy has efficacy for individuals in an acute schizophrenic episode. EMDR therapy has
shown potential for use in patients with schizophrenia and further research is warranted. These are exciting times.
REFERENCES:

5. Ross CA, al e. *Dissociation 1988 1(3).*
SCID (Box…)

The following are extracts from his completed SCID:

- He was fully orientated and cognitively intact
- There were delusions of: reference, persecution, passivity, grandiosity and religious delusions
- Auditory Hallucinations; including command hallucinations
- He reported his 1st psychotic phenomena at 12 years-of-age
- When the psychotic phenomena were at their worst they had a moderate effect on function
- The longest duration of active psychotic phenomena was 22 years
- He describes being prodromal from 11 years-of-age (his mother tried to shoot his father at this time)
- Psychological precipitants: abuse; home environment
- Insidious onset (>6 months)
- Scores for depression (12 years-of-age he reports his worst depression)
- Reports “low mood” for most of life
- No mania; No schizoaffective phenomena
- Major depression & delusions / hallucinations co-occurred
- Delusions / hallucinations were present when NOT depressed (24 months on the longest occasion)
- No alcohol dependence
- No illicit drug use
- Level of functioning across lifetime; moderately good
- Moderately full life
- Significant deterioration in function at times of psychosis
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**Criteria for Dissociative Schizophrenia (after Colin Ross)**

A type of schizophrenia in which the clinical picture is dominated by at least three of the following:

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<th>Present in Patient Janus</th>
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1. Dissociative amnesia
2. Depersonalization
3. The presence of 2 or more distinct identities or personality states
4. Auditory Hallucinations
5. Extensive Comorbidity
6. Severe Childhood trauma