

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR) TREATMENT IN SOCIAL ANXIETY DISORDER: A CASE REPORT

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INTRODUCTION

Social anxiety disorder (SAD) also known as social phobia is an anxiety disorder characterised by an intense fear in one or more social situations causing considerable distress and impaired functioning in at least some parts of daily life as defined in DSM-V (APA 2013). There are primal fears in SAD such as to be in center of attention, talking nonsense in community, talking with strangers, eating or drinking with somebody else. These fears, anxiety or avoidance behaviors are continuous and persist for at least six months or longer. This situation cause personal distress and impairment of functioning in one or more domains, such as interpersonal or occupational functioning. The most common psychotherapeutic treatment approach in SAD is cognitive behavioral therapy method (Leichsenring & Leweke 2017).

Eye Movement Desensitization Reprocessing (EMDR) therapy is a manualized 8-phase psychotherapy approach that was developed by Shapiro (2001) based on the Adaptive Information Processing (AIP) model. Much as EMDR is a proven psychotherapeutic approach in posttraumatic stress disorder, there are studies about efficiency in some other psychiatric disorders (Banerjee & Argaez 2017). In addition it can be conducted on various cases in addition to other treatments such as medication or another therapy (Ostacoli et al. 2018).

CASE PRESENTATION

M.T. is a single male patient with social anxiety disorder who is at the age of 29, graduated from the university and unemployed. He referred to State Hospital with complaints such as tremor in hands, fear of being in community and overexcitement in some conditions. He told that, he cannot talk easily with strangers and also with his friends and family members. He had fear of being laughed at in community therefore he always had behavioural avoidance from the community. He never had a girlfriend before. His symptoms have been present for 8 years. He has been using psychiatric medication since the beginning of the symptoms. He told that he used sertraline, fluoxetine, paroxetine, mirtazapine,

olanzapine, clonazepam and alprazolam before. He indicated that only alprazolam and clonazepam medications worked. In the last 2 years, he had cognitive behavioral therapy and still using bupropion 300 mg/day, escitalopram 10 mg/day, propranolol 40 mg/day and indicated he still has symptoms significantly when he first referred to us. He told that there was no psychiatric disorder in his family. Before his psychiatric treatment he had completed his blood tests, cranial magnetic resonance imaging and no organic pathology had been determined. After a detailed psychiatric examination he was diagnosed with social phobia according to DSM-V. No additional psychiatric disorder was observed. EMDR therapy was decided to be applied and the patient was informed about the EMDR. An accredited EMDR practitioner implemented the treatment and used EMDR therapy standard procedure (Table 1). To evaluate the efficiency of therapy Liebowitz social anxiety scale (LSAS), Beck depression scale (BDS) and Beck anxiety scale (BAS) were applied at the beginning of the therapy, just after 4 sessions of EMDR therapy and after 6 months beginning from the therapy. Patients medication left as it was before. Before EMDR sessions LSAS scores was 144, BDS scores was 48 and BAS scores was 35. Before the sessions a "safe place" created. For better and safe sessions, additional safe places were created by the patient. Totally 4 EMDR sessions were applied. During the sessions sometimes anxiety levels of the patient was increased but with the help of safe places imagination and relaxation techniques anxiety levels decreased. Sessions started with the last disturbing memory related with his social phobia. During the sessions all disturbing memories, which came along desensitized and reprocessed. During the 3rd session the patient suddenly remembered a memory, which could be his source disturbing memory. In this memory the patient was 6 years old and was playing with his friends inside a mosque toilet. He remembered that got beaten up by the gatekeeper of the mosque and got himself wet because of fear. Negative cognitions for his memory were "I am powerless, I am weak, I am useless" and positive cognitions were "I am strong enough, I can do my best". Subjective units of disturbance (SUD) level was 10 and

validity of cognition (VOC) level was 2. He described stomachache, and burning in his stomach as physical symptoms. After desensitization and reprocessing of this disturbing memory, SUD level regressed to 1 and VOC level increased to 7. After 4 sessions of EMDR therapy, desensitization and reprocessing procedures were completed and the patient described general well being. Just after EMDR sessions were completed LSAS scores were 76, BDS scores were and BAS scores were 17. And 6 months after beginning from the therapy LSAS scores were 58, BDS scores were 9 and BAS scores were 13.

Table 1. EMDR therapy standard procedure (Shapiro 2001)

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

EMDR: Eye movement desensitization and reprocessing

DISCUSSION

We report the successful application of EMDR therapy standard procedure, in a person with social phobia that had lasted eight years despite previous pharmacotherapy and cognitive behavioral therapy. Although only proven treatment field of EMDR is posttraumatic stress disorder, there are articles and case reports that EMDR is working on other psychiatric disorders such as anxiety disorders and depression (Banerjee & Argaez 2017). According the literature single or combined usage of medical agents and cognitive behavioral therapies is the most common and effective method in treatment of SAD (Wild & Clark 2011). Recent research has shown that negative, intrusive mental imagery plays a prevalent and causal role in SAD (Homer & Deepröse 2018). In a study conducted in Turkey found average LSAS scores associated with childhood trauma experience among

patients with SAD (Belli et al. 2017). The results of these studies and in this case result suggest that the use of EMDR may be effective in SAD patients.

CONCLUSION

The combined use of medication and EMDR therapy can be useful and EMDR therapy can be an alternative treatment method in SAD.

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Contribution of individual authors:

Eser Sagaltici: research idea, study design, manuscript, writing, literature search.

Onur Okan Demirci: manuscript writing, literature search, study design.

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