A comparative traumatherapy study:

EMDR versus Brainspotting

- Study Design -

by

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1 Introduction

The aim of this study is compare the efficacy of a newly developed therapeutic procedure called Brainspotting with the established EMDR-therapy. Participants who had experienced a traumatic situation and/or are suffering from PTSD or an acute stress syndrome will be treated either with Brainspotting or with EMDR. After three therapy sessions, the outcome of the two procedures will be compared. All therapists involved are experienced trauma therapists who have completed an EMDR training as well as a Brainspotting training (Phase I). The treatment efficacy will be evaluated one week after the last therapy session and at a follow-up assessment (6-months after the last therapy session).

2 Method

2.1 Treatment Conditions

2.1.1 Treatment Procedure: EMDR

Eye Movement Desensitization and Reprocessing (EMDR) was developed by Francine Shapiro (2001). It is a well-established therapy for the treatment of post traumatic stress disorders or other trauma associated diseases. EMDR (Schubbe, 2006) consists of eight phases, from which phases three to six are original EMDR stages. After establishing a good therapist-client relationship and after the introduction of relaxation techniques or other stabilisation techniques, the client is asked to reexperience the traumatic situation while focusing on the therapist’s finger tips which are moving on a horizontal axis in front of his or her eyes. In a safe environment and as part of a good therapeutic relationship, the client relives the traumatic situation and reprocesses the feelings, emotions, cognitions and body sensations connected to the trauma. EMDR is recognized as an efficient therapy in treating PTSD as recommended by the International Society for Traumatic Stress Studies (ISTSS). The efficiency of EMDR was shown in a meta-analytic study by Van Etten & Taylor (1998).

2.1.2 Treatment Procedure: Brainspotting
Brainspotting™ is developed by David Grand (Grand, 2008). It identifies and heals core neurophysiological sources of psychological and body pain, conflict and symptomatology. By slow eye tracking, either with one eye or with two eyes, locations for Brainspotting are identified. To find these locations, the techniques of either “inside window” or “outside window” can be used. The „inside window“ utilizes the client’s felt sense, the „outside window“ helps to locate this location by observation of clients’ reflexive response such as blinks, eye twitches or wobbles, pupil dilation, quick inhalation by the therapist. Additionally, the effects of Brainspotting™ is improved by bilateral sound stimulation.

Brainspotting™ is a powerful, focused treatment method that works by identifying, processing and releasing core neurophysiological sources of emotional/body pain, trauma, dissociation and a variety of other challenging symptoms. Brainspotting is a simultaneous form of diagnosis and treatment, enhanced with Biolateral sound, which is deep, direct, and powerful yet focused and containing. Brainspotting functions as a neurobiological tool to support the clinical healing relationship. There is no replacement for a mature, nurturing therapeutic presence and the ability to engage another suffering human in a safe and trusting relationship where they feel heard, accepted, and understood. Brainspotting gives us a tool, within this clinical relationship, to neurobiologically locate, focus, process, and release experiences and symptoms that are typically out of reach of the conscious mind and its cognitive and language capacity. Brainspotting works with the deep brain and the body through its direct access to the autonomic and limbic systems within the body’s central nervous system. Brainspotting is accordingly a physiological tool/treatment which has profound psychological, emotional, and physical consequences.

The treatment group received three individual treatment sessions of Brainspotting™ using a standardized protocol with “two eyes”, the “inner window” and “additional bilateral stimulation” (BioLateral Sound Recordings). The first session lasts 90 minutes (= 30 min pretest, 60 min treatment), the second lasts 60 minutes (= 60 min treatment) and the third session lasts 90 minutes (= 60 min treatment, 30 min posttest).

2.1.3 Participants and Procedure

There will be three assessments: The first assessment (pretest assessment) will take place at the beginning of the treatment, the posttest assessment will take place one week after the last
therapy session. And there will be a six months follow-up assessment. This evaluation study is a multi-site study. Therapists in the USA, Israel, Argentina and Germany will be involved in the evaluation study. All therapists need to be licensed therapists and fully educated in EMDR through an accredited training facility. And they must have completed the Phase I training in Brainspotting by David Grand. All clients need to be eighteen or older and must have had experienced a traumatic situation and/or are now suffering from acute stress disorder or PTSD. Each therapist treats an equal number of clients with Brainspotting and with EMDR.

At least three therapy sessions need to be administered to each client. If after the first session the SUD-level is zero, two additional enhancing sessions are needed. Written consent needs to be obtained from all participants.

### 2.2 Assessment Instruments

#### 2.2.1 Posttraumatic Diagnostic Scale (PDS)

The Posttraumatic Diagnostic Scale (PDS; Foa, 1995) was designed as a self-report questionnaire based on which it is possible to yield a diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000). The PDS consists of four parts. Part 1 and 2 encompass the type, time, and circumstances of the most traumatic experience. In addition, the client needs to specify the reactions to the traumatic event (e.g., helplessness, horror, mortal danger). This information is needed for Criterion A of the DSM-IV-TR. Part 3 of the PDS assesses information regarding the three symptom clusters of intrusion, avoidance, and hyperarousal, needed for criteria B, C, and D of the DSM-IV-TR. Every item is rated on a four-point scale ranging from 0 = never to 3 = daily. All items of part 3 refer to a 1-month period prior to the assessment. The English (Foa et al., 1997) and German (Ehlers et al., 1996) versions of the PDS revealed satisfactorily internal consistencies for the three scales: intrusion $\alpha = .78/.90$ (English/German); avoidance $\alpha = .84/.89$ (English/German), and hyperarousal $\alpha = .84/.89$ (English/German). This questionnaire is filled in by the patients at the pre- and posttest and follow-up assessment.
2.2.2 Hospital Anxiety and Depression Scale (HADS)

Besides the PDS, the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) is the second primary outcome measure. It is generally used in non-psychiatric populations (Herrmann, 1997), but it has also been used in clinical settings where anxiety and depression can co-occur with physical pathology (Barczak et al., 1988). It is a short self-report questionnaire with 14 items. Seven items belong to the subscale anxiety (HADS-A) and seven to the subscale depression (HADS-D). Thus this questionnaire consists of two distinct dimensions. Answers can be given on a four-point scale (e.g. “not at all”, “sometimes”, “very often”, “nearly all the time”). It has demonstrated good internal consistency with Cronbach alpha values ranging from .68 to .93 for HADS-A, and from .67 to .90 for HADS-D (Bjelland, Dahl, Tangen Haug & Neckelmann, 2002, in Woolrich, Kennedy, & Tasiemski, 2006, p. 81). Quintana et al. (2003) demonstrated that test-retest reliability of the HADS is good (r = .85). Patients will fill in the HADS in the pre- and posttest assessment and at the follow-up assessment.

2.2.3 Clinical Global Impressions (CGI)

The Clinical Global Impression (CGI) is used to assess treatment response in psychiatric patients. Usually it is a three-item scale which asks for Severity of Illness, Global Improvement and an efficacy index. For this study, only the first item will be used. With regard to Global Improvement, the clinician appraises how much the patient’s illness has improved or worsened relative to a baseline state. It is rated on a seven-point scale with 1 = very much improved to 7 = very much worse.

The Severity of Illness item requires the clinician to rate the severity of the patient's illness at the time of assessment, relative to the clinician's past experience with patients who have the same diagnosis. Considering total clinical experience, a patient is assessed on severity of mental illness at the time of rating according to: normal (not at all ill); borderline mentally ill; mildly ill; moderately ill; markedly ill; severely ill; or extremely ill (Guy & Bonato, 1970). This item is only used at the posttest and follow-up assessment.
2.2.4 **Subjective Unit of Disturbing Scale (SUDS)**

The Subjective Unit of Disturbance Scale (SUDS) was used as an in-session process measure. It was developed by the behavioral psychologist Joseph Wolpe in 1958. “It asks the patient to pair the target image with the negative cognition and then observe whatever feelings are elicited” (Grand, 2003, p.31). In other words, the client states his or her level of emotional disturbance associated with a specific traumatic experience (Edmond, Rubin, & Wambach, 1999). Wolpe's scale is a continuum from 0 (no disturbance) to 10 (highest disturbance) on which the patients can assess their intensity of subjective distress (Wolpe, 1958). There is only less literature available about the validity and reliability of the SUDS (Edmond, Rubin, & Wambach, 1999). The SUDS will be administered and recorded at the beginning of the first session and the end of each treatment session.

2.2.5 **Health Records/ Personal Information**

The following data will be obtained in terms of questionnaires: Sex, date of birth, marital status, and race/ethnic description (client information).
3 References


