EDITORIAL

A SECOND SPECIAL ISSUE ON EMDR IN PTSD AND OTHER PSYCHOPATHOLOGICAL CONDITIONS

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I have the pleasure to present a second special issue of *Clinical Neuropsychiatry*, as the previous one completely dedicated to "EMDR beyond PTSD".

The first issue contained papers about EMDR and Depression, Eating Disorders, Panic Attacks, OCD, Childhood and Adolescence, Refugees and Asylum Seekers and a review by Marco Pagani and Sara Carletto about the EMDR's mechanisms of functioning.

In this second issue, the reader will find papers about different topics, written by some of the major scholars of the items: EMDR and Complicated Grief (by Roger Solomon), EMDR and Personality Disorders (by Dolores Mosquera), EMDR in Emergency (by Elan Shapiro), EMDR in Psychoncology (by Elisa Faretta) and two short papers on EMDR in Bipolar Disorders (by Ludovica Bedeschi) and Psychosis (by Michele Marconi and Andrea Polidoro).

The effectiveness of EMDR therapy in treating Post-Traumatic Stress Disorder (PTSD) has been evaluated by several meta-analyses (Van Etten and Taylor 1998, Bradley et al. 2005, Davidson and Parker 2001, Seidler and Wagner 2006, Benish et al. 2009, Jonas et al. 2013, Chen et al. 2014, 2015); this led to its inclusion in many international clinical guidelines and eventually to the final recognition by the World Health Organization (2013) of EMDR as an elective treatment for PTSD in children, teenagers, and adults and by the more recent appreciation of the U.S. Veterans Affairs Department (2017).

Nevertheless, someone considers EMDR as a therapy still partially controversial: the American Psychological Association (APA) Practice Guidelines for the Treatment of Post-traumatic Stress Disorder (2017) concluded that there was strong evidence for cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), cognitive therapy (CT), and exposure therapy, yet weak evidence for Eye Movement Desensitization and Reprocessing (EMDR). This is despite the findings from an associated systematic review which concluded that EMDR leads to loss of PTSD diagnosis and symptom reduction. Depression symptoms in PTSD were also found to improve more with EMDR than control conditions. In that review, EMDR was marked down on strength of evidence (SOE) for symptom reduction for PTSD. However, there were several problems with the conclusions of that review.

Dominguez and Lee (2017) point out how this review highlights some serious inaccuracies regarding the way studies were handled in the statistical review of papers, particularly with respect to evidence concerning EMDR. Therefore, they believe that the subsequent conclusions of the draft guidelines are flawed. Such failure to acknowledge errors explains why the proposed 2017 guidelines are at odds with other best practice guidelines from other countries and international based guidelines such as Cochrane Reviews (2013), the World Health Organization in 2013 (World Health Organization 2013), the U.S. Veterans Affairs Department (2017).

In any case, as we tried to show in the first special issue of this Journal, the application of EMDR is nowadays no longer limited to the treatment of PTSD: its use is currently expanding to the treatment of other psychopathological conditions and comorbid disorders (de Bont et al. 2013, Novo et al. 2014, Perez-Dandieu and Tapia 2014).

It is important to remember that traumatic events surely contribute to the etiological conditions of many psychiatric disorders (Kim and Lee 2016, Millan et al. 2017) and that a comorbid diagnosis of PTSD can worsen the prognosis of other psychiatric disorders (Assion et al. 2009). Therefore, several studies have analyzed the effect of EMDR on other mental health conditions such as complicated and prolonged grief, emotional disturbances present in cancer diagnosis, emergential situation, psychosis, bipolar disorder, unipolar depression, anxiety disorders, substance use disorders, and chronic pain. In some of these conditions – for example in phobias (De Jongh and ten Broeke 2007) – there are many data available and it is quite probable that in the next future EMDR will be considered an evidence-based treatment. Then, as Valiente-Gomez et al. remember (2017), EMDR therapy has demonstrated preliminary positive evidence in one Randomized Control Trial (RCT) as a promising therapy to treat depressive symptoms in unipolar depression (Hase et al. 2015). Furthermore, it might be a helpful tool to facilitate psychological and somatic improvement in patients with myocardial infarction who suffer subsequent depressive symptoms (Behnammoghadam et al. 2015). EMDR therapy has demonstrated in 4 RCTs a positive effect on anxious and OCD symptoms (Feske and Goldsteina 1997, Nazari et al. 2011, Doering et al. 2013, Triscari et al. 2015) and it could also be a useful therapy in substance use disorders with a history of traumatic life events, in order to improve the prognosis of these patients (Perez-Dandieu and Tapia 2014). Besides, EMDR therapy could help as an adjuvant psychotherapy to standard treatment of alcohol dependence directly decreasing craving (Hase et al. 2008). EMDR seems to be a safe and effective therapeutic strategy also in reducing pain intensity and disability in patients with chronic back pain. For other conditions, for example psychotic disorders, despite the impact and the high prevalence of comorbid PTSD in them, evidence of the use of EMDR in psychosis is still scarce (Valiente-Gomez et al. 2017).

We now know more about the neurophysiological mechanisms implicated in EMDR (Pagani et al. 2017), and the next step will be exploring the following questions: are the Eye Movements and the other forms of Bilateral Stimulation useful only for reprocessing

traumatic events or can they be useful also for other psychpathological dimensions and cognitive disfunctions? Do we risk considering EMDR an oversolution for too many conditions? An answer to these questions could come only from many RCTs. At the moment, RCTs are a limited number and some of them take into account studies with very few therapeutic sessions and high heterogeneity in number and duration of EMDR therapy sessions (Hase et al. 2015, Kim et al. 2010, Behnammoghadam et al. 2015).

In general, EMDR therapy seems to be a safe intervention, without significant side effects (Feske and Goldsteina 1997, Hase et al. 2015, Doering et al. 2013, Novo et al. 2014, Perez-Dandieu and Tapia 2014; Triscari et al. 2015, van den Berg et al. 2015, Gerhardt 2016). This is of importance as it allows clinicians to consider EMDR therapy an appropriate treatment in various psychiatric comorbid conditions without causing side effects.

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