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TITLE APPLICATION of EYE MOVEMENT DESENSITIZATION and REPROCESSING on PSYCHIATRIC IN-PATIENTS in a PSYCHIATRIC HOSPITAL SETTING

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Summary

Looking back a decade on the field of psychiatry and psychotherapy it is now a given fact: the concept of postraumatic stress disorder has gained a broad acceptance. The efforts seem to focus on building up special wards or units for the treatment of PTSD and complex PTSD. The general psychiatric hospitals seem to a bit at the rear of the line. Recently some researchers studied the prevalence of PTSD in the in-patient population of a psychiatric hospital. Liebermann reported a prevalence of 26.22% patients qualifying for the diagnosis of PTSD according to SCID criteria in the in-patient population of a psychiatric hospital serving an urban catchment area. This underlines the need to integrate PTSD treatment in psychiatry in general. Even if the traumatized patients are diagnosed in the psychiatric hospital, there are often concerns about the application of Eye Movement Desensitization and Reprocessing (EMDR), regarding the stability of the patient etc.. More often than not, the focus lies on cases of complex PTSD or even dissociative disorders. But there is ample opportunity for the integration of EMDR in psychotherapy within the psychiatric hospital. One has to keep in mind that beside PTSD, the acute stress disorder, adjustment disorders, anxiety disorders, depression, complicated mourning and personality disorders justify the application of EMDR (Shapiro 2002 (b)). Even if the scientific evidence isn´t as compelling as on PTSD, there is a growing body of research . The EMDR Chemical Dependency Treatment Protocoll offers a promising modell in the psychotherapy of addictions. In general Shapiros theory of Adaptive Information Processing provides the rationale for the application of EMDR (Shapiro 2001).

The “Niedersaechsisches Landeskrankenhaus Lueneburg”, a psychiatric hospital founded in 1901, has recently undergone intensive restructuring, now organised in two separate psychiatric units each serving a mixed rural and urban catchment area in the north of Germany. Both offer psychiatric services for patients as young as 18 y. of age up to old age psychiatric services. The addiction therapy is integrated. The hallmark of the psychiatric service there, is integration and the intensive networking with the community based services. The Psychiatric Clinic 1 has integrated traumatherapy and especially EMDR in it´s scope of treatments. The impetus to provide appropriate treatment for traumatized patients stood at the beginning of the development of traumacentered psychotherapy in Lueneburg. The process mirrored the process in society: a fight for recognition against a marked tendency to deny the existence of trauma within psychiatry. The introduction of EMDR met some resistence. Minute documentation of treatment outcome provided data suitable to convince scepticals. Stemming from personal experiences and a system point of view general principles of integrating traumacentered psychotherapy and EMDR in psychiatric in-patient treatment take into account the needs of the population served, structure and frame of reference of the hospital, attidude of the management, motivation and ability of the staff. It needs grass-root-work to develop motivation and ability of staff and to coach the management towards a decision allowing the application of traumacentered psychotherapy and EMDR. Four case-examples illustrate the effectiveness of EMDR in the treatment of acute stress disorder and adictions, the elderly, depressive disorder and anxiety disorders. The model of adaptive information processing provides a general theory in which EMDR case formulation and EMDR treatment can be applied with great benefit for the patient.

The prevalence of posttraumatic stress disorder in psychiatric in-patients

Athough there are numerous publications on the comorbidity of posttraumatic stress disorder (PTSD) and various psychiatric disorders, studies on the prevalence of posttraumatic stress disorder in psychiatric patients are rare. Studies focus on certain aspects of the interaction of PTSD and other psychiatric disorders. Some authors described the negative consequences of the interaction of PTSD and other psychiatric disorders, e.g. on the realationship between involuntary admission in schizophrenic patients and PTSD symptomatology (Priebe 1998; Jacobsen 2001). Before 2002 studies examined the prevalence of childhood sexual abuse (CSA) and adult sexual abuse (ASA) in psychiatric patients, mostly women. Most of the studies included out-patients. Mueser included in-patients and male subjects and found a 44,7 % prevalence of PTSD. There are only 4 studies on PTSD in a psychiatric population, mostly out-patient, reporting a prevalence of PTSD between 28% and 44%. McFarlane reported a 28% prevalence of PTSD on an in-patient population. Mueser again reported a 43% prevalence of PTSD in an mixed psychiatric population. Mueser though might be criticized for not using a structured interview. Mueser et.al. reported, that only 3 of 119 patients who qualified for PTSD had been officially diagnosed previously accoding to chart-records (Mueser 1998). Zimmermann & Mattia found that applying a structured interview doubled the number of PTSD diagnosed (Zimmerman and Mattia 1999). Jacobsen et.al. reviewed the literature on substance abuse disorder in PTSD-patients and reported a significant amount of PTSD on substance abuse disorder in-patients (Jacobsen 2001). As a consequence one might assume that there is significant percentage of PTSD among psychiatric in-patients, that the comorbidity leads to problems in adaptation and treatment, but that more rigorous research is still missing.

Liebermann undertook the effort to screen for PTSD in an in-patient population of a psychiatric hospital including the day-clinic in Germany, (Evangelische Stiftung Tannenhof, Tagesklinik Barmen & Elberfeld, Suchtklinik Langenberg), using a structured interview. The „Kölner Trauma Inventar“ provided data suitable to diagnose according to SCID-criteria (Liebermann 2002). The study included in-patients from 19 - 65 yerars of age, living in the catchment area. Geriatric patients were excluded to avoid the problem of dementia. The number of patients participating in the study was 164 patients. Liebermann reported a prevalence of 26,22% qualifying for PTSD according to SCID-criteria at the time of the study and reported a life time prevalence of 43,9% of PTSD. Among those diagnosed with PTSD 81,4% reported multiple trauma in the course of life. In a subpopulation of addictions he reported a prevalence of 11,76% of PTSD at the time of the study and a 17,64% life-time prevalence. Childhood sexual abuse (CSA) was found in 42% , adult sexual abuse (ASA) in 37,21% and CSA plus ASA in 20,93% of the subjects with PTSD diagnosis. Out of the domain CSA and ASA several types of traumata were found. For instance with F2x diagnoses suicide of parents in the childhood was often reported. It is not astonishing, at least not for the experienced clinician, that PTSD is high in the group of patients with affective disorders, especially depression. Meanwhile researchers reported on the link between adverse childhood experiences and subsequent psychiatric disorder (Wise, Zierler et al. 2001; Felitti 2002), again especielly depressive disorders. The data relying on research on a great number of sujects are compelling. These data underline the problem of comorbity of PTSD and other psychiatric diorders. So it seems appropriate to integrate traumatherapy into general psychiatry. The application of EMDR as a standard treatment of PTSD is in line with the above mentioned ideas.

On the other hand there is some evidence on the efficacy of EMDR with a variety of disorders like bodydysmorphic disorder, phantom limb pain, complicated mourning, specific phobias, pain and complex PTSD (Brown 1997; Tinker 2000; Sprang 2001; De Jong 2002; Grant 2002; Korn 2002). The EMDR Chemical Dependency Treatment Manual offers a promising approach in the treatment of substance dependency disorders (Vogelmann-Sine 1998), although research and outcome data are still missing. Though there is ample evidence for the application of EMDR as a treatment of PTSD one could broaden one´s view and speculate about another rationale for the application of EMDR. EMDR not only as a tool, but as psychotherapeutic method based on a specific pathogenetic theory.

Adaptive Information Processing

The theory of an adaptive information processing system provides a rationale for the application of EMDR on a variety of disorders. It provides a specific pathogenetic theory.

Francine Shapiro discovered the ameliorating effect of eye movements incidentally at her famous walk through the park. It is her contribution to the field of psychotherapy to envision its healing quality, devellop first EMD, then EMDR and to start intensive research on EMD/EMDR which lead to the recognition of EMDR in the field of psychiatry and psychotherapy. Shapiro formulated the accelerated information processing theory (AIP) to explain the observed effects of rapid change towards healing with EMDR in traumatized individuals and applied the model to predict the efficacy of EMDR with other disorders as phantom limb pain. (Shapiro 1995; Shapiro 2001). In the second edition of Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures Shapiro elaborated and renamed the model *adaptive information processing* system (Shapiro 2001).

The basic assumption refers to "an inherent system in all of us that is physiologically geared to process information to a state of mental health" (Shapiro 2001). Information means all input from world or body via all sensory systems. Partly we adress the information as experience. Adaptive information processing allows for the reduction in distress and negative emotions and leads to integration of actual information in overall concepts of self and world. The remaining information, - irrelevant information can be "forgotten" - is approriately integrated and so available to adjust to future situations in the ongoing struggle of life. The adaptive information processing system may be hindered or blocked by trauma or other severe stress. The treshold for an impairment of the information processing system is variable. The organisms genetically determined resilience, the developmental period, previous experience and available information including belief-systems and spiritual guidance determine the treshold. Actual individual factors like illness or fatigue and the impact of the incident have to be taken into account. For instance in one of the case-examples given at the end of the text a misinterpreted remark led the patient to the belief of suffering from bone cancer. Her restricted information about treatment options contributed considerably to severe stress thus leading towards a block in adaptive information processing. In another case the patient was hit by a misleading remark of a physician after lying in labour for hours giving birth to her first child. Worn out and tired her resilience was weakened and adaptive information processing impaired.

A block in adaptive information processing leaves the original memory stored in a state specific form in a disparate neuro network. The memory is a blend of sensation, cognition and emotion. The dysfunctionally stored memory can be activated by present-day stimuly and then sensory components, cognition and/or emotion are coming to life again, thus determining present perception and consecutive action. The past pervades into the present. The individual reacts directly to the emotion or engages in coping or defensive strategies. This can be described as psychopathology. The dysfunctional stored memory forms the core of psychopathology. In EMDR the dysfunctional stored memory is activated and the adaptive information processing system maintained in a dynamic form. The result is reprocessing of the dysfunctional stored memory. Desensitization of emotion, cognitive restructuring or changes in sensory fragments are just the observable byproducts of memory reprocessing. Like dreaming is a byproduct of a special neurochemistry which goes with offline memory processing in rem-sleep (Stickgold 1998).

The reprocessing of a former dysfunctional stored memory should, if succesful, lead to changes in awareness, perception and action. The necessity for coping or defensive strategies lessens and the individual gains more freedom in life. Psychopathology subsequently dissolves. This effect depends on the selection of the appropriate target memory, a pivotal memory according to Shapiro. It depends further on the load of previously experienced trauma or severe stress. Neuro networks containing a massive load of maladaptive memory need to be adressed in a more comprehensive therapy (Hofmann 1999; Melbeck 2003), even if EMDR often leads to rapid change.

Integration of traumacentered psychotherapy and EMDR in the psychiatric hospital

The development of traumatherapy in the psychiatric hospital should start on the assesment of needs in the catchment area. Also networking with the out-patient services and other institutions providing counselling and therapy for traumatized people should have priority. The survey and networking provides data to open up a discussion within the hospital. Compelling data on the prevalence of PTSD and on the efficacy of EMDR can illustrate the necessity to provide traumatherapy. Data and a solid rationale are necessary to overcome fear or prejudice. Discussion should lead to a permission of the management for at least a test-phase or limited operation of a special service. Although physicians and psychologist are mostly motivated to pay for their education in general traumatherapy and a special method like EMDR, funding for education and training is necessary. A small group of academics can be at the core of future traumatherapy at the psychiatric hospital. Funding is needed to train nursing staff. At least staff on one ward or unit should be educated on traumatherapy and trained in the basic skills. In the beginning careful consideration on the selection of patients should be taken. It is advisable to select patients who can be treated within the frame of competence and experience of the team. The premature treatment of severe and complex PTSD is harmful for patient and system. The dictum in traumatherapy "the slower you go, the faster you´ll get there" is also applicable to the development of services in the psychiatric hospital. The integration of EMDR also needs some consideration. EMDR may seem strange and unscientific for the layman and uneducated physician. Therefore it is important to introduce EMDR as a tool in the frame of traumatherapy. The data on the efficacy of EMDR in the treatment of PTSD are compelling. The recommendation within the guidelines on the treatment of PTSD by the ISTSS (Foa 2000) and other scientific societies or providers of services (Flatten 2001; 2001) provide a secure foundation to introduce EMDR. The general theory guiding the action in the hospital should be recognized. The "synclectic" concept (Shapiro 1995) allows integration within biological psychiatry, psychodynamic approaches, behavioral and cognitive-behavioral and other approaches. The integration in other approaches has led to a very lively and enriching discussion (Shapiro 2002) far from the "scientific combat" to often observed. Once EMDR has been introduced in the scope of treatments at a hospital it is possible to open up one´s view and apply EMDR to other psychiatric disorders than PTSD only.

The *Niedersaechsisches Landeskrankenhaus Lueneburg* is a state owned hospital for psychiatry, psychotherapy, child- and adoloscent psychiatry and forensic psychiatry. The hospital was founded in 1901. In 1901 the hospital was very modern, providing good accomodation and a scope of state of the art treatments. The backbone of psychiatric treatment was occupational therapy. The hospital deteriorated in the post WW2 years. The number of patients rose to a maximum of roughly 1500 in the 1970´s. Since the late 1980´s the management steered a course of restructuring and modernisation. Long-term units were closed and patients transferred into community based services. The hospital supported the development of community based services and achieved a reduction to 188 psychiatric beds in 2003. Two separate psychiatric clinics provide integrated in-patient services for two mixed rural and urban catchment areas. Each psychiatric clinic provides general adult psychiatry, psychiatry of the elderly and addiction treatment. The integration of services and intensive networking with other providers of service in the area match the need of the population in each catchment area. The Psychiatric Clinic 1, serving the Landkreis Lueneburg, has been integrating traumatherapy and EMDR in its scope of treatment since 1995. Integration means EMDR, is available for every patient if it is of benefit. There is no special ward for traumatherapy, but one ward serves as a stronghold and center of competence in traumatherapy and EMDR. The idea of networking and integration of specialized treatment into an overall therapy regime holds the promise of greater flexibility and opening up ressources. An idea which seems of great importance in a rapidly changing system, when economical problems become more and more obvious. After traumatherapy and EMDR had been established inside the hospital it has been an important aim to provide education and supervision for other providers of treatment in the region. The number of patients of the ICD-10 F 4.x catagory admitted to the hospital patients fell in 2001, after a rise in the mid 1990´s. This could indicate, that the competence in the region grew after offering training in traumatherapy and EMDR Institute training since 1999. Hospitals shouldn´t provide a stand-alone therapy, but act as a motor of development in their catchment area.

The application of EMDR – good clinical practice

Selecting a patient for EMDR is often one of the most exciting and important stages of therapy. PTSD and associated disorders are not always clear cut and easy to recognize. Amnesia, dissociation or years of diagnostic errors may hinder a proper diagnosis. Dysfunctional stored information as the target for EMDR may be even more difficult to discover. Assesment and identification of target memories is crucial as EMDR is a tool for the reprocessing of pathological memory contents. The best use of EMDR is on specific memories, linked to the patients symptoms, disorder or problem.

Basic guidelines can be found in the description of Phase 1 of the EMDR treatment as given by Fracine Shapiro (Shapiro 2001). Specific symptoms, like flashbacks, intrusive thoughts or images and panic attacks provide vital cues. Existing triggers, especially triggering emotion, signal the existence of dysfunctional stored information. Dysfunctional stored information may not bring up spontaneous intrusions. But in history taking the emotional disturbance at a certain point, the change in the patients report from past to present tense are a red flag to the experienced clinician. If questioned the patient will mostly report vivid imagery or other vivid sensory components, e.g. the voice of mother, linked to the memory in question. The Impact of Event Scale (IES) may be applied to distinguish a relevant from an irrelevant memory. The belief system may be questioned to elicit negative cognitions. Present disturbance can be the entrance to the network of dysfunctionally stored information. The affectbridge technique is helpfull to elicit early memories serving as a target for EMDR (Hofmann 2003). The initial cause of the symptomatology should be reviewed. If the patient pinpoints the beginning of his problems, a relevant memory can often be discovered. The next step is to assure client readyness and safety. I will not elaborate on EMDR treatment planning, as the basic principles, protocols and procedures provide guidelines for the application of EMDR. On the other hand I want to underline, that screening for a dissociative disorder is absolutely necessary before applying EMDR. Gast reported on the astonishingly high prevalence of dissociative disorders among psychiatric in-patients (Gast, Rodewald et al. 2001)The Dissociative Experiences Scale (DES) is helpful, but has it´s limits. Structured interviews like the SCID-D (Steinberg 1994) or helpful for rigorous assesment, if severe dissociative disorders have to be excluded before EMDR. Other instruments, like the IES, PTSS-10, CAPS, SCID or symptom checklists may be used as the setting requires. I can recommend the collection of outcome data. These are useful to defend traumatherapy and EMDR against the inevitable criticism in the process of implementing a new therapy in an institution. And they may serve as a measure of quality and motivation for reflection on the therapy.

The application of EMDR should be conducted with strict adherence to the procedural outlines, standard protocol and protocols for special clinical according to Shapiro. The structure of EMDR contains valuable therapeutic elements beside dual attention stimulation. Therefore the structure should not be varied if not absolutely necessary to meet the needs of a patient. For example would a mentally handicapped patient need more active help in eliciting negative or positive cognitions or elements of EMDR with children may be used (Tinker 1999).

In my clinical experience it is very important to facilitate an initial positive experience with EMDR. Educating the patient, preparation and the safe place exercise are very helpful indeed. In more complex cases ressource installation is a valuable adjunct. Although we are able to operate in the basic EMDR procedures in the majority of cases the moment of transition into reprocessing of traumatic memories needs to be adressed. Early in treatment the processing of a minor disturbing memory can offer a smooth start into the following reprocessing of traumatic memories. A memory with a SUD of 5 at maximum and emotion opposed to the emotion of the patients major traumatic experiences is appropriate. The initial experience of the resolution of the minor disturbing memory in the beginning of treatment adds to the patients motivation and resilience for the following, sometimes stressful, reprocessing of traumatic memories (Hase in Press).

Case-examples

The following case-examples are supposed to illustrate my ideas on the integration of EMDR in general psychiatry and psychiatry of the elderly. One case example reaches into addiction therapy although the focus remains on the treatment of acute stress disorder (ASD). The case-examples are not science, but a report from clinical practice. Nevertheless the may be of value to the recipient.

The first two case examples cover more or less the treatment of ASD and PTSD. It seems appropriate to begin with these, as the development of EMDR began in the treatment of PTSD. Please note, that these are not straightforward ASD or PTSD case histories. Fortunately trauma was noticed and traumatherapy, EMDR, initiated. Otherwise the outcome might have been less favourable.

W.K. – acute stress disorder and alcohol abuse

Patient W.K. was admitted to the ward for the treatment of substance abuse disorders for detoxification. He reported a massive relapse into alcohol abuse for about three weeks. W.K. was 55 years old and on early retirement. He lived alone after his wife died of cancer seven years ago. W.K. had a history of alcoholism and had received in-patient detoxification and addiction treatment 12 years ago. He had managed to stay sober since his addiction treatment with the help of an AA-group through a considerable length of time, Even as the illness and death of his wife had been a stressful span of life.

After detoxification in the first week of the two weeks treatment staff noticed anxiety and hyperarousal. When questioned W.K. reported, that the relapse had occured after he became eye witness of the violent death of a young man who had been overrun incidentally by a train at a railway crossing. He had been suffering from intrusive imagery, hyperarousal, sleep disturbance and posttraumatic nightmares since the event. The abuse of alcohol as self-medication had forced him rapidly in the relapse. He qualified for acute stress disorder (DSM-IV). The Impact of Event Scale (IES) and Trauma Screening Questionaire (TSQ/TSF) helped to verify the diagnosis. Except the early loss of his father and his wife´s illness there was no significant trauma in his history. Screening with the Dissociative Experiences Scale (DES) showed no sign of a dissociative disorder. After installation of the container exercise and light stream technique two hot spots of the critical incident could be reprocessed according to the EMDR protocoll for recent traumatic events. W.K. experienced great relief. Posttraumatic nightmares vanished. Hyperarousal and intrusive imagery lessened considerably. The IES dropped from a pre-treatment score of 44 to a posttreatment score of 12. W.K. terminated treatment after two weeks. In a 6 months follow-up interview via telephone he reported to be symptom-free and living abstinent from alcohol with support from his AA-group.

R.W. – PTSD and depression in an elderly woman

R.W. was 67 years old when she was admitted to hospital for the first time in her life. R.W. was admitted to the closed ward for the elderly after committing a severe suicide attempt. After her partner left her she had developed a major depressive disorder and tried to put an end to her life by the ingestion of hydrochloric acid in the bedroom of her home. The enormous pain forced her to call emergency services and after intensive medical treatment and surgery the psychiatric treatment started. Under a combination of antidepressants and mood stabilizers the depression subsided and she was transferred to an open ward and then to the day-clinic for the treatment of the elderly.

During the treatment at the day-clinic she became more “depressed” and developed suicidal ideation again. She had to be transferred to the open ward again. Assesment showed marked symptoms of PTSD according to ICD-10 criteria. The traumatic memory of the suicide attempt was triggered every evening at home and drove psychopathology. Pre-treatment assesment using the IES, Posttraumatic Stress Scale 10 Items (PTSS-10), Symptoms Checklist 90 Items revised (SCL-90-R) and DES safeguarded the diagnosis of PTSD and ruled out a dissociative disorder. After psychoeducation on PTSD and EMDR, treatment began with the installation of the safe place exercise. After the reprocessing of a minor disturbing memory to create a smooth start into EMDR,

memories of the suicide attempt, the following intensive care treatment and actual disturbances related to the trauma were reprocessed according to the EMDR standard protocoll. After five sessions of EMDR she showed marked improvement. Anxiolytic medication could be terminated. She remained on antidepressants. Just before her discharge from hospital she developed an acute intestinal obstruction, actually a delayed complication of the emergency surgery, and had to undergo intensive surgery again. Astonishingly she recovered rapidly and the incident had no adverse effect on her psyche. Hospital treatment was continued for another four weeks, so she could build up some strength again. R.W. is now living in her home again and is in out-patient treatment. Her condition is stable on a single antidepressant for a three month follow-up period after discharge and she is leading an active life again. Post- to pre-treatment scores showed a significant reduction (IES pre-treatment 52 vs. 5 post-treatment , PTSS-10 pre-treatment 45 vs. 12 post-treatment).

The following two case-examples illustrate assesment and EMDR therapy according to the AIP outside the field of PTSD according to ICD-10 criteria.

M.B. – Depression and dysfunctional stored information

The fourty year old woman was admitted to hospital because of depressive episode running for six months and suicidal ideation. As it was her first psychiatric in-patient treatment she was prejudiced and anxious. History taking revealed a history of depression since an artifically terminated pregnancy, a marital conflict and a loss of sense in life, as she noticed the growing independency of her children. M.B. was motivated for in-patient psychotherapy and her husband agreed to join in on couples therapy. The marital relation improved, as the husband developed empathy and lerned to express his feelings in a constructive manner. M.B.´s condition did not improve very much. Psychoanalytic psychotherapy in combination with psychodrama showed little improvement. The psychotherapist in charge of the case reported a feeling of a block, like a wall of concrete, of blocked emotion.

A revision of the patient history and renewed assesment gave interesting results. M.B. could pinpoint the beginning of the current depressive episode to one afternoon in December half a year previous. When she talked about that certain afternoon she suddenly switched into present tense in her report and seemed to be very much involved in her memory. Enquired about the contents of the memory and sensory representation she reported vivid imagery and vivid auditory contents. The sensory fragments were not intrusive spontanously, but showed extraordynary vividness if she was asked to bring up the memory. On the other hand she did not show emotion during her report and experienced a feeling of numbness. The memory covered a visit at her physician. She picked up a remark of her physicians locum which gave her the impression of suffering of bone cancer. Though this proved not to be the case, she interpreted the message as a death sentence and long, horrible suffering. She described her feelings as receiving a shock, like electricity, numbness and derealisation on her way home and the onset of depression the same evening. Positive results of following therapy couldn´t remove the shadow on her life. The intrusive-like quality of the memory and the dissociation of emotion gave reason to take a deeper look. Pre-treatment assesment showed caseness in the SCL-90-R and an IES score of 43 on the memory mentioned above. After education on EMDR and installation of the safe place the memory could be reprocessed in single 90 minute session showing a moderate abreaction of grief and anger. Post-treatment tests showed an IES score of five and the loss of caseness in the SCL-90-R. Furthermore the depression vanished. Following the EMDR session M.B. was able to engage in psychoanalytic psychotherapy and work on the memories of artifically terminated pregnancy and other relevant issues with great benefit. She reported a stable condition in a six month follow-up.

U.B. – anxiety and depressive disorder and dysfunctional stored information

The woman of 47 years of age was admitted to hospital under the diagosis of depression and paranoia. She had been in psychiatric treatment for about ten years. Chart review revealed a history of anxiety disorder, panic, depression and alcohol abuse. The assesment didn´t show psychotic features. In the recent years the treatment had been a combination of various antidepressants,

benzodiazepines and antipsychotic drugs. A chart review showed that early in her career a psychiatrist reported the onset of the disorder following the birth of her first child.

Questioned about the onset of her anxiety she reported a vivid memory of her labour, which had been long and strenous. While she was exhausted and anxious her obstetrician proposed a cesarian section. She remembered the anaestethist asking for her signature on a form and the obstetrician replying: "There´s no time for such. We´re lucky if we can safe the mothers life!" (The daughter is 22 and student at a university today) Further history taking showed witnessing of intrafamiliar violence in her family of origin and violence in her first marriage. Clinical assesment lead to the idea of adressing memories of violence. Except the DES - no evidence of dissociative disorder - tests were scheduled for the following week. After introducing the safe place exercise the memory of her daughters birth was singled out for the reprocessing of a minor disturbing memory to create a smooth start into EMDR on the memories of violence. IES showed a pre-treatment score of 5. The reprocessing was undertaken in one single 90 minute EMDR-session. U.B. showed a moderate to severe abreaction of panic. She experienced great relief. Medication was cut down to combination of one antidepressant, one mood-stabilizer and an antipsychotic. The antipsychotic medication was cut down but couldn´t be terminated during the in-patient treatment because the patient terminated the treatment shortly after the EMDR-session as she felt much better and wanted to help in the family business. In the follow-up interview she reported a stable condition, felt relieved, enjoyed life and stated to be free from anxiety. She intended to take up out-patient EMDR therapy to adress remaining issues.

Discussion

PTSD is common in psychiatric in-patients. There are straightforward cases of single trauma patients and of course cases of complex PTSD. Often trauma is easy to recognize and the diagnosis of PTSD is easy. But in a considerable amount of cases PTSD may be hidden behind comorbid disorders, the primary psychiatric disorder or hard to detect because of amnesia and dissociation. Beside the straightforward PTSD cases the clinician should pay attention to comorbidity, adjustment disorders and the effect of dysfunctional stored, incompletely processed information in a variety of psychiatric in-patients. The EMDR model provides the theory of adaptive information processing (AIP) and it´s pathology as a pathogenetic model. This model is of great use in assesment and treatment planning. It is necessary to detect dysfunctional stored memories, which can be targeted and reprocessed in the EMDR treatment.The integration of traumatherapy and EMDR in the psychiatric hospital setting needs consideration and careful planning. Clinicians should refrain from premature treatment of complex PTSD. Complex PTSD/DESNOS and dissociative disorder patients can be treated succesfully if the treatment setting is sufficient, the team experienced and well educated and the treatment planning is in relation to the patients needs. Often clinicians state that they are not able to apply EMDR because of the severity of the disorder. This is in my opinion often not the case. Selecting the appropriate patient and timing of therapy, especially EMDR does the trick.

Four case-examples give evidence of the potential of the application of EMDR in psychiatric in-patients. Certainly one has to bear in mind that the in-patient treatment is not the panacea for the patients disorder. Other help like the AA-group in the case of W.K., or continuing out-patient treatment are important and contribute to the favourable outcome reported. The recent traumatic event wasn´t reprocessed in total according to the EMDR protocoll for recent traumatic events.Time restraints are more the rule than the exception on in-patient treatment of addictions. But EMDR can be integrated into short term in-patient treatment. In the case of R.W. the therapy with antidepressants cured the depression. But EMDR was the appropriate therapy for the PTSD. Elderly patients can be treated succesfully with EMDR, if the treatment adresses trauma in connection with the actual disorder. R.W.´s case may give also evidence on an effect of EMDR seldom discussed: the possible protective value of a succesful EMDR therapy against renewed trauma. Some researchers reported on this effect (Lamprecht 1999; Rost 2002). Succesfull EMDR may add to the feeling of mastery and competence in fighting against one´s PTSD. Astonishingly EMDR patients tend to remember only the positive cognition even a long time after treatment. EMDR might lead to

inner restructuring allowing a better access to ressources and so increasing the individuals resilience. Using a metaphor one could say succesful EMDR builds the tracks on which the train of natural adaptive information processing rolls easier after renewed trauma. In the case of M.B. a combination of psychotherapeutic methods proved helpful. EMDR was definately needed to reprocess the emotion of dysfunctional stored information which hindered the progress of therapy. The case of U.B. calls for systematic psychotherapy. EMDR is not a one to three session cure and adherence to the standard protocoll is imprtant. But the timing of the EMDR brought relief and increased her motivation to engage in psychotherapy. Psychiatric in-patients suffer mostly from more severe disorders. The appropriate choice of therapy and combination of all we´ve got to treat the disorder is necessary. EMDR can be integrated in the multimodal therapeutic regime and applied with the promise of great benefit for the patient.

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Die Signatur wurde nicht überprüft.

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