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EMDR Therapy for Traumatized Patients With Psychosis

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Introduction

The most prominent psychotic symptoms are hallucinations and delusions. *Hallucinations* are perceptual experiences without the corresponding external visual, auditory, olfactory, gustatory, or tactile source. Auditory verbal hallucinations are voices that often say negative things; for example, commands (*"Kill yourself"*), comments (*"He's a moron"*), or threats (*"Let's get rid of him"*). Hallucinations are common in psychotic disorders like schizophrenia, but also occur in other disorders, such as borderline personality disorder (Kingdon et al., 2010), bipolar disorder (Hammersley, Taylor, McGovern, & Kinderman, 2010), depression (Gaudiano, Young, Chelminski, & Zimmerman, 2008), posttraumatic stress disorder (PTSD), and dissociative disorders. In the healthy population, especially in children and adolescents, hearing voices is also a relatively frequent phenomenon (Kelleher et al., 2012).

Delusions are strong convictions that are uncommon in a cultural context and that are maintained despite evidence to the contrary. The delusional content varies widely, but the most prevalent delusion is paranoia (Garety & Hemsley, 1987; Stompe et al., 1999). Paranoia is characterized by threat appraisals in which others are thought to have malevolent intentions. For instance, a patient may think that others are spying on him or are out to get him. Delusions can arise as explanations for anomalous or unsettling experiences, like hallucinations. Although some paranoid thinking exists harmlessly in the healthy population (Freeman et al., 2005), in patients it is usually accompanied with preoccupation, anxiety, and safety behaviors. Paranoid delusions are common in psychotic disorders, and frequent in affective disorders (Goodwin & Jamison, 1990; Haltenhof, Ulrich, & Blanenburg, 1999).

A psychotic disorder is often accompanied by at least one comorbid disorder, such as PTSD, depressive disorder, social phobia, substance abuse and dependence, or obsessive–compulsive disorder (Braga, Mendlowicz, Marrocos, & Figueira, 2005; Buckley, Miller, Lehrer, & Castle, 2009; Grech, van Os, Jones, Lewis, & Murray, 2005). With or without comorbidity, a psychotic condition is usually very disruptive. Patients often experience difficulties with their day-to-day functioning. A comprehensive treatment program offered by a multidisciplinary team is recommended (e.g., NICE Clinical Guidelines for Schizophrenia, 2009). This includes pharmacotherapy, case management, cognitive behavioral therapy (CBT), supported employment, family interventions, and peer support. It is within this comprehensive context that eye movement desensitization and reprocessing (EMDR) can be applied.

Trauma and Psychosis Are Related

Trauma and psychosis may interact in three different ways (Morrison, Frame, & Larkin, 2003).

- First, even with distinct onsets, PTSD can exert a negative influence on psychotic symptoms and vice versa (Mueser, Rosenberg, Goodman, & Trumbetta, 2002).
- Second, the experience of psychotic symptoms can be traumatic and lead to PTSD (Shaw, McFarlane, & Bookless, 1997).
- Third, trauma is a substantial risk factor for the development of psychosis (Matheson, Shepherd, Pinchbeck, Laurens, & Carr, 2013; Varese et al., 2012).

Thus, assessing traumatic life experiences is crucial for creating an individual case formulation within the treatment of psychotic symptoms. Ascertaining the links between trauma, PTSD, and psychosis in patients—by evaluating their occurrence, onset, content, and course—enhances insight and reveals relevant targets for treatment. In this chapter, we will elaborate on these interactions and provide a rationale for the EMDR treatment of these symptoms.

Psychosis and Comorbid PTSD

The prevalence of comorbid PTSD in patients with psychoses is high (12.4–29%; Achim et al., 2011; Buckley et al., 2009; de Bont et al., 2015) compared to the general population (less than 5%) (Kessler, Chiu, Demler, & Walters, 2005; Mueser et al., 1998; Perkonigg, Kessler, Storz, & Wittchen, 2000). Psychotic disorders and PTSD may sometimes even be difficult to disentangle, as both disorders are characterized by intrusive experiences, negative symptoms, and avoidance behaviors (Stampfer, 1990).

Psychosis and PTSD may have independent origins (e.g., a person diagnosed with schizophrenia is involved in a car crash and develops PTSD). One disorder may also cause the other, as is the case in "Post-Psychotic PTSD"; about half of the patients reported PTSD symptoms related to a psychotic episode or admission, directly after dismissal from a psychiatric ward (Shaw et al., 1997). It has been found that although these symptoms spontaneously remit in some patients, a year after dismissal one third of the patients still experienced PTSD symptoms related to their first episode of psychosis (McGorry et al., 1991).

PTSD may contribute to psychotic symptoms and increase relapse rates in psychosis (Mueser et al., 2002). The mechanisms for this include PTSD's high stress levels, sleeping problems, difficulties in coping with situations, and low self-esteem. Furthermore, PTSD is associated with substance abuse and retraumatization. Mueser and his colleagues found that in patients with psychosis, those with comorbid PTSD experience more severe delusions, as well as lower functioning in daily life (Mueser, Lu, Rosenberg, & Wolfe, 2010).

Trauma and Psychosis

More than two thirds of the women and more than half of the men with psychosis report sexual or physical abuse as a child (Read, van Os, Morrison, & Ross, 2005). A meta-analysis found that being traumatized as a child almost triples the chance of developing psychosis in adulthood (Varese et al., 2012). Another meta-analysis showed that people with schizophrenia are 3.6 times more likely than those with other psychiatric disorders and nonpsychiatric controls to have experienced severe childhood trauma (Matheson et al., 2013). Almost all studies found a dose–response relationship: the more severe the trauma, the greater the risk of developing psychosis and the worse the prognosis. Trauma exerts direct and indirect influences on the development of psychotic symptoms. Each route requires its own conceptualization, after which the Standard EMDR Protocol can be applied to achieve symptom reduction or relief.

The Direct Route

Similar to other psychopathology, psychotic symptoms often have their origin in real-life experiences. Direct temporal associations may exist between the stressful or emotional life event and the onset of psychotic symptoms. An example is the development of paranoia after being threatened in a pub (Freeman et al., 2013). In a Dutch study, 70% of the patients who heard voices stated that their voices started after an emotional or traumatic experience (Romme & Escher, 1989).

Even in the absence of a clear temporal association, the content or theme of the psychotic symptom may be meaningfully associated with certain life events. It has been found that auditory verbal hallucinations are directly related to actual life experiences in a significant minority of people hearing voices (Hardy et al., 2005; McCarthy-Jones et al., 2012).

The Indirect Route

Basic assumptions about oneself, others, and the world are included in most cognitive models of psychotic symptoms, for they are thought to be important factors in the development and maintenance of these symptoms (e.g., Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001). Negative core beliefs about oneself (e.g., "I am guilty, weak, defenseless"), and others (e.g., "Other people are dangerous, untrustworthy, bad") can form a cognitive link between traumatic life experiences and psychosis (Fowler et al., 2006; Gracie et al., 2007). Basic assumptions may determine the nature of a delusion, as in "Bad me," or "Poor me" paranoia (Trower & Chadwick, 1995). Similarly, negative responses to critical voices have been found to be associated with negative self-esteem, depression, and early life experiences of maltreatment (Birchwood & Chadwick, 1997). Because traumatized voice hearers view themselves as inferior or powerless, they are also inclined to adopt this submissive stance when relating to their voices. This, in turn, increases the intensity and frequency of the voices, as well as the distress they cause (Birchwood & Chadwick, 1997; Vaughan & Fowler, 2004).

Imagery in Psychosis

Mental imagery appears to be an important factor in the onset and persistence of emotional disorders (Beck, 1970; Hackmann, Surawy, & Clark, 1998). Emerging research shows that mental imagery is also highly prevalent in psychosis. About three quarters of the patients with psychosis report visual imagery related to their delusions or hallucinations (Lockett et al., 2012; Morrison et al., 2002; Schulze, Freeman, Green, & Kuipers, 2013). Morrison et al. (2002) found the following three types of imagery to be most dominant in psychosis:

- Images of feared catastrophes (often in paranoia)
- Visualizations of the perceived origin or content of a symptom (often in voices)
- Images of negative life experiences that are somehow related to the psychotic symptoms (actual memories)

Research

Because people with severe mental illnesses are usually excluded from treatment studies, data on the feasibility of standardized treatment protocols for comorbid psychopathology in this population are rare (Bradley, Greene, Russ, Dutra, & Westen, 2005). Many therapists fear that trauma-focused therapy is dangerous for patients with psychosis, and as a consequence a psychotic disorder has long been an exclusion criterion in almost all PTSD treatment studies (Spinazzola, Blaustein, & van der Kolk, 2005). In fact, psychosis is the most frequently applied exclusion criterion in trials on effectiveness of PTSD treatment (Ronconi, Shiner, & Watts, 2014).

However, times are changing and some studies have shown that it is safe to use trauma-focused approaches for patients with psychosis and comorbid PTSD (Frueh et al., 2009;

Mueser et al., 2008). In a within-subjects controlled case study (N = 10; de Bont, van Minnen, & de Jongh, 2013), EMDR and Prolonged Exposure (standardized treatment manual by Foa, Hembree, & Rothbaum, 2007) were both effective in reducing PTSD symptoms (12 sessions, 90 minutes). These effects were maintained at 3-month follow-up. Dropout was 20% and no serious adverse events were found.

In an open study, outpatients with a lifetime diagnosis of psychosis and comorbid PTSD received six EMDR sessions of 90 minutes each (N = 27; van den Berg & van der Gaag, 2012). Significant improvements were found on PTSD symptoms, depression, anxiety, hallucinations, and self-esteem. The dropout rate was relatively low: 18.5%. One patient had a one-time relapse in drug use; this was the only adverse event. To further test safety, effectiveness, and mechanisms of change, a randomized clinical trial—applying EMDR and Prolonged Exposure for PTSD in patients with psychosis in addition to treatment as usual—was conducted in the Netherlands (de Bont, van den Berg, et al., 2013). Results showed that an eight-session treatment using standard protocols was feasible, effective, and safe (van den Berg et al., 2015). Subjects receiving therapy showed greater reduction in PTSD symptoms and were more likely to achieve loss of diagnosis during treatment than those on the waiting list. The effects were maintained at 6-month follow-up for both treatment conditions. There were no differences in serious adverse events between conditions. Prolonged Exposure and EMDR Therapy showed no difference on any of the outcomes and no difference in dropout (24.5% and 20.0%, respectively).

The only published study thus far that applied EMDR to target psychotic symptoms is a randomized clinical trial in a hospital setting (N = 45; Kim et al., 2010). All patients were admitted for an acute psychotic episode and received extensive treatment, including pharmacotherapy. Three sessions—of either EMDR or relaxation exercises—were added to the treatment as usual. Both groups improved; but as a consequence of the design, the improvements should probably be attributed to the effects of the treatment as usual. No significant differences between EMDR and relaxation were found. Yet, this study demonstrated that EMDR may be accepted by patients with psychosis, and can be applied safely.

Recently, Croes et al. (2014) published three case reports on psychotic outpatients, who received an average of six sessions of EMDR on psychosis-related mental imagery. Results were promising and suggest that it is possible to diminish negative affect related to psychotic imagery. Depressive symptoms subsided and patients reported less safety behaviors and increased cognitive insight. Noteworthy is that these patients reported most profound effects after treatment of mental imagery resembling worst-case scenarios (i.e., flashforwards).

According to these findings, standardized treatment protocols are feasible without adaptations and are effective in treating comorbid PTSD. Serious adverse effects do not appear to occur.

EMDR Therapy for Traumatized Patients With Psychosis Script Notes

Considering the diversity and severity of psychotic symptoms and problems in daily life, one should not expect EMDR Therapy to solve all problems. Patients with a severe mental illness, such as schizophrenia, will usually not be cured by EMDR Therapy. Clearly though, EMDR is a powerful intervention for reducing anxiety levels, delusional preoccupation, or the impact of hallucinations on self-esteem. This is especially the case when EMDR Therapy is embedded in a more comprehensive (cognitive behavioral) treatment approach. In order to intervene efficaciously with EMDR Therapy, one should first select the targeted symptom and then look for meaningful life experiences that caused or contributed to its onset. Merely shooting from the hip will not lead to a better clinical outcome. Rather, therapist and patient should behave like snipers.

In order to enhance diagnostic reliability, the use of validated, standardized measures is recommended. Its purpose is to assess symptoms and problematic functioning, construct a case formulation, and evaluate treatment effects. For instance:

- Mini-International Neuropsychiatric Interview-Plus (M.I.N.I.-Plus; Sheehan et al., 1998); it is suitable for diagnosing Axis-1 disorders and reduces the chance of overlooking relevant comorbidity.
- Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995); it is the gold standard in diagnosing PTSD.
- Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein, & Opler, 1987); it is a semi-structured interview to determine the range and severity of symptoms related to psychosis.
- The Psychotic Symptom Rating Scale (PSYRATS; Haddock, McCarron, Tarrier, & Faragher, 1999); it includes the Auditory Hallucinations Rating Scale (AHRS) and Delusion Rating Scale (DRS), and is an excellent instrument for the evaluation of treatment effects.

For practical reasons, the most relevant questions are listed in the script in Phase 1.

Case Conceptualization Methods

Case conceptualization refers to the process of gathering information about a patient and integrating this information with a theory on mechanisms that may be causing or maintaining symptoms. A case conceptualization organizes information and guides the process of therapy. It offers insight on what is needed to bring about change and it helps to tailor therapeutic interventions to the individual. We distinguish three different ways of conceptualizing in EMDR treatment, depending on the goal of treatment (summarized in Table 3.1 in the Scripted Protocol). Once the target memory is selected, the Standard Protocol of EMDR can be used.

For case conceptualizations in the context of EMDR, we strongly recommend the use of the First and Second Methods (de Jongh, ten Broeke, & Meijer, 2010; see Figure 3.1). This so-called Two-Method Approach offers a clear rationale for a treatment plan for problems other than PTSD per se (see de Jongh et al., 2010, for a detailed description). It is a highly structured procedure for questioning the patient in the Preparation Phase (Phase 2), in order to select the target memories that need to be processed to achieve symptom relief. In addition, the authors have had positive experiences with adding a Third Method—an expansion of the Two-Method Approach—that deals with unrealistic expectations or negative imagery related to psychosis. First, each of these three case conceptualization methods is briefly described and explained. They are summarized in Figure 3.2. The questions to be asked are all scripted in Phases 2 and 3 of the Scripted Protocol.

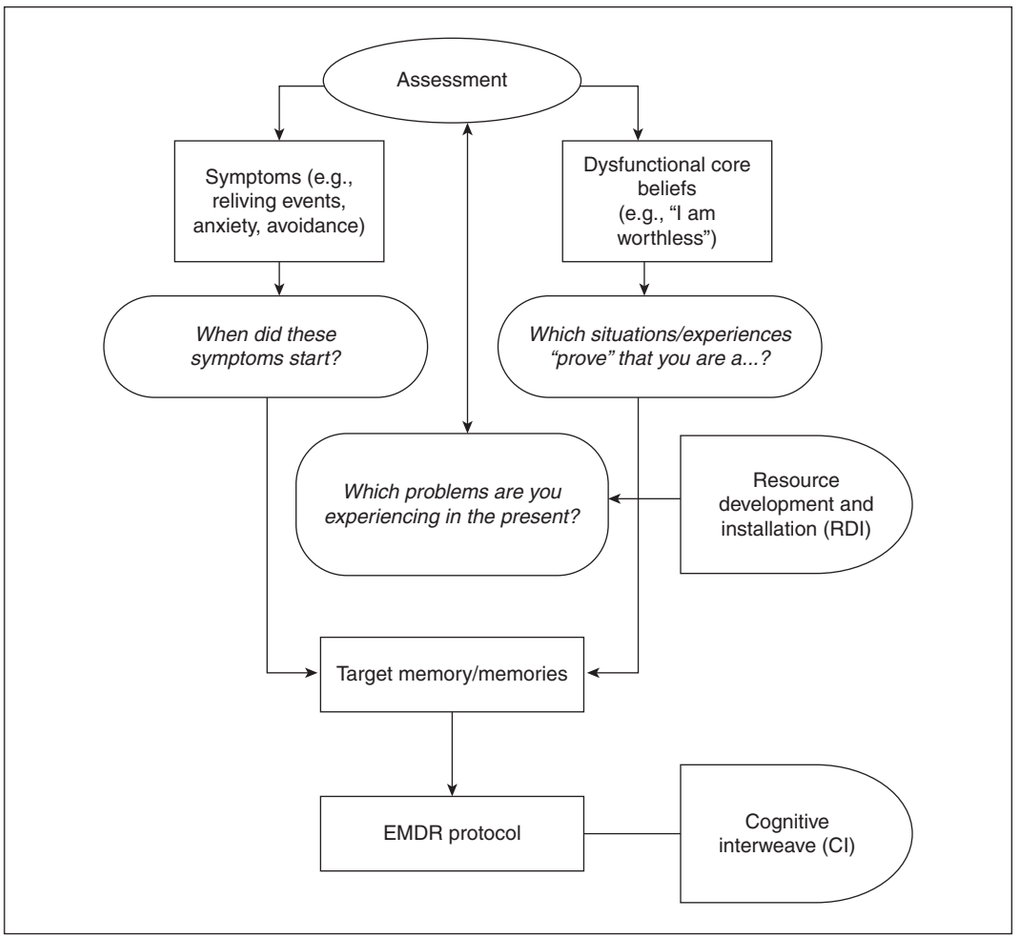

Figure 3.1 Two-method model of EMDR.
De Jongh et al. (2010).

The First Method

The First Method is primarily aimed at conceptualizing EMDR Therapy in the treatment of *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) disorders (which in earlier versions of the *DSM* were referred to as Axis-I disorders), including PTSD. The starting point is the selection of the target *symptom* (or cluster of symptoms), after which etiological and subsequent aggravating events are identified and visually summarized on a timeline (de Jongh, ten Broeke, & Meijer, 2010). This First Method is applicable for psychotic symptoms that can be directly related to certain life events (see The Direct Route section). Prompts may include:

- *"From your point of view, which events are responsible for the current symptoms?"*
- *"Which event(s) led to these symptoms?"*
- *"Which event(s) might have worsened these symptoms?"*

The course of the symptoms is then plotted on the timeline. Memories of experiences that are strongly related to the onset and aggravation of the selected symptoms are processed chronologically to achieve symptom reduction.

The Second Method

The Second Method is used to identify memories that underlie dysfunctional basic assumptions. This method is primarily used in complex psychopathology and personality disorders, where dysfunctional basic assumptions exert their influence. The starting point in the Second Method is the negative dysfunctional basic assumption(s) that is/are associated with the patient's problems. This method should be used if negative core beliefs form a cognitive link between life experiences and psychosis (see The Indirect Route section). Target images of experiences that have led to the formation of negative beliefs about oneself, others, and the world (the so-called proof/evidence) are identified. An analogy that describes the search strategy is that of a Google search, with the learning history of the patient being the World Wide Web and the core belief being the keyword entered. The memories that are most relevant to the credibility of the core belief are selected for processing. Using this Second Method, prompts are as follows:

- *"What caused you to start believing/believe that you are (a)* _____ (state the core belief)?"
- *"What 'taught' you that you are (a)* _____ (state the core belief)?"
- *"Which early situations currently still 'prove' to you emotionally, so to speak, that you are (a)* _____ (state the core belief)?"
- *"Think of a more recent situation that shows you that you are (a)* _____ (state the core belief)."

These pieces of evidence are then ranked in a hierarchy (from strong to weak "proof") and processed with the Standard EMDR Protocol. This is done to deactivate the negative schemas and decrease their credibility.

The Third Method

The Third Method is added to identify the unrealistic and terrifying expectations or negative imageries that are related to psychosis. In some patients, imagery may even be the actual internal activating event that triggers paranoid ideation or rumination about voices. Reprocessing such imagery using EMDR Therapy, and in that way removing the trigger for rumination, may reduce patients' symptoms. Many patients experience intrusive imagery that is related to their psychotic symptoms (Morrison et al., 2002). Imagery can be so frightening (e.g., the mental image of getting murdered in the context of paranoid fears, or imagining the voices like horrific creatures) that it results in extensive avoidance behaviors. Processing the worst-case scenario using EMDR can substantially decrease anxiety. EMDR focused on intrusive psychosis imagery or worst-case scenarios can be conceptualized as flashforwards (Engelhard et al., 2011; Engelhard, van den Hout, Janssen, & van der Beek, 2010; Logie & de Jongh, 2014). If the patient has a still image of the worst moment of his catastrophic ideation in mind, he is asked to make it as detailed as possible. Next, the Negative Cognition (NC), Positive Cognition (PC), Validity of Cognition (VoC), emotions, Subjective Units of Disturbance (SUD), and bodily location are elicited in the usual way to process the target. Since patients generally experience a lack of control when bringing up their flashforwards, they are, in fact, powerless against the—by definition—intrusive image. Therefore, when using EMDR aimed at patients' flashforwards, it usually works best to use the NC, "I am powerless," as the default NC; "I am in control [of the flashforward]" or "I can handle it" (i.e., the flashforward, not the feared event actually happening) should then be used as the standard PC. Next, all the remaining phases of the Eight-Phase Protocol (Shapiro, 2001) need to be executed until a SUD of 0 and a VoC of 7 have been reached. After this is done successfully, patients can more easily be motivated to expose themselves to feared stimuli or execute behavioral experiments that they feared beforehand.

	Key Question
First Method	When did the psychotic symptoms start or worsen? Use the timeline to ascertain the event after which the psychotic symptoms started and when the symptoms grew worse.
Second Method	Which experiences emotionally still "prove" that you are ____? Establish the dysfunctional, problematic beliefs. Google-like approach for target selection based on dysfunctional, problematic beliefs. Look for the "evidence" for the dysfunctional, problematic beliefs.
Third Method	What is the intrusive thought or image that you fear may happen in the future? Look for sheer disaster fantasies or worst-case scenarios. Look for visualization of perceived origin or content of psychotic symptoms.

Figure 3.2 Summary of methods for case conceptualization.

Obstacles and Related Treatment Strategies

Clinical experience is that standard EMDR procedures can be followed, although some remarks and caveats need to be made.

Adaptations to the EMDR Standard Protocol

Especially when cognitive impairments are present or patients' thoughts and feelings are disorganized, it is important that sessions be highly structured and instructions clearly formulated in short sentences. Some formulations in this protocol may thus be stated somewhat differently than in the Standard Protocol.

- *Content of Phases 1 and 2*: Phase 1 is a general inventory of current symptoms and problems. This information is used to get an agreement on the goals of treatment and leads to a decision on what method to use for conceptualization (e.g., First, Second, or Third Method). The actual conceptualization is then beyond the scope of an intake assessment and is an in-therapy assessment, preparing the processing, thus Phase 2. In Phase 2 a structured search strategy is used, leading to testable hypotheses about how experiences and symptoms are connected.
- *Keeping focus*: To assist patients in keeping some focus, in Phase 4 (Desensitization) we prefer instructions like: "Stay with that," or "Concentrate on that," over "Go with that."
- *Back to target adaptation*: When applying EMDR with psychotic patients, we recommend a minor adaptation for going Back to Target. Rather than going back to the *incident*, patients are asked to recall the initial *image* that was used to establish the NC/PC (as it is represented in the mind now, if it has changed during processing). In this way, the image is used as the portal to the memory. It is our experience that this strategy helps patients maintain a straight focus on the memory that is being worked on. Using a clear focus on the aspects of the target image that trigger the affect not only appears to be practically helpful (for instance, when asking to rate the SUD),

but also facilitates connecting of the nodes in the fear network that still need to be processed.

- *Distinction between self-esteem and responsibility*: Another adaptation from the Standard Protocol is in the formulation of the NC and PC. Restricting the categories by a distinction between the cognitive domains of self-esteem (e.g., "I am weak" or "I am a bad person") and responsibility (e.g., "I am guilty") is preferred.
- *Positive lessons*: At the end of every session patients are asked for positive lessons learned during the session ("positive closure"), to consolidate changes and improvements that have occurred.

Ongoing Traumatization by Psychotic Experiences

Patients may be unable to feel safe at all (in spite of using the Resource Development and Installation procedure) when they are continuously being threatened by voices or when they are convinced that every hour may be their last. SUD scores will be high and will not drop, irrespective of the selected target or distracting stimulus. A Cognitive Interweave can be used on this type of "blocking belief," but more cognitive interventions may be needed to challenge attributions and patients' delusional convictions. As soon as there is at least some doubt about delusional ideas or preoccupation, EMDR can be used by directly targeting patients' imagery (Third Method). Almost always, this needs to be followed up with behavioral experiments and exposure assignments, as is described in the end of Phase 8 of this Scripted Protocol.

Cognitive Impairments

Poor concentration and working memory deficits are often present in psychotic disorders (Bora, Yucel, & Pantelis, 2009). Hallucinations can make it even harder to concentrate. Patients may have difficulty remembering EMDR instructions or following the distracting stimulus with their eyes. The therapist continues in the usual way, repeating the instructions.

The working memory theory (Andrade, Kavanagh, & Baddeley, 1997) states that in order to keep a visual memory representation in the visuospatial sketchpad (VSSP) of the working memory, it is constantly retrieved from and reconsolidated in the visual long-term memory. This refreshment procedure requires working memory resources that are limited in everyone, and even more limited in many patients with a psychotic disorder. Simultaneously performing a dual task that taxes working memory (for instance, following the therapist's fingers or listening to beeps) is an extra effort. The dual task competes with the refreshment procedure for the limited resources. This may result in a decrease of the vividness and emotionality of the memory representation. In accordance with this working memory explanation of EMDR (see Gunter & Bodner, 2008), the decline in vividness and emotionality of a memory is indeed related to the degree of taxing of the working memory by the dual (distracting) task (van den Hout et al., 2010). While research shows it is good clinical practice to apply eye movements as the first choice of modality when using EMDR (de Jongh, Ernst, Marques, & Hornsveld, 2013), eye movements at a usual pace may be too demanding for some patients with a psychotic disorder. Yet, enough working memory load is required to compete with the refreshment procedure. This dual processing may require individual fine-tuning. The taxing of working memory can be adjusted by speeding up or slowing down the passes when eliciting eye movements, or switching to tasks that require less working memory capacity such as beeps.

Difficulty With Eye Movements

Saccadic eye movements are the directional movements over a large angle that eyes make in order to construct a three-dimensional view of the surrounding world. Schizophrenia is associated with impaired saccadic eye movements (Krebs et al., 2010). Saccadic eye movements can be slower or impaired by involuntary movements; this may be connected to prefrontal impairments in motor inhibition. However, it is the authors' opinion that saccadic

impairments are unlikely to be an obstacle for EMDR, since the results of a wide array of experimental studies suggest that rather than the eye movements themselves, it is the taxing of the working memory during recall of aversive memories that is the agent of change (van den Hout et al., 2010). Nevertheless, other tasks may be used, for instance, bilateral auditory beeps, tapping, drawing, simple games, and so on.

Antipsychotic Medications

EMDR may work because it activates the cholinergic system in the brain, associated with learning, memory, and attention (Elofsson, von Schèele, Theorell, & Söndergaard, 2008). Both antipsychotic medications and medication preventing motor side effects of antipsychotics (e.g., hydrochloride) can affect cholinergic receptors. It is uncertain whether EMDR is less effective when patients are on these medications, but it might be the case. If a patient is not responding and, at the same time, is heavily medicated, consider lowering the dosage.

Low Affective Expression

It can be difficult to judge the distress that a patient experiences during EMDR, due to some of the negative symptoms of schizophrenia (e.g., apathy, anhedonia, and affective flattening). Research findings suggest that affective flattening is limited to less emotional *expression*, while the subjective emotional experience remains unaffected (Foussias & Remington, 2010). Therefore, when patients report high SUD scores, while at the same time their facial expressions show no signs of distress, discuss the subjective scale of SUDs with patients to ascertain what is (un)bearable. Engaging patients in this manner is useful in helping them stay within the "optimal arousal zone" or "window of tolerance" (Ogden & Pain, 2006).

Unusual Side Effects and Destabilization

As in other populations, unusual reactions or abreactions may occur. Most patients with serious mental illnesses have a relapse prevention or coping plan that they have established with their caretakers. It is a good thing to discuss this plan, and, if needed, actualize it, before treatment starts.

Psychotic symptoms may increase temporarily in or between sessions. It is recommended to suggest this possibility so patients will not be surprised, and precautions or an action plan can be created together. It is helpful to normalize these types of reactions when they occur (e.g., "Good, this is an indication we are treating the right target because the voices are responding to it") and continue treatment. Also, it is useful to educate patients' social support systems and to improve coping strategies if necessary.

Dissociation is a possible response as well. If this is a familiar response, patients often know what works well for them, if it occurs. Therapists can discuss beforehand what can be done to help stop dissociating. Although uncomfortable, and sometimes exhausting, the dissociative response is always temporary. In our opinion, dissociation is a biopsychological coping mechanism to deal with very high stress levels, and therapists can explain this perspective in the following way:

> *Your stress level rose too high. We'll just wait until the stress is manageable again. Please take your time and do what you have to do to regain control. I'll stay here, with you. Take your time.*

It can be useful to help the patient focus on the here and now, for example, by naming objects in the room or touching things.

Occasionally, other uncommon reactions occur. For instance, one patient kept hearing the beeps that were used as auditory bilateral distracting stimuli for several days after a treatment session. Again, a normalizing attitude is probably best, for these effects have, thus far, always disappeared again.

Therapeutic Stance

The disclosure of traumas, negative schemas, and delusional thinking can cause discomfort. As always, the therapist should be empathic and goal oriented. An inquisitive and self-confident attitude is the ideal combination. For example, when treating arachnophobia, it is important not to show your fear of spiders, and it is preferable that first-aid doctors look unaffected emotionally by blood. It is the same with EMDR and treating patients with psychosis: it is important for therapists to transmit to patients that addressing trauma may be burdensome but harmless. For instance:

> *I am sorry that you experienced such terrible things. While these things are in the past, you are still experiencing memories of them. Memories can be very unsettling, but they cannot really harm you (*give an example such as*, "Your father used to hit you; but the memory of your father cannot"). In treatment, we will work through some of your worst memories to help you experience that you have the strength and resilience to cope. I am confident that you will succeed.*

EMDR Therapy for Traumatized Patients With Psychosis Scripted Protocol

Phase 1: Symptom Selection

Current and Future Concerns

Say, *"Do you experience any psychological problems at the moment? What worries you? Which kinds of things are upsetting you?"*

_____

_____

_____

_____

Say, *"What do you think may happen in the future?"*

_____

_____

Say, *"What triggers these thoughts?"*

_____

_____

Say, *"What are the images you have about what may happen in the future?"*

_____

_____

Say, *"What triggers these images?"*

_____

_____

Say, *"How do you feel as a result of these thoughts and images?"*

Say, *"What is happening in your body as a result of these thoughts and images?"*

Say, *"What do you do because of these thoughts and images?"*

Say, *"What is your worst-case scenario?"*

Say, *"What is the most likely scenario?"*

Posttraumatic Stress Symptoms

Say, *"In short, what has your life been like so far? Tell me some of the highs and some lows."*

Say, *"Have you experienced, witnessed, or were you confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of yourself or others?"*

If so, say, *"At the time, did you feel terror, helplessness, or horror?"*

The following questions concern present time (last week or month):

Say, *"Do you often think about or reexperience vivid memories of what happened to you in the past? Are those memories intrusive?"*

Say, *"Do you have recurrent and intrusive dreams of the event?"*

Say, *"Do you sometimes act or feel as if the event were recurring?"*

Say, *"Are you distressed when exposed to situations or symbols that resemble the traumatic event (psychologically/physiologically)?"*

Say, *"Do you try to avoid thoughts, feelings, activities, places, or people that are associated with the incident?"*

Say, *"Are you unable to recall an important part of the incident?"*

Say, *"Do you have a pronounced decreased interest in activities that were once important to you?"*

Say, *"Are you feeling detached or estranged from others?"*

Say, *"Are you feeling flat or down?"*

Say, *"Do you have a sense that your future will be short?"*

Say, *"Have you had problems falling or staying asleep?"*

Say, *"Have you felt especially irritable or showed strong feelings of anger?"*

Say, *"Have you found it difficult to concentrate on what you were doing or on things going on around you?"*

Say, *"Have you been especially alert or watchful, even when there was no real need to be?"*

Say, *"Have you had any strong startle reactions?"*

For all of the above symptoms, if an answer is positive, ask the following questions with regard to that symptom:

a. Examples: Say, *"What is that like?"*

Frequency: Say, "*How much of the time in the past week/month did you feel that way?"*

b. Intensity: Say, *"How difficult was that for you? How much does that interfere with your everyday life at the moment?"*

Based on this information, is there an indication for the treatment of frequent and disturbing trauma-related symptom(s)? ☐ Yes ☐ No

Symptom(s): _____

Onset: Say, *"When did you first start experiencing this/these symptom/s?"*

Psychotic Symptoms—Delusional Ideas

Say, *"Do you ever feel that others cannot be trusted?"*

Say, *"Do you ever think that others are after you, are spying on you, or want to harm you in any way?"*

Say, *"Are you convinced others can read your mind or hear your thoughts? Or the other way around?"*

Say, *"Have you had the experience that someone is putting ideas in your mind? Or is controlling you in some way?"*

Say, *"Do you receive messages (on TV, radio, or in newspapers) that are expressed/transmitted especially for you?"*

Say, *"Are you special in some way? Do you have any special gifts?"*

For all of the above symptoms, if an answer is positive, ask the following questions with regard to the symptom(s):

Say, *"Tell me about it. What is it like?"*

Say, *"How often does this happen?"*

Say, *"How disturbing is this for you?"*

Based on this information, is there an indication for the treatment of frequent and disturbing delusional ideas? ☐ Yes ☐ No

Delusion(s): _____

Onset: Say, *"When did you start having these thoughts?"*

_____

_____

Psychotic Symptoms—Auditory Verbal Hallucinations

Say, *"Do you hear voices or other sounds other people cannot hear?"*

_____

If the answer is positive, ask the following:

Say, *"What kind of things do they say?"*

_____

_____

Say, *"What do you think of them?"*

_____

_____

Say, *"Where do they come from?"*

_____

Say, *"Who are they?"*

_____

Say, *"What is their goal?"*

_____

_____

Based on this information, is there an indication for the treatment of frequent and disturbing auditory hallucinations? ☐ Yes ☐ No

Voice(s) sound like: _____

Onset: Say, *"When did you first start hearing these voices?"*

_____

_____

Psychotic Symptoms—Visual Hallucinations

Say, *"Do you have visions while awake? Do you see things that other people cannot see?"*

_____

If the answer is positive, ask the following:

Say, *"What kind of things?"*

Say, *"What do you think of them?"*

Say, *"Where do they come from?"*

Say, *"Why do you see them?"*

Based on this information, is there an indication for the treatment of frequent and disturbing visual hallucinations? ☐ Yes ☐ No

Vision(s): _____

Onset: Say, *"When did you first start seeing these things?"*

Dysfunctional Core Beliefs

Core beliefs are not just thoughts but long-standing enduring beliefs that are generalized and absolute in nature. Unhealthy negative core beliefs undermine self-esteem, impair the ability to solve problems, and/or cause relational problems.

Say, *"What do you think of yourself?"*

Say, *"What do you think about others?"*

Say, *"What do you think about the world?"*

Say, *"Are any of these core beliefs dysfunctional in that it undermines your self-esteem, impairs your ability to solve problems, and/or causes relational problems?"*

Say, *"If so, please give me some recent examples of that."*

Based on this information, is there an indication for the treatment of dysfunctional core beliefs? ☐ Yes ☐ No

Dysfunctional core belief: _____

Onset: Say, *"When did you first start having this negative belief about yourself?"*

Psychiatric History

Say, *"Have you experienced any psychiatric problems and/or psychiatric hospitalizations?"*

Say, *"If so, how did you experience being admitted?"*

Say, *"Have you been in therapy before? If so, what was it like for you?"*

Say, *"Which medications have you taken in the past?"*

Say, *"Which medications have been prescribed and you are taking at the moment?"*

Say, *"Do you take your medication as prescribed?"*

If not, say, *"Why not?"*

Substance Abuse History

Say, *"Are you currently using any drugs or alcohol?"*

If so, say, *"How much?"*

Then say, *"When did you start using these substances?"*

If not, say, *"In the past?"*

Symptom Selection

Say, *"Considering all that, what current symptoms* (e.g., hallucinations, delusions, core beliefs) *should decrease to help you live a fulfilling life?"*

Note: Make sure a symptom (or a cluster of symptoms) is selected!

The purpose here is to formulate the goal of treatment, *not* to identify relevant life experiences.

Proceed to the Preparation Phase and use either the First, Second, or Third Method Protocol, depending on the selected goal, as listed in Table 3.1.

Table 3.1 Indications and Conceptualization for EMDR in Psychosis

Goal	Target	Method
Reduction of comorbid PTSD symptoms	Memories of traumatic life events that are frequently relived	Standard EMDR Protocol
Reduction of psychotic symptoms	Memories of life events that are directly connected with psychosis	The First Method
	Memories of life events that are indirectly connected with psychosis, because in the patient's view these are "proof" of the negative core beliefs	The Second Method
	Relevant flashforwards or psychosis-related imagery	The Third Method

Note: EMDR, eye movement desensitization and reprocessing; PTSD, posttraumatic stress disorder.

Phase 2: Preparation—In General

Be attentive to factors that influence patients' ability to undergo EMDR. When treating patients with psychosis, stabilizing interventions like medication, a crisis coping plan, and case management have often already been implemented. The authors have good experiences applying this protocol without using additional stabilization techniques like Resource Development and Installation. However, therapists should judge the necessity of developing appropriate resources using their clinical expertise, since there are no data that show clear indications.

> Say, *"Now that we have defined the goal of treatment, it is time to provide you with information on the therapy that I think will help you achieve this goal. This therapy is called Eye Movement Desensitization and Reprocessing; in short: EMDR. We will use eye movements to decrease the emotional load of experiences that have contributed to the problems you are experiencing now. Often, the memories of experiences that are treated with EMDR become less vivid, but what is most important is that the distress and negative influence caused by these memories is decreased. Research has demonstrated that EMDR is highly effective in doing so."*

Provide patients with as much information and explanation as needed, but be aware that postponing the start may increase the stress about what is going to happen.

> Say, *"Addressing these memories can be unsettling, but processing them will help you experience that you have the strength and resilience to cope. I am confident that you will succeed."*

> Say, *"To keep the burden of therapy as low as possible, I will use a very structured way of asking you questions. I request you to answer these questions and digress only when I ask you to. I will interrupt when I think we are going off track, is that OK with you?"*

> Say, *"Do you have any questions so far?"*

Proceed to either the First, Second, or Third Method Protocol (see following section), depending on the selected goal as listed in Table 3.1 (at the end of Phase 1).

The First Method

Phase 2: Preparation—The First Method

Say, *"Now we have to find out what memories are crucial to understand the symptoms we are going to work on. What caused them and what made them worse? When we know what elicited and/or worsened these symptoms, we can use EMDR to disarm these memories by reducing their emotional load. You will not forget these memories, but due to EMDR their interference will wane and* _____ (state the selected symptom) *will decrease."*

Say, *"From your point of view, what event or events is/are responsible for the onset of the selected symptom?"*

Say, *"Which event(s) led to this symptom?"*

Say, *"When was that? How old were you?"*

Check, say, *"Are you sure you never experienced these symptoms before that event?"*

Say, *"From your point of view, which event or events is/are responsible for the worsening of the selected symptom?"*

Say, *"When was that? How old were you?"*

On the *x*-axis of the graph, write down the identified events in the patient's life chronologically. On the *y*-axis, chart the severity of one symptom (e.g., voices) over time to see

the correspondence between an event and the increase or decrease in the severity of the symptom. Do a separate graph for each symptom.

Say, *"I am going to write down these events on a timeline so we can see what it looks like."*

Say, *"Next, we'll have a closer look at how your* _____ (state the symptom, e.g., 'voices') *were influenced by these events over time. So we are going to graph them on this timeline* (draw the *y*-axis.*) The x-axis represents time, the y-axis the severity of* _____ (state the symptom*). If an event made it worse, we'll see the graph line increase. Do you understand what I mean?"*

Say, *"You weren't born with* _____ (state the symptom), *right?"*

Draw the graph line, starting from the intersection of the axes. The severity is (close to) zero, until the event that caused the symptoms occurred.

Say, *"Please complete this graph. If an event made it worse, the line rises. Yet, it may very well be that* _____ (state symptom) *has not been present to the same degree ever since, so the graph may also go down during certain times in your life."*

Note: All relevant memories will be reprocessed in chronological order.

Always start with the memory of the event that is hypothesized to have led to the symptom at first (the conditioning experience), unless there is a good reason to assume that a certain memory very strongly increased a symptom (a striking rise in the graph line, resembling a strong deterioration).

Phase 3: Assessment—The First Method: Event That Caused Psychotic Symptoms to Start

Traumatic Memory

Say, *"I am sorry that you experienced such terrible things. While these things are in the past, you are still experiencing memories of them. Memories can be very unsettling, but they cannot really harm you* (give an example such as, "Your father used to hit you, but the memory of your father cannot"). *In treatment, we will work through your worst memories. This will help you experience that you have the strength and resilience to cope. I am confident that you will succeed."*

Say, *"I would like you to describe the incident that caused your current symptoms. You need not go into much detail. Just give a general account of what happened. It's how you remember the incident that is most important, not what actually happened."*

Make sure that the patient tells the entire story, starting where the memory begins to the point where the traumatic experience ends.

Say, *"When you bring up the incident, what is the worst moment for you now?"*

Say, *"Stop the film at that moment so that you can get a snapshot of this part of the incident. The snapshot is not the image of the moment that was most difficult for you then. Describe the image that is the most difficult to see now, looking back. Please describe this image to me in detail."*

Say, *"Where are you in it?"*

If the patient has difficulty understanding, say the following:

Say, *"Imagine that you have a photo album in your mind, and that this photo album contains photos of how you remember the incident and you are present in all the photos. Which photo is the worst for you to look at now?"*

Help the patient to focus by saying the following:

Say, *"What do you see in the image?"*

Say, *"Where are you in the image?"*

A drawing can be made of the image, if desired.

Say, *"Please draw a picture of how this worst moment is represented in your mind."*

Listen for cues about the cognitive domain the NC is in. The narrow categories facilitate connecting of the nodes in the fear network that still need to be processed:

- Responsibility and guilt: "I am guilty" ☐ Yes ☐ No
- Control: "I am powerless/helpless" ☐ Yes ☐ No

- Self-esteem: "I am a bad person," "I am worthless/stupid" ☐ Yes ☐ No
- Safety in relation to the image: "I am still in danger" ☐ Yes ☐ No

Check by saying the following:

Say, *"Just to make sure. Is this the image that is the most difficult for you to think about <u>now</u>? Or, is it mainly what was worst for you <u>then</u>?"*

_____

Negative Cognition (NC)

Help the patient to stay in the present!

Say, *"What we need to discover next is why this image is still so disturbing for you, when you bring it up now. This probably has to do with a negative conclusion that you have drawn about yourself in relation to the incident. What conclusion is that?"*

_____

_____

Say, *"What is it that still makes this image so awful for you?"*

_____

If the answer is not at a level of identity, continue to question the following until the patient reaches an "I am . . ." statement that may serve as an appropriate NC:

Say, *"What words express the negative belief about yourself that go best with the image? How would you describe such a person?"*

_____

Say, *"What does it say about you as a person?"* _____

Say, *"What would you call such a person?"* _____

Say, *"What is this sort of person often called?"* _____

NC: _____

Before going any further, check the NC by noticing if the following criteria are met:

- Dysfunctional? ☐ Yes ☐ No
- Statement about oneself as a person? ☐ Yes ☐ No
- Valid in the here and now? (Expressed in present tense!) ☐ Yes ☐ No
- Emotionally charged? ☐ Yes ☐ No

Positive Cognition (PC)

Say, *"When you bring up that image again, what would you prefer (like) to think about yourself, instead of* _____ (state the NC)?"

_____

_____

Listen for cues about the cognitive domain the PC is in. Unless the patient objects, the PC is in the same domain as the NC.

- Responsibility and guilt: "I did what I could," or "I am innocent" ☐ Yes ☐ No
- Control: "I can do it," "I can handle it," or "I can manage it" ☐ Yes ☐ No
- Self-esteem: "I'm okay," "I'm worthwhile," "I'm competent," or "I'm fine" ☐ Yes ☐ No
- Safety: "I am safe now" ☐ Yes ☐ No

PC: _____

Validity of Cognition

Say, *"When you look at the image, how true do those words* _____ (repeat PC) *feel to you now? On a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Emotions

Say, "When you bring up the image and those words _____ (state the NC), what emotion(s) do you feel now?"

_____

_____

Subjective Units of Disturbance

Say, *"When you bring up the image and you say to yourself* _____ (repeat NC), *how disturbing does it feel to you now? 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?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it (the disturbance) in your body?"*

_____

Note: Proceed with the desensitization of the target image and installation of the PC, linking the PC with the image (see Phases 4 and 5, and further).

When finished, return to Phase 3/Assessment (see the following section) and repeat the procedure on memories of event(s) that caused symptoms to worsen.

Phase 3: Assessment—The First Method: Event That Caused Psychotic Symptoms to Worsen

Traumatic Memory

Ensure that the patient tells the entire story from where it began to the point where the traumatic experience ended.

Say, *"I would like you to describe the incident that caused your current symptoms to worsen. You need not go into much detail. Just give a general account of what happened. It's how you remember the incident that is most important, not what actually happened."*

Say, *"When you bring up the incident, what is the worst moment for you now?"*

Say, *"Stop the film at that moment so that you can get a snapshot of this part of the incident. The snapshot is not the image of the moment that was most difficult for you then. Describe the image that is the most difficult to see now, looking back. Please describe this image to me in detail."*

Say, *"Where are you in it?"*

If the patient has difficulty understanding, say the following:

Say, *"Imagine that you have a photo album in your mind, and that this photo album contains photos of how you remember the incident and you are present in all the photos. Which photo is the worst for you to look at now?"*

Help the patient to focus by saying the following:

Say, *"What do you see in the image?"*

Say, *"Where are you in the image?"*

_____

_____

A drawing can be made of the image, if desired.

Say, *"Please draw a picture of how this worst moment is represented in your mind."*

Listen for cues about the cognitive domain the NC is in. The narrow categories facilitate connecting of the nodes in the fear network that still need to be processed:

- Responsibility and guilt: "I am guilty" ☐ Yes ☐ No
- Control: "I am powerless/helpless" ☐ Yes ☐ No
- Self-esteem: "I am a bad person," "I am worthless/I'm stupid" ☐ Yes ☐ No
- Safety in relation to the image: "I am still in danger" ☐ Yes ☐ No

Check by saying the following:

Say, *"Just to make sure. Is this the image that is the most difficult for you to think about now? Or, is it mainly what was worst for you <u>then</u>?"*

_____

Negative Cognition

Help the patient to stay in the present!

Say, *"What we need to discover next is why this image is still so disturbing for you, when you bring it up now. This probably has to do with a negative conclusion that you have drawn about yourself in relation to the incident. What conclusion is that?"*

_____

_____

Say, *"What is it that still makes this image so awful for you?"*

_____

If the answer is not at a level of identity, continue to administer the following questions until the patient reaches an "I am _____" statement that may serve as an appropriate NC:

Say, *"What words express the negative belief about yourself that go best with the image? How would you describe such a person?"*

_____

Say, *"What does it say about you as a person?"* _____

Say, *"What would you call such a person?"* _____

Say, *"What is this sort of person often called?"* _____

NC: _____

Before going any further, check the NC by noticing if the following criteria are met:

- Dysfunctional? ☐ Yes ☐ No
- Statement about oneself as a person? ☐ Yes ☐ No
- Valid in the here and now? (Expressed in present tense!) ☐ Yes ☐ No
- Emotionally charged? ☐ Yes ☐ No

Positive Cognition

Say, *"When you bring up that image again, what would you prefer (like) to think about yourself, instead of* _____ (state the NC)?"

_____

_____

Listen for cues about the cognitive domain the PC is in. Unless the patient objects, the PC is in the same domain as the NC.

- Responsibility and guilt: "I did what I could," or "I'm innocent" ☐ Yes ☐ No
- Control: "I can do it," "I can handle it," or "I can manage it" ☐ Yes ☐ No
- Self-esteem: "I'm OK," "I'm worthwhile," "I'm competent," or I'm fine" ☐ Yes ☐ No
- Safety: "I am safe now" ☐ Yes ☐ No

PC: _____

Validity of Cognition

Say, *"When you look at the image, <u>how true</u> do those words* _____ (repeat PC) *feel to you now? On a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Emotions

Say, *"When you bring up the image and those words* _____ (state the NC), *what emotion do you feel now?"*

_____

_____

Subjective Units of Disturbance

Say, *"When you bring up the image and you say to yourself:* _____ (repeat NC), *how disturbing does it feel to you now? 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?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it (the disturbance) in your body?"*

_____

Note: Proceed with the desensitization of the target image and installation of the PC, linking the PC with the image (Phases 4 and 5 and further).

When finished, return to the assessment and repeat the procedure on the other memories of event(s).

The Second Method

Phase 2: Preparation—The Second Method

List of Dysfunctional Core Beliefs (Obtained in Phase 1)

_____

_____

_____

_____

Say, *"Core beliefs are basic assumptions about yourself, others, and the world. They are largely based on previous life experiences, predominantly experiences from our childhood. Negative core beliefs commonly arise from experiences such as being bullied, physically abused, blamed, neglected, or sexually abused. These experiences make people believe that their negative core belief is true. When these experiences instinctively/emotionally still prove that the core belief is true, it is very difficult for them to think differently."*

Start with the dysfunctional core belief that is most explicitly related to the symptom(s).

Say, *"What would you like to believe about yourself* (others/the world) *instead of* _____ (state negative core belief)*?"*

_____

Say, *"What we are going to work on is that you will be able to believe that you are* ____ (state the positive core belief) *wherever you are, whatever you do, and whatever you are thinking of. To allow this to happen, we are going to remove the evidence for your negative core belief. EMDR will be helpful to process the memories of these negative experiences."*

List of Targets Proving the Dysfunctional, Problematic Beliefs

Collect the "proof" for the first dysfunctional core belief by identifying approximately three relevant experiences in the learning history of the patient. This can be a homework assignment, but it is preferably done within the session, at least for the first belief.

Say, "*Which experiences instinctively still 'prove' to you* _____ (state the dysfunctional belief)*?"*

_____

_____

Or say, *"What have you experienced that still convinces you that* _____ (state the dysfunctional belief)*?"*

_____

Or say, *"What made you (start to) think* _____ (state the dysfunctional belief)*?"*

_____

_____

Note: Often patients provide evidence that is not a single experience but recurrent experiences, or concerning a period of time in life (for instance, bullying). If this is the case, the metaphor of an "archive" in which it is necessary to identify "files" is helpful. Another useful metaphor is that of a Google search in the long-term memory using the negative core belief as a keyword.

Dysfunctional Belief #1: _____
Proof 1.1: _____
Proof 1.2: _____
Proof 1.3: _____

Dysfunctional Belief #2: _____
Proof 2.1: _____
Proof 2.2: _____
Proof 2.3: _____

Dysfunctional Belief #3: _____
Proof 3.1: _____
Proof 3.2: _____
Proof 3.3: _____

Note: Core beliefs and basic assumptions usually evolve in childhood. Sometimes patients only mention recent experiences in relation to their current negative core beliefs (for instance, "I lost my job," or "My wife left me"). If this happens, help patients to look for earlier proof for the targeted belief. It is also possible to work on the later (often confirmatory) experiences, but working on childhood memories will be more effective in reducing the credibility of negative core beliefs in the present.

Phase 3: Assessment—The Second Method: Most Powerful Proof

Say, *"Now, we will have to select the experience we are going to start with. We will start with the experience that emotionally is the strongest proof for* _____ (state dysfunctional core belief) *now. Which one is that?"*

Most powerful proof:

_____

Say, *"I would like you to describe this incident. You need not go into much detail. Just give a general account of what happened. It's how you remember the incident that is most important, not what actually happened."*

Note: Make sure that the patient tells the entire story, up to the point where the traumatic experience ends.

Say, *"When you bring up the incident, what is the moment that is the most powerful, emotional proof for you now?"*

Say, *"Stop the film at that moment so that you can get a snapshot of this part of the incident. The snapshot is not the image of the moment that was most difficult for you then, but the image that is now proving most clearly to you that your core belief* _____ (state the core belief) *is true. Please describe this image to me in detail."*

If the patient has difficulty understanding, say the following:

Say *"Imagine that you have a photo album in your mind, and that this photo album contains photos of how you remember the incident and you are present in all the photos. Which photo is the best proof for you now?"*

If necessary, say, *"Which image represents the entire evidence?"*

Help the patient to focus by saying the following:

Say, *"What do you see in the image?"*

Say, *"Where are you in the image?"*

A drawing can be made of the image, if desired.

Say, *"Please draw a picture of how this worst moment of the incident is represented in your mind."*

Listen for cues about the cognitive domain the NC is in. The narrow categories facilitate connecting of the nodes in the fear network that still need to be processed:

- Responsibility and guilt: "I am guilty" ☐ Yes ☐ No
- Control: "I am powerless/helpless" ☐ Yes ☐ No
- Self-esteem: "I am a bad person," "I am worthless/stupid" ☐ Yes ☐ No
- Safety in relation to the image: "I am still in danger" ☐ Yes ☐ No

Check by saying the following:

Say, *"Just to make sure. Is this the image that is representing the most convincing evidence for you to think about now? Or is it mainly what was worst for you <u>then</u>?"*

_____

Negative Cognition

Help the patient to stay in the present!

Say, *"What we need to discover next is why this image is still so conclusive for you now, when you look back on it. This probably has to do with a negative conclusion that you have drawn about yourself in relation to the incident. What conclusion is that?"*

_____

If the answer is not at a level of identity, continue to question the following until the patient reaches an "I am _____" statement that may serve as an appropriate NC.

Say, *"Which words express the negative belief about yourself that go best with the image? How would you describe such a person?"*

_____

Say, *"What does it say about you as a person?"* _____

Say, *"What would you call such a person?"* _____

Say, *"What is this sort of person often called?"* _____

NC: _____

Before going any further, check the NC by noticing if the following criteria are met:

- Dysfunctional? ☐ Yes ☐ No
- Statement about oneself as a person? ☐ Yes ☐ No
- Valid in the here and now? (Expressed in present tense!) ☐ Yes ☐ No
- Emotionally charged? ☐ Yes ☐ No

Positive Cognition

Say, *"When you bring up that image again, what would you prefer (like) to think about yourself, instead of* _____ (state the NC)?"

_____

_____

Listen for cues about the cognitive domain the PC is in. Unless the patient objects, the PC is in the same domain as the NC.

- Responsibility and guilt: "I did what I could" or "I'm innocent" ☐ Yes ☐ No
- Control: "I can do it," "I can handle it," or "I can manage" ☐ Yes ☐ No
- Self-esteem: "I'm OK," "I'm worthwhile," "I'm competent," or "I'm fine" ☐ Yes ☐ No
- Safety: "I am safe now" ☐ Yes ☐ No

PC:_____

Validity of Cognition

Say, *"When you look at the image, how true do those words* _____(repeat PC) *feel to you now? On a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Emotions

Say, *"When you bring up the image and those words* _____ (state the NC), *what emotion do you feel now?"*

_____

_____

Subjective Units of Disturbance

Say, *"When you bring up the image and you say to yourself:* _____ (repeat NC), *how disturbing does it feel to you now? 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?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it (the disturbance) in your body?"*

_____

Note: Proceed with the desensitization of the target image and installation of the PC, linking the PC with the image (Phases 4 and 5, and further).

When finished, repeat the procedure on the next proof (see earlier).

When finished with all the evidence for this problematic core belief, continue the procedure with the next core belief, and so on.

The Second Method is always part of a more comprehensive treatment. EMDR is integrated or alternated with cognitive and behavioral interventions; for instance, Socratic questioning, probability reasoning, or behavioral experiments. (For more information on CBT, see, for instance: Beck, Freeman, & Davis, 2006; Morrison, Renton, Dunn, Williams, & Bentall, 2004; Wright, Basco, & Thase, 2006).

The Third Method

Phase 2: Preparation—The Third Method

We suggest that you use this method only if patients are aware that their feared scenarios are not fully realistic or that intrusive experiences actually do not deserve that much attention. If there are no doubts about the (psychotic) conviction(s), it is best to start with cognitive and behavioral work first (see Morrison et al., 2004).

Patients can be hesitant or unwilling to execute behavioral experiments or exposure assignments when they fear terrible consequences. If so, desensitizing the worst-case scenario may be helpful; this is also known as using EMDR on flashforwards (see Engelhard et al., 2010, 2011).

Next to reprocessing flashforwards, EMDR can also be helpful when patients experience intrusive imagery, related to the origin, appearance, or content of a psychotic symptom that is not an actual memory of something that has happened. By desensitizing this imagery, emotional involvement and preoccupation can be reduced (van den Berg, van der Vleugel, Staring, de Bont, & de Jongh, 2013).

Intrusive Thoughts or Images (Future Concerns/Psychotic Symptoms Obtained in Phase 1)

_____

_____

In case of feared future events, continue with the Flashforward Procedure (see the following section).

In case of psychosis-related imagery, continue with Visualization of Psychotic Symptom (see later).

Flashforward Procedure

It is important to create a framework that allows and enables the patient's thinking about the impending doom of the worst-case scenario.

> Say, *"What we need to do is figure out is what kind of image is in your mind that makes you anxious about a future confrontation with the thing/the one you fear. What do you fear will happen and will go wrong when you are confronted with the situation you are avoiding now in the worst-case scenario? Basically we should look for your ultimate disaster image."*

_____

_____

To help identify the patient's worst catastrophic fantasy, the therapist may ask additional questions like:

> Say, "*What do you imagine might go wrong if* _____ (state a relevant worst catastrophic fantasy, such as 'Your neighbor will be talking to the police')*?*"

_____

_____

Say, *"In your worst nightmare, what is the worst thing that could happen to you?"*

Ask the patient to bring up the image of the worst-case scenario.

Say, *"What does the most disturbing image look like to you?"*

Say, *"What is the worst or most awful part of that for you?"*

Use this as a target for processing.
Continue with Phase 3: Assessment—The Flashforward Procedure (see later).
The NC is in the domain of powerlessness or threat and arousal is usually high.
Always, the PC is "I can handle this."

Visualization of Psychotic Symptom

In Phase 1, information was collected about psychotic symptoms like hallucinations and delusional beliefs. Delusions can be primary (e.g., "The CIA is spying on me") or secondary to hallucinations (e.g., "The voice belongs to my former boss, who wants to ruin my life"). If the patient has an image of the perceived origin, appearance, or content of a symptom (i.e., activating event), the Protocol can be used. The target can be an image of the persecutor, for instance, or of the patient with a man next to him yelling nasty things through a loudspeaker. The NC and the PC may belong to any domain.

Psychotic Imagery (take from Phase 1 information):

Continue with Phase 3: Assessment—Imagery and Phase 3: Assessment—The Flashforward Procedure

Worst Moment of Feared Future Event

Say, *"If you anticipate what might happen, what is the worst moment for you <u>now</u>? Stop the film at that moment so that you can get a snapshot of this part of it. The snapshot is not the image of what will be the most difficult for you <u>then</u>. Describe the image that is most difficult for you to see <u>now</u>, while anticipating it in the future. Please describe this image to me in detail."*

Say, *"Where are you in it?"*

If the patient has difficulty understanding, say the following:

Say, *"Imagine that you have a photo album in your mind, and that this photo album contains photos of what will happen and you are present in all the photos. Which photo is the worst for you to look at now?"*

Help the patient focus by saying the following:

Say, *"What do you see in the image?"*

Say, *"Where are you in the image?"*

A drawing can be made of the image, if desired.

Say, *"Please draw a picture of how the worst moment is represented in your mind."*

Check by saying the following:

Say, *"Just to make sure. Is this the image that is the most disturbing for you to think about now?"*

Negative Cognition

Say, *"The fact that this image is so disturbing to you probably has to do with the fear that you will not be able to cope with it. Is that right?"* ☐ Yes ☐ No

Say, *"Is, 'I am powerless,' the negative belief about yourself that goes with the image?"* ☐ Yes ☐ No

Unless the patient objects, the NC is "I am powerless."

NC: _____

Positive Cognition

Say, *"When you bring up that image again, would you prefer to believe 'I can handle it'* (the image)*?"*

Unless the NC was not formulated as "I am powerless," the PC is "I can handle it."

PC: _____

Validity of Cognition

Say, *"When you look at the image, <u>how true</u> do those words* _____ (repeat PC) *feel to you now? On a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Emotions

Say, *"When you bring up the image and those words* _____ (state the NC)*, what emotion do you feel now?"*

_____

_____

Subjective Units of Disturbance

Say, *"When you bring up the image and you say to yourself, 'I am powerless,' how disturbing does it feel to you now? 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?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it (the disturbance) in your body?"*

_____

Note: Proceed with the desensitization of the target image and installation of the PC, linking the PC with the image (Phases 4 and 5 and further).

Phase 3: Assessment—Imagery

Most Disturbing Psychotic Imagery

Say, *"Which image represents the most disturbing part of this now?"*

_____

_____

Make sure this is a still image (or a photograph)!

If the patient has difficulty understanding, say the following:

Say, *"Imagine that you have a photo album in your mind, and that this photo album contains photos of* _____ (state psychotic conviction, for instance, 'The people that are out to get you') *and that you are present in all the photos. Which photo is the worst for you to look at now?"*

_____

_____

Listen for cues about the cognitive domain the NC is in. The narrow categories facilitate connecting of the nodes in the fear network that still need to be processed:

- Responsibility and guilt: "I am guilty" ☐ Yes ☐ No
- Control: "I am powerless/helpless" ☐ Yes ☐ No

- Self-esteem: "I am a bad person," "I am worthless/stupid" ☐ Yes ☐ No
- Safety in relation to the image: for example, "I am still in danger" ☐ Yes ☐ No

Help the patient to focus by saying the following:

Say, *"What do you see in the image?"*

_____

Say, *"Where are you in the image?"*

_____

A drawing can be made of the image, if desired.

Say, *"Please draw a picture of how the worst moment of the incident is represented in your mind."*

_____

Negative Cognition

Say, *"This is not a pretty image, but what we need to discover next is why this image is so awful for you. This probably has to do with a negative conclusion that you have drawn about yourself in relation to this image. What conclusion is that?"*

_____

If the answer is not at a level of identity, continue to question the following until the patient reaches an "I am . . ." statement that may serve as an appropriate NC.

Say, *"Which words express the negative belief about yourself that go best with the image? How would you describe such a person?"*

_____

Say, *"What does it say about you as a person?"* _____

Say, *"What would you call such a person?"* _____

Say, *"What is this sort of person often called?"* _____

NC: _____

Before going any further, check the NC by noticing if the following criteria are met:

- Dysfunctional? ☐ Yes ☐ No
- Statement about oneself as a person? ☐ Yes ☐ No
- Valid in the here and now? (Expressed in present tense!) ☐ Yes ☐ No
- Emotionally charged? ☐ Yes ☐ No

Positive Cognition

Say, *"When you bring up that image again, what would you prefer (like) to think about yourself, instead of* _____ (state the NC)?"

_____

_____

Listen for cues about the cognitive domain the PC is in. Unless the patient objects, the PC is in the same domain as the NC.

- Responsibility and guilt: "I did what I could" or "I'm innocent" ☐ Yes ☐ No
- Control: "I can do it," "I can handle it," or "I can manage" ☐ Yes ☐ No
- Self-esteem: "I'm OK," "I'm worthwhile," "I'm competent," or "I'm fine" ☐ Yes ☐ No
- Safety: "I am safe now" ☐ Yes ☐ No

PC: _____

Validity of Cognition

Say, *"When you look at the image, how true do those words* _____ (repeat PC) *feel to you now? On a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Emotions

Say, *"When you bring up the image and those words* _____ (state the NC), *what emotion do you feel now?"*

Subjective Units of Disturbance

Say, *"When you bring up the image and you say to yourself:* _____ (repeat NC), *how disturbing does it feel to you now? 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?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it (the disturbance) in your body?"*

_____

Note: Proceed with the desensitization of the target image and installation of PC, linking the PC with the image (Phases 4 and 5 and further).

Phase 4: Desensitization

Say, *"From the moment you follow my hand, I want you to act as an observer. Observe what comes up. This can be thoughts, feelings, images, physical responses—all kinds of things. What comes up can be clearly linked to the incident, but it is also possible that it seems to have nothing to do with it at all. Just observe what comes up, without judging, without influencing. Just follow my instructions. When starting the procedure, it is important you have a close look at the image in your mind, but as soon as you start doing the eye movements, there is no need to stick to the image, it is just the starting point. We will go back to the image (how it is stored in your head) every now and then, however, to see how disturbing it is to look at it. It is possible that the image will change. Remember it is impossible to do it wrong, as long as you just observe and follow what comes up. OK?"*

Say, *"Before we start, just one more thing: If anything comes up that is extremely distressing, do not stop the procedure, continue to follow my fingers. Just think of it as a train running through a dark tunnel. If you do not want to be there, you should not pull the emergency brake, for then it will take longer to reach the end of the tunnel. Instead of stopping the train, you would do better to speed up. Do you understand? The best thing you can do is to concentrate on my fingers even more. Think of my fingers as the accelerator. OK? So keep your mind at rest and just follow my fingers with your eyes."*

Hold your hand in front of the patient's eyes.

Say, *"Look at my fingers. Bring up the image,* (pause), *and say to yourself* _____ (repeat the NC)*."*

Say, *"Notice the feeling of* _____ (repeat emotion) *in* _____ (repeat location in the body)*."*

Allow the patient time to concentrate, and ask, *"OK, have you got it?"*

Say, *"Follow my fingers with your eyes."*
Provide a series of eye movements of approximately 30 seconds.

Say, *"What comes up?"* or, *"What do you get now?"* or, *"What are you noticing now?"*

Do not start a dialogue!

Say, *"Concentrate on that"* (or *"Go/stay with that"*).

Provide a series of eye movements of approximately 30 seconds.

Say, *"What comes up?"* or, *"What do you get now?"* or, *"What are you noticing now?"*

Do not start a dialogue!

Say, *"Concentrate on that"* (or *"Go/stay with that"*).

Repeat this procedure for 5 to 10 minutes (or shorter if there are no changes in associations for several times in a row). Then, go Back to Target by saying the following:

Say, *"Bring up the original image as it is stored in your brain now. When you look at the image, how disturbing does it feel to you now? On a scale of 0 to 10, where 0 is not disturbing at all or neutral, and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Do not proceed with the Installation of the PC if the SUD > 0!
If the SUD > 0, say the following:

Say, *"Look at the image. What aspect of the image makes you feel so distressed?"*

Or, use the number, and say, "*What do you see in the image that is causing the* _____ (state the number)*?"*

_____

Say, *"Concentrate on that.* (Pause) *Have you got it?"*

_____

Provide a series of eye movements of approximately 30 seconds.

Say, *"What comes up?"* or, *"What do you get now?"* or, *"What are you noticing now?"*

_____

Do not start a dialogue!

Say, *"Concentrate on that"* or, *"Go/Stay with that."*

Provide a series of eye movements of approximately 30 seconds.

Say, *"What comes up?"* or, *"What do you get now?"* or, *"What are you noticing now?"*

Note: Repeat this procedure as long as needed, and go Back to Target every 5 to 10 minutes, until the SUD = 0. Then proceed with the installation of the PC linked to this image (Phase 5, see the following section).

Phase 5: Installation

Say, *"How does* _____ (state the PC) *sound?"*

Say, *"When you look at the image, <u>how true</u> do those words* _____ (repeat PC) *feel to you now? On a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Say, *"Think of the image and hold it together with the words* _____ (state the PC)*."*
Do a long set of eye movements. Do not ask what comes up!

Say, *"When you look at the image, <u>how true</u> do those words* _____ (repeat PC) *feel to you now? On a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Say, "*Think of the image and hold it together with the words* _____ (state the PC)*.*"

Do a long set of eye movements. Do not ask what comes up!

Check the VoC and repeat this procedure until VoC = 7.

If VoC < 7 after repeated (> 20) series of eye movements, check for blocking beliefs.

Say, *"What prevents it from being a 7?"*

_____

_____

Say, "*Where did you learn this* (in your life)*?*"

_____

_____

Continue by reprocessing this issue.

Check the VoC of the PC again, with regard to the (original target) image.

Phase 6: Body Scan

Say, *"Close your eyes and keep in mind the target image, as it stored in your brain now, and the positive cognition. Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness, or unusual sensation, tell me."*

_____

If a sensation of discomfort is reported, this is reprocessed using eye movements until the discomfort subsides. Finally, the VoC has to be checked.

Note: Check whether the unusual sensation is related to emotional distress rather than motor side effects from antipsychotic medication.

Say, *"When you look at the image, how true do those words* _____ (repeat PC) *feel to you now? On a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Phase 7: Closure

At the end of every session, consolidate the changes and improvements that have occurred.

Say, "*What is the most positive thing you have learned about yourself in this session with regard to* _____ (state the incident, theme, or image)*?*"

_____

If the answer is not already on an identity level, say the following:

Say *"What does this say about you?" ("What kind of person* _____*?")*

_____

Say, *"Concentrate on that/Go with that."*

Install with eye movements until no further positive changes occur.

Say, *"Things may come up, or they may not. If they do, great. It is not unusual and it is a sign of reprocessing. You can use a log to write down what triggers, images, thoughts or cognitions, emotions, and sensations come up. Please write down the positive experiences, too. It is best to not use sedatives afterwards so your brain can do the healing. If it is absolutely necessary, use the lowest dose possible. If negative feelings do come up, try not to elaborate on them. Remember, it is still just the old stuff. Just write it down for next time. Of course you can give me a call if you need to."*

Phase 8: Reevaluation

Ask the patient to focus on the target you have already reprocessed and review the responses. This is to check whether positive results are maintained.

Say, *"When you bring up the image that we were working on last time, 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?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Based on this reevaluation, decide whether to move on to a new target (if SUD = 0) or to revisit this target for additional reprocessing and integration (return to Phase 4). If the disturbance level has increased, these reverberations need to be targeted or otherwise addressed.

When it appears that the patient still experiences anticipatory fear of confrontations with certain objects or situations, this should alert you to the possibility of unexplored past traumatic events or psychosis-related imagery that remain to be processed. Once these have all been fully resolved, and/or it is not possible to identify any past event that appears to be relevant to the feared future event, it would then be appropriate to use the Flashforward Procedure.

Flashforward: Worst Moment

Say, *"If you think about what might happen, what is the worst moment for you <u>now</u>? Stop the film there so that you can get a snapshot of this part of it. The snapshot is not of what will be the most difficult for you <u>then</u>, but of what is most disturbing for you now, while anticipating it in the future. Please describe this image to me."*

_____

_____

Say, *"Where are you in it?"*

_____

If patient has difficulty understanding, say the following:

Say *"Imagine that you have a photo album in your mind, and that this photo album contains photos of what will happen and you are present in all the photos. Which photo is the worst for you to look at now?"*

_____

_____

Help the patient focus by saying the following:

Say, *"What do you see in the image?"*

_____

Say, *"Where are you in the image?"*

_____

A drawing can be made of the image, if desired.

Say, *"Please draw a picture of how the worst moment of the incident is represented in your mind."*

_____

Check the following:

Say, *"Just to make sure. Is this the image that is the most disturbing for you to think about now?"* ☐ Yes ☐ No

Negative Cognition

Say, *"The fact that this image is so disturbing for you probably has to do with the fear that you will not be able to cope with it. Is that right?"* ☐ Yes ☐ No

Say, *"Is 'I am powerless' the negative belief about yourself that goes with the image?"* ☐ Yes ☐ No

Unless the patient objects, the NC is "I am powerless."

NC: _____

Positive Cognition

Say, *"When you bring up that image again, would you prefer to believe, 'I can handle it* (the image)*?'"*

_____

Unless the NC was not "I am powerless," the PC is "I can handle it."

PC: _____

Validity of Cognition

Say, *"When you look at the image, <u>how true</u> do those words* _____ (repeat PC) *feel to you now? On a scale of 1 to 7, where 1 feels completely false and 7 feels completely true? I do not mean in the case this feared event would come true—I just mean with regard to this image in your head."*

1 2 3 4 5 6 7

(completely false) (completely true)

Emotions

Say, *"When you bring up the image and those words* _____ (state the NC)*, what emotion do you feel now?"*

_____

_____

Subjective Units of Disturbance

Say, *"When you bring up the image and you say to yourself, 'I am powerless'* (repeat the NC)*, how disturbing does it feel to you now? 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?*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it (the disturbance) in your body?"*

_____

If the patient's flashforward has been fully processed (i.e., the SUD related to the flashforward is zero), and the patient still indicates feeling uncomfortable with future confrontations with certain stimuli or formerly phobic situations, or in case of extensive avoidance behavior, then other procedures need to be used. This includes installing a Future Template. A limited script is provided; for a more elaborated script, see Shapiro (2001, pp. 210–214; 2006, pp. 51–53, or see Appendix A).

Future Template

Ask patients to imagine a future situation that they have avoided, or experienced with a lot of anxiety, or anticipated with anxiety.

Say, *"What situation have you avoided until now, but you are planning to encounter this week?"*

_____

_____

_____

_____

Say, *"Bring up this image, and say to yourself, 'I can handle it.' OK, have you got it?"*

_____

Provide a series of eye movements.

Say, *"Go with that."*

Say, *"Bring up the image again. On a scale of 1 to 7, to what extent do you think you can manage it? Here I really mean the actual event, not just the image."*

1 2 3 4 5 6 7

(completely false) (completely true)

Repeat the procedure until the VoC = 7, as you do with the installation of the PC.
Note: Do not ask for the SUD score.

Other procedures of additional value are the "mental video" procedure, which is part of Shapiro's Phobia Protocol (see also de Jongh, 2009), and the use of exposure in vivo or "behavioral experiments." It is important for patients to achieve a degree of self-mastery and experience that they are able to handle a certain level of anticipatory anxiety and fear with confidence again. The use of these cognitive behavioral procedures can be indispensable. In

the end, patients need to expose themselves to the feared stimulus to learn that their negative expectations actually do not occur. Some patients will do this automatically following EMDR sessions. Others need the structure and rationale of exposure or behavioral experiments. Some need more cognitive work to really challenge their negative beliefs.

Video Check

Say, *"This time, I would like you to imagine yourself stepping into the future. Close your eyes and play a movie from the beginning until the end. Imagine yourself coping with any challenges that come your way. Notice what you are seeing, thinking, feeling, and experiencing in your body. While playing this movie, let me know if you hit any blocks. If you do, just open your eyes and let me know. If you don't hit any blocks, let me know when you have viewed the whole movie."*

_____

_____

If patients encounter blocks and open their eyes, the therapist says the following:

Say, "*Say to yourself, 'I can handle it' and follow my fingers."*

To provide the therapist with an indication regarding patient self-efficacy, have them rate their responses on a VoC scale from 1 to 7. This procedural step may give the therapist feedback on the extent to which patients are capable of in vivo confrontations.

Say, *"When you think of the incident, 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?"*

1 2 3 4 5 6 7

(completely false) (completely true)

If patients are able to play the movie from start to finish with a sense of confidence and satisfaction, they are asked to play the movie once more from the beginning to the end, using eye movements, and the PC, "I can handle it" is installed, analogous to a Future Template.

Say, *"Okay, play the movie one more time from beginning to end and say to yourself 'I can handle it.' Go with that."*

_____

_____

Prepare the Patient for In Vivo Confrontations

Say, *"Many people appear to avoid certain activities for so long that they no longer know how to behave and how to feel secure in this situation. To be able to help further alleviate your fears and concerns, it is important that you learn to counter the negative belief that contributes to this sense of threat and anxiety. Therefore, you need to actually test the catastrophic expectations you have that fuel your anxiety in real life. I would like to ask you to gradually confront the objects or situations that normally would provoke a fear response. It may seem odd, but if you have a positive experience and it appears that the catastrophe you fear does not occur, it helps you to further demonstrate—or to convince yourself—that your fear is unfounded."*

Say, *"I want you to understand that nothing will be done against your will during the confrontation with the things that normally would evoke fear. The essence of this confrontation is that it is safe."*

In Vivo Exposure

In Vivo Exposure is done to reduce avoidance and evoke mastery, while observing that no real danger exists. It is essential that therapists help patients to pay attention to the features of the phobic object or situations that are positive or interesting while being exposed to it.

Say, *"Please describe the most notable features of the situation. Are you noticing any interesting elements about* _____ (state the phobic object or situation)*?"*

_____

_____

To identify negative thought content, say the following:

Say, *"What are you thinking as you pay attention to* _____ (state the phobic object or situation)*?"*

_____

_____

To cognitively reconstruct the situation, say the following:

Say, *"How would someone who is not afraid of* _____ (state the phobic object or situation*) view or evaluate this situation?"*

_____

_____

If needed, give advice to help cope with both the situation and the mental and body sensations. It is helpful to make variations with regard to the stimulus dimensions such as action, distance, and time.

Say, *"Isn't it interesting to notice that now that you are confronted with this* _____ (state the object or situation) *and* _____ (state the catastrophe the patient normally would have feared to happen) *does not occur?"*

_____

_____

Say, *"Do you notice that your anxiety is not as physically harmful as you might have expected?"*

_____

_____

Say, *"These emotional reactions will subside and fade over time. Therefore, it is important that you continue exposing yourself to the feared stimuli as long as you feel that you have achieved a certain degree of self-mastery. Please note that you are gradually learning to feel that you are capable of handling a certain level of anticipatory anxiety with confidence."*

The therapist should make sure that confrontations are repeated so that the reduction in distress is fully consolidated before moving on.

The results can be checked by assessing the validity of the catastrophe.

Say, *"If you would encounter* _____ (state the phobic object or situation) *again, on a scale of 1 to 10, where 1 feels completely false and 10 feels completely true, how true does it feel you are in danger?"*

0 1 2 3 4 5 6 7 8 9 10

(completely false) (completely true)

Summary

EMDR is a valuable intervention in the treatment of various mental disorders, especially if symptoms are associated with negative life experiences. In this chapter, the authors describe possible interactions between trauma and psychosis and offer several methods for conceptualizing a case to facilitate the application of EMDR in the treatment of people with psychosis. Clinical experiences, exploratory studies, and emerging scientific proof of effectiveness are promising and defy the long-standing belief that psychosis is a contraindication for trauma treatment. On the other hand, it should also be clear that EMDR alone is usually not comprehensive enough to treat psychotic disorders, so a combination of effective therapies is advocated. Moreover, we stress the importance of therapist competence. EMDR in the treatment of patients with psychosis should be delivered by well-trained therapists who are familiar with psychosis and cognitive behavioral treatment of psychotic symptoms, and who collaborate in multidisciplinary treatment teams.

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