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EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol

Ad de Jongh

Introduction

When a person starts to demonstrate an excessive and unreasonable fear of certain objects or situations that in reality are not dangerous, it is likely that the person fulfils the criteria for specific phobia as stated in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*; American Psychiatric Association, 2013). The main features of a specific phobia are that the fear is elicited by a specific and limited set of stimuli (e.g., snakes, dogs, injections, etc.); that confrontation with these stimuli results in intense fear and avoidance behavior; and that the fear is "out of proportion" to the actual threat or danger the situation poses, after taking into account all the factors of the environment and situation. Symptoms must also now have been present for at least 6 months for a diagnosis to be made of specific phobia. The *DSM-5* distinguishes the following five main categories or subtypes of specific phobia:

- Animal type (phobias of spiders, insects, dogs, cats, rodents, snakes, birds, fish, etc.)
- Natural environment type (phobias of heights, water, storms, etc.)
- Situational type (phobias of enclosed spaces, driving, flying, elevators, bridges, etc.)
- Blood, injury, injection type (phobias of getting an injection, seeing blood, watching surgery, etc.)
- Other types (choking, vomiting, contracting an illness, etc.)

Research

Evidence suggests that with respect to the onset of phobias, particularly highly disruptive emotional reactions (i.e., helplessness) during an encounter with a threatening situation have the greatest potential risk of precipitating specific phobia (Oosterink, de Jongh, & Aartman, 2009). Regarding its symptomatology, some types of specific phobias (e.g., those involving fear of choking, road traffic accidents, and dental treatment) display remarkable commonalities with posttraumatic stress disorder (PTSD), including the reoccurrence of fearful memories of past distressing events, which are triggered by the phobic situation or object, but may also occur spontaneously (de Jongh, Fransen, Oosterink-Wubbe, & Aartman, 2006).

Although in vivo exposure has proven to be the treatment of choice for a variety of specific phobias (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008), results from uncontrolled (e.g., de Jongh & ten Broeke, 1994; de Jongh & ten Broeke, 1998; de Roos & de Jongh, 2008; Kleinknecht, 1993; Marquis, 1991) and controlled case reports (e.g., de Jongh, 2012;

de Jongh, van den Oord, & ten Broeke, 2002; Lohr, Tolin, & Kleinknecht, 1996), as well as case control studies (de Jongh, Holmshaw, Carswell, & van Wijk, 2011) show that eye movement desensitization and reprocessing (EMDR) can also be effective in clients suffering from fears and phobias. Significant improvements can be obtained within a limited number of sessions (see de Jongh, ten Broeke, & Renssen, 1999 for a review).

EMDR Therapy may be particularly useful for phobic conditions with high levels of anxiety, with a traumatic origin or with a clear beginning, and for which it is understandable that resolving the memories of the conditioning events would positively influence its severity (see de Jongh et al., 2002).

The aim of this chapter is to illustrate how EMDR Therapy can be applied in the treatment of specific fears and phobic conditions. The script has frequently been used in both clinical practice and research projects (e.g., de Jongh et al., 2002; Doering, Ohlmeier, de Jongh, Hofmann, & Bisping, 2013). For example, a series of single-case experiments to evaluate the effectiveness of EMDR for dental phobia showed that in two to three sessions of EMDR treatment, three of the four clients demonstrated a substantial decline in self-reported and observer-rated anxiety, reduced credibility of dysfunctional beliefs concerning dental treatment, and significant behavior changes (de Jongh et al., 2002). These gains were maintained at 6 weeks follow-up. In all four cases, clients actually underwent the dental treatment they feared, most within 3 weeks following EMDR Therapy treatment.

Similar results were found in a case control study investigating the comparative effects of EMDR Therapy and trauma-focused cognitive behavioral therapy (TF-CBT), among a sample of 184 people suffering from travel fear and travel phobia (de Jongh et al., 2011). TF-CBT consisted of imaginal exposure as well as elements of cognitive restructuring, relaxation, and anxiety management. In vivo exposure, during treatment sessions, was discouraged for safety and insurance reasons, but patients were expected to confront difficult situations without the therapist (e.g., returning to the scene of the accident, self-exposure to cars, or other anxiety-provoking cues). Patients were considered to have completed treatment when it was agreed that patients' improvements had plateaued or they were unlikely to make significant further progress in treatment. The mean treatment course was 7.3 sessions. No differences were found between both treatments. Both treatment procedures were capable of producing equally large, clinically significant decreases on measures indexing symptoms of trauma, anxiety, and depression, as well as therapist ratings of treatment outcome.

The efficacy of EMDR Therapy was also tested in a randomized clinical trial among 30 dental clients who met the *DSM-IV-TR* criteria of dental phobia, and who had been avoiding the dentist for more than 4 years, on average (Doering et al., 2013). The participants were randomly assigned to either EMDR or a wait-list control condition. Clients in the EMDR Therapy condition showed significant reductions of dental anxiety and avoidance behavior as well as in symptoms of PTSD. These effects were still significant at 12 months follow-up. After 1 year, 83% of the clients were in regular dental treatment.

The Diagnostic Process

Treatment of a fear or a phobic condition cannot be started if the therapist is unaware of the factors that cause and maintain the anxiety response. Therefore, one of the first tasks of the therapist is to collect the necessary information. This is usually done by means of a standardized clinical interview, such as the Anxiety Disorder Interview Scale (ADIS-R), which is primarily aimed at the diagnosis of anxiety disorders (DiNardo et al., 1985). This clinical interview has two important aims:

- To gain insight into the interplay of factors on several possible problem areas, including the possibility of *secondary gain issues*; that is, the extent to which the client derives positive consequences by avoiding anxiety-provoking situations, such as losing a job or receiving extra attention and consideration from others.
- To establish the relative importance of the interrelated problems that many of these clients have and how they are related to the diagnosis-specific phobia. For example, it

may be that a client's claustrophobia is not very specific and occurs in a variety of situations; in this instance, it may be wiser to consider (or to rule out) the possibility of the diagnosis panic disorder, as this condition generally requires more elaborate treatment.

To further enhance the reliability of the diagnostic process, it is often desirable to use valid and standardized diagnostic measures. These can be of help in getting a clear picture of the severity of the anxiety, in detecting other possible problem areas, and in making it possible to evaluate the course of treatment. Many examples of useful self-report questionnaires for fears and specific phobias can be found in Antony, Orsillo, and Roemer's practice book (2001).

Another factor of significance is the motivation of the client. For example, it is important to find out why the client seeks treatment at this particular time. Different issues that affect motivation are as follows:

- *Self versus forced referral*. There may be a marked difference in effectiveness of the treatment depending on whether the client requested referral himself or was forced into it (e.g., "My wife said she would leave me if I did not get my teeth fixed").
- *Past experience with therapy*. Also, clients' experiences of therapy in the past may determine their attitudes toward treatment. If, for whatever reason, it did not work in the past, it is useful to find out why and to attempt to discriminate between genuinely fearful reluctance and lack of effort.
- *Comorbid psychiatric issues*. The therapist should remain aware that comorbid psychiatric illness, such as severe depression, might be a contributing factor toward a lack of motivation.
- *Low self-esteem*. If the phobic client suffers from feelings of low self-esteem, which, in the opinion of the therapist, contribute to a large extent to the client's avoidance behavior, the self-esteem issue may be resolved first and becomes a primary target of processing.

The Phobia Protocol Single Traumatic Event Script Notes

Phase 1: History Taking

During Phase 1, history taking, it is important to elicit certain types of information.

Determine to What Extent the Client Fulfills the DSM-5 *Criteria of Specific Phobia*

Identify the type and severity of the fear and to what extent the client fulfills all *DSM-5* criteria for specific phobia.

Identify the Stimulus Situation (Conditioned Stimulus, CS)

An important goal of the assessment is to gather information about the current circumstances under which the symptoms manifest, about periods and situations in which the problems worsen or diminish, and about external and concrete (discriminative) anxiety-provoking cues or CS. The therapist should also be aware of other types of anxiety-producing stimuli, including critical internal cues, for example, particular body sensations (e.g., palpitations), images, and negative self-statements (e.g., "I can't cope").

Identify the Expected Consequence or Catastrophe (Unconditioned Stimulus, UCS)

To understand the dynamic of the client's fears or phobia, it is necessary to determine not only the aspects of the phobic object or situation that evoke a fear response (the CS), but also what exactly the client expects to happen when confronted with the CS and then the UCS (for a more elaborate description, see de Jongh & ten Broeke, 2007). For example, a dog phobic may believe that if he gets too close to a dog (CS), it will attack him (UCS), whereas

an injection phobic may believe that if she has blood drawn (CS), she will faint or that the needle will break off in her arm (UCS).

The most commonly used method to elicit this type of information is to ask the client a series of open-ended questions that can be framed in the context of hypothetical situations (e.g., "What is the worst thing that might happen, if you were to drive a car?") or actual episodes of anxiety (e.g., "During your recent appointment with the dentist, what did you think might happen?"). If the client remains unspecific about the catastrophe (e.g., "then something bad will happen"), it is useful to respond with more specific questions (e.g., "What exactly will happen?" or "What bad things do you mean?") until more specific information is disclosed ("I will faint," "I will die," "I will suffocate," etc.).

Please note that the UCS, being the mental representation of the catastrophe the client fears, should refer to an event that automatically evokes a negative emotional response. It is not always immediately clear where this information might have come from; that is, when and how the client ever learned that her catastrophe (e.g., fainting, pain, etc.) might happen. The therapist should be aware of the following possible events that may have laid the groundwork for the client's fear or phobia:

1. A distressing event the client once *experienced herself*. For example, she might have fainted in relation to an injection (traumatic experience) at an early age.
2. A horrific event the client once *witnessed* (vicarious learning). For example, witnessing mother's extremely fearful reaction to a needle.
3. An unpleasant or shocking event the client *read or heard about* that happened to someone or from learning otherwise that injections or anesthetic fluid can be dangerous (negative information).

Assess Validity of Catastrophe

The severity of a client's fear or phobia is reflected in the strength of the relationship between the stimulus and the patient's perceived probability that the expected negative consequence would actually occur. This relationship can simply be indexed using a validity of catastrophe rating (in this case, the validity of catastrophe that expresses the strength of the relationship between the CS and UCS in a percentage between 0% and 100%, using an IF-THEN formula. For example, IF (. . . "I get an injection," CS), THEN (. . . "I will faint"). Such a rating could be obtained before and after each EMDR session. The general aim of the EMDR treatment of the phobic condition would then be to continue treatment until the client indicates a validity of catastrophe rating as low as possible.

Provide Information About the Fear or Phobia if Necessary

If adequate information about the dangerousness of the object, the animal, or the situation is lacking—and the client has irrational and faulty beliefs about it—it is of paramount importance that the practitioner provide appropriate and disconfirming information to the contrary. However, some clients need to be guided past the initial awkwardness or need for such education. For example, if the client's lack of knowledge of the phobic objects (e.g., about airplanes and their safety) is likely to play a part, it may be wise to spend some time on this aspect first, and suitable reading material should be provided where appropriate.

Determine an Appropriate and Feasible Treatment Goal

There are a wide variety of treatment goals, from simple goals to more global or complex goals. An example of a limited goal for a needle-phobic individual might be pricking a finger, while a more global goal might be undergoing injections or blood draws, while remaining confident and relaxed. Generally speaking, treatment is aimed at reducing anxiety and avoidance behavior to an acceptable level and at learning how to cope. Goals can be formulated concerning both what the therapist would like the client to achieve during a single therapy session and what exactly the client should manage to do in natural situations

when confronted with the phobic object. Clearly, the treatment aim is set in consultation with the client and will depend both on the client's level of commitment and the therapist's clinical judgment about what seems realistic or ecologically feasible. However, sometimes clients formulate a treatment goal that is not within their reach, unnecessarily difficult, or simply dangerous, such as a person with a dog phobia who set himself the target of acquiring the ability to spontaneously pet all sorts of dogs. A more appropriate aim of treatment, however, could be the ability to walk outside without having to change direction because of the appearance of a dog. The therapist should be clear about the objectives for each session but also be prepared to adapt to unexpected happenings.

Identify the Conditioning Experience

In general, with regard to the procedure, the memories of the meaningful and disturbing past events (i.e., the first, possible earlier ancillary experiences and other relevant events that had a worsening effect on client's symptoms) are used as a focus for a series of subsequent EMDR Therapy (basic protocol) procedures that are applied separately, each involving a distinct target memory.

The first target that has to be identified is the origin; that is, the memory of the event that has caused (or in the patient's perception clearly worsened) the fear (e.g., being bitten by a dog in case of a dog phobia, or having undergone a horrific medical or dental treatment that led to a medical phobia).

Check for Possible Earlier (Ancillary) Experience

Check whether this is indeed the first event. If not, identify the incident when the fear was felt for the first time.

Identify Other Relevant Experiences

The assessment should focus not only on the experiences pertinent to the development of the phobia per se, but also on *all* other, subsequent meaningful events that contributed to the fear. The therapist needs to check for related memories of events that could be considered as "collateral damage"; for example, being ridiculed by peers when the patient reacted with extreme fear when confronted with a small dog. These kinds of experiences are likely to have had an effect on an individual's self-image and self-worth in general and therefore may also have to be addressed.

Phase 2: Preparation

The reprocessing work should not start until rapport and trust have been established and the client has been introduced to EMDR Therapy; that is, what EMDR Therapy is and what the client can expect to happen. A basic example (Shapiro, 2001) of what therapists can say is given in the script that follows. Clearly, the explanation could be changed, based on the current state of knowledge on trauma and trauma resolution, as well as certain personality characteristics, such as age and sophistication of the client.

Another well-established guideline, when using EMDR, is the preparation of the client for EMDR Therapy. To this end, it is important to make sure that the client is not afraid of her own fear reactions, since many phobias entail a fear of fear. If the client has never been able to deal with fear adequately, these things have to be worked out before targeting any traumatic memory. One helpful way to deal with it is to apply self-control procedures before a confrontational method such as EMDR Therapy is used. In particular, training a client in the use of distraction may be a way of challenging the client's faulty beliefs (for example, the perception that she can exert no control over her anxiety). Later in therapy, distraction can be used as an immediate anxiety-management strategy. Examples of distraction techniques include mental exercises such as counting backward from 1000 in 7s, remembering a favorite walk in detail, and so on. In the case of a child, distraction can be applied, for instance, by thinking of animals beginning with each letter of the alphabet in turn. One of

the benefits of using distraction is that once the client feels confident with its use, these skills are helpful to direct his attention away from thoughts concerned with possible catastrophic happenings or with evaluating his own performance.

It is essential to explain how important it is to prepare oneself for possible discomfort and any between-session disturbance and to practice with what has been learned. This makes it more likely that the client will become proficient and confident in the utilization of such techniques.

There are indications that blood or injury phobics display an atypical symptom pattern in which an initial increase in heart rate and blood pressure is followed by a sudden drop and sometimes fainting. In such cases, it may be important to teach clients the Applied Tension Technique, as this procedure takes into account the diphasic response pattern that is considered to be characteristic of this type of phobia (Öst & Sterner, 1987). This tension technique teaches clients to tighten their muscles, which seems to counteract the drop in blood pressure. This tension–relaxation cycle should be repeated several times within each practice session. If the therapist has access to equipment for measuring blood pressure, it may be instructive to demonstrate the effect of the tension technique to the client. The client should be requested to start practicing the tension technique prior to the actual beginning of the EMDR treatment. Practicing should be done several times throughout the day. If the client has a medical condition that could be affected by the procedure, such as hypertension, she should consult a physician prior to practicing this technique. It is important to note that when the client has headaches during the practices, the strength of the tension should be decreased.

Phase 3: Assessment

Target Selection

Select a target image (stationary picture) of the memory. (See Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal for the series of targets that have to be processed.)

Obtaining Negative Cognition (NC) and Positive Cognition (PC)

The selection of cognitions within the EMDR Therapy treatment is an idiosyncratic process and will greatly depend on the client and the specific characteristics of the target event. For example, the clinician should be sure that cognitions meet the following criteria:

- Appropriate for the issue
- Formulated in the here and now
- Connected to the target image
- Convey the present state about the current belief in relation to the past event, such as “I am out of control,” not a statement of what was experienced in the past such as “I was out of control”
- Describe the actual experience in terms of a belief statement (e.g., NC: “I am prey”) and not the emotional state (e.g., NC: “I am desperate”)
- Are found in the control domain (e.g., “I am helpless,” “I am powerless,” “I am not in control”); in the majority of the cases, it is the NC of the memory of the conditioning experience

Therapists will discover in their work with clients suffering from phobic conditions that certain categories of cognitions pertain to specific types of fears, for example:

ANIMAL TYPE PHOBIAS

I am powerless	I am in control
I am weak	I am strong
I am prey/in danger (e.g., dogs and insects)	I am safe
I am a coward	I am okay

SITUATIONAL TYPE AND NATURAL ENVIRONMENT TYPE PHOBIAS

I am a coward	I am okay
I am powerless	I am in control

BLOOD-INJURY-INJECTION TYPE PHOBIAS

I am a number, a piece of meat	I am okay
I am powerless	I am in control

The main criteria of the PC selection are the following:

- Level of meaning parallels (in the same cognitive domain) the NC
- Empowerment of the individual (e.g., "I can handle it")
- Ecologically valid or feasible (e.g., PC: *not* "I have control over the spider")

In case it appears necessary to address other relevant memories (see Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal), the therapist should take into account that the NC and PC of these targets may have different cognitive domains (e.g., within the self-worth domain rather than within the control domain).

Phase 4: Desensitization

Apply the Standard EMDR Protocol for All Targets

The Standard EMDR Protocol is used to process all targets. There is, however, one difference. To adequately tap into the memory network, it is most useful to have a somewhat different strategy for going back to target than is recommended for using the Standard EMDR procedure. More specifically, after having gone back to target, the client is asked to focus on *the most salient detail* of the target; that is, the aspect that (still) provokes the most disturbance. Therefore, the client may need time to connect emotionally with the disturbing material, but as soon as the client has decided what aspect is now perceived as most disturbing, bilateral stimulation (BLS)[1] is introduced. Such a strategy of using a clear focus on the aspects of the target image by which the affect is triggered has proven to be an excellent way to facilitate a connecting of the nodes in the fear network that still have to be processed, often effectively activating a new flow of associations.

The work in Phase 4 follows the Standard EMDR Protocol. This procedure is to be repeated until the subjective units of disturbance (SUDs) = 0. Then the PC is installed. Each traumatic event associated with the problem that is not reprocessed during the normal course of the first target must be processed using the Standard EMDR Protocol until the SUDs reach an ecological 1 or 0 and the PC is installed.

[1] Although this term is often used in relation to EMDR, support for bilaterality as a necessary condition for effectiveness in EMDR Therapy has a weak empirical base. It might be more appropriate to use the term "working memory taxation" in this respect (see de Jongh, Ernst, Marques, & Hornsveld, 2013).

Phase 5: Installation

The work in Phase 5 follows the Standard EMDR Protocol.

Phase 6: Body Scan

The work in Phase 6 follows the Standard EMDR Protocol.

Check the Other Targets

See Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal and decide whether it is still necessary to reprocess these experiences (SUDs when bringing up the memory > 0). If the SUD is > 0, continue with other memories that may still contribute to or "fuel" the client's current phobic symptoms.

Check Whether the Client Has (Still) Any Disaster Image About the Future (Flashforward)

After all old memories—that currently "fuel" the fear—have been resolved, check whether the patient has an explicit disaster imagined about the future (called a *flashforward*). What does the patient think will happen to her, in the worst case or "doom scenario," if what is feared cannot be avoided? If the client has a flashforward with a SUD > 0, continue with the Flashforward Procedure (Logie & de Jongh, 2014).

Check for Future Concerns

INSTALLING A FUTURE TEMPLATE

If all targets (Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal), including the flashforward, have been successfully processed, as well as current triggers, clients may still have to anticipate future situations in which the former stimuli are present (e.g., a dental treatment situation) and in which they need to interact with these stimuli. To check whether clients are fully capable of that, and to prepare for a future confrontation with the (former) anxiety-provoking object or situation, they are asked to mentally progress in time to identify a specific mental image of a typical future situation by which the fear prior to this session certainly would have been triggered. This may be a situation that clients usually avoid because of fear or a situation that they, until now, were not able to enter or to undergo without fear.

For the future template, it is useful to have clients select a picture of a situation in which they behave and feel in the way they really want it to happen. The goal of this procedure is merely to check that there are no future relapse triggers anymore and to prepare the client for future confrontations with the situation, thereby further increasing the feelings of self-confidence. From a practical point of view, clients are requested to hold in mind their picture and to visualize this scene as well as possible, while keeping in mind a standard PC (e.g., "I can cope," or "I can handle it"). Next, the BLS is introduced. This is continued as long as clients report a strengthening of validity (until validity of cognition or VoC = 7). Thus, when this form of installation procedure has succeeded, clients fully believe that they are able to deal with their mental representation of the experience.

The therapist continues with this procedure (instruction and VoC rating), until the future template is sufficiently installed (VoC = 7).

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

Video Check

After the incorporation of a positive template for future action, the clinician asks the client to close his eyes, and to run a mental video. That is, the client imagines himself in the future and mentally runs a videotape of the time between the present session and a next possible (but successful) confrontation with the anxiety-provoking stimulus or situation (e.g., an upcoming dental treatment: waking, going to the dentist, taking a seat in the waiting room, etc.). The client is asked to identify any disturbing aspect in the mental video and is instructed that as soon as any disturbance arises during the running of the videotape, he should stop, open his eyes, and inform the therapist.

Next, these disturbing aspects are targeted with BLS, where appropriate. This is done by holding in mind the same PC as was used in the previous step ("I can handle it"), while a long set is administered.

The mental videotape is repeated until it can be viewed entirely without distress.

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

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

In Vivo Confrontations

PREPARE THE CLIENT FOR IN VIVO CONFRONTATIONS

It is likely that, through the application of the previous steps of the EMDR procedure, the meaning or severity of the initial event has been effectively reappraised. Yet, it could be that clients are not completely convinced of their ability to cope with a future encounter with the phobic stimulus. Sometimes, clients have avoided certain activities for so long that they no longer know how to behave and how to feel secure in their formerly phobic situation. If this is the case, it is important that the therapist identify and counter existing irrational beliefs that contribute to a sense of threat and anxiety, for instance, by the use of in vivo exposure assignments or behavioral experiments.

If clients are actually confronted with the stimuli that normally would evoke a fear response and clients gain an experience that the catastrophe they fear does not occur, this would help to demonstrate that their fears may be unfounded.

A behavioral experiment is an excellent opportunity to test if the treatment effects are generalized to all associated triggers or aspects of the situation. To this end, real-life exposure to the anxiety-provoking stimulus after successful reprocessing of the traumatic memories may further strengthen the believability of the PC, as the NC (and other still existing assumptions and beliefs) is contradicted by the consequences of acting in new ways.

As with any of the other steps in the phobia protocol, the in vivo exposure part should be a joint venture of client and therapist. Unforced willingness must be ensured. Some gentle persuasion is certainly permissible, but it must be clear to the client that nothing will happen against her will during the confrontation with the phobic stimuli or situation. Also, unexpected introduction of new fearful material is counterproductive, as this can both damage confidence and lead to a revision of estimates of the likelihood of threat and increased caution.

IN VIVO EXPOSURE

In vivo exposure is applied to reduce avoidance and promote the opportunity to evoke mastery through observing that no real danger exists. All varying stimulus elements within a situation should be explored. Therefore, the eliciting situation should hold the client's attention. For instance, a person fearful of high places could be encouraged to be on the

roof of an apartment building that is not too distressful while paying attention to what is happening on the street or to certain objects such as trees, cars, and people.

It is essential that the therapist help the client pay attention to features of the phobic object or situation that are positive or interesting while being exposed to them.

It is important to anticipate various possibilities regarding elements that can be manipulated to ameliorate or to intensify the impact. It is this author's experience that it is helpful to make variations with regard to the stimulus dimensions such as action, distance, and time. That is, in a real-life confrontation, for example with an animal, the animal can be induced to be more or less lively, close or more distant, to be positioned with its head to the client or not, and during a long or a more limited period of time. If necessary the therapist can demonstrate to the client how the therapist would handle the feared object (e.g., by petting a dog).

The therapist should make sure that confrontations are repeated so that the reduction in distress is fully consolidated before moving on. Thus, the overall aim is to foster confidence in a general ability to cope despite variations in circumstances.

The therapist should act in such a confident and relaxed manner that the client feels prepared for any eventuality. Check the results by assessing the validity of the catastrophe.

Phase 7: Closure

At the end of every session, consolidate the changes and improvement that has occurred by asking the client what has been learned during the session.

Planning Self-Managed Homework Assignments

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

Clients should be told to stop any current avoidance behavior as much as possible, and to consider each confrontation with the feared stimulus as an opportunity to put the newly acquired skills into practice. By using self-managed assignments, clients should be encouraged to incorporate as many critical situations in real life as possible. This allows clients to gain self-confidence through overcoming their fears on their own, learning of new and more independent and appropriate ways of coping, and perceiving further progress. Thus, dependence on the therapist should certainly be avoided. Clients are expected to confront situations regularly and alone on the basis of agreed homework tasks. These may include taking a holiday flight, visiting a dentist for a check-up, opening a window of the house on summer days when wasps are flying, using elevators, meeting people with dogs, climbing towers in cases of height phobia, or swallowing solid food in cases of choking phobia.

With regard to blood phobia, the procedure is different in that clients are instructed to practice the Applied Tension Technique (see Preparation Phase) in real-life situations, while exposing themselves to their anxiety-provoking stimulus as much as possible, such as watching violent films with bloodshed, paying visits to a blood bank, and talking about blood-related topics.

Phase 8: Reevaluation

The length of the interval between sessions will depend on several factors, including the nature of the problem, the frequency with which significant eliciting situations are encountered, and the availability of the therapist and the client. It is sometimes inevitable that clients experience a relapse. In many cases, this is due to the fact that clients now expose themselves to situations that they avoided for a long period of time. Also, a spontaneous return of fear should be expected to occur during the interval between sessions. This may lead to increased arousal, which in turn could render clients disappointed about the improvements that they expected, thus interpreting this as a signal that their problems will only worsen. It is therefore important to label their behavior in a positive sense and to redefine the relapse as a challenge to put into practice what is learned.

After application of the phobia protocol, there may still be a need for additional targeting and other strategies to ensure that the treatment goals are met. An evaluation of what still remains to be done should be made at the beginning of the next session. Clients are asked about their current symptoms and about their progress in terms of success in carrying out homework tasks. It is advisable to always evaluate in terms of clients' SUDs level on the already processed material.

If the disturbance level has increased, these reverberations should be targeted or otherwise addressed. An extra test should be carried out by checking that the patient does not have any flashforward that is emotionally charged and thus has to be processed.

Further, the therapist should assess the necessity of teaching clients additional self-control and other relevant exercises that could further enhance their ability (e.g., the Applied Tension Technique) to confront the former anxiety-provoking situation in real life. Repeated rehearsal and reinforcement for success must be emphasized. To encourage hope and foster engagement in treatment, it is crucial that therapy sessions and homework assignments furnish experiences of success that clients can attribute to themselves. In this respect, these successes provide clients with direct experiential evidence that anxiety can, through their own effort, be controlled. Clinically, it is often observed that once clients manage to realize even a small achievement, the vicious circle of dependency, low self-esteem, avoidance, and further anxiety is broken. Therefore, it is important to work toward attainable and personally gratifying goals.

The Phobia Protocol Single Traumatic Event Script

Phase 1: History Taking

Determine the Type of Fear and Its Severity

Say, "*What is the fear or concern that has brought you in today?*"

_____

_____

Say, "*Does this fear or concern seem excessive or unreasonable to you?*"

_____

_____

If so, say, "*Tell me about it.*"

_____

_____

_____

_____

Identify the Stimulus Situation (CS)

An important goal of the assessment is to gather information about the current circumstances under which the symptoms manifest, about periods and situations in which the problems worsen or diminish, and about external and concrete (discriminative) anxiety-provoking cues or CS. The therapist should also be aware of other types of anxiety-producing stimuli, including critical internal cues, for example, particular body sensations (e.g., palpitations), images, and self-statements (e.g., "I can't cope").

Say, "*Describe the object or situation that you are afraid of.*"

Or say, "*What exactly do you need to see, hear, or feel in order to get an immediate fear response?*"

Say, "*What exactly about* _____ (state the object or situation) *triggers your fear most?*"

Say, "*Which incident caused your fear of* _____ (state the object or situation)*?*"

Identify the Expected Consequence or Catastrophe (UCS)

To understand the dynamic of the clients' fears or phobia, it is necessary to determine not only the aspects of the phobic object or situation that evoke a fear response (the CS) but also what exactly clients expect to happen when confronted with the CS and then the UCS.

Say, "*What are you afraid of that could happen when you are exposed to* _____ (state the object or situation: CS)*?*"

Say, "*Which incident caused your fear of* _____ (state the catastrophe the client expects to happen)*?*"

_____

_____

_____

_____

Assess Validity of Catastrophe

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

_____

_____

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

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

(completely false) (completely true)

Provide Information About the Fear or Phobia if Necessary

If adequate information about the dangerousness of the object, the animal, or the situation is lacking—and clients have irrational and faulty beliefs about it—it is of paramount importance that the practitioner provide appropriate and disconfirming information to the contrary. However, some clients need to be guided past the initial awkwardness or need for such education.

Say, "*What do you know about the relative dangerousness of* _____ (therapist fills in the information specific to the phobic stimulus with which he or she is dealing)? *Since there are other people that are not that fearful as you of* _____ (state the phobic object or situation), *wouldn't it be wise to spend some time investigating whether it is really as dangerous as you think it is? Just to be sure that you don't overestimate the probability of the danger or that something bad will happen to you. I mean, even if it appears to be more dangerous to be exposed to* _____ (state the phobic object or situation) *than you think it is now, it is important to find out, don't you think? Thus, let's look for the information we need. Where shall we start?*"

_____

_____

_____

_____

Determine an Appropriate and Feasible Treatment Goal

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

Identify the Conditioning Experience

The first target that has to be identified is the origin; that is, the memory of the event that has caused the fear (e.g., being bitten by a dog in case of a dog phobia, or having undergone a horrific medical or dental treatment that led to a medical phobia).

Say, "*What we have to figure out now is what memories are crucial to understand your fear. I assume that you were not born with this fear. So your fear started due to a certain event or series of events. Through these experiences you have learned to fear* _____ (state what learned to fear, for example, 'a dog'). *These experiences are, as memories, still active. One could say that every time you are exposed to a difficult situation such as* _____ (state client's difficult situation, or, for example, 'a walk in a park,' or 'being exposed to a dog'), *memories of a former 'damaging' event, such as* _____ (state client's former damaging event, for example, being bitten by a dog), *are—consciously or unconsciously—triggered and reactivated. With EMDR, I will help you to resolve these memories, so that they lose their emotional charge. Once these memories become neutral, they will no longer stand in the way of your entering certain situations that might be related to your fear of* _____ (state the client's fear) *and thereby increase your confidence in doing so. To find the right memories, I'll ask you to search in your mind through time, like a time machine, to determine which event on your timeline has started, or has aggravated, your fear.*"

Say, "*To begin with, which incident caused you to be afraid of* _____ (state the stimulus or CS)*?*" Or, in other words, "*When did this fear begin?*"

Or say, "*When did you notice this fear for the first time?*"

Or say, "*What incident causes you to be afraid of* _____ (state the feared consequence or UCS)*?*"

Check for Possible Earlier (Ancillary) Experience

Check whether this is indeed the first event. If not, identify the incident when the fear was felt for the first time.

Say, "*Is this indeed the first incident related to this fear? I mean, are you absolutely sure you did not have this fear or phobia prior to this incident?*"

Identify Other Relevant Experiences

Say, "*What other past experiences might be important in relation to the acquisition or worsening of your fear or phobia?*" For example, "*After what event/s did the fear get worse?*" or "*Which other experiences gave rise to how fearful you are now?*"

Phase 2: Preparation

Explanation of EMDR Therapy

Say, "*When a trauma occurs, it seems to get locked in the nervous system with the original picture, sounds, thoughts, and feelings. The eye movements we use in EMDR seem to unlock the nervous system and allow the brain to process the experience. That may be what is happening in REM or dream sleep—the eye movements may help to process the unconscious material. It is important to note that it is your own brain that will be doing the healing and that you are the one in control.*"

Teach distraction techniques for immediate anxiety management between sessions such as the following:

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

Distraction techniques also include mental exercises such as counting backward from 1,000 in 7s, remembering a favorite walk in detail, and so on. For example, say the following:

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

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

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

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

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

Continue education about the process.

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

Teach the Applied Tension Technique for blood or injury phobics who often have an initial increase in heart rate and blood pressure that is followed by a sudden drop or fainting.

For clients with blood or injury phobias:

Say, "*Please make yourself comfortable. Now, tense all of your muscles in your body, including those in your arms, torso, legs, and face. Please increase this tension. Now hold this tension* (for about 15 seconds) *until there is a warm feeling in your head. Okay? If so, release the tension and let your body return to its normal state* (for about 30 seconds)."

This tension–relaxation cycle should be repeated five times within each practice session.

Say, "*You can start practicing the tension technique this week, as we will begin our EMDR treatment next time. Practicing means doing the technique several times throughout the day. If you have hypertension, it is wise for you to check with your physician before practicing this technique. If you experience any headaches during the practices, decrease the strength of the tension.*"

Phase 3: Assessment

Target Selection

Select a target image (stationary picture) of the memory. (See Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal for the series of targets that have to be processed.)

Say, "*What picture represents the most disturbing part of this incident now?*"

Obtaining the NC and PC

The following are examples of the types of NCs and PCs seen with specific phobia clients:

ANIMAL TYPE PHOBIAS

I am powerless	I am in control
I am weak	I am strong
I am prey/in danger (e.g., dogs and insects)	I am safe
I am a coward	I am okay

SITUATIONAL TYPE AND NATURAL ENVIRONMENT TYPE PHOBIAS

I am a coward	I am okay
I am powerless	I am in control

BLOOD–INJURY–INJECTION TYPE PHOBIAS

I am a number, a piece of meat	I am okay
I am powerless	I am in control

NEGATIVE COGNITION

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

_____

_____

POSITIVE COGNITION

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

_____

_____

VALIDITY OF COGNITION

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

1 2 3 4 5 6 7

(completely false) (completely true)

Identify Emotion, SUD Level, and Location of the Feeling

EMOTIONS

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

_____

_____

SUBJECTIVE UNITS OF DISTURBANCE

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

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

LOCATION OF BODY SENSATION

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

_____

_____

Phase 4: Desensitization

Apply the Standard EMDR Protocol for All Targets

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

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

_____

_____

This procedure is to be repeated until the SUDs = 0. Then the PC is installed. Each traumatic event associated with the problem, that is not reprocessed during the normal course of the first target, must be processed using the above protocol until the SUDs reach an ecological 1 or 0 and the PC is installed.

Note: This protocol uses a different strategy to go back to target than in the Standard EMDR procedure.

Say, "*When you go back to the original incident, on a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?*"

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

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

Say, "*Look at the incident as it is now stored in your head. What aspect of it is most disturbing?*"

_____

_____

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

_____

_____

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

_____

_____

Do sets of eye movements or other BLS until SUD = 0.

Phase 5: Installation

Install the PC

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

1 2 3 4 5 6 7

(completely false) (completely true)

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

_____

_____

Continue this procedure until the VoC is 7.

Phase 6: Body Scan

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

_____

_____

If any sensation is reported, the therapist introduces BLS. If it is a positive or comfortable sensation, BLS is used to strengthen the positive feelings. If a sensation of discomfort is reported, this is reprocessed until the discomfort subsides. Finally, the VoC has to be checked.

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

1 2 3 4 5 6 7

(completely false) (completely true)

Check All Other Targets

See Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal and decide whether it is still necessary to reprocess these experiences (SUD when bringing up the memory > 0).

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

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

If the SUD is > 0, continue the procedure and start at Phase 8: Reevaluation.

Check for any "Flashforward" Still Fueling Client's Anticipatory Anxiety

THE FLASHFORWARD PROCEDURE

The Flashforward Procedure addresses clients' irrational fears and anticipatory anxiety responses, which might persist after the core memories of past events have been fully processed. What does the patient think will happen to her, in the worst case or "doom scenario," if what is feared cannot be avoided?

Say, "*We have now dealt with all the events from your past that seem to have been feeding into your current problems and these are no longer distressing you. But, it could be that you are still left with some fear and dread of what might happen in the future, which has been left behind, even after all the past events have been dealt with. If so, we are going to focus on the future, and what it is that you are dreading, using the same procedure as we used for the past events.*"

Determine the Flashforward

Step 1: Identify the Catastrophic Event

Say, "*We need to figure out what kind of image is in your head that makes you scared about a future confrontation with what you fear. What is the worst thing you could imagine happening? Basically, we should look for your ultimate doom scenario.*"

_____

_____

If necessary, the therapist asks additional questions, for example:

Say, "*What do you imagine might go wrong if you* _____ (state the concern, such as 'come across a dog,' 'have a dental treatment,' 'climb a tower,' etc.)?"

Say, "*If you had a terrible nightmare about* _____ (state the concern, such as 'driving your car to work on a busy road'), *what would the most disturbing picture look like?*"

_____

_____

continued

Step 2: Follow the Event to Its Ultimate Conclusion

Say, "*Why would this be so terrible for you?*"

_____

_____

Say, "*What would be the worst thing about that?*"

_____

_____

Repeat as necessary until the client cannot identify anything worse.

Step 3: Make a Detailed Picture of Flashforward

Image

The therapist might then ask the client to make a still picture of this scene. Ask that the picture be as detailed as possible.

Say, "*Exactly what would* _____ (the flashforward identified above) *look like?*"

_____

_____

Or say, "*What can you see in that?*"

_____

_____

If clients still have more than one picture, they are asked to contrast these images, for example, by saying the following:

Say, "*If you were forced to choose, what would be most disturbing for you now: the picture of* _____ (state the first example of what is disturbing, for example, your dying), *or the picture that* _____ (state the other disturbing problem, such as the situation of being unable to care for your family)?"

_____

_____

Negative Cognition

Say, "*What words go best with that picture* _____ (state the flashforward) *that express your negative belief about yourself now?*" or "*When you think of* _____ (state the flashforward), *what negative thought do you have about yourself now?*"

Note: The therapist can suggest, "I am powerless."

_____

_____

continued

Positive Cognition

Say, "*When you bring up the* _____ (state the flashforward), *what would you like to believe about yourself now?*"

Or suggest, "*I am in control/ I can deal with it/ I can handle it.*"

_____

_____

Validity of Cognition

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

1 2 3 4 5 6 7

(completely false) (completely true)

Emotions

Say, "*When you bring up* _____ (state the flashforward) *and those words* _____ (state the negative cognition), *what emotion do you feel now?*"

_____

_____

Subjective Units of Disturbance

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

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

Location of Body Sensation

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

_____

_____

Continue Phases 4 to 5 according to the Standard EMDR Protocol. For Phase 6, do the body scan and add the video check:

Say, "*This time, I'd like you to imagine yourself stepping into the scene of a future confrontation with the object or a situation for which the future template was meant* (e.g., making a trip on an airplane, meeting an unknown person, a dog, a dentist*). Close your eyes and play a movie of this happening, from the beginning until the end. Imagine yourself coping with any challenges that come your way. Notice what you are seeing, thinking, feeling, and experiencing in your body. While playing this movie, let me know if you hit any blocks. If you do, just open your eyes and let me know.*

continued

If you don't hit any blocks, let me know when you have viewed the whole movie."

_____

_____

If clients encounter a block and open their eyes, this is a sign for the therapist to instruct clients to say the following:

Say, "*Say to yourself 'I can handle it' and follow my fingers*" (or other form of BLS).

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

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

Do this until the movie can be played without any blocks or significant disturbances.

Continue Phases 7–8 according to the Standard EMDR Protocol.

Check for Future Concerns

INSTALLATION OF THE FUTURE TEMPLATE

If all targets (Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal), including the flashforward, have been successfully processed, as well as current triggers, clients may still have to anticipate future situations in which the former phobic stimuli are present (e.g., a dental treatment situation) and in which they need to interact with these stimuli. To prepare for that, clients are asked to mentally progress in time to identify a specific mental image of a typical future situation by which the fear, prior to this session, certainly would have been triggered. This may be a situation that clients usually avoid because of fear or a situation that they, until now, were not able to enter or to undergo without fear.

Say, "*Okay, we have reprocessed all of the targets that we needed to that were on your list. Now let's anticipate what will happen when you are faced with* _____ (state the anxiety-provoking object or situation). *Think of a time in the future and identify a mental image or photo of a typical situation that would have triggered your fear prior to our work together. What would that be?*"

_____

_____

Say, "*I would like you to imagine yourself coping effectively with* _____ (state the fear trigger) *in the future. Please focus on the image, say to yourself, 'I can handle it,' notice the sensations associated with this future scene, and follow my fingers* (or any other BLS)."

_____

_____

Say, "*To what extent do you believe you are able to actually handle this situation* (VoC) *on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?*"

1 2 3 4 5 6 7

(completely false) (completely true)

The therapist continues with this procedure (instruction and VoC rating) until the future template is sufficiently installed (VoC = 7).

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

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

_____

_____

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

_____

_____

Video Check

After the incorporation of a positive template for future action, the clinician asks clients to close their eyes, and to run a mental video.

Say, "*This time, I'd like you to imagine yourself stepping into the future. Close your eyes and play a movie from the beginning until the end. Imagine yourself coping with any challenges that come your way. Notice what you are seeing, thinking, feeling, and experiencing in your body. While playing this movie, let me know if you hit any blocks. If you do, just open your eyes and let me know. If you don't hit any blocks, let me know when you have viewed the whole movie.*"

_____

_____

If clients encounter a block and open their eyes, this is a sign for the therapist to instruct clients as follows:

Say, "*Say to yourself 'I can handle it' and follow my fingers* (or other form of BLS)."

The mental videotape is repeated until it can be viewed entirely without distress.

Say, "*Please repeat the video until it can be viewed entirely without distress.*"

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

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

1 2 3 4 5 6 7

(completely false) (completely true)

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

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

_____

_____

In Vivo Confrontations

PREPARE THE CLIENT FOR IN VIVO CONFRONTATIONS

If clients are actually confronted with the stimuli that normally would evoke a fear response and clients gain an experience that the catastrophe they fear does not occur, this would help to demonstrate that their fears may be unfounded. A behavioral experiment is an excellent opportunity to test if the treatment effects are generalized to all associated triggers or aspects of the situation.

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

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

IN VIVO EXPOSURE

This is done to reduce avoidance and evoke mastery while observing that no real danger exists. It is essential that the therapist help clients pay attention to features of the phobic object or situation that are positive or interesting while being exposed to it.

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

_____

_____

It is our experience that it is helpful to make variations with regard to the stimulus dimensions such as action, distance, and time.

Say, "*Isn't it interesting to notice that now that you are confronted with this* _____ (state the object or situation) _____

(state the catastrophe the client normally would have feared to happen) *does not occur?*"

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

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

The therapist should make sure that confrontations are repeated so that the reduction in distress is fully consolidated before moving on.

Check the results by assessing the validity of the catastrophe.

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

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

(completely false) (completely true)

Phase 7: Closure

At the end of every session, consolidate the changes and improvement that has occurred.

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

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

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

Say, "*Go with that.*"

Install with eye movements until there are no further positive changes.

Next, check the results by assessing the validity of the catastrophe.

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

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

(completely false) (completely true)

Next, an explanation is provided about the coming three days concerning agreements, diary, and contact information.

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

Planning Self-Managed Homework Assignments

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

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

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

By using self-managed assignments, the client should be encouraged to incorporate as many critical situations in real life as possible. This allows clients to gain self-confidence through overcoming their fears on their own, to learn new and more independent and appropriate ways of coping, and to perceive further progress.

Say, "*Please make sure to put yourself in as many critical situations in real life as possible. The more that you do this, the more you will gain in self-confidence as you overcome your fears and learn more independent and appropriate ways of coping and see your own progress.*"

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

For clients with blood phobia, say the following:

Say, "*Please practice the Applied Tension Technique in real-life situations as much as possible, while exposing yourself to* _____ (state anxiety-provoking stimulus)*. That may, for example, be talking about blood-related topics with friends, watching a medical documentary, a violent film with bloodshed, or paying a visit to a blood bank.*"

Phase 8: Reevaluation

Evaluate whatever is left to be done.

Say, "*What have you been noticing since our last session*?"

Say, "*What are the current symptoms (if any) you have been noticing*?"

Say, "*What kind of progress have you noticed, especially in terms of the homework?*"

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

0 1 2 3 4 5 6 7 8 9 10

(no disturbance) (highest disturbance)

If the disturbance level has increased, these reverberations should be targeted or otherwise addressed.

If the client has relapsed, say the following:

Say, "*As we spoke about before, it is not unusual to experience a relapse, as you expose yourself to situations that elicit your response. This is because you have exposed yourself to situations that you have been avoiding for a long period of time. You might have even noticed a return of some fear and become disappointed because you had expected improvements and now feel that your problems have only worsened. However, I see it really as a challenge that will allow you to put into practice what you have learned. What are your thoughts about what I am saying*?"

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

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

Repeated rehearsal and reinforcement for success has to be emphasized.

Say, "*As we have discussed before, the more you practice putting yourself in these situations that have provoked your fear over a long time, and use all that we have worked on, the more you will be able to overcome your problem.*"

To encourage hope and foster engagement in treatment, it is crucial that therapy sessions and homework assignments furnish experiences of success that clients can attribute to themselves.

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

_____

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Summary

This chapter illustrates how EMDR Therapy can be applied in the treatment of fears and specific phobias. These conditions are highly prevalent in the general population, and are characterized by an unreasonable and severe fear related to exposure to specific objects or situations, which tend to result in active avoidance of direct contact with these stimuli.

Clients with specific phobias display commonalities with PTSD in that they often experience vivid and disturbing memories of earlier events associated with the beginning of their fears. Activation of these mental representations plays an important role not only in the symptomatology of fears and phobias, but also in the process contributing to the maintenance and aggravation of clients' symptoms. EMDR Therapy has been shown to be capable of resolving such memories, alleviating clients' fears, and successfully reducing clients' avoidance tendencies (de Jongh et al., 1999, 2011; Doering et al., 2013).

Like most other anxiety disorders, for specific phobia there are treatment approaches that have been found to be effective, particularly those with a cognitive behavioral signature. Although there always should be good reasons to deviate from such evidence-based treatment standards, EMDR has proven to fulfill a pivotal role in resolving memories of past events that started the fear or phobia, or those that still contribute to the severity of the client's fear response (de Jongh, Ernst, Marques, & Hornsveld, 2013), particularly when these are likely to be activated when the clients are confronted with their phobic stimuli. Contrariwise, in many instances EMDR Therapy could profit from elements of CBT that add significant practical value and elevate the effectiveness of its use. That is the reason that in the present phobia protocol, EMDR is used for the processing of memories, while cognitive behavioral procedures (e.g., applied tension and in vivo exposure)—that are meant to teach clients to confront their feared stimuli until they feel they have achieved a degree of self-mastery that is needed to feel comfortable with handling these situations—are included as well.

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