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REFLECTIVE PRACTICE

EMDR Therapy With First Episode Psychosis: Intervening Early

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The links between trauma and psychosis are well established in empirical literature (Giannopoulou et al., 2023) and qualitative research (Campodonico et al., 2022). Developmental trauma increases the risk for psychosis symptoms in adulthood, and often leads to poorer outcomes and more severe symptoms (Bloomfield, 2019). Different types of traumas have been linked to different symptoms of psychosis, such as childhood sexual abuse with the experience of hearing voices, and emotional abuse and neglect with paranoia (K. V. Hardy & Mueser, 2017). Dissociation, posttraumatic stress disorder (PTSD) symptoms and emotional dysregulation have been found to mediate developmental trauma and hallucinations, and negative schemata appear to mediate developmental trauma, delusions and paranoia (Bloomfield et al., 2021). Dissociation itself can be a driver of hallucinations, not just a mediating factor (Moskowitz et al., 2019). Although 'psychosis' is referred to throughout this article for brevity, it is important to acknowledge that the diagnosis of psychosis has challenges, especially when considering the entanglement with trauma and dissociation (see Miller, 2016).

In addition to the role of trauma in the development of psychosis, the trauma of the experiences may be associated with an episode of psychosis itself. Rates of PTSD following psychosis range from 11% to 67% (Berry et al., 2013), which include trauma arising from the psychosis symptoms as well as from treatment experiences, such as hospitalisation. Qualitative research also highlighted posttraumatic reactions following psychosis (Lu et al., 2017) and has identified common themes such as frightening symptoms, suicidality and uncharacteristic behaviour, as well as the trauma of treatments, including involuntary or long hospitalisation, coercive treatments and medication side effects. Co-occurring PTSD and psychosis has been linked to poorer clinical and functional outcomes, difficulties with engagement and poor treatment response (K. V. Hardy & Mueser, 2017), and increased suicidality and hospitalisation rates (Buckley et al., 2009).

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Treatments for Trauma and Psychosis

A systematic review conducted by Bloomfield et al. (2020) examined 24 studies focused on the provision of trauma-informed care for adult survivors of developmental trauma with psychotic and dissociative symptoms. Treatment targets included emotional regulation, acceptance, interpersonal skills, trauma re-processing and integration of dissociated ego states. Hardy et al. (2023) published a 'state-of-the-art' review on trauma therapies for psychosis. They specifically included eye movement desensitization and reprocessing (EMDR) therapy for psychosis, and concluded that there were promising results, although more research was needed. PTSD interventions are recommended by international guidelines for co-occurring PTSD and psychosis, including for first episode psychosis (FEP) (Early Intervention in Psychosis Network, 2021), and EMDR therapy is endorsed.

EMDR Therapy and Psychosis

The role of EMDR therapy with people who experience psychosis has been explored for more than 15 years (see Kikuchi, 2008), including the acute phase of psychosis (Kim et al., 2010). Van den Berg et al. (2013) produced some guidelines for EMDR therapy conceptualisation and treatment in psychosis. Where the treatment goal was to reduce comorbid PTSD symptoms, they suggested using the standard protocol to target memories of traumatic life events that are being frequently re-lived. Where the goal is reduction of psychotic symptoms they suggested three targets with different methods, as follows.

1. Where memories of life events are **directly** connected with psychosis, then the starting point is targeting symptoms; for example, 'What events led to your symptoms?'
2. Where memories of life events are **indirectly** connected with psychosis, then the starting point is negative core beliefs connected to the problems; for example, 'What caused you to start believing you are...'
3. Targeting relevant psychosis-related imagery; for example, 'flashforwards' (Logie & De Jongh, 2014), feared catastrophes and mental images of voices.

   (Adapted from van den Berg et al., 2013)

Several years later, the same group (P. de Bont et al., 2019) continued to advocate that trauma-focused therapies, such as EMDR therapy, can successfully be used to reduce trauma-related symptoms in people with

psychosis. There are also growing indications that psychotic symptoms such as delusions and hallucinations can be targeted directly and indirectly using EMDR therapy (Miller, 2016).

Miller (2016) proposed a specific model for conceptualising and targeting psychosis with EMDR therapy, which was the 'indicating cognitions of negative networks' (ICoNN) model. An 'icon' is a graphic that represents and links to an underlying programme, but is not the actual programme. Psychotic phenomena are dissociative in nature and act as 'icons' that can be focused on, and in some case followed back to the 'source programme' (dysfunctional memory network; DMN) and in other cases the 'icon' can be used as a proxy to access the programme (i.e. DMN) and facilitate processing. Modifications to the standard protocol are proposed, based on four different categories of presenting issue. However, the literature on EMDR therapy and psychosis remains sparce, and a recent review (Adams et al., 2020) included just six studies, only one of which was a randomised controlled trial (RCT). That review suggested EMDR therapy was safe and feasible with this group, and was associated with reduced delusional and negative symptoms, and reductions in mental health service use and medication. The impact on auditory hallucinations and paranoia was mixed. It was clear that more research in this area is needed.

There is also support for EMDR therapy with this client group from a health-economic perspective, with de Bont, van der Vleugel et al. (2019) recommending that PTSD treatments, including EMDR therapy, as the better economic choice as they yield better health and reduced PTSD symptomology at lower costs than treatment as usual (TAU). In clinical practice, therapists need support and supervision to build confidence in delivering EMDR therapy with clients experiencing psychosis (Phillips et al., 2021). There is value in helping multi-disciplinary teams and the wider systems working with this client group to shift towards trauma-responsive models of care (Wood et al., 2023) and recognise the utility of EMDR therapy.

Current Research and Developments

A number of recently published and ongoing research projects focused on EMDR therapy with psychosis indicate the application of EMDR therapy with psychosis is growing in clinical practice and research. This includes research that is being conducted here in Aotearoa New Zealand. Every-Palmer et al. (2024) conducted a RCT that compared EMDR therapy with TAU for PTSD among 24 adults with psychosis in forensic settings. After 6 months, clinician-rated PTSD symptoms were lower, and there were improvements in self-esteem, depressive symptoms and disability. A parallel qualitative study (Every-Palmer et al., 2023) presented the important and often overlooked lived

experience of participants receiving the EMDR therapy intervention. Ten participants were interviewed, which showed that participants experienced 'positive transformative change, extending beyond symptom reduction'.

Marlow et al. (2023) conducted a pragmatic exploratory RCT to explore the effectiveness of EMDR therapy for psychosis; 24 participants that received EMDR therapy were compared with 12 that received TAU. The EMDR therapy group had significant improvements in Impact of Events Scale (IES) scores at 10 weeks and 6 months. Improvements on the PTSD Checklist Civilian Version and negative symptoms scores on the Positive and Negative Symptoms Scale were also associated with treatment.

Varese et al. (2023) conducted a feasibility RCT of EMDR therapy for psychosis (EMDRp) in early psychosis. EMDRp was adapted from earlier guidelines published by van den Berg et al. (2013) and consists of a 16-session manualised EMDR intervention specifically modified to target distressed outpatients with early psychosis (Varese et al., 2021). EMDRp was compared with TAU for 60 participants in a UK early intervention in psychosis (EIP) service. There were promising signs of efficacy for EMDRp at 6 months on measures of psychotic symptoms, subjective recovery from psychosis, PTSD symptoms, depression, anxiety and general health. Results remained positive for PTSD symptoms and general health status at 12 months, although other outcomes were less pronounced.

Valiente-Gómez et al. (2020) are currently conducting a multi-site RCT in Spain to compare EMDR therapy with TAU in people with FEP and psychological trauma. They have recruited 80 participants split across EMDR therapy and TAU groups and will assess outcomes including: relapse rates; trauma-related, psychosis and affective symptoms; overall functioning; and quality of life. In the Netherlands, Burger et al. (2022) are conducting the RE.PROCESS trial, which is a single-blind, multicentre RCT comparing cognitive restructuring, prolonged exposure, EMDR therapy and waitlist control with 200 participants with PTSD and psychosis.

Clinical Applications of EMDR therapy in FEP

Jackson et al. (2019) published a comprehensive overview of FEP recovery and early intervention treatment approaches. Their book includes a useful section on trauma following FEP, although it focuses on cognitive-behavioural treatments for trauma and psychosis. In my clinical experience working with FEP clients, I have found EMDR therapy to be a helpful approach for many of the young adults I work with. The adaptive information processing (AIP) model (F. Shapiro, 2001) is helpful to formulate and plan treatment by identifying what experiences are relevant for the person and how they may link to their experience of psychosis in later life. This is especially helpful given the diagnostic uncertainty we experience with this FEP client group,

especially when it comes to disentangling the roles of trauma, psychosis and dissociation in someone's experiences. I regularly use the EMDR standard protocol with FEP clients, which can help address memories related to their psychosis (treatment experiences and memories of symptoms) as well as past traumatic experiences, which may or may not be associated with their psychosis episode, or traumatic experiences occurring after their episode. Specific protocols are also useful to address a range of additional issues, such as substance use, grief and loss.

My work using EMDR therapy with FEP clients has included target memories that have been considered by the treating team to be 'delusional' in nature, but as the client's experience is of them is real, we have targeted these in the same way for processing rather than getting caught up in therapy about whether these are 'real' or not. Sometimes this has appeared to be helpful, such as decreasing the distress associated with the 'delusional' memory and reducing associated PTSD symptoms, thereby enabling the person to move forward in their life. At other times this has been less helpful, such as for a person who remained stuck in a system of delusional beliefs, even though the 'memory' targeted became less of a focus for them. As yet, I do not have sufficient cases to propose any patterns or hypotheses about why some people or psychosis symptoms respond more effectively to EMDR therapy than others; this would be an interesting area for further research. Using the AIP model, I may consider that where the trauma that underpins the delusional network remains unprocessed, there would be a higher likelihood of a delusional 'memory' remaining, or being replaced by an alternative delusion or 'memory', as this is serving some function for the internal system of the person or remains a trauma response to the unprocessed 'real' memories. For a more comprehensive exploration of memory, trauma and delusions, see Moskowitz and Montirosso (2019).

The area of hallucinations, much like delusions, is complex. The experience of hearing voices has been associated with trauma (Bailey et al., 2018; Steel, 2015), and is a common experience among people with additional symptoms of psychosis. There are different theories that seek to make sense of hallucinations, particularly auditory verbal hallucinations or voice hearing. The work of Eleanor Longden, a psychologist and researcher with lived experience, brings a particularly compelling voice to this area. In one paper she wrote, 'VH [voice hearing] experiences, including those in the context of psychotic disorders, can be most appropriately understood as dissociated or disowned components of the self (or self–other relationships) that result from trauma, loss, or other interpersonal stressors' (Longden et al., 2012, p. 28). This short quote highlights the intrinsic links between psychosis, dissociation and ego states/components of self (or 'parts'). In my clinical experience, it can be hard to disentangle these. Rather than trying to distinguish between different types of hallucinations diagnostically, I focus on exploring these experiences and developing collaborative formulations and treatment plans. This process

is informed by a range of models and approaches such as the AIP model (F. Shapiro, 2001), the theory of structural dissociation of the personality (van der Hart et al., 2006), ego state therapy (R. Shapiro, 2016; Watkins & Watkins, 1997), voice dialogue or 'talking with voices' approaches (e.g. A. Hardy et al., 2023; May & Svanholmer, 2019; Stone & Stone, 1989) and the work of Dolores Mosquera on working with voices and dissociative parts (Mosquera, 2019).

The ability to work with voices from these approaches can be invaluable, including with presentations such as bipolar experiences, as well as dissociation. This raises interesting questions regarding the conceptualisation of a person's presenting experiences and how the traditional diagnostic model (which may differentiate psychosis from dissociation or 'parts' of self) is not always well suited to the complex young people I work with, and highlights the importance of looking at psychosis through a 'trauma lens' (Campodonico et al., 2022). Another protocol that I commonly use and have found helpful to address the trauma of the psychosis episode, is the recent-traumatic events protocol (R-TEP), although there is no literature reporting the use of R-TEP following an episode of psychosis.

R-TEP in FEP

There is a branch of EMDR therapy interventions designed to intervene early following a traumatic experience (E. Shapiro & Maxfield, 2019). One type of early EMDR therapy intervention is the R-TEP (E. Shapiro & Laub, 2014), which uses an adapted version of the standard EMDR therapy protocol and can be delivered in a small number of sessions.

Although there have been some diverse applications of the R-TEP (Tofani & Wheeler, 2011) there is no research currently available that looks specifically at using this protocol with people experiencing post-traumatic stress symptoms (PTSS) following FEP. R-TEP is well suited to early intervention in psychosis settings for several reasons. FEP and treatment experiences can be particularly traumatic and PTSS are common. There is also an increased suicide risk for people who have trauma and FEP (Tarrier et al., 2007). Often, psychological or personal recovery is negatively impacted by the trauma of psychosis and treatment experiences, and can also block social recovery. Therefore, intervening as early as possible where the person has been traumatised by their episode could help to improve their recovery.

Even though psychological therapies are a mainstay of early intervention in psychosis, in reality it is often difficult for people to access psychological interventions in a timely manner, and these interventions can be prolonged in nature, which adds to long waitlists for treatment. This is especially challenging when trying to adhere to an 'early intervention' ethos. Services may only have up to 2 years to deliver all the necessary interventions before discharge and

it may take some time for someone's acute episode to resolve and for them to feel ready to begin psychological therapy. Therefore, interventions that can be delivered early and in a small number of sessions could be valuable in clinical practice to help ensure waiting lists for psychological treatment are not prohibitive. The R-TEP gives a way of offering brief intervention within 3–6 months following a first (or subsequent) episode.

The R-TEP is not suitable for all clients, such as where traumatic experiences are broader than just the psychosis episode, or where more engagement, stabilisation and other issues need to be focused on first. However, the R-TEP also has some specific aspects of that makes it a useful approach to embed within broader EMDR therapy when specifically addressing the memories of the psychosis episode, even if standard protocol is being used for other memory networks. For example, the containment of this protocol to the episode itself and the use of dual bilateral stimulation methods (BLS) (e.g. eye movements and buzzers).

Also of particular note is the narrative component, where the person tells their story of the episode, with BLS. This is quite a deviation from the EMDR therapy standard protocol. My experience and feedback from clients about this part of the intervention suggests this is helpful because it provides the opportunity to tell their story, in their words, with no interruption or judgements. This can be validating, and it may help them realise that they remember more than they thought and help the episode feel less scary and unknown. With the client's permission, and sometimes at their request, I have had their case manager sit in on this session, which again is a deviation from how I would usually conduct EMDR therapy processing. This can have benefits such as providing useful information about the lead up to the episode and symptoms that can help with formulation, staying well planning and filling gaps in the case manager's knowledge about the person's episode. It can demonstrate the person's level of self-awareness into what happened even when the person has been deemed 'insightless'. It has also helped case managers to increase their awareness about EMDR therapy, and therefore be in a better position to refer clients and support them through the process.

In my clinical practice I have used the R-TEP with many clients to address a range of traumatic memories linked to their episode of psychosis. There are a number of common themes that have arisen (e.g. distressing memories of hospital admission, memories of behaviour during a manic or psychosis episode causing shame and memories of distressing psychosis beliefs such as thoughts of a sexual nature). Typically I would offer these sessions once a client is in the recovery phase following their episode of psychosis, if they are no longer experiencing acute symptoms of psychosis, but are troubled by the memories of their episode. There is research indicating that EMDR therapy can be useful during the acute phase (Kim et al., 2010), although not likely using the R-TEP. Although group work can be valuable in EIP

services, especially targeting aspects of social recovery, I have not provided the group-traumatic events protocol (E. Shapiro, 2015) in my service because of the logical challenges of delivering group therapy in an early intervention service. However it would be an interesting approach to consider and pilot if resourcing would allow it.

Case Example

I would like to highlight the utility of the R-TEP in early psychosis with an example from my clinical practice. Like other suitable clients for the R-TEP, this person was referred for clinical psychology input because of the distress they were experiencing related to their experiences of psychosis. During their psychology assessment session, no other issues were identified as current priorities and they were deemed suitable and agreeable to a short-term intervention, targeting the posttraumatic stress symptoms, using the EMDR R-TEP.

This participant received five sessions using the R-TEP, following their assessment session and one additional follow-up session to address substance use issues at his request. The sessions were provided several months after the first episode of psychosis. Prior to the intervention he had been thinking about his experiences of psychosis for at least 20 minutes per day and this triggered anxiety. He was distressed by the nature of some of his psychosis beliefs (e.g. sexual in nature) and was missing some of the other beliefs (e.g. powerful in nature). The intervention followed the R-TEP as per Shapiro and Laub (2014). The main components of the R-TEP involve:

1. Stabilisation technique
2. Narrative of episode while receiving BLS, both tactile (buzzers) and eye movements
3. Scan episode non-sequentially for point of disturbance (POD) with BLS
4. Target POD using EMDR protocol except body scan
5. Once POD is completed, repeat scan and process further PODs until none remain
6. Check overall subjective units of distress (Wolpe, 1969) for episode then identify positive cognition for episode as a whole, and install with BLS
7. Body scan for whole episode.

Results

Four PODs were identified and processed, three related to distressing delusions (two sexual in nature, one about suicide) and one related to his suicidal thoughts because of the distressing voices. Adaptive shifts included him moving from thinking 'there is something wrong with me' and 'I'm a nutcase' to 'it's random' and 'it's just an episode'.

Following the intervention, he reported not thinking about his psychosis on a daily basis anymore, he could recognise the randomness in his experiences which reduced his shame around the symptoms, and he reported feeling 'lighter' and no longer distressed. There were reductions in posttraumatic stress symptoms (as measured by the IES-R) from 16 to 0. When asked about his experience of the R-TEP, he reported *'talking about my experience out loud helped me...learning my experience was common...learning my episode was random...not feeling judged...you fixed me!'* (R-TEP participant).

Summary and Clinical Implications

This brief case example demonstrates that the R-TEP can be effective in reducing PTSS in young adults who have experienced an episode of psychosis. As with several similar clients receiving the R-TEP following FEP, this was achieved in a short number of sessions, and feedback from participants on the intervention has been positive. The themes that arose in the participant's PODs were consistent with the common posttraumatic reactions following psychosis reported by Lu et al. (2017) and included trauma from symptoms of psychosis and the treatments received. This suggested that the R-TEP is successfully able to identify and target a range of aspects related to someone's experience of psychosis. The intervention provides opportunities for psychoeducation and normalising information to be shared, and can also provide useful information about the episode that could be used for staying-well planning. The improvement of PTSS and cognitions and emotions related to the episode can in turn help with social recovery actions and outcomes.

Where clients have wanted to participate in this approach, they almost always complete the intervention and report positive feedback about the outcomes. Of course, this intervention does not necessarily reduce the risk for relapse of psychosis, although we know that stress is a big factor in perpetuating the risk for relapse. In one example, a young lady who engaged well in the R-TEP to good effect in a short number of sessions had a relapse some months later. The R-TEP did not help prevent this relapse, but this second episode was reportedly not distressing like the first and her psychological and functional recovery was much quicker this time around once her symptoms resolved, without the need for additional psychosocial intervention.

Although formal research is needed, I have found the R-TEP invaluable in clinical practice, where suitable, providing good results in a short timeframe. This makes it easier to provide interventions more quickly, which reduces the amount of time that clients must wait for psychological intervention for PTSS following their episode. Where clients require a longer-term psychological intervention to address historical memories or other trauma, or would like to focus their treatment more widely than just the episode memories, then the EMDR standard protocol would be more appropriate. However, in this instance, the R-TEP for their psychosis experience could still be of value and offered, embedded into the longer-term work.

REFERENCES

Adams, R., Ohlsen, S., & Wood, E. (2020). Eye movement desensitization and reprocessing (EMDR) for the treatment of psychosis: a systematic review. *European Journal of Psychotraumatology*, *11*(1), 1711349. https://doi.org/10.1080/20008198.2019.1711349

Bailey, T., Alvarez-Jimenez, M., Garcia-Sanchez, A. M., Hulbert, C., Barlow, E., & Bendall, S. (2018). Childhood trauma is associated with severity of hallucinations and delusions in psychotic disorders: A systematic review and meta-analysis. *Schizophrenia Bulletin*, *44*(5), 1111–1122. https://doi.org/10.1093/schbul/sbx161

Berry, K., Ford, S., Jellicoe-Jones, L., & Haddock, G. (2013). PTSD symptoms associated with the experiences of psychosis and hospitalisation: a review of the literature. *Clinical Psychology Review*, *33*(4), 526–538. https://doi.org/10.1016/j.cpr.2013.01.011

Bloomfield, M. A. P. (2019). Developmental trauma and psychosis. *Schizophrenia Bulletin*, *45*(Supplement_2), S155. https://doi.org/10.1093/schbul/sbz022.168

Bloomfield, M. A. P., Chang, T., Woodl, M. J., Lyons, L. M., Cheng, Z., Bauer-Staeb, C., Hobbs, C., Bracke, S., Kennerley, H., Isham, L., Brewin, C., Billings, J., Greene, T., & Lewis, G. (2021). Psychological processes mediating the association between developmental trauma and specific psychotic symptoms in adults: A systematic review and meta-analysis. *World Psychiatry*, *20*(1), 107–123. https://doi.org/10.1002/wps.20841

Bloomfield, M. A. P., Yusuf, F. N. I. B., Srinivasan, R., Kelleher, I., Bell, V., & Pitman, A. (2020). Trauma-informed care for adult survivors of developmental trauma with psychotic and dissociative symptoms: a systematic review of intervention studies. *The Lancet Psychiatry*, *7*(5), 449–462. https://doi.org/10.1016/s2215-0366(20)30041-9

Buckley, P. F., Miller, B. J., Lehrer, D. S., & Castle, D. J. (2009). Psychiatric comorbidities and schizophrenia. *Schizophrenia Bulletin*, *35*(2), 383–402. https://doi.org/10.1093/schbul/sbn135

Burger, S. R., van der Linden, T., Hardy, A., de Bont, P., van der Vleugel, B., Staring, A. B. P., de Roos, C., van Zelst, C., Gottlieb, J. D., Mueser, K. T., van Minnen, A., de Jongh, A., Marcelis, M., van der Gaag, M., & van den Berg, D. (2022). Trauma-focused therapies for post-traumatic stress in psychosis: study protocol for the RE.PROCESS randomized controlled trial. *Trials*, *23*(1), 851.

Campodonico, C., Varese, F., & Berry, K. (2022). Trauma and psychosis: a qualitative study exploring the perspectives of people with psychosis on the influence of traumatic experiences on psychotic symptoms and quality of life. *BMC Psychiatry*, *22*(1), 213. https://doi.org/10.1186/s12888-022-03808-3

de Bont, P. A. J. M., van der Vleugel, B. M., van den Berg, D. P. G., de Roos, C., Lokkerbol, J., Smit, F., de Jongh, A., van der Gaag, M., & van Minnen, A. (2019). Health-economic benefits of treating trauma in psychosis. *European Journal of Psychotraumatology*, *10*, 1565032.

de Bont, P., de Jongh, A., & van den Berg, D. (2019). Psychosis: An emerging field for EMDR research and therapy. *Journal of EMDR Practice and Research*, *13*(4), 313–324. https://doi.org/10.1891/1933-3196.13.4.313

Early Intervention in Psychosis Network. (2021). *Quality standards for early intervention in psychosis services* (2nd ed.).

Every-Palmer, S., Flewett, T., Dean, S., Hansby, O., Freeland, A., Weatherall, M., & Bell, E. (2024). Eye movement desensitization and reprocessing (EMDR) therapy compared to usual treatment for posttraumatic stress disorder in adults with psychosis in forensic settings: Randomized controlled trial. *Psychological Trauma: Theory, Research, Practice, and Policy*. https://doi.org/10.1037/tra0001643

Every-Palmer, S., Ross, B., Flewett, T., Rutledge, E., Hansby, O., & Bell, E. (2023). Eye movement desensitisation and reprocessing (EMDR) therapy in prison and forensic services: a qualitative study of lived experience. *European Journal of Psychotraumatology*, *14*(2), 2282029. https://doi.org/10.1080/20008066.2023.2282029

Giannopoulou, I., Georgiades, S., Stefanou, M.-I., Spandidos, D., & Rizos, E. (2023). Links between trauma and psychosis (Review). *Experimental and Therapeutic Medicine*, *26*(2), 386. https://doi.org/10.3892/etm.2023.12085

Hardy, A., Keen, N., van den Berg, D., Varese, F., Longden, E., Ward, T., & Brand, R. M. (2023). Trauma therapies for psychosis: A state-of-the-art review. *Psychology and Psychotherapy: Theory, Research and Practice*, *00*, 1–17.

Hardy, K. V., & Mueser, K. T. (2017). Editorial: Trauma, psychosis and posttraumatic stress disorder. *Frontiers in Psychiatry*, *8*, 220. https://doi.org/10.3389/fpsyt.2017.00220

Jackson, C., Baggott, E., Bernard, M., Clutterbuck, R., Ryles, D., & Turner, E. (2019). *Recovering from a first episode of psychosis: An integrated approach to early intervention* (1st ed.). Routledge. https://doi.org/10.4324/9781315460734

Kikuchi, A. (2008). Application of EMDR for schizophrenia. *Clinical Psychology: Various Aspects*, *27*(2), 317–324.

Kim, D. C., Choi, J., Kim, S. H., Oh, D. H., Park, S.-C., & Lee, S. H. (2010). A pilot study of brief eye movement desensitization and reprocessing (EMDR) for treatment of acute phase schizophrenia. *Korean Journal of Biological Psychiatry*, *17*(2), 93–101.

Logie, R. D. J., & De Jongh, A. (2014). The "flashforward procedure": Confronting catastrophe. *Journal of EMDR Practice and Research*, *8*(1), 25–32. https://doi.org/10.1891/1933-3196.8.1.25

Longden, E., Madill, A., & Waterman, M. G. (2012). Dissociation, trauma, and the role of lived experience: Toward a new conceptualization of voice hearing. *Psychological Bulletin*, *138*(1), 28–76. https://doi.org/10.1037/a0025995

Lu, W., Mueser, K. T., Rosenberg, S. D., Yanos, P. T., & Mahmoud, N. (2017). Posttraumatic reactions to psychosis: A qualitative analysis. *Frontiers in Psychiatry*, *8*, 129. https://doi.org/10.3389/fpsyt.2017.00129

Marlow, S., Laugharne, R., Allard, J., Bassett, P., Priebe, S., Ledger, J., Kerr, J., Priest, D., Vanhoorn, A., Boland, C., & Shankar, R. (2023). A pragmatic randomized controlled exploratory trial of the effectiveness of Eye Movement Desensitization and Reprocessing therapy for psychotic disorder. *Journal of Psychiatric Research*, *169*, 257–263. https://doi.org/10.1016/j.jpsychires.2023.11.024

May, R., & Svanholmer, E. (2019). *Self help guide to talking with voices*. https://openmindedonline.files.wordpress.com/2019/09/self-help-guide-to-talking-with-voices-r.-may-and-e.-svanholmer-sep-2019.pdf

Miller, P. W. (2016). *Therapy for schizophrenia and other psychoses*. Springer Publishing Company, LLC.

Moskowitz, A., Dorahy, M. J., & Schäfer, I. (2019). *Psychosis, trauma and dissociation: Evolving perspectives on severe psychopathology* (2nd ed.). John Wiley & Sons.

Moskowitz, A., & Montirosso, R. (2019). Childhood experiences and delusions: Trauma, memory, and the double bind. In A. Moskowitz, M. J. Dorahy, & I. Schäfer (Eds.), *Psychosis, trauma and dissociation: Evolving perspectives on severe psychopathology* (2nd ed., pp. 117–140). John Wiley & Sons.

Mosquera, D. (2019). *Working with voices and dissociative parts: A trauma-informed approach*. Instituto Intra-Tp, S.L.

Phillips, R., McSherry, P., Pinto, C., & Maguire, T. (2021). Exploring therapists' experiences of applying EMDR therapy with clients experiencing psychosis. *Journal of EMDR Practice and Research*, *15*(3), 142–156. https://doi.org/10.1891/emdr-d-21-00018

Shapiro, E. (2015). *EMDR group traumatic episode protocol (G-TEP)* [Unpublished manual].

Shapiro, E., & Laub, B. (2014). The recent traumatic episode protocol (R-TEP): An integrative protocol for early EMDR intervention (EEI). In M. Luber (Ed.), *Implementing EMDR early mental health interventions for man-made and natural disasters* (pp. 193–215). Springer Publishing.

Shapiro, E., & Maxfield, L. (2019). The efficacy of EMDR early interventions. *Journal of EMDR Practice and Research*, *13*(4), 291–301. https://doi.org/10.1891/1933-3196.13.4.291

Shapiro, F. (2001). *Eye movement desensitization and reprocessing - Basic principles, protocols, and procedures*. Guilford.

Shapiro, R. (2016). *Easy ego state interventions: Strategies for working with parts*. W.W. Norton.

Steel, C. (2015). Hallucinations as a trauma-based memory: Implications for psychological interventions. *Frontiers in Psychology*, *6*. https://doi.org/10.3389/fpsyg.2015.01262

Stone, H., & Stone, S. (1989). *Embracing our selves: The voice dialogue manual*. New World Library.

Tarrier, N., Khan, S., Cater, J., & Picken, A. (2007). The subjective consequences of suffering a first episode psychosis: trauma and suicide behaviour. *Social Psychiatry and Psychiatric Epidemiology*, *42*(1), 29–35. https://doi.org/10.1007/s00127-006-0127-2

Tofani, L. R., & Wheeler, K. (2011). The recent-traumatic episode protocol: Outcome evaluation and analysis of three case studies. *Journal of EMDR Practice and Research*, *5*(3), 95–110. https://doi.org/10.1891/1933-3196.5.3.95

Valiente-Gómez, A., Pujol, N., Moreno-Alcázar, A., Radua, J., Monteagudo-Gimeno, E., Gardoki-Souto, I., Hogg, B., Álvarez, M. J., Safont, G., Lupo, W., Pérez, V., Amann, B. L., & FEP-EMDR Research Group. (2020). A multicenter phase II RCT to compare the effectiveness of EMDR versus TAU in patients with a first-episode psychosis and psychological trauma: A protocol design. *Frontiers in Psychiatry*, *10*, 1023. https://doi.org/10.3389/fpsyt.2019.01023

van den Berg, D. P. G., van der Vleugel, B. M., Staring, A. B. P., de Bont, P. A. J., & de Jongh, A. (2013). EMDR in psychosis: Guidelines for conceptualization and treatment. *Journal of EMDR Practice and Research*, *7*(4), 208–224. https://doi.org/10.1891/1933-3196.7.4.208

van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. Norton & Co.

Varese, F., Sellwood, W., Aseem, S., Awenat, Y., Bird, L., Bhutani, G., Carter, L.-A., Davies, L., Davis, C., Horne, G., Keane, D., Logie, R., Malkin, D., Potter, F., van den Berg, D., Zia, S., & Bentall, R. (2021). Eye movement desensitization and reprocessing therapy for psychosis (EMDRp): Protocol of a feasibility randomized controlled trial with early intervention service users. *Early Intervention in Psychiatry*, *15*(5), 1224–1233. https://doi.org/10.1111/eip.13071

Varese, F., Sellwood, W., Pulford, D., Awenat, Y., Bird, L., Bhutani, G., Carter, L.-A., Davies, L., Aseem, S., Davis, C., Hefferman-Clarke, R., Hilton, C., Horne, G., Keane, D., Logie, R., Malkin, D., Potter, F., van den Berg, D., Zia, S., & Bentall, R. P. (2023). Trauma-focused therapy in early psychosis: results of a feasibility randomized controlled trial of EMDR for psychosis (EMDRp) in early intervention settings. *Psychological Medicine*, 1–12. https://doi.org/10.1017/s0033291723002532

Watkins, J. G., & Watkins, H. H. (1997). *Ego states: Theory and therapy*. W.W. Norton.

Wolpe, J. (1969). *The practice of behavior therapy*. Pergamon.

Wood, H. J., Babusci, C., Bendall, S., Sarpal, D. K., & Jones, N. (2023). Trauma and trauma-informed care in early intervention in psychosis: State of implementation and provider views on challenges. *Psychiatric Services*, *74*(12), 1240–1246. https://doi.org/10.1176/appi.ps.20220624