

Relevant Information Regarding First OEI Study (2003)

Summarized by R. A. Bradshaw, Principal Investigator

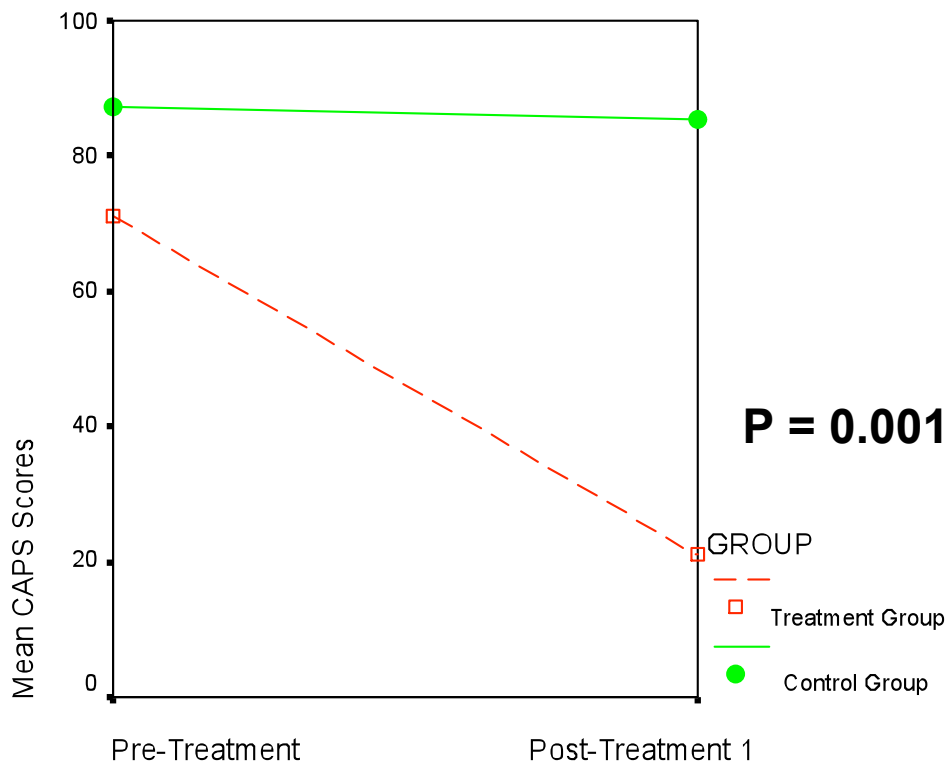
In 2003 a program of formal research was initiated to assess the effectiveness, and understand the underlying mechanisms, of Observed & Experiential Integration (OEI) --- (formerly referred to as "One Eye Integration"). It was anticipated that critics would claim that OEI was the same therapy as Eye Movement Desensitization & Reprocessing (EMDR), because there are techniques in both therapies that involve visual tracking of moving objects. To counter that argument, only one of the three OEI techniques was implemented, known as "switching" (Grace, 2003). This involves simply focusing on a disturbing event, emotional state, inner voice/statement, or body sensation; and alternately covering and uncovering the eyes. In other words, no tracking of movement was required, so any mechanism theoretically occurring in the saccadic eye movements of EMDR could not be said to be activated. Since that study, Lefebvre (2004) pilot tested an initial application of the same OEI technique (switching) to relieve migraine and tension headaches.

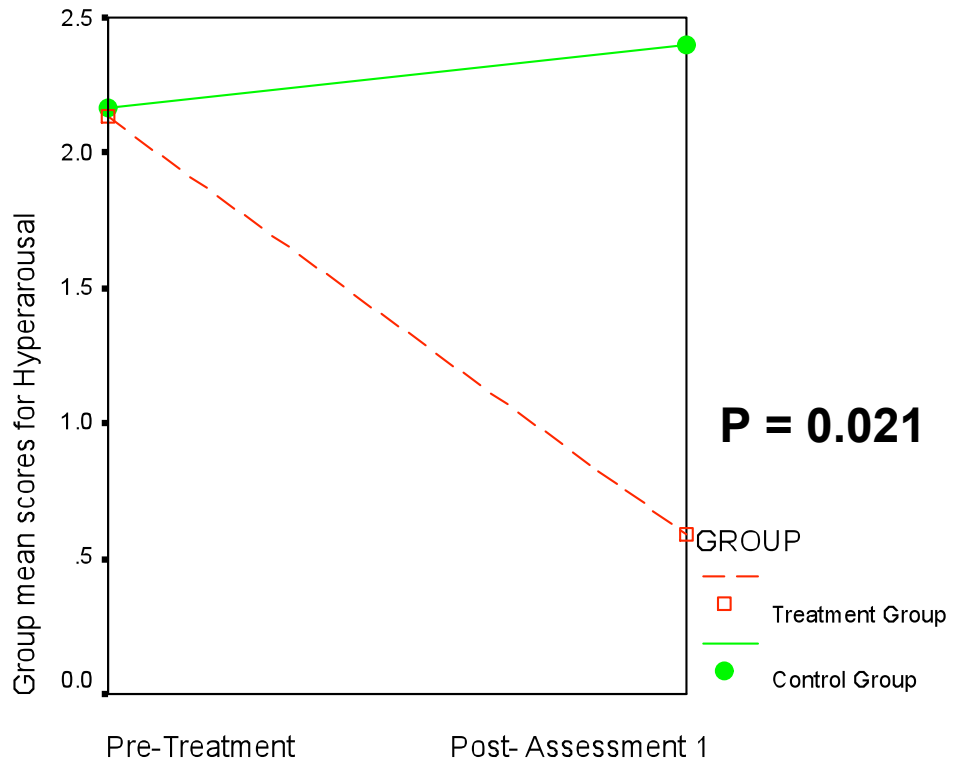
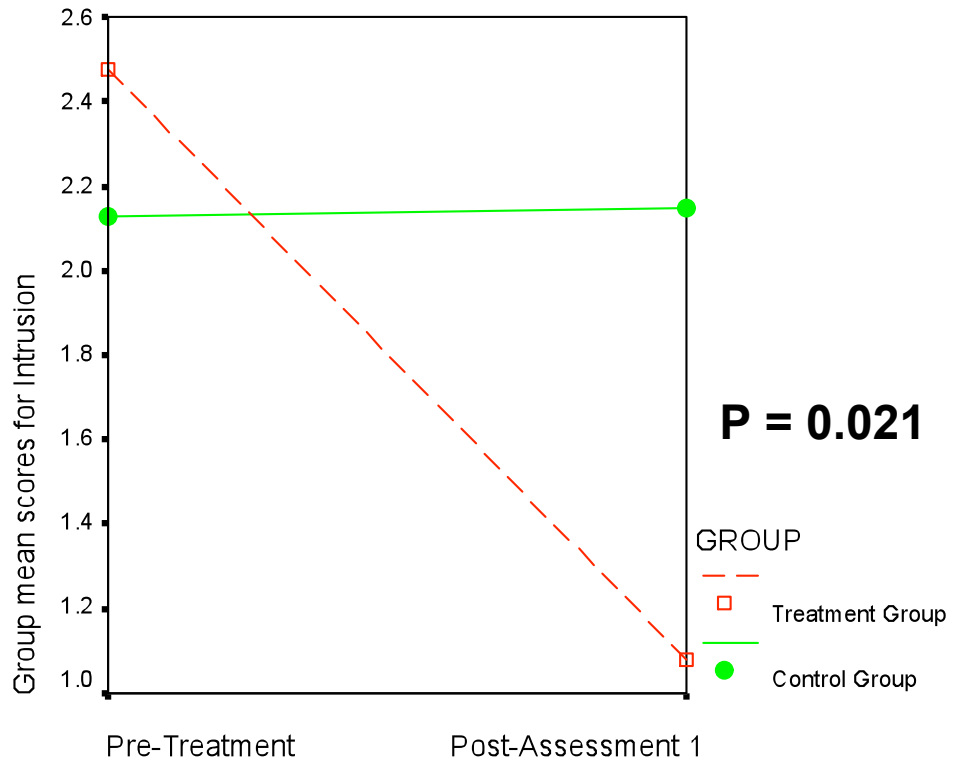
A search was undertaken for the most appropriate instruments and procedures for researching Posttraumatic Stress Disorder (PTSD). Several leading studies had used a procedure known as "script-driven symptom provocation" (Pitman et al., 1987; Lanius, Bluhm, Lanius, & Pain, 2005). This involves the creation of a 30-45 second audiotape of the most disturbing portions of a traumatic incident, excerpted from each participant's description of his or her most traumatic event on an instrument known as the Traumatic Scene Form (TSF; Hopper & van der Kolk, 2001). These same researchers also developed an instrument and procedure for evaluating the qualities of traumatic remembrances triggered by these recorded, individualized trauma scripts, known as the Traumatic Memory Inventory – Post-Script Version (TMI-PS). Finally, the two PTSD measures selected were the Impact of Event Scale-Revised (IES-R) and the Clinician-Administered PTSD Scale (CAPS), a 45-minute structured interview. The former was selected because it was the most widely-used PTSD instrument in trauma therapy literature, and the latter was selected because it was endorsed by the National Center for PTSD and constituted a more comprehensive and interactive assessment of PTSD symptom frequency and intensity. Both measures include all 3 clusters of symptoms for PTSD from the Diagnostic and Statistical Manual of Mental Disorders text revision (DSM-IV-TR) from the American Psychiatric Association (APA, 2000): Intrusion, Avoidance/Numbing, and Hyperarousal.

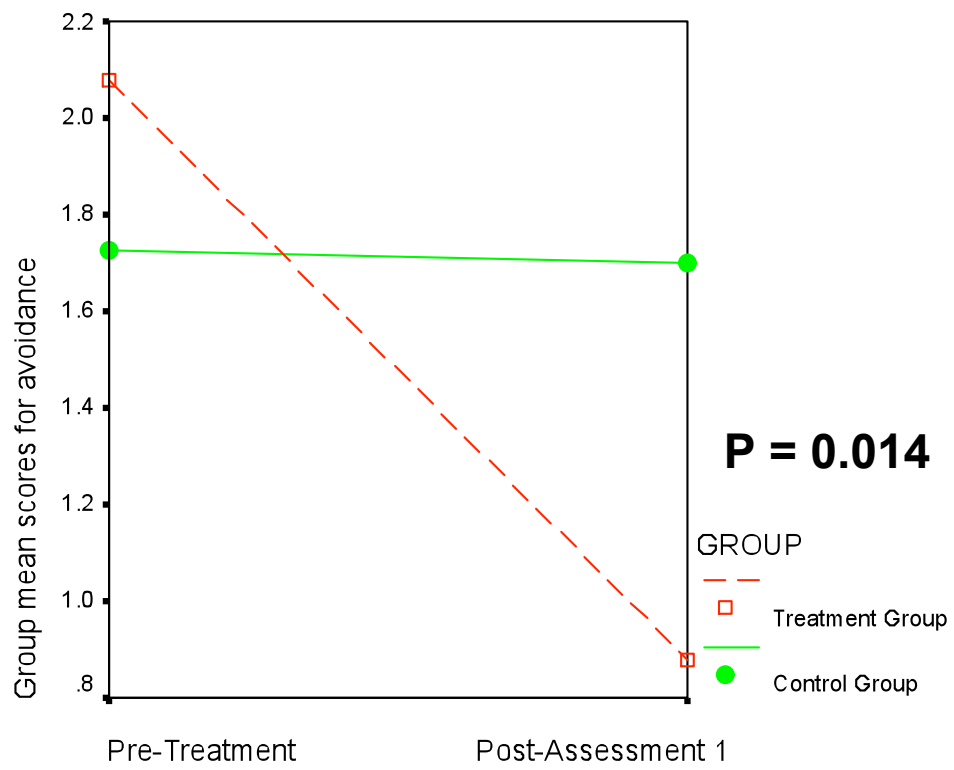
It was anticipated that critics would claim that it was the script-driven symptom provocation that had reduced PTSD symptoms, rather than the OEI switching. For that reason, the delayed treatment control group was subjected to 2 extra exposures to the trauma script (one after each of the three one-hour therapy sessions). There were no significant differences between the treatment and post-therapy control groups in terms of PTSD symptoms, supporting the contention

that it was not the exposure to the trauma script that constituted the active therapeutic ingredient (Austin, 2003). Other researchers have also pointed out that the short, intermittent doses of exposure inherent in EMDR (and, by association, OEI) would actually be expected to increase the intensity of PTSD symptoms, according to behavioural exposure theories (Rogers & Silvers, 2004).

That small (N=10) initial randomized experiment involved a heterogeneous sample of trauma survivors (3 males, 7 females). The findings constitute support for the efficacy of OEI (Bradshaw, Grace, & Swingle, 2004). Results of mixed between-within subjects repeated measures ANOVAs are as follows:







References

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