LETTER

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Eye movement desensitization and reprocessing therapy for personality disorders in older adults?

Eye Movement Desensitization and Reprocessing (EMDR) is a kind of psychotherapy, which is growing in popularity, particularly for treatment of post-traumatic stress disorder (PTSD). When Shapiro first introduced EMDR in 1989, it was approached as a controversial treatment because of lack of evidence. However, nowadays there is growing evidence for EMDR efficacy in PTSD (Mc Guire *et al.*, 2014) and EMDR is recommended by international and national treatment guidelines for PTSD. Moreover, EMDR is also used for the treatment of other anxiety disorders, such as panic disorders (De Jongh *et al.*, 2002). Furthermore, research continues on effects of EMDR in addiction, somatoform disorders and psychosis. So far, there is no empirical research on the efficacy of EMDR treatment in older adults.

EMDR seems to have a direct effect on restoring the distressing memory. The idea is that the memory and associated stimuli of the event are inadequately processed, and are stored in a dysfunctional manner. The goal of EMDR therapy is to process these distressing memories, reducing their lingering influence, and allowing patients to develop more adaptive coping mechanisms. During the processing phases of EMDR, the patient focuses on disturbing memory in multiple brief sets of about 15–30 seconds. Simultaneously, the patient focuses on the dual attention stimulus (e.g. therapist-directed lateral eye movement, alternate hand-tapping, or bilateral auditory tones). This process of alternating dual attention and personal association is repeated many times during the session. The sessions are subdivided to address the past, present, and future aspects of a traumatic or distressing memory that has been dysfunctional stored. Most of the EMDR sessions take 60 to 90 minutes with a frequency of sessions between 5 and 15 usually on a weekly basis. However, for patients with a history of multiple traumatic experiences mostly more EMDR sessions are needed.

The positive effects of EMDR on main dysfunctional cognitions have also been described in personality disorders (PDs). People with PDs act in dysfunctional ways because their core beliefs about themselves, others and the world lead to misinterpretation of situations. For example, the core belief "you can't trust anybody" in a borderline PD leads a person to become vigilant for rejection. This is comparable with complex PTSD in which disturbing core beliefs arise from traumatic experiences and these disturbing beliefs result in interpersonal problems. When using EMDR in complex PTSD, detection (and reprocessing) of memories of etiological experiences happens through main dysfunctional cognitions and these key memories will be desensitized. For example, someone has to cope with the aftermath of being bullied as a child which makes him feel like a stupid person. As a consequence, the main dysfunctional cognition "I'm worthless" has arisen and leads to symptoms of social withdrawal, anxiety to start something new, and feelings of depression. If the main dysfunctional cognition "I'm worthless" loses strength, then our hypothesis is that symptoms may reduce because new experiences will be gained. Therefore, EMDR may also be a suitable treatment for PDs in older adults. So far, little is known about the treatment of PDs in older adults. Videler *et al.* (2014) found fair outcomes of schema therapy for PDs in Dutch elderly outpatients. Schema therapy improves dysfunctional schemas into adaptive schemas by techniques such as "imagery rescripting;" the patient imagines the original traumatic event and creates a new script with a more satisfactory outcome.

In EMDR "imagery rescripting" becomes a form of "cognitive interweave". A cognitive interweave introduces new information or a new perspective into the processing system to proceed with the process. In PDs it's often necessary to use cognitive interweaves for successful processing painful experiences. However, empirical research of EMDR in older adults with PDs is missing. The main benefit of EMDR, compared to more comprehensive forms of psychotherapy such as schema therapy, is that EMDR sessions work fast in processing deep-seated painful experiences. Besides, EMDR may be less intensive because processing happens without discussing upsetting experiences in great detail. Neither there are homework assignments. Intellectual and cognitive function is not important for effective EMDR therapy, based on positive treatment outcome in children and people with an intellectual disability (Mevissen *et al.*, 2012; Diehle *et al.*, 2015). Concerning schema therapy, however, patients are expected to have good intellectual and cognitive capacities.

In short: EMDR is a relatively straightforward treatment method, easy to use, also when cognitive functioning is suboptimal with relatively modest frequency of sessions compared to other psychotherapeutic interventions such as cognitive behavioral therapy or schema therapy. Therefore, we suggest EMDR is especially suitable for older adults. As far as we know, EMDR efficacy research on both adults and older adults with PDs is lacking. A proof of concept study to investigate the treatment effect of EMDR in older adults with PDs is a first step to explore the added value of EMDR in this population.

Conflict of interest

None.

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