Andrew M. Leeds

A Guide to the Standard EMDR Protocols for Clinicians, Supervisors, and Consultants

SPRINGER PUBLISHING COMPANY

13

Treating Specific Phobia

ADDITIONAL ISSUES FOR TREATING SPECIFIC PHOBIAS

OVERVIEW

In this chapter, we will examine additional issues to be considered when applying Eye Movement Desensitization and Reprocessing (EMDR) to the treatment of individuals with specific phobias. We will consider the nature of specific phobias both those of traumatic and nontraumatic origins. We will examine the similarities and differences of specific phobias of a traumatic origin with posttraumatic stress disorder (PTSD). We will discuss the absence of controlled research on all treatments for specific phobias of a traumatic origin. We will review the literature on case reports of EMDR treatment for specific phobias and discuss rationale for applying EMDR to the treatment of specific phobias. We will go through all eight phases of the standard protocol for EMDR treatment of specific phobias including how to identify targets, how to prepare patients, and the sequence of treatment for applying EMDR reprocessing. As we proceed, we will review a series of case vignettes that illustrate key aspects of applying EMDR to the treatment of specific phobias.

THE NATURE OF SPECIFIC PHOBIAS

Specific phobias involve marked anxiety or panic that disrupts personal or social functioning and leads to anxious anticipation, avoidance, or distress. People with specific phobias recognize their fears as excessive or irrational (American Psychiatric Association [APA], 1994). Specific phobias are common in the general population with lifetime prevalence rates reported in the range of 9.4%–12% (Becker et al., 2007; Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996; Stinson et al., 2007). In spite of their adverse impact on people's lives, most specific phobias go untreated.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (APA, 1994, 2000) identifies five subtypes of specific phobias. These are: (a) animal type—such as phobias of spiders, insects, snakes, dogs, or rodents; (b) natural environment type—such as phobias of heights, lightning, or water; (c) situational type—such as phobias of elevators, enclosed spaces, driving, flying, or bridges; (d) blood-injury-

injection type—such as phobias of getting injections, or seeing blood; and (e) other types—such as phobias of choking, vomiting, or contracting an illness. Individuals with specific phobias often have multiple fears. The greater the number of separate fears, the greater their severity tends to be (Magee et al., 1996).

TRAUMATIC AND NONTRAUMATIC ORIGIN FOR SPECIFIC PHOBIAS

From the perspective of the Adaptive Information Processing (AIP) model, it is essential to consider the etiology of specific phobias to conceptualize clinical cases, consider an appropriate role for EMDR reprocessing, and develop appropriate treatment plans. Specific phobias may be viewed as deriving from two distinct origins. Some phobias clearly have an identifiable traumatic origin. These include driving phobia after a motor vehicle crash, medical phobia after a traumatic medical procedure, or choking phobia after an experience of choking on food. In the AIP model, these traumatic experiences are viewed as being encoded in state-specific form in a maladaptive memory network. Current stimuli—such as thinking about or confronting the phobic situation—give rise to maladaptive perceptions, attitudes, and behaviors emerging from the maladaptive memory network. Specific phobias can also be viewed from the behavioral perspective of classical conditioning (Davey, 1997). For example, if the traumatic experience of the motor vehicle crash is the unconditioned stimulus (UCS), being in the car is the conditioned stimulus (CS).

On the other hand, many specific phobias derive from a nontraumatic origin. Some specific phobias of a nontraumatic origin begin with revulsion or disgust (De Jongh, Ten Broeke, & Renssen, 1999). These include fears of blood, spiders, rodents, snakes, and frogs and may involve innate disgust responses interacting with operant conditioning (Mulkens, de Jong, & Merckelbach, 1997, p. 1994). A tendency toward fainting in those with blood-injury phobia may lead to the onset of injection phobia independently of innate disgust (Gerlach et al., 2006). All of the published, randomized, controlled research on the use of EMDR for specific phobias has been with spider phobia, a phobia of a nontraumatic origin (Muris & Merckelbach, 1997; Muris, Merceklbach, Holdrinet, & Sijsenaar, 1998; Muris, Merckelbach, van Haaften, & Mayer, 1997). These studies have been criticized (De Jongh et al., 1999; Shapiro, 1999) for several limitations and weaknesses, including limited fidelity and lack of applicability to other types of phobias especially those of a traumatic origin.

History taking often reveals that these nontraumatic fears evolve over time. They may be shaped by social responses, such as a lack of compassion or overt social ridicule. Based on their clinical experience, De Jongh et al. (1999) believe that phobias without an identifiable traumatic component in their etiology respond less strongly to EMDR reprocessing. Answers to this question await further studies that examine nontraumatic phobias other than spider phobia and that would meet research standards for fidelity to full, published treatment protocols. De Jongh et al. (1999) suggest that specific phobias of a nontraumatic origin can generally be treated with prolonged exposure, and they point out that essentially all research on single specific phobias—not just EMDR related research—has been on phobias of nontraumatic origin. A search of the literature on specific phobias confirmed the paucity of controlled treatment outcome research on specific phobias of a traumatic origin. Thus, there is little guidance from controlled research for selecting treatments of specific phobias of a traumatic origin.

The Role of In Vivo Exposure in Treating Specific Phobias

As discussed by De Jongh and Ten Broeke (2007), in vivo exposure appears not to be as effective or appropriate for phobias of known traumatic origin. For example, with medical-dental phobias, initial treatment failure rates of 25% have been

reported. Another 36% relapsed into avoidant behaviors (Van der Zijpp, Ter Horst, De Jongh, & Makkes, 1996). This poor tolerance for in vivo exposure in traumatic medical phobia leads us to consider other treatment options for most patients. In vivo exposure may not be the best received nor the most effective initial treatment for some specific phobias with a traumatic origin. However, as discussed below, in vivo exposure can be an important element in the later stages of EMDR treatment plans for many specific phobias with a traumatic etiology and is essential in treating specific phobias of a nontraumatic origin.

RATIONALE FOR APPLYING EMDR TO SPECIFIC PHOBIAS OF A TRAUMATIC ORIGIN

With some specific phobias of a traumatic origin, it is simply not practical to use in vivo exposure in structured treatment, such as for lightning phobia. With flying phobia, in vivo exposure requires several expensive airplane flights. In my own clinical experience, flying phobia can sometimes be resolved in four to eight 50-minute EMDR reprocessing sessions. Based on several published case reports, there appears to be an appropriate role for EMDR reprocessing for specific phobias with a traumatic etiology. Many of these case reports are reviewed below together with some cases of specific phobias of nontraumatic origin. For further reviews and comments on case reports of EMDR treatment of specific phobias, see De Jongh & Ten Broeke (2007), De Jongh et al. (1999), and Shapiro (2001).

Case Reports of EMDR Treatment of Specific Phobias

Marquis (1991) was the first to report EMDR to be effective as part of treatment of 10 patients suffering from specific fears including flying, high places, and animals. Kleinknecht (1993) reported a patient with a 16-year history of blood and injection phobia who was successfully treated with EMDR in four brief sessions. Lohr, Tolin, and Kleinknecht (1995) reported two other cases with blood–injury–injection phobia that both showed an initial decrease in Subjective Units of Disturbance (SUD) scale ratings, and in scores on the Symptom Checklist 90-R (SCL-90-R) (Derogatis, 1977). However, treatment was limited in its effectiveness because both of these patients were offered a single session, thus not following the comprehensive treatment plan proposed by Shapiro (1995, 2001). Nonetheless, both cases showed partial gains on treatment goals with this incomplete treatment. Young (1994) reported success in treating two female patients with multiple personality disorder with EMDR. One patient with a snake phobia was treated in one session, and the other with extreme fear of moths was treated in two sessions. Although Young reported the gains were maintained after 6 months, it appears from the report that neither the full standard EMDR procedure, nor the full phobia protocols were used.

Muris and Merckelbach (1995) reported using an abbreviated version of the EMDR phobia protocol in two subjects with spider phobia in a single, 1-hour session, which led to gains on self-reported fear and a behavioral measure. Next, both subjects were given 2.5 hours of in vivo exposure after which both were able to touch the spider. Muris and De Jongh (1996) reported treating a young girl with spider phobia of traumatic origin from age 2 years. Again, a single, 1-hour session of EMDR was offered after which her score on a self-report measure dropped close to zero with significant gains on a behavioral approach test. Then they provided 1 hour of in vivo exposure after which she allowed the spider to walk on her hand.

De Jongh and Ten Broeke (1994) reported success in using EMDR with a female patient with a fear of vomiting in a single session with stable gains maintained at 4-month follow-up. Ten Broeke and De Jongh also reported (1993) successful treatment of a mouse phobia in a 63-year-old woman whose fear had not resolved during

prior in vivo exposure. After a single session of EMDR treatment, they reported that her fear was reduced, and had not returned at 6-month follow-up.

De Jongh, Ten Broeke, and Van der Meer (1995) describe the case of a man with dental phobia who avoided dental treatment for 12 years after an extremely painful tooth extraction. His phobic avoidance had not been alleviated by five sessions of graded exposure and coping skills training. After a single session of EMDR treatment, he resumed dental treatment with a level of distress he found acceptable. In another case, De Jongh and Ten Broeke (1996) describe a woman who avoided dental treatment for 30 years after a traumatic incident from age 8 of having her dentist restrain her arms to the dental chair with towels. One year of previous behavior therapy had failed to alleviate her symptoms. After two sessions of EMDR treatment, she was able to start dental treatment. They reported that at 2-year follow-up, she had completed her dental work and remained free of panic attacks.

Schurmans (2007) described treating a woman who developed a severe choking phobia following an allergic reaction to an herbal beverage. The severity of her avoidance led to her being hospitalized several times because of her inability to consume food and beverages. However, a diagnosis of choking phobia may be incomplete because this patient had a complex trauma history that included being adopted from an orphanage and was repeatedly hospitalized as a child. In addition, she had a chaotic home life growing up with verbal abuse and restricted access to food as well as adult traumatic exposures with a physically and emotionally abusive husband. The patient disclosed traumatic incidents of being choked by both her mother and her husband. Prior to treatment with EMDR, the patient had 4 years of a series of treatments including brief psychodynamic therapy, cognitive behavioral therapy, psychopharmacological, and eating disorder treatment. These prior treatments all failed to eliminate her disorder. Consistent with this more complex case presentation, Schurmans (2007) provided a series of 20 sessions of EMDR treatment addressing childhood etiological events. This led to a complete remission of the choking phobia.

The Need for Controlled Research on Specific Phobias of Traumatic Origin

With regard to phobias that include a traumatic etiology, controlled research is clearly needed to explore the issues of patient–treatment matching and differences in treatment effectiveness among EMDR, in vivo exposure, systematic desensitization, and prolonged imaginal or virtual reality exposure. To help guide clinical decision making, such body of research would need to compare active treatment methods. Until such controlled research becomes available, it is reasonable to consider the use of EMDR as an initial treatment intervention of specific phobias of a traumatic origin for two reasons. First, as summarized above, there is support from various published case reports (De Jongh & Ten Broeke, 2007; Schurmans, 2007; Shapiro, 2001). Second, with striking similarities in etiology between PTSD and specific phobias of a traumatic origin, the AIP model predicts that EMDR is likely to be an effective treatment for Specific Phobias of a traumatic origin.

DIFFERENCES BETWEEN PTSD AND SPECIFIC PHOBIAS

Although there are similarities between phobias of a traumatic origin and PTSD, these conditions differ in several ways. Patients with PTSD have greater general distress and a broader range of symptoms. They experience spontaneous intrusive memories and hyperarousal that generally interferes with sleep. Patients with specific phobias do not have chronic sleep disturbances associated with their fears and become anxious only when deliberately thinking of their feared situation or when confronted with cues that stimulate their fear.

THE TREATMENT PLAN FOR SPECIFIC PHOBIA

In broad outline, EMDR treatment planning for patients with specific phobia is similar to treatment planning for patients with PTSD. Follow the same eight-phase approach to treatment and the three-pronged treatment plan. Reprocess targets first from the past, then the present, and finally the future. The assessment phase (phase 3) of specific targets is the same as with PTSD. The reprocessing of targets follows the same basic procedural steps in the desensitization phase (phase 4) and the installation phase (phase 5) as for PTSD.

However, treatment plans for specific phobias differ in several ways from those for PTSD. One of these differences relates to an issue identified by Shapiro in both her 1995 (p. 222) and 2001 (p. 226) texts. Shapiro proposed a distinction between *simple phobias* and *process phobias*. This distinction focused on the role of anticipatory anxiety and the need to make deliberate choices to encounter the phobic object or situation. As pointed out by De Jongh et al. (1999, p. 73), nearly any specific phobia can function as a *process phobia*. Based on many years of clinical experience with EMDR, I agree with the suggestion made by De Jongh et al. (1999, p. 74) when using EMDR to treat all specific phobias as process phobias. This means that to achieve full treatment effectiveness in most cases of specific phobia, it is necessary to plan to incorporate in vivo exposure and more structured future templates into the later stages of the treatment plan. When treating PTSD with EMDR, it is not always necessary to include such fully structured future templates or to incorporate in vivo exposure.

Although such comprehensive phobia treatment plans may turn out to be more than what is needed, it is best to plan for comprehensive treatment. The treatment plan can always be simplified should the patient achieve a complete elimination of the phobia with more limited treatment. Next, we will examine how to apply

13.1 Specific Phobia Protocol Summary

1) History Taking (Phase 1)
   - A) Clinical assessment, diagnosis, and case formulation
   - B) Selecting appropriate treatment goals
   - C) Selecting and sequencing of targets

2) Preparation (Phase 2)
   - A) Psychoeducation on fears (if indicated)
   - B) Introduce EMDR and obtain informed consent to treatment
   - C) Teaching and rehearsing self-control procedures
     - i) Breathing exercises and other calming procedures for anxiety
     - ii) Applied tension for fainting (Öst & Sterner, 1987)

3) Reprocessing of targets
   - A) Past events
     - i) Background stressors (if any were identified)
     - ii) First event
     - iii) Worst or representative event
     - iv) Most recent event
   - B) Current external and internal cues
   - C) Future template

4) Commitment to action plan
   - A) Positive template with mental rehearsal

5) In vivo exposure (generally done independently)

6) Reevaluation and further reprocessing, if indicated

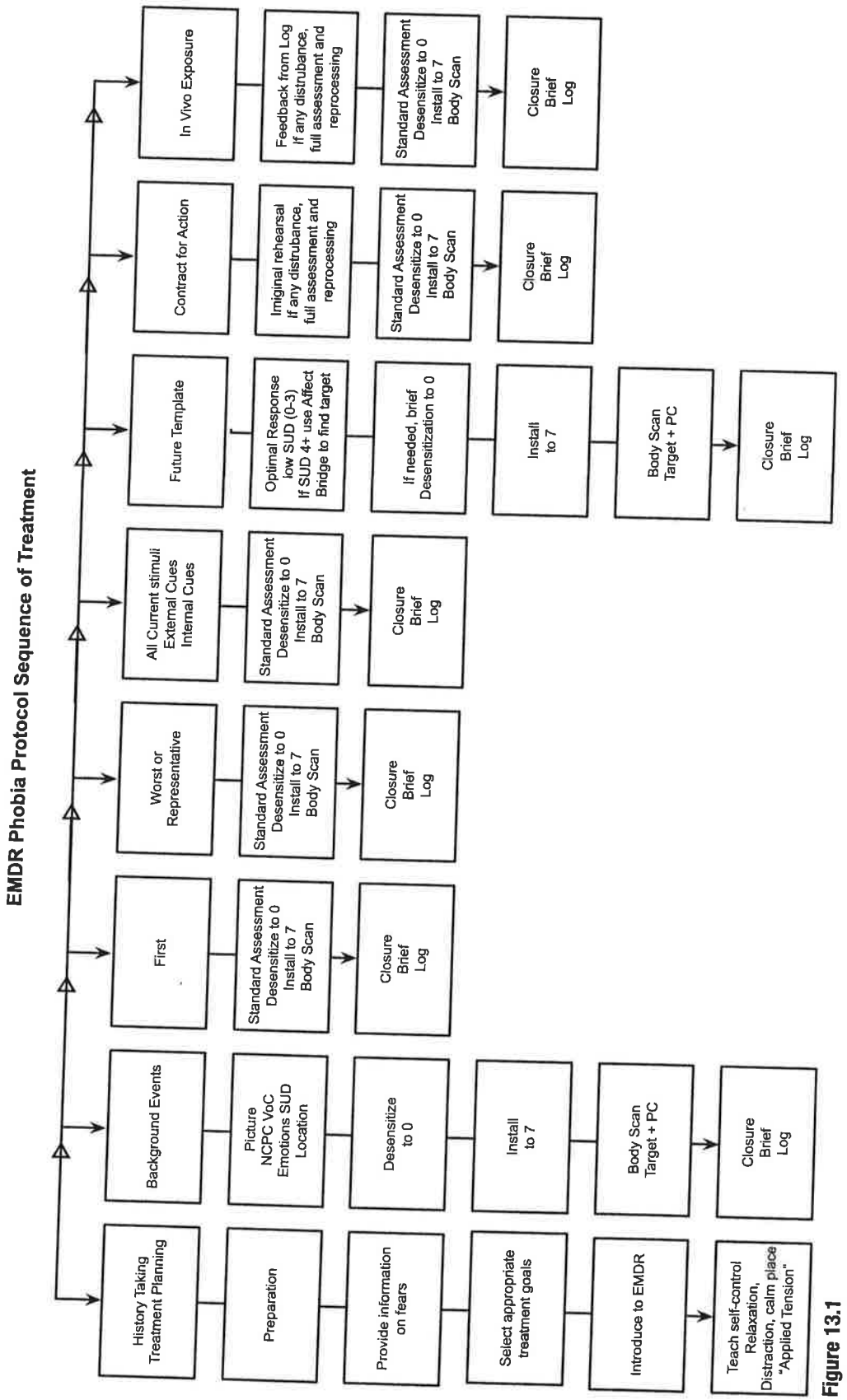
EMDR Phobia Protocol Sequence of Treatment
History Taking Treatment Planning
Preparation
Provide information on fears
Select appropriate treatment goals
Introduce to EMDR
Teach self-control Relaxation, Distraction, calm place "Applied Tension"
Background Events
Picture NCPC VoC Emotions SUD Location
Desensitize to 0
Install to 7
Body Scan Target + PC
Closure Brief Log
First
Standard Assessment Desensitize to 0 Install to 7 Body Scan
Closure Brief Log
Worst or Representative
Standard Assessment Desensitize to 0 Install to 7 Body Scan
Closure Brief Log
All Current stimuli External Cues Internal Cues
Standard Assessment Desensitize to 0 Install to 7 Body Scan
Closure Brief Log
Future Template
Optimal Response low SUD (0-3) If SUD 4+ use Affect Bridge to find target
If needed, brief Desensitization to 0
Install to 7
Body Scan Target + PC
Closure Brief Log
Contract for Action
Imiginal rehearsal If any distrubance, full assessment and reprocessing
Standard Assessment Desensitize to 0 Install to 7 Body Scan
Closure Brief Log
In Vivo Exposure
Feedback from Log If any distrubance, full assessment and reprocessing
Standard Assessment Desensitize to 0 Install to 7 Body Scan
Closure Brief Log

Figure 13.1

EMDR to specific phobias across all eight phases of treatment with an emphasis on features unique to the treatment of specific phobias.

PHASE 1: HISTORY TAKING AND TREATMENT PLANNING

As in the treatment of PTSD, when planning treatment for a specific phobia, begin with a comprehensive history, a clear diagnosis, and a strong case formulation. Many clinicians prefer to begin their information gathering with an open or unstructured clinical interview. When working within the AIP model, explore both the nature of the patient's problems and their etiology. Identify issues that were present at the onset of the phobic response and that serve to maintain it. It is helpful to identify patterns of response, including frequency, number, and severity of phobic episodes. Have these episodes increased in frequency or severity over time or remained stable? Have there been previous treatment episodes or self-directed attempts to overcome the phobia? What have been the results of these efforts? In exploring the issues surrounding the phobic responses, it is important to at least briefly explore the role of family of origin experiences, presence of anxiety disorders and other mental health issues in other family members, traumatic stressors, work and personal life stressors, life style, diet, and patterns of exercise.

Standardized Assessment with Structured Interview and Objective Instruments

In settings where a standardized assessment is required or desired, a structured interview can provide an efficient and comprehensive differential diagnosis. The Anxiety Disorders Interview Schedule for *DSM-IV* (ADIS-IV; Brown, DiNardo, & Barlow, 2004) is a structured interview designed to assess current episodes of anxiety disorders, and to permit differential diagnosis among the anxiety disorders according to DSM-IV criteria. The ADIS-IV also provides sections to assess current mood, somatoform, and substance use disorders, as well as medical and psychiatric treatment history. There are also screening questions for psychotic and conversion symptoms and familial psychiatric history.

Standardized assessment instruments can assist in determining the severity of anxiety symptoms, recognizing other possible problem areas, and documenting the course of treatment. Common self-report instrument for specific phobias include the Fear Survey Schedule (FSS; Wolpe & Lang, 1964, 1969), the Fear Survey Schedule-II (FSS-II, Geer, 1965), the Fear Questionnaire (FQ; Marks & Mathews, 1979), and the Symptom Check List-Revised (SCL-90-R; Derogatis, 1991).

Treatment plans for specific phobias must consider co-occurring disorders

Consider co-occurring disorders when developing a case formulation and a treatment plan. Specific phobias often co-occur with other anxiety disorders and with mood disorders (Barlow, 2002). In some cases, claustrophobia or another situational phobia may be the only anxiety symptom. In other cases, there may be a range of situational phobias linked by panic disorder. In such cases, the treatment plan must be for the broader issues of panic disorder. Panic disorder is covered separately in Chapter 14, as it often requires more extensive treatment than a specific phobia.

With other co-occurring disorders, when the memory networks for co-occurring disorders are substantially distinct, it is possible that each disorder can be approached and treated separately with EMDR. For example, it may be possible to provide focused and effective EMDR treatment for a patient with a specific phobia of a traumatic origin such as choking phobia after choking on food who also meets criteria for alcohol abuse. Of course, if an incident of choking occurred as a direct consequence of alcohol abuse, such as during an episode of intoxication, there

could be overlaps between the memory networks for the two disorders that would lead to a more complex and interlinked treatment plan. In cases where there is no direct linkage between these two disorders, it may be possible to focus initially on the application of EMDR to the choking phobia and defer attention to the alcohol abuse, because there may be little or no overlap between the memory networks associated with these two conditions.

On the other hand, when memory networks for co-occurring disorders overlap to a significant degree, the treatment plan for the specific phobia may not be separable from the treatment for the second condition. For example, when a patient suffers from a second anxiety disorder such as chronic, complex PTSD (Herman, 1992a, 1992b) or obsessive-compulsive disorder and a situational specific phobia—such as fear of lightning after witnessing a nearby lightning strike—there may be too much overlap between memory networks and general difficulties in assessing threat cues.

For example, a clinician wanted to refer a patient for adjunctive, specific treatment with EMDR for lightning phobia who also suffered from complex PTSD related to childhood abuse and neglect. Her lightning phobia began when she first ran away from the family home at age 14. She had finally gathered the courage to disclose to her mother her sexual abuse at the hands of her stepfather. Her mother's response was to minimize and avoid the issue. The patient's traumatic experience of nearly being hit by lightning, alone on a rural road at night, was directly related to her attempt to flee from both her mother's failure to protect her and her stepfather's abuse. Any attempt to target and apply EMDR reprocessing to the memory of the near-lightning strike experience would likely involve the central issues of the larger childhood trauma. To use EMDR in such a case would likely require a more comprehensive treatment plan. Brief, focused, adjunctive treatment with EMDR on the lightning phobia alone might not be possible.

Identifying Targets for EMDR Reprocessing

When treating specific phobias, identify the earliest or first occurrence of a fearful experience related to the phobia. In most cases of traumatic onset, this first occurrence is a distinct vivid memory. In other cases of gradual onset with phobias that appear to begin with disgust or revulsion, there may not be a distinct first memory. In these cases, just select the earliest memory the patient can identify. You should also identify subsequent experiences related to this specific phobia with special attention to a worst experience—if there is one—as well as how the patient is currently affected. What kind of current situations does the patient avoid, and what are the specific situations that trigger the fear. This includes identifying external cues such as places, sounds, smells, objects, or animals and internal cues such as physical sensations—a racing heart beat, sweaty palms, tightness in the chest, or a large piece of food in the mouth. These events and cues can be written down on the master plan list of targets—Table 4.14—to guide the selection and sequencing of targets for reprocessing.

Treatment Goals

It is essential to identify the patient's treatment goals and to consider for what kind of future exposures to the phobic object or situation the patient wants to prepare. With medical, dental, or dog phobias, it may be essential to prepare for future encounters with the phobic situation. Required medical and dental procedures may be essential to the patient's health and well-being. It is likely impossible to avoid encountering dogs. In these cases, specific future targets need to be identified for future templates and for in vivo exposure. On the other hand, some more seldom and randomly encountered phobic objects and situations, such as spider and snake phobias, may not require that the patient prepare for deliberate planned future exposure. Nevertheless, these objects or situations can remain associated with persistent

13.2 Questions to Identify Specific Phobia targets

Nature of phobia
What object or situation are you afraid of?
What is it about _____ (the object or situation) that you most fear?

First event
What was the first time you had this fear or the earliest time you can remember having this fear?

Background stressors
What other stressful experiences were going on in your personal, family, school, or work life at about time of that first occurrence?

Worst or representative event
What is the most intense or the most frightening experience of _____ (the object or situation) you have ever had?
If there is no "worst" experience, describe a significant, typical experience of your fear.

Most recent event
What is the most recent experience of this fear?

Current external and internal cues
What aspects of _____ (the object or situations) seem to stimulate your fear?
What bodily sensations or feelings do you associate with times you experience your fear?

Future template
Please describe a future situation where you would be able to do what you would like to do free of this fear.

Check for secondary gains
What would you get to do or have to do if this fear were resolved?
And how would that be?
What would you get to stop doing or have to give up if this fear were resolved?
And how would that be?

anxiety and avoidance of environments where they are more likely to be encountered; thus, treatment goals should still be identified and both future templates and in vivo exposure should still be included in the treatment plan to assure comprehensive, stable treatment results.

Secondary Gains

In considering treatment goals, be alert to potential issues of secondary gains. Phobic anxiety can provide an excuse to avoid a situation the patient prefers to avoid but is pressured to engage in by their spouse, family, or friends. Examples include a woman who does not want to participate in her husband's hunting trips and has a fear of snakes and insects, or a man who is unable to visit a demanding and controlling mother because she lives on the other side of the country because of his fear of flying. Although secondary gains are present infrequently, they need to be considered in each case. When present, secondary gains need to be explored sensitively and thoroughly, the patient's treatment goals need to be clarified. Where phobic anxiety serves a secondary, practical purpose, EMDR reprocessing cannot succeed until an alternate set of coping strategies for the stressor are identified and developed.

The simplest way to identify the possible presence of secondary gain is to ask: "What would you get to do or have to do if this fear were resolved?" Then ask, "And how would that be?" In some cases, it may be helpful to ask the follow up question, "What would you get to stop doing or have to give up if this fear were resolved?" Then ask, "And how would that be?"

Background Stressors may need to be Distinct Initial Targets

In the history-taking phase, explore whether there may be background stressors that were factors in the patient's vulnerability to developing a phobic response at the time of the first phobic reaction. Although some phobic reactions of traumatic origin—such as choking phobia after nearly choking to death—can be understood as deriving entirely from the nature of the initial experience, others appear to involve an interaction between background stressors and situations (conditioned stimuli – CS) without external threat—such as a bridge phobia that develops after an initial anxiety attack on a bridge. Consider what background factors or events may have led to the vulnerability to having that initial anxiety episode on the bridge.

Thomas presented with a specific phobia for bridges. History taking revealed his first anxiety attack took place on a bridge. The night before he had been out late, drinking to excess. He was young and engaged to be married for the first time. He was deeply involved with a technology business he had started that was struggling and about to fail. His financial situation was therefore strained and uncertain at a time he was getting ready to be married. He was facing the prospect of having to take a job and give up his dream of getting rich with his start-up company. Surprisingly, Thomas had never connected the effects of these significant background stressors as possible factors in his first anxiety attack on the approach to the bridge. The failure of his start up was a huge blow to his sense of identity and self-worth. He seldom drank and rarely to excess. Yet, the night before his first phobic bridge experience, his distress over recognizing that his business was failing had led him to drink to excess. Ultimately, his business did fail and he found a well-paying position based on his technical knowledge and skills.

Several years later, Thomas presented for treatment as he prepared to begin looking for a better, higher-paying job in another geographic location where he would have to drive across bridges on a daily basis. The background stressor of the collapse of his start-up business and its impact on his sense of self remained significantly disturbing. It needed to be included as a target and reprocessed before the target of the first occurrence of the phobic response. As a result, when treatment shifted to the first occurrence of the phobic response, the reprocessing of that experience was straightforward, without any complicating associations to the background stressors that led up to the first occurrence.

PHASE 2: PREPARATION PHASE

The preparation phase for treating specific phobia is parallel to treatment of PTSD. There are four main elements to be addressed: teaching self-control methods for reducing anxiety, providing psychoeducation about the phobic situation, obtaining informed consent to treatment, and introducing the bilateral stimulation with the calm place exercise or a resource installation.

Self-Control Methods for Reducing Anxiety

In cases of specific phobias, patients can be taught self-control methods for reducing the fear of fear. These methods were reviewed in Chapter 6. Although these methods for reducing anxiety cannot eliminate the phobic response itself, they can provide an increased sense of self-control and mastery that can help prepare the patient for EMDR reprocessing and for in vivo exposure in the later stages of the treatment plan. Only some specific phobia patients need to learn or practice self-control methods to reduce anxiety before starting EMDR reprocessing.

Applied Tension

As noted above, patients with blood–injury–injection type phobia often have a tendency toward fainting. This is referred to as *vasovagal syncope*. The self-control

13.3 Applied Tension

Sit in a comfortable chair and tense the muscles in your arms, legs, and trunk for about 10–15 seconds. Hold the tension until you start to feel a warm sensation in your head. Then, relax for 20–30 seconds. Repeat this five times.

Practice this five times per day for at least a week.

If you develop a headache during or after practicing applied tension, use less tension when you practice.

exercise for a tendency toward fainting is not relaxation training but *applied tension*. This technique, first described by Öst and Sterner (1987), can help patients gain enough control over their tendency toward fainting to permit EMDR reprocessing and then graduated in vivo exposure. More recent research suggests that rhythmic tension may be as or more effective as applied tension especially at raising diastolic blood pressure (Bodycoat, Grauaug, Olson & Page, 2000).

With patients who have a blood–injury–injection type phobia, first provide an explanation of the purpose of the applied tension exercise. Applied tension does not reverse the drop in blood pressure caused by the vasovagal response. Instead, it prevents an excessive pooling of blood in the lower extremities and maintains enough blood supply in the head to prevent fainting. After giving the purpose of applied tension, then explain and demonstrate the exercise. Then have the patient practice applied tension. Give feedback or guidance to help the patient optimize the use of applied tension. Finally, request the patient to practice applied tension five times a day for at least a week. If the patient develops a headache when practicing applied tension, just encourage the patient to reduce the amount of tension during practice sessions.

Psychoeducation About the Phobic Situation

For some types of specific phobia, it can be helpful to make sure the patient has accurate information about the feared object or situation. A good example is with flying phobia, where patients often misperceive the discomfort caused by turbulence as a danger signal. Air turbulence is not a cause of forced landings or air disasters. It is more like rough seas in the ocean that pose no threat to passengers' safety on a modern ocean liner, in spite of causing motion sickness for some. Air turbulence causes injuries or death to airplane passengers only when they are not wearing their seat belts. Although providing accurate information about the safety of flying is not likely to lessen the severity of a flying phobia, it is important to correct any misinformation that patients have acquired about their phobic situation.

Obtaining Informed Consent to Treatment

Patients being treated for a specific phobia need the same essential information as was described in chapter 6 on the preparation phase for the treatment of PTSD. They need (a) an introduction and basic information about EMDR procedures and common responses to treatment, (b) a metaphor to enhance mindful noticing without expectations or judgments during the bilateral stimulation, (c) an acceptance of the nature of reexperiencing psychological, emotional, and somatic aspects of previous phobic encounters that may occur during reprocessing, and (d) the risk of other disturbing memories emerging during reprocessing.

As discussed earlier in this chapter, many patients with a specific phobia will have a co-occurring disorder and other disturbing or traumatic memories which they may not initially associate with their specific phobia during the intake and treatment planning process. Patients need to understand and *consent* to the pos-

sibility that they may associate to any other disturbing life experience during reprocessing. When a patient reports a history of witnessing domestic violence in childhood and claims, this is not related to their driving phobia, it remains essential that the patient consent to the possibility that memories and feelings related to these adverse childhood events may emerge spontaneously during reprocessing and may need to be directly addressed as part of the treatment plan.

When a patient indicates an unwillingness to have to think about or deal with these other adverse experiences in treatment, it is not possible or ethical to proceed with EMDR reprocessing. Whether these experiences may not emerge during or after reprocessing sessions cannot be guaranteed. Clinical assessment may suggest that such associations to adverse childhood experiences may be likely in such cases. Although such a refusal to deal with other possible adverse memories is infrequent, it is essential not to offer unwarranted reassurances that it will not occur. Instead, at that point, you have two options. First, explore the basis of the patient's concerns about the possibility of dealing with these other memories. It may be that with further discussion the patient will be able to identify potential solutions to these concerns and then develop sufficient trust, self-confidence, or resources to face the possibility of these other memories emerging. Second, offer the patient an alternate treatment strategy other than EMDR reprocessing.

Another major aspect of informed consent to treatment for phobic patients is agreement to reexperiencing aspects of the conditioning events that shaped the phobic response. Such reexperiencing can include mental images of sights, sounds, smells, and tastes from these memories as well as negative thoughts and dialogue. Often, reexperiencing will lead to emergence of emotional states such as fear, sadness, loneliness, grief, or shame. De Jongh and Ten Broeke (2007, p. 53) describe the case of Donald who had a water phobia and could not, at first, recall the origin of his fear during the history taking phase. As his earliest image of his fear, he initially selected an image, possibly from a movie, of a person swimming in the ocean with a shark out of sight below. Starting with this image, after many minutes of bilateral stimulation in the midst of reprocessing, Donald began to experience loneliness and then remembered an incident in which his younger brother nearly drowned and was saved by some passersby. Reprocessing of this remembered incident led to resolution of his phobic reactions to water. Informed consent to reexperiencing such emotional states and to the reemergence of such childhood memories is an essential aspect of preparing the patient for EMDR reprocessing.

Patients who had noxious or painful sensations during the adverse experiences that led to or shaped their phobic responses will commonly reexperience these sensations to some degree during EMDR reprocessing, and they need to be prepared for this possibility. Generally, the sensations will be experienced at a lower level of intensity than during the original experience and with successful reprocessing, these sensations will soon attenuate. After successful reprocessing, these memories will no longer be held in a form in the brain where they can be restimulated.

Emily had developed a fear of medical procedures and insomnia after a traumatic outpatient surgical experience. She had been traumatized by intensely painful sensations during the surgery because the anesthesia had not been effective. She remained awake but was unable to speak or move. In her case, informed consent had to include acceptance of the likely reexperiencing of the memory of these intensely painful sensations. During the reprocessing, she did reexperience these painful sensations for several minutes. However, they then faded away, and never returned. For Emily, more distressing than the memory of the painful sensations themselves, were feelings of helplessness and her inability to express the frustration and anger she felt when she was immobilized by the anesthesia. These emotional responses to the experience also resolved during the reprocessing when she spontaneously rehearsed verbalizing what she had been unable to say to the surgeon and anesthesiologist during the procedure.

In summary, providing informed consent includes describing the possibility of other memories emerging and reexperiencing incidents, emotions, or unpleasant

sensations. Preparing patients for reprocessing includes providing metaphors—such as the train metaphor described in chapter 6—to help orient patients to the witnessing stance that facilitates effective reprocessing. Once you have obtained informed consent to treatment with EMDR reprocessing, proceed to introducing the mechanics of the bilateral stimulation.

Introducing Bilateral Stimulation with the Calm Place Exercise or RDI

As described in chapter 6, it is always a good idea to practice the eye movements or alternate form of bilateral stimulation before commencing reprocessing of the first disturbing memory. This demystifies the mechanical aspects of the procedure. It also gives some assurance that the patient can tolerate horizontal and diagonal eye movements without eyestrain or dizziness. Next, it is helpful to introduce abbreviated reprocessing with the calm place exercise or a resource installation. This provides two benefits. For the patient, it creates an initial positive set of associations with reprocessing. Because the unknown is nearly always slightly anxiety provoking, experiencing the calm place exercise—or a resource installation—offers the patient a psychophysiological experience of moving from initial anxiety to increasing calm and well-being associated with bilateral stimulation. This initial positive experience with reprocessing tends to create a pattern for future sessions in which patients will start with an even more anxiety-producing memory and then allow it to reprocess to a more neutral state. In addition, as an assessment intervention, when patients have a simple, positive response to the calm place exercise, it is more likely that they will experience effective reprocessing when working on their phobic memories begins.

PHASE 3: ASSESSMENT OF THE TARGET

When treating a specific phobia, the procedural steps for the assessment of the target selected for reprocessing are identical to those used when treating PTSD. These are described in detail in chapter 7. Begin with eliciting a picture that represents a sensory aspect of the specific incident to be reprocessed. Then help the patient identify the negative and positive cognitions and obtain a baseline Validity of Cognition (VoC). Next, using the picture and the negative cognition, ask for the specific emotion. Then get a baseline SUD rating on the experience and identify the body location where the patient feels it now.

When dealing with specific phobias of a traumatic origin, it is more likely to find negative self-appraisals reflecting the perception of danger in the environment—"I am not safe" or "I will be hurt"—or a lack of control—"I am helpless" or "I am weak." Even in cases of medical and dental phobia, where patients perceived themselves as having been mistreated, it is less likely that you will encounter negative beliefs reflecting defectiveness or shame—"I am worthless" or "I am unlovable"—as when working with memories of childhood abuse. In these cases, you may encounter beliefs reflecting guilt—"I should have known better" or "I did something wrong." With blood-injury type of specific phobias as well, negative beliefs tend to be focused on danger and lack of control.

PHASES 4-6: REPROCESSING PROCEDURES FOR SPECIFIC PHOBIAS

Procedures for reprocessing of targets for specific phobias are essentially identical to those for PTSD and are described in detail in chapters 8, 9, and 10. Reprocessing begins with the desensitization phase (phase 4) of the earliest identified conditioning experience. Criteria for deciding when to return to target and for how to deal

with ineffective reprocessing are the same when treating specific phobia and PTSD. Continue the desensitization phase until the SUD is reported to be stable at zero. Then proceed to the installation phase (phase 5) checking to see if the patient still prefers the originally selected positive cognition or if a better positive cognition has emerged. Then have the patient rate the VoC and continue installation with sets of bilateral stimulation (BLS), checking the VoC after each set of BLS until the VoC is reported to be a 7 and is not getting any better.

Move to the body scan phase (phase 6), which involves asking the patient to hold the incident in mind, think of the positive cognition just installed, and then ask the patient to scan for any notable physical sensations. If negative sensations are reported, reprocess these down a channel of associations until they are gone. Then conduct the body scan again until the patient reports only neutral or positive sensations. If time remains and the patient reports positive sensations, provide more sets of BLS until the positive sensations are not getting any better.

PHASE 7: CLOSURE PROCEDURES

When treating patients for specific phobias, it is rare to encounter patients at risk for tension reduction, self-injurious, or threatening behaviors as you do when treating patients for PTSD and disorders of extreme stress not otherwise specified (DESNOS). The presence of such additional symptoms would indicate the presence of a co-occurring disorder and the need for a more comprehensive treatment plan. Therefore, even when treatment sessions for specific phobia are incomplete and the SUD level is still reported to remain significantly disturbing, it will seldom be necessary to provide containment, grounding, or anxiety management procedures. However, in some cases in the course of reprocessing, additional highly disturbing memories that the patient had previously forgotten or dissociated could emerge and bring the patient to the end of the session in a vulnerable, regressed, or agitated state. In these cases and in other cases where specific phobia patients become and remain significantly distressed at the end of the session, make use of the procedures described in chapter 6, The Preparation Phase, to assist the patient to return to a stable, grounded and well-oriented state.

During the closure phase, always offer the standard briefing reminders—described in chapter 10—to be mindful of new insights, memories, dreams, and new patterns of response and to keep a written log of these for the next session. Because patients often feel remarkably calm at the end of a successful EMDR reprocessing sessions, they may assume that their phobic anxiety has been completely eliminated from a single successful reprocessing session. Although this certainly occurs, it is unusual. It can be helpful to remind the patient that the treatment plan calls for reprocessing several incidents as well as current stimuli and finally mental rehearsal of future encounters over a series of sessions. It may be predicted that there may still be noticeable anxiety when confronting or thinking of confronting the phobic object until the treatment plan is complete. This avoids the patient developing unrealistic expectations and becoming discouraged when they experience residual, intersession phobic anxiety.

PHASE 8: REEVALUATION

In the subsequent session, we review information from the patient's log and check the status of the target from the previous session. The reevaluation steps are described in detail in chapter 11. If the previous session had been completed—SUD of 0, VoC of 7, and only neutral or pleasant sensations in the body scan—simply reconfirm the SUD and VoC on the previous target, then move to begin the assessment phase on the next target in your treatment plan. If the previous session was incomplete, return to the target memory and resume reprocessing.

MOVING THROUGH THE TREATMENT PLAN FROM PAST TO PRESENT

The sequence of treatment of a specific phobia—see Figure 13.1 or Table 13.1—follows the standard EMDR treatment sequence of selecting targets first from the past, then the present, and finally the future. After reprocessing any background events, the first occurrence and the worst or a representative phobic experiences, ask the patient to scan for memories of any other phobic experiences that remain disturbing. If any remain disturbing, these should be assessed and reprocessed until the patient has no further disturbance associated with any phobic memories.

Next, turn attention to the current stimuli that the patient identified during the history taking and treatment planning phase as well as those stimuli that the patient has reported in feedback from the log between treatment sessions. Occasionally, treatment effects will be generalized so completely to external cues during the reprocessing of the past memories that the patient reports no residual phobic anxiety. Any external or internal cues that remain sources of anxiety or distress should be reprocessed next.

INCORPORATING THE FUTURE TEMPLATE

James had developed a choking phobia after an incident of nearly choking during dinner in a restaurant. Although his near-choking experience was brief, during the reprocessing of this memory it turned out to have been associated with a highly disturbing childhood memory of witnessing his father nearly dying in a choking episode in a restaurant. His father had needed the Heimlich maneuver, which was promptly performed by another restaurant patron. As a 6-year-old boy, he recalled his own sense of helplessness and horror of witnessing his father being rendered helpless while eating. After reprocessing both the memory of witnessing his father choking and the memory of his own incident of choking, James reported an episode of anxiety when he had eaten out the next week by himself during a 1-day business trip. He had been preoccupied with the possibility of choking with no one there to rescue him if he needed assistance. During the assessment phase on his current anxiety, the SUD level was between 4 and 5. With reprocessing, this residual disturbance was quickly resolved, and he was able to achieve high confidence in a preferred belief, "I'm in control now." James was then asked to imagine eating alone in a restaurant. His SUD level on this future template was about a 2 and quickly dropped with further reprocessing to a 0. To further challenge James' scenario, his EMDR clinician then asked him to imagine that some food got briefly stuck in his throat while eating. He was able to imagine taking a few sips of water, easily dislodging the stuck food, and then swallowing it. He was then able to fully accept the preferred belief "I am in control now" to a VoC of 7. In the body scan, he then reported only positive physical sensations of ease, comfort, and a sense of confidence. These feelings were strengthened with further sets of bilateral stimulation. Follow up 4 weeks later indicated that he was eating alone on his occasional business trips with confidence and enjoyment.

In this case example, the initial SUD on the future template was low, indicating that the associated memories had been successfully reprocessed. It is always a good idea to challenge the patient with some plausible scenarios to probe for a residual material that needs further reprocessing and encourage further generalization of treatment effects. For example, when reprocessing the future template in treating a speaking phobia, ask the patient to imagine confronting problems with the audiovisual system, a disruption from an adjacent meeting room, or a difficult question from the audience. In treating a patient with a flying phobia, during the reprocessing of the future template, ask the patient to imagine encountering moderate turbulence or having the plane bypass the initial landing attempt and have to go around for a second landing attempt.

Visualizing the Future as a Movie

Some specific phobias involve the simple, unanticipated confrontation with the phobic situation as in the choking phobia described above. Other specific phobias require planning and a series of steps such as medical and flying phobias. For phobias for situations that require advance planning, a simple, single scene future template may fail to uncover residual anxiety. To assure comprehensive resolution of all aspects of these phobias, you can ask patients to visualize all the steps leading up to and through the target situations for their treatment goals.

This mental movie should have a series of scenes covering all the actions that require the patient to confront previously avoided or anxiety-provoking situations. Patients can visualize this series of scenes with their eyes open or closed, whichever best enables them to visualize. Instruct patients in advance to notice if they experience any part of their imagined future scenario as still disturbing. If so, ask them to pause at that point to briefly describe the aspect that is disturbing and where they feel it in their body. Then offer them further bilateral stimulation until the disturbance has been cleared. Then, ask them to resume their visualization until they can imagine all the facets of their future scenario with no further disturbance. Then, ask them to review this positive "mental movie" of the future and thinking of their preferred belief while providing further bilateral stimulation until patients reports their VoC on the future template is 7.

Evaluating and Responding to Feedback from In Vivo Exposure

At this point, patients need to make specific plans for in vivo exposure. In vivo exposure assures patients achieve their treatment goals by providing opportunities for discovering and mastering any residual anxiety as well as for consolidating gains made during in-office reprocessing. Patients should be instructed to self-monitor their level of comfort or anxiety with each of the requisite steps in their plan, so that they can report their gains and any residual issues that may be encountered during in vivo exposure. Occasionally, in vivo exposure will lead to uncovering of significant issues that would benefit from further reprocessing. You can then select appropriate current stimuli or past events as targets for reprocessing. In most cases, in vivo exposure itself will allow for direct resolution of any residual anxiety encountered.

SUMMARY

Published case reports indicate that EMDR treatment of specific phobias appears to hold great promise as an effective treatment for patients with phobias of a traumatic origin (De Jongh & Ten Broeke, 2007; De Jongh et al., 1999; Schurmans, 2007; Shapiro, 2001). These patients often have the most elevated levels of anxiety. These case reports suggest that EMDR provides the same type of efficient—rapid—treatment effects for phobias of a traumatic origin observed in the treatment of PTSD. These reports are consistent with the widespread, repeated, controlled research findings that EMDR is an effective treatment for those with both full and partial PTSD symptoms after traumatic exposure (Bisson & Andrew, 2007; van Etten & Taylor, 1998; Wilson, Becker, & Tinker, 1997).

Behavioral studies of exposure show that those with high levels of phobic anxiety appear to benefit more from distraction during exposure than from a pure exposure-focused condition (Johnstone & Page, 2004; Oliver & Page, 2008; Penfold & Page, 1999). EMDR is, in part, a method that intrinsically incorporates distraction as part of its dual attention condition. It is therefore reasonable to hypothesize that EMDR reprocessing will turn out to be an effective component in the treatment of nontraumatic phobias as well as those of traumatic origin.

EMDR treatment plans for patients with specific phobias share many similarities with treatment plans for PTSD. Both sets of treatment plans follow the basic eight-phase model with comprehensive history taking, development of a treatment plan, patient preparation, and reevaluation phases. Reprocessing is sequentially applied over a series of treatment sessions following the standard treatment sequence. This standard treatment sequence focuses first on targets from the past, then the present, and finally the future. Targets from the past are treated in sequence starting first with background stressors—when present—then to the first phobic exposure, then to the worst or a representative phobic experience, and finally to more recent phobic experiences. Only after targets from the past are no longer disturbing does reprocessing shift to current internal and external cues that remain sources of phobic anxiety. Finally, reprocessing is applied to mental rehearsal of future in vivo exposure. However, an essential difference from treatment plans for patients with PTSD is that when treating patients with specific phobia reevaluation follows actual in vivo exposure. In vivo exposure should be included as part of a comprehensive treatment plans for applying EMDR to specific phobias to assure and confirm consolidation and generalization of treatment gains from reprocessing sessions.