

Home Study Audio Course

“EMDR treatment of Panic Disorder with and without Agoraphobia: Two Model Treatment Plans”

Session 333 Presented at the EMDR International Association Annual Conference October 2, 2010 by Andrew M. Leeds, Ph.D.

You are welcome to use this PDF version of the EMDRIA CE Credit Examination as a study aid for this course. When you are ready to take the exam for EMDRIA Credits, read over this entire page, then pay for the exam(s) you wish to take at:

<http://www.andrewleeds.net/training/orderCEproductsonline.html>

Then, chose the (A) online exam or (B) paper exam option.

A) How to take the online exam.

1) Take the online exam at: <http://www.andrewleeds.net/training/EMDRIADL/onlineexams.html>

When you complete the online exam it will create a pre-addressed encrypted email. Just click send. If you do not pass the online exam, you may take it again without additional charges.

2) Complete the course evaluation at:

<http://www.andrewleeds.net/training/EMDRIADL/onlineexams.html>

After we receive both your email confirming you passed the online exam and your course evaluation, we will confirm you have paid for the course. Then we will email you a PDF of your certificate of completion listing the credits you have earned.

B) How to take the paper exam.

1) Print this **exam and circle the correct answers**. Return it with the included **course evaluation** and **course affirmation** pages by fax or mail.

2) Note there is an additional paper exam fee of \$5 (for EMDRIA Conference exams). We suggest you pay the paper exam fee at the time of original exam purchase. You may also add \$5 per paper exam later.

<http://www.andrewleeds.net/training/orderCEproductsonline.html>

Or mail a check payable to: Andrew M. Leeds, Ph.D.

Fax to: **707-579-9415** Mail to: **1049 Fourth Street, Ste G., Santa Rosa, CA 90504.**

Home Study Audio Course

“EMDR treatment of Panic Disorder with and without Agoraphobia:
Two Model Treatment Plans”

**Session 333 Presented at
the EMDR International Association Annual Conference
October 2, 2010**

**by
Andrew M. Leeds, Ph.D.**

EMDRIA CE Credit Examination

1. Initial panic attacks are frequently perceived as life threatening and a common cause of visits to hospital emergency rooms where
 - A. Patients are commonly evaluated for potential heart attacks and cardiac problems.
 - B. Patients are treated adequately in the emergency room to prevent further episodes of panic attacks.
 - C. Patients consume emergency room resources that could be directed to those with medical conditions.
 - D. A and B.
 - E. A and C.
2. Patients with PD who use benzodiazepines (tranquillizers) on an “as needed” basis:
 - A. Generally respond effectively to psychotherapy.
 - B. Show superior outcome compared to those who use benzodiazepines on a steady regime.
 - C. Show poorer outcome in psychotherapy compared to those who use benzodiazepines on a steady regime.
 - D. None of the above.
3. Goldstein’s (1995) suggestions which have relevance for the AIP model and EMDR based therapy of PDA patients are
 - A. These patients’ implicational meaning schema (dysfunctional memory networks) are not based only on logic or belief systems.
 - B. When the maladaptive memory network of early formative experiences is triggered, patients can go into a state similar to a panic attack that goes on for hours.
 - C. Change in the maladaptive memory network can only take place when it is being accessed.
 - D. All of the above.
 - E. A and B only.

4. The case for linking PDA with the model of Structural Dissociation can be made based on:
 - A. Goldstein (1995) proposed that PDA patients have disconnected or dissociated their early formative experiences of intense sense of isolation from their current experiences during a panic attack.
 - B. Epidemiological research shows that 58% of patients with PDA meet full criteria for DDNOS or DID.
 - C. Prolonged panic attacks can be viewed as intrusions of a structurally dissociated part of the personality (EP) into the consciousness of the apparently normal part of the personality (ANP).
 - D. A and C.
 - E. All of the above.

5. Dura et al (2009) found in a longitudinal study of childhood predictors of adult dissociation maximum variance in the scores were accounted for by:
 - A. Level of disrupted communication measured in the laboratory.
 - B. Mother's lack of positive affective involvement assessed at home.
 - C. Mother's flatness of affect at home.
 - D. Childhood physical and sexual trauma.
 - E. All of the above.
 - F. Options A, B and C only.

6. Goldstein (1995) proposed that the types of formative experiences frequently reported by PDA patients involved
 - A. Intense and frequent childhood physical trauma.
 - B. Severe forms of childhood sexual trauma with multiple perpetrators.
 - C. Early parent-child role reversal where children gained recognition from meeting the needs of an impaired parent, while their own needs for nurturance and safety tended to go unmet.
 - D. All of the above.
 - E. Option A and B only.

7. Etiological events are described as
 - A. Early childhood experiences.
 - B. Experiences following which the patient immediately develops overt symptoms.
 - C. Events that create a vulnerability to later experience of symptoms.
 - D. All of the above.
 - E. Option A and C only.

8. The relationship between contributory events and symptoms is:
 - A. There is a very short time lag between an experience and development of overt patient symptoms.
 - B. There is a direct relationship between experience and patient symptoms, e.g., after a car crash the patient develops a phobia of driving.
 - C. There may be no immediate overt symptoms, but instead these experiences create a vulnerability to the later emergence of symptoms after other stressors.
 - D. All of the above.
 - E. Option A and B only.

9. Patients with “simple” PD without agoraphobia, during EMDR processing of first, worst, and recent occurrences of panic attacks typically:
 - A. Show simple associations within the memories of panic experiences.
 - B. Report changes in vividness of images, sensations and emotions associated with experiences of panic.
 - C. Begin to connect to deeper feelings of dread of loneliness.
 - D. Begin to recall distressing childhood attachment-related memories
 - E. All of the above
 - F. Option A and B only.

10. EMDR reprocessing of past and present targets with “simple” PD leads to:
 - A. Reduction of the fear of panic attacks.
 - B. Reduction in the fear of interoceptive cues related to panic attacks.
 - C. Reduction in the fear related to external cues associated with panic attacks.
 - D. All of the above.
 - E. Options B and C only.

11. With cases of “complex” PD and PDA, EMDR reprocessing of memories of panic attacks eventually leads to the uncovering of associations to childhood memories of :
 - A. Parental separations.
 - B. Strict parenting or superficial parenting without “mindsight”.
 - C. Experiences of parent-child role reversal.
 - D. Severe physical or sexual abuse.
 - E. Options A, B and C only.
 - F. Any or all of the above.

12. Mindsight, as Siegel (1999) refers to, is
 - A. A unique human capacity based on mirror neurons which enables the observer to detect the affects, action impulses and mental state the observed person may be experiencing.
 - B. A mindfulness skill, which patients can cultivate with deliberate practice.
 - C. Is a unique type of mental telepathy skill some patients are gifted with.
 - D. A meditative practice for self-soothing.

13. For patients with PDA it is also important to consolidate a new sense of self because they often have a limited sense of connection to themselves. Clinicians can do this through:
 - A. Installing positive templates.
 - B. Installing future templates.
 - C. Doing work with RDI.
 - D. All of the above.

14. In history taking, the clinician should look for potential medical and lifestyle factors that may contribute to panic attacks such as:
 - A. Caffeinated beverages and over-the-counter medications, which contain caffeine and pseudoephedine hydrochloride.
 - B. Changes in prescription medication around the time frame of the onset of the panic attacks, as well as current prescriptions.
 - C. Sleep deprivation, which can contribute to anxiety states.
 - D. All of the above.
 - E. Option A and B only.

15. The selection of the initial targets for reprocessing of panic attacks should be as follows:
 - A. In keeping with the AIP model, early contributory experiences should be targeted first.
 - B. Use the Inverted Protocol, and start with future, anticipatory concerns.
 - C. Background stressors that immediately preceded or directly contributed to the first panic attack (if any were identified).
 - D. Option A and C only.

16. Once targets are identified for reprocessing with EMDR:
 - A. It is advisable to move in subsequent sessions from one target to another even if the reprocessing is not complete.
 - B. Be sure to complete reprocessing on each target and verify stability of results during re-evaluation before going to the next target.
 - C. Focus on current triggers only as they cause the most distress to patients.
 - D. None of the above.

17. When associations to early memories surface during initial reprocessing sessions, with complex PD and PDA patients, who have limited self-capacities for affect tolerance, clinicians need to:
- A. Encourage patients to simply “Go with it” as it helps to reprocess early disturbing memories.
 - B. Stop reprocessing immediately and redirect patients’ attention to their calm place or to diaphragmatic breathing techniques.
 - C. Acknowledge the importance of these associations, express appreciation for identifying these important memories, assure them they will be addressed later, and return attention to the selected panic attack target memory and continue reprocessing with this narrowed focus.
 - D. Help patients to develop resources, which will help them to manage the distress evoked by associations to early disturbing memories.
18. Two major indicators for clinicians in making the transition to targeting contributory childhood experiences in “complex” PD and PDA patients are:
- A. Patients become more skilled at identifying NC and associated early childhood memories of trauma experiences.
 - B. Patients are able to install with greater ease modified PCs in incomplete reprocessing sessions.
 - C. Patients report decreased frequency and intensity of current panic symptoms.
 - D. Patients verbalize a growing awareness and realization that childhood experiences of perceived abandonment, misattunement, humiliation, or early parent-child reversals were contributory to panic symptoms and need to be addressed.
 - E. Options A and B only.
 - F. Options C and D only.
19. With some patients with “complex” PD or PDA you may elect to offer “early” installation of a modified positive cognition when the desensitization phase is incomplete and the SUD has only dropped to 2, 3, or 4. The aim of “early” installation is:
- A. To identify and modestly strengthen transitional gains in mastery with a modified PC while avoiding triggering unresolved material.
 - B. To help patients stabilize in their current situations.
 - C. To reduce the frequency and intensity of panic attacks.
 - D. To help patients gain practice and confidence in reprocessing early childhood material with EMDR.
 - E. All of the above.

20. When preparing for reprocessing future template targets, if the SUD ratings are above 4 in the assessment phase, clinicians should:
- A. Probe for additional past targets by using the affect or somatic bridge techniques.
 - B. Identify and install useful resources to keep help patients manage their high disturbance levels.
 - C. Begin reprocessing future template targets, as the SUD rating will soon reduce.
 - D. Discontinue reprocessing. Instead, return to coaching patients in more anxiety management techniques.
 - E. None of the above.

Course Evaluation
Session 333

**Andrew M. Leeds, Ph.D. - EMDR treatment of Panic Disorder with and without Agoraphobia:
Two Model Treatment Plans**

Credit Provider Andrew M. Leeds, Ph.D.

Please rate the following items using the scale below.

1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

OVERALL COURSE RATING: _____

- | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|---|---|---|
| 1. Presentation was consistent with objective and title..... | 1 | 2 | 3 | 4 | 5 |
| 2. Content was valuable and/or useful. | 1 | 2 | 3 | 4 | 5 |
| 3. Course was appropriately challenging. | 1 | 2 | 3 | 4 | 5 |
| 4. Course was taught at the promised level..... | 1 | 2 | 3 | 4 | 5 |
| 5. The following objective were met. | | | | | |
| A. Able to identify key strengths and weaknesses of evidence based cognitive and behavioral therapies, pharmacotherapy, and EMDR treatments for Panic Disorder (PD) and Panic Disorder with Agoraphobia (PDA).. | 1 | 2 | 3 | 4 | 5 |
| B. Able to identify specific PD targets and treatment goals within the Adaptive Information Processing model. | 1 | 2 | 3 | 4 | 5 |
| C. Able to select and implement anxiety management strategies in the preparation phase of treatment for PDA and PD with co-morbid anxiety or Axis II disorders..... | 1 | 2 | 3 | 4 | 5 |
| D. Able to define the key differences between Model I and Model II treatment plans for cases of PDA or PD with co-morbid anxiety or Axis II disorders..... | 1 | 2 | 3 | 4 | 5 |
| E. Able to identify and recognize 13 factors suggestive of PDA and co-morbid PD cases with a need to prune early associations to core childhood attachment material in the initial series of EMDR reprocessing sessions. | 1 | 2 | 3 | 4 | 5 |

Comments:

Please rate the following using the scale below.

1 = Poor 2 = Below Average 3 = Average 4 = Above Average 5 = Excellent

PRESENTER:

_____ Communication Skills	_____ Knowledge of EMDR model
_____ Ability to answer questions	_____ Responsive to participants' needs

MATERIALS:

_____ Quality of audio recording	_____ Usefulness of course manual
----------------------------------	-----------------------------------

ADMINISTRATION:

_____ Administration of course	_____ Helpfulness of staff
--------------------------------	----------------------------

Course Affirmation

“EMDR treatment of Panic Disorder with and without Agoraphobia: Two Model Treatment Plans”

**Session 333 Presented at
the EMDR International Association Annual Conference
October 2, 2010**

**by
Andrew M. Leeds, Ph.D.**

By signing below you affirm that you: 1) listened to the entire Distance Learning Audio Course; 2) you read the corresponding handout that you have indicated; and 3) you completed the examination(s) by yourself without assistance from anyone else.

Print Name: _____ Date: _____

Signed: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

License Type & Number: _____