

EMDR TREATMENT OF PANIC DISORDER WITH AGORAPHOBIA: CASE REPORT

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INTRODUCTION

Eye movement desensitization and reprocessing (EMDR) is an integrative psychotherapy that has been extensively evaluated in its approach to trauma and posttraumatic stress disorder (PTSD). In brief, the AIP model is based on the idea that the neurobiological system naturally attempts to process current perceptions in a manner that promotes associations to relevant stored information, to facilitate learning, and to relieve emotional distress. The resulting transfer of information from implicit to explicit memory systems (Shapiro 2001) allows disturbing thoughts, emotions, and bodily sensations to be resolved by facilitating access to the stored material and linking it with more adaptive information. However, the intense effect and subsequent dissociation that accompany trauma may interfere with this process, causing the information (e.g., images, thoughts, emotions, and sensations) to be dysfunctionally stored within the memory network. Because the event is isolated within the network, preventing associations with adaptive information, the unresolved material is easily triggered during similar encounters, often leading to intrusive thoughts, emotions, and somatic responses. The consequent habitual response patterns can manifest in characterological difficulties, psychopathology, and the avoidance behaviors associated with phobias and panic disorders (Shapiro 2001, 2002). EMDR's ability to access and target an etiological conditioning event is appreciated and it is also possible to address past, present, and future symptoms in the absence of a known etiological event. Thus, EMDR has the ability to address panic and phobia regardless of the method by which the symptoms, or fear, were acquired. Once the appropriate targets are chosen, the EMDR protocol addresses all experiential components (images, thoughts, emotions, bodily sensations) to stimulate the information processing system as explained by the AIP model (Shapiro 2001, 2002).

EMDR was introduced in Bosnia and Herzegovina (BH), in 1998 just three years after the war (1992-1995). The first training was organized in 2009, and in 2014 Association of EMDR Therapists in Bosnia and Herzegovina was established (Hasanović et al. 2018).

So the mental health workers who were properly educated started to use EMDR therapies in everyday helping to BH citizens in need (Trlin & Hasanović 2018, Hasanović et al. 2021).

The aim of the following case is to present how EMDR treatment was used to successfully address panic disorder with agoraphobia.

CASE REPORT

Mia presented for treatment at the age of 33, with a diagnosis of panic disorder with agoraphobia. Her symptoms first appeared at the age of 16 and by the time of treatment her panic attacks were not occurring so often but they were preventing her to live a normal life.

Presenting Complaints

Mia was reporting a constant underlying tension, worry, and pervasive apprehension for the next panic attack, which contributed to her agoraphobic avoidance. A daily activity most affected by Mia's panic attacks was staying home alone. Her symptoms included a feeling of tachycardia, sweating, feeling faint, and a fear of dying. Eventually, Mia's agoraphobia extended beyond her fear of being alone to include any place where it might be difficult to escape or to receive help in case of a panic attack. These included being blocked in a traffic jam, church, and shopping. Naturally, this significantly affected her ability to function, in that it substantially limited her outings. Mia was unable to take her kids to school, shopping, or go to the supermarket. Using the subjective units of disturbance scale (SUD; Wolpe 1958), where 0 reflects no disturbance and 10 the highest imaginable, Mia rated her anxiety-provoking situations to range from being home alone (SUD = 6) to going to supermarket alone (SUD = 10).

History

During the first phase of EMDR treatment, a complete history is taken to identify relevant information for a focused treatment plan. Past Events related to the distress are investigated, as well as present

situations triggering the disorder and behaviors or skills the client requires. In Mia's case, it was discovered during this phase of treatment that there were no other cases of panic disorders or mental problems in her family. When Mia was 6 years of age she was separated from her parents during the war. She was staying with her aunt who was cruel to her and Mia was often punished when doing something wrong. During this half-year period of staying with her aunt Mia overheard a telephone conversation about her parents being killed. Nobody bothered to explain her anything and she did not ask about this information. Her reaction was freezing and being very scared about what is going to happen to her now that she has no parents. When Mia was 9 years of age she witnessed a girl in church falling faint during the ceremony of Holy Communion after which she started being afraid of dying. Mia was afraid to remain home alone and to go somewhere by herself. Now, Mia is married and has 3 children. Her husband is working from home so she would not be home alone. She had received pharmacological treatment. Pharmacological treatment improve her panic symptoms but they did not disappeared overall. This is the first time she is contacting a psychotherapist.

Assessment

Mia recorded her panic symptoms in a weekly diary for the first 2 weeks to assess her behavioral, physiological, cognitive, and emotional responses. She was asked to write the date, the situation, the trigger, the intensity (from 0 to 10), the duration, who was with her at the time of the attack, and the symptoms. The diary was also kept for 2 weeks at the post-treatment and the follow-up after 1 year. Physical symptoms were "need for air," dizziness, heart rate acceleration, and weakness at the legs. The trigger was the fear of fear. Avoidance of situations that could provoke panic attacks (e.g., going to the supermarket, staying at home alone, and so on). Mia stated that because she always had an accompanying person in anxiety-provoking situations, her diary was only partial and did not reflect all the symptoms caused by the disorder. In addition to the elimination of the panic attacks and the anticipatory anxiety, Mia articulated the treatment goals in four domains:

- *Behavioral* - to be able to stay at home alone, take children to school without depending on someone else.
- *Cognitive* - to overcome and change the belief of not feeling well, to no longer perceive staying at home as or being alone as a potential danger or threat. To change the tendency of seeing and anticipating catastrophes.
- *Physiological* - To eliminate and resolve accelerated heart rate, feeling of not being able to breathe, dizziness, and weakness in the legs. To learn to relax to face these situations with nobody disturbance.

- *Emotional* - to learn to master her fear and manage her emotions (fear, tension, worry, blocks). To overcome the feeling of tension in places where an accessible exit is not visible (e.g., shopping malls, churches, traffic jams, and so on).

Case Conceptualization

Many clinicians, regardless of their theoretical approach, believe that small and severe traumas experienced in early childhood have a significant impact on the insurgence of psychological distress. Raskin, Peeke, Dikman & Pinker (1982) reviewed the antecedents of anxiety disorders and found that 53% of the participants suffering from panic disorders had experienced separation from their parents in childhood or adolescence, whether through death, divorce, or other means. These findings also indicated that the impact of traumatic life events depended on the age at which they occurred. Brown, Harris & Eales (1993) confirmed the impact of abandonment and separation on the development of panic disorders, adding that exposure to unpredictable and uncontrollable stimuli in childhood may also contribute to such symptoms. These results are consistent with the AIP theory (Shapiro 2001, 2002), in that these events may have created enough distress to impair the information processing of the event, resulting in stored effects and sensations that form the base of the pathology. Although most would acknowledge that the intensity of a traumatic event contributes to the impact on the individual, the participants' mental processing skills must also be considered. For instance, a harmless event for an adult may be traumatic for a child. According to the AIP model, these events are considered small t trauma, although the events needed to diagnose PTSD such as accidents and natural disasters are considered large T traumas (Shapiro 2001, 2002). As mentioned previously, if the adult's neurological structure is still affected by traces of an insufficiently processed traumatic childhood experience, an neutral current event can be experienced by the participant as suffering and bring out an intense anxiety reaction. The correlation between symptoms and previous negative or stressful experiences is particularly clear in panic disorders. In fact, concerning the role of unpleasant events in the etiology and maintenance of emotional disturbance, memory plays a mediating role (Williams 1996) between event and psychopathology. Therefore, working on negative and damaging experiences is considered a key to accessing and changing dysfunctional knowledge and behavior. Given EMDR's proven effectiveness in this regard, one would expect it to effectively address the traumatic etiological events related to panic disorders. However, before using EMDR, therapists must take a thorough client history to identify and define the experiences that have created a vulnerability to these symptoms. The therapeutic goal is to identify the moment and the situation responsible for dysfunctional

learning experiences. Often, this involves incidents of abuse, parental arguments, accidents, and separations or losses. Because these experiences have been dysfunctionally stored in the memory, information is fragmented, stored as sensory impressions, and later experienced as anxiety and distress. Evidence suggests that symptoms experienced during panic attacks (anxiety, extreme agitation, exaggerated startle response, irrational thinking, and blocking beliefs, harrowing emotions, eventual depersonalization, and derealization experiences) become traumatic experiences in their own right (McNally & Lukach 1992). Therefore, it is necessary to address the memories of particularly traumatic panic attacks, including the first, the worst, the last, and a projected future event. EMDR is an integrative psychotherapy that uses an 8-phase treatment approach and standardized phobia protocol to address these issues (Shapiro 2001).

Course of Treatment and Assessment of Progress

The primary focus of EMDR treatment is in-session processing of etiological events, triggers, and new behaviors. Targeting individual memories often leads to insights and the revealing of other triggers and events for subsequent processing. In all, 13 sessions of EMDR focused on the processing of etiological memories and triggers and 3 on the development and enhancement of future behaviors. All in vivo exposure was self-initiated by the client and done without therapist assistance. The history-taking phase was conducted in the first three sessions. During the second phase of EMDR treatment (client preparation), a therapeutic alliance is strengthened between the client and the clinician. Alliance building and three sessions of psychoeducation on anxiety symptoms, including self-control techniques, were conducted before reprocessing began. The EMDR process and effects were explained to Mia, and she was provided with a safe place exercise, which asked her to bring up an image of a place that elicited a positive feeling of well-being (e.g., walking on her bare feet on the sand beach, feeling the softness under her feet). While concentrating on this image, she felt lightness on her whole body and associated it with the word relax. The image, emotions, and physical sensations were then increased through simultaneous pairing with bilateral stimulation. Mia would then be able to use this exercise to regain her emotional calmness if disturbing material was re-experienced during therapy or between sessions. During the first history-taking and preparation sessions, Mia had gained awareness of the issues or situations that contributed to this disorder and was able to identify the relevant triggers. This information was key in formulating the treatment plan, which involved a very specific method of addressing these issues. Allowing six sessions for history-taking and preparation fostered a

sense of participation in Mia and became central to the psychoeducation, which set the stage for subsequent reprocessing. Explanations to Mia regarding the standard EMDR protocol that targets etiological events that are experiential contributors to the disorder, recent triggers, and future templates became part of the psychoeducation process. During the third phase of EMDR treatment (assessment), the client and the clinician identify the target to be processed in that session and choose the image that represents the worst part of the traumatic event, along with a statement that expresses a current negative belief about herself (e.g., “I am in danger”). Then the therapist encourages the client to find a related positive statement that she would like to believe instead (e.g., “I am safe now”). The validity of cognition scale (VOC; 1 = feels completely false to 7 = feels completely true) is used to obtain a rating of how true the positive statement feels. The client also identifies the negative emotions (e.g., fear, anger) linked to the memory and to the negative statement “I am in danger.” The intensity of these emotions is measured using the SUD scale and the accompanying bodily sensations (e.g., tension, spasms) are identified. To illustrate, it was decided to target Mia’s first panic attack for EMDR treatment because it was the most disturbing event in the history of her disorder. This was when she was 16 years old and coming back from school alone, she felt dreadful, though she is about to die and would not make it home. Mia, guided by her therapist, linked the image of this scene, to a negative self-belief “I cannot control the situation.” The positive statement, that is, what she would rather think about herself (“I can handle the situation”) did not feel very true to Mia (VOC = 2 of 7). The emotion linked to this memory (SUD = 10 of 10) was terror, and the distress was noticed in the arms, chest, and legs. During the fourth phase of EMDR treatment (desensitization), eye movements or other forms of bilateral stimulation are used while the client focuses on the image, negative cognition, and bodily sensations. This enables the dual focus of attention, whereby the client concentrates on her inner experience associated with the traumatic memory while also attending to the external bilateral stimulation administered by the therapist. The therapist guides the client through several sets of eye movements until the SUD level has decreased to a value of 0 or 1 (e.g., when the reaction is appropriate to the present circumstances). After each set of eye movements, the therapist asks the client, “What do you notice now?” to facilitate the verbalization of any new associations that might emerge. After 10 sets of eye movements, Mia noted that her distress had substantially reduced. The scene of the first panic attack had faded and other memories, associations, and sensations began to emerge. The positive associations that emerged over time were increasingly adaptive and provided evidence that Mia was starting to distance herself emotionally from the

situation. This was evident by such statements as “looking at this scene does not bother me” or “I can handle these situations.” After further sets of eye movements, Mia gradually produced several meaningful memories and associations. For instance, she reported seeing herself handling that situation because she managed to reach home despite her feelings. She noted, “I never lost control...” During the next phase of treatment (installation), the positive belief is strengthened after the client no longer feels the distress related to the targeted traumatic memory. This is obtained in practice by associating the positive cognition (“I can handle these situations”) with the traumatic experience and adding eye movements. Installation is considered complete when the client considers her positive statements totally true (VOC = 7). For Mia, the positive statements included “I can trust my ability to manage emotions” or “I can handle these situations.” The therapist instructed Mia to mentally recall the distressing event (first panic attack) and to associate it with the positive statement during the sets of eye movements. For Mia, these statements were particularly meaningful because she could connect them to other similar events (other panic-related episodes and subsequent avoidance situations). Therefore, the associative link between the positive belief and the memory of the disturbing event is strengthened so that when the traumatic event is recalled, it is linked to the new positive belief (e.g., “I can handle these situations”). The positive belief may also generalize to other similar situations that have occurred in the client’s life and may change the client’s attitude toward present and future life events. This phase, focusing on the installation of the positive self-assessment, is a crucial step toward a positive therapeutic outcome. After installation, the client is instructed to recall the original event while simultaneously focusing on the words associated with the positive cognition (e.g., “I can handle the situation”) and mentally scanning her entire body from the top down. The purpose of this phase (body scan) is to identify any residual tension. After processing the first panic attack, Mia still had some tension in her arms and legs, which was resolved with additional sets of eye movements. After each processing session, the closure phase prepared Mia for the processing that may continue in the following hours or days. She was encouraged to keep a log of thoughts, dreams, and memories that emerged between sessions. The reevaluation phase took place at the beginning of each subsequent session. Mia was asked to recall the previously processed traumatic event and to evaluate her response. This determines whether reprocessing effects have been maintained. In this phase, new possible targets, memories, or situations to be reprocessed with the EMDR protocol may emerge. She very clearly associated her current difficulties with the traumatic event experienced at the age of 6 (having heard her parents were killed during the war). Thus, the

image of her standing near her aunt and feeling frightened became the next EMDR target. As she recalled this event and focused on this image, she reported the negative cognition as “I am in danger,” which was associated with an intense fear (SUD = 8) that she felt in her stomach. This memory was processed to resolution, that is, until Mia could think about this episode without distress. The following week, Mia remained at home alone for an hour, which was a vast improvement, as she had been unable to stay home alone, even for 1 minute. Mia reported experiencing just a few moments of anxiety, lasting 2 or 3 minutes, but no panic attacks. Reevaluation of the distress associated with the previous week’s target was zero (no distress) and the VOC was 7 for the positive cognition “I am safe.” After processing this episode, Mia realized that the first key episode of great distress occurred at the age of 9, when she witnesses another girl falling faint during the church ceremony of Holly Commitment. Mia pictured herself in the church feeling scared not being able to breathe. The negative cognition associated with this memory was “I am going to die” and the emotion presently felt while recalling the event, was fear (SUD = 7), located in her chest. During reprocessing, it became evident that her fear of dying developed after that day. Also, because her parent-run over to help a girl who fainted and she was left alone, she realized that this was the point at which she developed her fear of being alone. This fear was associated with the anxiety-provoking thought “What if I faint?” Mia eventually understood the influence that this experience had on her fear of letting herself go and on her constant state of alert. After reprocessing the memories regarding the church event with EMDR, Mia no longer suffered from fear of fainting. However, the fear associated with the thought “I am far away from home” remained and triggered anxiety. This appeared to be related to the fear of being separated from her parents (as in her childhood story) and to her worst panic attack, which was so traumatic that it led her to avoid being alone and to need constantly her parents’ presence to feel reassured. Mia’s worst panic attack was then targeted to resolve her need to be accompanied by her parents. As Mia began to address her fear of staying home alone, she pictured her worst panic attack, which occurred when she was coming back from school. Her negative cognition was “I am in danger (because I am alone)” and she wanted to believe “I am safe” (VOC = 2). She felt fear (SUD = 8) in her stomach as she recalled this event. The event was successfully processed, because, at the end of the EMDR session, she could recall the memory of the worst panic attack and feel no disturbance. The client was asked how true she felt “I’m safe” from 1 to 7 and she said “7”. Then, she said she could think of the incident and of the words “I’m safe” feeling her body relaxed and light. The following week, Mia reported staying at home alone and going to a mall, and feeling

relaxed. At this point in therapy, Mia was able to recall her worst panic attack without negative thoughts and distress (SUD = 0, and VOC = 7). A future template (imaginary work plus bilateral stimulation; see Shapiro, 2001) was used to strengthen Mia's ability to restructure her thoughts and to manage her now low-grade relationship anxiety by saying to herself, "It is just the ordinary anxiety." The session ended with Mia's expressing her desire to try some short walks away from home. Because Mia still reported some disturbance associated with walking alone, this was targeted further through future templates as anticipatory anxiety. By the end of the processing session, she was able to recall a particular moment of healthy functioning before the age of 16. She stated "I am free and safe now." These words and this belief were installed. The processing strengthened the belief that "I can go back to these moments, I can feel good as I did in the past." Mia concluded with another spontaneous image, "I see myself as I am now, a grown-up woman, married with 3 children. I continued to grow and live even with the burden of anxiety. I am strong." In the overall therapeutic process, the reconstruction of a person's identity, as well as the reinforcement of the person's health is very meaningful. Mia came to the 19th session saying she went walking away from home alone and she felt great. Previously, this type of situation would have caused considerable anxiety and would have been perceived as an obstacle or something blocking her. In the final sessions, EMDR therapeutic work focused on the consolidation of these changes to promote generalization. Future situations were targeted and it was decided to focus on the past behavior to be changed, staying at home alone, without her husband. This was the last agoraphobic symptom and the most anxiety-provoking situation in her hierarchy because it involved giving up the secondary gain of her husband's role. After desensitizing this target (SUD = 0) with the EMDR standard protocol, Mia stated, "It is true, I am capable to be on my own and my husband and I can do a lot of other things together." She confirmed the cognition "I am capable," which felt completely true in terms of her ability to stay to work alone. The session ended after installing this positive belief with some sets of eye movements. A week later, Mia tried to stay alone and did it with a manageable level of anxiety. In the following weeks, she continued enacting this behavior. Therapy ended after approximately 25 sessions a remission of panic disorder and agoraphobic behavior symptoms. The 25 sessions included 3 sessions of history taking and treatment planning; 3 sessions of preparation for EMDR sessions; 16 EMDR processing sessions of etiological events, triggers, and future behaviors; and 6 sessions reviewing results. Follow-up at 3 months, 6 months, and 1 year confirmed maintenance of the above effects. Her post-treatment and follow-up diary not only reported no symptomatology but all of

her treatment goals were met as indicated by the following results: Elimination of anxiety and panic attacks, Elimination of avoidance behaviors, Establishment of independent functioning through the ability to be alone and drive, Resolution of agoraphobic symptoms, Insight and understanding about symptoms and secondary gains, and Establishment of a new self-perception, which included an adjustment of interpersonal relationships, and return to normal daily life functioning.

DISCUSSION

In this case, several distressing situations were effectively addressed by EMDR. It is worth noting that the EMDR processing of a particular selected target - for instance, the first panic attack - can spontaneously and directly associate with other related episodes. Although sometimes the reasons for these connections are not immediately clear to the therapist when they arise spontaneously during a set of eye movements, continued processing generally reveals the logic and meaning in terms of the foundation of the disorder. EMDR works on a multisensory level providing a simultaneous emotional desensitization, change of physical sensations, and elicitation of client insights regarding event. The simultaneous shift in emotional and cognitive content allows the client to re-establish a more appropriate contact with reality, thereby promoting new behaviors. Once this process is set in motion, clients can take an appropriate emotional distance enabling them to gradually accept the risk of facing their emotions and new situations. In this particular case, Mia began to recall and to connect all of the events that were related to the panic attacks. It seems that EMDR provides direct access to the memory network and allows previous memories to be metabolized. The sequence of treatment procedures demonstrated in the present case is very significant. The AIP model guiding EMDR treatment posits that that dysfunction is primarily generated by the dysfunctionally stored memories, which can best be treated by direct targeting. It is hypothesized that the anxiety and fear felt by the client are the emotions and physical sensations inherent within the implicit memory network (Shapiro 2001). Therefore, the processing of the etiological events that have caused and maintained the dysfunction is the pivotal aspect of EMDR treatment. In vivo exposure is suggested only after the etiological events have been processed and the fear largely resolved. The in vivo exposure is then used to reveal any specific triggers or ancillary targets that need to be processed. As noted in this case, clients often begin spontaneously to drop avoidance and emit new positive behaviors subsequent to EMDR processing. As demonstrated in this case, Mia began to stay alone without the therapist's prompting.

CONCLUSION

EMDR processing of one specific, selected target can be spontaneously and directly linked to other similar targets. EMDR is functioning on a multisensory level by providing simultaneous emotional desensitization, changing physical sensations, and challenging the client's knowledge of the event. Simultaneous shift in emotional and cognitive content allows the patient to establish more appropriate contact with reality and thus promote new behaviors

Acknowledgements: None.

Conflict of interest: None to declare.

Contribution of individual authors:

Ivana Trlin: conception and design of the manuscript and interpretation of data, literature searches and analyses, clinical evaluations, manuscript preparation and writing the paper;

Mevludin Hasanović: made substantial contributions to conception and design, participated in revising the article and gave final approval of the version to be submitted.

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