Ego Strengthening and Eye Movement Desensitization Reprocessing in Post Traumatic Stress Disorder

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Introduction

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder, which occurs after exposure to overwhelming stress like combat, rape, serious accidents, violent crime and other catastrophic events. The essential characteristics of the condition are recurrent intrusive memories, images, thoughts or dreams of the trauma, persistent arousal, emotional numbing and avoidance of the situations reminiscent of the trauma. 15-20% of individuals experiencing significant trauma are known to develop PTSD [1]. Although anxiolytic, anticonvulsant, antipsychotic and antidepressant drugs have been tried, none have been consistently associated with improvement [2]. Eye Movement Desensitization Reprocessing (EMDR) is being increasingly utilized as a valid method of treatment for this distressing condition [3-7]. Ego Strengthening (ES) is a sequence of simple psychotherapeutic suggestions given under hypnosis [8]. A long standing case of PTSD treated with EMDR and ES is reported.

EMDR is done as follows [9]-

1. The therapist first explains the rationale in this way. "When trauma occurs, it seems to get locked in the nervous system with the original picture of the memory, its sounds, thoughts and feelings. The eye movement that we use in this method unlock the nervous system and allow the brain to process the experience".
2. Image : Patient is asked to focus on the traumatic memory and get an image. "*Make a picture of the memory*".
3. Negative Cognition (NC): Elicit a belief statement about the memory "Express your belief about yourself now". e.g. "*I am helpless*", "*I am powerless*", etc.
4. SUDS (Subjective Units of Discomfort): Ask the patient to assess the distress on a subjective scale of 0-10.
5. Location of body sensation: Ask the patient to identify the physical location of distress.
6. Positive Cognition (PC): Elicit a preferred belief statement about the memory. e.g. "*I am in control*", "*I am safe*" etc.
7. Value of cognition (VOC): Ascertain the strength of PC on a scale of 1-7 (1=totally untrue, 7=totally true).
8. Eye Movement (EM): Patient is asked to visualize the image, rehearse the NC and concentrate on the physical sensation and as he does so, he visually tracks the therapists's finger which is held at a distance of 25-30cms from the patients eyes and moved rapidly and rhythmically back and forth across the line of vision. An average 'set' consists of 24 back and forth movements.
9. After each "set" patient is asked to blank out the image, take a deep breath and bring back the image and attendant feeling to assign SUDS.
10. When the SUDS reach 0, patient's estimation of VOC is ascertained again.
11. Installation: Regardless of the VOC rating (even if 7), patient is asked to visualize the original image along with the desired cognition (PC) and another set of movements are generated.
12. Body Scan: Finally patient is asked to concentrate on the image and scan the body for feelings. Positive feelings are reinforced by another "set" of movement.

Case Report

A 45 years old medical officer came for psychiatric consultation for chronic anxiety. Psychiatric evaluation

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brought out that when he was 10 years of age, on one evening, he saw three men rushing past him towards his father who was walking away at a distance unaware of the fast approaching danger. Petrified in horror, he watched the tallest of the three men deliver the first blow to the head of his father with a club as the others joined the merciless mayhem. The deed done, they left the man for dead (fortunately the father survived) and left the scene. Ever since, the patient was tormented by the intrusive memories of the incident, frightening nightmares and constant tension. Though he carried out his duties, he felt numb and emotionally distant in relationships. He avoided situations with the slightest hint of violence.

The first session was devoted to detailed evaluation. After evaluation the diagnosis was told to the patient. Second session was devoted to the explanation of hypnosis, EMDR and ES. During the third session hypnosis was induced and deepened. ES was carried out in the fourth session. Finally two sessions were devoted to combined ES and EMDR.

The patient brought up the image of the club landing on his father's head as representative of the trauma. He recalled his legs feeling like wood and a warm uneasiness in the stomach and rectum. He thought he was helpless and useless (N C) and desired that he would shout and tell himself "I am confident" (PC). He rated SUDS as 9 and gave VOC score of 1 for desired belief.

After 14 sets of EM, SUDS came to 6 but no further progress could be made even after another 14 sets. On enquiry, it was found that another image, that of his bleeding father slumped on a chair, was interfering. This image was desensitized over 12 sets at SUDS score of 4. SUDS did not improve even after another 12 sets. On further enquiry it was found that an image of a group of legs rushing past him and pounding the earth as they went was intruding into the picture. This image was desensitized over 16 sets. SUDS score for the first image reached '0' (zero) after 12 sets.

The patient was followed up every month for 8 months. He remained asymptomatic and declared himself a free man.

Discussion

Though it was found that PTSD symptoms could be eradicated in just one session of EMDR success in symptom reduction has not always been reported to be so spectacular. Four to six sessions were utilized by some therapists [5,6]. Montgomery and Ayllon (6) conducted EMDR on a patient who suffered two distinct traumas and found no generalization of benefit across the images. The present patient suffered only one trauma but the memory of it seems to have been captured and stored in the form of hierarchically organized noxious images. The patient brought out one manifest image initially but during the treatment two more latent images emerged

and demanded exclusively before the core image could be worked through to bring lasting symptom relief. The mechanism underlying the effectivity of EMDR has not yet been elucidated fully. Elements of exposure and cognitive restructuring are obviously transparent. What is novel to the procedure is the induction of eye movements in the patient. A possible link between the effect of EMDR and that of REM stage of sleep has been postulated [9]. Unconscious material surfacing during dreaming is probably desensitized by rapid eye movements during REM phase of sleep. Some support to the above contention comes from the fact that combat veterans from PTSD were found to have a longer latency to enter REM sleep and spent less time in REM sleep [9,10]. EMDR is a tiring procedure. Judicious spacing may give the necessary time frame for optimum patient co-operation.

References

1. Creamer M, O'Donnell M. Post traumatic stress disorder. Current opinion in psychiatry 2002;15(2):163-68.
2. Gorman JM, Justine MK, Jerney DC. Current and emerging therapeutics of anxiety and stress disorders. In: Kenneth L Davis, Dennis Charney, Joseph T Coyle, Charles Nemeroff, editors. Neuparmacology. Baltimore: Lippincot Williams and Wilkins, 2002;967-80.
3. Ironson G, Freund B, Strauss JL, Williams J. Comparison of two treatments for traumatic stress: A community based study of EMDR and prolonged exposure. Journal of Clinical Psychology 2002;38(1):113-28.
4. Chemtomb CM, Nakashima JP, Carlson JG. Brief treatment for elementary school children with disaster related post traumatic stress. Journal of Clinical Psychology 2002;58(1):99-112.
5. David Forbes, Mark Creamer, Pamela Rycroft. Eye movement desensitization and reprocessing in post traumatic stress disorder. A Pilot study using assessment measures. J Behav Ther and Exp Psychiat 1994;25(32):113-20.
6. Robert W Montgomery, Teodoro Ayllon. Eye Movement Desensitization Across Images : A single case design. J Behav Ther and Exp Psychiat 1994;25(12):23-8.
7. Gross L, Ratner H. The use of hypnosis and EMDR combined with energy therapies in the treatment of phobias and dissociative post traumatic stress and eating disorders. In: Gallo FP, editor. Energy psychology in psychotherapy : A comprehensive source book. New York: Norton,2002;219-31.
8. Hartland J. Medical and dental hypnosis. Baltimore : Williams and Wilkins. 1982;197-204.
9. Francine Shapiro. Eye movement desensitization and reprocessing : Basic principles, protocols and procedures. New York: The Guilford Press. 1995;363-8.
10. Francine Shapiro. Eye movement desensitization and reprocessing: Basic principles, protocols and procedures. New York: The Guilford Press. 1995;24-5.