EMDR THERAPY IN THE TREATMENT OF DEPRESSION

By Arne Hofmann M.D., and Maria Lehnung Ph.D.

Depression is one of the most common psychological disorders in the U.S. Each year 17.3 million people suffer from a major depressive episode. This number represents 7.1 percent percent of all U.S. adults. Depression can cause people to suffer greatly and function poorly at work, at school, and in the family. In adolescents (18-25 yrs.) 13 percent suffer from depression (SAMSA, 2017). This problem has grown significantly during the COVID-19 pandemic.

Depressive disorders show a great deal of variability. Whether depressive symptoms have disappeared completely (complete remission) plays an essential role in the further development of the illness. Residual depressive symptoms represent one of the strongest risk factors for a depressive relapse (Nierenberg et al. 2003). It is recognized that the risk for a depressive relapse—in the case of an incomplete remission of the depressive disorder— is about five times higher than for a patient with complete remission. On average, the expected probability of a full remission two years after completing a successful treatment of a depressive disorder is about 40-50 percent (de Jong-Meyer et al. 2007).

Internationally, experts calculate that only about 25 percent of depressive patients suffer from a single depressive episode. Seventy-five percent of patients suffer from repeated episodes, depending on the length of observation. For about 20 percent of patients, the illness becomes chronic. So for the vast majority of depressive patients, it can be assumed that the illness is either chronic or reoccurs in depressive episodes.

The most frequently used forms of treatment are medication, psychotherapeutic treatment, and a combination of medication and psychotherapeutic treatment. Additional therapeutic processes often used supplementally—in combination with the forms of therapy named above—include light therapy, wake therapy, sports, electroconvulsive therapy (ECT), and transcranial magnetic stimulation (TMS). All of these therapeutic options have improved the treatment of depressive illnesses.

However, many patients suffer from relapses and chronifications, so an increasing number of researchers are searching for new approaches to understanding and treating depressive disorders.

The study results laid out in this article lead to two conclusions:

1. EMDR therapy for primary depression is at least equivalent in its effectiveness as current guideline-based psychotherapy for depression, including cognitive behaviorial therapy (CBT).
2. There are studies that show EMDR therapy may result in a

higher rate of complete remissions from depressive symptoms and possibly a lower rate of relapses. However, this is still the focus of current research and can only be addressed by greater RCT studies with longer follow-up.

DEPRESSION AND STRESSFUL LIFE EVENTS

Two of the most essential influential variables, which have repeatedly been the subject of investigation in the search for new therapeutic approaches to treat depressive disorders, are genetic factors and stressful or traumatic life experiences. Researchers hoped that the treatment of genetic factors would lead to new pharmaceutical treatment approaches. The expensive, over 15-year long search for a candidate gene for depression, however, has been disappointing. So in the last few years, especially due to recent neurobiological trauma research, growing evidence shows that stressful life experiences may be a far stronger risk factor for depression than previously assumed. Even more, studies show a dose-effect relationship between the severity of the stressful or traumatic events and the severity of the following depressive episodes (Teicher et al. 2006).

In other studies a time relationship between stressful life events and the beginning of a depressive episode was found (Kendler 2003). Most of these events, however, seem to have been linked to stressful attachment events: losses, separations, shaming, and humiliations. The losses included also material losses.

Looking from the angle of the adaptive information processing (AIP) model of EMDR therapy, the memory networks that trigger depressive episodes may not fulfill all criteria for the definition of "traumatic memories" (post-traumatic stress disorder (PTSD) Criterion A). However, they completely fit into Dr. Francine Shapiro's description of dysfunctionally stored memories. Since we don't definitively know how these memories are stored, it's better to describe these specific type of memories as pathogenic memories (Hase et al. 2017). Pathogenic memories are biologically active and the cause of symptoms of diseases.

These stressful life events, which often happen shortly before the onset of a depressive episode, are one of the common features that can be seen in many depressive patients.

So identifying and processing these memories that we labeled episode triggers became one of the cornerstones of our EMDR DeprEnd treatment protocol.

EMDR IN THE TREATMENT OF DEPRESSION

From the beginning, when Dr. Shapiro developed EMDR therapy, a number of other clinicians trained by her tried to apply EMDR in patients with depression (Shapiro & Silk Forrest 1997). Many of them were successful and helped patients to recover better. Their work was described in several case studies published in journals and books. However, there were no systematic studies published, and the treatment approaches in these EMDR treatments often differed.

In 2009 Bae and Kim published a case series of two adolescent patients with major depression treated with EMDR therapy. Both had suffered from stressful life events and did not fulfill a PTSD diagnosis. Nevertheless, in a few sessions that focused on the stressful life events, the depressions remitted completely, and the results were stable at a three-month follow-up (Bae & Kim, 2008).

Encouraged by this publication, we started our first retrospective systematic study. In our German EMDR Institute, we asked our senior trainers and consultants if they had treated patients with recurrent depression (without PTSD) with EMDR therapy. We then asked them to contact their former patients and inquire about their current health status and potential relapses.

Together we recruited 10 patients for our study.The number of previous depressive relapses was on average 6.4. All patients had been in outpatient treatment for an average of 60 sessions, including 7.4 EMDR sessions with memory processing. The follow-up from our therapists was 3.6 years after initial treatment ended. The therapists reported that seven of the

10 patients had complete remission at the end of therapy.

In the follow-up, 3.6 years later, they found that nine of the 10 patients now were fully remitted. Only one of the patients reported two short depressive episodes, which were treated successfully with three months of antidepressant medication. The episode trigger for these episodes was the severe disease of her husband. Three of the other patients had also experienced significant stressors (death of partner, myocardial interpretation, and fire in the flat/apartment), but none had experienced a depressive relapse.

We published two controlled pilot studies in the following years, built a network of European researchers, and developed an EMDR protocol to treat depressive disorders (Hofmann, 2016). In 2010 the EDEN research network was founded to further study the application of EMDR in depression (European Depression EMDR Network).

STATUS OF EMDR IN CURRENT RESEARCH

Until today nine randomized controlled studies (RCTs) have been published internationally that have studied the effectiveness of EMDR therapy in treating primary unipolar depression. In all of these studies, EMDR showed at least a similar effectiveness to the comparison treatment. One important study was generously supported by the EMDR Research Foundation (Ostacoli, 2018).

In most of these studies, EMDR treatment resulted in a higher reduction of depressive symptoms or a higher rate of remissions at the end of treatment than the control group. Additionally one of the studies showed a difference after EMDR treatment in a one-year follow-up. In the study, 30 psychiatric inpatients received an average of 8.5 EMDR sessions versus a similar number of standard psychotherapy sessions (Hase, 2018). The study found significant differences in work status after one year: From the six patients who had received TAU treatment and reported back, five were not working. The EMDR group was significantly different: Nine of the 10 patients who responded were currently working. Only one was not working.

Two additional studies looked at the reduction of suicidality in depressive patients after EMDR treatment. One followed 72 patients with a psychiatric crisis and suicidality who had reported at least one traumatic event (which most patients did) and were referred to a crisis team in a mental health hospital. EMDR therapy started within days after the initial assessment. An average of eight sessions of EMDR was applied. In most cases, after 12 EMDR sessions, no follow-up treatment was necessary. At the end of treatment, depression, anxiety, and suicidality were significantly improved, and the patients felt better. In a follow-up 12 months after the end of the treatment, hospital admissions and mental health contacts had been reduced by 78 percent and 69 percent respectively (Proudlock 2020).

In a new meta-analysis nine RCT studies comparing EMDR treatment of primary depression with other interventions, data of 373 participants were analysed (Carletto, 2021). The overall effect sizes of EMDR post-treatment were large (Hedges g=1,07). In three studies that compared EMDR with cognitive behavioral therapy (CBT), the effectiveness of EMDR was at least equivalent.

THE EMDR-DEPREND PROTOCOL

The basic outline of this EMDR DeprEnd protocol was published 2016 in Marilyn Luber's EMDR scripted protocols (Hofmann, 2016) and is described in more detail in the upcoming book *Treating Depression with EMDR* Therapy, which is currently being translated from German (Hofmann et al. 2020).

The six steps of the EMDR DeprEnd protocol are:

1. Get an overview and a treatment plan
2. Check for comorbidity and the need for stabilization
3. Focus and process episode triggers
4. Focus and process negative belief systems
5. Focus and process residual depression related states
6. Initiate relapse prevention

1 *Getting an overview and a treatment plan*

Before treatment can start, several issues need to be taken care of.

Some depressive patients who come for treatment are not in a state where they are able to successfully engage in psychotherapy. They may be suicidal or so depressed that they cannot engage in psychotherapy.

- In these cases the first step of treatment is crisis intervention using all tools available for guideline oriented standard psychiatric care. This includes the exclusion of medical problems like depression caused by medication side effects or thyroid disorders.
- In this assessment phase, the psychosocial network of the patient and stressful relationships or overburdening with tasks in the the family and workplace must be assessed and taken care of. In a similar way, resources in past or present relationships and positive lifestyle behavior like healthy eating, exercise, and stress management should be assessed as resources to be strengthened.
- In the next step, the patient is asked for his or her current symptoms and how they developed. Assessment and diagnosis is completed with

standard tools. In this diagnostic step, a bipolar disorder should be identified as well as other significant comorbidities that can influence the treatment plan.

- In the last step of this phase, a history is taken while considering the patient's current mental state and focusing on the parts of history that are currently necessary to start a treatment plan. In the EMDR DeprEnd protocol, a main goal of history taking is to understand the current symptoms from an AIP perspective and look for the pathogenic memories involved in the patient's current problems.

2 Checking for comorbidity and the need for stabilization

About 60 percent of patients with depression suffer from additional disorders like addictions, anxiety, and different types of trauma-based disorders. In an EMDR treatment plan, the diagnosis and assessment of comorbidity is very important because patients with PTSD, complex PTSD, and dissociative disorders usually need significantly higher doses of EMDR memory processing sessions. These depressive patients often need to be balanced with the EMDR focus on events that are closely linked to the current depressive symptoms.

Another problem is the timing of the first memory processing in a situation where the affect tolerance for the patient is still limited. Nevertheless there are several good EMDR techniques available to assess and tritation to facilitate increasing of affect tolerance and to limit the exposure to high affects during memory processing.

3 Processing episode triggers

A central element in the EMDR DeprEnd protocol is the processing of the memory networks that trigger and maintain the current depressive episode. Mostly these triggering events can be identified by looking at the stressful events that, in most cases, happen one or two months before the beginning of the current depressive episode. In most cases, these are not events that fulfill criterion A of PTSD diagnosis, and most of them could be counted as attachment trauma. Stressful memories that often function as episode triggers for depressive episodes are separations, losses (persons and material losses), and humiliations. Sometimes these episode triggers are clusters of events like a separation of a partnership or the death of a loved one.

A clinical question that often comes up is the question of which trigger episodes need to be processed first. Focusing on the current depression is most often the first clinical step. When planning treatment for patients with recurrent depression, looking at the most recent episode is often helpful.

An important observation from using EMDR therapies with depressive patients is that the depressive symptoms often are reduced significantly after the trigger event is processed with EMDR. This is the reason why we think that these trigger events do not only trigger episodes of depression but maintain them. Following is a case example of using EMDR therapy to process triggering events.

Cathrine is a schoolteacher. She comes to therapy presenting with a recurrent depressive disorder. She has been raised in a difficult family where alcohol played a major role, and she often felt very powerless and alone. Already in her childhood, she experienced depression and sleeping disorders. There was a time during her childhood, though, where she felt well. This was during a time when her mother had decided to leave her drinking husband. They stayed at her grandmother's house where she felt good. Sometime later, her mother decided to move back with her husband and give him another chance. But things got worse for Catherine. The father did not change his behavior, and Catherine was bullied at her new school. When she was only 16, she left her family and moved to a friend's house. From that time on, she developed very well. She says, "That's where I started to live." She managed to get good schooling, became a social worker, and later became a teacher. She says, "I always had good mentors who believed in me." For a long while, she was not depressive at all. She had several relationships with men, and at the times when these relationships broke up, she had short depressive episodes. But each time she also managed to get out of depression. Only once she had brief therapy and was treated with antidepressants. Then

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she met her current husband, and she had many years without any depressive episodes. She was feeling fine, and also had a very rewarding hobby, mountain biking. She was a successful and well-respected teacher at her school.

Sometime later she got a new supervisor at school, a moody woman difficult to deal with. Catherine felt bullied by her. And then she relapsed into a new depressive episode. This episode was rather severe, she was not able to work any longer, and her doctor encouraged her to go to a hospital for some time. When she came back, she felt things where no better than before. Her doctor wanted her to take some medication, but she thought maybe there is a better way, and then she turned up for EMDR therapy.

According to the DeprEnd protocol, we assessed her depression history. Since she was completely symptom free before this present trigger event, we decided to start the EMDR treatment by processing the precipitated event for this current depressive episode, which was connected to her new supervisor.

We started with an event where she was falsely accused of bullying a colleague and had to meet with her supervisor. Her negative cognition was "I am alone." The SUD was 8 to 9, and she felt it in her chest and head. At the end of the reprocessing of this event appeared to be unimportant, the SUD was 1. Her positive cognition was "I am superior." And she was able to experience joy again. This was the first time that she was able to experience joy.

From that day on, she started to improve a lot, and the depressive episode began to remit. The therapist was puzzled that at the beginning of phase five, when discussing the positive cognition, she suggested I'm OK as I am," but this only had a VOC of 2. So we moved on to "I am superior." which felt very true. But the therapist thought: "Why can't she think of herself I am OK as I am? Is there something else we have to address?"

Indeed, in this case, this patient had an additional problem that is a significant risk factor for recurrent depression: a negative belief system.

4 Processing the memories behind negative belief systems

For many patients with depression, it is sufficient to process the trigger event to achieve a full remission of their symptoms. For others this is not the case. They have difficulties identifying the triggering event or events that precipitated their depressive symptoms.

In both situations, it is important to look for negative belief systems. For EMDR therapists, it is often an interesting observation that many of these negative self-referring thoughts change without any additional cognitive intervention after the memory behind these thoughts is processed with EMDR (cognitive changes without cognitive work). This is an effect that we use in treating negative belief systems.

An important sign of a negative belief system is that one or several intrusive negative self-referring thoughts often appear in the patient's everyday life in different situations. In EMDR therapy of patients with depression, it is important to recognize them and write these intrusive thoughts down. The next step is to prioritize these negative beliefs along with their intrusiveness and the disturbance they create in everyday life.

Thinking from the AIP model, the next step is to find the memory network and the important stressful events that are behind this intrusive thought. There are two ways we try to identify these networks in the EMDR DeprEnd protocol.

The first way to identify the networks is to look for Proof Memories. A good way to find these Proof Memories was identified by Dutch researchers (de Jongh et al. 2011). They asked the patient: What memories in your life prove that these negative beliefs about yourself are true? It is interesting how many patients after this question spontaneously remember events that feel for them like a proof for those negative beliefs. The therapist then lists these events and prioritizes the events that look like the strongest "proofs" in the patient's eyes. In the end the therapist has a list of proof events.

The second way to identify the networks behind the negative beliefs is a float back. In some cases, the memory identified this way is from an early age and has a strong proof character.

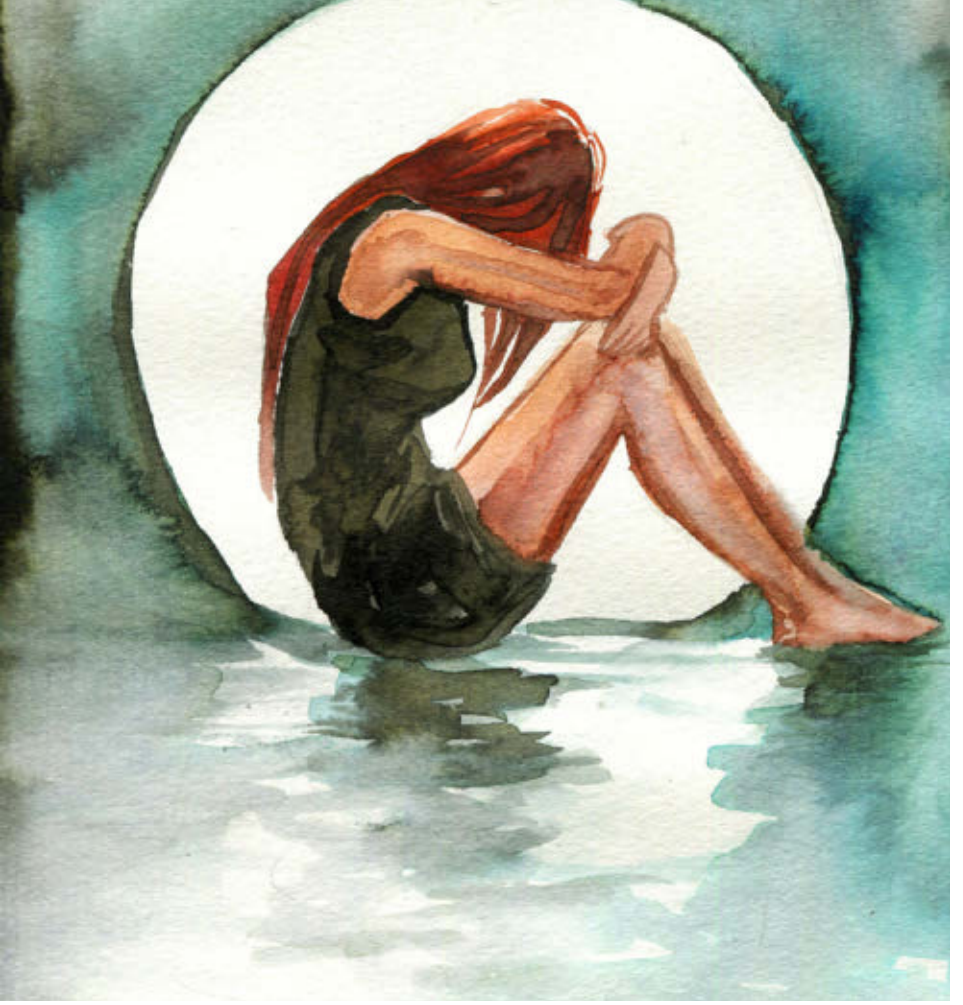
After these steps, we have an overview of the memories that are foundational for the negative belief system and start processing them with EMDR.

In the following case, we will show how this works in clinical practice.

Continuing with Catherine's case, we started out working with processing an episode trigger that had led to the present depressive episode. After processing this episode, Catherine started to get much better. The present depressive episode began to remit.

Yet, both of us sensed that there was still more to do. Her feeling of being an outcast, not belonging, and not being ok and acceptable seemed to be the kind of belief system we talked about earlier in this article. This belief system was strongly interwoven into her life from the beginning.

When we started looking at this belief system, we at first worked with the events around being bullied at school (Proof Memories). But then we found out that similar things also happened much earlier in her life, in her family where she was also treated as an outcast. The touchstone memory



was an event where she was called names by her family.

When we processed this event, the negative cognition was "I am wrong." Her positive cognition was "I am good as I am," but the VoC was only a 3. She felt sad, SUDs were 10 (!). She felt it in her chest.

During reprocessing, she first felt all this pain. Later in the process, positive things appeared, mainly people who had shown her that they believed in her, like her grandmother and later many other people. She also remembered that she had taken the chance to develop her skills in a good and successful way when she had the chance. At the end of the process, the positive cognition was "I'm good as I am," and it felt true. She also felt very relaxed in her body. As in many cases, this process was a breakthrough for her, and her depression remitted completely.

5 Processing depressive and suicidal states

In some of our depressive patients, the processing of episode triggers and negative belief systems is insufficient to resolve the depressive symptoms completely. In many cases, feelings of being depressed or even feeling suicidal appear as body feelings or vague feelings of dysthymia that can be triggered or get worse in certain situations.

If such a depressive state is identified and processed with EMDR, the depressive state can be resolved in most cases, and the patient feels much better afterward.

Below is a case example.

A 40-year-old patient was treated for his third severe depressive episode in an inpatient setting. He was married and had a successful career in the security field. In the hospital, he was treated with EMDR DeprEnd, and the episode triggers of his current and earlier depressive episodes were processed successfully with EMDR. This negative belief system was identified, and the network behind it was successfully processed with EMDR. The patient improved significantly clinically. However, a depressive feeling, mixed with the feeling of energy loss that contrasted with the patient's clinical improvement, persisted.

When asked about this feeling, the patient reported that he remembered the long months of depression as painful and torturing. The patient could identify the worst memory of this period. He had sat on the sofa after duty. It felt impossible for him to follow up on his planned activities. He felt alone and isolated from life, which he could observe through the window on the street below. The situation usually ended in darkness as the patient could not force himself to turn the light on. All this was accompanied by a strong fear that his partner would phone and discover how he suffered.

The image was the view out of the window and a part of the sofa. The negative cognition was "I am a weakling." Feelings of sadness, fear, and disappointment were part of the memory that was experienced with the SUDs of 9. This memory was processed down to a SUD of 0. His positive cognition was "I am motivated," and the VoC went up to 6 in the installation phase.

After this session the well-being of the patient improved significantly.

The second type of state, that will only be mentioned briefly here is the suicidal state. Some people have not only depressive but also suicidal states, and they describe feelings of suicidality that are triggered in certain situations and sometimes perceived as ego dystonic. Sometimes they are connected with earlier suicide attempts. Work with suicidal states is still experimental. Nevertheless, in a number of our

patients, we have observed and treated depressive and suicidal states with EMDR and found both processes went very well. Of course, this should not be done early in therapy but only when appropriate measures have been taken to keep the patient safe during memory work.

Even if EMDR therapy can result in a full remission, this is insufficient to keep away depressive relapses. So it is crucial to convince patients, especially if they have had recurrent depressive episodes, not to stop EMDR treatment here, even if they feel well, but do step six of the EMDR DeprEnd protocol: relapse prevention.

6 Relapse prevention

Relapse prevention plays a significant role in the EMDR DeprEnd protocol. Often in depression therapy, therapists are happy and content when the depressive episode remits, and patients can go back to a normal life. In many cases, relapse has not been addressed, maybe out of fear of disturbing patients and maybe even triggering them into a new depressive episode. Yet, patients who have experienced several depressive episodes nearly always fear the relapse, whether they mention it or not. And so, addressing a potential new relapse into a depressive episode is the best relapse prevention we can do.

There are several aspects, aside from lifestyle or systemic interventions, that must be considered. It is important to also process issues that are potential contributors to future depressive episodes.

At first, the fear of the patient herself, the fear of experiencing a new depressive episode, might be addressed and reprocessed. We usually do this by future template. We ask for the patient's image of a possible new depressive episode. Many patients have this image clearly in their minds. Many patients report significant relief after this future template work.

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We can also ask patients for trigger situations that might trigger a new depressive episode. For these potential situations, we can install specific resources with EMDR so that these situations can be handled well by the patient in the future.

Installing positive resources always implies focusing on positive body states. This fact may be the reason for the powerful changes and developments we see, especially in depressive patients when using this resource installation. They feel a positive state in their body. That's a big difference.

The EMDR DeprEnd protocol has shown its usefulness in studies and in clinical practice, especially in cases of recurrent and chronic depressive patients who report stressful events that precede the beginning of their depressive episodes.

Dr. Arne Hofmann, M.D., is a specialist for psychosomatic and internal medicine, founder of the EMDR-Institute Germany, and one of the heads of an EMDR trauma hospital in Wesseling, Germany. He learned EMDR in 1991 from Dr. Francine Shapiro and has introduced it in German-speaking countries. Dr. Hofmann is a co-founding board member of EMDR Europe, a co-founder of the German-speaking Society of Traumatic Stress Disorders (DeGPT), and the German National Guideline Commission on PTSD. He is also a steering committee member of the EMDR Council of Scholars, a council that EMDRIA has organized to build an international group of experts to help chart the future of EMDR therapy. He teaches, researches, and publishes psychological trauma, depression, and EMDR. He has been teaching at Cologne, Boston, and Peking Universities. He co-founded the European EDEN research group that has co-published five controlled studies that have shown that EMDR is highly effective in the treatment of depression. His work has received several awards, including the EMDRIA Outstanding Research Award 2015 and 2018 and the Order of Merit of the Federal Republic of Germany.

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