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INTEGRATION OF EMDR AND CBT TECHNIQUES IN TREATMENT OF PANIC DISORDER WITH AGORAPHOBIA - A CASE REPORT

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INTRODUCTION

Panic disorder is a term reserved for a panic attack with a sudden onset in its earliest stages, which is not conditioned by a particular situation or position. There is a widespread belief that a panic attack is a symptom of a more serious condition, such as a cardiologic one. A panic attack encompasses a sudden appearance of four or more aforementioned medical and physical symptoms that are characteristic of major anxiety; high heart rate, shortness of breath or choking sensation, chest tightness or pain, shivering and twitching, alternating sensation of coldness and warmth, perspiration, pallor, dizziness, feelings of fatigue and mild migraine, nausea and gastrointestinal symptoms, sharp pain or numbness of limbs, a threatening fear of loss of physical control, threatening fear of „madness“, feeling of dissociation and derealization, and sensation of impending demise.

Symptoms reach their highest intensity within 10 minutes of their appearance, and disappear as suddenly as they appeared. Panic attacks may cause major discomfort, but do not cause physical damage, despite the sufferer's belief to the contrary. They are frequent and commonplace- a third of population experiences them each year. In majority of these cases, the sufferer may begin to avoid the location or situation in which the attack occurred, and thus is this aspect closely related to agoraphobia (Wright 2014).

Agoraphobia literally denotes fear (phobias) of open space (agora). More precisely, an agoraphobic person is afraid of being in open public areas or places frequented by many, particularly if deprived of an escape route. Many agoraphobia sufferers harbor an additional fear that they may under the specified circumstances lose their control over the panic fear and be entirely helpless before strangers. Actual nature of the fear is different among individuals. Agoraphobia can severely impair a person's normal routine, as a person affected tends to avoid confrontation with the fear-inducing situation. In gravest instances, all outdoor activities are avoided, confining the sufferers to their homes. Many experts recognize two forms of this disorder: agoraphobia without panic attacks, and agoraphobia with panic attacks (Wright 2014).

Cognitive- behavioral therapy (CBT) is deemed efficient in a fight against panic attacks and anxiety. Its focus rests on changing non-functional beliefs and behavior by integrating behavioral techniques of systematic desensitization and exposure with cognitive restructuring of negative thoughts and beliefs, and shifting the focus to thoughts and emotions (Wright 2014).

Eye Movement Desensitization and Reprocessing (EMDR) is an integrative method in psychotherapy centered around information reprocessing and desensitization of anxiety linked to stressful experiences in conditions of bilateral stimulation (visual, tactile or audio), that permits simultaneous application of different approaches in psychotherapy: psychodynamic, CBT, or physical, interactive and client-focused psychotherapy.

EMDR approach is normally considered to allow activation of adaptive neurophysiological mechanisms that ensure a more functional information processing through the process of memory reconsolidation related to stressful experiences (dysfunctional memory storage). Thus EMDR therapy results not merely in reduction of anxiety and improvement of symptoms, but likewise in a positive effect, emergence of perception, as well as a change in beliefs and behavior (Shapiro 1991, Hasanović 2014). EMDR therapy standard procedure consists of eight phases:

- *Phase 1* - Anamnesis;
- *Phase 2* - Preparation: Strengthening of therapeutic relationship, psycho-education and expectation assessment, treatment plan and relaxation techniques;
- *Phase 3* - Assessment: The aim of this phase is to enable access to EMDR processing target through processing primary memory aspects;
- *Phase 4* - Desensitization: Reprocessing the network of target memory;
- *Phase 5* - Installation: Developing positive cognitions followed by complete integration of their positive effects via linking to the original target situation;
- *Phase 6* - Search for body sensations (Body Scan);
- *Phase 7* - Closing the session: Client stabilization and completion of EMDR session;
- *Phase 8* - Re-evaluation: Result assessment and preservation (Shapiro 1995).

Literature illustrates how EMDR yields good results in treatment of sufferers from panic attacks without agoraphobia, as is the case with CBT. The complete strength of both approaches is visible from their practical integration (Albin 2012, Faretta 2013, Triscari et al. 2015).

The goal of this work is to demonstrate the value of integration of both approaches in practical usage, emphasizing the importance of preparation and resolution of actual causes of panic attacks (by EMDR techniques) in treatment of complex conditions of anxiety.

CASE REPORT

The patient was a 40-year-old male patient, with high school education level, unemployed, war veteran, unmarried and childfree. He visits a psychologist, per his psychiatrist's instruction, due to a panic disorder with agoraphobia. The client states that it first appeared around six months prior, and was aggravated by his mother's death. On a cognitive level, a negative thought „ I will die, I will suffer a heart attack" was present, whereas on a physical level he experienced daily panic attacks, with pronounced symptoms of agoraphobia, impairing his everyday functioning. The client was unable to leave home of his own accord, stay at and visit public places, and was unable to return to his place of origin and enter the front yard of his family's home, as well as the house itself. In addition, he was unable to visit his mother's grave. The client was undergoing a high-intensity treatment between the months of May and August of 2014. Meetings were conducted on a weekly basis. The treatment consisted of 16 sessions: 12 CBT sessions + 3 EMDR sessions + 1 assessment session.

The treatment saw the usage of the classical CBT protocol in cases of panic attacks with agoraphobia, including the following steps: evaluation, psycho-education, relaxation, preparation of presentation, mock and live presentation, homework. During a live presentation, a halt in treatment occurred after which the later preparation for live presentation resorted to the classic EMDR protocol.

During the first meeting, an initial interview was conducted in accordance with the CBT principles, a work plan was composed as well as the dynamics of 60-minute weekly session. During the first meeting, the client's psychological state was dominated by high-level anxiety. The first CBT sessions with the client addressed the issue of panic attacks, constant concern accompanied by anxiety, with another noteworthy and aggravating factor in therapy being the inability to recognize personal emotions. The client was prepared for work on behavioral assignments, and a plan of presentation was drafted. During a live presentation, there was a halt in treatment during exposure to high-grade stressors (7-10 on scale of fear hierarchy). In this case, further preparation for live presentation necessitated the classical EMDR protocol.

After introducing the client with the techniques and possibilities of EMDR, relaxation methods were addressed next („Safe place" and „Diaphragmatic breathing"), with the client being assigned with practicing them in high-stress situation until the next scheduled session, as well as recording their efficacy. The following session was used to define the standard EMDR target plan and start the work on Touchstone Event. The subject presented was illness and loss, with the father's return from the hospital and the moment of him being informed of the mother's death being selected as the most disturbing image related to the event. The cited negative cognition was „I am not good enough" whereas the positive one was „I deserve well" or „I am worthy".

The level of positive cognition on Validity of Cognition scale (VoC), between 1 and 7, was measured 3. The accompanying emotion was one of sadness, and the level of disturbance on the scale of Subjective Unit of Disturbance (SUD) of between 0 and 10 was measured 6.

The spot of physical sensation was -the belly. Bilateral stimulation (BLS) was initiated afterwards through eye movement (EM). The several initial EM sets yielded no change, but the fourth EM set spurred a spike in disturbance, difficulty in breathing, proclamations of „impending panic attacks" and that „another aggravating image was before his eyes" (association to the morning following the mother's death).

EM reprocessing and desensitization was initiated on a newly opened channel. The disturbance occurred alongside turbulent emotional responses and varied across EM sets, only to begin to gradually subside, following a change in course and vigor in EM.

After the twelfth EM set, the level of disturbance on SUD scale was measured 0. Bearing in mind that the time allotted for the scheduled session was about to expire, the standard EMDR procedure for closing an incomplete session was applied in form of explanation for abortion of therapy, gratification for preceding accomplishments and relaxation exercises.

The client arrived to his next weekly session in a visibly improved mood, elevated interest in work and greater optimism about the continuation of presentation. Continuation of work on Touchstone Event (the loss of mother) was announced by bringing back the most disturbing image of the event (the moment of being informed) after which the BLS EM was initiated. Throughout EM sets the disturbance was gradually subsiding, and was measured 0 following the fifth SUD set. This was followed by an additional EM set, and afterwards by installation. The validity of positive cognition from the previous session was assessed ("I deserve well") and is in close correlation with the Touchstone Event and was followed by bilateral stimulation through eye movement until the level of positive cognition on Validity of Cognition scale was measured 7. After the procedure described, the next phase was to scan the body, during which the client reported a sensation of pleasure and warmth in the area of stomach, as well as a state of relaxation. Another

EM set was conducted with the aim of consolidating the sensation of pleasure, concluding the session with the outlining of a plan of continuation of presentation according to the hierarchy for the next session.

EPILOGUE

During the application of EMDR, the client reprocessed the traumatic memories and pain due to the loss of his mother. This resulted in relief of pain, as well as positive memories and emotions. Following the second EMDR session, he voiced his desire to go to countryside and visit the family house without the mother (the stressor measured 8 and a matter of halt in therapy), which was successfully completed. Afterwards, the presentation followed the proposed hierarchy without any problems. The goals of the treatment were reached and the client returned to normal everyday functioning. The treatment consisted of 16 sessions: 12 CBT sessions + 3 EMDR sessions + 1 assessment session.

DISCUSSION

In the reported case, CBT techniques proved themselves a foremost method of resolution of acute panic attacks, whereas resorting to EMDR at the key moment of halt in treatment demonstrated that the solution of traumatic memories, such as loss of mother, can considerably alter one's attitude towards negative thoughts which aggravate the procedure of presentation, and in return attenuate present symptoms of panic disorder with agoraphobia. The success rate of integration of CBT and EMDR technique was demonstrated beforehand through research conducted by Triscari and others in 2015 on a specific instance of flying phobia proving the success of integration of CBT and EMDR techniques in the very treatment without raising the number of sessions necessary for the treatment's completion. The success of integration of CBT and EMDR technique is similarly attested in works of Albin (2012) in his works placing a particular emphasis on the special value of practical integration of the two approaches, the importance of proper preparation and resolution of actual causes of panic attacks (through CBT techniques) and recent traumatic events in individuals (through EMDR techniques) which is of utmost importance in treatment of complex conditions of anxiety.

Furthermore, according to Albin (2012), CBT considerably changes the relationship towards the negative automatic thoughts which aggravate the procedure of presentation, and in return, attenuates the present symptoms of panic disorders. Negative cognitions are irrational beliefs present in clients as a consequence of previous traumatic events. However, such beliefs typically reinforce the negative style of thought among the individuals in question which is reflected in other areas of life, and in return reduces everyday functionality. The level of insight and commitment to change varies between individuals, and may impede CBT, however, in such cases, EMDR can aid the individual in gaining insight and lowering the level of spontaneous reactions in similar situations. EMDR aids in integration of a sensation of body relaxation contributing to overall calmness in life, and combined with CBT may prompt the person to start integrating a healthy approach to thoughts in his later everyday life and restore their functionality, as was demonstrated in this case.

The rest of the available research addressing the efficacy of treatment of states of anxiety through EMDR and CBT (Albin 2012, Faretta 2013, Triscari et al. 2015) mostly provides a description of efficacy of techniques and duration of treatment. The general conclusion of the said research is one of equal efficacy of EMDR and CBT in treatment of states of anxiety and phobia, with the same number of required sessions numbering between 12 and 16, corroborated by our case which required a 16-session treatment.

This case study, as well as the research cited illustrate the value of integration of CBT and EMDR approaches, and stress the necessity for further research in area of integration of CBT and EMDR techniques during treatment.

CONCLUSION

The study illustrates the value of CBT and EMDR approach, emphasizes the importance of proper preparation and resolution of actual causes (through CBT techniques), as well as recent traumatic events in individuals (through EMDR techniques) in treatment of complex conditions of anxiety.

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