

# the Behavior Therapist

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### President's Message

## The Coalition to Protect Research

*Patricia A. Resick, VA Boston Healthcare System and University of Missouri—St. Louis*



Perhaps you have read about it in a respected journal such as *Science* (11/28/03) or the *New England Journal of Medicine* (12/4/03). Perhaps it appeared as a news story in your local newspaper, or you noticed it in *US News and World Report* (2/24/04).

Perhaps you saw it reflected in an episode of *The West Wing* (3/3/04). You may hear more about it in both professional and public outlets as the country winds up for an election year. What I refer to is the attack on National Institutes of Health (NIH) grants, which began last summer and grew through the fall. This week, as this column goes to press (3/3/04), there will be a congressional briefing on the public health implications of sexual health research, sponsored by the Coalition to Protect Research, of which AABT is now a member. This briefing is one step in a spirited defense of the importance of research on sexuality, HIV prevention, and the peer review process that has come under attack by right-wing groups this past year.

In July of 2003, Representative Patrick Toomey of Pennsylvania offered an amendment to the House of Representatives' debate on the Labor, Health and Human Services Appropriations bill:

None of the funds made available in this Act for the National Institutes of Health may be used to fund grant number R01HD043689, R03HD039206, R01DA013896, or R01MH065871.

### instructions for authors

The Association for Advancement of Behavior Therapy publishes the *Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

■ **Feature articles** that are approximately 16 double-spaced manuscript pages may be submitted. ■ **Brief articles**, approximately 6 to 12 double-spaced manuscript pages, are preferred. ■ **Feature articles and brief articles** should be accompanied by a 75- to 100-word abstract. ■ **Letters to the Editor** may be used to respond to articles published in the *Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

Please contact the Editor or any of the Associate Editors for guidance prior to submitting series, special issues, or other unique formats. All submissions should be in triplicate and formatted according to the *Publication Manual of the American Psychological Association, 5th edition*. Prior to publication, authors will be asked to provide a 3.5" diskette containing a file copy of the final version of their manuscript. Authors submitting materials to *tBT* do so with the understanding that the copyright of published materials shall be assigned exclusively to the Association for Advancement of Behavior Therapy. **Please submit materials** to the attention of the Editor: George F. Ronan, Ph.D., Department of Psychology, Central Michigan University, Mount Pleasant, MI 48859.

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including advertisements, are for the informa-  
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More chilling than the fact that  
Congress considered overriding the peer re-  
view process of NIMH funding, and that  
they selected for de-funding ongoing pro-  
jects regarding HIV high-risk behavior or  
human sexuality, was the fact that this  
amendment was defeated by only two  
votes: 212 to 210. In late October,  
Representative Henry Waxman of Cal-  
ifornia, the ranking member of the House  
Committee on Government Reform, sent a  
letter to Secretary of Health and Human  
Services (HHS) Tommy Thompson express-  
ing his "outrage" regarding the "existence  
of a 'hit list' identifying more than 150 sci-  
entists (250 grants) researching HIV/  
AIDS, human sexuality, and risk taking be-  
haviors" supported by the NIH. Credit for  
this "hit list" was claimed by the Traditional  
Values Coalition, which sent the list to some  
members of Congress.

Last summer the Coalition to Protect  
Research (CPR) was founded and co-spon-  
sored by the Consortium of Social Science  
Associations (COSSA) and the American  
Psychological Association (APA). The pur-  
pose of the CPR is to promote public health  
through research and to educate policy-  
makers about the public health relevance of  
research into sexual health and behaviors  
and the value of utilizing this research to  
make sound public health policy. The con-  
gressional briefing is one such effort.  
Member organizations also receive frequent  
e-mail updates and they have a Web site  
([www.cossa.org/CPR/cpr.html](http://www.cossa.org/CPR/cpr.html)) to inform  
people about efforts, articles, editorials, and  
other responses to the issues of the peer re-  
view process and sexual health research. In  
December, the Board of Directors of AABT  
voted unanimously to join the coalition and  
release a press statement. The press release  
is found on p. 71 of this issue of *BT* (see op-  
posite page). We are in good company. At this  
point there are 47 organizations enrolled,  
including the APA, the American Psych-  
ological Society, the American Sociological  
Association, the National Association of  
Social Workers, the American Association  
for the Advancement of Science, and many  
specialty organizations. Statements of sup-  
port have also been offered from the  
American Psychiatric Association, the  
Association of American Universities, the  
Association of Schools of Public Health, and  
American College of Obstetricians and  
Gynecologists, among others.

Aside from the response by many scien-  
tific organizations, NIH also responded.  
The Director of NIH, Elias Zerhoni, con-  
ducted an internal review and announced

that he was standing by the scientific merit  
of the grants that had come under attack.  
He sent a letter to key congressional com-  
mittee members in late January. He pointed  
out that HIV is a very serious public health  
problem affecting between 800,000 and  
900,000 people living in the United States  
and more than 42 million worldwide.  
Understanding risk factors and high-risk  
behaviors is an important step in prevention  
planning. He explained the rationale and  
public health implications for some of the  
studies under attack. He went on to discuss  
the importance of studying sexual function-  
ing and dysfunctions. Each of the five  
grants was explained and justified in this  
document, followed by a description of the  
NIH peer review process, review panels,  
and the two-tier system of merit review and  
the advisory council, which consists of both  
expert reviewers and lay or community  
members. In mid-February, CPR sent a let-  
ter of support to Dr. Zerhoni that was  
copied to Secretary Thompson and all of the  
NIH Institute and center directors.  
Appended to that letter was a list of all of  
the consortium members, including AABT.

Although this may just be a pseudo-  
issue raised in the hopes of distracting pub-  
lic attention away from concerns about the  
economy and the war in Iraq during the po-  
litical primary season, it is important that  
we, as scientists and citizens, respond and  
protect the integrity of the peer review  
process and the importance of these lines of  
research. On the CPR Web site you can see  
how your representative to Congress voted  
on this amendment. You can let your legis-  
lators know how you feel about these issues.  
I would urge you to continue to keep in-  
formed as this politically charged year  
marches on toward November. ✍

*The full press release  
can be found on p. 71*

The Association for Advancement of Behavior Therapy (AABT) strongly supports the scientific peer review system of the National Institutes of Health (NIH). Indeed, many of the NIH study sections have been and continue to be staffed by AABT members. In light of our active involvement in the grant review process, AABT has grave concerns about reports that the names of 157 peer-reviewed NIH-funded researchers have appeared on a list generated by an ideologically biased coalition and then circulated to congress and NIH with questions regarding the legitimacy of their research. These studies include research on sexual behaviors, HIV/AIDS transmission, contraceptive use, and substance abuse. This appears to be an attempt to censor researchers from examining questions regarding reproduction, sexually transmitted diseases, high-risk behaviors, or substance use. The public health implications alone of restricting these lines of research are chilling. The objections raised about these studies appear to reflect objections to the behaviors or to the populations being studied. However, these problems cut across all segments of our society, across all ethnic backgrounds, income levels, and religious ideologies. The only way to address these issues is through an unbiased health research agenda, soundly based on scientific principles. Therefore,

AABT supports all funding decisions stemming from the NIH peer review process, without interference from other government agencies or ideological groups. Projects funded by NIH are of the highest scientific quality after being reviewed by a group of scientists qualified to judge its merit. The integrity of this process is compromised when personal ideologies are allowed to influence the scientific review. It is the hope of AABT that our nation's leaders and the people of this country will step forward, in the interests of public health and the advancement of science, to protect the integrity of the scientific review process. AABT is a professional, interdisciplinary organization that is concerned with the application of behavioral and cognitive sciences to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriate utilization of these interventions. We have approximately 4,000 members. Our members are active in conducting research and are engaged in clinical practice working with a wide range of populations including those directly affected by these public health issues.

## Research-Training Link

# Undergraduates Can Learn About Behavior Therapy by Using It to Help Others

John M. Malouff, *University of New England*

Behavior therapy often involves clients in *learning by doing*—for instance, by practicing relaxation or social skills or trying feared behaviors (e.g., Spiegler & Guevremont, 2003). I apply the principle of learning by doing when I teach behavior therapy to upper-level undergraduates by asking them to use behavior therapy procedures to help a person overcome a mental health problem. Over the past 12 years I have used this assignment with over 500 students. I felt confident originally about the appropriateness of this assignment because research comparing treatment outcomes of clients randomly assigned to either briefly trained paraprofessional therapists (e.g., hospital workers and college students) or mental health professionals has repeat-

edly found that the outcomes of the paraprofessionals are relatively good (Hattie, Sharpley, & Rogers, 1984). This article describes the structure and evaluations of the assignment as I most recently used it.

## The Assignment

For the assignment students must apply assessment and treatment procedures set out in the class textbook, *Contemporary Behavior Therapy* (Spiegler & Guevremont, 2003). The students choose a "client" who wants help overcoming a mental health problem. In the most recent class, which included 147 students (a huge group!), the problems targeted included insomnia, encopresis, nail biting, alcohol abuse, and many others.

The students must disclose to the person they wish to help that they are doing a class project and obtain consent from the person. The person being helped remains anonymous to me. Students must submit a written assessment and treatment plan to me within 4 weeks of the start of the semester and their final report about 8 weeks later.

For safety reasons, I tell the students beforehand that I will not approve projects involving a client who is psychotic or where there is any risk of harm to the student, the client, or anyone else, ruling out cases involving suicide risk, domestic violence, and anorexia. To avoid interfering with ongoing treatment, I rule out trying to help someone who is currently obtaining mental health treatment. To avoid students getting involved in projects that tend to have only brief effects, I also rule out projects in which the goal is weight loss, school-related stress, or exercise. I also prohibit students from using any form of punishment, on the theory that punishment is usually appropriate only after other methods have failed. Further, I do not allow interoceptive exposure (which is used to treat panic disorder) because I consider it too dangerous for students to apply.

I suggest that students find individuals to help who are highly motivated to change and who are not close family members. I stress seeking permanent changes. Because of the short treatment period, I ask students to help the person create a plan for the time after the students submit the project paper.

To allow for instances where students do not know anyone who wants help or feel incapable of helping another person, I allow students to carry out a change project on themselves as an alternative (with no loss of points). For these students, the assignment is much like the self-change assignment described by Anderson (2000). I refer the self-change students to chapter 25 of Martin and Pear (2003) for information about self-control methods.

When I receive the proposals, usually by e-mail, I work quite fast to evaluate each within a day or so and provide suggestions. To save myself time, I don't grade the proposals, but I deduct points from the final paper for proposal lateness. When I do not know the usual behavior therapy treatment for a problem, I do a literature search on PsycINFO or Google and pass on relevant ideas to the student. For instance, when a student wanted to try reinforcement of lower rates to reduce nocturia (frequent nighttime urination in adults), the literature I found suggested that the problem is generally out of voluntary control, so I advised the student to find a different problem. I reject poor or vague proposals and ones that violate the assignment requirements. Also, some proposals contain possible dangers that I have never anticipated. This last semester, for instance, two proposals involved clients who needed quick treatment to avoid deterioration (e.g., a client who needed dental care right away but had a dental phobia). In these cases, I advised the students to refer the person to a professional and to continue with the project only if the person refused or was unable to see a professional soon.

### Evaluation of the Assignment

In 2003, 147 students completed the unit. Of these, 119 (81%) completed projects intended to help another person, and 28 (19%) completed projects on themselves. The most common assignment goals across other-directed and self-projects were reducing phobic avoidance (20 students; 14%) and smoking cessation (19 students; 13%).

Fifty-three of the students (36%) completed an anonymous evaluation of the assignment. The evaluation questionnaire

asked the students, "Compared to most assignments in other psychology units you have taken or are now taking, [indicate whether] this assignment was (1) less interesting, (2) about as interesting, (3) more interesting." The students also answered the same question with regard to how "memorable" and how "valuable" the assignment was. The mean response was 2.79 ( $SD = 0.41$ ) for interesting, 2.88 ( $SD = 0.32$ ) for memorable, and 2.88 ( $SD = 0.34$ ) for valuable, all quite high. When asked whether they succeeded in changing the behavior they wanted, 23 (53%) of the 43 students who tried to help another person said "yes," 20 (47%) said "partly," and none said "no." Three of the 10 students who tried to change something in themselves said "yes," 7 said "partly," and none said "no." When asked for comments, 14 students wrote that they valued the practical experience the assignment gave them.

In order to estimate long-term success of the projects, I randomly chose 15 (10%) students for a 3-month check on the successfulness of their project. This was after students had received their grades for the unit and the term had ended. I gave students the option of responding by e-mail or responding anonymously by mail. The students chose among response options of "not at all," "somewhat," "mostly," and "entirely" to answer the question, "AT THIS TIME, to what extent has your client ['have you' for self-projects] achieved the goals of the project?" Eight of the 15 students (53%) selected for the follow-up responded, all by e-mail. Of these, 5 of the 6 students who tried to help another person indicated that the person had "mostly or entirely" accomplished his or her goals; 1 of the 2 students who tried to reduce his own problems indicated that he "mostly" succeeded. The students who mostly succeeded directed their efforts toward nail biting, depression, social anxiety/phobia (3 students), and binge eating.

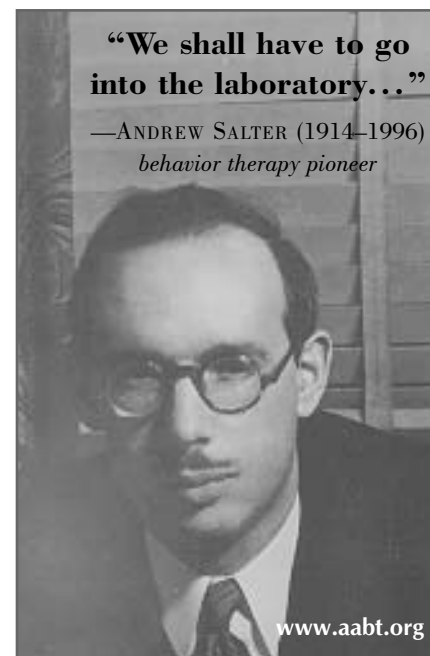
No significant problems occurred during this semester or during any of the prior 12 years when students completed the same assignment in large classes in a public university in Australia or in smaller classes in a private university in the United States. There were no complaints from students, those helped, or health care providers. The most difficult situations, fortunately rare, occurred when a person being helped became unavailable. In these cases, I suggest that the student change the project, and I give an extension of time for submitting the paper.

### Conclusion

Learning by doing is an active, interesting, and memorable way to learn. The assignment described above applied learning by doing with good success to teaching an undergraduate class in behavior therapy. Because the assignment was to help eliminate a psychological problem, the assignment had a potential to help the students begin to truly understand what behavior therapy involves and to help them or another person overcome a significant problem. Both of these desirable outcomes occurred to some extent. The careful structuring of the assignment minimized the chance that students or those they tried to help would suffer any harm. Other instructors who are behavior therapists can use the same sort of carefully structured and managed assignment to create a course students will long remember.

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In order to qualify for this career position you should have a Ph.D. and/or M.D. degree in a relevant field of biomedical behavioral science and appropriate experience. Appointees must be U.S. citizens, resident aliens, or nonresident aliens with a valid employment authorization. Salary is commensurate with experience and expertise.

Your letter of interest for this position, including a brief description of career interests, a curriculum vitae and a bibliography, should be submitted by May 15, 2004 to: Dr. Henry Haigler, NIMH, NIH c/o Ms. Amita Patel, 6001 Executive Blvd., Room 6166, Bethesda, MD 20892-9609; Tel. (301) 443-8865; FAX:(301) 480-3402 or e-mail: [apatel@mail.nih.gov](mailto:apatel@mail.nih.gov). For information concerning the nature of the job, contact Dr. Henry Haigler at (301) 443-7216 or e-mail [hhaigler@mail.nih.gov](mailto:hhaigler@mail.nih.gov). The Institute has a strong commitment to the diversity of its workforce and a biomedical research environment that reflects the diversity of the American population (<http://oeo.od.nih.gov/>).

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## Crooked Mirrors: The Externalization of Self-Image in Body Dysmorphic Disorder

Eda Gorbis, *Westwood Institute for Anxiety Disorders, Inc.*

Body dysmorphic disorder (BDD), also known as dysmorphophobia, manifests itself as an abnormal dissatisfaction with one's physical appearance. BDD affects about 2% of the U.S. population, striking males and females in equal proportion. The abnormally persistent preoccupation can focus on a particular body part or overall appearance. It is a challenging disorder for a person to confront alone because the focus of the obsession can move from one body part to another. Seventy percent of BDD cases evince an onset of symptoms before the age of 18. People with BDD often change their social and professional lifestyles so as to avoid appearing in public and spend excessive time trying to look "presentable" (Phillips & Castle, 2001). Phillips and Castle note that the diagnosis of BDD is often missed in mental health settings until significant consequences emerge. Only recently has BDD been thought of as a form of obsessive-compulsive disorder (OCD).

Estimates suggest that as many as 50% of BDD patients seek cosmetic surgery or other professional treatment to correct perceived defects in their appearance. Because BDD is not typically recognized by plastic surgeons and general practitioners, these patients can undergo a succession of invasive procedures. A 2000 *Psychiatric Bulletin* article (Veale, 2000) reported on 25 patients with BDD who had undergone a total of 46 procedures before BDD was diagnosed. The same article also presented disturbing evidence that 9 out of the 25 BDD patients had performed their own surgical procedures. BDD patients are typically dissatisfied with the results of cosmetic surgery and/or their preoccupations shift to another body part. This dissatisfaction with surgical procedures and the physicians who perform them is often displayed as anger directed toward the plastic surgeon and can range from verbal confrontations to litigation (Phillips, Grant, Siniscalchi, & Albertini, 2001). As might be expected, practitioners involved with cosmetic surgery are motivated to detect these "problem patients" so

that surgical procedures can be withheld (Cotterill, 1996).

Current treatment procedures for BDD include cognitive-behavioral psychotherapy and medical interventions (Slaughter & Sun, 1999). Due to their recent development, these treatments are only beginning to show signs of effectiveness. Early detection and treatment of BDD appears to result in the best outcome. For instance, a March 24, 1999, report by the Brown University News Bureau revealed that 64% of the teens who received surgical treatments for perceived flaws showed some symptom improvement. Similarly, half of a sample of 19 younger subjects treated for BDD with serotonin reuptake inhibitors experienced a decrease in symptoms after 4 to 16 weeks of therapy. Unfortunately, findings from a sample of 30 mixed patients revealed that 8 underwent a total of 25 plastic surgery or dental procedures and only 2 demonstrated symptom reduction (Sarwer et al., 1998). The complexity of the problem and a growing awareness of its toll on patients has spurred the development of additional models for the treatment of BDD.

Although previous studies demonstrated various degrees of success in response to medical interventions, cognitive-behavioral therapy methods should also be considered. Early in treatment patients face three significant challenges. First, patients can benefit from education regarding the nature of BDD and concomitant symptoms. Second, patients often report difficulty in coping with the shame and fear related to the beliefs and rituals related to their preoccupation. Finally, patients often require support for dealing with the lack of knowledge about the extent and depth of this disorder among family members, family physicians, and those within the cosmetic industry. All three of these concerns can be addressed using well-validated cognitive-behavioral techniques.

BDD patients present a special challenge to cognitive-behavioral practitioners, especially those following intensive treatment protocols developed from the methods of exposure and response prevention.

Patients suffer from a body image distortion that is internalized through social factors (e.g., peer pressure and parental critique) and/or an as yet undefined neurological deficit (Slaughter & Sun, 1999). This internalized perception prompts them to ritualize their behavior by constantly checking the "problem part" in mirrors and reflective surfaces before seeking help to "fix the problem." It is difficult for a mental health practitioner to habituate such a patient to the internalized irrational stimuli. Exposure to external referents is usually preferable. Because different BDD patients are concerned about the perfection of different body parts, patients have been thought to require individually tailored treatment modalities. Creating personalized exposure and response prevention protocols for this group of BDD patients is a difficult task that requires highly developed skills and intuition. A standardized method was recently developed and adopted by the Westwood Institute for Anxiety Disorders. The method involves the use of distorted mirrors to counter the false beliefs and ritualistic obsessions associated with BDD. A set of distorted mirrors made from highly reflective (anodized) aluminum surfaces bent in different directions are practical in clinical settings because they are inexpensive, easily concealed behind curtains, and occupy little space.

The use of distorted reflective surfaces reverses the process. By externalizing the distorted body image, the patient initiates outside processes that habituate his or her exaggerated image of physical deformity. Thus, the patient gains control of concurrent anxiety and even prevents responses to the feared internal self-image. The therapist teaches the patient how to control his or her anxiety when viewing the grotesquely misshaped image in the mirror. Gradually the patient learns how to control anxiety and responses to internal images such as "unruly hair," "beaked nose," or "tiny breasts." Patients are trained to increase the hierarchy of exposure, building up the degree of distortion and exposure time to reduce their concerns about perfection and to allow them to accept imperfections of their body.

This distorted mirror exposure involves fifteen 90-minute therapy sessions. While the small sample size does not allow for any significant generalizations regarding efficacy, five of the seven treated BDD patients improved. One of the two patients failed to demonstrate treatment gains; the second nonresponder is still receiving services. A successful case, discussed at the American Psychiatric Association's 156th annual

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meeting, involved a 45-year-old female BDD patient who had 17 plastic surgeries prior to participating in this distorted mirror exposure. She had not responded to several prior treatments for OCD and BDD or a variety of SSRIs. The patient was demoralized because her condition had persisted for many years and she met criteria for severe BDD and OCD. She scored 32 on the Yale-Brown Obsessive-Compulsive Scale for Body Dysmorphic Disorder (BDD-YBOCS; Goodman et al., 1989). The patient was afraid of getting old, looking ugly, and being imperfect. She established rituals in an effort to protect herself from aging and becoming ugly. She performed 20 to 30 facial wraps a day, washed her face 40 times daily, scrutinized the symmetry of her body parts, put cosmetics on in a particular order, and frequently looked into mirrors seeking reassurance that she was attractive. Her facial rubs and other rituals of perfection required more than 8 hours a day. In one instance she missed her 35th birthday party and appeared at the place of the party 32 hours later because she was so absorbed in perfecting the look of her face.

During treatment she was exposed to the distorted mirrors, instructed to wear mismatching jewelry and clothes, and put makeup on one eye but not the other. The distorted mirrors exaggerated her perceived imperfections. By the end of the treatment

scores on the BDD-YBOCS had decreased from 32 to 10. Five-year follow-up contacts revealed that she had not undergone any further surgeries.

Distorted mirrors were used to assist three additional patients in understanding the exaggerated nature of their perceived imperfections. One patient had undergone two plastic surgeries and, like most others with BDD, was not satisfied with the results. Another patient never had plastic surgery, but did need a number of surgeries to reconstruct and fix body parts that were destroyed and distorted as a result of her obsessive-compulsive behavior (e.g., obsessively working out to the point of injury). The last patient was fortunate to be treated before having plastic surgery. In total, patients exposed to the distorted mirror intervention initially obtained an average score of 33 on the YBOCS-BDD scale and an average score of 7.29 at termination. Follow-up interviews conducted with patients who were successfully treated revealed no post-treatment plastic surgery.

Methodologically rigorous treatment evaluations are needed prior to making any firm conclusions regarding the utility of this distorted-mirror technique. The hope is that these initial case studies will stimulate further work in this area.

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## Open Forum

# Extramarital Affairs: The Much-Overlooked PTSD

Frank M. Dattilio, *Harvard Medical School*

The winter 2003 issue of *the Behavior Therapist* featured an article by Monson, Guthrie, and Stevens on cognitive-behavioral couples' treatment for PTSD.

This well-written article was also comprehensive, covering a number of salient areas, such as the relationship of gender and PTSD and the fact that individuals with PTSD report a greater frequency and severity of intimate relationship dysfunction, including intimate aggression. The article also addressed relationship issues that include a wide range of mental health and relational problems associated with a PTSD symptomatology.

Monson et al. (2003) focused on the specific types of symptoms that are particular to various types of traumas, such as disaster, car accidents, and so on. The authors cited several studies of conjoint therapy for PTSD that identified intimate relationship problems associated with PTSD and discussed the role of traumatized individual patterns during the course of trauma treatment.

Although I found the article to be quite thorough in its coverage, I was surprised that the authors omitted one of the most important and most difficult circumstances resulting in PTSD in couples: the trauma caused by extramarital affairs (EMA). An increasingly common occurrence in con-

temporary marriages, EMAs draw attention to the dilemma of when PTSD is associated with one partner as the victim of the other's actions. Some national studies have found that nearly one-quarter of husbands and more than 1 in 10 wives have had extramarital sex during their marriage (Laumann, Cagnon, Michael, & Michaels, 1994; Smith, 1994). EMAs are considered to be one of the most frequent problems brought to couple therapy and they are seen as the second most damaging to relationships. Only physical abuse has a more negative effect. In fact, affairs are reported to lead to divorce at twice the rate of any other problem (Whisman, Dixon, & Johnson, 1997).

A quick scan of the literature indicates that little has actually been written on this topic, although several researchers have investigated the effects of and types of intervention in the recovery process following an extramarital affair (Glass, 2000, 2002, 2003; Gordon & Baucom, 1999; Olson, Russell, Higgins-Kessler, & Miller, 2002). Glass (2003) has specifically written about the traumatic effects of marital infidelity on both partners and about the fact that many

of the symptoms may mimic symptoms that are found with individuals who are exposed to a wide variety of stresses, such as combat-related trauma or disaster situations. This is particularly relevant when symptoms involve avoidance of affective expression or of intimacy, which have long been linked to diminished relationship satisfaction (Gottman & Levenson, 1986).

This issue merits further consideration, especially as Monson et al. (2003) note in their article that individuals treated for PTSD in the course of couples' therapy are not confronted with specific traumatic experiences with the goal of inducing anxiety situations, but rather the idea is consistent with a cognitive conceptualization of PTSD: "Individuals are encouraged to focus on the various emotions surrounding their memories and reminders of the events as well as the meaning of the events for the here and now" (p. 396). This appears to contradict the specific work that is done in treating PTSD with couples when infidelity is the issue. That is, oftentimes, dealing with the surrounding memories and reminders of the event, including the sight of the offending spouse, is what triggers considerable negative emotion in the relationship and can elicit reoccurring PTSD symptoms.

Monson et al. (2003) go on to cite McCann and Pearlman's (1990) work, which is incorporated into cognitive processing therapy (Resick & Schnicke, 1993) and provides cognitive content relevant to PTSD and intimate relationships that are specifically targeted for cognitive intervention. The authors outline five areas of functioning frequently affected by traumatic experience: safety, trust, power/control, esteem, and intimacy. In part, the approach typically uses the partner not diagnosed with PTSD as a support system. However, in the case of extramarital affairs, or any intimacy violation, the partner with PTSD is the partner whose actions have caused the problem and so his or her support becomes problematic, particularly when it comes to matters of trust and power/control.

Through in-depth interviews with individuals who have experienced marital infidelity, Olson et al. (2002) have found that there is a three-stage process following disclosure of the affair, beginning with an emotional "rollercoaster" and proceeding through a "moratorium" period before efforts at trust building are recognized. It is in the initial rollercoaster period that many of the posttraumatic symptoms are likely to first be observed. Immediate responses to a partner's disclosure of infidelity or of an in-

discretion were often found to be intensely emotionally charged, and it is during this phase that many of the negative outcomes of the affair are most apparent. In the period following the disclosure, the partner may confront the offending spouse and express anger, as well as attempt to manage conflicting feelings. This response to betrayal includes strong emotions and behaviors, many of which meet the criteria of posttraumatic stress. A moratorium stage usually follows in which there is less emotional reactivity and there are fewer attempts to make meaning out of the infidelity. In fact, there

may even be a period of calm and acceptance. The third stage, trust building, is a long and difficult phase. This part of the process was a highlight of the article by Monson et al. (2003) as it emphasized how important trust building is in overcoming normal cases of PTSD.

The issue revolves around the reactions of a victim of spousal extramarital affairs and how many of his or her PTSD symptoms may go unrecognized. For example, Glass (2003) found that the response of an individual upon learning of a partner's unfaithfulness is similar to the response found

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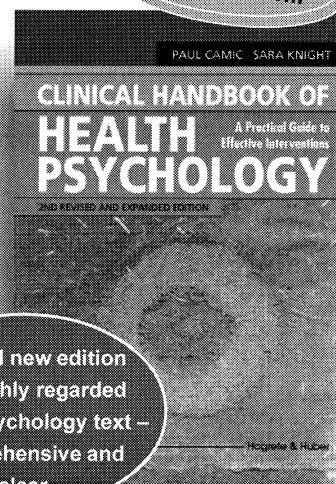
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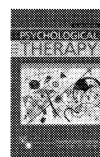


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with individuals under attack. The person will express a sense of threat, which includes such aspects as preoccupation, difficulty with appetite, difficulty with sleep, powerlessness, loss of control over emotions, anxiety, grief, and so forth. In fact, Glass uses an interpersonal recovery plan that parallels the ones used for victims of car accidents, natural disasters, wars, violence, and rape. Again, EMAs constitute a particular quagmire because, in most PTSD cases, one spouse becomes the healer, but in cases of infidelity, the spouse without PTSD is the offender. Consider the vignette that follows.

### Case Vignette

Tom and Karen were a young couple in their early- to mid-30s, married 10 years with two children, a 7-year-old girl and a 5-year-old boy. They were referred for marital counseling by their friend because of a trauma that had occurred in the relationship. Tom recently learned that Karen had been involved in an extramarital affair with a coworker. He learned of this after Karen broke down one night in a moment of weakness and divulged that she had had an affair, which had just ended. Tom's reaction required him to see his family physician for medication to help him sleep. During the course of Karen's revealing the affair, it also came out that she had had a brief affair with someone else earlier in the marriage. Tom claimed that this news "Simply blew my mind. I had no idea, no clue. This hit me like a ton of bricks."

During the evaluation, Tom confessed initially that he was in a state of shock. However, subsequently, he began to manifest many symptoms that resemble those of PTSD. For example, he recalled a movie that he and Karen had seen a couple of months prior to her admitting the affair. The movie, *Unfaithful*, was about a wife's spontaneous infidelity and the traumatic effect it had on her husband. Tom stated that he couldn't get the scenes of the movie out of his head and, in fact, he rented the movie several times, watching it repeatedly, and stewing over the similarities between what had happened in the film and what his wife had done to him. He would experience recurrent or intrusive and distressing thoughts. There were certain triggers for these thoughts. For example, he conveyed to me that he was lying on the bed in their

bedroom at one point, waiting for Karen to come out of the shower. As she exited the shower and he watched her drying off, he became sexually aroused. However, his sexual arousal was thwarted by the intrusive thought, "I'm not the only one who has seen her naked." When this type of reaction occurred, it soon escalated into a panic, and he experienced emotional distress. Tom also experienced recurrent and intense thoughts about the affair three or more times a day. He had experienced a sense of dread and hopelessness, feeling that his marriage to Karen would never be the same as before. He was often irritable and he would experience outbursts of anger. All of this made it hard for him to concentrate. He also felt detached from others, particularly his family. In the wake of Karen's admission, Tom also felt a great deal of insecurity about his own masculinity. In fact, Tom was a handsome man with a muscular build.

Tom had no history of any symptoms of anxiety or posttraumatic stress prior to these difficult revelations. He had problems falling and staying asleep, and he needed to take medication. His mood was unpredictable and sometimes volatile. He was also hypervigilant about Karen's activities, calling her incessantly during the day. More important, his recurrent and intrusive thoughts about Karen's betrayal were almost constant, even seeping into his dreams. Unfortunately, these subsequent behaviors contributed to additional tension in the relationship and made treating and healing from the EMA all the more difficult. However, this is not unusual, since many individuals who suffer infidelity on the part of a spouse do indeed experience some form of posttraumatic stress.

### Discussion

It is interesting that this is an area that was virtually overlooked by Monson et al. (2003). Politically, it may not be a topic that is considered dramatic because it fails to rise to the level of a life-threatening event. In fact, many may not believe that infidelity can be compared with the trauma that would be caused by a car accident or a disaster, but, in fact, in some cases, infidelity may cause longer-lasting emotional scars with regard to trust. EMA is a situation that clinicians need to keep in mind, particularly as they are more likely to see clients who are

dealing with this type of trauma in their clinical practice than any other types. Further, EMAs should also be strongly considered for a treatment regime that is equivalent in intensity and duration to any other treatment of PTSD.

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## Bilateral Stimulation in EMDR: A Replicated Single-Subject Component Analysis

Karen M. VanDeusen, *Western Michigan University*

The effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) has been a focus of empirical research, critical analysis, and debate since Francine Shapiro introduced its earliest form (EMD) as a new treatment for trauma (1989a). The standard EMDR protocol involves eight treatment phases. As part of the treatment, clients are asked to focus initially on a traumatic memory or image, associated negative cognitions, affect, and somatic responses while following therapists' fingers with their eyes in a back-and-forth motion. Saccadic eye movements are then interrupted periodically and clients are asked to report on their cognitive, affective, and physical experience (Shapiro, 1995). This process continues until clients report a significant decrease in disturbance (desensitization), reflected in a score of 0 or 1 on the 11-point Subjective Units of Disturbance Scale (SUDs; Wolpe, 1982) and self-selected positive cognitions are "installed," reflected in a score of 6 or 7 on the 7-point Validity of Cognition Scale (VoC; Shapiro, 1995). Shapiro (1989b, 1995, 1999, 2002) and others (Bauman & Melnyk, 1994; Davidson & Parker, 2001) have since reported that the eye movements in EMDR may be substituted with other forms of bilateral stimulation to obtain positive treatment effects.

The goals of EMDR include anxiety reduction (desensitization), positive changes in cognition and behavior, increased insight, and adaptive changes in previously held maladaptive information (reprocessing) thought to underlie the symptomatology (Shapiro, 2002). While some have argued that the effectiveness of EMDR is due to its cognitive-behavioral elements (Cusack & Spates, 1999; Herbert et al., 2000; Lohr, Tolin, & Lilienfeld, 1998), Shapiro suggests that it is the integration of EMDR's eight phases, derived from cognitive-behavioral, psychoanalytic, interpersonal, and physiological theoretical frameworks, that leads to its effectiveness (Shapiro, 2002).

### Outcome Research

Shapiro (1989a) first reported positive EMD treatment effects after only one session, based on 22 subjects who experienced various traumas. EMDR has since been reported to result in moderate to significant positive treatment effects in several published case studies of trauma survivors (e.g., Cocco & Sharpe, 1993; Forbes, Creamer, & Rycroft, 1994; Greenwald, 1995; Hyer, 1995; Kleinknecht & Morgan, 1992; Lipke & Botkin, 1992; McCann, 1992; Page & Crino, 1993; Puk, 1991; Shapiro, 1989b; Spates & Burnette, 1995; Spector & Huthwaite, 1993; Thomas & Gafner, 1993; Wolpe & Abrams, 1991). Early uncontrolled studies (e.g., Forbes et al., 1994; Vaughan, Wiese, Gold, & Tarrier, 1994) re-

ported similar positive results, with the exception of Oswalt, Anderson, Hagstrom, and Berkowitz (1993), who reported mixed EMDR findings, with three subjects showing moderate positive effects and five subjects showing neutral or negative effects.

Several controlled studies found EMDR to be slightly to significantly more effective in the treatment of trauma when compared to nontreatment controls (Boudewyns, Stwertka, Hyer, Albrecht, & Sperr, 1993; Rothbaum, 1997; Wilson, Becker, & Tinker, 1995, 1997; Vaughan, Armstrong, et al., 1994), individual or group psychotherapy (Marcus, Marquis, & Sakai, 1997), standard VA treatment (Boudewyns & Hyer, 1996; Jensen, 1994), active listening (Scheck, Schaeffer, & Gillette, 1998), biofeedback (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998), relaxation training (Vaughan, Armstrong, et al., 1994), and cognitive-behavioral treatments involving some form of exposure (Boudewyns et al., 1993; Ironson, Freund, Strauss, & Williams, 2002; Rogers et al., 1999; Vaughan, Armstrong, et al., 1994). In contrast to the latter studies, Devilly and Spence (1999) and Taylor et al. (2003) found EMDR to be less effective than a cognitive-behavioral treatment with an expo-



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sure component. Recent meta-analyses found EMDR to be as effective as exposure treatments for PTSD (Davidson & Parker, 2001; van Etten & Taylor, 1998). In a recent review of empirical literature, Chambless et al. (1998) found EMDR to be a validated treatment for civilian PTSD.

### Component Research

A number of between-group (Andrade, Kavanagh, & Baddeley, 1997; Feske & Goldstein, 1997; D. Wilson, Silver, Covi, & Foster, 1996) and single-subject (Lohr, Tolin, & Kleinknecht, 1995, 1996; Montgomery & Ayllon, 1994) studies found EMDR to yield more positive treatment effects when compared to a similar procedure without eye movements. Others found EMDR to be no more effective than modified EMDR procedures without the eye movement component (e.g., Bauman & Melnyk, 1994; Devilly, Spence & Rapee, 1998; Dunn, Schwartz, Hatfield, & Wiegele, 1996; Pitman et al., 1996; Renfrey & Spates, 1994; Sanderson & Carpenter, 1992). To date, the findings of EMDR component analyses are considered inconclusive due to methodological limitations including small sample sizes, lack of treatment fidelity, and the use of other forms of bilateral stimulation (e.g., hand taps, tones) that are accepted alternatives to eye movements in EMDR (Shapiro, 2002).

### Current Study

The current study investigated whether the eye movement component of EMDR is necessary to obtain positive treatment effects in subjects meeting the diagnostic criteria for posttraumatic stress disorder (PTSD). To meet *DSM-IV* (American Psychiatric Association, 1994) criteria for the diagnosis of PTSD, individuals must have witnessed or experienced a traumatic event that involved the threat of serious harm or death to self or others and responded with feelings of extreme fear or helplessness. In addition, individuals must reexperience the trauma through nightmares, flashbacks, or intrusive thoughts; avoidance memories, feelings, or other stimuli associated with the trauma, and emotional numbing; and increased arousal symptoms such as sleep disturbance, startle response, and hypervigilance. Symptoms must be present for at least 1 month and result in significant impairment in current functioning (American Psychiatric Association, 1994).

In the current study, the effectiveness of EMDR was compared to the effectiveness of

a modified EMDR treatment: instead of eye movements, the eyes remained in a natural state, without directed focus and without an alternative form of bilateral stimulation. Allowing the eyes to remain in a natural state was thought to control for the contribution of distraction that has been discussed as a possible mechanism of action in EMDR (e.g., Armstrong & Vaughan, 1996; Dyck, 1993) without substituting any other form of bilateral stimulation.

It was hypothesized that: (a) EMDR and the modified EMDR treatment without eye movements would show a positive combined treatment effect, when comparing results on pre (baseline) and post measures, as demonstrated by a significant decrease in PTSD symptoms, subjective distress, and greater belief in positive cognitions; and (b) that EMDR would result in a greater reduction in PTSD symptoms and subjective distress and greater belief in positive cognitions when compared to the modified EMDR treatment without eye movements.

### Design and Methodology

A single-subject alternating treatments design (Barlow & Hersen, 1984) was replicated across four subjects with PTSD. Each subject received both treatments: (a) EMDR standard protocol (Shapiro, 1995) and (b) a modified EMDR treatment in which the eyes remained in a natural state. The eye movements were isolated (the only variable manipulated) and all other EMDR components were held constant. Following baseline, both treatments were alternated every other session for each subject. Initially, six female subjects participated in the study. In an attempt to control for potential order effects, the initial treatment was selected randomly for three subjects, and the presentation of the first treatment was counterbalanced in the other three subjects. Due to subject attrition, however, this method proved ineffective and three of the four subjects who completed the study received the modified EMDR treatment as the initial treatment.

The researcher applied the treatment in both conditions to all subjects, increasing the possibility of experimenter bias. A strength of this approach included the minimization of potential inter-therapist variability that might have otherwise compromised between-subject comparisons. Efforts to minimize the possibility of experimenter bias included the use of an independent rater who was blind to the treatment conditions and to the hypotheses underlying this study. The researcher had

completed all doctoral course work in clinical psychology, held a master's degree in clinical psychology (1997), a master's degree in social work (1988), was trained in EMDR at Level I and Level II, and was a practicing clinician for 10 years at the time the study was conducted.

### Subject Eligibility

Subjects were required to be between 20 and 65 years of age and to meet *DSM-IV* criteria for the diagnosis of PTSD. They were recruited from a clinical population and screened through initial scores on dependent measures. Exclusion criteria included diagnosis of a thought disorder, obsessive-compulsive disorder, an active substance abuse problem, dissociative identity disorder, or a medical condition that might place the subject at risk.

### Measurement

The Structured Clinical Interview for *DSM-IV*, Version 2 (Mini-SCID; First, Gibbon, Williams, & Spritzer, 1995), a computerized version of the Structured Clinical Interview for *DSM-IV* (SCID; Spitzer, Williams, & Gibbon, 1987), was used to determine whether subjects met diagnostic criteria for PTSD. The Mini-SCID measures PTSD symptoms as outlined in the *DSM-IV* and is administered and scored by computer, reducing the potential of experimenter bias. Reviewers of the first edition of the Mini-SCID (Raffoul & Lyles, 1993) found it to be a good and efficient diagnostic tool for obtaining Axis I diagnoses. Raffoul and Lyles note that a limitation of the Mini-SCID is that it may provide false positives and false negatives.

The Trauma Symptom Inventory (TSI; Briere, 1995) is a 100-question self-report measure that assesses a broad range of PTSD symptoms. In a standardization sample ( $N = 828$ ), the TSI's 10 Clinical scales were found to have good reliability, ranging from .74 to .91, with a mean of .86. In a clinical sample ( $N = 370$ ), the reliability of TSI's Clinical scales ranged from .74 to .90 with a mean reliability of .87. Women with a history of sexual or physical assault showed significant elevations on Depression and Intrusive Experiences subscales. In a subset of the standardization sample ( $N = 449$ ), evaluation of convergent and discriminant validity showed the TSI's Anxious Avoidance scale correlated most with the SCL-90-R's Arousal scale; the TSI's Intrusive Experiences scale correlated best with the Intrusion scale of the Impact of Event scale and SCL; and the TSI's



Defensive Avoidance scale correlated best with the Avoidance scales of the IES and SCL (Briere, 1995).

The Impact of Event scale (IES; Horowitz, Wilner, & Alvarez, 1979) is a frequently used self-report measure with 15 questions that assess the impact of trauma, including intrusive and avoidance symptoms. The IES has good psychometric properties including the total score split-half reliability of .86; internal consistency of .78 for intrusions and .82 for avoidance; and test-retest reliability of .87 for the total score, .89 for intrusion, and .79 for avoidance.

The Symptom Checklist 90-R (SCL-90-R; Derogatis, 1992) is a 90-item self-report measure that assesses a broad range of psychological symptoms. The SCL-90-R was chosen as a reliable and valid measure of global psychological distress. In a sample of symptomatic volunteers ( $N = 219$ ), the SCL-90-R's symptom dimensions were found to have a mean reliability of .84, comprised of a mean internal consistency of .84, and a mean test-retest reliability of .84. The SCL-90-R is commonly used as an outcome measure in research and has been reported to have good convergent validity based on its correlation to other measures, including the MMPI (Derogatis, 1992).

The SUDs (Wolpe, 1982) was used to measure subjects' subjective level of disturbance on an 11-point scale in which 0 reflects no disturbance and 10 reflects the highest level of disturbance.

The VoC (Shapiro, 1995) was used to measure changes in positive cognitions on a 7-point scale in which 1 reflects no belief in the targeted positive cognition and 7 reflects complete belief in the targeted positive cognition.

#### Procedure

##### *Baseline and Posttreatment*

During an initial assessment, informed consent and brief trauma history were obtained to determine subject eligibility. Baseline measures were administered including SUDs, VoC, Mini-SCID, TSI, SCL-90, and IES. These measures were readministered following completion of the study.

##### *Treatment Phase*

Sessions were 90 minutes in length and took place once per week. SUDs and VoC ratings were taken at the beginning and end of each treatment session to account for within-session change. The treatment phase concluded when subjects reached an

optimal level of desensitization: SUDs of 0 or 1 and a VoC of 6 or 7 as established by EMDR protocol (Shapiro, 1995). The treatment phase was videotaped to increase treatment fidelity and assist with data collection. A detailed treatment manual was developed and followed closely by the researcher. Instructions for the application of EMDR were taken from Shapiro's (1995) standard protocol.

Two subjects did not complete the treatment phase and were referred to their prior therapist for alternative treatment. One of

these subjects ended treatment abruptly following a death in her family. The second subject chose to discontinue participation in the study and return to her previous clinician due to experiencing a heightened level of distress.

#### Subjects

Subject 1 was a 38-year-old Caucasian female. She had experienced multiple traumas, including repetitive sexual abuse as an adolescent, sexual assault as an adult, and trauma related to the losses of loved ones.

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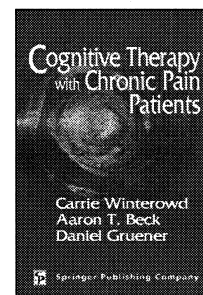
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Table 1  
Baseline (Pre) and Posttreatment Results

Measures	Subject 1		Subject 2		Subject 3		Subject 4	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Mini SCID	PTSD	No PTSD	PTSD	No PTSD	PTSD	No PTSD	PTSD	No PTSD
TSI	633*	471	605*	478	602*	436	586*	533*
SCL-90-R	73*	61	68*	60	69*	50	73*	69*
GSI								
IES	22*	2	37*	0	27*	3	33*	4
SUDs	8	0	8	0	7	1	7	0
VoC	2	6	2	7	5	7	3	7

Note.  $N = 4$ . Mini SCID = The Structured Clinical Interview for DSM-IV, Version 2; TSI = Trauma Symptom Inventory; SCL-90-R GSI = Symptom Checklist 90-R, Global Severity Index, > 63 indicates clinical range; IES = Impact of Event Scale; SUDs = Subjective Units of Disturbance scale; VoC = The Validity of Cognition Scale; \* indicates clinically significant range.

Table 2  
Subjective Units of Distress\* ( $N = 4$ )

	Subject 1	Subject 2	Subject 3	Subject 4	Mean
Baseline	8.0	8.0	7.0	10.0	8.25
EMDR	1.7	2.3	2.5	0.0	1.6
Without Eyes	5.7	1.0	4.5	1.5	3.2

Note. Table presents mean results.  
\* $t = 9.79$ ,  $p = .002$ .

Table 3  
Validity of Cognition\* ( $N = 4$ )

	Subject 1	Subject 2	Subject 3	Subject 4	Mean
Baseline	3.0	2.0	3.0	2.0	2.5
EMDR	5.0	5.3	6.5	6.0	5.7
Without Eyes	4.0	6.0	5.5	6.0	5.4

Note. Table presents mean results.  
\* $t = -8.88$ ,  $p = .003$ .

Table 4  
Impact of Event Scale\*<sup>a</sup> ( $N = 4$ )

	Subject 1	Subject 2	Subject 3	Subject 4	Mean
Baseline	28*	35*	35*	33*	32.8
EMDR	14.6	7.0	3.0	26.5	12.8
Without Eyes	13.3	8.5	9.0	7.0	9.5

Note. Table presents mean results.  
\* $t = 15.75$ ,  $p = .001$ . <sup>a</sup>IES ranges: 0-8 Subclinical, 9-25 Mild, 26-43 Moderate, 44 + Severe (Horowitz et al., 1979).

Table 5  
Pre and Post Within and Between Treatment Results ( $N = 4$ )

Measures	Baseline	Posttreatment	$t$ score	$p$ value
		(B + C)		
SUDs	8.25	.25	9.79	.002**
VoC	2.5	6.75	8.88	.003**

Note. \*\*significance at the .01 level; \*\*\*significance at the .001 level.

(continued from p. 81)

Her treatment history included 1 year of psychotherapy for depression a few years before the study and five sessions of supportive psychotherapy just prior to inclusion in the study.

Subject 2 was a 58-year-old Caucasian female who immigrated to the United States as a young adult. She had experienced multiple traumas, including early war memories, domestic violence, adult sexual assault, and a serious car accident. Subject 2 reported experiencing a depressed mood, hypervigilance, startle response, sleep disturbance, and intrusive thoughts of the trauma resulting in heightened anxiety and panic symptoms. Her treatment history included 2 years of psychotherapy for depression a few years before the study and six sessions of cognitive-behavioral therapy just prior to inclusion in the study.

Subject 3 was a 34-year-old Caucasian female. She reported experiencing repeated childhood sexual abuse by a family member. Her treatment history included 4 months of counseling as an adolescent following disclosure of the sexual abuse. She also attended 4 months of family counseling a few years before the study. During the initial assessment, Subject 3 reported experiencing sleep disturbance, reexperiencing symptoms, hypervigilance, startle response, avoidance of reminders of the trauma, and sexual difficulties.

Subject 4 was a 38-year-old, Caucasian female. She reported experiencing multiple traumas, including repetitive sexual abuse, a serious car accident as an adult, sexual assault as an adult, and her purse stolen at gunpoint. Her treatment history included receiving 18 months of supportive psychotherapy before inclusion in the study. Subject 4 reported that she experienced intrusive thoughts, hypervigilance, startle response, sleep disturbance, and relational difficulties.

## Traumas Targeted During Treatment

During assessment, subjects ranked their traumatic experiences from most disturbing to least disturbing. Subjects chose their most disturbing traumatic memory, related affect, and cognitions as the target of treatment. Subjects 1, 3, and 4 chose to target memories of sexual abuse, and while she had also experienced sexual trauma, Subject 4 chose a traumatic memory of surviving a bombing when she was a child.

## Results

### Baseline and Posttreatment

Four Caucasian female subjects who participated in these replicated studies met *DSM-IV* criteria for PTSD baseline per the Mini-SCID. Following completion of treatment, all four subjects no longer met criteria for the diagnosis of PTSD on the Mini-SCID.

At baseline, subjects reported trauma-related symptoms that fell within the clinical range on the IES and TSI, and global symptoms that fell within a clinical range on the SCL-90-R. At baseline, Subject 1's scores on the TSI fell within the clinical range on 6 of the 10 subscales (Anxious Arousal, Depression, Anger/Irritability, Dissociation, Sexual Concerns, and Impaired Self Reference): none were in the clinical range at posttesting. Subject 2's scores on the TSI fell within the clinical range on five subscales (Anxious Arousal, Depression, Intrusive Experiences, Defensive Avoidance, and Dissociation): none were in the clinical range at posttesting. At baseline, Subject 3's scores on the TSI fell within the clinical range on two subscales (Sexual Concerns and Impaired Self Reference): none were in the clinical range at posttesting. Subject 4's scores were in the clinical range on three TSI subscales at baseline (Anxious Avoidance, Dissociation, and Impaired Self Reference): the Dissociation subscale remained elevated at posttesting.

On the SCL-90-R, baseline GSI scores fell within the clinical range for all four subjects. At posttesting, Subjects 1, 2, and 3's SCL-90-R GSI scores no longer fell within the clinical range, while Subject 4's scores remained in the clinical range (see Table 1).

While Subject 4 continued to present with a clinically significant level of global distress and dissociative symptoms at the time of posttest, her overall symptom presentation did not appear to meet criteria for the diagnosis of PTSD based on her decreased level of subjective distress and reduction in avoidance and intrusion

symptoms as measured by the IES. These findings suggest a positive combined treatment effect of EMDR and the comparison treatment without eye movements across all four subjects (see Table 1).

### Within-Session Results

The *t* test for paired samples was used to determine if differences between treatments reached statistical significance at the .05 level.

*SUDs.* Subjects showed significant improvement on the SUDs from baseline to posttreatment ( $t = 9.79, df = 3, p = .002$ ). Subjects showed significant improvement in SUDs level following both EMDR ( $t = 5.572, df = 3, p = .011$ ) and the without-eye-movements treatment ( $t = 3.241, df = 3, p = .048$ ). There was no statistical difference in subjective distress between treatments.

*Validity of cognitions.* Subjects showed increased acceptance of positive cognitions during both EMDR and the comparison treatment as measured by the VoC. Subjects showed significant improvement in VoC level from pre- (baseline) to posttreatment ( $B + C$ ) ( $t = -8.88, df = 3, p = .003$ ). Subjects showed significant improvement in VoC level following both EMDR ( $t = -7.51, df = 3, p = .005$ ) and the without-eye-movements treatment ( $t = -4.004, df = 3, p = .03$ ). There was no statistical difference in belief in validity of cognitions between treatments.

### Between-Session Results

*IES.* Subjects completed the IES the week following each treatment and before the administration of the alternative treatment. This method was utilized to account for between-session changes. Subjects showed significant decreases in trauma-related symptomatology (avoidance and intrusions) from baseline to posttreatment ( $t = 15.75, df = 3, p = .001$ ). Subjects showed significant decreases in trauma-related symptomatology both following EMDR ( $t = 3.322, df = 3, p = .045$ ) and the without-eye-movements treatment ( $t = 8.121, df = 3, p = .004$ ). There was no statistical difference in trauma-related symptomatology (avoidance and intrusions) between treatments.

## Discussion

This study attempted to determine whether the eye movement component of EMDR was necessary to account for positive treatment effects in subjects with PTSD. A single-subject alternating treat-

ments design was replicated across four subjects to compare the effectiveness of EMDR with the effectiveness of a modified EMDR procedure in which the eyes remained in a natural state. The comparative procedure was chosen to eliminate the contribution of distraction and the addition of any other form of bilateral stimulation.

The first hypothesis was supported. Subjects showed statistically significant pre- (baseline) to posttreatment improvement following EMDR and the modified EMDR procedure (without eye movements). These findings show a combined positive treatment effect ( $B + C$ ) as measured by the SUDs and VoC (within sessions), IES (between sessions), and Mini-SCID, TSI, and SCL-90-R (pre-post).

The second hypothesis was not supported. While subjects significantly improved following both EMDR and the modified, without-eye-movements EMDR procedure, there were no statistically significant differences between treatments on within- or between-session measures. Instead, both treatments were found to be effective in reducing trauma and global symptoms in the four female subjects who participated in the study. While these findings support others (Bauman & Melnyk, 1994; Devilly et al., 1998; Feske & Goldstein, 1997; Pitman et al., 1996; Renfrey & Spates, 1994) that suggest eye movements in EMDR may not be necessary for positive treatment effects, they additionally suggest that an alternate form of bilateral stimulation may not be needed to obtain equivalent positive EMDR effects.

A limitation of the present study is that the researcher was the clinician who administered both treatment conditions, suggesting the potential for experimenter bias. Utilizing the same clinician across treatments may result in more consistency across treatment applications, making it more likely that the only variable manipulated is the eye movement component. In an attempt to minimize the potential for experimenter bias, an independent rater was used to administer and score all pre-post measures, except the computer-scored Mini-SCID. The possibility of expectancy effects was minimized as EMDR was not shown to be more effective than the modified EMDR procedure without eye movements, in contrast to the second hypothesis. Efforts to counterbalance the initial treatment across subjects were unsuccessful due to subject attrition, increasing the possibility of order effects. The possibility of order effects, however, is considered minimal since subjects improved following both treatments.

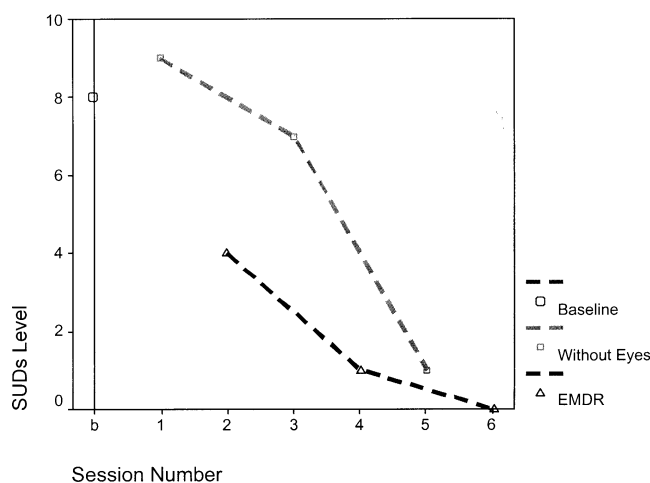


FIG. 1. SUDs scores for Subject 1.

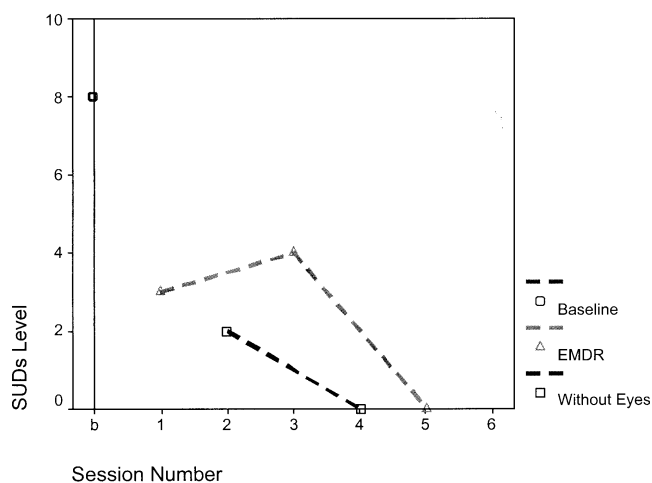


FIG. 2. SUDs scores for Subject 2.

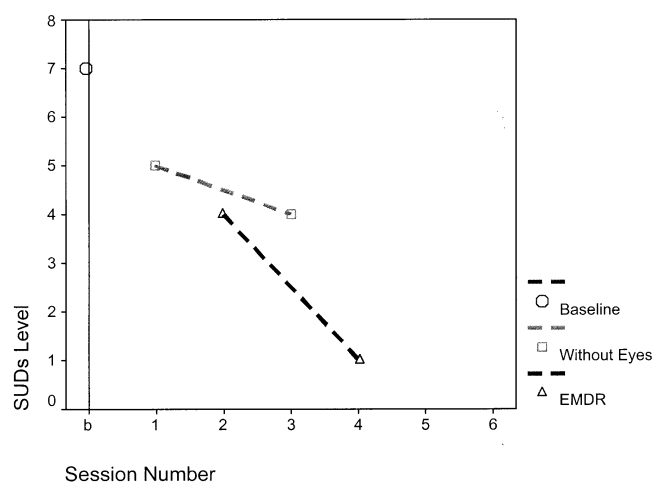


FIG. 3. SUDs scores for Subject 3.

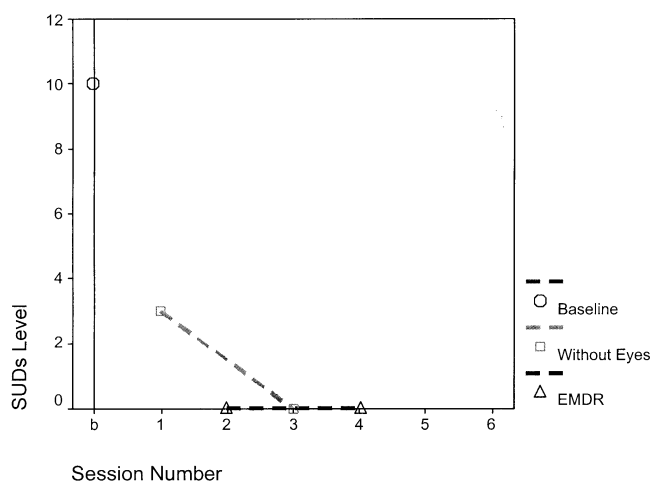


FIG. 4. SUDs scores for Subject 4.

Another limitation is that the measures used in this study relied on self-report, thus raising the possibility of biased responding. A strength of the present study is that the comparison treatment was identical to EMDR in all aspects, with the exception of the eye movement component. Subjects maintained their eyes in a natural state, eliminating the contribution of distraction, set focus, or any other form of bilateral stimulation. In addition, the current study met three of five of Shapiro's (2002) guidelines for EMDR component research, including that subjects met the diagnosis of PTSD; the study was controlled given that each subject during the baseline phase acted as their own control; and treatment fidelity was increased due to the close following of a treatment manual. Guidelines that were not followed included the inclusion of a large sample size and the utilization of sub-

jects who experienced multiple traumas. In an effort to address the latter limitation, one trauma was targeted for treatment across all subjects. Given the small sample size, it is recommended that the findings of this study be considered preliminary.

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**POSTDOCTORAL FELLOWSHIPS.** The Institute for Children at Risk at the NYU Child Study Center invites applications for two postdoctoral research fellowships beginning July 2004. A two-year commitment is required. The successful candidates will work with a team of investigators directed by Laurie Miller Brotman, Ph.D., on one of two federally funded prevention trials with parents and preschoolers. Please send your curriculum vitae and letter describing relevant experience and education to: Kathleen Kiely Gouley, Ph.D., Associate Director, Institute for Children at Risk, NYU Child Study Center, 577 First Ave. CSC 207, New York, NY 10016. [Kathleen.Gouley@med.nyu.edu](mailto:Kathleen.Gouley@med.nyu.edu)  
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Dr. Daniel S. Kirschenbaum is Clinical Director of Healthy Living Academies and a professor at Northwestern University Medical School. He has developed several very successful weight loss programs at hospitals and has authored over 100 journal articles and eight books, including *Treatment of Childhood and Adolescent Obesity* and *The 9 Truths About Weight Loss*.



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