2

EMDR Therapy Protocol for Panic Disorders With or Without Agoraphobia

Ferdinand Horst and Ad de Jongh

Introduction

Panic disorder, as stated in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*; American Psychiatric Association, 2013) is characterized by recurrent and unexpected panic attacks and by hyperarousal symptoms like palpitations, pounding heart, chest pain, sweating, trembling, or shaking. These symptoms can be experienced as catastrophic ("I am dying") and mostly have a strong impact on daily life. When panic disorder is accompanied by severe avoidance of places or situations from which escape might be difficult or embarrassing, it is specified as "panic disorder with agoraphobia" (American Psychiatric Association, 2013).

EMDR Therapy and Panic Disorder With or Without Agoraphobia

Despite the well-examined effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) Therapy in the treatment of posttraumatic stress disorder (PTSD), the applicability of EMDR Therapy for other anxiety disorders, like panic disorders with or without agoraphobia (PDA or Pathological Demand Avoidance), has hardly been examined (de Jongh & ten Broeke, 2009).

From a theoretical perspective, there are several reasons why EMDR Therapy could be useful in the treatment of panic disorder:

1. The occurrence of panic attacks is likely to be totally unexpected; therefore, they are often experienced as distressing, causing a subjective response of fear or helplessness. Accordingly, panic attacks can be viewed as life-threatening experiences (McNally & Lukach, 1992; van Hagenaars, van Minnen, & Hoogduin, 2009).
2. Panic memories in panic disorder resemble traumatic memories in PTSD in the sense that the person painfully reexperiences the traumatic incident in the form of recurrent and distressing recollections of the event, including intrusive images and flashbacks (van Hagenaars et al., 2009).
3. Besides the panic attack itself being a threatening experience, there are indications that PDA often develops after other stressful life events (Faravelli & Pallanti, 1989; Horesh, Amir, Kedem, Goldberger, & Kotler, 1997).

The same research group (Feske & Goldstein, 1997; Goldstein, de Beurs, Chambless, & Wilson, 2000; Goldstein & Feske, 1994) conducted almost all of the studies concerning the

use of EMDR Therapy in the treatment of PDA. They found a decrease in panic complaints and anticipatory anxiety in most clients treated with EMDR (Goldstein & Feske, 1994). These studies are limited by the extent to which the EMDR procedure was applied, because in the description of the procedure some essential parts of the current EMDR protocol were lacking (de Jongh & ten Broeke, 2009).

The purpose of this chapter is to illustrate how EMDR Therapy can be applied in the treatment of panic disorder with or without agoraphobia. In this chapter, the EMDR protocol for panic disorders with or without agoraphobia is scripted; it is based on the Dutch translation (ten Broeke & de Jongh, 2009) of the EMDR protocol of Shapiro (2001).

DSM-5 Criteria for Panic Disorder With and Without Agoraphobia

Before identifying suitable targets for EMDR Therapy in the treatment of panic disorder with or without agoraphobia, it is important to determine whether or not the client has panic attacks and meets all *DSM-5* (American Psychiatric Association, 2013) criteria of a panic disorder with or without agoraphobia.

Panic attacks are recurrent and unexpected and include a surge that may range from intense discomfort to extreme fear cresting within minutes. They are accompanied by at least four or more of the following physiological symptoms: paresthesias (tingling sensations or numbness); sensations of heat or chills; experiences of dizziness, lightheadedness, unsteadiness or weakness; queasiness or abdominal upset; chest pain or distress; feeling of choking; unable to catch breath or feeling smothered; trembling or quaking; perspiring; and fast or irregular heartbeat. There are also intense cognitive distortions such as feelings of unreality (derealization) or being disconnected from oneself (depersonalization); fear of going crazy or losing control; and/or fear of dying.

In order to meet the criteria, a person must be either continuously worrying about having another panic attack or their consequences (such as losing control, having a nervous breakdown, etc.) or significantly changing behavior to avoid having another panic attack over the period of 1 month after the attack. If the symptoms can be ascribed to the physiological effects of a substance (such as a medication or drug abuse) or another medical condition (such as cardiac disorders or hyperthyroidism) or another mental disorder (such as social anxiety disorder or specific phobia), panic disorder is not diagnosed.

In contrast to *DSM-IV-TR* (American Psychiatric Association, 2000), where panic disorder is diagnosed with or without agoraphobia, the *DSM-5* considers agoraphobia as an independent disorder. Therefore, agoraphobia is diagnosed irrespective of the presence of panic disorder. This diagnosis includes a separate *DSM-5* code for agoraphobia. In case both disorders are present, both should be assigned. Agoraphobia is characterized by fear about situations related to being in enclosed or open spaces, being in line or in a crowd, being outside of the home alone or using public transport. These situations are difficult because in the event of panic symptomatology, the fear is that escape might be difficult and help might not be available is predominant leading to the avoidance of these situations or the need for the presence of another person. The fear or anxiety that is felt is out of proportion to the actual situation itself; this includes when another medical condition is occurring as well. This type of fear, anxiety, or avoidance lasts 6 months or more, impairs functioning in social, occupational or other areas of functioning and is not explained by other mental disorders.

Measurement

Standardized Clinical Interview

To determine whether a client suffers from panic disorder with or without agoraphobia, and its severity, a standardized clinical interview, such as the Structured Clinical Interview for *DSM-IV* Axis I disorders (SCID-I; First, Spitzer, Gibbon, & Williams, 2002), should

be administered. The answers to the questions reveal whether the client suffers from panic disorder and/or other anxiety disorders, like PTSD, depression, specific phobia, or generalized anxiety disorder that are more prominent and possibly require other treatment. (At the time the present chapter was written, an updated version for *DSM-5* was not yet available).

Mobility Inventory

When a client is diagnosed with panic disorder with agoraphobia, the Mobility Inventory (Chambless, Caputo, Jasin, Gracely, & Williams, 1985) can be administered to determine the severity of the disorder. This inventory is a self-report questionnaire to measure the degree of agoraphobic avoidance across 27 situations. These situations are subdivided according to whether the client is encountering them with a trusted companion or alone.

Agoraphobic Cognitions Questionnaire

To identify the intensity of a client's catastrophic cognitions when feeling anxious or tense, the Agoraphobic Cognitions Questionnaire (Chambless, Caputo, Bright, & Gallagher, 1985) can be used. This questionnaire has 14 catastrophic cognitions, divided into two subscales, which include anxiety about physical consequences and anxiety for social consequences.

Panic Disorder With or Without Agoraphobia Protocol Script Notes

Identifying Useful EMDR Therapy Targets

When identifying useful targets for EMDR Therapy in the treatment of panic disorder with or without agoraphobia, any experience in the client's panic history that "fuels" the current pathology can be used; these experience include memories of event(s) after which the complaints—panic, anticipatory fear responses, and avoidance tendencies—originated and/or worsened, and are experienced as still emotionally disturbing today (for a proper case conceptualization, see de Jongh, ten Broeke, & Meijer, 2010). Examples are panic attack memories, traumatic memories, and/or agoraphobic situations.

Panic Attack Memories

As mentioned earlier, panic attacks are likely to occur totally unexpectedly, and clients experience them as life threatening, causing a subjective response of fear or helplessness. Therefore, based on Shapiro's Adaptive Information Processing (AIP) model that negative thoughts, feelings, and behaviors are the result of unprocessed memories, it is a logical step to determine the first and/or worst panic attack memory, most recent memory, and eventually other panic attack memories as suitable targets for EMDR Therapy. When reprocessing of the panic attack memories is completed, it can be expected that these memories will no longer fuel the panic disorder symptoms and that such symptoms will alleviate or dissolve.

Traumatic Memories

Besides the panic attack itself being a threatening experience, there are indications that panic disorder with or without agoraphobia often develops after other stressful life events (e.g., the loss of a loved one, a serious accident, or a divorce). These life events as such, most of the time, do not meet (full) PTSD criteria, but could be considered precursors for the start and development of the panic disorder. Based upon the assumptions underlying the AIP model, it could be hypothesized that panic disorder symptoms will reduce or dissolve following the processing of the underlying traumatic memories/life events.

Agoraphobia Memories

Clients with panic disorder often develop agoraphobia. Since the agoraphobia develops after the start of the first and/or worst panic attack, it can be expected that, in the most ideal situation, the severity of the symptoms characterizing the agoraphobia (e.g., avoidance of a certain situation) will be reduced when the panic attack memories are completely processed. But, when the anticipatory anxiety for clients' typical agoraphobic situations does not dissolve, it is important to determine the presence of other (disturbing) memories of past events that possibly keep the agoraphobic fears vivid.

In certain cases, clients who have been treated with EMDR Therapy and who no longer experience panic attacks still avoid situations where there would be difficulty in escaping if the need arose. It seems that they have avoided certain activities for such a long period of time that—even without panic attacks—they do not know how to behave and feel secure in situations that would precipitate their agoraphobic symptoms. The most logical step is to apply EMDR Therapy to client's most feared catastrophic future event (the client's so-called flashforward; see Chapter 2).

If the client's flashforward has been fully processed and the Validity of Cognition (VoC) of the flashforward in combination with the Positive Cognition (PC; "I can handle it") has reached 7, it should be evaluated whether or not the potentially agoraphobic situations are no longer avoided, as would be expected. If not, the client should be supported and assisted to encounter the agoraphobic situations in order to convince herself that the fear is unfounded. In these instances, in vivo exposure might still be needed to (gradually) confront the client with the situation so that she can experience the nonoccurrence of the catastrophe she fears.

Panic Disorder With or Without Agoraphobia Protocol Script

Currently, no official guideline is available for the treatment of panic disorder with or without agoraphobia using EMDR Therapy. In the present protocol, the authors used the theoretical perspective discussed earlier to give direction to identifying suitable targets in the treatment of panic disorder. This scripted EMDR Therapy protocol for panic disorder with or without agoraphobia is largely based on Ad de Jongh's chapter "EMDR and Specific Fears: The Phobia Protocol Single Traumatic Event" in *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations* (Luber, 2009), *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols with Summary Sheets: Special Populations* (Luber, 2012), and the "Two Methods Model for Establishing Case Conceptualizations for EMDR" (de Jongh et al., 2010).

Phase 1: Client History

Determine to what extent the client fulfills the *DSM-5* criteria of a panic disorder with or without agoraphobia (American Psychiatric Association, 2013).

Identify the Targets

FIRST PANIC ATTACK/STIMULUS SITUATION

Identify the first panic attack or stimulus situation.

Say, *"Please describe your first panic attack that you remember."*

Check whether this is indeed the first panic attack.

Say, *"Is this indeed your first panic attack? I mean, are you absolutely sure you don't remember having had a panic attack prior to this incident?"*

WORST PANIC ATTACK/MOST REPRESENTATIVE EXPERIENCE

Identify the worst panic attack or most representative experience.

Say, *"Please describe the worst panic attack you remember."*

MOST RECENT PANIC ATTACK

Identify the most recent panic attack.

Say, *"Please describe the most recent panic attack."*

IDENTIFY OTHER EXPERIENCES RELEVANT TO THE ONSET OF THE PANIC DISORDER

Identify other experiences relevant to the onset of the panic disorder.

Say, *"What other past experiences might be important in relation to the onset of the panic disorder you have? Please describe."*

Or say, *"If the panic attacks started with a traumatic event, which one was that?"*

Or say, *"Do the panic attacks remind you of another specific event?"*

Or say, *"Do you remember having been exposed to any traumatic* (other) *event prior to the start of your first panic attack?"*

_____

_____

_____

Introduce the Timeline

Introduce the timeline for the client's panic and trauma experiences.

Say, *"Let's draw a timeline of your panic history and traumatic experiences until now. The horizontal line represents the time, and the vertical line the severity of the symptoms."*

Help the client draw the timeline on a piece of paper.

Expected Consequence/Catastrophe

Identify the expected consequence or catastrophe (e.g., physical consequences, like "I must have a brain tumor" and/or social consequences, like "I am going crazy").

Say, *"What are you afraid could happen when you get a panic attack?"*

_____

_____

_____

If the client meets the criteria of agoraphobia, say the following:

Say, *"What are you afraid could happen when you are confronted with or exposed to* _____ (state the agoraphobic situation)*?"*

_____

_____

_____

Assess the Validity of Catastrophe

State the reality of the fear of exposure and assess the percentage of fear that a client feels if exposed to the agoraphobic situation using the VoC score.

Say, *"Is it true you are saying that IF you would be exposed to* _____ (state the agoraphobic situation) *THEN you would* _____ (state the catastrophe the client fears would happen)*?"*

_____

_____

_____

Say, *"On a scale from 0% to 100%, where 0% means it is completely false and 100% means it is completely true, how true does this feel?"*

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

(completely false) (completely true)

Treatment Goal

Determine an appropriate and feasible treatment goal(s).

Say, *"Based on all that we have been talking about, let's discuss our goal(s) for treatment. What is/are the goal/s and how will you know when you have reached your goal(s)?"*

Addictive Medications

Assess for any addictive medications.

Say, *"Are you using benzodiazepines?"*

If yes, and client is using benzodiazepines, say the following:

Say, *"Would you be willing to stop or to reduce your benzodiazepine consumption before starting EMDR Therapy?"*

Phase 2: Preparation Phase

Explanation of EMDR Therapy

Explain EMDR Therapy to the client.

Say, *"When a negative and distressing event, like a panic attack, occurs, it seems to get locked in the nervous system with the original picture, sounds, thoughts, and feelings. The eye movements we use in EMDR seem to unlock the nervous system and allow the brain to process the experience. Those eye movements may help to process the unconscious material. It is important to remember that it is your own brain that will be doing the healing and that you are the one in control."* (Shapiro, 2001)

Teach Working Memory Taxation Techniques

Teach working memory-taxing methods for immediate anxiety management between sessions, such as the following:

Say, *"Please describe out loud the content of the room with as much detail as you can."*

The types of exercises that tax clients' working memory include mental exercises such as counting backward from 1,000 by 7s, remembering a favorite walk in detail, and so on. For example, try the following:

Say, *"Please count backward from 1,000 by 7s."*

Or say, *"In detail, tell me about a favorite walk that you took."*

In the case of a child, distraction can be applied, for instance, by thinking of animals beginning with each letter of the alphabet in turn.

Say, *"Think of an animal that begins with the letter A."*

Say, *"Great, now let's continue finding the names of animals using the rest of the alphabet. What would the name of an animal be for the letter B?"*

Continue finding the names of the animals with the rest of the alphabet.

Say, *"These exercises that we have been practicing may help you when you are dealing with anxiety-eliciting situations. It is really important for you to prepare yourself for possible discomfort between sessions by practicing these exercises. The more you practice, the better you will get at them."*

Phase 3: Assessment Phase

Past Memories. Target Selection

Select a target image (stationary picture) of the memory. (See Phase 1: Client History for the series of targets that have to be processed. It is recommended to start with the first and/or worst panic attack.)

Say, *"You've just told me how this event is present in your mind. Now I'm asking you, at this moment, if you look at it right here and right now, what is the most disturbing picture of this memory? Look at it, as if it's a film, and stop it, right at that second, so it becomes a picture. We are looking mostly for a picture with you in it. It's not about what you found most disturbing at that time, but what is now, at this moment, the most disturbing picture to look at, including pictures that show what could have happened."*

If it helps, you can also ask these questions:

Say, *"So you're looking at yourself from a distance?"*

_____

_____

Say, *"What does this picture look like?"*

_____

_____

Negative Cognition

Obtain the NC and PC.

Say, *"What words go best with the picture that express your negative belief about yourself now?"*

Note: The NC, most likely and most preferably, is "I am powerless." Suggest this NC if the patient does not come up with this by himself.

_____

_____

Positive Cognition

Say, *"When you bring up the picture of the incident, what would you like to believe about yourself now?"*

Note: The PC, most likely and most preferably, is "I can handle this." Suggest this PC if the patient does not come up with this by herself.

_____

_____

Validity of Cognition

Say, *"When you bring up the picture of the incident, how true do those words* _____ (repeat the PC) *feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Identify emotion, SUD level, and location of the feeling.

Emotions

Say, *"When you bring up the picture* (or incident) *and those words* _____ (state the NC), *what emotion do you feel now?"*

_____

_____

Subjective Units of Disturbance

Say, *"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does the picture* (or incident) *feel now?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

Say, *"Where do you feel it* (the disturbance) *in your body?"*

_____

_____

Phase 4: Desensitization Phase

Hold your hand in front of the patient's eyes.

Say, *"Look at my fingers* (or fingertips)*."*

Say, *"I want to ask you to be a spectator who is observing the things that are happening to you from the moment you start following my hand. Those things can be thoughts, feelings, images, emotions, physical reactions, or maybe other things. These can relate to the event itself, but also to other things that seem to have no relationship to the event itself. Just notice what comes up, without trying to influence it, and without asking yourself whether it's going well or not. It's important that you don't try to hold onto the image that we will start with or keep it in mind all the time. The image is just the starting point of anything that can and may come up. Every once in a while we will go back to this image to check how disturbing it still is to look at. Keep in mind that is impossible to do anything wrong, as long as you just follow what's there and what comes up."*

_____

Then say, *"Bring up the picture and the words* _____ (repeat the NC) *and notice where you feel it in your body. Now follow my fingers with your eyes* (or other BLS)*."*

_____

This protocol uses a different strategy to go back to the target than in the Standard EMDR procedure, in that the authors would like to identify explicitly what type of aspects are still causing the existing disturbance.

Say, *"Please go back to the picture that we started with as it is now stored in your head. How disturbing is it now to look at the picture, on a scale from 0 to 10, where 0 is not disturbing at all, and 10 is as disturbing as it can get?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

If the SUD is 1 or higher, options are as follows:

Say, *"What aspect of the picture is causing that disturbance/tension* (you may name the number, e.g., *'What is there in the picture that is causing the 4?'*)*."*

Or say, *"What is there in the picture that is causing the* _____ (state the SUD level)? *What do you see?"*

Then say, *"Concentrate on that aspect. OK, have you got it? Go with that."*

Repeat the "Back to target" procedure until SUD = 0.

If SUD = 0, say the following:

Say, *"Are you absolutely sure that there isn't a little bit of disturbance or tension somewhere? If so, try to let it affect you."*

If necessary, continue the desensitization until the original picture feels completely neutral. Then continue with installation.

Phase 5: Installation Phase

Install the PC

Say, *"How does* _____ (repeat the PC) *sound?"*

Say, *"Do the words* _____ (repeat the PC) *still fit, or is there another positive statement that feels better?"*

If the client accepts the original PC, the clinician should ask for a VoC rating to see if it has improved:

Say, *"As you think of the incident, how do the words* (the PC) *feel from 1 being completely false to 7 being completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Say, *"Think of the event and hold it together with the words* _____ (repeat the PC). *Go with that."*

_____

_____

Continue this procedure until the VoC = 7.

Check the Response and the Symptoms Regarding the Previous Processing

If, after the previous steps, the client still suffers from symptoms such as panic attacks or agoraphobic fears that persist after all memories of all past events that could be identified as contributing to the current symptoms have been fully processed, the Flashforward Procedure (Logie & de Jongh, 2014; see Chapter 3 in this volume) should be applied. This procedure addresses clients' irrational fears and anticipatory anxiety responses/triggers and is focused on the mental representation that represents the worst possible outcome of a confrontation with the object or situation that provokes the fear.

Check the Other Targets

See Phase 1: Client History and decide whether it is still necessary to reprocess these experiences (i.e., SUD when bringing up the memory > 0).

Say, *"OK, let's check the next target that is in your list* _____ (state the next target). *On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Phase 6: Body Scan

Say, *"Close your eyes and keep in mind the experience* (e.g., a panic attack) *that you will have in the future. Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness, or unusual sensation, tell me."*

_____

_____

If any sensation is reported, introduce eye movements.

If it is a positive or comfortable sensation, a new set of eye movements is introduced to reinforce the positive sensation.

If a sensation of discomfort is reported, this is reprocessed until the discomfort subsides. Finally, the VoC has to be checked.

Say, *"As you think of the incident, how do the words feel, from 1 being completely false to 7 being completely true?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Present Triggers. Flashforward

After all old memories that currently "fuel" the fear have been resolved, check whether the patient has an explicit disaster image about the future. What does the patient think will happen to him, in the worst case, if what is feared cannot be avoided?

Say: *"What we have to figure out now is what you fear will happen* (will go wrong) *when you are confronted with* _____ (object or situation that is avoided). *So basically, what catastrophe do you expect to happen, that prevents you from doing what you want or need to do? What is that 'doom scenario' or 'worst nightmare' that's in your head?"*

_____

_____

Let the client create a still image of this disaster scenario and process this mental representation with the Standard EMDR Protocol (SUD = 0, VoC = 7). Here the NC is the standard: "I am powerless" (in relation to the disaster image), and the PC is the standard, "I can deal with it" (the image).

Future Template

For installing the future template, instruct the patient by asking her to imagine a future situation that—until now—has been avoided (or experienced with a lot of anxiety) and/or has been anticipated with extreme anxiety because of the fear of getting a panic attack. In this situation, the preferred behavior is expressed. When doing so, check for catastrophic aspects in the picture. If so, ask the patient to make a picture in her mind without these "disasters."

Install the Future Template

Say, *"OK, we have reprocessed all of the targets that we needed to do that were on your list. Now, let's anticipate what will happen when you are faced with* _____ (state the (agoraphobic) fear). *What picture do you have in mind?"*

_____

_____

_____

_____

Say, *"I would like you to imagine yourself coping effectively with* _____ (state the fear trigger) *in the future. Bring up this picture and say to yourself: 'I can handle it', and feel the sensations. OK, have you got it? Follow my fingers* (or any other forms of BLS)*."*

_____

_____

Say, *"Bring up the picture again. On a scale from 1 to 7, where 1 feels completely false and 7 feels completely true, to what extent do you think you can manage to really do it?"*

1 2 3 4 5 6 7

(completely false) (completely true)

Install with sets of eye movements until a maximum level of VoC has been achieved.

If there is a block, meaning that even after 10 or more installations, the VoC is still below 7, there are more targets that have to be identified and addressed. The therapist should use the Standard EMDR Protocol to address these targets before proceeding with the template (see Worksheets in Appendix A). Also, evaluate whether the client needs any new information, resources, or skills to be able to comfortably visualize the future coping scene. Introduce this needed information or skill.

Say, *"What would you need to feel confident in handling the situation?"*

_____

_____

Or say, *"What is missing from your handling of this situation?"*

_____

_____

Use BLS. If blocks are not resolved, identify unprocessed material and process with the Standard EMDR Protocol.

Video Check (Future Template as Movie)

Say, *"This time, I'd like you to imagine yourself stepping into the scene of a future confrontation with* (the object or the situation for which the future template was meant; e.g., a confrontation with a dog). *Close your eyes and play a movie of this happening, from the beginning until the end. Imagine yourself coping with any challenges that come your way. Notice what you are seeing, thinking, feeling, and experiencing in your body. While playing this movie, let me know if you hit any blocks. If you do, just open your eyes and let me know. If you don't hit any blocks, let me know when you have viewed the whole movie."*

_____

_____

If the client encounters a block and opens her eyes, this is a sign for the therapist to instruct the client as follows:

Say, *"Say to yourself 'I can handle it' and follow my fingers* (introduce a set of eye movements)*."*

To provide the clinician with an indication regarding the client's self-efficacy, ask her to rate her response on a VoC scale from 1 to 7. This procedural step may give the clinician feedback on the extent to which the goals have been met.

Say, *"As you think of the incident, how do the words* (restate the PC) *feel from 1 being completely false to 7 being completely true?"*

1 2 3 4 5 6 7
(completely false) (completely true)

If the client is able to play the movie from start to finish with a sense of confidence and satisfaction, then the client is asked to play the movie once more from the beginning to the end, BLS is introduced, and the PC "I can handle it" is installed. In a sense, this movie is installed as a future template.

Say, *"OK, play the movie one more time from beginning to end and say to yourself, 'I can handle it.' Go with that."*

In Vivo Confrontations

Prepare the client for in vivo confrontations.

Say, *"Many clients with a panic disorder with agoraphobia appear to avoid certain activities for so long that they no longer know how to behave and how to feel secure in this situation. To be able to help further alleviate your fears and concerns, it is important that you learn to counter the negative belief that contributes to this sense of threat and anxiety. Therefore, you need to actually test the catastrophic expectations you have that fuel your anxiety in real life. I would like to ask you to gradually confront the* (agoraphobic) *situations that normally would provoke a fear response. It may seem odd, but if you have a positive experience and it appears that the catastrophe you fear does not occur, it helps you to further demonstrate—or to convince yourself—that your fear is unfounded."*

Say, *"I want you to understand that nothing will happen against your will during the confrontation with the things that normally would evoke fear. The essence of this confrontation is that it is safe. Do you understand? Do you have any questions?"*

In Vivo Exposure

In vivo exposure is done to reduce avoidance and evoke mastery while observing that no real danger exists. It is essential that the therapist help the client pay attention to features of the (agoraphobic) situation that are positive or interesting while being exposed to it.

Say, *"Please describe the most notable features of the situation. Are you noticing any interesting elements about* _____ (state the situation)*?"*

To identify negative thought content, say the following:

Say, *"What are you thinking as you pay attention to* _____ (state the situation)*?"*

To cognitively reconstruct the situation, say the following:

Say, *"How would someone who is not afraid of* _____ (state the situation) *view or evaluate this situation?"*

If needed, give advice to help the client cope with both the situation and his own mental and body sensations.

Note: It is helpful to make variations with regard to the stimulus dimensions such as action, distance, and time.

Say, *"Isn't it interesting to notice that now that you are confronted with this* _____ (state the situation) _____ (state the catastrophe the client normally would have feared to happen) *does not occur?"*

Say, *"Do you notice that your anxiety is not as physically harmful as you might have expected?"*

Say, *"These emotional reactions will subside and fade over time. Therefore, it is important that you continue exposing yourself to the feared stimuli as long as you feel that you have achieved a certain degree of self-mastery. Please note that you are gradually learning to feel that you are capable of handling a certain level of anticipatory anxiety with confidence."*

The therapist should make sure that confrontations are repeated so that the reduction in distress is fully consolidated before moving on. Check results by assessing the validity of catastrophe.

Say, *"If you would encounter* _____ (state the situation) *again, on a scale from 0% to 100%, where 0% means it is completely false and 100% means it is completely true, how true does this feel that the situation is still catastrophic?"*

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

(completely false) (completely true)

Phase 7: Positive Closure

At the end of every session, consolidate the changes and improvements that have occurred.

Say, *"What is the most positive thing you have learned about yourself in the last hour with regard to* _____ (state the incident or theme)*?"*

If the cognitions are not already on the identity level, say the following:

Say, *"What does this say about yourself as a person?"*

Say, *"Go with that."*

Install with BLS until there are no further PCs.

Next, check the results by assessing the VoC.

Say, *"If you would be exposed to* _____ (state the situation), *on a scale from 0% to 100% where 0% means it is completely false and 100% means it is completely true, how true does this* (the PC) *feel?"*

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

(completely false) (completely true)

Explain the expectations for the time in between sessions, which may include any contracts, diary keeping, and contact information.

Say, *"Things may come up or they may not. If they do, great. Write it down and it can be a target for next time. If you get any new memories, dreams, or situations that disturb you, just take a good snapshot. It isn't necessary to give a lot of detail. Just put down enough to remind you so we can target it next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it's still just the old stuff. Just write it down for next time."*

Planning Self-Managed Homework Assignments

After the therapy has been concluded, the therapist makes it clear that it is important to keep practicing during daily life to ensure that the changes are maintained.

Say, *"It is very important to keep practicing with exposing yourself to difficult situations during your daily life in order to maintain the changes that you have experienced."*

"Each time that you have a chance to see _____ (state the feared stimulus), *it is an opportunity for you to practice these new skills that you now know how to do. So, the more that you encounter* _____ (state the feared stimulus), *the better you can get at* _____ (state the goal). *Your brain learns to do new behaviors by practicing."*

Phase 8: Reevaluation

Say, *"Make sure to write down your responses when you are practicing your new skills. Sometimes, even with the skills, you might find that you reexperience your fear* (e.g., a panic attack). *I want to tell you that this can happen sometimes, and it is not unusual. What you can do at that time is to note what has led up to the feeling, what is going on around you, and what you did to help yourself handle the situation. Jot down some notes about what happened as soon as you can so that you won't forget what happened and then bring them to the next session so that we can figure it out."*

Evaluate whatever has not been completed.

Say, *"As you think back on the target that we were working on last time, on a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"*

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

If the disturbance level has increased, these disturbances must be targeted or otherwise addressed.

The therapist should assess the necessity of teaching the client additional self-control and perhaps relaxation techniques or other relevant exercises that could further enhance his ability to confront the former anxiety-provoking situation in real life.

Say, *"So, what other resources do you think might be helpful in assisting you to deal with this situation?"*

Repeated rehearsal and reinforcement for success should be emphasized. To encourage hope and foster engagement in treatment, it is crucial that therapy sessions and homework assignments furnish experiences of success that clients can attribute to themselves.

Say, *"I can see that through all of the work you did between sessions that you are really working hard* (reinforce what the client has done that has been successful)*."*

Summary

The purpose of this chapter is to illustrate how EMDR Therapy can be applied in the treatment of panic disorder with or without agoraphobia. There are indications that this condition often develops after other stressful life events (Faravelli & Pallanti, 1989; Horesh et al., 1997). Literature argues that panic attacks themselves are often experienced as distressing, causing a subjective response of fear or helplessness, which therefore can be viewed as life-threatening experiences (McNally & Lukach, 1992; van Hagenaars et al., 2009). Furthermore, panic memories accompany reexperiences of the traumatic incident and therefore resemble traumatic memories as in PTSD (van Hagenaars et al., 2009). Effectiveness of EMDR Therapy in the treatment of PTSD is well examined. However, research on the effectiveness of EMDR Therapy for other anxiety disorders is scarce. Thus, currently no official guideline is available for the treatment of panic disorder with or without agoraphobia.

Therefore, this chapter showed how EMDR Therapy can be applied in the treatment of panic disorder with or without agoraphobia. In this chapter, the EMDR Therapy scripted protocol for panic disorders with or without agoraphobia is based on the Dutch translation (ten Broeke & de Jongh, 2009) of the EMDR Therapy protocol of Shapiro (2001).

References

Chambless, D. L., Caputo, G. C., Jasin, S. E., Gracely, E. J., & Williams, C. (1985). The Mobility Inventory for Agoraphobia. *Behaviour Research and Therapy*, *23*, 35–44.

de Jongh, A., & ten Broeke, E. (2009). EMDR and the anxiety disorders: Exploring the current status. *Journal of EMDR Practice and Research*, *3*, 133–140.

de Jongh, A., ten Broeke, E., & Meijer, S. (2010). Two method approach: A case conceptualization model in the context of EMDR. *Journal of EMDR Practice and Research, 4*, 12–21.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC.

Faravelli, C., & Pallanti, S. (1989). Recent life events and panic disorder. *American Journal of Psychiatry*, *146*, 622–626.

Feske, U., & Goldstein, A. J. (1997). Eye movement desensitization and reprocessing treatment for panic disorder: A controlled outcome and partial dismantling study. *Journal of Consulting and Clinical Psychology*, *65*, 1026–1035.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured clinical interview for DSM-IV-TR axis I disorders, research version, client edition. (SCID-I/P)*. New York, NY: Biometrics Research, New York State Psychiatric Institute.

Goldstein, A. J., de Beurs, B. E. Chambless, D. L., & Wilson, K. A. (2000). EMDR for panic disorder with agoraphobia: Comparison with waiting list and credible attention-placebo control conditions. *Journal of Consulting and Clinical Psychology*, *68*, 947–956.

Goldstein, A. J., & Feske, U. (1994). Eye movement desensitization and reprocessing for panic disorder: A case series. *Journal of Anxiety Disorders, 8*(4), 351–362.

Horesh, N., Amir, M., Kedem, P., Goldberger, Y., & Kotler, M. (1997). Life events in childhood, adolescence and adulthood and the relationship to panic disorder. *Acta Psychiatrica Scandinavica*, *96*, 373–378.

Logie, R., & de Jongh, A. (2014). The "Flashforward procedure": Confronting the catastrophe. *Journal of EMDR Practice and Research, 8*(1), 25–32.

Luber, M. (Ed.). (2009). *Eye movement desensitization and reprocessing (EMDR) scripted protocols*: *Special populations*. New York, NY: Springer.

Luber, M. (Ed.). (2012). *Eye movement desensitization and reprocessing (EMDR) scripted protocols with summary sheets: Special populations*. New York, NY: Springer.

McNally, R. J., & Lukach, B. M. (1992). Are panic attacks traumatic stressors? *American Journal of Psychiatry, 149*, 824–826.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York, NY: Guilford Press.

ten Broeke, E., & de Jongh, A. (2009). *Praktijkboek EMDR: casusconceptualisatie en specifieke patiëntejagroepen*. Amsterdam, The Netherlands: Pearson.

van Hagenaars, M. A., van Minnen, A., & Hoogduin, K. A. (2009). Reliving and disorganization in posttraumatic stress disorder and panic disorder memories. *The Journal of Nervous Mental Disease*, *197*, 627–630.