Spiritual Issues in Psychological Clinics: The Case of an EMDR Protocol of a Psycho-Traumatized Believer

Mengue Assila Marie Serge

Université de Yaoundé 1, Yaoundé Cameroun Fondation de Psychologie RAPHA-PSY, Yaoundé, Cameroun

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ABSTRACT

Clinical observations in the RAPHA-PSY Psychology Foundation in Yaoundé have noted a constant link between spiritual and psychic suffering in the traumatized believer. Our objective is to grasp the profound role of spirituality in the understanding and care of a psycho-traumatized believer in a psychological clinic. We have taken the principles regulating the link to transcendence as specific modalities of the spirituality variable to study this role. To achieve this goal, this unique case study is built based on the clinical method. She therefore carries out a detailed investigation of the psychological processes at play in this care and consequently has no desire to generalize her results (De Luca, 2020). The results of this case reveal that, on the one hand, the traumatic experience made the psychological functioning of this psycho-traumatized believer rigid, which led to spiritual suffering. In turn, this contributed to the over-traumatization, leading to psychological distress. On the other hand, within the framework of the EMDR protocol, the corpus of spirituality has favoured the management of psycho-trauma in Miss M, particularly in the reprocessing of her traumatic memories. Spirituality is therefore posed in the traumatized believer, in the light of this case study, both as a relational dimension which, in normal times, constitutes a protective factor, but altered becomes a factor of *overtraumatization*; or as the core of all our experiences for which, altered, the controlled use of the corpus can facilitate care.

Key words: Spirituality and psycho-trauma, clinical psychology, spiritual suffering, psychological suffering, spirituality and EMDR

Résumé

Des observations cliniques dans la Fondation de Psychologie RAPHA-PSY de Yaoundé ont relevé un lien constant entre souffrance spirituelle et souffrance psychique chez le croyant traumatisé. Notre objectif est de saisir le rôle profond de la spiritualité dans la compréhension et la prise en charge d'une croyante psycho-traumatisée en clinique psychologique. Nous avons pris les principes régulant le lien à la transcendance comme modalités spécifiques de la variable spiritualité pour étudier ce rôle. Pour atteindre cet objectif, la présente étude de cas unique est construite sur la base de la méthode clinique. Elle procède de ce fait à une investigation détaillée des processus psychiques en jeux dans cette prise en charge et n'a conséquemment aucune velléité de généralisation de ses résultats (De Luca, 2020). Les résultats de ce cas révèlent que, d'une part, l'expérience traumatique a rigidifié le fonctionnement psychologique de cette croyante psycho-traumatisée, lequel fonctionnement a entraîné une souffrance spirituelle. À son tour, celle-ci a contribué à la *surtraumatisation*, entraînant une détresse psychique. D'autre part, dans le cadre du protocole EMDR, le corpus de la spiritualité a favorisé la prise en charge du psycho-traumatisme chez Mademoiselle M, notamment dans le retraitement de ses souvenirs traumatiques. La spiritualité se pose donc chez le croyant traumatisé, à la lumière de cette étude de cas, à la fois comme une dimension relationnelle qui, en temps normal constitue un facteur de protection, mais altéré devient un facteur de *surtraumatisation* ; ou comme le noyau de l'ensemble de nos expériences pour lequel, altéré, l'usage maîtrisé du corpus peut faciliter la prise en charge.

Mots-clés : spiritualité et psycho-traumatisme, psychologie clinique, souffrance spirituelle, souffrance psychique, spiritualité et EMDR

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INTRODUCTION

The Clinic is at the center of practice in the health institution. Both medical and psychological practice refers to it, insofar as this term refers to an activity, a knowledge and a place with the patient (Pedinielli, 2016). However, the psychological clinic is particularly different from the medical clinic from which it is derived. For, unlike the latter, which holds the objectification of the clinical situation, thereby resorting to the *desubjectivation* of the latter, the former prioritizes meaning, implication and totality in its conceptions (Pedinielli, 2016). Thus, since its beginnings, it has been interested in suffering, seeking to grasp it, whatever its form. Suffering does indeed come in different forms, so it is not uncommon for spiritual suffering to be found in the psychological clinic. But spirituality is not studied in this clinic as a primary material, but can arouse interest in a secondary way, if it is of clinical interest, in particular if it is linked to the expression of suffering in the clinic, or if its corpus can promote or facilitate therapeutic work. It is in this second case that it will be of interest to the present study.

Context

Psychology and spirituality

Spirituality is a concept that is not sufficiently rooted in scientific research. For Roussiau and Renard (2021), the misuse of the term spirituality itself represents the main obstacle to its intelligibility. We will therefore not conceive of it, in this study, in the sense that is often reserved for it in popular circles, namely as belonging to the realm of the mysterious, the unintelligible or the scientifically elusive. We are thus basing ourselves on recent scientific literature approaching the question objectively. It apprehends it according to two different orientations: religious spirituality and areligious spirituality, which can be explicitly or implicitly (Roussiau & Renard, 2021). Guided by this, we will limit ourselves to a dimension of the notion of spirituality that is objectively graspable and of particular interest to the psychological clinic.

To date, several fields of psychology have been interested in spirituality (Richard, 1992). It appears to be at the center of concerns in the psychology of religion (Roussiau & Renard, 2021). But it is also more or less implicitly present in other fields such as humanistic psychology, existentialist psychology, positive psychology, health psychology, and more recently in psychotherapy (Roussiau & Renard, 2021), all fields of psychology that have been interested in spiritual experience.

Spiritual experience is thus presented as having verified benefits on the psychological level. Indeed, Van Cappellen and Zhang (2021) have identified the emotions associated with this experience. As such, they presented self-transcendence, wonder, gratitude, love, and compassion. They have also identified their major functions, which are: the improvement of well-being, the development of prosocial behaviours and the maintenance of spiritual practices.

And moreover, we do not claim to innovate in the interest of spiritual issues in psychological clinics. Recent work has addressed the issue appropriately. This is the case of the work of Bellehumeur (2021), who is interested in this question and, after highlighting the historical link between psychotherapy, religion and spirituality, presents psychotherapies interested in spiritual experience. In this regard, he identifies psychotherapies such as "*psychotherapeutic approaches that appeal to values; mindfulness-based psychotherapeutic approaches; the ACT model, or acceptance and commitment therapy; the spiritually integrated psychotherapy of Kenneth Pargament and the therapy of meaning of Paul Wong*" (Roussiau & Renard, 2021, p. 16).

Also of note is this study by Brandt et al. (2021) who, in the field of health psychology, approach spirituality as a resource for coping with illness, and implicitly recommend that it be considered in both cognitive-behavioural therapies and psychodynamic approaches. Finally, Renard and Roussiau (2021) take a completely different direction. They propose to present on the one hand, the different dimensions of spirituality. They evoke, among other things: meaning, transcendence, the sacred, the feeling of connection, wonder, the self, the relationship to time. On the other hand, they reveal that a rich spiritual experience could lead to positive effects on the general health of the individual. This sounds like a boon for clinical psychology, insofar as these effects can be used in the clinical setting.

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Adaptative Information Processing (AIP)

The psychological clinic incorporates a method for naming certain states and behaviours to offer care such as psychotherapy. In this logic, one of the current modern therapeutic approaches is EMDR (Eye Movement Desensitization and Reprocessing) psychotherapy. This approach fills the often-observed ineffectiveness of the innate system of adaptive information processing (AIP) designed to overcome the psychological distress related to disturbing events (Cornil, 2023). EMDR thus succeeds in reactivating the AIT, which "*restarts the digestion process, during which awareness is made, the necessary associations are established, the person learns what is useful to him, and the appropriate emotions are established* " (Shapiro and Silk-Forrest, 1997, cited in Iracane, 2023). But in certain circumstances, this mechanism freezes: the information remains unchanged, disturbing emotions persist, and the patient does not progress: these are the blockages (Iracane, 2023). These blockages, if not identified and treated, are likely to lead not only to therapeutic stagnation but also to a risk of worsening the symptoms, or even withdrawal of the patient.

The blockages mentioned above manifest themselves in two main ways. Strict *blockade* corresponds to a total absence of evolution after several series of alternating bilateral stimulations (SBA). The patient tirelessly repeats the same content without opening to new associations. Looping, also known as "*looping*", gives the illusion of movement: thoughts and images change but negative emotions remain the same, which prevents any cognitive reorganization (Iracane, 2023).

Their causes are multiple but can be grouped into two categories. The first includes those relating to EMDR treatment that may stem from a lack of stabilization, a fragility of a therapeutic alliance or resistance related to the fear of change and the secondary benefits of the pathology. The second part includes the causes related to the TAI itself. In this case, the blockage may be due to a lack of adaptive information, emotional overactivation that overwhelms the patient, underactivation that cuts off the associative flow, or the persistence of unchanged cognitions and sensations (Iracane, 2023). Faced with these obstacles, several types of interventions are proposed. Among these, cognitive weaving occupies a central place. It is a one-time intervention in which the therapist helps the patient relate the traumatic experience to a present and appropriate perspective. This technique makes it possible to introduce missing information, to rectify a perverted belief or to mobilize resources that were previously inaccessible. Weaving can be cognitive, somatic, or creative (Shapiro, 2018), depending on whether the blockage is expressed through thoughts, bodily sensations, or persistent images. It aims to reset the AIT process and restart self-healing.

Clinical presentation of patient

Miss M is a 34-year-old woman, victim of a hostage-taking that lasted more than 3 months. She comes from a middle-class background and comes from a region that is highly conservative in cultural and religious values. Although she had a degree in economics, she embarked on a career as a social worker in a humanitarian field, more out of necessity than conviction. She comes from a large polygynous polygamous family, the 24th of 28 siblings. She lost her parents at a very early age (her mother when she was 3 years old; her father when she was 5) but was taken care of by the eldest of the family, who imposed himself as the father figure and his wife as the maternal one.

Self-employed since the end of her studies, she is single and rather suffers the situation: she has experienced two particularly painful breakups. The first occurred just after her teenage years, when she was 23 years old, she was forced by her family to break up with her fiancé who did not share their religion. The second is more recent, when she is 32 years old, she is disappointed in her new fiancé who suddenly ended their engagement. This second breakup is the most painful, because it occurred when she had not recovered from a huge shock she had had only a few months before. She had then been the victim of a serious traffic accident that ended in a fire. Even if she had not had any significant physical after-effects, this accident seems to have left a great psychological distress, amplified by this sudden breakup.

At the time we are dealing with Miss M's case, we are working as a psychologist for an NGO that has experienced the hostage-taking and then the captivity of their employees by a terrorist group, and which has requested our services for the occasion. Our first contact with Miss M was online. We had a discussion with the head of the

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NGO who had gone to welcome the ex-hostages after their release in a neighbouring country. He explains the long procedure that will lead to the repatriation of the latter. Seeing the deteriorated psychological state in which they were, he suggested that we start the treatment by teleconsultation. After this online debut, I will see Miss M in person two days later, and the rest of the care will be done in this context, within the office of the Foundation in which we work.

Diagnosis and analysis of case

Direct exposure to a threat of death, as in this clinical case, refers to the issue of trauma, in particular complex post-traumatic stress disorder (Herman, 1992, cited in Iracane, 2023) or type 2 (Terr, 1991, cited in Iracane, 2023).

Criterion A "Exposure to actual death or threat of death, serious injury or sexual violence".

A1: Being directly exposed to one or more traumatic events (APA, 2013).

Clinical Evaluation Results

Miss M experienced extremely violent events on the psychological level, both destructive and disorganizing, for more than three months. The clinical evaluation was done through three clinical examinations. The *Post Check List adapted to the DSM-5 (PCL-5)* revealed a proven post-traumatic stress disorder (score: 39), with three significantly high levels: the level of Intrusion, the level of avoidance and that of Cognitive symptoms and mood*;* the *Beck Anxiety Inventory (BAI)* revealed severe anxiety (score: 36); the *Beck Depression Inventory (BDI)* revealed moderate depression (score: 29, without suicidal ideation). We therefore formulate the diagnostic hypothesis of PTSD as a comorbidity with the anxio-depressive syndrome.

Evaluation Analysis

The events from the kidnapping to the liberation, including the moments of captivity, experienced by this young woman have been traumatic and impacted her psyche. It presents manifestations of a state of shock equivalent to the annihilation of the sense of Self, as well as that of the capacities to resist, act and think, and thus exceed its capacity to cope with the situation, as Ferenczi (1931-1932) already described. She describes an intense feeling of psychological distress when exposed to situations evoking an aspect of the emotional shocks experienced, and marked physiological reactions related to them; recurring experiences of feeling detached from oneself; efforts to avoid conversations and interpersonal situations that awaken memories of emotional shocks; a clear increase in the frequency of negative emotional states (fear, sadness, guilt, shame, etc.).

Similarly, Mademoiselle M describes the confrontation with the reality of death at several moments: during the kidnapping, at the moment when they are announced, weapons pointed, that they are taken hostage; during captivity. She gives as an example the scene of the young man pointing a gun at her and threatening to shoot him, ...; at the time of liberation with several blindfolded trips to unknown destinations, without specifying the final destination. With each twist and turn, she experienced a new rupture in the psychic arrangements she was trying to set up. This generated in her a real emotional shock that was so violent, according to her descriptions, leading to the overflow or even the surpassing of the ego and its mechanisms, the latter undergoing a form of self-dissolution. Thus, she arrived at psychic stupefaction, as at the moment when the young man pointed the gun at her, confessing that he would not hesitate to shoot because where they are, she is nothing and represents nothing. She had then had an involuntary psychic reaction for a moment, where she was frozen, unable to react, staring at her tormentor, without words.

Spiritual suffering

Miss M's suffering is enormous. First, she manifests great psychological distress as described above, depriving her existence of its meaning. She very often presents such detachment from her environment, "*as if I have taken leave of my own life, as if I have decidedly deserted it*," she declares incessantly. She lives as if nothing has any meaning for her anymore, perceiving her life as meaningless, meaningless, meaningless. For example, she describes her relationship with her partner as floundering, but, she says, "*it doesn't matter*." She says that since

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her release, her partner has been distant from her, "*as if he reproaches me for having cheated on him with my captors...!* She says ironically. Her partner reportedly did not believe her when she told him that she had not been sexually abused during her captivity. But Mademoiselle M does not deny it. She tells us: "*Now that the case has been publicized and my image has been presented on TV, what man would still want me? What man will believe that I have not been touched?* ". She declares it as if she were satisfied with it.

But in this loss of the meaning of her existence, what seems to make Miss M suffer more is the break, or even the break with what she has always considered to be the foundation of her life: her deep belief. Since her release, Miss M has felt cut off from her transcendental being, "Allah", as she calls him. She is consumed by guilt, she confides that she broke her link with Allah, because she declared that she was married and had children when her invaders were interviewing the abducted women on this subject. She knew the outcome of the answers to these questions. The negative response would have earned her sexual violence, and, as she tells us, she probably could not have returned home, as her captors could make her one of their many wives. And she adds: "*Maybe I wouldn't have come home alive, because I would only have tolerated it on my corpse!* ". However, the affirmative answer she gave, an answer she describes as a lie, sounds like the act of rupture with her divine. She considers that she preferred the fleshly life to her salvation.

This feeling of disconnection with his transcendental being seems to have weakened him and shaken his values. On a personal level, she feels worthless. When asked about the issue, her answers connote a high level of devaluation: "*I feel worthless, as if I were useless, ... like a sheep...* ", she says. This intense "*spiritual distress*" seems to resonate with psychic distress, in an articulation of mutual influence, likely to create blockages in the context of the psychotherapy set up for his psychological care.

Framework for intervention

Framework

When we meet Miss M for the first time, we discover a young woman in a neat outfit with the hijab marking her Muslim faith. She appears frail, shy, clearly speaking, but showing a suspicious attitude. She tells us that the circumstance is a great first for her, because she had never consulted a psychologist or psychiatrist and even less a psychotherapist. She describes secure and supportive attachment bonds within her family of origin. In addition, there is a wide variety of internal resources such as its great culture. However, the young woman seems to have been in a state of psychological destabilization in the pre-morbid phase. Indeed, the episodes of life related to the accident 2 years ago and the disappointment in love only sometimes later do not seem to have been overcome despite these resources. They also seem to have constituted fertile ground for the installation of the psycho-trauma of the morbid phase. This sensed psychological destabilization of this young woman testifies to the presence of fragile and unstable narcissistic foundations. To this day, it appears to be shaken and diminished. She describes very restless nights, a somatic symptom, mental ruminations and great guilt. There is also an exaggerated startle reaction, a cyclical mood with a labile affect.

Miss M appears apathetic, distraught, in great psychological distress. The account of his abduction by armed men is made with great difficulty. She always breaks down in tears when she recounts this event. It relates a moment of rupture, of rupture with the feeling of security, at the moment when these men point their weapons at them and teach them that their lives depend a lot on what they decide to do. This confrontation with the reality of death, unimaginable, this feeling of the end haunts her, and she can't get rid of it. Similarly, there is this image, she describes: "*... where this young man in his twenties [the one who kept her in his cell] points this gun at me, and tells me that I am nothing, he can, if he wants, shoot me at any time*," and, she adds, "*and he tells me that it would not even be a sin in the eyes of Allah*." She reports that these words remain engraved in her memory, resounding repeatedly, as if nothing else existed. She always bursts into tears when certain images come back to her. She tells us about another intensely painful material: "*As they didn't give me anything for my intimate hygiene, I sometimes remained chained during my menstrual period, without being able to clean myself... [ineffectively suppresses tears in sudden silence]* ". When she describes the facts, she confides that she is not sure that it is all over. She describes her condition during the three months of captivity as "*endless moments*" when she had lost track of time. Moments so interminable that she had resigned herself to accepting this new

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condition. This moment of reification during captivity led to the loss of the sense of existence. A distress amplified by the great guilt she

Analysis of the intervention

Our analysis of the case of Miss M led us to the conclusion of isolated dysfunctional memory networks, unable to reconnect to the more appropriate ones of her functioning. The EMDR protocol therefore seemed to us to be more appropriate for the resolution of the case (Cornil, 2023; Iracane, 2023). In this study, we will not go back over the presentation of the EMDR protocol itself, the reader interested in the question will be able to find a rich, abundant and recent literature (Shapiro, 2010, 2007, 2001, 1995; Shapiro and Laub, 2015; Cornil, 2023 Iracane, 2023; …). Nor will it be a question of literally exposing the conceptualization of the case of Miss M, that is not part of our objectives. On the other hand, it is a question, in this part, of presenting the eruption of spiritual suffering in the psychological clinic, in particular during the EMDR protocol, on the one hand; and, on the other hand, the facilitation of the process of adaptive treatment using the spiritual corpus.

Summary of the conceptualization of the case of Miss M

Thus, the goal of the request was the reduction of symptoms. It was broken down into intermediate objectives, the first of which was the stabilization of the patient. After building a strong therapeutic relationship during the first few sessions, we found it necessary to strengthen his resources during the first four sessions. The summary of the targeting plan is presented in the following box (*Box 1*).

Box 1: Miss M's targeting plan

1. Traumatic memory networks

- Current problem: PTSD.
- Clinical Themes:
  - *Responsibility (guilt and shame).*
  - *Security; and*
  - *Control (NB: all three are present.*
- Current triggers:
  - *Leaving her home, when she closes her door leaving her house.*
  - *Menstrual period, when she must make her intimate toilet.*
  - *Aircraft noise.*
  - *Perception of a man in uniform, especially when holding a firearm.*
  - *Etc.*
- The most disturbing situation retained: stagnation of menstruation on her
  - *Feeling: Wet feeling in my crotch.*
  - *CN and CP of the targeting plan: "I am a disgrace" and "I am honourable"*
- Events of the past:
  - *Memory 1 of the past "their nocturnal movement, blindfolded, to an unknown destination, after the news of the refusal to pay their ransom by their NGO".*
  - *Memory 2 of the past "her guard pointing his gun at her, threatening to shoot her".*
  - *Memory 3 of the past "herself tied up and bathed in her menstruation, without the possibility of changing herself".*
  - *Memory 4 of the past "noise of the plane (army fighters) and exchanges of fire between the army and their attackers"*
  - *Etc.*
- Source memory: "their assailants getting off motorcycles with guns pointed at them".
- Future scenario:
  - *Being able to leave her house, to close her door leaving her house while remaining calm.*
  - *To be able to live the period of menstruation calmly.*
  - *Remain calm to the perception of aircraft noise.*
  - *Be able to remain calm to the perception of a man in uniform even if he is holding a firearm.*
  - *Etc.*

2. Adaptive memory networks

- Resources:
  - *A safe therapeutic relationship.*
  - *Ability to think.*
  - *Close family.*
  - *Health professionals.*
  - *To be able to regulate one's emotions effectively.*
  - *To be able to read.*
  - *Income and financial security.*
  - *Have a job.*
  - *Access to the therapist.*
  - *Is part of a spiritual community (Islam).*
  - *Etc.*

This box is a simplified summary of the conceptualization of the case of Miss M.

Data from the evaluation phase

The treatment of Miss M experienced blockages during the desensitization and reprocessing of the first targets. All these blockages were related to beliefs directly related to his spiritual life. We present here an illustration of a salient moment of these blockages. After a preparation carried out in four sessions over two weeks, and after having been reassured of the patient's stability and her eligibility for the desensitization and retreatment phase, the evaluation phase of the first target, the most disturbing situation, provided the information contained in the following box (*box 2*).

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Box 2: Evaluation phase of target 1

- Target: Menstrual stagnation on her
  - *Feeling: Wet feeling in my crotch.*
  - *Negative cognition: "I'm a disgrace"*
  - *Positive cognition: "I am honorable"*
  - *Validity of positive cognition (VOC): 2/7.*
  - *Emotions felt shame, feeling of helplessness.*
  - *Emotional disturbance level (SUD): 8/10.*
  - *Location of physical sensation: node at the level of the heart (chest)*

Manifestation of spiritual suffering in the EMDR protocol

During the desensitization phase, everything goes well at the beginning. But after several series of alternating bilateral stimulations (SBA), Miss M's SUD evolves normally and then freezes at 4. There, the content of its associations stagnated, and remained unchanged, the new association being based on the same content. We close the session and put the patient back in her window of tolerance by exercising the safe place. In the following sessions, the patient's SUD remained unchanged at 4. We undertake different strategies, including mechanical approaches (lengthening the duration of SBA series, increasing their speed, changing their direction, and even the stimulation modality); the change of register (we go from the cognitive register to the emotional one, then the somatic one); the Image, Cognition, Emotion, Sensation (ICES) strategy. Subsequently, we undertake to strengthen the patient's resources again for better stabilization.

When we resume phase 4, the patient's SUD remains unchanged at 4 and the VOC blocked at 2, this begins to generate bodily manifestations of anxiety resistant to the alternative strategies mentioned above, we then recommend cognitive weaving. We ask Miss M what this number 4 of the VOC says about her. And there, she replies painfully and abundantly: "*that I am a shame, an impure, because I chose to save my life instead of respecting the commandments of Allah*." She alluded to the fact that, during her captivity, her assailants, fundamentalist Islamists, had asked her if she was married and if she had children. To these questions, she answered in the affirmative, for fear of being subjected to sexual violence and perhaps even of not being able to return home, she told us in a previous interview.

After this answer on the meaning of SUD 4, knowing his great knowledge of the sacred book of Islam, the Qur'an, we ask him: can you remind me of the last sentence of Surah Al-Ma'idah verse 32? She replies mechanically: "*... who saves a life, it is as if he saves all of humanity*", and we retort: "*What does it mean?* She continues more calmly: "*Everything that contributes to saving a life is blessed by Allah*." We ask her to continue with this and apply a series of SBAs, after which she breathes a sigh of relief and later adds, "*It's clear, it saved a life..." It saved my life*." From this moment on, we start to evolve normally again, the SUD finally goes to 0. The VOC will finally increase to 1, a figure that she will describe as ecological. We finally reached the installation phase without any problems, then that of the body scanner and we closed the session. The other sessions will be done under the same modality, with a strong presence of cultural elements relating to the patient's spirituality, and by using the corpus of this spirituality, we finally manage to resolve the case of Miss M after four months of therapy.

DISCUSSION

The results from the exploitation of the case of Miss M show the co-presence and a reciprocal influence of spiritual and psychological suffering. The analysis of the case shows that the latter – fuelled by the traumatic experience that the patient suffered during her captivity and earlier during her abduction – made her psychological functioning more rigid. This is what the psychological examination showed, showing the presence of PTSD with, among other things, a high level of cognitive and mood symptoms, as well as an anxiety-depressive syndrome. These cognitive and mood symptoms have clearly led to cognitive distortions resulting in rigid and maladaptive beliefs. Miss M feels responsible for what happened to her, believing that she caused her torment by her sin. This highly rigid

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functioning caused a rupture of his link with his transcendental Being, thereby causing great spiritual suffering, observable by his self-accusation and his great guilt, reinforcing his conviction of his eviction from the celestial plane. In turn, the great spiritual distress resulting from this psychic rigidity clearly contributes to the patient's *over-traumatization*. She considers that she has lost salvation, which generates such distress obstructing the reprocessing process that has begun, is the cause of the blockages observed during the EMDR protocol.

Moreover, the solution to this great distress is found in the corpus of his spirituality. Indeed, the orientation of Miss M towards passages from the corpus of her spirituality, she integrates an adaptive information that allows the establishment of a link between the past experience relating to the trauma and the perspective of a current well-being made possible by an awareness of the erroneous and outdated nature of the prior information. Thus, the psychic rigidity maintained by the shock of the events experienced surrounding her hostage-taking has frozen her in distress causing the reprocessing of dysfunctional memory connections to be blocked. The belief in the deprivation of one's salvation has made it difficult to evolve the EMDR protocol. But a new cognitive solicitation, initiated by us around his spiritual corpus, particularly the focus on the 32nd verse of Surah Al-Mâ'idah, has allowed a modification of the associative material. Through this strategy of cognitive weaving oriented towards the spiritual material, the EMDR protocol has been unblocked and conducted with efficiency. Based on these observations, we posit that spirituality in psychological clinics can also reinforce psychological distress through the related suffering, which is likely to contribute to the *overtraumatization* of the spiritual patient; that it can promote the recovery process through the appropriate use of its corpus.

This postulate converges with the position of Devereux (1971) who already pointed out the duality of the impact of culture on health behaviour. He then presented culture as a dynamic system that generates its own tensions and its own remedies. In other words, Devereux posits culture as a central and dynamic actor in the processes of health/disease. He was therefore already insisting on the imperative need to consider the patient's cultural framework in order to understand his suffering and offer him a care that made sense to him. Sow (1977) adds to this by positing that one cannot effectively treat a patient using an imaginary that is foreign to him. In the specific context of spirituality, our results converge with Bellehumeur's (2021) position that "spirituality can be part of the problem or part of the solution" (p. 60).

Concerning the EMDR protocol in particular, our procedure converges with several conceptualizations of this protocol. First, Shapiro (2007, cited in Iracane 2023) describes blockages under the EMDR protocol as when "*information that has not reached the appropriate level of desensitization, remains unchanged after two consecutive rounds of SBAs*." (p.142) She also conceives three categories of blockage: cognitive, emotional and somatic (Shapiro, 2018). These positions are in line with our results, which start from an identical conception of blocking, and describe, in the same sense, the category of cognitive blocks, one of the three designed by Shapiro (2018). In the same vein, Wesselmann et al. (2021) found that patient blockage may result from the patient's inaccessibility to adaptive cognition. Our results reached a similar conclusion, although they specify the nature of this adaptive cognition as related to the culture, and more particularly to the spirituality of the patient.

CONCLUSION

In short, spirituality and psychology remain very closely linked. In the field of health, it is not uncommon to see the irruption of spirituality in the psychological clinic. Here, spirituality can be appreciated in different ways. The data from this case study show that, on the one hand, in its morbid form – spiritual suffering – it can influence each other with psychological suffering, and thus cause greater distress. In the case presented in this work, we observe spiritual suffering, fueled by the rigidity of psychic functioning caused by the trauma, amplify the latter. The patient, being immersed in rigid functioning, developed cognitive distortions, plunging her into cognitive biases, reinforcing erroneous and maladaptive beliefs which, in turn, exacerbated the traumatic experience. It is this mechanism that systematically undermined the treatment process initiated under the EMDR protocol, through blockages.

On the other hand, spirituality as a resource offers new perspectives for elaboration to the patient during the therapeutic process. The orientation of the patient by the therapist towards more suitable associative material through her spiritual corpus has allowed the unblocking by the awareness of the erroneous and outdated nature of the prior information. In the present clinical case, spirituality in the psychological clinic is therefore presented

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both as being able to amplify the problem and as being able to orient the final solution. The clinical psychologist will have won by immersing himself in the patient's spiritual variable and handling it with great delicacy. Because if it had been handled clumsily, it could have caused the failure of the therapeutic process set up, but its control increased the effectiveness of this process. Further research could then be carried out to extend these observations in a mixed methodology, to rule on the possibility of generalization of the present results, a generalization that was not the objective of the present study.

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