

SINGLE CASE DESIGN GUIDELINES

How can practitioners contribute to EMDR research?

Many EMDR practitioners inquire about how they might contribute to the research on EMDR. Some basic guidelines on doing research are presented here—they have been adapted from an EMDR Institute Listserv post by Louise Maxfield.

The purpose of research is to test the effectiveness of a specific protocol. To do this, we have to be able to say that the results would not have been achieved without the treatment; i.e., that the person would not have improved as a result of time or attention. There are 2 simple designs that can be used by practitioners to collect such data. These are single case designs and waitlist designs. A third design is treatment comparison, which tests whether EMDR is more effective than another therapy. This other therapy might be CBT, standard care, or modifications of EMDR, etc. The following are simple descriptions of these designs. Please note that these can often be more complex.

In a single case design, measures are administered to evaluate the severity of symptoms. It is recommended that the clinician use recognized and standardized inventories or tests, so that other therapists and researchers can readily understand the extent of the client's problem and its improvement. It is also possible to use individualized counts of targeted problems or behaviors. For example, in the treatment of agoraphobia, in addition to using standardized measures of pathology, one could count the number of panic attacks per week, and the number of weekly hours that the client spends in a crowded public place.

The measurements are taken on several occasions prior to the start of treatment to establish a baseline. This evaluates the severity of symptoms over time without treatment. Then, when treatment starts, the measures are administered on a regular basis. The same thing is done after the end of treatment to measure maintenance of treatment effects. What you end up with is a graph with 3 sections, Pre, During, and Post treatment. Each section of the graph has a line with several data points measuring symptom severity. For example:

	<i>Pre</i>			<i>During</i>					<i>Post</i>			
Week	1	2	3	4	5	6	7	8	9	10	11	12
Scores	78	60	76	54	49	35	42	26	20	23	22	18

Just collecting the data during and post treatment is not considered scientifically compelling, because it is possible that the person may have had a similar improvement without treatment. The pre-score baseline demonstrates that this is probably not the case. Published studies generally show a series of clients with the same disorder, using the same measures. The simplest single case designs (pre, during and post) are called A-B-C designs (A for baseline, B for intervention phase, C for follow-up). These designs are easy to implement, but aren't as rigorous as more complex single case designs which can establish an

intervention's effectiveness more convincingly.

Many practitioners may choose to collect "During" and "Post" data in their own practice to document the effectiveness of the therapy they provide. This is also very useful, but has a different goal. Therapists can use this type of information to help them to identify any patterns of response among their own client group, the advantages of changing or modifying the protocol, etc.