The CLINICIAN

Spring 1997 Vol. 28 No. 2

The Newsletter of the New York State Society for Clinical Social Work, Inc.

Eye Movement Desensitization And Reprocessing Explored

Four views of a somewhat controversial treatment

EMDR: TRICK OR TREATMENT

By: David Grand, RCSW, BCD

Eye Movement Desensitization and Reprocessing (EMDR) has been characterized in many ways: as an advance or hocus pocus, a healing therapy or hype.

As a trained EMDR therapist and facilitator (hands on teacher of the method) who has treated hundreds with this approach, my bias is clearly pro-EMDR. However, skepticism is not only acceptable but necessary and appropriate for those first encountering this unusual treatment modality. A serious clinician should also be a scientist, demanding hard evidence and extensive first-hand experience before accepting any new approach.

First, it is useful to understand how EMDR was discovered and developed. In 1987 Francine Shapiro, a psychologist in California, was strolling through a park wrestling with distressing thoughts when suddenly she realized that her associated negative affect had disappeared. She recalled that her eyes had been darting around when the emotional transformation occurred. She focused on other troubling memories and shifted her eyes back and forth, with the same

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SOCIAL WORK PROFESSION AGREES ON LICENSING BILL

by Marsha Wineburgh, MSW, BCD, Licensing Chair

Four months after the dissolution of the licensing coalition, the leadership of the social work profession in New York State reconvened and essentially approved a final version of our scope of practice legislation. Signing off in agreement after nearly six years of continuous effort are the Clinical Society, the City and State Chapters of NASW, the Association of Deans of Social Work Schools, the Hospital Social Work Administrators and Directors and the New York State Social Work Education Association.

This bill will license the entire profession on the "MSW-no experience level," the present "certified social worker" or CSW level. The BSWs are prohibited from practicing in those areas for which they have no education. Most important for Clinical Society members is the practice definition. It says in part:

Social Work practice includes but is not limited to: biopsychosocial assessment, differential diagnosis, testing and measurement of psychosocial functioning, development of social service plans and interventions, treatment planning, crises intervention, short-term and long-term psychotherapeutic treatment; social work outreach, case management and supportive interventions; social work discharge, referral and continuity of care planning; social work consultation and supervision; social group work; and community organization.

The scope of practice describes all services and functions which social workers provide in accordance with their education and training. Three titles reflect the different practice levels: "Licensed Baccalaureate Social Worker" (LBSW), "Licensed Masters Social Worker"(LMSW, aka CSW) and "Licensed Clinical Social Worker"(LCSW). The LBSWs must practice in a public, not-for-profit or proprietary incorporated entity under the continuous supervision of a LMSW. They are further restricted from providing the following services: differential diagnosis, tests and measurements of psychosocial functioning and short-term and long-term psychotherapeutic treatment. The distinction between a LMSW and LCSW is three years of full-time, supervised experience providing direct (face-to-face) services to individuals, couples, families and/or groups.

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Once again, I am writing to you on my return from Washington, DC, where I was installed in the National Academies of Practice, along with two other prominant New York social workers - Miriam Pierce and Roberta Graziano. Both are leading practitioners, teachers and activists. Other leaders in social work installed this year were Chad Breckenridge, Past President of the Federation; Maurie Cullen, managed-care expert; Irmgard Wessel, Education Chair of the Federation; Maria Tupper, current candidate for the Vice-President of Professional Development of the Federation; and finally, Marga Speicher and Nancy W. Veeder, both researchers, teachers and activists. Each of us was given a medal and installed by Betty Jean Symar, Co-Chair of the Academy, with Golnar Simpson, President-Elect of the Federation at a lovely black-tie ceremony.

The National Academies of Practice consists of nine groups in the health care professions and each Academy is limited to a 100 members. The groups include medicine, dentistry, podiatry, osteopathy, psychology, social work, nursing, veterinary and optometry. Their mission statement reads, "The National Academies of Practice is dedicated to quality health for all, by serving as the nation's distinguished interdisciplinary policy forum that addresses public policy, education, research and inquiry."

The focus of this year's work for the Academies is to put prevention into practice. The social work and psychology sections of the Academy resolved to work hard, hand-in-hand, to promote awareness of the role of mental health treatment in prevention of physical illness. Several psychologists whom I met during the installation ceremonies are interested in promoting medical savings accounts and single payer legislation.

In another week, I will be back in Washington again at our National Federation Meetings. We will be visiting legislators, asking them to sponsor Representative Norwood's bill to regulate managed care. It promises to be another exciting chance to make a national difference.

VIRGINIA CASE SETTLED

CAN CLINICAL SOCIAL WORKERS DIAGNOSE AND TREAT?

by Marsha Wineburgh, MSW, BCD, Licensing Chair, NYSSCSW

With the generous support of the NYS Clinical Society, the National Federation, ABE Board and the National Membership Committee on Psychoanalysis filed an amicus ("friend of the court") brief with the Fourth Circuit U.S. Court of Appeals in Richmond, Virginia. The brief explained that clinical social workers are well qualified by training and experience to diagnose and treat mental and nervous disorders, including "post traumatic stress disorder" (PTSD).

The case began when Teresa Hensler quit her job at the O'Sullivan Corporation. She stated in her resignation letter that, although she had initially enjoyed her employment, the work environment had deteriorated and in the end she sued for sexual harassment. Further, she claimed she had suffered serious emotional distress.

Ms. Hensler offered the testimony of her psychotherapist, a clinical social worker who was treating her for PTSD. The trial judge refused to allow the clinical social worker to testify, despite the fact she was licensed, experienced and well-credentialed. He ruled that licensed clinical social workers are not qualified to "render a diagnosis of a medical condition," or to testify whether Ms. Hensler's condition was caused by sexual harassment on the job. In the trial judge's view, these were "medical opinions" which a clinical social worker is not qualified to render.

Ultimately, the trial judge dismissed Ms. Hensler's case for lack of proof and Ms. Hensler appealed. At this juncture, the amicus brief was filed. Before the appeal was scheduled to be argued, Ms. Hensler settled with her employer and the case was dismissed. As noted by Ken Adams, our national advocate, "next to a reversal by the Court of Appeals on this specific ground, this is the best possible outcome, as it avoids the risk of a bad precedent."

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC.

The Clinician is published three times each year by
The New York State Society for Clinical Social Work, Inc.
Society Phone: 1 (800) 288-4279.
Editorial Office: 21 East 22nd Street,
New York, NY 10010. (212) 533-7381.
Editor: Ivy Miller.
Society Editorial Consultants:
CSWs Sheila Peck, Lesley Post and Carolyn Colwell.
Deadlines: January 10, April 5 & September 1.

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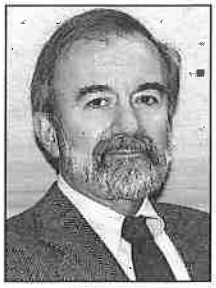
New Diplomates Are Chosen

Sharon Kern-Taub, C.S.W.
Membership Committee Chair

The State Society has conferred Diplomate status on six members and will award their certificates at the annual conference on May 17th. The honorees were selected by the Society's State Board of Directors for their sustained commitment and distinguished contributions to the field of clinical social work.

Barbara Feld

Alice Medine King



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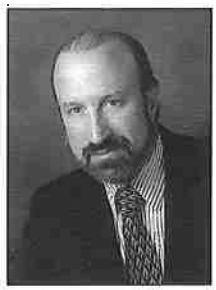

Richard Alperin

Barbara G. Feld, CSW, BCD, of Manhattan, became a fellow of the Society in 1990 and has been in committee and state board leadership since 1992. In full-time private practice with individuals, families and groups since 1975, she began her career as a caseworker at Montefiore Hospital,.and later became head of the Family Therapy Unit of the Department of Psychiatry. From 1992-94 she helped build the State Committee on Group Practice and headed a similar committee in the Met chapter. As chair of the State Family Practice Committee, in addition to helping launch chapter study groups, she planned a yearly panel for the State conference. Ms. Feld also has been chair of the Met's Group Practice and Family Practice committees and on the chapter board. She provides leadership in discussions on such topics as alcoholism, domestic violence, eating disorders, gender issues, lesbian couples, the good marriage, systems /structural approaches and object relations.

Alice Medine King, CCSW, RCSW, BCD, of Great Neck, has been in full-time private practice since 1977 and active in supervision, administration and organizational work for some 30 years. A practitioner of psychoanalytical developmental psychotherapy, for many years she has played a significant role nationally as an advocate for mental health in the reform movement to minimize the negative impact of managed care. Ms. King was chair of the Legislative Committee of the National Federation from 1992 to 1995, and, concurrently, legislative chair of the Psychoanalytic Consortium and of the Coalition for Mental Health Professionals and Consumers, which she helped to found. In 1995 she was inducted into the National Academies of Practice. She has been a frequent presenter at local, State and national NMCOP conferences.

Fred Mazor, DSW, BCD, president of the Met chapter, has been in private practice in Manhattan since 1970, working with children and adults individually, in couples, families and groups. A Society fellow since 1969, he was chair of the Membership Committee, member-at-large of the State Board and workshop leader on computer use, among other activities. At the chapter level, he has been photographer and advertising manager of the *Met Chapter Forum*, expanding the newsletter's ad base to make the publication almost self-supporting.

Judith M. Weiss, CSW, BCD, President of the Staten Island Chapter for three terms, has increased membership, participation and visibility of the chapter. She also has pioneered unionization of independent practitioners and is on the committee to explore the creation of a referral service. She trained at the National Psychological Association for Psychanalysis and, starting in 1980, provided therapy, supervised and consulted with psychiatrists at Staten Island University Hospital. She is in full time private practice on Staten Island and in Manhattan, focusing on individuals, couples, and family psychotherapy.

Fran J. Levy, Ed.D., BCD, of Brooklyn (a member of the Staten Island chapter), has been in private practice since 1973 as a psychotherapist and a dance movement/creative arts psychotherapist. Her doctoral dissertation was published as a book in 1988 and reprinted recently as *Multimodal Psychotherapy* . It is considered the leading textbook in the field. Another book, *Dance and Other Expressive Art Therapies: When words are not enough*, is also used as a text here and abroad. A pioneer in the use of art as a tool for CSWs, she has made several presentations at Society conferences. Since 1972, she has conducted training workshops for the American Society for Group Psychotherapy and Psychodrama and the American Dance Therapy Association. An adjunct professor at Hofstra University, she has travelled worldwide as a keynote speaker at conferences on Multimodal Psychotherapy.

Richard M. Alperin, DSW, BCD, in full time private practice since 1977, focuses on individual, couples, group psychotherapy and psychoanalysis and supervision. From 1991 to 1996, he chaired the State Committee on Psychoanalysis, moderating panels at annual conferences and promoting peer study and supervisory groups, etc. Since 1985, Dr. Alperin has taught at the Fordham Univ. Graduate School of Social Service. He also supervises analytic candidates and teaches at the Object Relations Institute for Psychoanalysis and Psychotherapy, the N.J. Institute for Training in Psychoanalysis and the Psychoanalytic Psychotherapy Study Center. One of three social workers in Who's Who in the World, he is the author of many publications, and recently coedited a book with Dr. David Phillips, "The Impact of Managed Care on Psychotherapy: Innovation, Implementation & Controversy." He is on the National Study Group on Social Work of the NMCOP.

A Critique of the Consumer Reports Psychotherapy Survey

and Other Client Satisfaction Surveys

by Jacinta Marschke, PhD., CSWR, Research Committee Chair

Finally there is a clinical outcome study that supports long-term over short-term psychotherapy and social workers as psychotherapy providers. Published in November 1996 in Consumer Reports, it is a client satisfaction survey of 7,000 respondents, one of the largest ever conducted. Consumer's Union, the survey's sponsor, is a well-respected, not-for-profit, independent research organization. Some of the significant results are listed here:

- ***Treatment was helpful for the vast majority of respondents.***
- ***Social workers, psychologists and psychiatrists were equally effective.***
- ***Longer treatment duration was associated with better outcomes.***
- ***Psychotherapy with and without medication was equally effective.***
- ***Third party limits on treatment were associated with poorer outcomes.***
- ***All modalities of treatment produced similar outcomes.***

The timing of the publication of these results could not be better. Since the entry of managed care into the mental health field, clinicians have been asked to demonstrate "empirically" the effectiveness of their interventions. However, many well-publicized empirical research results have questioned the efficacy of most clinical interventions. Managed care companies continue to rely heavily upon client satisfaction surveys, the type used in the Consumer study, to assess the effectiveness of their enrollees' mental health care and determine whether or not to retain current mental health network providers. Are these surveys reliable?

In fact, the Consumer study suffers from weaknesses common to all such surveys. This article summarizes the study's design and results, and outlines the strengths and weaknesses of this and other client satisfaction surveys. If clinicians who practice within a managed care context are to advocate more effectively for themselves and their clients, they must understand these and other practice evaluation techniques. The author's hope is that this review will stimulate interest in advancing practice evaluation research in general.

Study Design and Results

The sponsor of the study, the Consumers Union, is a not-for-profit research group that conducts independent studies of a wide range of goods and services. The Union accepts no advertising and prohibits use of its findings in product promotion.

The psychotherapy outcome study was conducted because of widespread consumer interest and concern about the nature, quality and cost of mental health care, the proliferation of managed care companies and the increased suspicion that many individuals may not be getting the mental health services they need because of the restrictive policies of managed care companies (Gurin, 1996).

A client satisfaction survey of readers who acknowledged that they experienced and sought help for emotional problems between 1991 and 1994 was conducted as part of the much larger general annual readership survey in 1995. Seven thousand (7,000) respondents, 3.8% of the total number of annual survey respondents (n=184,000), returned the complete questionnaire, indicating they were mental health consumers. A second validation survey was then completed to determine whether this initial sample was representative of the magazine's overall readership, and researchers found that it was.

The mental health section of the annual questionnaire solicited information about the following areas: respondents' emotional state and symptoms prior to and after treatment; the quality of their functioning before and after treatment; the clinician's theoretical treatment perspective; the professional discipline of the clinician; consumer satisfaction with the clinician and treatment; the specific intervention mode (individual therapy, self-help, medical consultation); the duration and frequency of the treatment; the nature of HMO involvement and the rationale for termination.

To analyze the data, the investigators established a multivariate measure consisting of three composite subscales for each subject, including a measure on symptom/problem improvement, overall treatment satisfaction and improvement in overall functioning. The scores on each of the scales were then "transformed" and weighted equally to arrive at a final summary score ranging from 1-300 for each subject. Regression analysis was used to determine whether there were relationships among the outcome summary scores and other specific descriptive variables.

Summary of Strengths and Weaknesses

The major strengths of the Consumer study are its large sample size, the investigators' reputation for objectivity and the resonance of the results with other psychotherapy outcome studies. The major weaknesses of this study, which pertain to all client satisfaction surveys, include sample bias, the questionable quality of the data and the reliance on quan-

titative research methods to conduct research of mental health treatment.

Strength:

Large Sample Size

Because outcome research is both expensive and time consuming, few researchers have had the luxury of entertaining a study as large as the one conducted by Consumers Union. Access to such a large number of mental health consumers (n=7000) allowed for sophisticated data analysis not feasible with smaller samples and, because there is "strength in numbers," generated findings which, when statistically significant, carry much more weight than the same findings would in a smaller study. Also, the results from the larger study indirectly bolster earlier and smaller studies when both report similar results.

Strength:

Credibility of the Investigators

The Consumer's Union is known for its unbiased and objective inquiries. The perception is that these investigators have nothing to gain from positive or negative outcome findings, whereas clinician-investigators are viewed as vulnerable to bias because they do have something to gain — proof that their interventions are effective. It could be argued that no investigator is immune to potential bias and that the clinician's bias may be "less dangerous" than other investigators' because it is so obvious and therefore likely to be ferreted out in advance. Subtle bias is more likely to go undetected. Consider, for example, the potential for subtle pressure on investigators at Consumers to generate results that would increase circulation/ readership of the journal. Aside from these considerations, it was expected that respondents would be more candid about their psychotherapy experience in the Consumer study because the investigators had nothing to do with the treatment and there was no risk of offending respondents' treating clinician.

It is always reassuring when the results of a study are replicated by subsequent inquiries. In the Consumer study, the vast majority of respondents (87%) found their psychotherapy experience helpful. The work of Bergin, (1971), Howard of Northwestern University, (Jacobson, 1996), and Luborsky (1975), are good examples of studies that have yielded similar results. All three report that psychotherapy is effective in increasing clients' hopes about the future, relieving symptoms and enhancing functioning. In an age when many studies' results suggest that the differences between short and long term therapy are at best equivocal (Smith & Green, 1977) and placebos are as effective as "real" treatment (Benson, 1996), the Consumer Study findings validate what psychotherapists believe and clients attest to.

Weaknesses Discussed

No research study is without weaknesses and practice research has historically been replete with methodological problems. Such research has been conducted by either practice clinicians themselves or outside "empirical" researchers. Each has different and seemingly conflicting perspectives on what constitutes reality, appropriate research methodology and foci for investigation. Each has lodged serious criticisms of the other's methodological choices and as a result questioned the value of each other's data. Their differences have resulted in a dearth of sound research that integrates the expertise of both the empiricist and clinician.

On the one hand, empirical clinical researchers often embrace a linear view of reality that drives them to try to identify psychotherapy variables that predict to specific outcomes in the larger population. They prefer quantitative research designs (large samples) and attempt to pre-operationalize (define) all variables (patient, treatment, therapist and outcomes) and to control for all confounding factors (dual diagnoses or multiple interventions, such as medication, skills training or family work) to yield results that are generalizable to the larger population.

On the other hand, direct practice clinicians embrace a view of the reality that is interactional, dynamic and ecological. In this view, multiple factors continuously impact and effect all phenomena, causing reality to be dynamic and ever-changing. Direct practice clinicians assert that empiricists' efforts to identify one or several critical causative and/or predictive variables is, at best, of questionable value. Instead, practice clinicians focus on identifying the multiple, interactive factors that contribute to each patient's unique context. Thus, the practice clinician focuses on the unique features of the individual and is less concerned about the larger population.

Direct practice clinicians fear that empiricists are trying to operationalize mental health treatment into a "technology" with pre-defined procedures, and that this effort is antagonistic to patient-focused treatment. Rather than adopting predefined procedures, the direct practice clinician believes that he/she must remain flexible and open to altering intervention procedures to be responsive to new and/or unexpected client realities. Also practice clinicians attempt to identify and understand the nature of the relationships among all relevant factors in the treatment process, rather than make attempts to isolate "independent" and "dependent" variables. Because of these aims, practice clinicians prefer exploratory studies that rely on qualitative methods and small samples rather than quantitative designs and large samples.

The differences between empiricists and practice clinicians were largely ignored until the managed care movement successfully mandated increased practice accountability. Now that managed care companies are using practice research results to develop policy decisions, both groups are receptive to reviewing all current practice research methods and to work to articulate and address their differences.

For example, empiricists note that many treatment models do not lend themselves to observable/ behavioral research because the concepts and processes are not adequately defined. Concepts like insight, identity or well-being, and processes like transference and projective identification, defy behavioral definition. It is therefore difficult, if not impossible, to specify what clinicians do for which patients under what circumstances. Empiricists also note that clinical judgment,

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Jacinta "Cindy" Marschke is a full-time Assistant Professor at Fordham University, Graduate School of Social Service and in private practice in New Paltz, New York. She is a past president of the State Society and is the current chair of the Research Committee. Members interested in learning more about clinical research should contact her to join the committee.

If clinicians who practice within a managed care context are to advocate more effectively for themselves and their clients, they must understand practice evaluation techniques. The author's hope is that this review will stimulate interest in advancing practice evaluation research in general.

Book Review

by Lesley Post, CSW

French Toast for Breakfast: Declaring Peace with Emotional Eating

by Mary Anne Cohen, CSW, BCD
1995 Gurze Books, Carlsbad, Ca., (718) 788-6986

Mary Anne Cohen, now the director of the New York Center for Eating Disorders, was a college student spending her junior year abroad in Spain when she made a moving discovery. In the middle of the night she had snuck down the back stairway to the pantry where the cookies were kept. In the darkness she stuffed cookie after cookie into her mouth until she realized she was not alone. At the other end of the pantry was the family's 13-year-old daughter. Mary Anne Cohen realized in horror that she had walked in on the girl's binge. At the same moment, she realized for the first time in her life that she was not the only person in the world who had a disturbed and secret relationship to food.

This realization, one step along the road to Ms. Cohen's own recovery from an eating disorder, informs her recent book, "French Toast for Breakfast: Declaring Peace with Emotional Eating." It is, in a simple and clear format, an invitation to emotional eaters to come in out of the darkness and get help. That help is offered in a variety of approaches, with dogmatism set aside in favor of a tailor-made approach to each eater's eating "fingerprint."

The book is written in the first person, with Ms. Cohen referring to herself as "I" and to the emotional eater as "you," and it is intended to be read by patients as well as by professionals. Each chapter ends with "food for thought" exercises meant to encourage the patient to deepen self-knowledge. Nonetheless, "French Toast" will be very helpful to clinicians who may be seeing eating-disordered patients for the first time or who typically have seen them as only a small part of their practices. The book is a bread-and-butter guide, using an analytically-informed approach, that will give the clinician an immediate orientation and clear sense of how to proceed when working with anorectics, bulimics, chronic dieters and compulsive eaters.

Emotional eating is broadly defined as being hungry from the heart, not from the stomach. Declaring peace with emotional eating is defined as learning to accept that food is not the enemy and that true healing has to do with an inner state of mind. "Binging, purging, starving and even obsessing about diets are all indirect ways of finding some relief from the pressure of unexpressed feelings— temporary though the relief might be," Ms. Cohen writes. Peppering her message with anecdotes from her private practice, she organizes her material into a three-stage approach. The first stage is to describe the inner psychological world of the emotional eater. The second is to explore the tools for change. The third is to create an individual "plan for peace."

The first stage — understanding the patient's psychological world — begins with "decoding" the real intrapsychic reasons for the patient's fear of fat. One woman whose mother was a concentration camp survivor had been told her whole life that she couldn't have what she wanted, such as a sweet sixteen party, because no one in the camps had had one! Through the analysis of a dream, it was understood that the patient kept herself fat and miserable so as not to betray her mother. The patient commented, "She always hated herself for being fat. If I share this with her, at least she won't be so alone in that way."

"French Toast" reviews some of the more prevalent conflicts that trigger eating disorders: shame and intimacy, sexuality and self-expression, anger and assertiveness, and a fear of success. Describing, for example, the role of anger, she quotes a comedian who said, "My mother was always a 'blamerexic' — she keeps sticking her finger down everyone else's throat." Ms. Cohen makes the connection to the bulimic who, were she to redirect her finger from down her own throat, would be pointing accusingly at someone else.

The second stage — the tools and techniques for change — includes five chapters that help the clinician understand the pluses and minuses of treatment options, including medication if advisable. Ms. Cohen continues her own story of sneaking cookies during her college stay in Spain by saying that her most humiliating experience occurred one awful night mid-binge. Eating stealthily and steadily, she was horrified to discover that the cookies had ants on them. The best she could do was try to brush the ants off before she ate the cookies anyway.

The experience is used to capture the essence of addiction so that the clinician can identify when emotional eating also is addiction. For addicted emotional overeaters, she summarizes the pros and cons of Overeaters Anonymous, including the 12-step approach modelled after Alcoholics Anonymous. For the non-addicted emotional eater who has endured a lifetime of hopeless diet cycles, Ms. Cohen offers an alternative in the philosophy of the "no diet/no deprivation" approach. This involves an understanding of physical feelings such as hunger and fullness, and an answer to the question, "What if my stomach is not hungry, but my mouth is?" The answer lies in the emotional hunger that is triggering overeating.

Her chapter on psychotherapy addresses the fear of therapy, the fear of dependency, the fear of abandonment, and group vs. individual therapy. It also diagrams the initial therapy interview according to these topics: the patient's present situation, weight/diet/binge histories, family history and prior treatment history. The interview then leads to a treatment plan that is in part behavioral, such as asking patients to keep a daily eating journal, and in part emotionally-oriented. The emotional issues would be those that hae been camouflaged by the patient's eating problem.

She describes the stages of successful psychotherapy as (1) awareness of eating patterns, (2) exploration of the feelings that have prompted the patient to turn to food, (3) grief for hurts and betrayals that made food the solution, and (4) integration leading to trust in the patient's inner voice and intuition. Examples are offered of the therapy relationship with each type of patient.

The final section of "French Toast" offers an extensive assessment questionnaire whose answers can be plotted on a graph. It is meant to give the patient some sense of his/her needs, and it is another tool to help the clinician plot the best treatment course. The concluding chapter offers 30 typical questions, such as the misconception that laxatives lead to actual weight loss, rather than temporary dehydration.

This useful and well-thought-out book is named "French Toast for Breakfast" because of how many patients yearn for French toast but consider it a forbidden treat. For the countless patients struggling with eating disorders and the therapists who are working with them, it is the author's hope that peace will be declared with all foods and nurturance will be found in other satisfying ways as well.■

Mary Anne Cohen is a professional psychotherapist and director of the New York Center for Eating Disorders, Brooklyn. She hosted a New York radio show on eating disorders, also named "French Toast for Breakfast," and has authored a series of self-help tapes on resolving eating problems. She lectures extensively to professional and community groups.

Lesley Post, CSW, is a psychotherapist whose New York City practice includes many emotional eaters. She also is completing psychoanalytic training at the New York Freudian Society.

MANAGED CARE & VENDORSHIP

John Chiaramonte, CSW, BCD, Chair

COMMITTEE REPORT

We continue to respond to our members' complaints of non-reimbursement from self-insured companies by marketing to these companies for our members' inclusion in these plans. Self-insured companies are governed by the federal ERISA law (Employee Retirement Income Security Act) and therefore supersede state regulatory mandates for accepting clinical social work providers. Our efforts on behalf of membership are twofold: we work to get an exception made on behalf of the member, and then we work to alter the self-insured's policy by forwarding the information to our national marketing consultant. He, in turn, educates the company or plan as to the benefits of including clinical social workers as reimbursable providers. Our past successes are notable, and currently we are marketing to the following companies: Bear Stearns, IIT Research Inst., UIDC, Chemed Corp., Arrow Electronics, Barnes and Nobel, Caldor, Hertz, IBM (non-mc contract), Iron Workers of America, Joint International Board of Electrical Workers, Mercedes Benz, Nassau Carpenters Union, Pepsico, Sun Chemical, TGI Fridays, Unisys, Mark Hotels Inc., and Home Depot Inc.

The committee has generated a **consumer information letter** for Medicare recipients to caution them about the ways managed care Medicare can affect the use of their Medicare benefits. This letter will go out to the senior centers throughout NYS for posting.

The committee is participating in assisting **Local 1199's** effort to alter its mental health benefit package in order to make this a plan which supports enrollees' ability to access therapy with qualified mental health specialists.

The Committee as Your Advocate: We support the current multi-billion dollar **class-action lawsuit** brought by Joseph Sahid, Esq. against nine of the nation's largest mental health care-out organizations. The American Psychiatric Association, in addition to numerous other organizations representing psychotherapists, has joined in the suit as plaintiffs. Should you wish to join in this effort individually, please call Joseph Sahid, Esq. (212) 308-5930.

Our committee has actively joined with the Alliance for Universal Access to Psychotherapy, the National Coalition of Mental Health Professionals and Consumers, and the American Association of Private Practice Psychiatrists in an effort to interest the Justice Department and the Federal Trade Commission to open an **investigation of the managed care industry**. We have been concerned, as have these other clinical organizations, about what appears to be collusive actions on the part of the managed care industry. These actions were aimed at establishing minimal standards and measures for the delivery of mental health care, and having achieved that, have sought some legitimacy for these standards. The allegations that we are making suggest that there may be violations of the Sherman Antitrust Act with regard to various illegal and anti-competitive practices.

Last year 39 states passed more than 90 bills to regulate managed care. In Washington, Congress has also been swept up in managed care mania. Recently, President Clinton created a **federal advisory panel on consumer health protections** and both sides of the isle are interested in passing national managed care regulations.

The NYS law S 7553, while not perfect, is one of the better laws in the land. It has many protections both for the consumer and the clinician. The committee urges you to get a **copy of this new law by calling (800) 342-9860**. We also urge you to use, and to inform your clients, so that they too might use, the new Managed Care Complaint Line of the NYS Dept. of Health when violations of law occur. The number is: (800) 206-8125.

Ask what you can do for your profession: Unfortunately, many clinical social workers feel helpless and hopeless when having to deal with managed care. These feelings are our worst enemies. We have allowed Managed Care to continue to do its profit-driven best by our inability or our unwillingness to speak out with a loud unified voice. It is essential that we expose unethical and illegal managed care practices wherever we find them to the forces which can do something about them. It is important to question why (Aetna) HAI and ConservaCare charge non-refundable application fees ($75 and $100 respectfully), while most other companies who offer the same service do not . . . to ask how the Brick Kiln Company openly splits provider fees and then when confronted says, "well, everyone is doing it." It is important to ask why Oxford again has lowered its fees ($50) in NY and why Spectrum pays so little for clinical social work services ($30) or uses case rates of $167 each case . . .and how VBH/VYTRA can cull their provider list down, requesting their enrollees to terminate after 6 sessions and get a new therapist in the narrowed provider panel. Fee splitting, up-front fees, late payments, harmful clinical and administrative decisions, plan consolidation and the lowering of fees — it is time to speak up and be heard. This is the year we help the system change for our clients and for our profession.

Important phone numbers: Dept. of Health's MC Complaint Line - (800)206-8125; Dept. of Insurance - (518)474-6600; NFSCSW Federation Hotline - (800)270-9739; Your State Senator: (518)455-2800; Your State Assemblyperson: (518)455-4100■

PSYCHOANALYSIS

By Marilyn G. Schiff, CSW, Chair

COMMITTEE REPORT

Three more chapters have been added to those working to develop salons: Mid-Hudson, Queens and Suffolk. Again, anyone who wishes to join or begin a salon is invited to call your chapter COP chairperson or president, or to call me at (212) 255-9358. The expansion outward on Long Island and upstate is very encouraging. Let's keep it going.

Metropolitan Chapter: Joanne Horwitz, (212)477-0047. Joanne reports that all groups except for new graduates continue as before. That group has been transferred to the Mentorship Program. 3 psychoanalytic peer groups are in place. One more, to meet in the evening, is forming. They include these groups:

Tuesday morning, now closed; Wednesday morning, contact Rhoda Ritter, (212) 427-4942; Friday morning, contact Joanne Horwitz; Evening, being formed,contact Joanne Horwitz. Groups open to all are: Saturday a.m., monthly, contact Bonnie Cohen, (718) 601-7630; Tuesday evenings, contact Linda Marx, (212) 772-6491; Study group meeting every other Friday; Audrey Ashendorf, (212) 677-2132; Salon, third Sunday of each month, contact Lisa Miller, (212) 496-9716.

Mid-Hudson Chapter: Marian McClellan, (914) 679-4389, is setting up a salon in the northern Hudson Valley. Please call her if you would like to join.

Nassau County Chapter: Stephanie Zemon, (516)625-3927, reports that, in the main, the groups remain as before: Child therapy, about 15 members; Family therapy, 12 to 15 members; Group therapy, seeking members and 3 psychodynamic groups. However, the new practitioners group, run by Estelle Rauch, is ending. Estelle is organizing a new group for this population, practitioners with one to two years of experience. Stephanie will meet with members who have indicated an interest in peer study groups.

Queens County Chapter: Roslyn Gold, (718)380-3195,**Rockland County Chapter:** Janet Droga, (914)638-1412, **Suffolk County Chapter:** Pat Firestone, (516) 588-2857, and **Westchester County Chapter:** Susan Freydberg, (914)253-8144, all would like to start salons in their chapters. Please contact them.■

PUBLIC RELATIONS

By Sheila Peck, LCSW, Chair

COMMITTEE REPORT

On March 1, Dr. Georgia Witkin presented a piece on Channel 4 News, "How to Choose a Therapist," in which she mentioned only psychologists and psychiatrists. When we wrote to her, she replied with a gracious personal phone call, in which she apologized and asked that we send her material about us to her home address. She also asked for names of contact people in New Jersey and Connecticut, all of which was sent to her.

Carol Molesworth, a reporter for "Manhattan Users Guide," reached us via our 800 number. She is writing an article on how to find a therapist and was glad to hear about us. We will be mentioned in the next issue.

The Board approved submission of a Public Service Announcement to various broadcast and cable television stations.

A few new publications are available to any member sending a stamped, self-addressed envelope. These include: (a) Membership benefits sheets, which were recently developed for the Federation and which will tell you and any prospective members how joining may benefit; (b) two consumer or patient-oriented pages which were developed in response to the Hospital for Special Surgery's request: "How Clinical Social Work Can Help,": and a checklist of symptoms which might indicate the need for therapy; and (c) a legislative fact sheet, "The Universal Mental Health Profession: Social Work."

We also wrote a letter of appreciation to the producer of the January "Sixty Minutes" segment having to do with managed care.

"HOPE" Magazine, which recently called us and will include mention of the Society in an upcoming article about adoption, is interested in hearing any inspirational stories which clinicians might want to share. Please get in touch with me.

We're trying to develop a list of members who have websites or who are on-line. Please send this information to me at 1010 California Place South, Island Park, NY 11558, Fax/Phone (516) 889-2688. Or better yet, e-mail it to Sheila2688@aol.com.

Finally, in connection with Helen Krackow's attendance at the Inauguration, we wrote and distributed a press release to several local newspapers and sent it to all the State Chapter presidents as well.■

Speculations on the Neurobiology of EMDR

By: Uri Bergmann, CSW, LCSW, BCD

As Eye Movement Desensitization and Reprocessing (EMDR) celebrates its tenth anniversary, there are increasing demands for research on its efficacy, as well as explanations as to the neurobiological mechanisms that facilitate it. A good way to try to understand how EMDR appears to work is to outline the process of trauma, its sequelae in the brain and then how EMDR appears to return the brain to homeostasis.

Francine Shapiro posits that one of the simplest ways of describing integrative EMDR effects is to say that the target event of a trauma has remained unprocessed because the immediate biological responses to this trauma have left it isolated in neurobiological stasis. The processing mechanism of EMDR is physiologically configured to take misprocessed information to an adaptive level (Shapiro, 1994, 1995). To comprehend how this takes place at a neurobiological level, I believe that it is imperative to understand the relationship between the amygdala, a limbic structure, and the following: the other limbic structures, the neocortex, specific neurotransmitters, as well as the physiological aspects of dream sleep.

The target event of a trauma remains unprocessed because the immediate biological responses to it have left it isolated in neurobiological stasis. The processing mechanism of EMDR takes misprocessed information to an adaptive level.

For the purposes of this presentation, the term limbic system will be used to indicate a group of limbic structures and will be defined as composed of, collectively, portions of the thalamus, hypothalamus, hippocampus, amygdala, caudate nucleus, septum and mesencephalon (see fig. 2.27). These structures are located in the temporal lobe of the cerebral cortex (see fig. 2.26). This paper will address the particular limbic structures essential to this current discussion.

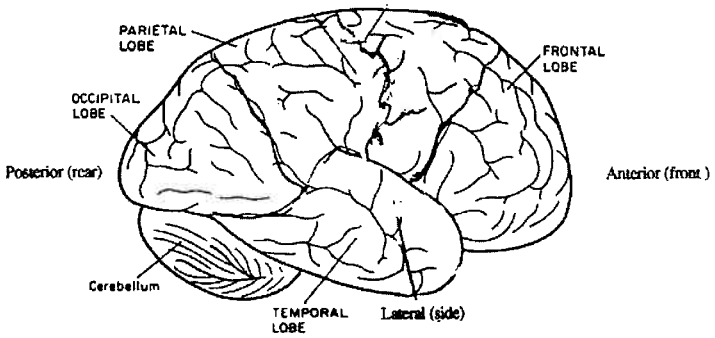


Fig. 2.26. *The right cerebral hemisphere* seen from the lateral aspect

Many researchers posit that the hippocampus and the amygdala do much of the brain's learning and remembering. The amygdala provides the central crossroads where information from all senses is finally tied together and endowed with emotional meaning.

The hippocampus is known to play a central role in retrieving the memory of events, objects, words, as well as other types of information (Brodal, 1992; Reiser, 1994). While the amygdala retains the emotional flavor of memory, the hippocampus retains the dry facts. It appears to process memory in terms of perceptual patterns and contexts (LeDoux, 1992; van der Kolk, 1994). It is the hippocampus that recognizes the different significance of a bear in the zoo versus one in your backyard. It also differentiates events that happened long ago from those that are recent.

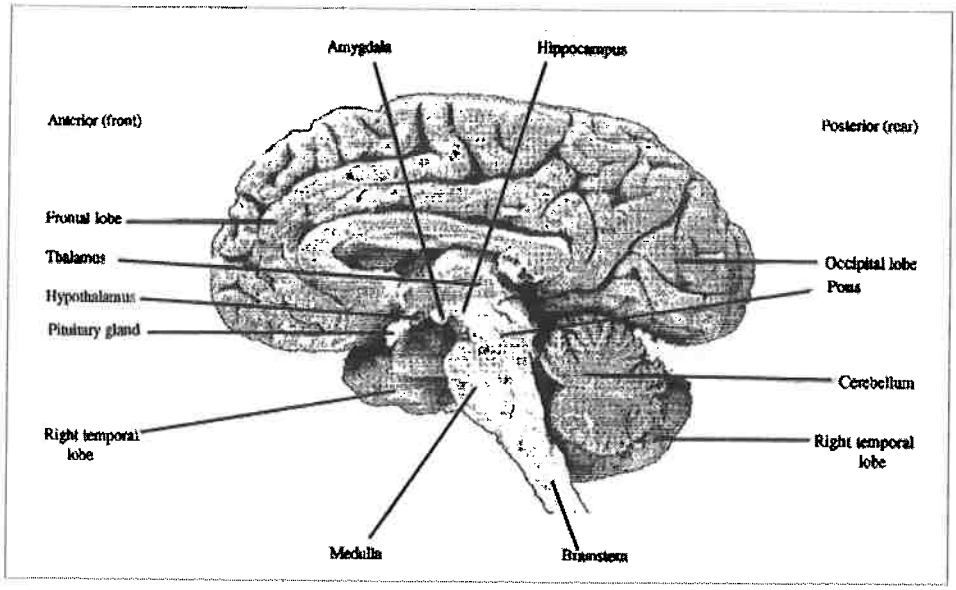
The brain's damper switch for the amygdala appears to lie at the other end of a major circuit, in the left prefrontal lobe. This neocortical part of the brain brings a more analytic and appropriate response to our emotional impulses, modulating the amygdala and other limbic areas (LeDoux, 1986).

The prefrontal cortex is the brain region responsible for working memory. The presence of circuits connecting the limbic brain to the prefrontal lobes implies that the signals of strong emotion, anxiety, anger and terror, generated in the amygdala can create neural static, sabotaging the ability of the prefrontal lobe to maintain working memory and homeostasis (Selemon et al, 1995). Similar observations have been made by van de Kolk (1994). He notes that external and internal stimuli, including stress-induced hormone production, decrease hippocampal activity.

An alarm

Recent studies of the amygdala (LeDoux, 1986, 1992, 1994) have demonstrated that it is poised like an alarm. Confusing signals from the senses let the amygdala scan every experience for danger. Sensory signals from the eyes, nose, mouth, skin and ears travel first in the brain to the thalamus, and then across a single synapse to the amygdala. A second signal from the thalamus is then routed to the neocortex — the thinking brain. This branching allows the amygdala to respond before the neocortex, which mulls the information through several layers of brain circuits before it fully perceives and initiates a response (LeDoux, 1986).

LeDoux has shown that some emotional reactions and memories can be formed with no cognitive conscious participation. The amygdala can store memories and initiate response repertoires that we enact without consciousness, because the shortcut from the thalamus to the amygdala bypasses the neocor-



A traumatic event occurs. The amygdala sounds the alarm and sends urgent messages to every major part of the brain . . . If the trauma continues unabated . . . the brain enters a state of PTSD.

Fig. 2.27. The left cerebral hemisphere with a cutaway of the temporal lobe which covers the medulla and limbic structures.

tex. This amygdaline arousal seems to imprint in memory most moments of emotional arousal with an added degree of strength. The more intense the amygdaline arousal, the strong the imprint (LeDoux, 1986). Similarly, van der Kolk (1994) posits that massive secretion of neurohormones at the time of the trauma plays a role in the over consolidation of traumatic memories. Memories are then stored in sensorimotor modalities, somatic sensation and visual images without the cognitive or semantic representation of the experience (van der Kolk & van der Hart, 1989). This method of allowing past, highly charged emotionally imprinted memories to control our present day functioning is at the core of most emotional problems.

Turning now to dream sleep (also known as D and REM sleep), many researchers have shown that its presence suggests some sort of internal information processing and that a necessary aspect of mammalian memory processing is the integration of individual experience into a strategy for future use (Winston, 1985, 1993). Experience gained during species-specific waking behavior is reaccessed and integrated into an animal's behavior strategy during D-sleep. The integrative memory process that occurs in humans is the same in lower species, with one modification. In humans, the information integrated is no longer confined to specific behaviors, but consists of all waking experiences that pertain to psychological survival (Winston, 1993).

REM sleep in humans was studied utilizing positron emission tomography (PET) scanning. The results showed a marked increase in activity in the limbic area, and below normal readings in the left frontal lobe. Given the role of the amygdaloid complexes in the acquisition influenced memories, Maquet et al (1996) posit that "the pattern of activation in the amygdala and the cortical areas provides a biological basis for the processing of some types of memory during REM sleep.

An important mechanism during REM sleep involves a distinct pattern of high amplitude electrical potentials in three areas of the brain. It is this activity that causes the rapid eye movement (REM) that is noticed during dream (D and REM) sleep. In order for this activity to ensue , there must be a suppression of the neurotransmitter norepinephrine (NE) (Winston, 1993).

The process of trauma

As noted earlier, a good way to try to understand how EMDR appears to work is to outline the process of trauma, its sequelae in the brain and, then, how EMDR appears to return the brain to homeostasis.

A traumatic event occurs. The amygdala sounds the alarm and send urgent messages to every major part of the brain: it triggers the secretion of the body's fight or flight hormones and the hypothalamus is signaled to order the pituitary gland to produce corticotropin-releasing factor (CRF). It mobilizes the cerebellum for movement and signals the medulla to activate the cardiovascular system, the muscles and other systems. Other circuits signal portions of the pons and other brain stem structures for the secretion of norepinephrine (NE) to heighten the reactivity of the brain centers, suffusing the brainstem, limbic system and the neocortex; setting the brain on edge. The hippocampus is signaled for the release of dopamine, to allow for the riveting of attention (van der Kolk, 1994). In most cases, the traumatic event wanes and the systems return to baseline.

If the trauma continues unabated, a feeling of loss of control and helplessness begins. The brain becomes overwhelmed, brain changes ensue and the brain enters a state that we know as post-traumatic stress disorder. Portions of the pons and the other brain stem structures become hyperactive, secreting extra-large doses of NE in situations that hold no danger, but are somehow reminiscent of the

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Uri Bergmann

Uri Bergmann, C.S.W., L.C.S.W., B.C.D. is in full-time private practice in Smithtown and Westbury. He is a facilitator and on the faculty of the EMDR Institute, a lecturer and consultant. He is board certified in Behavioral Medicine (Internti. Acad. of Behavioral Medicine, Counseling & Psychotherapy) and Pain Management (Amer. Academy of Pain Management) and a fellow of the State Society.

Utilizing EMDR Consultation in a Concurrent Treatment Model

·By: Carol Forgash, MSW

Carol Forgash

Carol Forgash is a clinical social worker in full time private practice in Smithtown. Trained in EMDR, she uses it with trauma survivors, patients with phobias, panic disorders, physical illnesses and in performance enhancement. She is Vice Chair of the Suffolk Co. Advisory Comm. on Child Protection and lectures for the Suffolk Co. Mental Health Dep't. and Child Abuse Prevention Services. This paper was first presented at a Harvard Univ./ Cambridge Hospital symposium.

Concurrent psychotherapy is valuable for providing timely interventions to patients with specialized needs. Clinicians refer patients for psychiatric consultations, group work and to therapists who specialize in problem areas such as panic disorder, trauma, child abuse issues and substance abuse. Such traumas as child sexual abuse, family violence and disasters result in a large population suffering from Post Traumatic Stress Disorder and other Dissociative Disorders. Other patients have long-standing depressions, panic and psychosomatic disorders, performance anxiety and phobias stemming from traumas which do not resolve in traditional psychotherapy.

Given such high rates of patients suffering from trauma and relatively low numbers of clinicians trained in trauma work, EMDR-trained therapists with experience in these specific areas are uniquely positioned to provide adjunctive treatment.

Treatment with sexual abuse survivors, for example, is often complex. Intrusive and dissociative aspects of Post Traumatic Stress symptoms produce treatment difficulties, which range from destabilization and dissociative episodes to more typical treatment impasses.

Resistance may involve fear of exposure or of violating taboos against "telling". Sequelae to revelations, overwhelming shame, and concern about rejection by the therapist are other issues. Patients fear being flooded by feelings and memories.

Immobilized and frozen, the patient may have a sense of "pseudo-safety" in the familiarity of these feelings. As the symptoms persist with small or no reduction in distress, patients experience high levels of frustration, feelings of defeat, depression and anxiety. Loss of belief in the efficacy of therapy often follows. This is often an appropriate time for the therapist to consider EMDR as an adjunctive course of treatment.

The primary therapist refers the patient to an EMDR-trained clinician who is experienced in trauma work. They develop a collaborative relationship, analyze risks and benefits of EMDR treatment for the patient relative to the stage of trauma work and the patient's present functioning (for example, if the EMDR work is for restabilization or for uncovering). During the course of EMDR treatment, goals are established, safety is maintained, and risk analysis continues. The patient signs appropriate releases and provides feedback to both clinicians.

Patient Responses

Patients report that this approach has contributed to the following perceptions:

- •The primary therapist is not "giving up."
- •The therapist recognizes the need for additional intervention.
- •Abandonment issues are minimized as the relationship with the primary therapist is maintained.
- •Two therapists can be models for collaborative teamwork that benefits the patient; providing open communication without secrets and a joint concern for the patient.

The patient has the opportunity to focus on specific problems in the EMDR treatment while continuing to explore feelings, dreams, reactions, etc. with their therapist. This provides additional targets for EMDR work. The patient with safety issues stays in the "known" with their primary therapist.

Since the EMDR protocol posits a patient-centered approach, the patient has significant control and choices regarding length of "sets" (eye movements) and choice of targets. This approach can shorten total treatment time. As targeted issues resolve, skill development and future planning can occur in the primary treatment.

In the author's experience, the following classification of sexual abuse survivors would be appropriate for EMDR referral:

A) Patients presenting with adult onset Post Traumatic Stress Disorder following a sexual assault. They were not sexually abused in childhood, but lived in families with conditions of chronic instability and violence. Such patients actually have chronic PTSD. The developmental deficits which ensued compromised their ability to resolve current trauma.

B) Certain trauma patients manifest somatic problems that are psychogenic. These symptoms represent symbolic body memories or are the results of injuries. Many trauma patients have been misdiagnosed or told to "live with the problem". Problems, such as muscle spasms, chronic pain and sleep disorder have not responded to either medical treatment or standard stress reduction/pain management treatment. These conditions are distressing and interfere with functioning.

C) Patients who have experienced childhood sexual abuse are especially vulnerable to assaults and may not restabilize in conventional treatment.

Case Examples

Prior to entering treatment, Ms. P., a woman in her late forties, was raped in her bedroom at four in the morning. "All of a sudden the impossible happened," she said. "The door knob turned and a hand holding a knife came through the doorway."

Continued on page 17

EMDR: TRICK OR TREATMENT

continued from p. 1

result. Later, she replicated the process with friends and subsequently developed a treatment protocol. The subject was instructed simultaneously to hold a "freeze-frame" image of the worst aspect of a traumatic experience and the associated distorted negative self-beliefs (e.g., I am worthless; I am to blame), together with the emotions and body sensations they elicited. Then the subject tracked Shapiro's finger as they swept left and right and was encouraged to free associate. Shapiro named the procedure EMD. At the time "R," the technique of reprocessing for positive, reality-based self-beliefs (e.g., I am good enough; It wasn't my fault; I'm safe now) was yet to be developed.

To test her procedure in a more empirical way, Shapiro arranged to treat a sample of 22 Vietnam veterans and rape victims manifesting the symptoms of PTSD (post traumatic stress disorder) and compare them to an untreated control group. The test yielded a reduction of anxiety and distorted beliefs in 75% of the subjects in response to one 90-minute session of EMD. Shapiro treated hundreds of more victims of trauma and eventually developing a training seminar in her method. In a few years she began presenting national and international seminars and to date has trained in excess of 20,000 practitioners worldwide.

Mechanisms of EMDR

More research has been conducted validating the effectiveness of treating PTSD with EMDR than all other studies on PTSD treatment combined. The most definitive research study demonstrating the efficacy of EMDR, by Wilson, Tinker and Becker, was published in December, 1995 in the Journal of Consulting and Clinical Psychology. However, some critics continue to challenge EMDR as insufficiently researched. An example is the recent article, *EMDR treatment: less than meets the eye?*, in the "Skeptical Inquirer" (Lilienfeld, 1996, p. 27). The article contains several errors in the description of the EMDR protocol and technique (e.g., stating incorrectly that after each set of eye movements clients are asked to rate their level of disturbance), thereby undermining the conclusions drawn.

Lilienfeld and many others also have claimed that EMDR is another version of hypnosis. However, alpha waves, emitted by the brain during the trance state, are usually absent in EEGs administered to test subjects while experiencing EMDR. Still others have stated that it is reckless to employ EMDR until its mechanisms have been fully understood. Yet, the precise way that psychotherapy works, and indeed the mechanisms of many accepted medical treatments, including the use of aspirin, have yet to be definitively determined.

In an effort to define the mechanisms of EMDR, the noted psychiatrist and researcher, Dr. Bessel Van Der Kolk, is conducting before-and-after SPECT Scan studies at Harvard University. He has discovered neurological changes in PTSD sufferers following a session of EMDR treatment. Activity has repeatedly been observed in the left prefrontal lobe of many of the subjects, the area of the brain that reflects optimism, after experiencing EMDR. Originally, it was theorized that the clinical effects resulted from simulating the processing of REM (rapid eye movement) sleep. More recently, attention has been given to the concept that EMDR elicits bilateral (left and right hemisphere) activity in the brain. Bilateral stimulation appears to reverse changes in brain function, particularly in the limbic system and the amygdala, which may have resulted from either a single or repeated traumatic experiences.

Intellectual awareness in trauma victims is usually, by itself, insufficient to ease their ubiquitous flashbacks and panic or alter deeply held distorted negative beliefs and self-perceptions. EMDR bilateral stimulation appears to integrate the cognitive and affective mental processes, thus facilitating the reprocessing of traumatic experiences and erroneous beliefs. This may explain the remarkably rapid and effective results found in treating PTSD.

I have repeatedly observed in my clinical practice that one to three extended sessions are often sufficient to resolve the effects of traumatic events, both in children and adults. Although considerably more time is necessary, use of EMDR also facilitates the treatment of adults who had suffered ongoing abuse in their developmental years. Additionally, I have experienced that EMDR fosters the acceleration and deepening of the treatment process in various other clinical situations, including anxiety and mood disorders, character pathology and dissociative conditions.

Railroad Engineers

I have treated more than 20 railroad engineers who were traumatized by fatal collisions with people committing suicide in front of their trains and pedestrians and drivers crossing closed railroad gates. One veteran engineer, Bob, suffered through six such accidents in six years. He had crystal clear recall of the painful details of each incident. As he passed each accident site daily, he suffered full blown flashbacks. His stomach was constantly in a knot and he reported that even after a full night of sleep he felt unrested. Bob dreaded facing work every day and believed that he had become "hell to live with." One collision of his train was with a stalled vehicle which exploded on impact, incinerating its occupants, a father and his two young children. Bob's recollection of the odor of burning flesh was so vivid, it made it impossible for him to attend a barbecue without becoming overwhelmed by panic attacks.

I met with Bob for one three-hour session, which included an hour of history-taking, an hour and a half of EMDR processing and a half hour of debriefing. After discussing his different options, Bob chose to focus first on the most recent incident. Six months earlier, a woman who was eight months pregnant walked along the tracks and at the last instant stepped in front of his oncoming train. Bob's most disturbing image was when he made eye contact with the woman just before the moment of impact. He paired it with the irrational self-belief, "I am a murderer." The emotions elicited were intense guilt, fear and rage, which he experienced as a "hot poker in my stomach" and a "straight jacket of fiery chains on my shoulders, chest and back." Bob was instructed to hold his disturbing image of eye contact with the woman and the statement, "I am a murderer," together with his emotional and somatic sensations. I guided him to visually track my fingers left and right, while uncritically observing the movement of his thoughts, images, emotions, memories or bodily feelings. During the next 45 minutes, his "frozen" image became "unstuck," and began to advance automatically, as if "frame by frame." Bob spontaneously came to his own realization that he had no control over

Continued on page 17

David Grand

David Grand, RCSW, BCD, is in full time psychotherapy practice on Long Island and supervises and consults on clinical issues and practice management/development. He holds a certificate in psychoanalytic psychotherapy and is a trained EMDR facilitator who has lectured widely on the subject. The chair of EMDR-HAP (Humanitaran Assistance Programs), he has performed pro bono EMDR clinical training in war-torn Northern Ireland and in Dunblane, Scotland, site of a tragic school shooting incident, and he coordinates EMDR training of inner city mental health providers. Past president of the Nassau chapter of the State Society and the Association of Psychoanalytic Study and Research, he is also a charter member of the Eye Movement Desentization & Reprocessing International Association.

EMDR: Joining Cognitive & Psychodynamic Therapies

By: Gina Colelli, C.S.W., B.C.D.

Today's trend to join cognitive and psychodynamic therapies has given rise to a new and somewhat controversial treatment, Eye Movement Desensitization and Reprocessing (EMDR). EMDR is a comprehensive methodology used for the treatment of disturbing experiences that often underlie many pathologies. Since its introduction in 1989 by a clinical psychologist, Dr. Francine Shapiro, it has been used in the treatment of a variety of diagnoses alone or in conjunction with psychodynamic and behavioral therapies. A treatment approach that utilizes eye movement and other forms of left-right brain stimulation, it has been proven to be an effective treatment, backed by group-designed treatment outcome research (Shapiro, 1995).

Gina Colleli

Shapiro hypothesizes that EMDR is an integrative information-processing paradigm that plugs into a person's innate ability to be "physiologically geared to process information to a state of mental health. "She sees the desensitization and cognitive restructuring as by-products of the "adaptive reprocessing taking place." What the client experiences is a freedom from the bondage of the traumatic event and the disturbing thoughts and images.

Case History: I Can Stand Up To Them:

I am working with Grace, a 40-year-old woman who was married to a sexually abusive husband who sodomized and raped her. Grace, who had been in a number of different traditional therapies, was very interested in EMDR. She was on disability, taking numerous medications for anxiety and depression, and terrified of her now-separated husband against whom she had obtained an order of protection.

In the first EMDR session, we targeted a childhood trauma. Grace grew up in an inner city neighborhood on the first floor of an apartment building where she could hear people begging for their lives before they were shot on the sidewalk. In addition, Grace was one of the few white girls left in the neighborhood and as a teenager she was frequently the target of gangs. We targeted one of the gang episodes that ended with her being escorted by the police to and from the bus stop after school every day for a week.

I asked Grace to measure her anxiety in relation to the memory of the gang episode on a scale from 0 to 10. A rating of "0" means no disturbance and a rating of "10" means extremely disturbing. Grace evaluated the anxiety level to be a 10. Since EMDR is a neurophysiologically-based treatment, I asked Grace to report the location in her body where she is experiencing the anxiety. She felt the anxiety in her chest and throat. When asked, "What would you like to believe about the experience?," Grace responded, "I can stand up to them." In response to how believable that statement was on a scale of 1 to 7, she reported a "2."

As the procedure began, I started a set of eye movements and at a certain point stopped, asked Grace to "blink it out and take a deep breath, then tell me what is happening." She said she can "see two girls" who have harassed her before. They "come at her" and she "can see more kids behind them" walking toward her. She described feeling extremely fearful of what was happening. She reported that the fear was running through her legs and chest. I began another set of eye movements, stopped them and repeated the same instructions. She reported seeing herself running from the gang. They catch up to her and begin to attack her. After several more sets of eye movements Grace related that the image changed. Now she sees herself turning and she stands up to them. She no longer feels afraid and the group that is attacking her fade out of the picture.

Grace was no longer experiencing any physical sensations, so we installed the positive cognition, "I can stand up to them" by placing the thought with the negative image and doing several sets of eye movements. Asked to evaluate how believable that statement is now on a scale of 1 to 7, Grace responded, "6."

Unlike traditional therapies where the therapist at a number of different moments may want to explore or interpret the information being shared, an EMDR-trained clinician will not. Seeing the free associations and vivid imagery that occur in a session as a reflection of the client's unique psychological processing of events, the clinician trusts that the procedure will process the event to a more effective level of functioning.

The most difficult session for Grace was reprocessing the rapes that occurring her marriage. When the session started, Grace reported an image of her former husband, unshaven, grubby with a "crazed look" in his eyes. I asked her, on a scale of 1 to 10, how disturbing the image is. It was a "10." I told her to concentrate on the feelings and we did a set of eye movements. After we stopped, she said she can "see" the image of being dragged by her hair into the bedroom and he attempts to sodomize her. When asked to measure how disturbing the image was, again she reported, "10." We did another set of eye movements and I had Grace blink it out and take a deep breath. I asked "What do you get now?" Grace reported kicking at him and fighting him with all her energy. I say, "good, hold that" and led her through another set of eye movements. Note, she was reporting a shift in her sense of competency. Next, she reported seeing a little girl in the doorway who grabs her and tries to pull her out the door. Her former husband "tries to hold onto her" on one side of the door while the little girl pulls her from the other side. Another set of eye movements and she reports the image of seeing herself on the street with the little girl. Her husband is nowhere to be seen.

Returning to the original target, Grace reported a level of "0" when asked how to rate the level of disturbance of the original image. However, she reported some body discomfort, so we went back and reprocessed it until the body discomfort was neutralized. At that point we installed the positive cognition: "I feel peaceful and calm within myself when I remember my former husband." She reported a "7" on a scale of 1 to 7.

Immediately after the session, Grace stated that she had never felt as if she could fight her husband and that she now felt stronger. Three weeks later, Grace walked into a local department store and found herself face to face with her former husband. During a session right after this occurrence, she related that she experienced absolutely no anxiety. She noted that he still wore his hair long but "at least" he had gotten a new winter coat. That night, however, she had a dream in which she was in the two-family house that they lived in. She went downstairs to tell some-

Continued on facing page

one by the name of "Gacy" that everything was "okay"— now she "can come out." In the dream, her former husband "comes down the stairs and wants to know what is going on." She tells him to "go upstairs and stay out of here." He turns and walks away.

Over the next several sessions, Grace reported additional evidence of the positive effects of EMDR when she described being able to ask for what she needed at work and defending herself against some petty office gossip started by a small group of women. In fact, her bosses were so impressed with the way she handled herself, they gave her a promotion. Grace has begun to come off all psychotropic medications and at this time seems to be able to function without them.

The two sessions reflect how EMDR can be utilized to address various problems — first we see how an earlier life event can be reprocessed, then a very traumatic event that placed the client at a tremendous risk to her mental health.

An eight phase treatment method

EMDR is used within a strong clinical framework that prepares the client for the use of the technique. EMDR is an eight phase treatment model:

1. Client history — a thorough client history is taken to ensure that the individual is appropriate for the treatment and to alert the therapist to the steps necessary to prepare the client for EMDR treatment.
2. Treatment plan — the therapist and client, develop an agreed-upon treatment plan.
3. Assessment — what the goal of the EMDR session will be.
4. Desensitization.
5. Installation of the positive cognition. — a method to provide cognitive restructuring of the event/image/thoughts.
6. Body scan — if there is any body disturbance, it may be an indicator that there is still desensitization and reprocessing left to be completed.
7. Closure— the clinician prepares the client with practical information on how to handle any additional processing that may occur. Not all sessions end with a full therapeutic resolution. In those cases, the clinician must provide a specific method to "close down" the session until they can complete the work started.
8. Reevaluation—to assess what work continues to be needed to come to a full therapeutic resolution.

Shapiro sees EMDR as an umbrella under which all other therapies can be placed. She says, "the model opens up new territory by defining pathology as dysfunctionally stored information that can be properly assimilated through a dynamically activated processing system." (Shapiro, 1995, pg. 52) Rather than focus on the label, the clinician can focus on the behavior that generates the diagnosis. EMDR has been utilized in the treatment of a variety of disorders, including Post Traumatic Stress Disorder (PTSD, Wolpe and Abrams, 1991; Lipke and Botkin, 1992; Viola and McCarthy, 1994, Shapiro, 1995); Multiple Personality Disorder (MPD; Marquis and Puk, 1994; Fine, 1994; Lazrove, 1994); Panic Disorders (Goldstein & Feske, 1993, 1994; O'Brien, 1993); Phobias (Doctor, 1994; Kleinknecht, 1993); Sexual Assault Victims (Gould, 1994; Parnell, 1994; Puk 1991a; Spector & Huthwaite, 1993; Wolpe & Abrams, 1991). Additional uses are listed in Shapiro (1995, pp. 10-11).

Training

Training in the procedure and all of its protocols is restricted to professionals in the mental health field and requires four and a half days of training. Clinicians receive supervised practice during the training. While it is very tempting to try EMDR by reading about the technique or hearing about it from a colleague who has been trained, it can not be emphasized enough that receiving the official training will ensure that your clients will receive the best treatment possible. For additional information regarding training, equivalency tests, affiliates, consultants and eligibility requirements, please contact the EMDR Institute, P.O. Box 51010, Pacific Grove, Ca. 93950, (408)372-3900.

Gina Colelli, CSW, is in private practice in Manhattan and Pawling specializing in eating disorders, trauma recovery and alcohol/substance abuse. She is Membership Chair of the Met Chapter. This article is an excerpt from the one first printed in the *Met Chapter Forum* and is reprinted courtesy of that publication.

Licensing Bill, continued from page 1

Each level requires a written examination to establish minimum competence. A grandfathering clause allows for the conversion of CSWs to LMSWs and for those CSWs with a "P"and/or "R", conversion to LCSW. For those CSWs who could meet the experience requirements for the "P" or "R" but have not been approved by the time the legislation becomes law, they will have a year to apply and be grandfathered in by the State Board for Social Work without examination.

Where are we now?

Existing legislation in the Senate and Assembly will be amended in early May to reflect this current version. The bill numbers will be: Senate: S.1123-A and Assembly: A. 6059-A. We are asking our membership to write to four particular legislators — the first two are sponsors, Thomas W. Libous (Senate, Rep.) and James Gary Pretlow (Assembly, Dem.)— to thank them for their support of and assistance in passing the bill. The last two are the Chairmen of the Higher Education Committees of both houses, Kenneth P. LaValle (Senate, Rep.) and Edward C. Sullivan (Assembly, Dem.). Letters should be respectful, bringing to their attention our legislation by number and the importance of passage to assure consumer protection and access to qualified practitioners. You might also reference:

* Social workers are currently regulated by NYS in Article 154 of the Education law.
* Social workers are already eligible for third party payments for mental health services as manadated by the Insurance Law, (Article 43, Sce. 4303). Call your Chapter Legislative Chair for further information:

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trauma. The hypothalamus becomes hyperactive, continuing to signal the pituitary gland to secrete hormones, alerting the body to an emergency that isn't there. The aroused amygdala signals opioid centers in the cortex to release endorphins. This triggers the numbing and anhedonia. In effect, the neocortex is taken out of the loop. The left prefrontal cortex is unable to shut the emergency systems down.

In a recent PET scan study, the mediating neuroanatomy of PTSD symptoms was examined (Rauch, et al, 1996). The subjects were exposed to recordings of scripts describing the subjects' past personal experiences, including the traumatic experiences that caused their PTSD. The script-driven scans, in contrast to the scans of neural thoughts, revealed findings of increase in activity in the right-sided limbic, paralymbic and visual cortex. No significant changes were found in the hippocampus or the thalamus. Decrease in activity were found in the left frontal and middle temporal cortex. These results suggest that emotions associated with PTSD symptoms are mediated by the limbic and paralimbic areas within the right hemisphere. Activations of the visual cortex may correspond to the visual component of PTSD re-experiencing phenomena.

The preponderance of right-sided brain findings is consistent with literature supporting the preferential role of the right hemisphere in anxiety, panic and phobic disorders. It may also support the speculation that one of the roles of the left frontal lobe is to mediate or inhibit the activity of the right frontal lobe and right-sided limbic structures (particularly, the amygdala).

Shapiro (1994) noted that the examination of EMDR clients by qualitative analysis of electroencephalography (QEEG) has shown a normalization in the slower brain wave activity in the two cortical hemispheres. She cited Nicosia's position that the phase relationship of the two hemispheres is disrupted by the failure of NE suppression. This asynchrony prevents integrative memory processing. Nicosia (1994) suggested that EMDR resynchronizes the activity of the two hemispheres, because the repetitive alternating stimulation mimics the activity of the pacemaker mechanism within the cortex that exists for this purpose and which was suppressed. This has also been corroborated by others (Kelly, 1991 and Winston, 1993).

It may be that EMDR stimulates or emulates the pacemaker cells in the septum and/or the pontine saccade generator in the midbrain and resychronizes the hemispheres. It is my opinion that if true, this might facilitate an integration of neocortical and amygdaline activity.

Stated more specifically, EMDR processing gradually shifts the brain activity from amygdaline hyperactivity to activation of greater neocortical functioning. In other situations, where no cognitions are available, a predominant focus on body sensations leads to the amelioration of symptoms by apparently facilitating amygdaline inhibition. Is it possible that attending to the traumatic belief, affect and body sensations brings the amygdala on line for EMDR stimulation and processing? This is probably most profoundly relevant to body sensations, since so much response is observed when processing them. Does focusing on affect and somatic sensations target dissociated mental representations of the experience that are not symbolically processed or placed in space and time? Can we view the reprocessing of the positive-adaptive belief as a stimulation of cells in the left prefrontal lobe of the neocortex?

If the above is accurate, it has great implications for our understanding and treatment of trauma, both chronic and acute, as well as other clinical conditions. It has long been known that many potent emotional memories date from the first few years of life. During this early period, brain structures like the hippocampus — which is crucial for forming consciously-accessible memories and, therefore, narrative memory, as well as the neocortex, the seat of rational thought — have yet to fully develop. The hippocampus is not fully myelinated until the third or fourth year of life. The amygdala, by contrast, matures very early in the infant's brain development (LeDoux, 1994; van der Kolk, 1994). As the central nervous system matures, memory storage shifts from primarily sensorimotor and perceptual representations to symbolic and linguistic organization of mental experience (Piaget, 1962; van der Kolk, 1994). LeDoux posits this as support for the position that pyschodynamic psychology has taken — that the experience of life's earliest years lays down a set of emotional lessons based on the level of atunement between infant and caretaker. This sheds light on the difficulty traditional psychotherapy has had in ameliorating neuroses and character disorders. These early interactions are so potent and difficult to understand and work through from the vantage point of adult life because they are stored in the amygdala as rough, wordless blueprints for emotional life (LeDoux, 1992, 1994).

To state it differently, the target event has remained unprocessed because the immediate biological responses to the trauma have left it isolated in neurobiological stasis (Shapiro, 1994, 1995).

A multitude of questions remain to be answered. The hypotheses contained in this discussion need to be verified and operationalized. The neurophysiological meaning of the chronicity of these brain changes versus their acuteness remains to be understood. The neurophysiological understanding of the brain and of EMDR is not just for those who are so inclined or curious. It is crucial because it informs practice. If EMDR is used to treat chronic neuroses and personality disorders and we understand that we are dealing with preverbal material, the above information may direct us to focus more on processing body sensations, using them as a language. What appears to be evident is that EMDR may be the first clinical tool that interfaces with the amygdala and the other limbic structures.

 This article is an excerpt from the paper "Further Thoughts on the Neurophysiology of EMDR," presented at Harvard University-Cambridge Hospital, at an all-day symposium on sensations — using them as a language. For more information and references, please contact the author.

Continued from page 10

EMDR: CONCURRENT TREATMENT MODEL

She had intrusive symptoms of PTSD, and was extremely hypervigilant. She had repetitive nightmares, flashbacks and insomnia.

Her mother (who had bipolar disorder) was often unstable during Ms. P's childhood. She never knew "which mother would be home," the normal mother or the mother who could burst from the doorway and attack her with her "claws."

After 18 months in treatment, the patient had progressed. She had more insight into her reactions and their link with childhood terror. She was able to drive in the dark (with discomfort) and she could stay alone in the house for a couple of hours. But she began to worry about ever completely resolving the trauma. She had expanded "her cage," but had not left it.

At this point, the patient was beginning to feel hopeless and frustrated. I proposed EMDR treatment to her. I discussed her problems with the EMDR consultant and she began weekly treatment. For several sessions the image of the hand coming through the doorway remained the same and then the doorway "became empty."

In sessions with the author while she also worked with EMDR, Ms P. shared anything significant that had occurred. She became more optimistic after two sessions. After 10 sessions she happily reported that, while alone in the house, she could take a shower and wash her hair. After the EMDR work concluded, she continued to make gains in resolving trauma. She soon felt free of residues from the rape and terminated therapy.

A second patient, Ms. B, was referred to the author by a therapist who had worked with her for two years. She was a child sexual abuse survivor with a 10-year history of panic anxiety and sleep disorder. The symptoms included difficulty falling asleep and frequent waking (every 1-2 hours). Her most overwhelming problem was the compulsive need to stretch her legs and arms throughout the night. Both psychiatric and medical intervention had not been helpful; several trials of medication were unsuccessful. Ms. B. believed that she was powerless and inadequate to solve her problem, crazy and undeserving of help.

She was eager to try "anything". In the first session, the patient almost immediately remembered that she had been bound, hand and foot for several hours after being sexually abused. The EMDR work explored her need to/and fear of expressing the anger she felt toward the perpetrator. In primary therapy, she dealt with the need to feel stronger before she could express anger. When she decided to register for a Tai Chi course, she experienced heightened anxiety. This was processed in an EMDR session and the patient visualized herself kicking out at her father and kicking the ropes off. The need to stretch ceased and she began to sleep normally. She enrolled in the course and enjoyed the work. The panic symptoms disappeared. Ms. B. ended EMDR work after eight double sessions and continued with her primary therapist. During the course of treatment the therapists had several telephone conferences. It was noted that the patient adapted well to the dual therapy, experienced no complications and felt the EMDR work was extremely helpful.

The author's experience with patients referred for concurrent EMDR work has been very positive. Patients have reported successful experiences working with EMDR while they continue with their primary therapist.■

Continued from page 11

EMDR: TRICK OR TREATMENT

the events and bore no responsibility at all. He then experienced progressive emotional relief and body relaxation. Most significant was his insight that he was the helpless victim of the woman who "imposed her suicide" on his life. Bob was then able to allow his rage and resentment for the woman to surface and naturally integrate these emotions as reasonable and appropriate. After the incident was fully desensitized, he was able to incorporate, with additional eye movements, the reality-based belief, "I am a good person who did the best I could." After this breakthrough, the frozen images of the other five accidents were "thawed" as well, each fully resolved in five to ten minutes. Afterwards, Bob was amazed that he could no longer retrieve the details of any of the incidents. When I asked how he experienced the treatment, he responded, "I feel like I had a mental enema. You gave me my life back."

Three years have since passed and Bob's PTSD remains fully resolved. He has referred about 25 engineers, who have come to me for treatment of their trauma symptoms stemming from incidents, some occurring as recently as two days before their visits and some as remote as 20 years earlier. They call me as "the eye guy." And, except in cases with severe histories of childhood abuse or crippling underlying psychopathology, these engineers have replicated Bob's rapid trauma resolution in one to three extended sessions. I have facilitated similar results with over 100 other individuals who have suffered trauma resulting from natural disasters, serious accidents, rapes, holdups, animal attacks, the murder of a loved one or military combat.

Without doubt, more scientific inquiry and debate is needed to determine the efficacy, mechanisms and clinical effect of EMDR. Future discussion should be serious, probing, respectful and open. ■

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one of the driving forces of clinical practice, is unmeasurable and a highly variable combination of the clinician's intuition, knowledge, personal and professional experience. In support of this criticism, Gifford (1996) wonders if practice clinicians have resisted explicit definitions of their work in an ill-advised effort to protect their autonomy. While Safran and Muran agree that the definitions should be made more explicit, they think that that will happen if clinicians themselves become more involved in research.

Talley and Strupp (1994), two renowned clinicians who conduct outcome research, argue that an obsessive focus by empiricists on methodology has compromised the relevance of their research to clinical practice. They and others assert that the empirical studies produce results that are invalid, trivial (Orlinsky, 1994), contrived (Bergin & Strupp, 1972), and/or "circumspect" (Kiesler, 1994). In an effort to isolate factors that are common to larger numbers, the empiricist, they maintain, often neglects idiosyncratic or contextual factors like maturation, age-appropriate developmental tasks, serendipitous life events (job promotions, downsizing, winning the lottery, losing a friend), and/or the therapeutic frame (treatment alliance, hopefulness).

The Consumer study suffers from many of the problems cited above. In addition, specific criticisms have been lodged about sample selection, the quality of the study data and choice of quantitative methods to investigate psychotherapy's effectiveness.

Weakness:

Sample Selection

The Consumer study involves a self- selected sample that represents a subgroup of The Consumers Report's readership that sought help for emotional problems between 1991 and 1994. It is assumed that the sample is financially secure enough to subscribe to this type of journal, intelligent, functional and interested enough to read it, and committed enough to take the time to complete and return a lengthy questionnaire. The sample is therefore biased. It is not representative of all individuals who sought help for emotional problems in the United States during the same period of time and probably underrepresents consumers with serious and persistent emotional disorders, those taking neuroleptic medications and /or those in inpatient facilities. The sample may also be biased in favor of "satisfied customers." According to Wadell (1996), client satisfaction surveys tend to generate a higher response rate from clients who, regardless of the program or service, feel favorably about their experiences.

The Consumer study sample best represents less disturbed, higher functioning, former psychotherapy consumers who have been satisfied with their treatment experience. These biases would be viewed as strengths if the study's aim was to learn about the factors that comprise and contribute to "successful" treatment or "satisfied customers."

It should be noted that the lack of a no-treatment control group in the study is not necessarily a weakness. Even with a control group, it would be difficult to assume that treatment would be solely responsible for any specific outcome. If better outcomes were reported by those who were treated versus those who were not, most clinicians still would not assume the difference to be a function of their interventions. Furthermore, because deliberately withholding treatment for research purposes would raise serious ethical issues, most clinical research of necessity does not include a traditional control group.

Weakness:

Quality of Study Data

The Consumer data are also criticized because it relies on clients' retrospective memories and subjective judgments and it fails to include standardized objective tools to measure subjects' functional and clinical outcomes. The memories may not be valid and/or the judgments about treatment may be colored by feelings toward the therapist or the therapy experience (Waldo, 1996). If the subject felt positively about the therapist, he/she might report favorably about the experience, regardless of whether treatment goals were realized, symptoms relieved or functional status regained or enhanced (Jacobson, 1996). To guard against this risk, prospective studies and objective assessments are advised. Unfortunately, both methods are time consuming, labor intensive and expensive. In prospective studies that use objective assessments, independent judges interview subjects in person or use subjects' responses on objective instruments to assess functional and clinical status before and after treatment. But even with these safeguards, the independent examiner still must rely on subjects' self-described reports.

Strupp, Hadley and Gomez (1977) also suggest that using independent judges to assess subjects' clinical status does not insure objectivity. In their study of the effectiveness of treatment, there was little agreement about outcome status among former patients, patients, family members and the actual therapists who conducted the treatment. While all four groups used the same treatment reports to make their judgments, they differed widely in their conclusions about the effectiveness of the treatment.

Standardized instruments are often recommended to reduce the bias associated with subjective self reports and ratings. Because all subjects are judged using the same measures, it is assumed that all data are comparable. But, in fact, standardized instruments may not produce comparable data across respondents, because the instruments are developed using circumscribed, idiosyncratic study samples — hospitalized psychiatric patients or college students, for example. These groups are not comparable to the Consumer study sample. Also, most instruments are narrowly constructed to assess only specific symptoms or areas of functioning. Currently, no standardized instruments are available that could be practically administered to large and diverse populations and that are sufficiently refined to capture the subtle and abstract dimensions of psychotherapy.

In Summary

In summary, from an empiricist's perspective, the reliance on retrospective and subjective data and the lack of a control group weakens the Consumer study. However, the costs associated with prospective studies, the questions of validity with "objective" assessments, and the absence of appropriate, standardized outcome and psychotherapy instruments limit the alternatives. The decision to rely solely on self reports would have been both methodologically and clinically sounder if some effort had been made to identify factors that compromise the validity of subjects' judgments. However, the lack of a control group in the Consumer study presents less difficulty for clinical practitioners than it does for empirical researchers. Their different reactions stem from their divergent world views and approaches to practice research.

Applicability of Quantitative Methods

Finally, the value of using quantitative research methods to learn about treatments and outcomes has been questioned because it suggests a cause/effect relationship between treatment and outcome that is not defensible, it establishes statistically-generated client profiles derived from groups that are not representative of clients in practice, and its relies on linear thinking that may distort complicated, multifaceted treatment phenomena.

Implications and Conclusions

While the Consumer study demonstrates that psychotherapy is helpful and that social workers are effective providers, it suffers from methodological weaknesses common to all client satisfaction surveys. Because managed care companies use the data from this type of research to establish policies and make treatment decisions, it is important that clinicians understand its limitations. Furthermore, clinical and empirical researchers must address and transcend their conceptual and methodological differences to generate valid and reliable data that reflects the wisdom of both perspectives and that yields results to better inform our understanding of patients and the treatment process.

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