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EYE MOVEMENT DESENSITIZATION OF MEDICAL PHOBIAS: TWO CASE STUDIES

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Summary — We treated two medical phobic subjects with eye movement desensitization (EMD). Using detailed images of fear-related events, the treatment design conformed to an additive, within-series phase change to examine enduring effects. Results indicated that both subjects' verbal reports of fear decreased substantially using the EMD procedure. There were no consistent changes in heart rate. Similarly, self-reported fear toward a simulated blood draw decreased, but heart rate and blood pressure did not. Data for a number of standardized measures of medical fear indicated posttreatment reduction for both subjects. Anecdotal reports of medical procedures revealed limited generalization of treatment effects.

Since the first published account (Shapiro, 1989a), eye movement desensitization has generated substantial clinical and professional interest (Baer, Hurley, Minichiello, Ott, Penzel & Ricciardi, 1992; Denicola, 1992; Lipke, 1992; Rosen, 1992; Shapiro, 1992a). At the same time, however, three methodological reviews (Acierno, Hersen, Van Hasselt, Tremont, & Meuser, 1994; Herbert & Meuser, 1992; Lohr, Kleinknecht, Conley, Dal Cerro, Schmidt, & Sonntag, 1992) have concluded that empirical support for its efficacy is meager. Despite these cautions, the range of disorders to which EMD has been clinically applied has expanded beyond post traumatic stress disorder to include other disorders of anxiety (Marquis, 1991; McCann, 1992; Pellicer, 1993; Wernik, 1993), depression (Marquis, 1991; Puk, 1991), sexual dysfunctions (Wernik, 1993), pain, chemical dependency, and AIDS symptoms (EMDR Newsletter, 1993).

While improved controlled experiments have

followed the original study (Shapiro, 1989), they have demonstrated limited and inconsistent effects of the technique. Boudewyns, Stwertka, Hyer, Albrecht, and Sperr (1993) randomly assigned combat related PTSD patients to one of three groups: EMD, exposure control or milieu only control group. Results indicated that posttreatment SUD ratings were lowest for the EMD group, and therapist ratings of treatment responders vs. nonresponders significantly favored the EMD group. However, the standardized measures of PTSD showed no differential effect of treatment, and physiological measures were unaffected by any treatment.

A more direct test of EMD treatment outcome for PTSD was conducted by Jensen (1994) who randomly assigned Veterans hospital patients to either an EMD group or a milieu treatment group. Analysis of SUD ratings replicated the findings of Boudewyns et al. (1993) showing lower ratings in the EMD group. However, the analysis also

showed no differences on standardized measures of PTSD or attainment of treatment goals. The results of these two studies indicate that the effect of EMD on SUD ratings does not extend to other measures.

In the first single-subject experiment investigating the effect of EMD on PTSD, R. W. Montgomery & Ayllon (1994) used a multiple baseline design to treat separate traumatic images of a near fatal automobile accident and a sexual assault at knife point. Visual inspection of the (A-B) phase-change on each image revealed parallel reductions in SUD ratings, heart rate, and systolic blood pressure during the EMD phase. Comparisons between images revealed that the effects of treatment of the first image did not generalize to the second image. A similar study using a multiple baseline across images (Acierno, Tremont, Last, & D. Montgomery, 1994) failed to show any within or between phase differences on behavioral, physiologic or cognitive assessment domains.

A second study (R. W. Montgomery & Ayllon, in press) used a multiple baseline across six individuals diagnosed with PTSD. Data were collected from three pairs of individuals treated in tandem. The within-series treatment phases were designed to assess the effect of adding components of the EMD procedure. Subjects were exposed during the baseline phase (A) to traumatic imagery with the accompanying negative cognition, SUD ratings were obtained, and positive cognitions were constructed. In the first intervention (B) phase, the standard orientation instructions for EMD were added to the baseline content. In the second intervention phase, eye movements were added to provide the complete EMD procedure (B+C).

In contrast to the first study, there were no statistically significant changes in heart rate or blood pressure across the different phases of the experiment. SUD ratings showed a statistically significant effect for repeated assessment, but not between treatment phases. Visual inspection of SUD ratings revealed little change across additive treatment phases. One subject showed no change, three showed equivocal change, and only two showed distinct change in magnitude and slope.

Other measures, including intrusive thoughts and trauma-related dreams, were examined across the phases of treatment. A *t*-test compared the A and B phases with the B+C and follow-up phases and showed lower ratings during and after the EMD treatment. However, the most critical comparisons between the B and the B+C phases showed no significant differences on any dependent variable. Thus, the specific effect of EMD on thoughts and dreams was not supported.

While the effect of EMD on PTSD must be interpreted with caution, it is reasonable to expect clinical extensions to disorders which share etiologic and symptomatic features, such as traumatically induced phobia. The acquisition process may involve pain and intense emotional distress which can serve as unconditioned stimuli for avoidance and negative affective imagery. The treatment effect of EMD may function to alter the affective content of pain reactivity. For example, a recent analogue study (Hekmat, Groth, & Rogers, 1994) has suggested that components of the EMD procedure are effective in managing cold pressor pain. This effect is consistent with analyses by Dyck (1993) and Burnette, Baranyai, and Spates (1994) who suggest that EMD may be mediated by conditioning and/or relaxation processes.

No other phobia has more potential for life-threatening consequences than that associated with blood, injections and other primary medical treatments. Moreover, Kleinknecht (in press) reports that a large proportion of individuals with medical fear report an incident wherein pain or emotional distress precipitated or greatly increased the phobic reaction. Because of these considerations, Ost and his colleagues (Ost, 1989; Ost, Hellstrom, & Kaver, 1992; Ost & Hugdahl, 1985) have developed an *in vivo* re-exposure protocol which effectively treats 80% of needle phobics in one 3-hour period (Ost et al., 1992). While efficient in terms of treatment time, the procedure requires that therapists administer injections or blood draws. A time-efficient treatment that did not require the application of invasive procedures would be more practical for the psychological practitioner. It appears that EMD may be one such procedure.

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