Winter_2024

A Three-Pronged Approach to Treating Anxiety with EMDR Therapy

By Jennifer L. Fee, Psy.D.

It hit me like an unexpected ocean wave as I was halfway up the wobbly steps

I of the portable stage in my too high-for-me-heels-but-goes-great- with-the-dress shoes. Anxiety.

I turned toward the bright lights and faced the room where I knew there were about 500 people, my biggest crowd to-date as a speaker. The lights were hot, expediating the sweat already dripping off my hands. I could only see the first few rows of faces, many looking at me with eager anticipation. I quickly scanned the crowd for a loved one, someone I knew had my back even if I forgot my name and uttered not a single word of my TEDx talk. I paused, took a breath, and smiled. The irony that I was beginning a talk about anxiety while experiencing intense anxiety did not escape me.

The experience of anxiety exists on a continuum of mild sensations at one end and a crippling anxiety disorder on the other. Helpful anxiety warns us that danger is present and protects us from certain harm. To illustrate, imagine you are just leaving a thought-provoking conference in a big city and pulling your luggage across the street to meet an Uber. Your mind is on what you just learned and how you might apply it to a client, and in the process, you do not look as you cross the street. Suddenly, you hear honking, you look up, and you are in the path of an oncoming bus. What happens? Your heart starts pounding, and you start moving fast to get across the street. You are faced with imminent danger, and your body enables you to deal with that danger.

Now, back to the beginning of my talk, where was the danger there? While I do not recall most of my thoughts when I turned to face the crowd, the danger may have been lurking in my mind. I could have easily been having thoughts like, “What if I forget my talk?” or “What if no one likes it?” Those kinds of thoughts tell the body that “danger is present,” and even though the danger is emotional in nature, the body, in turn, reacts as if there is a bus to escape or an enemy to fight. Alternatively, perhaps my body was the source of danger. As I approached the stage, my body experienced a plethora of physical sensations, such as difficulty walking in high heels, the temperature of the lights, and the sound of 500 people clapping. My nervous system easily could have interpreted the atypical physical sensations as something to be alarmed about.

These are just a few examples of the countless triggers of danger that might

result in the experience of anxiety. Indeed, there are so many facets to anxiety that no one can comprehensively cover all of them in one talk, article, magazine issue, research project, or interview. Anxiety is like the famous “31 flavors” ad campaign with the main idea of that advertising slogan being that while it is all ice cream, you can have a different flavor for each day of the month (Baskin-Robbins, n.d.).

If I tell you I had some ice cream today, you know some general things about my experience (temperature, texture, it is sweet, it tends to melt quickly). Still, you do not know my flavor (and there’s well over 1,000 flavors of ice cream now), if it was served on a cone, in a cup, or perhaps even in a root beer float or milkshake.

Like ice cream, we all know what it means to be “anxious.” At the same time, there are many facets and nuances that make it a vastly unique experience among people. The triggers, symptoms, intensity (from mild to panic attacks), and fears all vary. Triggers may come from innumerable sources; however, in my clinical experience, they generally fall into one of the following categories.

These include memories, thoughts, emotions, images, overstimulation, under-stimulation (boredom), body sensations, things experienced by the senses, and

other stimuli including fluorescent lights. Additionally, some anxiety results as a side effect of certain medications, particularly stimulants, asthma medication, thyroid medication, and Parkinson's Disease medication, to name a few.

While there are innumerable triggers, many clients will state that their anxiety "came out of the blue" or "happened for no reason." Since the experience of anxiety can range from unpleasant to completely paralyzing, most people prefer to eliminate the experience. Panic attacks are experienced as life threatening for some, which makes them valid EMDR therapy targets in and of themselves (Van Hagenaars, Van Minnen, & Hoogduin, 2009). At the same time, however, if anxiety is our warning system that "danger" is present, then it is in our best interest to explore what it is that we need to address.

> **While all my clients have taught me important lessons, these three helped me to understand the need to zero in on either the past, present, or future prong of the three-pronged protocol when it comes to treating anxiety with EMDR therapy.**

In my TEDx talk, I convey an overarching principle that gives a roadmap to help anyone uncover the mysteries of their anxiety. Briefly, anxiety is a messenger trying to point us to something important, something we need to give our attention to. Getting rid of anxiety without resolving the source is like cutting a weed off from the top without digging it out of the ground by the root. A cut weed will grow back. Attempts to eliminate anxiety without naming its root cause is akin to "killing the messenger" without ever receiving the message.

> **Let the message the anxiety is trying to convey help guide your EMDR therapy treatment planning.**

The idea that anxiety is a messenger pointing us to something important

The idea that anxiety is a messenger pointing us to something important dovetails nicely with the standard threepronged EMDR therapy protocol. Specialized EMDR therapy protocols are derived from this overall framework that past experiences, present situations or triggers, and future actions are all important realms for target selection. A treatment plan for anxiety may follow the standard protocol as outlined by Shapiro (2018) by reprocessing targets by the first, then worst, most recent, and finally, future projection. An alternative treatment plan is to use the Reverse Protocol (Adler-Tapia, 2012) where future oriented targets are processed first, followed by present, and then finally past targets. Adler-Tapia argues that the Reverse Protocol is helpful for clients overwhelmed by the prospect of processing past trauma and that it offers a way to avoid pausing EMDR therapy or extending the Preparation Phase. Additionally, the Reverse Protocol is suitable for some clients with anxiety, particularly those facing an imminent future event with overwhelming dread.

When creating a treatment plan for someone whose primary complaint is anxiety symptoms, I find it helpful to sequence targets based on the concept of what the anxiety is trying to point the client toward. Let the message the anxiety is trying to convey help guide your EMDR therapy treatment planning.

Clients are our best teachers as we strive to improve as clinicians. While all my clients have taught me important lessons, these three helped me to understand the need to zero in on either the past, present, or future prong of the three-pronged protocol when it comes to treating anxiety with EMDR therapy.

FOCUS ON A PAST TARGET: BURIED TRAUMATIC GRIEF

Anna was 75 when she was referred to me by her primary care physician due to symptoms consistent with agoraphobia. However, Anna had no history of agoraphobia, which has a typical age of onset in the mid to late twenties (Kessler et al., 2005). While late-onset agoraphobia can occur, Anna's history revealed that anxiety was rarely, if ever, problematic for her. She stated that until recently, she was "the opposite of a homebody" in that she loved to travel and was involved with many activities in her community. Anna's description of her usual lifestyle made her current symptoms of avoiding leaving the house due to a fear of having anxiety or a panic attack seem mysterious.

After completing a timeline of Anna's life, one event stood out. Anna's 50-year-old son had passed away two years prior after a difficult battle with cancer. Anna mentioned this event casually, and without emotion. "Have you been grieving the loss of your son?" I asked. "No," Anna responded, "I haven't cried once, not even at the funeral."

I told Anna that anxiety was not her primary problem and that I believed her symptoms would disappear once she faced the pain of losing her son. Anna told me that she preferred to learn strategies for alleviating her anxiety, thanked me for my time, and cancelled her next appointment. I spent the next few days questioning whether I had been too blunt too quickly but left her appointment slot open on a hopeful hunch that she might return. Anna called the day before what would have been our next appointment. "Can I come tomorrow? I am ready to grieve."

At her next appointment, Anna stated that while she was willing to grieve, she had no idea where to start. I began by asking her questions about her son's illness and death. As she bravely began to share some details with me, it became more difficult for her to stay emotionless when talking about her tragic loss. Several specific images emerged that caused Anna particularly high distress as she talked

about them. Those images became our targets for EMDR reprocessing.

Engaging in the phase four reprocessing of the targets was an emotional experience for Anna where she experienced the type of gutwrenching pain that she previously was so desperate to avoid. However, as Anna's focus turned toward tackling her traumatic loss head-on, her anxiety began to dissipate.

When the targets were complete, Anna reported that her anxiety regarding leaving the house was completely gone. She was sad and missed her son terribly, but she also began resuming activities outside her home that she had been avoiding due to her fear of anxiety and panic. Anna's anxiety was a message pointing her to unresolved traumatic grief. Once she allowed herself to experience the painful emotions, then trauma processing could begin. With the trauma targets cleared, she was left with normal bereavement and had no more need for anxiety to tell her there was something that needed her attention.

FOCUS ON A PRESENT TARGET: WHEN THE DANGER IS FALSE

Evan's struggle with panic disorder with agoraphobia was significantly interfering with his life when he began to see me. He had made numerous lifestyle changes to keep his anxiety at bay; however, those limitations were beginning to have a negative effect. To explain, Evan is an enthusiastic fan of Disneyland, and he, his wife, and two children have season passes. However, there were fewer and fewer rides that Evan was willing to stand in line for, which was beginning to limit what the family could do when they visited the park. Evan felt bad if his family rode without him (and it was difficult to explain why), but standing in line felt like being trapped. He anticipated, "What if I panic in line?" He also had a fear of certain rides breaking down and being stuck on them, which could also lead to that trapped feeling, the possibility of panic, or just the need to use the restroom. He asserted that his kids' favorite ride, "It's a Small World," was particularly harrowing because of how long it is.

> **While each item on the fear hierarchy was a potential EMDR target, we did not need to reprocess every item on it due to the generalizing effect EMDR reprocessing has on the brain. We did, however, begin with targets low on the hierarchy, which included driving past the DMV, parking in the parking lot, walking into the DMV, and asking an employee for a study booklet.**

Over the years, I have treated numerous clients with panic disorder using EMDR therapy. For many clients I have sequenced the first, worst, and most recent experience of panic attacks with much success. The logic of targeting the panic attacks themselves for reprocessing is that for many people with panic disorder, the experience of having a panic attack in and of itself is traumatizing (Van Hagenaars, Van Minnen, & Hoogduin, 2009). Another common method of treating panic disorder (with or without agoraphobia) with EMDR therapy is to look for stressful life events as potential targets as these disorders can develop after the experience of such events, either in childhood or in the recent past (Faravelli & Pallanti, 1989; Horesh et al., 1997).

Pallanti, 1989, Horesh et al., 1997).

Evan, however, was different. His recollection of past panic attacks did not come with the same vividness of memory and distress as they did for my other clients. He did recall a childhood trauma that seemed, at least to me, “tailor-made’ for the development of panic disorder. Evan’s SUDS for this trauma was only three, and we reprocessed it to zero SUDS quickly. There was no impact, however, on Evan’s present-day anxiety.

As Evan and I explored his current experience of anxiety further, we revisited the categories of anxiety triggers mentioned previously (memories, thoughts, emotions, images, overstimulation, under stimulation (boredom), body sensations, things experienced by the senses, and other stimuli, including fluorescent lights and medication). For sure, body sensations were a major trigger for Evan. At the first sign of a body sensation, Evan’s anxious, anticipatory thoughts began.

Anxiety or panic that starts from bodily sensations has been described as a learned behavior that can alter brain chemistry (Hamm, Richter, Pane-Farre, 2014). If Evan's brain was telling him that his body sensations were dangerous, then it made sense to focus our therapy on his here-and-now experience.

We began with resourcing. Evan picked a happy-go-lucky golden retriever to stand in line with him, an animal simply happy to be with his humans no matter what else was going on. Humor was also a valuable resource for Evan, and his ability to playfully engage with me regarding his struggles was a helpful asset. "What if I got stuck on It's a Small World?" he asked. "I don't know," I responded, "Is the music playing, or is it off?"

Specific rides became our EMDR therapy targets, which included standing in line, riding the ride, and the ride breaking down. We started with the least threatening ride and gradually moved to more threatening rides. "It's a Small World" was at the top of the list as the most threatening, so we saved it for last.

Meanwhile, Evan had numerous opportunities to visit Disneyland and observe how he was doing. Every reduction in symptoms felt like a victory, but it felt like therapy would not be complete until Evan could experience bodily sensations without having anxious "What if…?" thoughts. For Evan, his anxiety was pointing to his body as the source of danger, but in this case, the danger was not real, only perceived. What he needed to do was interpret his body sensations as sensations, not danger.

not danger.

Processing the present trigger of his trips to Disneyland worked for Evan. Sometime toward the end of our time together, I got a text message from him. It was a photo of him holding up a t-shirt in the It's a Small World Gift Shop. The t-shirt said, "I Conquered It's a Small World." His message read, "I know this is supposed to be a funny t-shirt, but in my case, it is actually appropriate. This is a step we can celebrate today."

FOCUS ON A FUTURE TARGET: LATE ONSET SOCIAL ANXIETY DISORDER

Mary came into my office with her right arm shaking uncontrollably. "It is a benign essential tremor," she explained, "it shouldn't progress into anything else, but it

won't ever go away either." Mary was 69 when she first came to see me and described in detail her struggles with anxiety that were consistent with a diagnosis of social anxiety disorder. Mary stopped going to restaurants, even with close friends, because they might judge her when they saw her struggle to use a knife and fork. She stopped hosting scrapbooking parties. She described intense feelings of shame and fear of humiliation. Like every client with social anxiety disorder that I had to date (prior to my use of electronic payment technology), Mary had her check written out in advance, so she would not have to write in front of me. She described her fears of people making assumptions about her, such as whether she could drive safely with her tremor.

Like Anna, Mary adamantly denied that she struggled with anxiety before the recent onset. Social anxiety disorder tends to have an even younger age of onset than agoraphobia with about 50 percent of cases diagnosed by age 11 and 80 percent by age 20 (Stein & Stein 2008). In my career as an anxiety specialist, I had never seen someone develop social anxiety disorder in their sixties.

However, as the statistics imply, there are exceptions. Several studies found that a substantial number of patients with a benign essential tremor in their sample (30 to 40 percent) developed symptoms consistent with late-onset social anxiety disorder (Schneier et al., 2001; Topcuoğlu et al., 2006).

Early traumatic events that involve shame are common among most people with social anxiety disorder (Erwin, Heimberg, Marx, Franklin, 2006). Examples of these traumatic events include bullying, shaming in a classroom setting, and familial abuse that involves shaming. Mary, however, reported none of these early experiences, so her social anxiety did not appear to be linked to the experience of early trauma.

Mary's negative cognition was "I am inadequate." This belief was reinforced by her difficulty holding her favorite teacups, writing neatly, and gracefully using a knife and fork. When Mary was relaxed, the intensity of her tremor lessened, but when she was anxious, the intensity increased dramatically. So, while the key to Mary's improved physical functioning was to lower her anxiety, her fear of humiliation and belief that she is inadequate made calming her anxiety extremely difficult.

Despite Mary's fear of humiliating herself in front of her friends, what her friends

Despite Mary's fear of humiliating herself in front of her friends, what her friends thought of her did not appear to be the primary source of Mary's danger. "All my friends have physical limitations," she remarked, "so it is odd that I do not want to show mine to them. They are very caring and compassionate."

After some exploration (using primarily Socratic questions) of what message Mary's anxiety was trying to point her toward, she revealed that at age 70 she would need to re-take the written driver's examination for her license as per state law. She was so afraid of a DMV employee making a negative judgment about her driving ability that she could not even drive past a DMV office, let alone look at the driver's license study materials. When Mary started discussing these fears, her arm would shake violently. We found a major message that her anxiety was pointing toward: the fear of not completing this task and losing her driver's license.

Once we uncovered the biggest danger, picking EMDR targets to process became easy, and they were all future-focused, meaning that the targets were related to Mary going to the DMV to take her written test. Her positive cognition was "I can be myself," meaning that no matter what anyone at the DMV thought of her shaking arm, she was a safe driver and could renew her license at age 70.

Regarding picking targets, we borrowed a Cognitive Behavioral therapy (CBT) technique and created a fear hierarchy. Creating a fear hierarchy involves breaking an event down into smaller events with the least feared event at the bottom and the most feared at the top. For Mary, seeing a DMV office on a TV show was at the bottom of her fear hierarchy, whereas signing her name in front of a DMV employee was at the top. When using CBT, items on the fear hierarchy are used for exposure therapy (Katerelos, Hawley, McCabe, 2008). While each item on the fear hierarchy was a potential EMDR target, we did not need to reprocess every item on it due to the generalizing effect EMDR reprocessing has on the brain. We did, however, begin with targets low on the hierarchy, which included driving past the DMV, parking in the parking lot, walking into the DMV, and asking an employee for a study booklet.

After processing targets on the list, we installed the PC "I can be myself," which included Mary signing for her license in front of a DMV employee while her arm was shaking. Once Mary had processed this dreaded future event, her anxiety

was shaking. Once Mary had processed this dreaded future event, her anxiety regarding embarrassment in front of her friends also dissipated. The primary message of Mary's anxiety was the future event of taking her written driver's test and what the DMV employees might assume about her.

Six months after we terminated therapy, I received a thank you card in the mail with a note that simply said, "I thought that you'd want to know that I passed!"

PUT ON YOUR DETECTIVE HAT

The standard protocol is our gold standard for treating anxiety disorders with EMDR therapy. Adaptions made to the standard protocol, such as the Reverse Protocol or additions to it, such as the implementation of CBT techniques like the fear hierarchy and vivo exposure (Horst, & Jongh, 2015), can help us tailor therapy better to address an individual's specific struggle with anxiety. One key to making these treatment decisions is to uncover specifically what our clients' anxiety is trying to tell them about what is dangerous in their world. This detective work requires a collaborative relationship with your clients. If you can inspire your clients to be curious about what is driving their anxiety, much of their fear and terror can be alleviated.

Jennifer L. Fee, Psy.D. is a clinical psychologist, EMDR Certified Therapist and EMDR Consultant, who has helped people with anxiety disorders for over 30 years. In addition to private practice, Dr. Fee spent a significant portion of her career in graduate education and directed a master's level program. She currently works at the EMDR International Association as the professional practice content specialist. Dr. Fee is passionate about fighting the stigma that surrounds mental health issues and advocating for EMDR therapy via writing and speaking. She has given a TEDx talk and made two appearances on Monique Coleman's Discovery channel series, "Gimme MO," discussing sexual assault, mental health, and EMDR therapy.

References

Adler-Tapia, R. (2012). A Proposal for an EMDR Reverse Protocol. j/https://emdrtherapyvolusia.com/wp-content/uploads/2016/12/Adler-Tapia_EMDR_Reverse_Protocol_Procedural_Steps_and_Script_July_2013.pdf

Fun facts: Baskin-Robbins. baskinrobbins.com. (n.d.). https://baskinrobbins.com.sg/content/baskinrobbins/en/funfacts

Erwin BA, Heimberg RG, Marx BP, & Franklin ME. (2006). Traumatic and socially stressful life events among persons with social anxiety disorder. *J Anxiety Disorders*. ;20(7) 896-914. doi: 10.1016/j.janxdis.2005.05.006.

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

Hamm, A. O., Richter, J., & Pané-Farré, C. A. (2014). When the threat comes from inside the body: A neuroscience based learning perspective of the etiology of panic disorder. *Restorative Neurology and Neuroscience*, 32(1), 79-93.

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

Horst, Ferdinand & Jongh, Ad. (2015). EMDR Therapy Protocol for Panic Disorders With or Without Agoraphobia. 10.1891/9780826121684.0002

With or Without Agoraphobia. 10.1891/9780826131683.0002.

Katerelos, M., Hawley, LL, Antony, MM, & McCabe, RE (2008). The exposure hierarchy as a measure of progress and efficacy in the treatment of social anxiety disorder. *Behavior Modification*, 32(4), 504-518.

Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005 Jun;62(6):593-602. doi: 10.1001/archpsyc.62.6.593. PMID: 15939837.

Schneier, FR, Barnes, LF, Albert, SM, & Louis, ED (2001). Characteristics of social phobia among persons with essential tremor. *Journal of Clinical Psychiatry*, 62(5), 367-372.

Shapiro, F. (2018). Eye Movement Desensitization and Reprocessing: Basic principles, Protocols and Procedures (3rd ed.). New York, NY: Guilford Press.

Stein, MB, & Stein, DJ. (2008). Social anxiety disorder. *The lancet*, 371(9618), 1115-1125.

Topçuoğlu, V., Bez, Y., Sahin Bicer, D., Dib, H., Kuşçu, MK, Yazgan, C., ... & Göktepe, E. (2006). Social phobia in essential tremor. *Turk Psikiyatri Derg*, 17(2), 93-100.

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