

EMDR Therapy  
for Schizophrenia  
and Other Psychoses

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# EMDR Therapy for Schizophrenia and Other Psychoses

**Paul William Miller, MD, DMH, MRCPsych**

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*For my family: Dad, who taught me the meaning of hard work, love, and perseverance; my wife Nicola and children Jessica and Joshua, my heart, my home, and my safe-place. Thank you for giving me the space and time for this project.*

*For Helen and Rosie: without you this book would never have been written; thank you for all your support.*

*E Pluribus Unum*

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An individual having unusual difficulties in coping with his environment struggles and kicks up the dust, as it were. I have used the figure of a fish caught on a hook: his gyrations must look peculiar to other fish that don't understand the circumstances; but his splashes are not his affliction, they are his effort to get rid of his affliction and as every fisherman knows these efforts may succeed.

—Karl Menninger, psychiatrist

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# Foreword

No psychiatric disorder is more shrouded in mystery, misunderstanding, and fear than schizophrenia. As Paul Miller notes, the original intention of Eugen Bleuler was for the diagnosis of “the schizophrenias” to represent a *group* of disorders. Upon examination of our contemporary scientific assumptions regarding schizophrenia in 2015, it is apparent that we may need to come *full circle* and carefully revisit the ideas Bleuler published in 1911.

The pendulum of mainstream psychiatry has, since the 1950s, swung overwhelmingly in the direction of endogenous and genetic models of schizophrenia. This mode of thinking has persisted despite the fact that the scientific data do not support a primarily genetic cause. As a specific genetic identifier is yet to be discovered, the current gold standard of evidence for genetically induced traits is monozygotic concordance. The classic twin study design relies on observing sets of twins raised together in the same family environment. Monozygotic (“identical”) twins share 100% of their genes, whereas dizygotic (“fraternal”) twins share only approximately 50% of their genes. Therefore, if a researcher compares the similarity for a particular trait between a set of identical twins to the similarity for said trait between a set of fraternal twins in that same family, then any excess resemblances between the identical twins should be attributed to genetics rather than the environment.

So, for example, if we examine traits that are obviously genetic, such as race, eye color, or gender, we find 100% monozygotic concordance. Similarly, in medical diseases that have clearly shown genetic causation, such as Huntington’s chorea, cystic fibrosis, and Tay-Sachs disease, we also find 100% monozygotic concordance. In studies examining schizophrenia, in contrast, we find only 30% monozygotic concordance. In fact, more recent studies with refined methodologies have found only approximately 22.4% concordance. Thus, the data do not support the claims that schizophrenia is predominantly genetic in origin. They support the conclusion that 22.4% to 30% may have genetic causation, whereas 70% to 78% of schizophrenia’s causation is, therefore, nongenetic. This calls into question the confidence with which the medical and scientific communities continue to make these claims despite decades of empirical evidence to the contrary.

Although Eugen Bleuler’s stature as one of the fathers of the schizophrenia field has endured, his descriptions of schizophrenia have been forgotten. Many of his phenomenological descriptions are almost identical to modern portrayals of dissociative identity disorder; for example, what Bleuler defines as “splitting” is synonymous with today’s definition of dissociation. He was furthermore aware that this group of schizophrenias also contained cases wherein a formal thought

disorder, rather than splitting/dissociation, was manifest. Bleuler observed that in the cases that he described as dissociative, histories of trauma were often evident. In contrast, some cases that he described as manifesting florid thought disorders were not overwhelmingly driven by traumatic histories. We've celebrated Bleuler, and honored many of his conceptualizations, but have managed to completely forget some of his most cogent and important observations.

Further examination of the amnesia and confusion in our medical and scientific communities requires an exploration of the mainstream criteria for the diagnosis of schizophrenia: Schneider's first rank symptoms. First rank symptoms (FRS) were first defined by Kurt Schneider as diagnostic of schizophrenia in 1959, at which point in time schizophrenia was already considered to be a purely genetic, endogenous thought disorder. Bleuler's phenomenological descriptions of splitting, dissociation, and trauma were forgotten, whereas his classifications of schizophrenia were still considered the gold standard.

To date, despite the lack of consistent empirical support, modern diagnostic criteria of schizophrenia continue to give particular emphasis to Schneider's FRS. Recent empirical explorations have noted numerous methodological flaws in previous studies that supported the diagnostic strength of FRS. The overwhelming majority of said studies suffered from insufficient sampling and methods of interview. An example: When examining whether FRS are predominantly features of schizophrenia, empirical standards dictate that it is necessary to examine whether the symptoms under examination are also found in non-schizophrenic patients, yet the overwhelming majority of studies lacked such a nonschizophrenic control group.

So, let's examine what this means in real life. Although Schneider, in the original German text, did not explain in detail his 11 first rank symptoms, they are considered to be as follows: voices commenting, voices arguing, made feelings, made impulses, made actions, made influences on the body, thought withdrawal, thought insertion, voice or thought broadcasting, delusions, and hallucinations.

Reflecting on the foregoing, it should come as no surprise to anyone at this point that people properly diagnosed with dissociative identity disorder (DID) consistently exhibit a majority of the first eight FRS (i.e., voices commenting, voices arguing, made feelings, made impulses, made actions, made influences on the body, thought withdrawal, thought insertion). They would thus appear to be symptoms of dissociation, not psychosis. They are often manifestations of alters speaking and of uncontrolled switching. In contrast, people properly diagnosed with the nondissociative schizophrenia thought disorder tend to overwhelmingly exhibit the FRS of voice or thought broadcasting, delusions, and hallucinations.

If this is known in the trauma and dissociation field, why is it ignored in the mainstream of psychiatry? Why do diagnostic interviews omit phenomenological explorations, such as "tell me about your life... what happened to you?" Is there some societal pressure causing us to cast a *blind eye*?

The author notes that Rolf Carriere, formerly of the United Nations, UNICEF, and the World Bank, has spoken of the "staggering global burden of trauma." Indeed, recent epidemiological studies suggest that with the increasing rates of trauma worldwide, posttraumatic stress disorder (PTSD) is on track to

become a major global public health problem. Despite its wide prevalence, PTSD continues, nonetheless, to be ignored or relatively underrecognized, with proper diagnoses complicated by stigma, comorbidity and symptom overlap, rigid onset criteria, and questionably high diagnostic thresholds.

Frank Putnam has argued that the study of dissociation, and DID in particular, appears to have been held to a different standard than that of any other disorder. Nowhere else has such a body of research, consisting of clinical case histories, series studies with structured interview data, and studies of memory, prevalence, neurobiology, and neuroimaging, utilizing samples of children and adolescents from North America, Europe, Latin America, Turkey, and Asia, been so entirely discounted.

Richard Lowenstein has opined that when viewed within a larger sociopolitical context, dissociation theory intersects with many of the most controversial social issues of modern times. The role of trauma in our culture, particularly intergenerational violence and sexual abuse, intersects with historically taboo subjects such as rape, incest, child abuse, and domestic violence, and their actual pervasiveness in our society. In addition, the study of trauma forces us to confront greater legal, social, and cultural questions related to peace and war, the implications of violence in our society, the meaning of good and evil, and even divergent religious views about the relationship between men, women, children, and the nature of the family.

Bessel van der Kolk contends,

A hundred years of research have shown that patients often cannot remember, and instead reenact their dramas in interpersonal misery. The professionals attending to these patients have had similar problems with remembering the past, and thrice in this century have drawn a blank over the hard-earned lessons. It is not likely that these amnesias and dissociations will be things of the past; they are likely to continue as long as we physicians and psychologists are faced with human breakdown in the face of overwhelming stress, which flies in the face of our inherent hubris of imagining ourselves as masters of our own fate, and as long as we need to hide from the intolerable reality of “man’s inhumanity to man.”

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Thus, the understatement of the impact of the vast epidemic of world PTSD—driven by centuries of history written in the blood of colonialism, wars, slavery, pogroms and holocausts, global economic and natural disasters—should hardly surprise us. Is it any wonder that on a global level, science ignores Bleuler’s observations regarding trauma and dissociation, and their relationship to psychotic processes?

From a clinical perspective, several questions are raised. If we reach back to Bleuler and bring his phenomenology forward to the present, how would this affect our diagnoses of schizophrenia? One possibility is that Bleuler was referring to both what are currently considered cases of DID as well as nondissociative schizophrenic thought disorders. Another possibility, as Colin Ross has suggested, would be that Bleuler was addressing a whole spectrum of disorders, such as nondissociative schizophrenia, dissociative schizophrenia, schizo-

dissociative disorder, and dissociative identity disorder. A third possibility, also proposed by Colin Ross, suggests that Bleuler intended to distinguish between dissociative schizophrenia and nondissociative schizophrenia; this would imply that we may not need the diagnosis of DID—we would simply follow Bleuler and discuss the various forms of *schizophrenias*. That would truly honor Bleuler's recommendations.

The good news is that we need not immediately answer these questions in order to implement Dr. Miller's clinical recommendations. We need only, as Colin Ross recommends, to begin to view these cases through a new lens, without necessarily reaching a definitive conclusion about their diagnoses. If we abide by Bleuler's emphasis on a careful phenomenological exploration, it becomes rather clear as to what specific treatment these different cases require.

Dr. Miller notes that, with respect to eye movement desensitization and reprocessing (EMDR) treatment, the following presentations can be discerned: people diagnosed with psychosis who are affected by identifiable trauma that appears etiologically linked; people diagnosed with psychosis who experience the psychotic phenomena and/or their treatment as traumatic; and those where the PTSD and psychosis are comorbid, with the comorbidity acting as a perpetuating factor in their presentation. In this book, perhaps the most seminal and promising recommendation that Paul Miller makes is that EMDR treatment can address psychotic symptoms without the need to identify a dysfunctional memory network, but rather by processing directly the core beliefs that are driving the psychosis.

This scholarly offering is a clarion call for us to listen to our patients and to let their stories inform their treatment. This book is a major contribution to furthering the understanding of trauma in general, and the schizophrenias in particular. It is written with a wonderful warmth and an ever-so-subtle twinkle of humor that lurks just below the surface. Paul Miller's ideas bring a healing sunlight to an area that has been encased for so long in darkness, and will open the doors to tens of thousands of people suffering from schizophrenia and other psychoses who have been denied effective comprehensive treatment. It is with the greatest of pleasure and admiration that I write this foreword.

**Uri Bergmann, PhD**

Past president, EMDR International Association  
Author, *Neurobiological Foundations for EMDR Practice*

# Preface

I asked a dear friend and mentor to comment on what he thought of this book, and with his consent I share what he sent to me in reply:

*Readers of this text will eventually end up in two categories:*

1. *Finally! A new approach, something radically different.*
2. *No! This is too radical, too different, too unproven.*

*My hope for the reader is that you avoid either category!*

*Let this text create arguments leading to a constructively improved adjunctive therapy for those who suffer and have not received sufficient help through traditional treatments.*

*Bring forward the doubts, the questions, the arguments: the constructive differentiations of these diagnostic categories.*

*Bring on the good that comes forth as you tentatively explore, implement, and personalize some of these ideas.*

*Stay united, as well, on the goal of all healers: to bring understanding, adaptation, comfort—a sense of wholeness—to those for whom suffering has been so poorly understood, so difficult for both the individual and for those whom he loves.*

*Walter Bahn, MSW*

The biggest impact of any person on my clinical practice as a psychiatrist was a patient I will call *Janus*, for he was the ending of my thinking that schizophrenia and psychoses were untreatable with psychotherapy and the beginning of my journey that witnessed a person, who met the strict *DSM-III-R* (*Diagnostic and Statistical Manual of Mental Disorders* [3rd ed., revised]—the diagnostic “bible” used for classifying mental illness) criteria for schizophrenia, that I learned to use as a member of Professor Kenneth Kendler’s Irish Schizophrenia Triad Study. At the time of writing, Janus is approaching 8 years symptom-free and medication-free; he has restarted his working life and is contented. I hope that these pages will entice you to make a similar journey.

I have always loved stories, and one of my mentors in psychiatry taught me that good psychotherapists are often good storytellers. Have a beginning, middle, and end . . . and have a point (i.e., meaning): These are the essential rules of narrative and they never need to be learned. We know them intuitively—from our earliest days we do not need to be taught how to understand or follow a

story; we are simply able to do so. This ability to generate narrative is a core part of the human condition and one that wreaks havoc when it ceases to function as designed.

I want to invite you to join me in a story, a journey through knowing and understanding a narrative that is in general about psychosis and in particular schizophrenia. If I follow the innate “rules” of narrative, then this journey will have a beginning, middle, and end and it will have meaning. I hope you will agree that I have stuck to this model when we finish our journey together. This story, like all good stories, has a number of sub-plots that create something that is bigger than any individual element: the story of psychosis and schizophrenia; the story of a client who changed my practice; the story of a woman, a “walk in a park,” and a community of open-hearted healers—Francine Shapiro and the EMDR therapy community.

This community introduced me to a wonderful and powerful psychotherapy that I have witnessed helping people in my community who have suffered from the internecine violence of what we in typically understated Ulster terminology called “the Troubles.” I have also seen it help bring wholeness and healing to clients with anxiety disorders, phobias, obsessive compulsive disorder, and depression, but the most powerful impact on me was when I realized its efficacy in schizophrenia and psychosis.

One day, while listening to a radio program on my commute to work, I heard the host interview an expert who made the following comment: “We wanted Jack, who was a six-year-old boy, to ask some of the big questions about the universe and life; so that we could record them.” But they were unable to get the boy to do so, as he simply wanted to tell them what he thought the answers to such questions were. Jack already had a narrative in place that explained the universe as he saw it, “the sky isn’t black; it is just, really . . . really blue.” This process of narrative generation is what we do throughout life and it begins when we are children. We are born to narrate the world around us; this is what allows us to feel our way through life and to place ourselves in the world. Random observations and data taken into the mind are sorted and assimilated to generate meaning, and this process helps us to orientate and feel safe. This is essentially the *adaptive information processing* (AIP) system that Francine Shapiro describes, which underpins *eye movement desensitization and reprocessing* (EMDR) therapy (Shapiro & Maxfield, 2002). AIP is a natural, in-born system, and the AIP model is the soil in which we sow the stories of our clients. The AIP mechanism is like a cartographer making a map, which allows us to navigate our way through the unknown landscape of life ahead, and AIP is the map-making system that we are all born with. People and societies have always told stories to help understand themselves and to allow them to find their place in the World. Dáithí O’Suilleabhain, a friend of mine who is a cartographer, once explained how many indigenous peoples have stories and songs that teach them about their environment (O’Suilleabhain, 2013). Often as an elder walks a person through the landscape, the elder will sing their journey. These songs orientate individuals, allowing them to find their way, and also teach them how to look after the land.

Dáithí explained to me, following a trip to Belfast,

When place, story, and song come together, indigenous people call it singing the land. We sing it into existence by story and song. It then fills our awareness. We can sing it as we journey through naming all the features we see left and right as we pass, Slieve Scroob & Dromara, Slievenaboley & Aughnaskeagh, Lappoges & Dromore Donaghcloney & Maheralin, Moira, Hillsborough & The Maze, Lisburn & Lambeg, Ballynahatty's Giant's Ring, Belvoir Forest. Queen's City, hidden Blackstaff River and The Docks. Mountains and hills of Collin, White, Divis, Black, Wolf, Squires, Cave and Knockagh, and Mariners naming each rocky crag of coastline Lough. Singing it into existence, singing a journey through, singing it back to health. (O'Suilleabhain, 2013)

However, what happens when the narrative process fails or flounders? Do we get meaningless jibber-jabber, or do we get a different form of narrative? In 1913 Jaspers built the foundation of psychiatric nosology on the dichotomy of neuroses and psychoses (Jaspers, 1913). For a long time, in the post-Jaspers age, we viewed psychosis as unintelligible and meaningless babble spewed out from the "broken mind" of the psychotic individual. No more worthy of study than spilled milk; all it represents was that a spillage had occurred. However, for those of us who are prepared to really listen, we discover that there is symbol and meaning in the psychotic material; this can at times be understood, and often it can provide access to the place where healing can be found. Schizophrenia is generally considered the most disabling form of psychosis; however, contrary to the assumptions of Jaspers, the mind of a person suffering with schizophrenia is not just a complex, broken machine with meaningless output; there is meaning in the symbols contained in the phenomena (delusions and hallucinations), and I believe that this principle is the key to seeing the negative cognitions and dysfunctional memory networks in psychosis as amenable to the psychotherapies such as EMDR therapy. We are creatures of symbols; they give us meaning, form the basis of language, and facilitate connection with each other. I want to invite us to think of the phenomena in psychosis as Indicating Cognitions of Negative Networks (ICoNNs), and it is these negative networks that the EMDR therapist ultimately wants to reprocess; they are what Shapiro calls "dysfunctional memory networks" (DMNs) in her AIP model.

Example:

*A man who comes to the clinic with a dog phobia presents his phenomena, and its functional impact, as an icon (ICoNN) of his underlying problem: the dysfunctional memory network relating to a time in childhood when a dog attacked him. Thus in EMDR therapy, considering his presentation within an AIP formulation, we identify and target the dog attack with the resulting functional outcome being that he is no longer afraid of dogs in the present.*

In the standard eight-phase treatment model of EMDR therapy, the target is the past event that connects us to the dysfunctional memory network, its affect and negative cognition. In the previous example the target would be

an aspect of the original dog attack. Yet, as the EMDR therapy model has been evolving clinically we see authors delineating protocols where the target is in the present. We see this in Elan Shapiro’s Recent-Trauma Episode Protocol (R-TEP; Shapiro & Laub, 2013) and Robert Miller’s Feeling-State Addiction Protocol (FSAP; Miller, 2010).

The R-TEP is an adaptation of the basic EMDR therapy protocol for treating recent traumatic memories—it is useful when the traumatic memory has not yet been consolidated or integrated into memory. The R-TEP protocol is a brief intervention (possibly on successive days) that may be used not only to treat acute distress, but also to provide a window of opportunity to prevent future complications from occurring and to strengthen resilience. Early intervention with EMDR therapy seems to reduce the sensitization and accumulation of trauma memories by means of rapid reduction of intrusive symptoms and a de-arousal response. R-TEP incorporates and extends existing EMDR therapy protocols together with additional measures for containment and safety.

The FSAP allows clinicians to work with substance and behavioral addictions, such as gambling compulsions, sex addictions, and smoking, that have been notoriously resistant to treatment. The feeling-state theory (FST) of addiction presents a new understanding of the etiology of addiction, hypothesizing that addictions are caused by a fixation of a positive feeling event. Afterward, whenever the person wants to experience that feel-good feeling, the link with that particular behavior is triggered. By utilizing this model of addictive behavior, Robert Miller has delineated the FSAP as a modified form of EMDR therapy that helps the client to break the fixation, resulting in the resolution of behavioral addictions with the elimination of the urges and cravings of substance addictions.

This book introduces the ICoNN approach, which is an adaptation to the standard eight-phase protocol that is helpful in working with psychosis. The ICoNN approach is similar to the R-TEP and FSAP, as the modification of the standard eight-phase, three-pronged protocol is in respect to target identification, which allows psychotic phenomena to be used as targets for reprocessing by a clinician using EMDR therapy. Once we repatriate schizophrenia into the spectrum of disorders that it was originally associated with, which is to say, “those which can be interpreted by a dissociation model” (Moskowitz, Schäfer, & Dorahy, 2008), we can more understandably apply a trauma-focused formulation to schizophrenia in particular and psychoses in general; then the potential effectiveness of the psychotherapies, such as EMDR therapy, in psychotic disorders becomes all the more apparent.

We have been speaking about psychosis and are also mentioning dissociation, seemingly interchangeably, and I have spoken of returning schizophrenia to the category of dissociative disorders. Dr. Colin Ross looks at the clinical phenomenological conundrum of “psychosis or dissociation” and states, “~~The overlap between the core features of dissociative identity disorder (DID) & schizophrenia cannot be reduced to a problem of comorbidity because the two are not discrete & separate categories. They cannot be comorbid with each other as they are too often and too much the same thing~~” (Ross, 2004). I concur with his opinion.

Essentially, from a psychological perspective, if trauma results in a failure of narrative generation this results in the formation of a DMN; this in turn is

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adapted to through dissociation, which suggests that if the DMN driving the dissociative (psychotic) psychopathology can be processed, then the pathology should resolve. This theory is in keeping with the AIP model of EMDR therapy. We will see from the small amount of case material that is presently available and from current international research that this is indeed what can be observed clinically in some, and those patients who respond positively can achieve long-term symptom control without the need for medication. Despite having more than 100 years of experience with the mental disorder formulated as schizophrenia, only a minority of cases can be said to make a full recovery; this observation invites us as clinicians and scientists to be, at the very least, curious about the apparent response to psychotherapeutic interventions. In many fields of science we have suffered from a them-and-us form of trench warfare: psychology versus psychiatry, nature versus nurture, and drug therapy versus talk therapy. I want to invite us to be more integrative and to consider allowing the content of this book's journey to inform a third space where we can allow dissonance to form and, I hope, to eventually bring clarity. Richard Rohr describes such a position well, and I share a section from a recent daily contemplation from his blog to give us a context for the "third space" that I am inviting you to join me in:

The House that Wisdom Builds—"Paradox" comes from two Greek words: *para* + *doksos*, meaning beyond the teaching or beyond the opinion. A paradox emerges when you've started to reconcile seeming contradictions, consciously or unconsciously. Paradox is the ability to live with contradictions without making them mutually exclusive, realizing they can often be both/and instead of either/or. G. K. Chesterton said that a paradox is often a truth standing on its head to get our attention! "Dialectic" is the process of overcoming seeming opposites by uncovering a reconciling third. The third way is not simply a third opinion. It's a third space, a holding tank, where you hold the truth in both positions without dismissing either one of them. It often becomes the 'house that wisdom builds' (Proverbs 9:1-6). It's really the fruit of a contemplative mind. (Rohr, 2014)

So, with this in mind, let us indulge our curiosity in our own third space.

"Curiosity has its own reason for existing. One cannot help but be in awe when he contemplates the mysteries of eternity, of life, of the marvellous structure of reality."

—Albert Einstein

(Recollection of a statement to William Miller, an editor,  
as quoted in *Life* magazine, May 2, 1955)

My own professional journey with EMDR therapy began in 1997 when a colleague, Dr. Michael Curran, invited me to attend an EMDR therapy training organized by Humanitarian Assistance Programs (HAP), which was being run to help the local mental health professionals in Northern Ireland in dealing with the violence of the previous decades: "the Troubles." The training was delivered

in the city of my birth, its very name a shibboleth—Derry/Londonderry feeling-state theory—and it remains so for many, and I have witnessed too many people who have been attacked and injured just for calling it the “wrong” name. All these things meant that it was a very appropriate birthplace for an area of my professional practice that is responding to the pain and hurt of the violence of the Troubles and for trauma in general. In that training I was excited to hear and experience this “new” therapy that was linking in with a developing neurobiological understanding of the psychological impact of a traumatic event. It also appeared readily scalable, as it built upon the existing professional skills of mental health professionals and has at its core the innate information processing of the human mind. I believed that it could provide much-needed treatment for posttraumatic stress disorder (PTSD) and the other psychological sequelae of trauma to a community that needed healing. EMDR therapy’s potential as a readily scalable psychotherapy for the treatment of posttraumatic psychological conditions was to be later picked up famously by Rolf Carriere, a development economist who worked for the United Nations and the World Bank. After he read Dr. Shapiro’s book, while a UNICEF representative in Bangladesh in the 1990s, he saw EMDR therapy’s potential for the people of Bangladesh who had been traumatized through a violent war of independence; 54 Bangladeshi psychiatrists and psychologists were initially trained after he serendipitously picked up Dr. Shapiro’s first book on the therapy (Carriere, 2013).

As in the United States (Manfield, 1998), Northern Irish psychiatry in the early 1990s was not generally accepting of EMDR therapy and it was treated with much suspicion; many viewed it as a dressed-up and repackaged form of cognitive behavioral therapy (CBT) at best. I recall a time, while at a revision course for my exams for membership in the Royal College of Psychiatrists, when the trainer was asking what psychotherapy models we had experience with; they looked with derision on EMDR therapy. I was repeatedly told that EMDR therapy was just a technique, and a colleague recently told me that a senior colleague had once told him that as a practitioner of EMDR he ought not to consider himself a psychotherapist.

At the same time in the field of psychotherapy, CBT was the rising star, and there was little space for other modalities. Nonetheless, I began to see people recovering from their traumas as I applied an EMDR therapy paradigm to their presenting problems, which largely consisted of PTSD. One of my favorite quotes that characterizes that period in my professional development is by Dag Hammarskjöld, a Swedish diplomat, the second United Nations Secretary-General, and Nobel Peace Prize recipient: “Never, ‘for the sake of peace and quiet,’ deny your own experience or convictions” (Hammarskjöld, 1966). When working with victims of the violence of the Troubles and of civilian trauma—road traffic collisions and childhood sexual abuse, for example—I began to see remarkable healing; I witnessed patients’ recovery and was powerfully impacted by this. Whereas some mental health professionals were negative or merely apathetic, Dr. P. S. Curran was supportive and encouraged me, saying, “the patients don’t read the textbooks.” As a consequence, they didn’t know that they were not supposed to improve, and so despite there being no strong published evidence at that time, I found my patients getting better. As I write this, there are now

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more than 30 randomized controlled trials (RCTs) worldwide examining EMDR therapy; the patients still haven't read them.

The battle for the recognition of the efficacy and validity of EMDR therapy was led in Northern Ireland by pioneers in the field such as Dr. Des Poole, who brought EMDR therapy to Northern Ireland; and the advocacy of Dr. Michael Paterson OBE was key in having Clinical Resource Efficiency Support Team (CREST) include EMDR therapy in its 2003 guidance for the psychological treatment of PTSD, guidance that preceded the wider UK National Institute for Health and Care Excellence (NICE) Guidelines. Many people are now benefiting because of these endeavors. The EMDR therapy community in the island of Ireland is now healthy and growing, with many active and openhearted participants.

We are also at a time of a highly significant paradigm change for the EMDR therapy community. Pathfinders forge ahead and make the path easier for those who follow. In the United Kingdom (UK), enormous efforts and commitment by Dr. Derek Farrell have resulted in the development and delivery of the first university-based EMDR therapy training at the University of Worcester, where it is delivered as a Masters in Science course (MSc). I am fortunate to be in the first group of EMDR Europe Trainers-in-Training who are being mentored by Dr. Farrell; the group has been drawn from the UK, Ireland, Greece, and Pakistan, and as a group we will be endeavoring to develop the research and further study and growth of EMDR therapy through academic training. We as trainers will be contributing to the teaching of the course, and many of us believe that this shift from an essentially entrepreneurial model of EMDR therapy training to an academically focused one will mark a paradigm shift for EMDR therapy training that is as vital and as important as the delineation of EMDR therapy itself. These are exciting times, and this book is written for such a time as this, where innovation can be tested and cupellated in the crucible of academia for the benefit of humankind and not seeking fame, reward, or a bigger bank balance.

I have now had the great honor to hear Dr. Francine Shapiro, the originator of EMDR therapy, speak many times, and she has been a source of great support and encouragement for me. She has called me the "father" of this area of development for EMDR therapy: the application of EMDR therapy in schizophrenia and psychosis. If I am the father, she must surely be the "mother," for I could never have birthed this area of innovation without her. At the start of her keynote addresses she asks the audience to indicate with a show of hands what areas of clinical practice they are applying EMDR therapy to. I have witnessed responses that cover depression, obsessive-compulsive disorders, addictions, pedophilia, the reduction of self-harming behaviors, and, of course, psychosis; her response is always the same: "publish." There is now a solid research literature examining EMDR therapy for PTSD, but the other clinical areas continue to lag behind. This is something that I believe will change fundamentally as we move EMDR therapy training and study into mainstream academia. I hope that this book will further encourage the exploration and research of the clinical applications of EMDR therapy, and to achieve that goal I believe that we need to take some "radical" approaches. I believe that this radical change will come through a return to the roots of the phenomenology of schizophrenia, with a repatriation of "the schizophrenias" into the category of psychiatric illnesses that can be framed within a

dissociation model (Moskowitz et al., 2008) that allows a trauma-focused formulation of cases to be made (Miller, 2014). Such a formulation sits readily within the architecture of the AIP model if we postulate that trauma leads to a derailment and failure of the adaptive information processing system, resulting in a dysfunctional memory network. I propose that by targeting and reprocessing the dysfunctional memory network through the biological facilitation of memorial processing, by the actions of dual attention stimulation/bilateral stimulation (DAS/BLS) acting via stochastic resonance (SR), we can achieve resolution of the psychotic phenomena, and this is indeed what I have observed. As the AIP model is the central paradigm that EMDR therapy is built upon, I wish to look at it in more detail next, and we will similarly explore how the proposed innate mechanism of SR, which is believed to be ubiquitous throughout nature, has a key role too.

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My early experience in psychiatry attracted me to the multidisciplinary team environment of psychogeriatrics (the psychiatry of old age), with the integration of mind and body formulations and treatments. Psychiatric colleagues such as E. Anne Montgomery, Stephen Compton, Jill Gilbert, and Noel Scott, to name a few, stoked my love for working with the over-65-years age group, and I am grateful for that. I found the field of old-age psychiatry to be richly multidisciplinary, maintaining a healthy connection with the brain, thus retaining a holistic approach.

The first consultant psychiatrist whom I worked under was Peter S. Curran, a local Northern Irish expert in psychological trauma, based at the Mater Hospital. I am grateful for his support and mentorship across the years. He taught me to respect every member of the team when I started in the Mater, Belfast. Subsequently, F. A. (Tony) O'Neill and Professor Kenneth Kendler gave me a wonderful opportunity within the GEMINI team, the Northern Irish arm of the Irish Schizophrenia Triad Study. This was a genetic epidemiological exploration of schizophrenia on the island of Ireland, and the training in the phenomenological assessment of schizophrenia that these men and the wider team gave me continues to be a wonderful gift.

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This book is a testament to a community of people; I hope that you find something in it that is of value. My prayer is that in the crucible of clinical practice and peer review the “hay and straw” will burn up and the “gold and silver” remain as a good work, well done.

“The way to get things done is not to mind  
who gets the credit.”

*Benjamin Jowett (1817–1893, English clergyman,  
educator, and classicist, quoted in John Gross,  
The Oxford Book of Aphorisms)*

# Introduction

## EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR) THERAPY AND THE ADAPTIVE INFORMATION PROCESSING (AIP) MODEL

Eye movement desensitization and reprocessing (EMDR) therapy is an integrative psychotherapy developed by Dr. Francine Shapiro (Shapiro, 2001). In 1989 she published the first research data examining and delineating the therapy, while a Senior Research Fellow in Palo Alto, California (Shapiro, 1989). Through the endeavors of the clinical community, EMDR therapy has gained recognition as an efficacious therapy for the treatment of posttraumatic stress disorder (PTSD). In the United Kingdom (UK), it has been recommended as a gold standard in the psychological treatment of those suffering from PTSD, being first recommended by the Clinical Resource Efficiency Support Team (CREST) in its document that gave guidance on the psychological management of PTSD, “The Management of Post-Traumatic Stress Disorder in Adults” (CREST, 2003). CREST operated in Northern Ireland, a UK region that has seen substantial loss of life and experienced severe trauma within its relatively small community of around 1½ million people. This was due to the internecine violence colloquially referred to as “the Troubles.” The work of CREST was duly followed in the rest of the UK with a similar recommendation by the National Institute for Health and Care Excellence (known as NICE; NICE, 2005), and most recently the World Health Organization (WHO) published *WHO Guidelines on Conditions Specifically Related to Stress*, which recommends the use of EMDR therapy in the treatment of posttraumatic stress disorder (PTSD) for children, adolescents, and adults—see specifically recommendations 14 and 15 (WHO, 2013).

## ADAPTIVE INFORMATION PROCESSING, PSYCHOPATHOLOGY, AND MALADAPTIVE ENCODING OF TRAUMATIC LIFE EXPERIENCES

Rolf Carriere has spoken of the “staggering global burden of trauma” (Carriere, 2013), and I believe that it is our duty to respond to this huge area of need. I have heard this articulated in many forms, but essentially it comes down to the same thing, hurt people, hurt people. As we will see later from the discussion of the epigenetics and neurobiological effects of trauma on the body, this cycle need not continue (Pembrey et al., 2006; Waterland & Jirtle, 2003; Weaver et al., 2004). A foundational postulate of the AIP model and of EMDR therapy is that we are

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all born with an innate information processing system that takes the experiential data of our lives and processes it into a cohesive, coherent, and contiguous narrative that allows us to make sense of the world around us and of our place in it. This system need not be learned or studied by the patient before he or she can benefit from its functioning. However, it is this same information processing system that can get derailed in a trauma, resulting in dysfunctionally stored material, which results in the pathologies we see clients presenting with in our offices and clinics. In the late 1880s, pioneering French psychologist, philosopher, and psychotherapist Pierre Janet developed detailed and comprehensive models of dissociation and traumatic memories (van der Hart & Dorahy, 2006). Although some have sought to erroneously state that he came to later repudiate his theories on dissociation, the evidence does not support this (Dorahy & van der Hart, 2006). Janet stated that traumatic memories are distinct from normal “bad” memories and postulated that they are stored differently in the brain and have differing properties—something that to my mind is very much a foundational aspect of the AIP model. These unprocessed, state-specific, frozen memories are conceptualized as *dysfunctional memory networks* (DMNs) by Shapiro (2007), and I believe that just as Jung’s “complex” derives from Janet’s “fixed idea,” the DMNs of the AIP model belong to the same lineage. Consider Jung’s description of a complex in his 1934 review, quoted by Moskowitz (2006).

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What then, scientifically speaking, is a “feeling-toned complex”? It is the *image* of a certain psychic situation which is strongly accentuated emotionally. . . . This image has a powerful inner coherence, it has its own wholeness, and in addition, a relatively high degree of autonomy . . . and therefore behaves like an animated foreign body in the sphere of consciousness (Jung, 1960/1934).

In this same review in 1934, Jung describes complexes as having a trauma at their genesis: “The aetiology of their origin is frequently a so-called trauma, an emotional shock or some such thing, that splits off a bit of the psyche (Jung, 1960/1934)” (Moskowitz, 2006). This is also how Janet described the formation of his “fixed idea,” and Jung acknowledges his debt to Janet, as I believe we must do too in regard to the DMN.

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## PIERRE JANET—ONE OF PSYCHOTRAUMATOLOGY’S GIANTS

I believe that we stand on the shoulders of giants; indeed, it is our duty to do so, and one such giant in the area of psychotraumatology is undoubtedly Pierre Janet. We will learn later in the book that Janet’s work had a significant influence on Bleuler and Jung (Moskowitz, 2006; Moskowitz, Schäfer, & Dorahy, 2008). The AIP model allows us to see further along this course of study, as it explains the basis of pathology, predicts successful clinical outcomes, and guides the clinician in case conceptualization (*formulation*) and treatment procedures (Shapiro, 2007). Within this innate information processing system we take the experiences of the outside world and process them, stripping them of extraneous data, automatically linking the perceptions of current situations with associated memory networks already in existence.



Everyone reading this book will know that one plus one equals two—it forms a part of our mathematical understanding—but very few of us, if any, will recall where we were and who we were with when we learned it. We simply do not need that level of information. When the AIP system processes new experiences, the incoming sensory perceptions are integrated and connected to related information that is already stored in the person’s memory networks. This conceptualization informs the intention and sequencing of the eight phases of EMDR therapy, and we know that the more closely treatment adheres to the eight-phase protocol the better the clinical outcome (Maxfield & Hyer, 2002).

## THE DOG BITE

If we explore a clinical example, this will aid our understanding of how the AIP model benefits us. Think of an individual who has had the experience of being bitten by a dog as a young boy; such an experience can be sufficiently negative and emotionally charged to overwhelm the innate processing system, resulting in unprocessed material. This material, we conceptualize, becomes stored as a DMN containing emotions and perceptual information in state-specific form. This DMN is cut off from the processed, functionally encoded, coherent memories that already exist in the person’s mind—perhaps happy memories of playful interaction with a dog—but it also remains cut off in the person’s future experiences. The unprocessed material can remain walled off like an abscess within a patient’s body, and it is this “psychic abscess” that can be triggered by idiosyncratic present experiences, manifesting disorder. The boy grows into a man and the DMN remains walled off from any new learning. So when he sees a dog of the same breed that bit him as a boy, this acts as a trigger to summon the DMN. The key characteristics of this DMN are that it exists outside of context and chronology and is stored in state-specific form—meaning it is frozen in time in its own neural network, unable to adaptively connect with other memory networks (Solomon & Shapiro, 2008). In this unprocessed form it is relived rather than remembered, in line with Pierre Janet’s model for dissociated traumatic memories (Janet). So considering our current example, even if a strong adult male was bitten by a very small dog such as a Chihuahua when he was a boy, the DMN—with its strongly negative state-specific perceptions, feelings, and cognitions—is triggered in the present by seeing a Chihuahua; this results in an intense emotional response. He may become frozen in fear in the presence of this breed of dog even though the actual risk to him is negligible in the present. In this example we can see how the AIP model predicts pathology and helps us to understand the client’s current presentation—that is, a severe fear response to and avoidance of Chihuahuas. The DMN is fear-laden and associated with “adaptive” avoidant behaviors triggered by this specific breed of dog.

## GETTING THE RIGHT TARGET FOR EMDR THERAPY

The AIP model directs the clinician to target the original trauma, which, like a pollutant entering a river, poisons everything downstream of its point of entry. In this metaphor of a polluted river, we can see that the best response is to

remove the pollution at the source, rather than to merely decontaminate the river downstream, and this is what the AIP model directs us as EMDR clinicians to do; we do so within the eight phases of the treatment model. The processing of the original trauma (the source of pollution) links the previously unprocessed material with existing functional memory networks and so removes the drive for pathology in the present and future, and this is indeed what we observe (Shapiro, 2007; Shapiro & Forrest, 1997; Shapiro & Maxfield, 2002). In EMDR we examine the past, present, and future within what is called the three-pronged process. This three-pronged process sits within the AIP model, and essentially the clinician processes the *past* “unmetabolized” DMN that generates the presenting pathology, processes the *present* situations that cause disturbance, and generates an adaptive *future* template to allow the individual to facilitate effective future action (Manfield, 1998). As already mentioned, the growing neurobiological understanding of memory processing and the effects of trauma helps us to understand the nature of the eight phases in the standard protocol and the logic for their sequencing. We can unpack this further if we consider the neurobiology of normal information processing according to the AIP model. Those wishing a deeper understanding of the current research on the neurobiological foundations of EMDR practice are directed to read Uri Bergman’s book *Neurobiological Foundations for EMDR Practice*, which I consider a seminal text in this area of study and that I recommend to you (Bergmann, 2012).

## SCHIZOPHRENIA/PSYCHOSIS AND THE TRAUMA MODEL

As the nature/nurture debate continues, I hope that we can hold both these considerations in a “third space,” as ultimately this will provide clarity and give the best hope of healing to this patient group. When we examine schizophrenia by formulating it within a trauma model, this allows us to consider the application of psychotherapies with a trauma focus. EMDR therapy is one of the current international gold-standard psychotherapies for PTSD, and early outcomes of its application to schizophrenia have been encouraging (Kim et al., 2010; Miller, 2010, 2014); however, more work is warranted. Of course, by holding to the principle of third space we can choose not to get stuck in the debate of talking therapy versus drug therapy (*either/or*), and instead we embrace a *both/and* approach. This makes sense clinically, as psychotherapy will not necessarily exclude the need for drug therapy completely in all cases. As clinicians we commit ourselves to life-long learning; psychiatrists and doctors refer to our work as a medical “practice”—we are not yet getting it perfectly right. If you think you are, perhaps you ought to think again.

## LIFE-LONG LEARNING

Francine Shapiro and the works of Colin Ross (2004, 2013), Jim Knipe (2014, 2015), and Carol Forgash (Forgash & Copeley, 2008) have been extremely influential. Their work encourages me to explore this area of EMDR therapy. I still recall the conversation that Jim Knipe and I had in Philadelphia, sitting outside in the sun during an EMDR International Association (EMDRIA) conference. Research

is not a simple and straightforward endeavor; it is difficult, complex, and challenging. However, seeing the commitment of individuals like Tony O'Neill and Kenneth Kendler encouraged me to take the risks and work toward getting the necessary research done and published. At the start of my research MD thesis (Miller, 2007), I quoted the words of Barbara W. Tuchman (American author and two-time Pulitzer Prize winner): "Research is endlessly seductive: writing is hard work" (Tuchman, 1979).

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Research and the statements based upon it have consequences—unintended as well as intended. We see this in the nosological journey that the DSM itself has taken with disorders such as PTSD. I believe that it is in community that we heal and can be healers; therefore, we need to understand mental disorder as it is experienced within and through a community context. The importance of the intersubjective within the EMDR therapy method is greatly enriched through the teaching of Mark Dworkin (2005). We are required to be fully present and connect with one another to undertake good therapy. It will therefore come as no surprise that I believe that healing takes place, in psychosis, schizophrenia, and dissociative disorders, within the intersubjective space. This is where we connect in the milieu of the very nature of our consciousness. At the start of a book that explores shell shock, the following appears: "A French doctor has said, 'Il n'y a pas de maladies' [*There are no sicknesses, there are only sick people*]" (Smith & Pear, 1917). I have been taught that those who are wounded in the crucible of community must heal in community, and this is an important consideration for the people who seek my help. The EMDR therapy community is eclectic, and, like the function of rapid eye movement (REM) sleep, I found that upon reaching out and forming new associations, I was able to advance the development of the Indicating Cognition of Negative Networks (ICoNN) model. The other communities where I have witnessed healing work are mythopoetic support groups, the community of faith, and the ManKind Project (MKP). These communities are all rich with story, and I have come to appreciate through them the power of myths as a healing dynamic. When we complete research, as we ought to, or even reflect upon our clinical work, we should share the outcomes—not keep it to ourselves, because that is shortsighted. We need to share it, present it at conferences, and publish it, so that it can be examined and debated. I am committed to life-long learning and continuing professional development. Colleagues teach me much; books and journals teach me something else, but it is the journeys that I make with people, like Janus, that teach me the most. I see their courage to share and seek healing in a safe community. This, more than anything, encouraged me to explore EMDR therapy's applicability to schizophrenia and psychosis.

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## LIGHTING A BEACON FIRE

I have, within these pages, the opportunity to explain and articulate my position on EMDR therapy for schizophrenia and the other psychoses. EMDR therapy is a powerful psychotherapy, but it is not a panacea. Neither ought it to be undertaken by those unfamiliar with the treatment of schizophrenia/psychosis. As the motto of the Royal College of Psychiatrists states, "Let Wisdom Guide." This work in the area of psychosis and schizophrenia is fledgling and requires more

research and critical examination. I heard the following story about a theologian who once visited a university chaplain:

The theologian observed that the chaplain would preach to the students by standing on a soapbox and haranguing them. At dinner that night in the University College the theologian was critical of the chaplain's "style" and method of communication. In response the chaplain asked the theologian how he preached the Gospel. The theologian responded that he did not preach the Gospel at all; he lectured on the theology of scripture. The chaplain responded then if that was the case, he liked the way he did it, better than the way the theologian didn't do it.

This book is not a declaration of complete and final knowledge as it pertains to the application of EMDR therapy for the treatment of psychosis and schizophrenia. This book is a beginning. When I lecture, I always begin with the following quotation:

"The mind is not so much a vessel to be filled,  
as a fire to be kindled."

—*Plutarch*

I hope that this book will act as academic kindling and I hope that researchers and clinicians will add their wisdom and clinical experience to this fire. Hopefully the light of this beacon will illuminate a path through the fog of battle.

## THE ROAD AHEAD

First we will explore the links between trauma, psychosis, and schizophrenia. This connection is one that was known and accepted from the earliest days of the characterization of the mental disorder (Bleuler, 1911, 1950; Kraepelin, 1881; Kraepelin, Barclay, & Robertson, 1919) that we now know as schizophrenia (Moskowitz et al., 2008). Then, with the passage of time, nosologically we lost our way for a season, choosing to see schizophrenia as an entirely organic illness that was psychologically incomprehensible (Jaspers, 1913, 1963). However, the wheel turns and we are returning once again to acknowledge the connection between trauma and psychosis/schizophrenia (Knipe, 2015; Lanius, Paulsen, & Corrigan, 2014; Moskowitz, 2006; Moskowitz et al., 2008; Ross, 2004, 2013).

Next, we look into the phenomenology and diagnostic entities of dissociation, psychosis, and schizophrenia. This is important because I believe that if we can see beyond and through the current labels of diagnosis, we can apply the healing power that EMDR therapy can bring to people with these experiences. I hope to guide you through the limitations of the current categorical diagnostic nosology of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and International Classification of Diseases (ICD) systems, as I believe we need to move through the current focus on diagnostic labels. By refocusing on the phenomenology beyond a mere label and through a therapeutic awareness of the intersubjective nature of these disorders, it is my belief that we will be more

capable of helping the people who present to us seeking assistance. Will it help all people with these experiences? I doubt that. Will it help some? In my opinion, it will. I hope that this book will make people think about who it might be helpful for and why. We ought not to be so wedded to our research or clinical “findings” that we cannot reappraise them in the light of new knowledge. Sticking to a position in the face of new experience may be the same dynamic that we propose occurs in the information processing system when overwhelmed by trauma: No new learning occurs. Sometimes we simply see research from a different perspective, one that comes from having traveled some distance further down the road of experience. It is not so much that I am suggesting that the current diagnostic labels are wrong as saying that they are mere labels. They are pale representations of the complex person who has joined us in therapy. We need labels at some level. Indeed, we can think of language itself as a collection of labels that we use to bring narrative to life. Language is the externalization of the inner experience of our minds and consciousness.

The next section explores the phenomenology of dissociation and psychosis. This naturally leads on to a suggested model for gathering the necessary information and thus assisting the person seeking our help. This is done through the outlining of a semistructured model of history taking and a review of how to examine the mental state.

After equipping ourselves with what to look for and how to look for it, we will look briefly at the current psychotherapies that are applied to psychosis and schizophrenia. In the light of these other paradigms we will then explore in particular the work around EMDR therapy for psychosis and schizophrenia. All good structures need a sound foundation, and so we will recap the standard EMDR therapy model first (Shapiro, 1989; Shapiro & Maxfield, 2002; Solomon & Shapiro, 2008). The ICoNN paradigm is a methodology that adapts and adds to the standard EMDR therapy model, so knowing where and why we are making a change is professionally and clinically important. As we have seen in the important work done by the Dutch team, there are occasions when EMDR therapy can be applied in psychosis without any modification to the standard eight-phase, three-pronged protocols (van den Berg & van der Gaag, 2012; van den Berg, van der Vleugel, Staring, de Bont, de Jongh, 2014; van der Vleugel, van den Berg, & Staring, 2012). There is a small but growing literature around the use of EMDR therapy in and for the treatment of psychosis/schizophrenia; this is reviewed and summarized for the reader. This literature and clinical experience are used to present the logic and argument in favor of using EMDR therapy in people with these experiences. I will also provide some guidance on how to identify those who are most likely capable of engaging with and benefiting from EMDR therapy. The next chapter will assist in the step from academic exploration to the clinical environment: the so-called *translational step*. We will look at how to generate a case formulation and develop a treatment plan in general before looking at the specifics of the ICoNN model’s methodology, which we will do with the aid of clinical examples. There are four key cases:

1. In the first case we will explore a formulation where the trauma is clearly known and believed to be etiologically connected to the psychosis that is

manifesting (Miller, 2010). It is a case of Cotard’s syndrome (*aka* walking corpse syndrome)—this is not specifically contained in the *DSM-5* (American Psychiatric Association, 2013). In the ICD-10 we can diagnose this as (F32.3): “Severe depressive episode with psychotic symptoms” (World Health Organization [WHO], 1992, 1993). We will see that the case formulation allows the application of the standard model with a resulting resolution of psychotic phenomena and depression. Interestingly, during a dip in mood during the recovery, there was no return of psychosis (Miller, 2010).

2. The second case (Miller, 2010) is one of a body dysmorphic disorder, which the ICD-10 classifies under the rubric of F45, “Somatoform Disorders.” Specifically, it is coded as F45.2, “Hypochondriacal Disorder” (WHO, 1992, 1993). In this case a young man presents with the belief that he has female breasts; in his case this was a delusional belief. Here I treat the emotional impact of the belief within EMDR therapy rather than challenging its veracity. The specifics of targeting and processing within the ICoNN method are described and discussed.
3. The third case is one of complex PTSD with marked dissociation. There are heard voices that can be engaged in dialogue—these are the “peopled wound” (McCarthy-Jones, 2012), and talking with them acts as a proxy for accessing the DMN.
4. The fourth and final case (Miller, 2010) is the one that prompted me to write this book. I introduced Janus to you in the Preface. Janus fulfilled the strict *DSM-III-R* criteria for schizophrenia used by the GEMINI team (American Psychiatric Association & American Psychiatric Association Work Group to Revise *DSM-III*, 1987). Janus was given the usual medication for the treatment for schizophrenia, but failed to respond over a suitable duration of time. Sensing that Janus possessed the capacity to engage in psychotherapy, we discussed the possible benefit of EMDR therapy, to which Janus consented. We outline the formulation and treatment plan as delivered. Janus is now 7 years symptom-free and medication-free and has been able to reenter the workplace successfully.

## THE PERSON IN THERAPY

Those who live with experiences of trauma, dissociation, and psychosis and those who have been given the label of schizophrenia are, first and foremost, people. The most human thing in our life journey is our innate desire to tell stories, to find meaning in our lives (Frankl, 1988, 1992). If we are to find a solution to the challenge of mental disorder, then I believe that we need to have all the information before us. A diagnosis is epistemologically a reduction and characterization of the complex phenomena of a person’s conscious experience. How on earth would a label fully encapsulate that? I believe it cannot. So, am I saying that we should eschew labels altogether? No, but we must never forget that they are labels. In the ICoNN model the labels can lead us to the real material that needs to be targeted in therapy. I use the analogy of talking to “the man behind the curtain” in the scene where Dorothy goes to meet the Wizard of Oz. We will never solve the problem fully by talking to the big scary green face of the “wizard”; that will send us on quests to do battle with witches and flying monkeys, but we

will not reach home until we look behind the curtain. It is the little dog that leads Dorothy to look behind the curtain. I believe that in the treatment of psychosis the little dog can be EMDR therapy, when applied through the methodology of the ICoNN model. So let us begin our journey as Dorothy and Toto did: one step at a time. The journey continues.

**Journey Well.**

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