

Mindfulness Meditation Training Combined with Eye Movement Desensitization and Reprocessing in Psychotherapy of an Elderly Patient

Tzan-Fu Sun, MD; Ching-Kuan Wu, MD; Nien-Mu Chiu, MD

We present our experiences with an elderly patient with depression that was attributed to a surge of physical ailments who also had trauma-derived fear of having to undergo a tracheotomy. He refused pharmacotherapy and was offered intensive training in Mindfulness Meditation (MM) plus Eye Movement Desensitization and Reprocessing (EMDR) therapy during the 2 weeks of hospitalization. This treatment combination had not been used previously. We suggest that EMDR eliminated his fear of surgery, whereas MM relieved his depression and attendant anxiety. However, the two techniques appeared to work synergistically. Following his discharge, he continued to practice MM, which prevented the recurrence of emotional distress, and even helped to reduce its causative physical symptoms. We offer an explanation for the success of our combined treatments and discuss the potential usefulness in specific psychotherapeutic situations. We also propose a place for MM within general geriatric care, and point out the reluctance to consider the therapeutic value of meditation. (*Chang Gung Med J* 2004;27:464-9)

Key words: depression, eye movement desensitization and reprocessing, geriatrics, meditation, mindfulness, trauma.

Mindfulness Meditation (MM) is "...the effort to intentionally pay attention, nonjudgmentally, to present-moment experiences, and sustain this attention over time".⁽¹⁾ Based on Buddhist practices, MM was introduced into Western medicine in 1979 by Jon Kabat-Zinn of the University of Massachusetts' Center for Mindfulness in Medicine, Health Care, and Society.^(2,3) Mr. Kabat-Zinn developed the MM-based educational/therapeutic method of Mindfulness Based Stress Reduction (MBSR) currently offered at over 200 sites worldwide. Most programs enroll outpatients referred by physicians for a variety of chronic, somatic, or emotional problems for 8-10 weeks of group-based (and some individual) training in various MM techniques. Graduates are

encouraged to construct individual practices and to keep meditating for a weekly total of several hours. As shown in some reports, MBSR has markedly improved participants' physical and mental health.⁽¹⁻⁵⁾ Our psychiatric patient received MM training (MMT), together with Eye Movement Desensitization and Reprocessing (EMDR) therapy - a combination that had not been tried previously.

Introduced by Francine Shapiro in 1989,⁽⁶⁾ EMDR is a form of brief psychotherapy for anxiety related to traumatic memories, and for other experientially based disorders.⁽⁷⁾ It proceeds in sessions with a formalized protocol as patients process a specific distressing experience or image in order to desensitize the related anxiety. The therapist applies

From the Department of Psychiatry, Chang Gung Memorial Hospital, Kaohsiung.

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Address for reprints: Dr. Nien-Mu Chiu, Department of Psychiatry, Chang Gung Memorial Hospital, 123, Dabi Road, Niasung Shiang, Kaohsiung, Taiwan 833, R.O.C. Tel.: 886-7-7317123 ext. 8765, 8753; Fax: 886-7-7317123; E-mail: chiune@ms5.hinet.net, suntf77@yahoo.com

sets of bilateral, alternating attention stimulation, by visual, tactile, or auditory means -- as with right-left hand movements. Patients report at intervals on the negative physical and emotional sensations that the image evokes, and rate their intensity using the 11-point Subjective Units of Disturbance (SUD) Scale (10 means highest anxiety; 0 means neutral feelings).⁽⁶⁾ They also verbalize a desired, positive self-cognition statement, and rate its perceived validity on the 7-point Validity of Cognition (VOC) Scale (1 means "completely false"; 7 means "completely true").⁽⁷⁾ For a therapist to consider a session properly completed, the patient's initially high SUD score should drop to 1 or 0, and the positive cognition statement should come to be regarded as completely true.

CASE REPORT

A 73-year-old man retiree was diagnosed at our outpatient department with major depressive disorder, including suicidal ideation. Depression was triggered largely by daily attacks of idiopathic dizziness (electroencephalography was normal) that started 2 months previous to his first visit, following a bout of the common cold, and usually lasted throughout the morning. Possibly contributing to his depression were his asthma, epigastralgia, and dysuria related to benign prostatic hyperplasia. He was also terrified of having to undergo a tracheotomy. This fear appeared 10 years prior to his initial visit when he was treated for asthma in a hospital emergency department, while another patient was tracheotomized. The dizziness attacks produced fear of asthma attacks, and this raised his anxiety about undergoing a tracheotomy. His mental state was aggravated by a rigid, perfectionist personality, with performance failures creating self blame and loss of confidence. We assessed his situation numerically using the Beck Anxiety Inventory (BAI)⁽⁹⁾ and the Beck Depression Inventory (BDI)⁽¹⁰⁾ questionnaires (BAI: 0-9, normal-no anxiety; 10-18, mild-moderate; 19-29, moderate-severe, 30-63, severe. BDI: 0-9, minimal depression; 10-16, mild; 17-29 moderate; 30-63 severe). The scores we recorded at intake were 20 for BAI and 24 for BDI.

Fearful of psychotropic drugs, the patient promised full cooperation with any other kind of treatment. He was offered 2 weeks of treatment in

the hospital using a combination of EMDR to desensitize specific causes of distress and intensive MMT for relief of overall emotional distress. He agreed to the extra expense of using a private room so he could meditate undisturbed. During his 2-week stay, he was seen 10 times. Each session involved MMT and three included EMDR sessions. The sessions with EMDR lasted 60 to 90 minutes, whereas non-EMDR sessions took 30 minutes or less.

On day 1, we had to stop the EMDR session initiated to process the depression that derived from the dizziness because the patient became very agitated. We immediately started MMT, instructing him to meditate for a total of 6 to 8 hr per day in 3 to 4 sets of "walking" (1 h) followed by "sitting" (1 h). Walking meditation primarily involves observing one's legs and body in motion. This can provide preparation for the more versatile sitting meditation which is conducted seated with eyes closed and observing one's breathing as well as physical and emotional sensations. Both techniques are key MBSR components.

The patient complied well with the routine and achieved good results. Several times during the first week of hospitalization he reported observing his dizziness and gastralgia during MM until the symptoms subsided or disappeared, and he felt calm. His dysuria decreased. Furthermore, his self-confidence improved, and he expressed trust in a positive outcome for his situation. On day 7, he completed an EMDR session, processing his tracheotomy trauma (SUD: 7→0). His positive cognition statement (VOC 5→7) was "I can be calm while thinking about a tracheotomy." Since then, he no longer fears surgery. The following week brought further improvement, as the patient claimed that his dizziness "was no longer a problem." He also stopped mentioning his gastralgia. During another completed EMDR session (day 13), we used his concomitant dizziness as the image, and it actually decreased during the session from a subjective, self-reporting score of 7/10, to a score of 2-3/10. He was discharged on day 14, with respective BAI and BDI scores of 4 and 7.

When seen at 3, 7, and 12 months after discharge, the patient reported having practiced MM for several hours daily. His respective BAI scores were 4, 4, and 6; and his respective BDI scores were 11, 8, and 9. He still experienced dizziness, but felt that meditation sometimes shortened its duration. His

fear of tracheotomy did not return, and his general mood and self-confidence had improved. Nine months after discharge, he was diagnosed with prostate cancer and underwent surgery. He used MM to deal with his emotional turmoil. During periods of worsening dizziness, and when hospitalized for the surgery, he was prescribed diphenidol (25 mg twice daily), with little or no benefit.

DISCUSSION

In assessing the contributions of our two interventions, we suggest that a single EMDR session "served to desensitize the anxiety related" to the patient's tracheotomy-related trauma. We express our views in words from the initial report by Shapiro⁽⁶⁾ since EMDR is still the subject of controversy, including challenges to its status of "one session cure".⁽¹¹⁾ Indeed, the one-session model has been largely replaced by a multi-session one.⁽⁷⁾ However, other researchers have also reported on the efficacy of a single session in allowing the memory of a single traumatic event lose its negative emotional intensity.^(12,13) By way of caution, we note that criticisms of EMDR range from paucity of controlled-research studies to aggressive commercial promotion,⁽¹¹⁾ and even to alleged serious adverse effects when severe symptoms were treated in an aggressive, prolonged manner.⁽¹⁴⁾ In our work, we have also encountered an instance of adverse effects, which caused us to stop EMDR. However, there is also a sizeable body of evidence reported in the literature in support of EMDR.⁽¹⁵⁾

In fact, we attribute most or all of the persistent relief of our patient's emotional distress to MM. The patient fully agrees. As we noted, our MMT regimen differed from typical MBSR. It was individual, in-hospital, relatively simple, and compressed in the amount of time spent performing the regimen. Moreover, his practice during and after hospitalization was particularly intensive. However, the overall amount of time and effort of both patient and therapists was equivalent to the MBSR's parameters. Hence it is appropriate to cite reports of MBSR producing marked drops in anxiety and depression in participants referred for psychiatric problems, with gains persisting for 3 years of follow-up, as confirmed by measures including BAI and BDI.^(1,2) We also noted that proponents of the novel program of

Mindfulness-Based Cognitive Therapy, claim that development of mindfulness skills can prevent relapse of recurrent depression.⁽¹⁶⁾ Program participants reported that mindfulness enhanced their coming to terms with life's situations, thoughts, or feelings as well as their awareness of signs of impending depression.⁽¹⁷⁾ Indeed, these ideas echo those of our patient.

To our knowledge, this is the first report of the successful combined use of MMT and EMDR. Moreover, the two approaches may work synergistically, in the sense of "the combined effect of two processes exceeding the sum of their individual effects." In fact, while practicing MM on his own, as well as during guided EMDR, the patient engages in the same activity, namely mindful observation of a distressing experience. Thus the two may reinforce one another. The week of practice that passed between the aborted EMDR session on day 1, and the completed session on day 7, certainly served to train our patient in mindfulness. Similarly, observing his dizziness during EMDR on day 13 was an intense version of the experience he had while meditating on it. We subsequently treated an outpatient with Social Anxiety Disorder who was deliberately instructed in MM after a first and failed the EMDR session. He returned to complete - and benefit from - subsequent sessions. Indeed, Shapiro suggested that successful EMDR involved a patient's cultivating a state of "mindful experience/being," rather than "mindless emoting" or "conceptualizing/doing," as formulated by Teasdale.⁽¹⁸⁾ Thus we propose that MMT plus EMDR be considered, if the following conditions apply: (i) presumed benefit from EMDR, (ii) pharmacotherapy and long-term psychotherapy are not options, and (iii) skilled practitioner(s) available. It might be advisable to start MMT first, to strengthen the responsiveness to EMDR.

By way of an addendum, our patient's benefits from sustained MM suggest there is a place for MMT programs in general outpatient geriatric care. In our experience, non-compliance is the main obstacle to the therapeutic use of MM. We postulate that retirees in declining health, with time on their hands, are more likely to maintain their practice. We note that MM offers a sense of participating in one's own treatment. It is a self-care measure that can be practiced at home, at any given time, independent of one's degree of mobility. To bolster our argument, we

point out the report by Reibel et al on 136 MBSR graduates with heterogeneous medical diagnoses, comprising 34 separate, chronic, physical and psychological conditions, and considerable comorbidities.⁽⁵⁾ The use of the program produced improvements in physical and emotional health, and these were maintained in a 1-year follow-up study of respondents (however, compliance and post-training persistence were poor in this group, with a mean age of 47.2 years). The authors highlight the value of a supportive group environment during training, and the program's cost-effectiveness in caring for a rapidly aging population. They also cite reports on MBSR's physical or emotional benefits (or both) for patients with specific complaints, including chronic pain, cancer, fibromyalgia, or psoriasis. These conditions share the characteristic of chronicity, which can be palliated, but rarely cured. This category certainly includes the aging-related deterioration of human health.

As noted elsewhere, Western-style Taiwanese medicine has shown no interest in meditative practices that are so deeply embedded in traditional culture and medicine.⁽¹⁹⁾ Indeed, not one MBSR program operates anywhere in Asia, the birthplace of MM. The Chinese scholar DH Zhou discussed the place of meditative elements in the general mind-body approach of traditional Chinese Medicine to preventive geriatrics, noting especially the goal of mental stress reduction.⁽²⁰⁾ Thus we recommend taking a fresh look at local, clinical use of MM, especially for elderly patients.

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合併內觀禪訓練與動眼減敏重整療法治療一憂鬱症之老人

孫讚福 吳景寬 邱念睦

我們報告一位因身體不適引發憂鬱症之老人，合併有恐懼被進行氣管切開術之心靈創傷。個案害怕精神藥物副作用，願意全力配合一切非藥物治療。故在兩週的住院期間，個案接受密集的内觀禪訓練，以及動眼減敏重整療法。動眼減敏重整療法有效除去個案對氣管切開術的恐懼，内觀禪訓練改善個案的焦慮與憂鬱。這是第一次動眼減敏重整療法與内觀禪訓練併用的報告，我們發現二者有互相加成的效果。個案出院後，持續每天練習内觀禪，用以減緩身體的不適，甚至可以防止因身體不適帶來的焦慮與憂鬱。我們討論在某特定情況下，動眼減敏重整療法與内觀禪訓練併用的成效與可行性，並提議將内觀禪訓練納入老人醫學中。(長庚醫誌 2004;27:464-9)

關鍵字：憂鬱，動眼減敏重整療法，老人醫學，禪修，内觀禪，心靈創傷。

長庚紀念醫院 高雄院區 精神科

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索取抽印本處：邱念睦醫師，長庚紀念醫院 精神科。高雄縣833鳥松鄉大埤路123號。Tel.: (07)7317123轉8768, 8753; Fax: (07)7326817; E-mail: chiune@ms5.hinet.net, suntf77@yahoo.com