

EMDR in the Treatment of Depression – The EMDR DeprEnd protocol

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Content

- Why the current concept of depression is failing many
- The use of EMDR in depression – a short overview
- The EMDR-DeprEnd protocol in clinical practice

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What is Depression?

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Depressive Disorders

The most common mental disorder - worldwide 264 million suffer from depression
17.3 Million in the US (7.1%) are depressed, in the age group 18-25 the percentage is 13.3%
47,000 annual suicides in the US (2017)
Many good treatments but
~ 15-20% of patients become chronic
~ 50% relapse after 2 years
Many risk factors for depression and a connection with genes and life events

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The Good News

Most Depressions respond to Therapy

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The Bad News

Risk of **chronicity**: 15-20% of patients dont respond to therapy and become chronic


High risk of **relapse**:

After 1 Year	- 37%
5 Years	- 75%

Maj et al. (1992), Am J Psychiatry, 149(6); 795-800

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The Genetic Track

2003: genetic study – A. Caspi (Science)
 Two variants of a gene (Polymorphism)
 One variant risk of depression of 10-15%
 If 3-4 events happened, the other variant had a risk of 25-30% for depression
 Are these genes a main cause for depression?
 (Candidate Genes)

Caspi et al. (2003), Science, 301:386-389

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The Genetic Track

Interaction Between the Serotonin Transporter Gene (5-HTTLPR), Stressful Life Events, and Risk of Depression A Meta-analysis

Neil Bhask, PhD
Richard Howes, PhD
Thomas Lehner, PhD
Kang-Yee Liang, PhD
Linda Lyons, PhD
Josephine Hib, PhD
Andrea Green, BS
Maura Keenan, PhD
Jing Ou, PhD
Kathleen Wu-Markoski, PhD

Context: Substantial resources are being devoted to identify candidate genes for complex mental and behavioral disorders through evaluation of environmental exposures following the report of an interaction between the serotonin transporter linked polymorphic region (5-HTTLPR) and stressful life events as an increased risk of major depression.

Objective: To conduct a meta-analysis of the interaction between the serotonin transporter gene and stressful life events on depression using both published data and individual-level original data.

Data Sources: Search of PubMed, EMBASE, and PsycINFO databases through March 2009 yielded 26 studies of which 16 met criteria for the meta-analysis.


Study Selection: Criteria for studies for the meta-analysis included published data on the association between 5-HTTLPR genotype (S, L, or LL), number of stressful life events (0, 1, 2, or 3) or equivalent, and a categorical measure of depression defined by the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) or the International Statistical Classification of Diseases, 10th Revision (ICD-10) or use of a cut point to define depression from standardized rating scales. To maximize our ability to use a common framework for variable definition, we also requested original data from all studies published prior to 2008 that met inclusion criteria. Of the 14 studies included in the meta-analysis, 10 were also included in a second sex-specific meta-analysis of original individual-level data.

Data Extraction: Logistic regression was used to estimate the effects of the number of short alleles at 5-HTTLPR, the number of stressful life events, and their interaction on depression. Odds ratios (ORs) and 95% confidence intervals (CIs) were calculated for each study and then weighted averages of the individual studies were

JAMA 2009

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The Genetic Track

Meta-analysis of 26 studies on
 Serotonin transporter gene variants
 Negative life events
 Risk for depression
 14 250 participants
No risk for depression related to gene or interaction life event/gene
 Risk increases with number of **events**

Risch et al. (2009), JAMA, 246:2-2471

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The End of the Candidate Genes 2019

No Support for Historical Candidate Gene or Candidate Gene-by-Interaction Hypotheses for Major Depression Across Multiple Large Samples

Richard Border, M.A., Emma C. Johnson, Ph.D., Luke M. Evans, Ph.D., Andrew Smolen, Ph.D., Noah Berley, Patrick F. Sullivan, M.D., Matthew C. Keller, Ph.D.

Objective: Interest in candidate gene and candidate gene-by-environment interaction hypotheses regarding major depressive disorder remains, in spite of controversy surrounding the validity of previous findings. In response to this controversy, the present investigation empirically identified 18 candidate genes for depression that have been studied 10 or more times and examined evidence for their relevance to depression phenotypes.

Methods: Utilizing data from large population-based and case-control samples (the ranging from 62,128 to 442,264 across subgroups), the authors conducted a series of pre-registered analyses examining candidate gene polymorphism main effects, polymorphism-by-environment interactions, and gene-gene effects across a number of operational definitions of depression (e.g., lifetime diagnosis, current severity, episode recurrence) and environmental moderators (e.g., sexual or physical abuse during childhood, socioeconomic adversity).


Results: No clear evidence was found for any candidate gene polymorphism associations with depression phenotypes or any polymorphism-by-environment moderator effects. As a set, depression candidate genes were no more associated with depression phenotypes than noncandidate genes. The authors demonstrate that phenotypic measurement error is unlikely to account for these null findings.

Conclusions: The study results do not support previous depression candidate gene findings, in which large genetic effects are frequently reported in samples of relatively smaller than those examined here. Instead, the results suggest that early hypotheses about depression candidate genes were incorrect and that the large number of associations reported in the depression candidate gene literature are likely to be false positives.

Am J Psychiatry 2019; 176:276-287 doi:10.1176/appi.ajp.2018.176.02

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Life events and Trauma

Depression is the most common documented outcome of childhood sexual abuse in adults (Putnam 2003)
 Exposure to trauma and household dysfunction account for about **50% of Major Depressions and suicides** (Fellitti, 2001, 2004)

Teicher (2009), J Clinical Psychiatry; 70(5): 684-91

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Which life events?

Life Event Dimensions of Loss, Humiliation, Entrapment, and Danger in the Prediction of Onsets of Major Depression and Generalized Anxiety

Kenneth S. Kendler, PhD; John M. Hettema, MD, PhD; Frank Batista, MD; Charles O. Gardner, PhD; Carol A. Prescott, PhD

Backgrounds: Although substantial evidence suggests that stressful life events predispose to the onset of episodes of depression and anxiety, the essential features of these events that are etiologic and antagonistic remain uncertain.

Methods: High contextual threat stressful life events, assessed in 98,592 person-months from 7,122 male and female adult twins ascertained from a population-based registry, were blindly rated on the dimensions of humiliation, entrapment, loss, and danger and their categories. Onsets of pure major depression (MD), pure generalized anxiety syndrome (GAS) (defined as generalized anxiety disorder with a 2-week minimum duration), and mixed MD-GAS episodes were examined using logistic regression.

Results: Onsets of pure MD and mixed MD-GAS were predicted by higher ratings of loss and humiliation. Onsets of pure GAS were predicted by higher ratings of loss and danger. High ratings of entrapment predicted only onsets of mixed episodes. The loss categories of death and respondent-initiated separations predicted pure MD but not pure GAS episodes. Events with a combination of humiliation (especially other initiated separations) and loss were more depressive than pure loss events, including death. No sex differences were seen in the prediction of episodes of illness by event categories.

Conclusions: In addition to loss, humiliating events that directly devalue an individual in a core role were strongly linked to risk for depressive episodes. Event dimensions and categories that predispose to pure MD vs pure GAS episodes can be distinguished with moderate specificity. The event dimensions that preceded mixed MD-GAS episodes were largely the sum of those that preceded pure MD and pure GAS episodes.

Arch Gen Psychiatry. 2013;60:789-796

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Life Events and Depression



Close relationship between depressive episodes and

Losses, Separations and Humiliations ($p < .001$)

Events with **danger for life** were only related to anxiety disorders (GAD)

Depression is a stress-related disease

Kendler et al. (2003), Arch Gen Psychiatry, 60; 789-796

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Summary



Depression is to a large extent a Stress- and Traumabased Disorder

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Is it all Trauma ?



No –
but many stressful life events



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This is where EMDR and the AIP model come in



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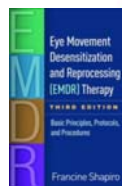
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The AIP model of EMDR

(Shapiro 1995/2018)



- Formulated to explain the clinical phenomena observed during EMDR therapy processing sessions
- Evolved from 1995 to 2018
- Basis of EMDR theory of disease
- Basis of treatment planning in EMDR
- Element of EMDR training



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The AIP model of EMDR

(Shapiro 1995/2018)

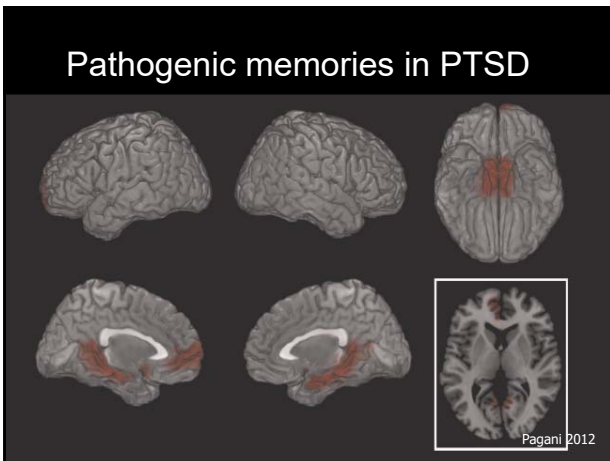


1. Stressful and traumatic life experiences can create pathogenic memories that can lead to a number of disorders (e.g. PTSD, Depression, Pain disorders).
2. The brain has an innate selfhealing system is able to transform these memories and heal the disorders

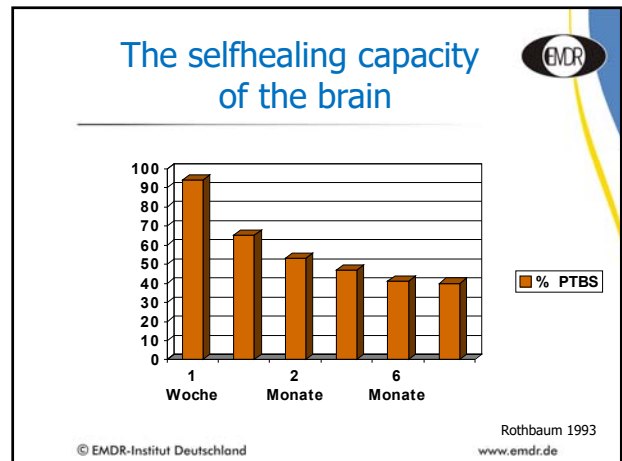
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Hofmann 2020, Hase 2017
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The AIP model of EMDR

3.

In some situations the innate information processing system of the brain is blocked so that pathogenic memories and the symptoms persist

4.

The stimulation of EMDR-therapy unblocks the self-healing system, transforms the pathogenic memories and helps to reach an adaptive resolution and healing.

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A Main Mechanism of EMDR

Article | Published: 13 February 2019

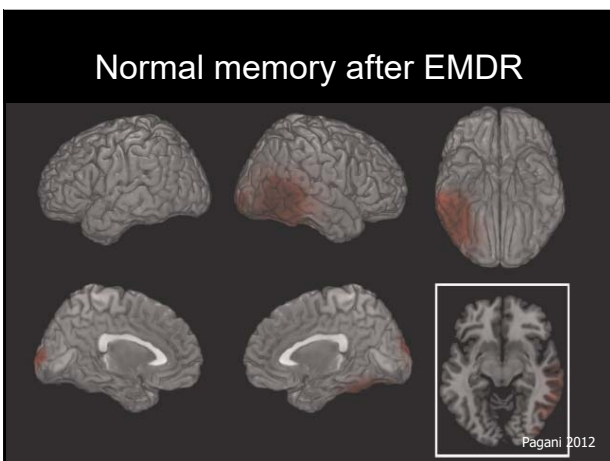
Neural circuits underlying a psychotherapeutic regimen for fear disorders

Jinhee Baik, Sukchan Lee, Taesup Cho, Seong-Wook Kim, Minsoo Kim, Yongwoo Yoon, Ko Keun Kim, Junweon Byun, Sang Jeong Kim, Jaeseung Jeong & Hee-Sup Shin

Nature 566, 339–343 (2019) | Download Citation

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AIP Model and EMDR - What is the difference for patients?

- A meta-analytic study by University College of London u.a. and NHS
- In a 2020 meta-analysis and review of 90 RCTs EMDR and TF-CBT were the most effective psychotherapy treatments for PTSD
- Based on that analysis a decision analytic model was developed with a review and network analysis to find the most cost-effective of 10 interventions for PTSD

Mavranzeouli 2020
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Quality life years and Cost-Effectiveness in EMDR Therapy

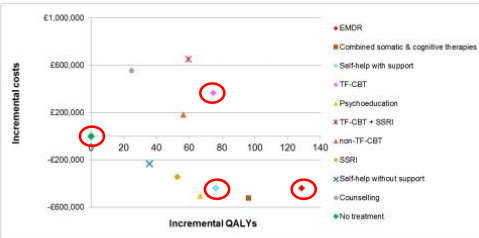


Fig 2. Cost-effectiveness plane: Base-case analysis results for 1,000 adults with PTSD.

<https://doi.org/10.1371/journal.pone.0232245.g002>

Mavranzouli 2020

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Summary

1. Depression is -to a large extent- a Stress- and Trauma-Based Disorder
2. It is - to a large extent - based on **Pathogenic Memories** (traumatic and non-traumatic)
3. EMDR Therapy works very well with these disorders and this type of memories

Centonze et al. 2005 Mol. Neurobiology,
Hase et al. 2017 Frontiers of Psychology

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EMDR for Depressive Patients

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EMDR in the Treatment of Depression

First published cases:

- F. Shapiro (1997), Patient "Mia" lost 12-year old child, MDD and suicide attempt
- Philip Manfield, Jim Knipe, Greg Smith, Robin Shapiro and others

Case Series:

- 2 cases of adolescents (Bae et al. 2009)

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EMDR in Adolescent Depression

- Patient 16 year old girl
- Father died a year ago (expected)
- Decompensates in boarding school
- DSM-IV: MDD, no PTSD
- 3 sessions EMDR (Focus death of father and future)
- Follow up: 3 months later

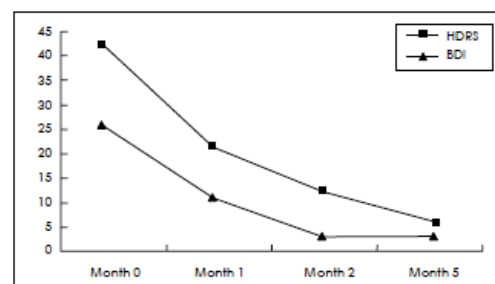
Bae, Kim & Park (2008), Psychiatric Invest, 60-65

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EMDR in Adolescent Depression



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EMDR in Recurrent Depressive Disorder (F 33)

Retrospective Study (N=10 Patients)

Age 52, 9 women, 1 man
 Five 33.2, two double depressions (MD+34.1)
 3 chronic depressions (>2 years)
 Previous relapses ~ 6.4 (3-13)
 Outpatient treatment CBT or PD
 Treatment 60 sessions including 7.4 EMDR
 Follow up 3.7 years (1-6)

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EMDR in Recurrent Depressive Disorder (F 33)

At follow up:

9 had a complete remission (7 at end of therapy)
 7 patients had no more medication
 4-5 relapses were expected
 Only 1 patient relapsed
 Trigger: Partner got cancer
 3 others had significant stressors, but no relapse (death husband, myocardial infarction, unstable angina)

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EDEN Pilot 1 - Krefeld

Prospective controlled study with outpatients of a CBT Training Institute
 Two groups compared (N=42)
 CBT (47 sessions) + medication = TAU vs. TAU (45) incl. ca. 6.9 sessions EMDR

Results:

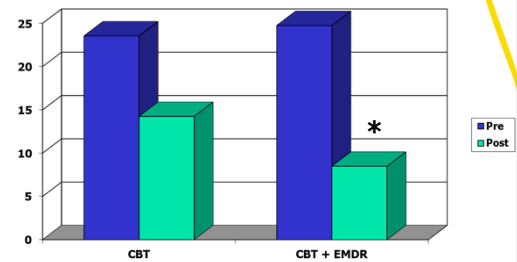
BDI better in EMDR group ($p=.029$)
 Complete Remissions EMDR group >80% (vs. Tau 38%, $p<.001$)

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Hofmann et al. 2014, JEMDR
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Krefeld Study Results BDI-II (N=42)



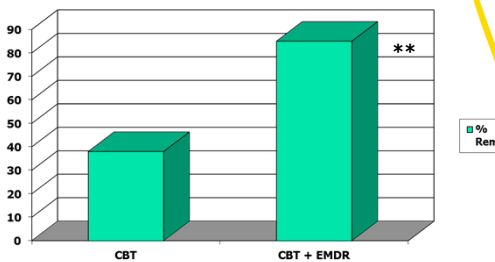
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* = .029

Hofmann et al. 2014, JEMDR
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Krefeld Study: Complete Remissions (N=42)



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** = .001

Hofmann et al. 2014, JEMDR
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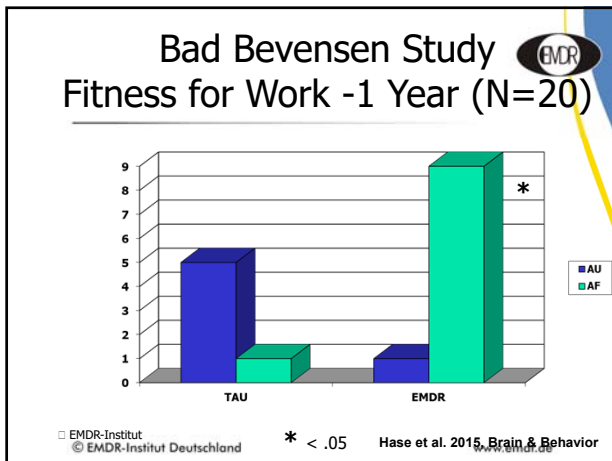
EDEN Pilot 2 - Bad Bevensen

32 Inpatients (32.X and 33.X)
 12 women, 20 men, age: 46 years
 All received group therapy plus:
 1. TAU (individual psychodynamic therapy)
 2. TAU vs. TAU+ 4-5 sessions EMDR
 One result: Follow up: EMDR group more at work (N=20, $p<.05$)

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Hase et al. 2015, Brain & Behavior
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EDEN RCT Study

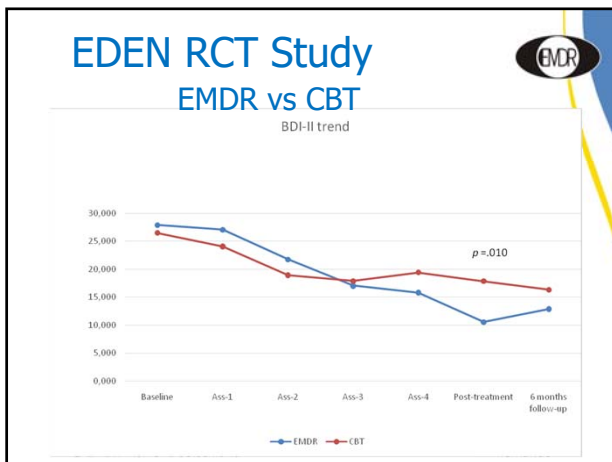
EMDR vs CBT

82 patients with recurrent depressive disorder
16 sessions of EMDR vs. CBT
Baseline, + 2 weeks, after every 4 EMDR sessions, post-treatment, follow-up after 6 months

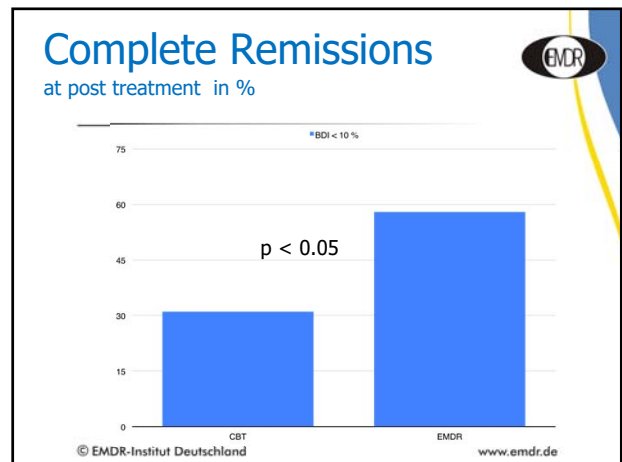
EMDR and CBT at least equally effective

Better reduction of BDI for the EMDR group at post treatment $p > .05$

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Meta-Analysis of EMDR Studies for Depression 3-2021

- 9 RCT studies with 373 participants analysed
- Effect size of EMDR treatment high: 1,07
- At follow-up (6 months): 0.62 (N=3)
- EMDR is at least as effective as other active control treatments like CBT**
- EMDR possibly leads the will lower relapse rate

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How to do you use EMDR DeprEnd in your practice?

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EMDR DeprEnd Protocol Step 1-6

1. Get an overview (AIP-glasses)
2. Check need for stabilization
3. Focus and process:
Episode triggers
4. Belief systems
5. Depression-related states
6. Relapse prevention
(mostly in this sequence!)

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EMDR DeprEnd[®] Step 1

Get an Overview

The AIP-Glasses:
Which memory networks
are involved?

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EMDR DeprEnd Step 1

Get an overview:

- "Symptom-Event Map"
- List all depressive episodes
- Look for trigger events of episodes
- Full or partial remission?
- Comorbid Complex PTSD or Dissociative Disorder ?

Hofmann, Hase et al. (2009)
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Symptom Event Map

EMDR-Symptom-Event Map (SEM)

Hofmann et al. (2009)
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Symptom-Event Map with 3 Components

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Symptom Event Map

DeprEnd EMDR-Symptom-Event Map

Hofmann et al. (2009)
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Life events and Depression



There is a close time relationship between depressive episodes and

1. Losses
2. Separations
3. Humiliations and
4. Material loss

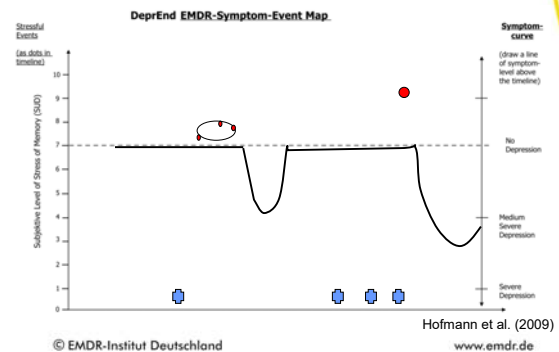
Kendler et al. (2003), Arch Gen Psychiatry, 60; 789-796

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Symptom Event Map

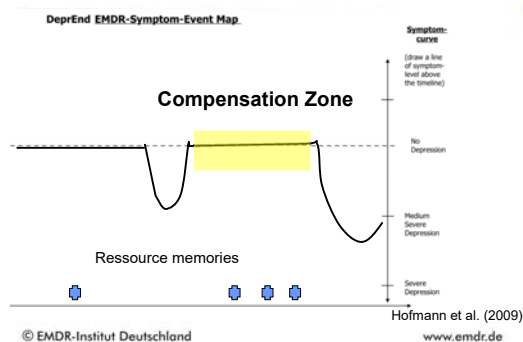


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Symptom Event Map



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The Compensation Zone



- Is it time of full remission after a depressive episode
- Can be seen in the symptom event map
- Is a time, when the self-healing processes of the patient can balance present earlier stressors
- Clinically the stressful events after such a zone matter much more than the stressors before

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EMDR DeprEnd[©] Step 2



Find out about need for stabilization (or not)

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EMDR DeprEnd[©] Step 2



- Find out about need for stabilization
- If patient is stable (Tests)
- Standard EMDR Protocol (without long stabilization)
- With low affect tolerance – usually cPTSD or DD:
 - Inverted Standard Protocol (IStP)
 - Stabilizing interventions (like RDI)

Hofmann, Hase et al. (2009)

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Bipolar Disorder

- About 15-20% of all depressive disorders
- Depression plus manic or hypomanic phases
- More genetically determined
- Stressfactors are similar to unipolar depression
- EMDR Researcher:
Prof. Benedict Amman, Barcelona

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EMDR DeprEnd Step 3

Processing Episode Triggers

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Step 3: Processing Episoder Triggers

- Episode triggers can be only one or multiple
- Can also be connected to former experiences and episodes (important: Overview Phase 1!)
- Often apparent in History-Taking - Phase 1 (time connection, high SUDs, intrusive)
- Work first with trigger of last episode (or with the strongest)
- After working with an episode trigger, you often get an obvious improvement of depressive symptoms (BDI)
- Episode trigger work uses the majority of EMDR processing sessions

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Step 3: Episode Triggers Case Example

- CEO, 59-years old, female
- Comes to therapy because her doctor can't find any somatic cause for her intense back pain
- Suffers from depressive mood, poor energy, poor sleep
- "That's not me!"
- No trauma in her history
- What happened before she got depressed?

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Step 3: Episode Triggers Case Example

- She was CEO of a Health Company
- They merged with another Company
- The corporate atmosphere changed
- She herself was to be replaced by a young, dynamic CEO
- She was not invited to an important meeting concerning the future of the business
- Episode triggers are the events before her dismissal

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Step 3: Episode Triggers Case Example

- First focus: Phone call where she realized that she was not invited to the meeting
- Next: Two other experiences in the company takeover
- Trigger: the administration building of the company
- Future Protection/Template: Inaugural ceremony of the new building that she had initiated
- NC: I am a loser, feelings of guilt, SUD = 7 – 8
- PC: I am successful
- The stress decreases completely during EMDR

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Step 3: Episode Triggers Case Example

- Result: The patient recovers her strengths and quality of life
- She can go back to work
- The patient decides to leave management and start something completely new
- She is full of energy and can sleep again
- Back pain is completely gone
- Full remission of depressive symptoms

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EMDR DeprEnd Step 3

- **Reprocessing Episode Triggers**
- Stressful life event preceding a depressive episode (1-2 months)
- Can usually be named by the patient
- Mostly not criterion A (loss, shaming, humiliation, material loss)
- Typically high SUDs, may be intrusive
- Can be connected to old material

Hofmann, Hase et al. (2009)
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Evolution of the Cognitions

- Cognitions are more important in Depression than in PTSD !
- Look for second (different) NCs in phase 3
- Note them, but focus on one on phase 4
- In phase 5 look again and possibly install it too
- Dont take a VoC of 7 as the end of instalation in depressive patients
- Install as long as there is more progress in selfimage

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EMDR DeprEnd Step 4

Processing Negative Belief Systems

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Negative Belief Systems

Worthless

Cognitive Intrusions

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Belief Systems in AIP View


Worthless

Memory Networks Cognitive Intrusions

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EMDR DeprEnd[®] Step 4




Working with belief systems

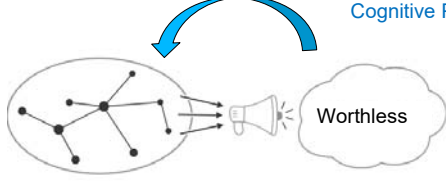
- How to recognize belief systems:
- Intrusive cognitions like: "I am worthless," "I will never be successful" (with high SUDs).
- Appear as negative cognitions in EMDR Phase 3
Look for memory network behind the belief!
- **Cognitive** Search: Proof memories
- **Affective** Search: Touchstone memories

Hofmann, Hase et al. (2009)
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Treating Belief Systems






Memory Networks Cognitive Intrusions

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EMDR DeprEnd[®] Step 4




- Diagnosis: Find cognitive intrusions
- If a negative belief system is diagnosed:
- Look for **proof memories** first
"What in your life proves that you are worthless e.g.?"
- Make a list (de Jongh, 2010)
- Prioritize
- Do not process it immediately!

Hofmann, Hase et al. (2009)
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EMDR DeprEnd[®] Step 4




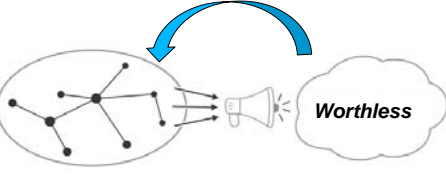
- Use a present trigger for the negative belief system and float back to find the **Touchstone Memory** (Shapiro, 2001)
- Sequence of Processing:
Go for the higher SUDs (usually touchstone m.)
Then, process **Proof memories**
Then, triggers and future projection/template
- Important role in relapse prevention
- Often longer installation phases!

Hofmann, Hase et al. (2009)
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Treating Belief Systems






Memory Networks Cognitive Intrusions

Affective Path
Float back

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Step 4: Belief System Case Example




- Patient, 45-years old clerk, married, one child (13)
- Depressive episode after death of her mother
- Disease-related anxieties and somatization
- First Step: Working with death of mother (episode trigger). That goes very well.
- Residual symptoms of sensitivity, irritability had the feeling: "I'm stupid", "I'm not okay," "I am unimportant."

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Step 4: Belief System Case example




- **Proof Memories:** Events of shaming in school
- NC: I'm stupid,
- Feeling: Shame; SUD = 10 !
- The memory is processed with impressive intensity
- At the end of the process: SUD is 0
- PC: "I am okay as I am," the body scan is clear

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Step 4: Belief System Case Example




- The belief "I am unimportant" is still charged
- Look for a **Touchstone memory** with Floatback
- Present trigger is a situation with the husband
- Touchstone memory found with the Floatback was where she ran away from home at age 5 and felt alone and unimportant (parents had a business and little time for her)
- NC: I'm unimportant PC: I'm important, VoC = 3, SUD = 10
- At the end of the session SUD = 0, VoC = 7

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Step 4: Belief System Case Example




- Treatment Results:
- Full remission of depression
- The patient feels she is back in life again
- No somatic problems
- She experiences herself as more confident

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EMDR DeprEnd[©] Step 5




Processing Depressive and Suicidal States

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What is a State?




- A memory network that remembers the "state" of being depressed or suicidal
- Often has no images or spontaneous cognitions
- Felt mainly in the **body**, behavior-related
- Using a representative symbol often helps such as visualization, verbalization
- Fits with concepts of Horowitz (1979) and AIP-model
- Different from spontaneous "Ego-State" with more consciousness involved (Federn 1952)

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Step 5: Depressive States Case Example



53-year old man with second depressive episode

Current episode started with humiliating talk with his boss

This episode trigger is processed well with EMDR

Residual Symptom: He suffers from morning low, especially on Mondays

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**Step 5: Depressive States
Case Example**

Asking for the background of the morning low, the patient remembers that the talk with the boss happened on Monday morning

Focusing on the memory "Morning low"

Image: My depressed face in the mirror

NC: I have no control

SUD=8, anger and fear → SUD 0

After EMDR: the morning low disappears

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**EMDR DeprEnd[©]
Step 5**

Suicidal States

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**Step 5: Suicidal State
Case Example**

- 55-year old patient with severe depression
- First episode at 13-years of age, since then 13 other episodes, mostly in spring
- Other episodes and after birth of first child
- Depressive episodes reappear after menopause
- Strong suicidal impulses, several "visits" to the railway track (without suicide attempt)
- Medication and psychotherapy for many years
- 10 sessions psychotherapy (4 EMDR processing)

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**Step 5: Suicidal State
Case Example**

10-sessions EMDR Psychotherapy

S.1-5. sessions History-Taking, Preparation and RDI

S. 6. EMDR session: Stressful image of last depressive episode (SUD 6,5 → 0)

S. 7-8. Sessions: Two other stressful memories, connected to episodes, processed (relief)

S. 9. EMDR session: Work with suicidal impulse
Image: Railway track "Urge to kill myself" (SUD=8)
"A feeling of desperation and hopelessness"

S. 10. During EMDR a memory appears (SUD=5-6):
Grandmother tells her about the war – (lost husband, the son – father of patient – came home-severely wounded home)

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**Step 5: Suicidal State
Case Example**

The SUD comes down to 0 in session that ends with an image of safety

Last session for closure

Patient in full remission at therapy end

Follow up **five years later**:
Two shorter depressive episodes triggered by the cancer diagnosis of her husband (citalopram 10mg for 4 months)

Present full remission, BDI II: 2

In situations of former suicidality
→ image of safety appears

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**EMDR DeprEnd[©]
Step 6**

Relapse Prevention

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Step 6: Relapse Prevention

Even if the depressive episode has ended
– remove/reduce risks for relapse:

- Look for residual episode triggers and trauma (before the compensation zone)
- Look for residual triggers (especially for belief systems)
- Look for social stressors and
- Look for fears of the future (relapse)

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Step 6: Relapse Prevention

Work with future projection

- Work with positive future templates
- Install specific resources for challenging future situations
- If body memories of the depressive episode still exist, work with these (depressive body state)

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Step 6: Relapse Prevention Case Example

- Soldier, 35-years old, married, two children
- Depressive episode that showed up during his stay in Afghanistan
- Extremely neglecting, adverse childhood experiences
- First Step: Working with events in Afghanistan (episode trigger). That goes very well.
- Next steps: working with believe systems stemmin from childhood.

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Step 6: Relapse Prevention Case example

- The depressive episode remits nicely, but he still fears to relapse into a new depressive episode.
- Picture: I'm sitting depressed on the edge of the bathtub.
- NC: I do't want to live any more
- PC: I want to live
- Feeling: Despair; SUD = 9 !
- This future projection is processed with impressive intensity
- At the end of the process: SUD is 0
- PC: "I want to live," the body scan is clear

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Step 6: Relapse Prevention Case Example

- Shortly after this session the patient says that he now feels really well.
- The fear of a new depressive episode has gone.
- A few sessions later he says that he feels so well that he doesn't need therapy any more.
- Therapy ends with a complete remission.
- Follow up after a year shows a complete remission and no further relapses.

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Case Example of a complex case of depression with trauma history (without PTSD)

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A Severe Case of Recurrent Depression



52-year old woman living on welfare
Panic attacks - many anxieties
Major Depression, more than 10 prior episodes (F33.2)
Relationship problems and present borderline disorder (F60.31)
Past alcohol abuse and eating disorder
3 suicide attempts, 5 hospital stays
Intrusions of abuse age 3-10, but no PTSD

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A Severe Case of Recurrent Depression



80 sessions of CBT plus (in midtherapy)
Better, but no change in intrusions and shame
5 sessions of RDI (inverted Protocol)
8 sessions of Standard EMDR Therapy
Broken relationship that triggered last episode (SUD: 6 down to 1) NC: "I am a failure"
Separation of her husband (SUD: 8 down to 0 in 2 sessions) PC: "It is over" VoC: 7
"Representative memory" of abuse by father (SUD 10) went down to 0 in two sessions

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A Severe Case of Recurrent Depression



8 sessions of Standard EMDR Therapy
PC after processing the abuse memory "I am worthy of being treated lovingly" VoC: 7
Focusing on a representative "memory" of childhood neglect
SUD of 9 came down to 0 in two sessions
PC: "I am loved" (linked to warm body feeling)
Since then no more intrusions and shame
At therapy end: Depression significantly improved and no more borderline diagnosis

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A Severe Case of Recurrent Depression



Follow up **six years later**:
No depression relapse, full remission
No more medication
Far better in relationships
Founded own business (with employees)
Recent Stressor: apartment burned down – she managed it without decompensation
BDI: 2

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Take Home Message



- Depression is to a large extent **a stress- and trauma-based disease**
- EMDR therapy for depression is at least as effective as CBT treatment (equivalent)
- Studies show that EMDR can lead to better results and fewer relapses
- If you use DeprEnd start with episode triggers first in outpatients and do complex PTSD patients later

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Thank you very much for your attention !



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