Synergism Between Mindfulness Meditation Training, and Eye Movement Desensitization and Reprocessing in Psychotherapy of Social Phobia

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We report on the successful treatment of a psychiatric outpatient with long-term Social Phobia (SP), at best only marginally responsive to pharmacotherapy. He was treated by Eye Movement Desensitization and Reprocessing (EMDR) because we suspected that his phobia derived from emotional trauma. He also received brief training in Mindfulness Meditation (MM), which enhanced his initially poor response to EMDR. The patient practiced meditation intensively during the treatment period and thereafter, and used it to relieve the distress that he experienced during both real and deliberately-imagined phobic situations. He recognized this distress pattern as identical to the one he reported to his EMDR therapist while processing traumatic images. The patient's condition was much improved at discharge and he continued to practice meditation during 3½ years of follow-up to sustain his relief. The two therapeutic approaches appear to be synergistic and useful in treating SP. We also comment on the usefulness of providing brief MM training, especially to highly-motivated patients. *(Chang Gung Med J 2006;29(4 Suppl):1-5)*

Key words: eye movement desensitization and reprocessing, mindfulness meditation, social phobia.

Eye Movement Desensitization and Reprocessing (EMDR) is a brief psychotherapy for anxiety especially related to traumatic memories.[1] It proceeds in sessions with a formalized protocol as patients process specific distressing images in order to desensitize the related anxiety. The therapist applies "sets" of bilateral, alternating attention stimulation by visual, tactile or auditory means, such as right-left hand movements. The patient reports at intervals on the physical and emotional sensations that the images evoke and on changes in the images themselves. During a session considered to proceed properly, the patient grows emotionally and physically calmer and more positive in outlook.

Buddhist Mindfulness Meditation (MM) has found a place in western medicine, notably as the Mindfulness-Based Stress Reduction (MBSR) program,[2,3] which trains patients in groups for 8-10 weeks to observe their physical and mental sensations in objective concentration, both during "formal" dedicated periods and "informally" at any chosen time. At our Psychiatry Outpatient Clinic, we have supplemented the treatment of some individuals with brief training in two MBSR components: "Walking Meditation" (WM) - observing one's legs in motion, and "Sitting Meditation" (SM) - seated and observing one's breathing but also all other sensations.

The subject of this report was trained in MM in an attempt to improve his responsiveness to EMDR. For the latter, we used the bilateral attention stimulation technique called "hand tapping" i.e. alternating

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taps above the seated patient's right and left knees.

CASE REPORT

Mr. L, a 38-year-old Taiwanese civil servant, was diagnosed with Social Phobia (SP), also known as Social Anxiety Disorder, at our Outpatient Clinic in 1996. Over time, he was prescribed various drug combinations including antidepressants, anxiolytics, a muscle-relaxant and a β-blocker. However, in 2001 he complained to a new therapist of his continued and increasing distress upon contact with people other than his family, especially co-workers. For example, he could talk with his supervisor only by phone and feared meeting a colleague on the street, whereupon he would become flushed and speechless, as did the startled colleague. He claimed that the drugs had helped him somewhat, whereas biofeedback training had not. We offered him EMDR therapy because he thought that his problem had started after an encounter with his military commander in 1984. However, he could not recall the exact, presumably traumatic, event. Since he insisted on continued pharmacotherapy, we prescribed alprazolam SR 0.5 mg twice a day and moclobemide 150 mg twice a day. Throughout treatment and follow-up, we recorded his scores on the Beck Anxiety and Beck Depression Inventories (BAI/BDI).[4,5]

At the first EMDR session (Day 1), Mr. L processed the image of his supervisor summoning him. This evoked feelings of nervousness and anxiety, plus a series of physical discomforts including hand tremors, "bloodshot" eyes, palpitations, facial flush, shoulder and temple pain, mouth soreness and head numbness. However, his processing was extremely slow. He would get "stuck" in the same physical sensation and in an unchanging image over a number of attention stimulation sets, and could not calm down or process additional images.

Consequently, Mr. L was instructed to practice one hour of WM daily, followed by one hour of SM. We surmised that this might enhance his response to EMDR because of the state of concentrated observation shared by MM and EMDR,[1] and because both hand-tapping EMDR and SM involved a seated, eyes-closed (as per Mr. L's choice) posture. Our instructions were brief and simple, taking about 10 minutes out of the two hour session. They were based on the therapist's own long-term practice and study. However, appropriate instructions exist in print.[2,6]

Indeed, in each of two subsequent EMDR sessions (Day 11 and Day 23), Mr. L readily processed several images (e.g. his startled colleague's flushed face). Each full session lasted about 90 minutes, including a brief review of his MM experience. He reported that he had complied with our instructions, and that MM calmed and relaxed him. Most notably, he recognized that the sudden, disabling distress that overwhelmed him during actual phobic episodes comprised the same specific sensations that he experienced and reported sequentially during EMDR. He would also deliberately imagine himself in phobic situations, thereby evoking his familiar distress syndrome, and would observe it mindfully until it subsided.

At this time, Mr. L chose to concentrate on MM for six weeks. At his therapist's suggestion, he would on occasion retreat during an actual phobic experience to observe his distressing sensations until they subsided. At discharge, we replaced the last planned EMDR session with a discussion of his MM and general situation. He considered himself much improved and reported that he now communicated face-to-face with his supervisor. In addition, he no longer tried to conceal his workplace anxiety. He also credited his formal and informal MM practice with greatly improving his general disposition and interpersonal relationships. His BAI score had dropped from a starting value of 26 (high "mild-moderate") to seven ("normal") and his BDI score had dropped from 12 ("moderate") to three ("minimal").

Following his discharge in late 2001, we have seen Mr. L monthly to review his condition and renew his prescriptions. His phobia has decreased markedly, with temporary setbacks attributable to circumstances such as family illness. He meditated daily for one year and then shifted his formal meditation to once or twice a week. He agreed to have his drug regimen decreased to the point of eliminating moclobemide and reducing alprazolam by 25%. His BAI/BDI scores were consistently at the bottom end of "normal/minimal", with final scores of 3/0.

DISCUSSION

Our results are in line with reports on EMDR's

usefulness in treating various phobias[7-9] and on MM producing relief from anxiety disorders, including panic disorder with agoraphobia,[10] and stress-related anxiety.[11] However, there have been no published reports linking these therapies to SP. For Mr. L, both approaches appear to have worked synergistically in successfully treating this disorder.

We suggest that the acquisition of mindful observation skills enhanced Mr. L's response to EMDR, which initiated his relief from phobia. In addition, his EMDR experience helped him recognize his specific distress pattern. He confronted phobic situations by mindful observation, much as others had used this skill to prevent the recurrence of depression brought on by specific situations.[12] Moreover, Mr. L actually appeared to "practice" EMDR on his own, by deliberately imagining himself in phobic situations and processing them mindfully.

As we indicated, our decision to try MM to improve the effectiveness of EMDR was intuitive. However, Shapiro noted that the nonevaluative "observer" stance that EMDR sought to cultivate in the distressed patient was also inherent to Eastern Meditative Practices.[1] She also suggested that successful EMDR involved a patient cultivating a state of "mindful experience/being," as formulated by Teasdale.[13] We have previously discussed the therapeutic potential of combining EMDR and MM in a report on a geriatric inpatient.[14] However, for that patient, MM was used to relieve a profound depression due to age-related ailments. In addition, the patient's fear of surgery was eliminated by EMDR but he was able to respond to this therapy only after prolonged, intensive and calming MM practice. The present report proposes that the combination of EMDR and MM is useful in treating a specific, well-defined disorder. As we noted, Mr. L believed that the drugs he took did him some good before he started EMDR/MM psychotherapy, and that they helped to maintain and even enhance his subsequent improvement. We cannot comment on this issue beyond reiterating that significant improvement occurred only after psychotherapy had been started.

We considered our geriatric inpatient's MM training to equal the MBSR training protocol in depth and duration but for Mr. L and other outpatients we have been able to offer only brief traing. Nevertheless, several of such patients have adopted MM as a way of life with considerable benefit. Like Mr. L, they practiced MM in a self-directed, introspective and intelligent way. For example, another outpatient - himself a medical professional - has credited his three years of sustained MM (also initially combined with EMDR) with curing an anxiety/depression complex whose manifestations ranged from intense conflict with his father to fear of driving to work (TFS: Unpublished results).

As we have noted,[14] the therapeutic and theoretical validity of EMDR has been a subject of continued controversy.[15,16] Indeed, in our practice we have found EMDR to be, in some cases, ineffective and even counterproductive, and in others only temporarily effective. However, we also consider it to have produced lasting relief in cases of distress due to traumas such as burglary, breakup of a romantic relationship, bereavement and witnessing a spouse's suicide (TFS: Unpublished results).

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以內觀禪訓練強化動眼減敏重整療法對社交畏懼症的療效

孫讚福 邱念睦

一位 38 歲男性社交畏懼症個案，長期對藥物治療反應不佳。評估其畏懼症狀可能源自社交創傷經驗，故施以動眼減敏重整療法 (EMDR: Eye Movement Desensitization and reprocessing)。因爲個案對第一次 EMDR 反應遲緩，故在心療結束前，教導個案內觀禪，並要求個案在家練習，藉以強化其日後對 EMDR 的治療反應。個案在四回 EMDR 心療期間，可在家密集練習內觀禪，助其緩解眞實或想像中的社交窘困情境，並在心療時與治療師討論禪修經驗。個案認爲治療師主導的 EMDR 與自己操作的內觀禪，在處理其畏懼症狀有異曲同工之妙。心療結束後，個案的社交畏懼症狀明顯改善。經過三年半的追蹤，其內觀禪的鍛練一直持續，社交畏懼症狀未再困擾他。由本個案的治療成功經驗，我們提出短時間內觀禪訓練，對 EMDR 治療社交畏懼症有加成作用，特別是有高度治療動機的個案。(長庚醫誌 2006;29(4 Suppl):1-5)

關鍵字：動眼減敏重整療法，禪修，內觀禪，社交畏懼症。

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