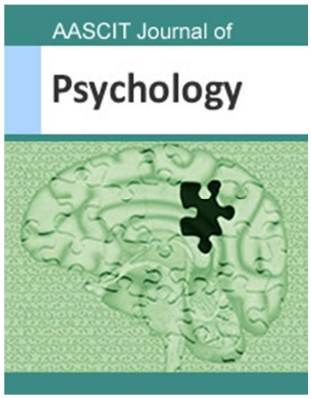
AASCIT Journal of Psychology
2017; 3(6): 85-89
http://www.aascit.org/journal/psychology
ISSN: 2472-9787 (Print); ISSN: 2472-9795 (Online)



Keywords
EMDR,
Major Depressive Disorder,
Negative Cognitions,
Traumatic Memories,
PTSD,
Attachment Disorder,
Scientific Review

Received: October 27, 2017
Accepted: November 14, 2017
Published: December 26, 2017

Treating Major Depressive Disorder with EMDR: Actuality and Prospect

Giudice Mickaël[1], Elkhatib Nancy[1], El Farouki Najwa[1], Veneziano Harmony[1], Gaillard Elea[1], Neveu Adeline[1], Palazzolo Jerome[1, 2, *]

[1]Department of Psychology, University of Nice Sophia Antipolis, Nice, France
[2]Department of International Health, International University Senghor, Alexandria, Egypt

Email address

palazz@free.fr (P. Jerome)
[*]Corresponding author

Citation

Giudice Mickaël, Elkhatib Nancy, El Farouki Najwa, Veneziano Harmony, Gaillard Elea, Neveu Adeline, Palazzolo Jerome. Treating Major Depressive Disorder with EMDR: Actuality and Prospect. *AASCIT Journal of Psychology.* Vol. 3, No. 6, 2017, pp. 85-89.

Abstract

A large volume of studies has proven the handicapping symptoms of depression and raised it to a major health issue. These symptoms include apathy, extended sadness, and impeded sleep and daily activities. The current research is focusing on EMDR (Eye Movement Desensitization and Reprocessing) known for its efficiency in treating disorders characterized by emotional disturbances such as Post-traumatic stress disorder (PTSD). The research's hypothesis suggests that EMDR may be efficient in treating post traumatic major depressive disorder. Several protocols have been studied for this research, Steele's [19], Hofman's [8], Grey and Morrow's [6] protocols. At last, our research explores the different protocols of EMDR adapted to major depressive disorder and its etiology. For the major depressive episode caused by "T traumas", the focus would be on targeting the triggering elements of the episode before working on changing negative cognitions. Regarding the major depressive episode caused by "t traumas", it seemed to require more cognitive interweaving and self-esteem restoring. Finally, building a "secure self" through EMDR adapted protocol has been more relevant for patients whose depression was associated with attachment disorder.

1. Introduction

Depression (as a major depressive disorder or clinical depression) affects wide spectrum of ages. It causes symptoms that are difficult to cope with in daily life such as persistent sadness, difficulty sleeping, early morning awakening or oversleeping, appetite or/and weight changes, anhedonia, sometimes apathy and suicidal thoughts or suicidal attempts. Consequently, more or less negative impacts are observed in the social, family and professional life of the patients suffering from depression.

Different types of depression are included in the modern psychiatric nosography, some with typical features and others with atypical features, in addition to seasonal affective disorder, postpartum depression, psychotic depression or persistent depressive disorder also called dysthymia. In fact, there are no less than twenty types of depressive forms according to the age of onset, the intensity of the disorder, the context of occurrence or its association with an organic disease.

In this article we are concerned with the major depressive disorder occurring after a traumatic event. According to studies, it is estimated that 5% to 15% of individuals experience at least one major depressive episode during their lifetime. Thus, the interest

of better understanding the functioning of this disorder within the trauma context and its management as it is becoming a global health concern.

In this regard, various psychotherapies have been recognized as effective in the management of depression, such as cognitive and behavioral therapies (CBT), systemic therapies, hypnosis and mindfulness meditation. In parallel, during the past decade numerous scientific studies seemed to prove that EMDR could also treat depressive episodes, in addition to its original purpose in treating post-traumatic stress disorder. With EMDR therapy, emotional distress seems to be relieved and negative beliefs are reformulated. The effects of the therapy lead us to suggest that it could be an emotional therapy that could deal with the inaccessible emotional charges in patients with depression.

2. Theoretical Framework

2.1. EMDR Presentation

The Eye Movement Desensitization and Reprocessing was developed by Francine Shapiro. Its soothing effect was fortuitously discovered by Shapiro. Inspired by the rapid eye movement (REM) occurring during paradoxical sleep, which would aim to treat the disruption of events experienced in real life, Shapiro discovered that mimicking the movement of her eye during dream sleep (REM) improved her mood considerably. However, when this disturbance is too strong, the REMs would be insufficient, where the EMDR would precisely relaunch the optimal processing of information. It is based on neurophysiological, cognitive-behavioral but also psychodynamic approaches. EMDR is considered as a brief comprehensive psychotherapy initially indicated for treating post-traumatic stress disorder (PTSD), structured by a standardized protocol of eight phases. In order to treat distressing memories, three types of Alternate Bilateral Stimulations (ABS can be used: visual, hearing, or tactile).

Fortunately, during the past few years several researchers such as Faretta [5], Amano et al. [1], or Marr [13] proved that EMDR is effective in treating phobias, panic disorders, behavioral disorders in dementia and obsessive-compulsive disorder.

2.2. EMDR & Depression

It appears that about 80% of patients with PTSD also suffer from depressive comorbidity. It was proved that depression tended to decrease gradually when PTSD was treated according to Van Etten & Taylor [21], then Ho & Lee [7].

On the other hand, the effectiveness of the protocols treating traumatic memories have rarely been studied for the isolated treatment of depressive disorder. In a study comparing the effects of EMDR to those of Prozac (antidepressant) on traumatized depressive subjects. Results showed that 75% of the subjects who were treated with 8 sessions of EMDR standard protocol could actually get rid of their depression. Some subjects had mixed results, the researchers suggested that with few extra sessions the subjects in question would have been treated [20].

3. Adaptive EMDR Protocols for Depression

3.1. EMDR Protocol Adapted to Depression Related to Traumatic Memories

The adapted EMDR protocol is an adaptive information processing (AIS) based model tackling the traumatic memories, maintaining the symptoms of the major depressive episode.

In order for the adapted protocol to be effective against the emergence, durability and recurrence of depressive episodes, Hofmann et al. [9] suggest in their book to be particularly attentive to four elements: the events triggering the current episode, negative cognitions, the subjective experience of the depressive state and suicidal ideation. Each type of depression may contain some or all four types of memory networks that are targeted by the EMDR protocol. Therefore, the protocol for treating depressive patients must be perfectly adapted to patients. The isolated depressive episodes are usually triggered by one or multiple events. Consequently, these triggering events are targeted in priority. Generally, clinicians and researchers first recommend improving the current state of depression and then working on relapse prevention on a second phase.

3.2. EMDR Protocol Adapted to a Severe Symptomatology of Depression

In some cases of PTSD associated with depression, the symptoms can be too intense to be treated by the standard protocol. Indeed, working on past memories while the present of the patient is too stressful makes the traumatic memories inaccessible as the stressful overwhelming current circumstances interfere with the emanation of the traumatic memories. For other cases, a reversed EMDR protocol [8] is suggested for patients who suffer from a very traumatic past that cannot be tackled first. It consists of treating life's events according to a reversed chronology, which means starting by future problems that the patient will possibly meet, then focusing on the present before addressing past memories. In other terms, we have to treat the disturbing material according to a reversed chronology compared to the standard protocol. However, the reversed protocol proposed by Hofmann [8] does not unfold easily. It requires an activation of the imaginary resources, which Shapiro et al. [17] consider as a memory association related to a positive feeling or well-being that the subject may possibly feel on the body level. Indeed, minimal changes in body sensations can optimize the therapeutic process. To illustrate this, the "safe place" is offered as a resource by many EMDR psychotherapists and was supported by Shapiro [17].

3.3. EMDR Treatment for Depression Linked to an Attachment Disorder

Among “t traumas”, it is possible to include attachment disorders, which refer to emotional and behavioral cognitive disorders. They are always linked to a child’s development that has been made throughout parental care deficiency during early childhood, leading to a distorted attachment. DSM IV describes “reactive attachment disorder” that might impact adulthood and favor the emergence of depressive episodes. In these cases, EMDR therapy is longer, and more adapted protocols have been entailed to create specific cognitive interweavings to generate resources.

Steele [19] proposed an adapted protocol to patients for whom EMDR has been inefficient for treating traumas. Actually, even though their pathological memories have been correctly treated, patients who experienced an attachment disorder do not notice an emotional improvement. The author suggested a protocol to build a secure self, relying on the relationship of the patient and his therapist to replace and overcome parental deficiency. It consists of favoring the enhancement of emotional management through the concept of imaginary support. This concept of imaginary support enables the patient to develop a new positive relationship with himself. This will require helping him in internalizing the experiences of the interpersonal support he felt during childhood and aims at establishing a secure stand. In concrete terms, cognitive interweaving will be proposed to launch him in imaginary experiences where he will identify to a child who receives this interpersonal and educational care. To maximize the chances of healing, Steele [19] suggests opting for slow alternate bilateral stimulations when using this method. Additionally, it is recommended to the patient, to start activities that will enhance his self-esteem between the sessions. The purpose is maintaining this new relationship with one’s self and certainly not triggering a personality change.

Alongside, Steele [19] developed the « therapist-client-child triad», which refers to the relationship between the therapist, the patient's “adult self” and “child self” that will be applied throughout the protocol. The clinician will position himself as a defender of the imaginary child, sometimes as a referent "educator". The patient is invited to develop a kind relationship with the child under the instructions of the therapist such as: "As an adult imagine taking you baby in your arms" it is necessary that the clinician remains responsive and available to the patient. Indeed, the patient focuses on the part of the child himself, on the other hand the therapist contains emotionally the patient as a child and an adult.

3.4. EMDR Protocol for Depression Linked to “t Traumas”

In her work, Shapiro, F. distinguishes “T trauma” which refers to major traumatic incident like car crash, sexual assault, attacks (as described in criterion A of PTSD in DSM V); whereas “t trauma” could be linked to events perceived hurtful and traumatic by the individual. This might be school bullying, repetitive humiliation, depreciation, etc.

Grey and Morrow [6] built up a “targeting plan” or “developmental targeting plan” to treat cases with many “t traumas” rather than a major traumatic memory; or potentially an endogenous factor that might foster depression, like genetic vulnerability.

The first step is to identify the developmental stages of the patient and the eventual generated “t traumas”. These traumas usually seem inaccessible to the patient. There is a particular urge to identify the times where the patient had to resort to external support for failing to develop an “internal control place” associated with a strong attachment to oneself. Consequently, Lewis & Elman [11] indicated that “t traumas” that occurred during crucial developmental stages, lead to the construction of an unsuitable self, referring to an external locus of control. This process can then lead to negative cognitions on oneself, thus favoring the emergence of depressive episodes.

Within this context cognitive interweaving will be used, by treating each target, to restore the relationship between two self-perspectives. Cognitive interweaving is strategies to introduce or elicit the positive information necessary to restimulate in order to link neural networks with adaptive cognitions [16]. Therefore, the therapist enquire questions that generate thoughts, images, or behaviors that will be interweaved to the materiel brought up by the patient. In fact, cognitive interweaving helps in revealing the materiel that has already been stored up, but can also bring out new information hindering the therapeutic process.

In other terms, a dichotomy will be proposed to the patient, between an “adult self” capable to support and protect the child, and a “child self” who is able to receive this support and protection. If the patient is a parent, this makes cognitive interweaving easier.

In fact, this process is based on social representation of the normal development of a child personality that we can have as an adult [14]. Clinically, targets are chosen by selecting the events that favored a “strong internal control locus”. Once the developmental tasks of the targeting plan have been identified, the clinician can follow the standard EMDR protocol. When the negative cognition emerges, then the clinician can propose the cognitive interweaving putting in perspective the two types of self defined previously.

3.5. EMDR, Depression & Self-esteem

In some forms of resistant depression, the mood disorder is rooted in low self-esteem related to shame. Knipe [in 15] suggested that it would be a defence mechanism to defend oneself against the harsh reality of an abused and neglected childhood. This could explain why many patients who have been abused idealise their mistreating parents and fall into guilt and self-blame. Those feelings can then take the form of a chronic depressive syndrome that can be treated by EMDR through the “two chairs technique” [9]. The therapist will place two imaginary chairs facing a wide screen that displays traumatic scenes (for instance, scenes that relate to parental

deficiency). The first chair will be assigned to the "adult patient" and the other will be allocated to the overlooked "child patient". Afterwards, the therapist will inquire the patient to display a traumatic childhood memory. Before initiating the bilateral stimulations (BLS), the "adult patient" will only watch his "child self" on the chair. The "adult self" then will be enhanced in a secure setting created by the clinician, to be able to picture his "child self" traumatic experience.

Knipe [in 15] provided a clinical example to illustrate the session. The therapist ask his patient the following: "Can you, as an adult, picture this child during this event (referring to the abuse's memory)? Yes, can you look at him and witness his shock? I will now move my hand and you go on with picturing this scene. What do you see now?".

4. Discussion

More and more scientists are considering depression as an inflammatory process. According to authors like Krishnade & Cavanagh [in 17], there is clear evidence that just like in infectious diseases, the body would also switch to an extinction mode in the depressive disorder. It seems that process aims at making the person lie down to trigger spontaneous healing. Hence, this leads to the first polyvagal theory developed by Stephen Porges in 2001 [8].

Shapiro [18] expressed in her book that two main nerves would bind the body and the brain:

The vagus ventral nerve which is split into two parts. The first one is a non-myelinated part that is activated when the body tries to retaliate to a threat. The second part is the myelinated one, which allows the person to pursue daily social or intellectual activities. Indeed, its activation induces a required calming down to maintain these activities.

The vagus dorsal nerve soothes the nervous system. Actually, it is associated to recovering when the body struggles against an inflammatory state. In fact, many studies link this inflammatory process with a major depressive state. In other words, depression would be, according to Shapiro [18], the chronic expression of the activation of the vagus dorsal nerve.

Therefore, considering post-traumatic stress disorder (PTSD) highlights a state of hypervigilance where the body is ready to defend himself or simply to run away. In this case, the non-myelinated part of the vagus ventral nerve is overly activated simultaneously with the amygdala. This can last many days and even months to keep this alertness. Alongside, the response of the vagus dorsal nerve occurs immediately. Shapiro [18]. EMDR solutions II. For Depression, Eating Disorders, Performance, and more. New-York: W. W. Norton & Company.

To sum up, the polyvagal theory underlines the subdivision of the vagus nerve into two branches: one allows an immediate freezing in cases of major threat whereas is involved in relationships and soothing activities. This theory may lead to a new path to explain why EMDR tackles efficiently the depressive disorder. Actually, according to Shapiro [18], the Adaptive Information Processing and the polyvagal theory convey that the body and brain aim at reaching a homeostasis state.

Hence, healing traumas or other pathologies with EMDR therapy, gives the body a way to regulate itself and invest energy in activities requiring social implication. Thus, individuals can easily crop up from distress (which is linked to the activation of the non-myelinated part of the vagus ventral nerve) and/or from a depressive state (corresponding to the activation of the vagus dorsal nerve). The defended hypothesis suggests that the desensitization phase of the EMDR protocol, would induce a balanced performance between the various branches of the vagus nerve, throughout the use of alternate bilateral stimulations.

5. Conclusion

EMDR (Eye Movement Desensitization and Reprocessing) is the first-line psychotherapy for treating PTSD. However, the standard protocol could be adjusted to the features, symptomatology and etiology of depression. Thereby, our research underlined different EMDR protocols specialized in the treatment of major depressive episode linked to different type of traumas (both "T traumas" and "t traumas"). Those protocols consist in targeting the trigger events of the depressive episodes to work, afterwards, on negative cognitions. Cognitive interweaving plays an essential role in restoring the patient's self-esteem through the development of an oriented target plan to decrease depressive symptoms. Furthermore, in cases of severe depressive symptoms, a reversed EMDR protocol [9] was developed to reduce the symptoms severity in order to facilitate the treatment of traumatic memories with the standard protocol. Finally, major depressive episodes linked to emotional attachment disorder are treated throughout an EMDR protocol that focuses on establishing a "secure self" using the imaginary support strategies and Knipe's technique.

References

[1] Amano, T., & Toichi, M. (2015). Efficacité de la méthode EMDR-sur-le-champ pour le traitement de symptômes comportementaux chez des patients atteints d'une démence sévère. *Journal of EMDR Practice and Research, 9* (3), E105-E122.

[2] American Psychiatric Association. (2003). DSM-IV-TR: manuel diagnostique et statistique des troubles mentaux (4e éd. rév.; traduit par J.-D. Guelfi et M.-A. Crocq). Paris, France: Masson.

[3] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders DSM-5 (5e éd.). Arlington, VA: American Psychiatric Publishing.

[4] Beck, A. T. (1972). Depression: Causes and treatment. Philadelphia, PA: University of Pennsylvania Press.

[5] Faretta, E. (2014). L'EMDR et la thérapie cognitive comportementale dans le traitement du trouble panique: Une comparaison. Journal of EMDR Practice and Research, 8 (2), E52-E66.

[6] Grey, E. & Morrow, R. (2011, September). Human neuroecology: Attachment, survival, and reflexes in couples. Présentation au congrès annuel de l'American Association of Marriage and Family Therapists, Fort Worth, Texas, Etats-Unis.

[7] Ho, M. S. K., & Lee, C. W. (2012). Cognitive behaviour therapy versus eye movement desensitization and reprocessing for post-traumatic disorder-Is it all in the homework then? Revue européenne de psychologie appliquée, 62, 253-260.

[8] Hofmann, A., & Luber, M. (2009). History taking: The time line. Eye movement desensitization and reprocessing (EMDR) scripted protocols: Basics and special situations, 5-10.

[9] Hofmann, A., Hase, M., Liebermann, P., Ostacoli, L., Lehnung, M., Ebner, F., Rost, C., Luber, M., Tumani, V. (2016). DeprEnd – EMDR Therapy Protocol for the Treatment of Depressive Disorders. Dans M. Luber (dir), EMDR Therapy Scripted Protocols and Summary Sheets. New-York: Springer Publishing CompanyHofmann, A., & Luber, M. (2009). History taking: The time line. Eye movement desensitization and reprocessing (EMDR) scripted protocols: Basics and special situations, 5-10.

[10] Hofmann, A., Hase, M., Liebermann, P., Ostacoli, L., Lehnung, M., Ebner, F., Rost, C., Luber, M., Tumani, V. (2016). DeprEnd – EMDR Therapy Protocol for the Treatment of Depressive Disorders. Dans M. Luber (dir), EMDR Therapy Scripted Protocols and Summary Sheets. New-York: Springer Publishing Company.

[11] Lewis, J. D., & Elman, J. L. (2008). Growth‐related neural reorganization and the autism phenotype: a test of the hypothesis that altered brain growth leads to altered connectivity. *Developmental science*, *11* (1), 135-155.

[12] Lôo, H., & Lôo, P. (2001). La Dépression (5ème éd.). Paris: PUF.

[13] Marr, J. (2013). Traitement EMDR du trouble obsessionnel compulsif: Étude préliminaire. *Journal of EMDR Practice and Research, 7* (2), E29-E43.

[14] Nico, D. & Daprati, E. (2009). The egocentric reference for visual exploration and orientation. Brain & Cognition, 69, 227–235.

[15] Palazzolo, J. (2008). Dépression et anxiété: mieux les comprendre pour mieux les prendre en charge (Ed. rev.). Paris: Masson.

[16] Shapiro, F. (2007). Manuel d'EMDR. Principes, protocoles, procédures. Paris: InterEditions.

[17] Shapiro, F. (2014). *Dépasser le passé, Se libérer des souvenirs traumatisants avec l'EMDR*. Paris: Seuil.

[18] Shapiro, R. (2009). EMDR solutions II. For Depression, Eating Disorders, Performance, and more. New-York: W. W. Norton & Company.

[19] Steele, A. (2007). Developing a secure self: An attachment based approach to adult psychotherapy (2e éd.).

[20] Van Der Kolk, B. A., Spinazzola, J., Blaustein, M. E., Hopper, J. W., Hopper, E. K., Korn, D. L., & Simpson, W. B. (2007). A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance. *Journal of clinical psychiatry*, *68* (1), 37.

[21] Van Etten, M. L., & Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: a meta-analysis.