EMDRIA™
NEWSLETTER
Vol. 3, Issue 4 Quarterly Publication December 1998

In This Issue

Message from the President: Remembering and Reaching Out

Daniel T. Merlis, M.S.W.

I write this message to you on the approach of Thanksgiving and find myself contemplating the theme of this holiday and of the holidays soon to come.

At this time of the year, there is for me both a turning inward which involves an active remembering and a reaching outward to the people I care about but see too little of. I dig out old letters, pictures, and family recipes. Indulging in long weekend phone calls with old companions, I feel blessed and thankful for the connections I have forged with others, living and passed.

I reflect on my life's work as a psychotherapist and the many learnings I have had through my contact with clients, teachers, and students over the past three decades. What are the teachings that have stayed with me through all the fashion changes in the field over the years? I invite you also to take a few moments during the holiday season to distill of your own learning and to reflect on that which you believe is most important to you in your work. Acknowledge your teachers, celebrate your clients' victories and achievements, cherish those special moments of unfolding and awakening which take place in your office. Consider what your goals are for the coming year. In what ways would you like to stretch yourself professionally? As an EMDR therapist? In what areas of EMDR practice would you like to improve? What contribution could you make to the field of EMDR practice and research?

I make a special appeal to EMDRIA™ members to consider contributing to our international research effort. Your single case study is not insignificant. We need to learn as much as we can about how EMDR can be used effectively with different clinical populations and under different circumstances. Of course, randomized and controlled research studies are of crucial importance to the field. Nonetheless, our understanding of EMDR came a long way on the shoulders of the individual clinician studying her/his work with clients, one case, or a group of cases at a time. Please commit to researching a case which is of interest to you and to sharing this with the EMDR community. We also need reviews of research studies that have been published. Please pitch in! Research-generated knowledge is an important community need.

Our EMDRIA™ committees have been hard at work this fall. The Training and Standards Committee has been working on policies related to the certification of EMDR therapists as well as standards for the categories of approved EMDR trainer and approved EMDR consultant. The standards will apply internationally while allowing an appropriate degree of flexibility to accommodate specific national needs or

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From The International Scene

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Time passes so quickly—here I am in the middle of autumn on the east coast of the United States. The leaves are especially beautiful this year. Bright reds, shimmering oranges, and iridescent yellows are a constant reminder of the beauty of the changes of the seasons.

In this issue, I would like to introduce all of you to my friend, Graciela Rodriguez, a dynamic, jubilant woman from Argentina. Graciela is full of energy and, wherever she travels, she mobilizes, encourages and cares for the people she serves.

A physician and psychiatrist, Graciela started her career as a psychoanalyst and then branched out to learn Ericksonian Hypnosis, studying under Jeffrey Zeig. She refers to EMDR as "a miracle in my career." Beginning in 1992, she traveled to the United States many times to participate in the EMDR Institute's trainings. Since then, she has worked tirelessly in public hospitals to bring what she has learned to various patient populations including alcoholics, AIDS survivors, Dissociative Identity Disordered patients, and victims of torture.

As her interest in EMDR deepened, Graciela became a facilitator and went on to become a trainer after studying with Francine Shapiro. She lived in Australia for more than a year, assisting in the continuation of the Institute training program after Gary Fulcher had to step down for medical reasons. She presented trainings in Sydney and Melbourne and assisted in the building of the EMDR Association-Australia.

As a result of her excitement and enthusiasm about EMDR, Graciela pioneered the introduction of EMDR into many countries: Malaysia, Nepal, Chile, Brazil, Argentina, Spain, Singapore, Mexico and Columbia. One of the most poignant trainings, she recalls, involved working with refugees from Buthan in Nepal through an organization that worked with torture victims. It is therefore not a surprise that the subject closest to Graciela's heart concerns the exchange of cultural information and how that affects the teaching of EMDR.

Graciela is interested in addressing cultural differences for the cultures to which she introduces EMDR and, in her words, she is "in search of the best way to introduce EMDR in different cultures." She found that her experience of using EMDR in Singapore and then Nepal taught her many new things about culture. Her belief is that "EMDR is excellent because any person can use it, even in places like Nepal with Buthanese refugees. It could be a common language all over the world!" Graciela hosted a seminar on this subject at the 1998 EMDR International Association Conference and hopes this topic will be a continuing presence at subsequent conferences. Also, she is experimenting with different teaching models to improve clinicians' mastery of the course material and case implementation.

Now that Graciela has returned to Argentina to live, she continues to travel and teach in Latin America and Spain. She is a strong proponent of the multi-cultural perspective that characterizes the spirit of the EMDR International Association and supports this organization in its international scope. She will be starting a Spanish discussion list on the web and invites interested clinicians to contact her at graciro@intergate.com.ar

News from around the world:

- **Belgium**: Marc Van Knippenburg writes that there will be training in Antwerp in May 1999. In September, he spoke at a European Colloquium in Italy where he presented on EMDR.
- **Canada**: EMDRAC sponsored a mini-conference on November 20th featuring a presentation by Andrew Leeds, and the EMDRAC Board of Directors met for the first time on November 21st.
- **Denmark**: Birgit Schulz and Lene Jacobsen report that Danish clinicians are responding to EMDR in a positive manner as "there is an emerging awareness in the profession that EMDR is an excellent method." There will be two trainings in Denmark in November resulting in 120 trained clinicians.
- **Europe**: EMDR Europe will have its second European meeting at the beginning of January. According to John Spector, "It was formed in an attempt to galvanise interest and development in EMDR across Europe and also to some extent to coordinate trainings and standards which were beginning to become very haphazard." John notes that there is a great deal of enthusiasm among his European colleagues.
- **France**: Francois Bonnel writes in that there will be beginning and advanced trainings in May in Paris.
- **Germany**: EMDR-Germany hosted its first, full-day workshop featuring Francine Shapiro in September. The day was well attended and heralds a strong beginning to continuing education in EMDR. Franz Ebner did a fine job in getting EMDR-Germany up and running. Eva Irle, Gerald Huether, Joachim Spiess, Annette Streeck-Fischer and Ulrich Sachsse are hosting the second International Trauma Congress in Gottingen from March 11th to 14th. 1999 called *Korper-Seele-Trauma*. Arne Hofmann, F. Lamprecht,

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(Message from the President - Continued from page 1)
circumstances.

The Regional Meeting Coordinating Committee has completed its work on establishing a network of EMDRIA™ Regional Coordinators in the U.S. An important function of the Regional Coordinators is to organize continuing education experiences on a non-profit basis. It is envisioned that the RCs will seek EMDRIA™ approval for Regional Meetings in order to offer education credits which will count towards the *EMDRIA™ Register* requirement of 12 credits every two years. (Note that the regional meetings organized by Regional Coordinators are not study groups. Study groups are loose affiliations of clinicians who gather to study EMDR, typically in a non-structured format. They do not operate under the auspices of EMDRIA™. We publish information concerning study groups in our newsletter as a service to EMDRIA™ members, but their activities are not reviewed or approved by EMDRIA™.)

The Professional and Public Relations Committee has developed a media kit to be available to EMDRIA™ members who anticipate contact with local media. The PPRC has also completed the text for the EMDRIA™ *Brochure for Professionals*, which is now in the hands of a graphic designer and should be available soon after the holidays.

The Publications Committee is working to expand the number of *EMDRIA™ Newsletter* issues in 1999 to six issues. Please consider contributing practice or research articles to the *The Newsletter*. Share your innovations, ideas, successes and failures with your colleagues.

The EMDRIA™ Board approved creation of the Health Care Committee. This committee will seek to work with larger health care organizations and managed care organizations to make EMDR more available to the public.

At present, we have vacancies in four committees: Health Care; Long-Range Planning; Publications; and Structure, Function, and Bylaws. Please contact me or the appropriate Committee Chair if you are interested in serving. We would like to have you work with us!

Plans for the 1999 EMDRIA™ Annual Conference are taking shape. Having reviewed the workshop proposals, I can say with assurance that this conference will be packed with great presentations. We will be in Las Vegas, from June 18th to 20th, in a non-gambling, spa hotel. Join us for a fulfilling mind-body experience!

I close by wishing Happy Holidays to you all! May you and your loved ones share many special moments during the weeks ahead.

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The Health Care Committee Needs You!

The Health Care Committee is a new standing EMDRIA™ committee whose ultimate goal is industry-wide acceptance of EMDR by the health insurance community. To that end, the Committee is currently moving the process of interaction with the managed care world into higher gear.

Contacts with the MCO world and Committee Members with experience working in the MCO world have clearly indicated that we must make direct presentations to managed care decision-makers. One of our Committee Members is drafting a protocol to approach, meet, and persuade managed care organizations to accept EMDR as a treatment component.

Anyone who would like to participate in the process is invited to e-mail the Chair of the Health Care Committee, Mark Dworkin, CSW, LCSW, at mdworks5144@aol.com.

We appreciate your help. Please understand that this will be a time-intensive project, and participants must know the research and be prepared to defend it.

Your Comments about This Project Are Welcomed and Encouraged!

(International Scene - Continued from page 2)

Unter Mitwirkung, and W. Lempa will be presenting on EMDR. Other EMDR-trained clinicians and researchers in the program include M. Huber, G. Fischer, B. van der Kolk, I. Ozkan, L. Reddemann, U. Sacchsse and V. Tumani.

- **Guatemala**: Michael Galvin reports that, along with John Hartung, he will be giving a fifth training in Guatemala in November.
- **Israel**: Udi Oren writes that Dr. Eva Eshkol and Zilla Ben-Nachum presented their work using EMDR to the Rehabilitation Psychology Annual Conference at the AMCHA International Conference by Yvonne Tauber, Elisheva van der Hal and Chaya Einav. Udi Oren and Brurit Laub were interviewed about EMDR on the national radio program.
- **The Netherlands**: Ad de Jongh reports that there will be two EMDR trainings in the Netherlands in January 1999.
- **South Africa**: Facilitator Reyhana Seedat Ravat was part of the trainers' training in Cologne, Germany. Currently, she is volunteering to support the Humanitarian Assistance Program by donating her time and services to train and support mental health care workers in Bangladesh. She will be sponsoring more training in South Africa in 1999.
- **Sweden**: Kerstin Bergh Johannesson informs us that she and her colleagues established EMDR-Sweden in September. Kerstin was elected chairman of the Board; Monica Chu, secretary; and Anne Martinell West, treasurer. Other members of the Board include Gunnel Ohlsson, Goran Hogberg, Svante Peterstrom, and Ramon Sato. "The aim of the organization is to be part of EMDRIA™ and EMDR Europe and to form a local network for information, workshops, and referrals." Sweden had its first advanced EMDR training with "32 very pleased participants." In December, they will be sponsoring an intern training for child psychiatrists. Kerstin sums up her message with the following: "The word is spreading both formally at professional presentations and informally, and EMDR, still young in Sweden, begins to be a well-known concept."
- **Switzerland**: A training is being organized in Schaffhausen for October, 1999. EMDRIA-Switzerland was founded on September 29, 1998, and the four Board members are Maya Hessig, Hanne Hummel, Sylvia Johnson and Rolf K. Foster.
- **United Kingdom/Ireland**: In her new position as clinical psychologist at the Maudsley, one of London's most prestigious hospitals, Sandi Richman writes that the staff is interested in EMDR and want her to give talks and seminars on the subject. John Spector notes that, on a national level, "EMDR is now accepted as an effective psychotherapy and clinicians working in PTSD at the highest level are experimenting with it and researching in it." He has just finished a paper, *The Current Status of EMDR*, which is under review. Another article will appear in the next edition of *Behavioural and Cognitive Psychotherapy* written by John, Desmond Poole, and Ad de Jongh. Also, John will present on EMDR at a PTSD Conference in London. John states, "I think these are all signs of the growing acceptance of EMDR here as a serious and effective psychotherapy."

I look forward to hearing from you—please send me your news and accomplishments at marluber@aol.com.

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ATTENTION: CLINICIANS WHO TREAT PERPETRATORS

February 15-28, 1999

John Marquis, Ph.D. will serve as guest host of the EMDR Institute Discussion List at:

EMDR@Maelstrom.StJohns.EDU

with posting, consultation, and dialogue for those who treat sex and violence perpetrators.

Dr. Marquis is sponsoring the discussion as advisor of the Committee on Ending the Cycle of Violence of EMDR HAP to help those who are treating aggressive offenders and, ultimately, to help victims.

INTRODUCING . . .THE PUBLIC AND PROFESSIONAL RELATIONS COMMITTEE

Sandra "Sam" Foster, Ph.D., Chair

One of EMDRIA's newest committees is the Public and Professional Relations Committee. Our Mission is to:

- Develop a positive relationship with the media in an effort to educate the general public and professionals about EMDR and EMDRIA™, as the organization dedicated to ensuring integrity and professionalism in the use of EMDR.
- Provide support, information and materials for EMDRIA™ members working within their communities to promote EMDR and EMDRIA™.

How the PR Committee Serves You

1. As Committee Members, we can help you prepare to interact with the media in your area, to do a local story on EMDR, or to assist you in responding to an inquiry from the national media (radio, television, or the print media—newspapers and magazines). When you provide the name of your media contact, we will furnish a media kit describing EMDR. If you wish, a Committee Member can assist in an interview either directly or by offering suggestions. Our Committee Member list below provides an indication of our geographical reach.
2. We have developed a brochure for a professional audience, a handsome piece that you can provide to physicians, other professionals in medicine, and others who might be interested in a description of EMDR and a summary of the research supporting it. Please call the EMDRIA™ office for ordering information, specifying the *Brochure for Professionals.*
3. You may also want to purchase our "EMDRIA™ Member Presentation Packet" by calling the EMDRIA™ office. This packet, designed to help you prepare a presentation to a grand rounds or a group of medical professionals or assist you in a conference workshop, includes:

- The six most recent EMDR research articles in which a controlled study was done.
- Eight print media articles on EMDR taken from major news publications.
- A copy of *Compelling Facts about EMDR*, a list of major points about EMDR that serves as a quick summary.
- Twelve overhead masters that offer *Compelling Facts* in presentation form and describe the EMDR research in the areas of treatment of trauma and anxiety disorders. These masters can be used to make your own handouts and transparencies.
- A cassette tape of an Interview with EMDR practitioner James Black, featured on Wisconsin Public Radio. This tape offers an excellent example of how to conduct an in-depth media interview about EMDR.
- A sample copy of the EMDRIA™ *Brochure for Professionals.*

To order this presentation packet or a set of the EMDRIA™ *Brochure for Professionals*, contact the EMDRIA™ office by telephone 512-451-5200, via fax at 512-451-5256, or by e-mail at emdria@aol.com.

Contact the PR Committee

We are interested in hearing from you. Please contact a Committee Member in your area if:

- You are involved in or aware of "newsworthy" projects or research.
- You would like assistance preparing for professional presentations, interacting with the media, or responding to controversy or misinformation about EMDR.
- You have contacts or established relationships with people in the media.

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Regional Meeting Coordinating Committee Report

Jocelyne R. Shiromoto, MSW, LCSW

I know many of you have been waiting for some time for us to finally "walk the talk" and provide those long rumored "Regional Meetings." We have journeyed long, but we are finally on our way as I write this article. Thus far, 56 members (with more still coming in) have requested applications for becoming EMDRIA™ Regional Coordinators throughout the United States. All applicants are in the process of reviewing the Terms of Condition and deciding on their ability to commit to the EMDRIA™ guidelines for coordinating the Regional Meetings. By the time you receive this *Newsletter*, we will have begun posting the Regional Meetings locations and Coordinators/Teams on the EMDRIA™ website, www.emdria.org. We will list them in the next *Newsletter* as well.

In talking to many who have applied for Regional Coordinator, it impresses me how many are willing to volunteer and dedicate themselves to the on-going assurance of the integrity of EMDR by providing opportunities for other clinicians to come together to "sharpen" their skills in EMDR and support one another. We want to thank all who have and will commit themselves to this challenging endeavor and to applaud their continuing passion to work toward the "bottom line" in this field—to lessen the suffering of many.

Have a peaceful and fun-loving holiday season. Until next time . . .

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New Brochure for Professionals Soon Available!

The Professional and Public Relations Committee is completing a new brochure about EMDR for mental health practitioners, physicians, and other professionals. The brochure is appropriate for distribution at speaking engagements, grand rounds, and conferences. Please contact the EMDRIA™ office at 512-451-5200 or emdria@aol.com for information.

EMDR AS A SPECIAL FORM OF EGO STATE PSYCHOTHERAPY

Part One of Two Parts

Mark Lawrence, M.D.
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Ego state therapy has become an increasingly recognized and utilized form of psychotherapy over the past 25 years, although it has been used primarily by hypnotherapists in the context of the treatment of dissociative disorders. The use of Eye Movement Desensitization and Reprocessing (EMDR) has also expanded extremely rapidly over the past ten years, primarily in the treatment of acute and chronic Post Traumatic Stress Disorder (PTSD). It is the thesis of this paper that EMDR can be conceptualized as a special form of ego state therapy. EMDR's unique contribution to the ego state therapy process is in its subtle, but profound, impact on the associative/dissociative process, and ego state therapy can be considered a meta model for informing EMDR therapeutic interventions, particularly with regard to impasses.

J. G. Watkins and H. H. Watkins (1997), basing their work on the writings of Paul Federn, have taken the lead in developing and teaching the basic ego state therapy concepts. They define an ego state as "an organized system of behavior and experience whose elements are bound together by some common principle." (H.H. Watkins, 1991, p. 233). Over the past 20 years, other writers (Edelstein, 1982; Fraser, 1991; Malmo, 1991; Newey, 1986; Phillips, 1993; Phillips & Frederick, 1995; Torem, 1987) have elaborated on the ego state therapy model. Most of them have approached the subject from a hypnotherapy perspective. Writers from other psychotherapeutic schools have also formulated models which can be seen as a reflection of ego state phenomenology, although the term "ego state" is not specifically used. Berne (1961, 1977), in his development of transactional analysis, talked about the parent, child, and adult parts of the self, as well as games that different parts play, all of which reflect the actions of different ego states. Assaglioli (1965), in his psychosynthesis writings, discussed the concept of subpersonalities, which can also be conceptualized as separate ego states. Schwartz (1995), coming from a family systems model, has written about "internal family systems," which is also a reflection of ego states or subpersonalities. Young (1994), with his cognitive therapy schema-oriented approach, talks about the schemas of patients in a way that is very close to that of an ego state model.

These are just a few examples of the many writers whose work might well be interpreted from an ego state model perspective. Similarly, EMDR can be conceptualized as a special form of ego state therapy.

This paper presents an abbreviated summary of an ego state theory of personality, psychopathology, and psychotherapy. This model is the author's personal formulation of ego state therapy and may not reflect the views of other ego state therapy practitioners. A brief overview of EMDR theory and technique follows. Finally, EMDR is conceptualized as a special form of ego state therapy, whereby the pre-therapy dissociative barriers between and within ego states are attenuated and new associative linkages are formed, such that a more integrated ego state structure emerges.

Ego State Therapy Model

The Development of Personality Structure

The fundamental basis for the structure of personality derives from the neuronal connections developed out of the state-dependent learning process. Rossi (1986) discusses how processes become "hard wired" together as a result of state-dependent learning processes. "Learning" in this context refers to the fact that biochemical and neuronal associations are made among components of a "state," linking them together. These interconnected components can be conceptualized as the simplest form of "ego state"—the totality of all that a person is in a single moment of time, incorporating all the components of the self. These components can be categorized according to Braun's BASC model -- Behavior, Affect, Sensation, Cognition (Braun, 1988). Or, they might be categorized according to the broader acronym proposed by Lazarus (1989) BASIC ID—Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal, and Drugs (which may be reformulated as Biology).

The *high intensity* of the terror of a traumatic experience tends to promote the creation of more enduring ego states. *Chronicity* or *repetitiveness* of an experience also tends to promote more enduring, strong ego states; hence, repetitive family patterns, including trauma, have a more powerful effect on the personality.

But associational linkages also develop among momentary ego states which occur sequentially in close proximity. These linkages are also stronger when associated with intense affect or regular repetition. Thus, for example, when we uncover the memory of an early childhood sexual trauma, the patient will experience a whole series of different affective ego states in close sequence, paralleling the initial experience, going from

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EMDR Consultations: The Need for Flexible Rigidity

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In addition to my work as an EMDR trainer and private practitioner, for the past several years I have provided supervision to EMDR-trained clinicians. During supervision, one of the most frequently asked questions has concerned how to handle requests for EMDR from a client currently in therapy with someone else.

People in the lay and professional communities have widely differing views and knowledge of EMDR. Some have heard that it is "one shot" therapy, while others see it merely as a technique. For example, when some therapists have contacted me about referring a client for EMDR it quickly became clear that they viewed me as an EMDR technician. As a technician, they simply expected me to draw some emotional blood, quickly analyze it, and give them the results. The wide variety of knowledge and expectations requires the EMDR consultant to educate both client and primary therapist as to what is needed to perform an effective consultation.

Consultations can be highly productive and stimulating if done properly; they can also be counterproductive if not. In this article, I want to share with you a series of steps that I have found to be important to provide an optimally effective consultation and avoid (or at least minimize) problems.

1. Contact

When the referral comes from another clinician, the EMDR consultation usually goes smoothly and productively. When the contact is initiated by a client who is in ongoing treatment with someone else, trying EMDR can be trickier. When contacted by such a client, I always ask for permission to contact the primary therapist. If the client agrees, I ask him to tell his clinician about his desire to try EMDR and to inform me when he has done so.

When notified, I reach out and call the primary therapist, because I want to do everything I can to minimize the chance that the other therapist feels threatened. The truth is that a referral means that something else is needed—that the current treatment is inadequate to meet the client's needs. I know how much this stirs up in me when it happens with my clients. Therefore, I want to reach out and do everything I can to make the primary therapist feel at ease so a treatment alliance is possible.

What do you do when the client does not agree to allow you to contact her therapist? This is one of the times where the clinician needs to be flexible—to some extent. Of course, the first questions are: why doesn't the client want you to contact her primary therapist? How valid are the reasons?

In a case in which the client only has sporadic contact with the other therapist and that treatment is primarily a form of maintenance, it may be reasonable to be flexible and forego the usual requirement that you speak to the other therapist. However, if the client is in regular treatment with someone else, it is important to contact the primary therapist.

I have often found the client's reluctance to involve the other clinician reflects one of the reasons he is in treatment. For example, he may have a hard time asserting his needs. He is afraid of being punished if he displeases an authority figure. He has a pattern of having affairs in which he does not leave one relationship until he has established another. Whatever the reason(s) may be, you do not want to be in an illicit relationship. These kind of relationships are not usually conducive to the kind of honest, intimate work needed if EMDR is to be effective.

2. Clarity

Once contact is made, it is important everyone involved have a clear idea as to the purpose of the consultation. Some of the questions to ask (and answer) are:

a. Why does the client feel the consultation is needed?

b. Why does the primary therapist feel the consultation is needed?

c. What is it hoped EMDR will provide that hasn't been accomplished so far? Associated with this are the issues of: Where has ongoing therapy been successful? What specific problems remain?

d. How realistic are the client's and primary therapist's hopes for the consultation?

e. How long will the consultation last?

f. What needs to be done to make sure the lines are

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Humanitarian Assistance Program Collaborations at Home and Abroad

MaryAnn Gutoff
HAP Admin Coordinator

[Note: The Humanitarian Assistance Program (HAP) is a 501(c)(3) nonprofit organization, supported by private donations and completely separate from EMDRIA™. HAP uses its international network of volunteer clinicians to provide the education, psychological intervention, and research necessary to restore emotional resiliency to survivors of natural or manmade disasters and violence in all its forms.]

In June 1998, UNICEF joined HAP in a pioneering effort to train all the existing mental health professionals in Bangladesh in the EMDR methodology. UNICEF Regional Director Rolf Carriere approached HAP after reading about the use of EMDR in a variety of clinician applications, reviewing the research, and interviewing a number of practicing clinicians. Carriere recognized the enormous healing potential EMDR could offer to millions of Bangladeshi citizens suffering from the ravages of natural and manmade disaster.

Mental health resources are severely limited in Bangladesh. Psychiatrists work in hospital environments, primarily treating patients requiring medication, and most psychologists are academicians without training in clinical skills. There has been an increasing interest in the effects of trauma and in expanding the availability of psychotherapy. HAP is helping to establish a framework for understanding the overall nature of trauma and its treatment by training the professionals, as well as the first graduating class of clinicians in Bangladesh.

Trauma resulting from natural disaster is widespread in Bangladesh. The poorest members of the population are hardest hit. Flooding from seasonal monsoons destroys homes, and causes death by drowning and disease from contaminated water supplies. Attending to past victims of floods and combat has been a high priority. HAP volunteers also have made site visits for supervision of sessions with trafficked children, victims of crime and abuse and cyclone survivors, as well as supervising sessions of trainees' hospital and clinic patients.

HAP trainings are evaluated by assessment teams that follow up with modifications designed to improve understanding and the effectiveness of subsequent trainings. Such a project would be impossible without the support of UNICEF and Bangladeshi professionals, who have provided valuable assistance in trainings and suggested modifications in procedures resulting in a form of EMDR tailored to Bangladeshi culture. Trainees have already initiated The EMDR Bangladesh Association, and a local coordinating committee of Bangladeshi professionals and UNICEF staff formed to help organize trainings.

Standing Against Global Exploitation

Nineteen EMDR therapists have volunteered through HAP to provide weekly pro bono sessions to clients of SAGE, a San Francisco-based agency committed to improving the lives of women and girls victimized by and/or at risk for sexual exploitation. SAGE (Standing Against Global Exploitation) treats between 250-300 women per week. Staff members are women who have 'beaten the odds"—all are former prostitutes who are dedicated to helping other women leave prostitution and begin living healthier lives . (See "Quitting the Streets," *Life Magazine*, November 1998.) SAGE's program has aided four generations of women in exiting prostitution.

SAGE founder Norma Hotaling specifically requested EMDR services. "Most of the individuals (women, girls, men and transgenders) we work with at SAGE have experienced serial episodes of violence and exploitation, including incest, rape, domestic violence, torture, kidnapping, prostitution and pornography," Hotaling said. "We know that with the proper treatment, including EMDR, our clients can be more than perpetual victims. They deserve to have as close to a normal life as possible. They deserve to be able to live self-determined, independent lives, free from abuse and violence. EMDR is the cornerstone in helping to provide for them."

"For those of us who have received proper care, including EMDR, we are living as survivors and thrivers, and are truly empowered," said Hotaling. "We are able to help ourselves stay safe and recover—and to help others survive."

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Call for Papers

Special *EMDRIA™ Newsletter* issue devoted to child and adolescent topics.
Supportive peer review.
March 1, 1999 deadline.

Please send inquiries/submissions to:
Ricky Greenwald, Psy.D.
rickygr@childtrauma.com (preferred)
-or-
P.O. Box 3907, Lihue, HI 96766

(EMDR Consultation - Continued from page 8)
clear as to who is the primary therapist, and, thus, who is responsible for the overall treatment of this client?

Given the questions that need to be asked and the goals to be achieved, everyone will be well served if the EMDR clinician takes the time to establish a legitimate therapeutic contract before proceeding with treatment.

3. Content

From my experience, an EMDR consultation often serves to impact ongoing treatment in one or more of the following three areas.

1. Removing specific blocks (perhaps related to the after-effects of a traumatic event). For example, one client was referred to me because, although many aspects of her current treatment were going well, the horrible images of finding her sister dead years ago continued to frequently overwhelmed her.

2. Stirring things up. Most of us have had the experience of "plateauing out" with some of our patients. The work feels flat; it's drifting. In these situations, I have often found EMDR can be a useful way to bring rich new emotional ore to the surface which the client and his primary therapist can then refine.

3. Evaluating the effectiveness of the client's current treatment. This is a tricky area that I shall discuss further below.

And what is the content needed? If you want your consultations to be maximally effective, you must realize that an effective EMDR consultation involves the same eight phases of treatment as regular EMDR work. For example, it is very important that you perform your own History-Taking. Things have gotten stuck for a reason. A review, a different point of view (yours), may often reveal unappreciated patterns and events that have heretofore escaped

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CALL FOR NOMINATIONS FOR EMDRIA™ BOARD OF DIRECTORS

Nominations are now being accepted for positions on the Board of Directors of EMDRIA™. There are three vacancies on the Board and three offices to be filled: President-Elect, Secretary-Elect, and Treasurer-Elect.

The EMDR International Association Board is a working board and Directors are responsible for the development of policy, programs and financial matters of the Association. Directors meet by conference call every other month (and the Executive Committee meets monthly and as needed). They act as Chairpersons or Board Liaisons to the committees created by the Board. Terms for Board Members are three years. Officers elect serve one year in the "elect" position until assuming the full office the following year.

The Nomination Committee is currently preparing an election slate. Members are encouraged to contact the Chair of the Nominations Committee if they wish to place a name in nomination:

Curtis C. Rouanzoin, Ph.D., Chair
(714) 680-0663
ccrounzun@aol.com

—paid advertisement—

Internet Discussion List

EMDR Institute trained clinicians are invited to join the EMDR Institute Discussion List. Participation in this electronic forum offers opportunities to discuss issues related to: clinical applications, specific protocols, theory and research on EMDR, EMDR Institute and EMDR HAP. Participants in the discussion list include EMDR trained researchers as well as EMDR Institute facilitators and trainers.

Send subscription request to: LISTSERV@MAELSTROM.STJOHNS.EDU
Leave a blank or enter a hyphen (-) in the subject line.
In the text of the message enter: SUBSCRIBE EMDR FIRSTNAME LASTNAME and send.

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notice.

Also, because EMDR is so different from most therapies, Client (and Primary Therapist) Preparation is crucial. Educating the primary therapist as to the course of processing—how the client may become more emotional during and between sessions—can help prevent disturbing calls from the other therapist. In this regard, sending the primary therapist articles regarding EMDR can be useful.

This can also be a wonderful opportunity to involve the other therapist as part of the treatment. For example, I often have the client schedule a session with his regular therapist a day or two after our EMDR work. By doing this, the client is given extra support, the therapist feels included, and she can alert you to any issues or problems that have developed.

4. Processing

Hopefully, it is clear that, in the vast majority of cases, an EMDR consultation is a process that needs to extend over several sessions. How many? Typically, I tell the client and the referring therapist that two or three initial sessions will be needed (History-Taking and Preparation) to determine if the client is appropriate for EMDR. If so, we schedule two double sessions for the EMDR processing. At the end of that time, everyone concerned should know whether or not EMDR has been helpful.

When told of the time required, some clients and some therapists have decided not to proceed with the consult. However, many more have appreciated the professionalism involved and responded positively.

Having another therapist involved allows you to accelerate both the History-Taking and Client Preparation phases of treatment. The primary therapist can give you both client history and his experience of working with the client. If the current therapeutic relationship is positive, it allows the EMDR clinician to proceed more quickly because the primary therapist can serve as the primary source of support, comfort, and safety.

During processing, one of the issues that often arises is the role of the other therapist. Should he be present at the EMDR sessions? (Of course, prior to

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intense apprehension, to outright terror, to feelings of dejection and helplessness. These momentary ego states unfold one by one, as if played on a videotape.

As one might expect, these neuronal linkages through time can get increasingly complicated, such that elaborate combinations of affect, behavior, cognitions, etc., become interconnected in consistent, repetitive ways. These elaborate patterns may be called subpersonalities. It is this aspect of ego state phenomenology that is reflected in the definition of ego state by Helen Watkins (cited above). The common theme of an ego state (subpersonality) may consist of the person at a certain age, which would then include different affects; or it might include a common mood or affect, with different behaviors; or it might be a certain type of interpersonal strategy.

In summary, it is the biological sub-stratum underlying ego state phenomenology, based on state-dependent learning processes and their derivatives, that gives power to ego state phenomenology and to the therapeutic use of the ego state model in working with psychological symptomatology. Previous writers have not emphasized this biological underpinning of ego state phenomenology. It is this biological sub-stratum for ego state phenomenology that may ultimately lead us to understand how EMDR impacts on ego state pathology.

Most previous ego state conceptualization refers only to subpersonalities or parts. In this paper, the term "ego state" will be used to refer to all ego state phenomenology, including the subpersonality or part of the self, as well as the ego state as the state of the ego in one moment of time, as might happen in a flashback.

The Role of Dissociation and Hypnosis

Although ego state phenomenology is derived directly from underlying biological linkages, these linkages are not consistently obvious because they are often overridden and hidden by the capacity of the mind to dissociate. Dissociation is the compartmentalization of consciousness, so that one part of the self is not aware of other aspects of the self. This compartmentalization may be between one component of an ego state and the other components of that ego state, such as remembering an event without affect or having a flashback of affect without any memory. Or the dissociation may be between ego states, such as in dissociative identity disorder (DID), where the dissociation is extensive. But all of us dissociate ego states to some degree; for example, when one is down in the dumps, it is often difficult to access a more optimistic ego state.

Now, because it is impossible for a person to maintain full consciousness of all components of all ego states at one moment in time, generally the energy and identity of the self tends to reside in only one ego state at a time, with the other ego states being *more or less* dissociated. The phrase "more or less" is critical, because the quantity and quality of dissociation among

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the ego states varies considerably from one personality structure to the next. The nature of the relationship between the currently dominant ego state and the other ego states that are temporarily less dominant will depend on two major types of variables —permeability and fluidity. Permeability is the ability of the primary ego state to access one or more of the components of other, temporarily more subordinate, ego states. Fluidity refers to the shift from one predominant ego state to another.

Psychopathology from an Ego State Perspective

One could view all psychopathology as the failure to maintain optimal dissociative barriers among the ego states, that is, to maintain optimal permeability and fluidity —in short, a failure of the psychological system to do an adequate job of time-sharing. Since all of the ego states have a certain energy or need for self-expression, if that energy or need is suppressed by the system, then that ego state that is suppressed will ultimately break through the suppression in the form of some sort of symptomatology. The symptomatic or problematic ego state is called the "hidden" ego state —hidden in the sense that it is unacknowledged or "disowned" by the predominant ego states. However, its presence is made known through the symptomatology. The ego state may be disowned because of an unbearable affect, such as anxiety or terror, or because of some "undesirable" behavior. However, the symptomatology generally does not give an indication of the full nature of the ego state driving it, ultimately requiring that the rest of the ego state associated with the symptoms become fully amplified and developed for therapeutic relief to occur. So, for example, in PTSD, intrusive feelings or thoughts present themselves, often without the patient's awareness of where they come from. Similarly, phobias, compulsions, and impulsive behavior are reflections of one aspect of an otherwise hidden or disowned ego state.

Sometimes psychopathology derives not from the suppression of a hidden ego state by a predominant ruling group of ego states, but rather from a conflict between two or more major groups of ego states. In this case, an overt or guerrilla war exists between these camps. Each camp believes that it is right and that if it only fights harder, it can win. Unfortunately, this process tends to polarize the warring camps and never leads to a real resolution. Either the power simply shifts from one camp to another, without real resolution between them, or one camp may seem to predominate for long periods of time, while the other camp fights a guerrilla war from behind the scenes. For example, an overweight patient may identify with an ego state or a group of ego states that want to lose weight, but there may be one or more ego states with an investment in either eating or being overweight, and these other ego states persist in maintaining the weight problem, in spite of repeated brief periods of successful dieting.

However the balance of power among the various ego states plays out, it is the system's maladaptive use of dissociative processes that allows the conflict and the pathology to persist. First, there is either the dissociation by the predominant ego states of the hidden ego state, or the dissociation by each camp of ego states of the other camp of ego states. Second, there is the dissociation of the fact that this previous dissociative strategy isn't working in either maintaining stability or in achieving the specific goals of the various ego states. Hence, dissociation may be conceptualized as the primary mechanism for maintaining psychopathology, not just of "dissociative disorders," but virtually all psychiatric disorders. For example, defense mechanisms—repression, isolation of affect, splitting—are technically variations of dissociative phenomenology. It is extremely important to attend to the nature of the dissociative barriers in understanding and addressing all psychopathology.

Ego State Psychotherapy

The major principles of ego state psychotherapy derive directly from the above formulation of psychopathology. First, it is essential to undo the maladaptive dissociation in order to achieve optimal permeability and fluidity. Second, it is important to promote a cooperative, collaborative attitude among the ego states, rather than a competitive, polarized posture, thereby moving the system toward "consensual democracy," with all parts having a say and none dominating autocratically.

When these goals are achieved, the psychological system is "integrated," meaning there is optimal interconnectedness among the ego states, and any ego state can easily access any other ego state that might be of use in a given moment. Integration does not imply fusion or merging of ego states. The biologically based ego state infrastructure developed initially still persists, even in an integrated personality. But ego state therapy diminishes the dissociative barriers within and among the ego states and develops new biological linkages among the ego states, so that one ego state can access the other ego states more readily and spontaneously. It is as if the dissociative barriers previously separating the various ego states were removed and replaced by

new "highways" or "communication wires" so that ego states have the potential of being interconnected at any time, even though these connections may be temporarily switched off.

The Ego State Bridge

In 1971, the Watkins' formulated the concept of the affect bridge, a technique for amplifying an affect while the patient is in a hypnotic trance. The patient is then invited to take that affect back in time, as if going across a bridge, to find its origins (J.G. Watkins, 1971). They subsequently developed the somatic bridge technique, which works like the affect bridge, but uses somatic sensations as the starting point for hypnotic amplification and age regression (J.G. Watkins, 1990). Grove (1989) amplifies both somatic sensations and imagistic-metaphorical representations of those sensations to elucidate the meaning of symptoms. The Gouldings (1979) developed Redecision Therapy, which invites the patient to amplify a cognition or decision and take it back in time to when it was first made.

It is clear that all of these techniques are based on the underlying biological ego state infrastructure. By accessing the here-and-now manifestation of affect, somatic sensation, image, behavior, or cognition, and then amplifying that ego state component, spontaneous associations to other dimensions of that ego state will unfold, due to the underlying biological connectedness of that ego state. Consequently, the earlier manifestations of the very same ego state will frequently unfold spontaneously, because they are associated biologically so closely to its present day manifestations.

This is the "ego state bridge" technique, with which *any* component of an ego state can be amplified and thus associated with its other components, including the historical and anamnestic pieces. Note that the bridge is a bridge in time, not a bridge to a different ego state. The technique amplifies whatever ego state components present themselves as much as possible, minimizes any anxiety driven dissociative barriers, usually through hypnotic techniques, and then allows the underlying ego state structure to unfold itself spontaneously. Generally, the affective and somatic components of the ego state provide the most powerful linkages to the rest of the ego state, but the imagistic component is the most powerful reflection of historical content. Working back and forth

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DEADLINE FOR POSTER SUBMISSIONS EXTENDED TO APRIL 15, 1999

The deadline for poster submissions for the 1999 Annual EMDRIA™ Conference has been extended!

Submissions will now be accepted at the EMDRIA™ office until the April 15th receipt date. To make a poster submission, simply use the standard abstract submission format from the Conference, leaving out the exam questions and the time estimates for your learning objectives. We encourage poster submissions of the following types:

- single case designs
- reports from small (or large) research or evaluation studies
- case studies
- conceptual posters that present new models for thinking about/or using EMDR, and
- innovative assessment models/ instruments for use with EMDR.

Poster sessions are a wonderful way to present your ideas in a non-threatening format, and they promote informal dialogue among colleagues.

Please consider using the poster session format for your Conference proposals!

Integrating EMDR with Schema-Focused Therapy

William M. Zangwill, Ph.D.

[Note: The following is an overview on the integration of EMDR with schema-focused therapy. For more in-depth information on this topic, readers can contact Audio Productions, Inc. at 1-800-488-5455 to request the 4-set audiotape series (#B 909a) of the author's presentation on this topic at the 1998 EMDR International Conference.]

"Effective EMDR processing depends on effective targeting."

—Shapiro

"Why does that memory still cause an emotional reaction for this client? What issues or underlying themes does it represent?"

—Zangwill

EMDR has always assumed that each clinician would integrate EMDR within their own conceptual framework. "...the model regards most pathologies as derived from earlier life experiences that set in motion a continued pattern of affect, behavior, cognitions, and **consequent identity structures**." (emphasis mine, p.14). However, many clinicians do not have a fully developed conceptual model to identify these structures, or the model they use is not sufficiently comprehensive. Therefore, many clinicians may need a comprehensive model that can help us and our clients better organize and better understand their experiences.

Jeffrey Young (1995) has developed a model, Schema-Focused Therapy, that addresses this issue and is especially appropriate for EMDR work. According to Young, 18 Early Maladaptive Schemas (EMS) are at the core of personality disorders.

An EMS is defined as an extremely broad, pervasive theme regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree. Shapiro's concept of childhood file folders is analogous to the concept of schemas. These 18 schemas are primarily unconscious but can be brought to awareness through various strategies, especially through EMDR. It is assumed that these schemas are the names for various neural networks in which memories are stored. It is important to be aware of the various schemas (neuro networks) that exist—their relative intensities and the maladaptive ways in which clients have adapted (avoiding, maintaining, or overcompensating) to these perceived deficiencies.

In this model, Schema-Focused therapy serves as the primary conceptual framework for working with the client, while EMDR is seen as the primary in-session change technique. Adding Young's model to provide in-depth case conceptualization enhances EMDR work in many ways. Knowing a client's most important themes or schemas provides indications as to where to initiate EMDR.

The case conceptualization is also extremely valuable when processing stops or is blocked in some way. (Remember Shapiro's concept of blocking beliefs.) For example, knowing that a client has the schema of Defectiveness/Shame alerts the clinician to the fact that this client may be particularly sensitive to whether or not he/she is doing the eye movements correctly and suggests the need to provide additional support and encouragement. On the other hand, a client with the schema of Emotional Deprivation may need to be allowed to talk more between sets of eye movements and at the end of the session to make sure that he/she feels heard.

Young's Schema-Focused Model provides a comprehensive means of helping client and clinician to better organize and understand the client's experiences. Thus, it is seen as an effective way to guide the EMDR clinician in helping the client understand why he/she is stuck; where to focus the initial treatment; and, perhaps most importantly, suggest what to do when treatment falters.

References

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures.* The Guilford Press. New York.

Young, J. (1995) *Cognitive therapy for personality disorders: A schema-focused approach,* Revised Ed., Professional Resource Press, Sarasota, FL, (941) 366-7913.

Young, J. & Klosko, J. (1994) *Reinventing Your Life.* Plume, NY.

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Mark Your Calendar!

for the

The 1999 EMDR International Association Conference

Alexis Park Resort & Spa

375 E. Harmon

Las Vegas, Nevada 89109

702-796-3300 or 800-453-8000

June 18th-20th, 1999

Look for the Conference Brochure in early 1999.

BioLATERAL™ SOUND RECORDINGS: AN EFFECTIVE ALTERNATIVE TO EYE MOVEMENTS

Invented and Produced by
David Grand, RCSW, EMDR Facilitator

What Are Bio*Lateral*™ Sound Recordings?

Bio*Lateral*™ Sound Recordings (or Bio*Lateral*™ for short) are tapes and CDs which can replace eye movements in EMDR stimulation. Their ability to integrate bilateral and psycho-acoustic stimulation is opening new vistas of treatment, healing, relaxation, and meditation. Bio*Lateral*™ offers one of the least costly of all alternative EMDR technologies and can be easily used by clients during, as well as in between, sessions. Through the use of Bio*Lateral*™, clients frequently report experiencing deeper meaning, increased insight, and improved ability to synthesize material.

More than 2000 BioLateral™ tapes and CDs have been sold and are being used around the United States, Canada, Europe, South America, and Australia. After more than two years of use, feedback regarding the efficacy of BioLateral™ tapes continues to reflect excitement and enthusiasm.

How Were Bio*Lateral*™ Tapes Developed?

Bio*Lateral*™ tapes were created in a production studio by myself and musician friend, Evan Seinfeld, the lead singer of the rock group Biohazard. Instead of making a tape limited to tones that alternated between the left and right speakers, we decided to incorporate music-like sound. We recorded and experimentally mixed six separate tracks using the healing sounds of ocean waves, a Tibetan bell, an Indian drum, and a synthesizer, utilizing computer technology to encompass frequencies across the sound spectrum. After production, we found that the free-form nature of the production process infused the tapes with human, creative, and spontaneous qualities.

The first tests of Bio*Lateral*™ were performed with friends and family, who uniformly reported they experienced a powerful relaxation effect with both soothing and deep, yet non-agitating, processing. I began using Bio*Lateral*™ with clients in session using a stereo "walkman," providing clients with a Bio*Lateral*™ tape for home use between sessions.

The success of the original tape led to requests for new ones. We accordingly returned to the studio and recorded Bio*Lateral*™ 2–*Going To Wave Lengths*, which combines ocean sounds with a bilateral brush tone and Bio*Lateral*™ 3–*Round the Lake*, which fully integrates the bilateral stimulation into music that sounds both Gaelic and Eastern, and Bio*Lateral*™ 4–*A Simple Progression*, a basic bilateral chorded eight-step progression. Responses to all of the tapes continued to be enthusiastic. I have also recently released a CD, *The Best of* Bio*Lateral*™, which contains tracks of all four Bio*Lateral*™ melodies, digitally remastered for the highest sound quality possible.

How Is Bio*Lateral*™ Used?

It is easy to personally evaluate the effectiveness of Bio*Lateral*™ simply sit in a quiet place and think of something that is bothering you at that moment. Work up your own protocol with a SUDS and follow your associations. Then, observe the nature of your processing and occasionally return to target and retake the SUDS. In session, work up or use an existing target and protocol. Then, have clients listen to the tape, again using stereo headphones (no eye movement is necessary). Inform clients that all they have to do is to observe the flow of their processing, although they have the option of keeping their eyes open or closed. You may stop them periodically to check "where they are" or have them stop when they have reached a period of quiescence or have something they want to verbally report.

How Will My Client's Benefit from Bio*Lateral*™?

Bio*Lateral*™ tapes and CDs take advantage of the client's ability to process through auditory stimulation and provide an effective, low-cost means of effecting bilateral stimulation, including the following advantages:

- The left/right aural tones produce the same bilateral stimulation as the eye scanning, eliminating the need for eye movement.
- Client eye strain, as well as therapist arm and shoulder stress, are eliminated.
- The passive stimulation of Bio*Lateral*™ tapes tends to reduce client distraction that can result from other methods.
- Clients can choose to process with their eyes closed, allowing for more imagery and deeper processing.
- The tapes and CDs allow each set to continue as long as you or the client chooses. Therapists have reported that educated clients are often better able to determine the length of a set as they are witnessing the processing "from the inside."
- With Bio*Lateral*™ tapes and CDs, sets can last for many minutes and may contain hundreds, and sometimes thousands, of repetitions.

- Bio*Lateral*™ can even be played during a non-EMDR session for deepening the process and enhancing insights.
- A number of therapists have reported that Bio*Lateral* has helped some dissociative clients process with less agitation.
- Clients can listen to Bio*Lateral*™ throughout the session, even when dialoguing with the therapist, often helping clients to experience deeper meaning, greater insight, and synthesis of material.
- Bio*Lateral*™ can be used in between sessions to reduce client agitation, generalized anxiety and panic attacks, insomnia, and to understand and control cravings and compulsive behaviors.

BIO*LATERAL*™ TAPES AND CD CURRENTLY AVAILABLE

Bio*Lateral*™ 1—*Original Recipe*

Comprised of six separate tracks, experimentally mixed, using the healing sounds of ocean waves, a Tibetan bell, and an Indian drum as well as Evan Seinfeld on the synthesizer. Utilizes computer technology that psycho-acoustically stimulates sound frequencies across the audible sound spectrum. The free-form production process infuses Original Recipe with a natural, creative, and spontaneous essence.

Bio*Lateral*™ 2—*Going To Wave Lengths*

Combines ocean sounds with a bilateral brush tone. Especially helpful for processing with individuals distracted by music. Particularly effective for combining with the client's safe place and reducing insomnia and agitation in between sessions.

Bio*Lateral*™ 3—*Round the Lake*

Fully integrates the bilateral stimulation into lilting, cheerful music with Gaelic and Eastern influences. Includes a background harp with a slow bass guitar tone and Evan Seinfeld on guitar live in studio.

Bio*Lateral*™ 4—*A Simple Progression*

Can be powerful in its evocative simplicity and accordingly should be played on a low volume. Effective with highly distractible clients due to the absence of background sound or music. Utilizes an eight step progression of piano chords simply delivered alternating between left and right ears.

Bio*Lateral*™ 5—No Frills

Basic bilateral tone at 120 beats per minute. At low volume simulates rain drops, played louder reminiscent of a conga drum. For those who prefer a faster cadence and uncomplicated sound.

RECENTLY RELEASED IN CD FORMAT! . . . *The Best of* Bio*Lateral*™

Contains all four Bio*Lateral*™ varieties (Original Recipe, Going to Wave Lengths, Round the Lake, and A Simple Progression) on one CD, digitally remastered for the highest sound quality possible. Clients can easily choose which Bio*Lateral*™ melodies they want to listen to, in or out of session. (Set CD player to repeat for continuous use of one melody.)

For More Information on Pricing and Other Bio*Lateral*™ Services,

please visit our Website at WWW.BIOLATERAL.COM or contact David Grand at:

E-mail: DGrand1952@aol.com

Telephone: (516) 785-0460 Fax: (516) 799-7625

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STUDY GROUP DIRECTORY

The following list is provided to give EMDR-trained clinicians an opportunity to join a Study Group in their area. These are "no fee" discussion meetings. If you would like to join a Study Group, please contact the group leader in your area.

[Please Note: Although Study Groups are listed in this EMDRIA™ Newsletter, these groups are not an affiliation of EMDRIA, nor does EMDRIA™ warrant or otherwise assume responsibility for content of meetings nor competency of group leaders.]

UNITED STATES

Alaska

City: Anchorage, AK
Name: Larry Holman
T: 907-272-7002 F: 907-272-2851
E-mail: lholman@alaska.net

Arizona

City: Prescot, AZ
Name: Laurie Tetreault, MA
T: 520-717-4901 F: 520-776-7366
E-mail: tetro@northlink.com
Northern AZ Level II monthly, Fri 10:30-12p

City: Phoenix, AZ
Name: Thelma Rowe Psy.D.
T: 602-864-1747
2nd Fri each month, 2-3pm (negotiable)

California

Southern CA (Santa Barbara-San Diego)
Advanced EMDR Clinician Study Group
Name: Jocelyne Shiromoto
T: 714-764-3419
E-mail: shiroflex@aol.com
Every two months. Location rotates.

City: Corona, CA
(Riverside to San Bernadino)
Name: Linda Vanderlaan
T: 909-279-7099 F: 909-279-4837
E-mail: Lvanderlan@aol.com
1st Fri each month, 9:30-11am

City: Fullerton, CA
Name: Curt Rouanzoin
T: 714-680-0663 F: 714-680-0570
E-mail: CCRounzun@aol.com
2nd Tues each month, 9:30-11am

City: Irvine, CA
Name: Lois Bregman
T: 714-262-3266 F: 714-262-3299
4th Fri each month, 9:30-11am

City: San Anselmo, CA (Northern CA)
Name: Phyllis Galanis
T: 415-924-2613 F: 415-924-8358
E-mail: Pgal100@aol.com
Meets monthly on Fri

City: San Diego, CA
Name: Liz Snyker & Carol Seidenwurm
T: 760-942-6347 & 760-944-7273
E-mail: esnyker@bigfoot.com
1st Sat each month, 9-10:30am

Colorado

City: Boulder, CO
Name: Keith Andresen
T: 303-443-5682 F: 303-443-5682
E-mail: kandre1041@aol.com

City: Denver, CO
Name: Laura Knutson
T: 303-753-8850 F: 303-753-4650
E-mail: lauknutson@aol.com

Connecticut

City: Hartford, CT
Name: David Russell
T: 860-233-7887
Bi-monthly, 2nd Sat, 10am-12pm

Delaware

City: Wilmington, DE
Name: Frankie Klaff
T: 410-392-6086
E-mail: klaf54944@dpnet.net
3rd Fri each month, 12-1:30pm

Florida

City: Orlando, FL
Name: Carl Nickeson
T: 407-898-8544 F: 407-898-9384
3rd Tues each month, 8:30-10am

City: Pompano Beach, FL
Name: Brenda Starr
T: 954-974-8329 F: 954-629-4779
E-mail: bastarr@loveable.com
Every 4 to 6 weeks, Fri 12-1:30pm

City: Tampa, FL
Name: Carol Crow
T: 813-915-1038 F: 813-914-0468
E-mail: cjcrow@juno.com
3rd Tues each month, 10:30am

Hawaii

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Name: Silke Vogelmann-Sine & Larry Sine
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Name: Darlene Wade & Terry Wade
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E-mail: wadeandwade@compuserve.com

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E-mail: HLipke@aol.com

Kansas

City: Overland Pass, KS
(Greater Kansas City area)
Name: Lawrence Nieters
T: 913-469-6069
E-mail: lnieters@juno.com
2nd Thurs each month, 8:30-10am

Kentucky

City: Louisville, KY
Name: Judith Daniel
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Meetings held monthly

Maryland

City: Baltimore, MD
Name: Catherine S. Weber
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E-mail: csweber@erols.com

Massachusetts

City: Brookline, MA
(Boston, Cambridge Area)
Name: Nancy Cetlin & Pat Thatcher
T: 781-237-0424 F: 617-731-3813
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Monthly on Mondays 10am-12 noon

Michigan

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Name: Zona Scheiner
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E-mail: zonagse@aol.com
Monthly, Fri afternoons

City: Ann Arbor, MI
Name: Cam Vozar
T: 734-747-9073 / 734-996-9100x232
E-mail: CVozar@aol.com
Last Fri each month, 2pm

City: Bloomfield Hills, MI
Name: Eileen Freedland
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Minnesota
City: St. Paul, MN
Name: Chris Baldwin
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Time open

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Announcing our

New & Improved

TheraTapper™

Gentle Bilateral Tactile Stimulation for EMDR® Therapy

The TheraTapper™ is a small electronic device which provides gentle alternating tactile stimulation conducive to EMDR® processing. It consists of a hand-held control box (with two knobs and two blinking lights) connected to two small pulsing units by two six-foot wires. The pulsers, which fit easily into the client's hands, briefly pulse in an alternating fashion, first one, then the other. Two control knobs adjust the tactile experience to suit each client. The left knob adjusts the pulse length (50-200 milliseconds), and the right knob adjusts the rate of alternating pulses, by varying the length of time between pulses (100-2000 milliseconds). Two small lights at the top of the TheraTapper™ blink on and off in an alternating fashion with each pulse, giving real-time visual feedback about the length and rate of the stimulations. A power switch on the side operates independently of the two knobs so settings remain fixed when the box is turned off and on between sets. It operates very efficiently with two AA batteries. (Batteries included.) Invented by Shirley Jean Schmidt, an EMDR® therapist, and her really smart husband, Jürgen!

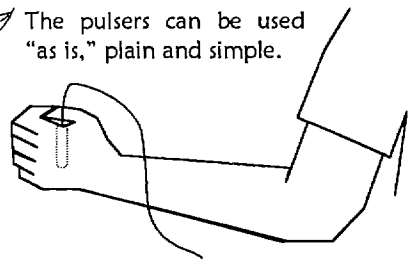
What's New... At the 1998 EMDRIA

Summer Conference we learned that some therapists and clients objected to the size and shape of our pulsing units in our Original version. We were encouraged to reconsider this aspect of our TheraTapper™ design. We have come up with an exciting solution that we believe will fit everyone's needs. We have preserved the cost-effective cylindrical shape, but the larger (3½" x ¾") pulsing units of our Original design have been replaced with smaller (2¼" x ½"), more intense pulsers. The new pulsers will be small enough to easily attach to, or be hidden in, "friendly" objects, such as beanie babies, or coin purses. Since the new pulsers have a more intense vibration, they can be felt easily through such objects. The New TheraTapper™ offers your clients many tactile stimulation options - four possibilities are pictured here:

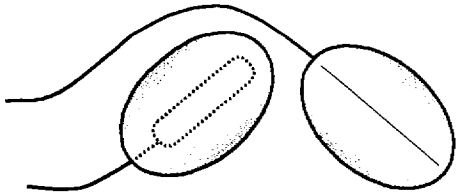
The Benefits ...

- **N**on-intrusive tactile stimulation
- **P**assive stimulation; requires no effort from client
- **C**lient and therapist can easily dialogue during sets
- **S**ets can be very long without strain to client or therapist
- **P**rocessing with eyes closed can lead to deeper processing
- **A** tactile stimulation alternative for clients threatened by therapist touch
- **M**any clients report the sensation is reassuring and grounding
- **P**ulsers can be placed in hands, pockets, shoes, etc.
- **S**afeguards against litigation claiming therapist touch was sexual
- **P**ulsers can be easily attached to or hidden inside of "friendly" objects such as beanie babies, coin purses, wristbands, etc.
- **N**o stress to therapist neck, back, wrists...
- **E**ffective with kids
- **T**ake notes during sets
- **L**ightweight & portable
- **I**nexpensive, call for price

The pulsers can be used "as is," plain and simple.

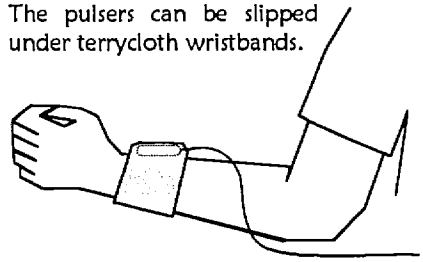


The pulsers can be hidden inside plastic coin purses, which are soft, cozy, and easy to grip. The flat shape makes them easy to slip under thighs or into shoes; the durable plastic is easy to clean.



Two FREE coin purses included with each New TheraTapper™ purchased.

The pulsers can be slipped under terrycloth wristbands.



(Ego State Psychotherapy - Continued from page 15)
among all ego state components is the key to optimizing the amplification of the ego state associative process./

The Ego State Shift

While the ego state bridge allows one to understand the full dimensions of a problematic hidden ego state, this understanding by itself is generally not enough to produce a lasting therapeutic effect. That ego state was largely hidden through dissociation, usually for a purpose, and that purpose almost always is to protect the system from excessive anxiety. Usually the patient has been "stuck" in this problematic ego state because at the time the ego state developed, the patient had no way alleviate the anxiety associated with that ego state, except through dissociation. The therapeutic task is to facilitate a natural shift from the problematic ego state to some other ego state that can soothe or relieve the anxiety associated with the problematic ego state. That shift, which the patient could not do by himself at the time of the development of that ego state (either because of the biological limitations on information processing during a traumatic experience or because of developmental immaturity), can usually be conducted fairly easily with the facilitative assistance of the therapist.

This process can be facilitated through the use of imagery, simply by inviting the patient to let whatever needs to happen in the image to happen. Usually the patient will know exactly what needs to happen to get relief from the anxiety or other affective tension being experienced in the initial ego state. Sometimes, however, the patient may need encouragement to "let go of historical reality" in order to allow the image to unfold as necessary. Most patients are then able to *shift* from the problematic ego state to a new ego state and provide relief for themselves.

For example, a patient with PTSD who has associated to the early origins of the trauma can resolve the terror of that traumatized ego state by shifting to an ego state that would provide a sense of empowerment with anger, or to an ego state that provides protection, nurturance, or comfort. Those ego states may not have been in fact historically available, but the patient is free in the here and now to access these ego states, so that he need not remain stuck in the previously helpless one. The advantage of imagery is that it allows the patient to discover his own ego state needs, rather than it being prescribed by the therapist, as some hypnotherapists are inclined to do. For example, a patient who needs nurturance and soothing will not respond therapeutically to a therapist who exhorts him to make an ego state shift by angrily beating up his abuser.

It is important to note that, as with the amplification of an ego state during the ego state bridge, a shift from a stuck ego state to a more adaptive ego state should be facilitated through whatever ego state component is optimal for that particular patient, whether it be affective, cognitive, somatic, behavioral, or imagistic.

The Internal Dialogue

Sometimes the pathological dissociation in a system is not aimed at keeping a single ego state hidden, but rather reflects dissociation between two or more major groups of ego states. For example, when the therapist invites an ego state shift to occur, the patient may appear to be unable to make such a shift, regardless of what technique or ego state component the therapist attempts to utilize. Such a patient is often labeled as "resistant." This resistance, however, simply reflects the presence of a *protector* ego state, which feels that it must protect the system by not allowing this ego state shift to occur. In other words, there are one or more ego states that are opposed to a change in the system, even though it means that the patient will not get symptomatic relief. It is now this protector ego state that is more or less covert, and this covert protector needs to be flushed out, explored, and engaged with in order to understand what its concerns and agenda are. Thus, whenever there is a significant therapeutic impasse, the therapist should suspect that there is a covert conflict, led by one or more covert protector ego states.

This therapeutic impasse is perpetuated by the maintenance of a dissociative barrier between the ego state(s) which hold the symptomatic pain, and the ego state(s) which are opposed to a change in the system. This dissociative barrier can be diminished by introducing an internal dialogue among these previously unconnected parts. The goal of the dialogue is to undo the dissociation between these parts and to foster a collaborative, cooperative attitude among them.

There is a great variety of specific techniques for facilitating such an inner dialogue, including imagery, the Gestalt empty chair, writing with the nondominant hand (Capacchione, 1991), psychodrama, voice dialogue (Stone & Windelman, 1989), the parts party (Satir, 1991), and internal family systems (Schwartz, 1995). Each of these techniques has certain advantages and disadvantages, but whatever the methodology, parts of the system will oppose the process, and these parts will need to be addressed. Regardless of the

therapeutic modality used, it is important to appreciate that the process is intended to facilitate reduction of the dissociative barriers among the separate ego states and to enhance a collaborative attitude among the parts. All parts must accept the notion that each part is entitled to have its needs addressed in some way.

This process of connecting the ego states interactively and non-dissociatively develops a biological infrastructure among the ego states so that they are now more likely to flow back and forth spontaneously and freely, thus optimizing the patient's adaptive functioning in the future.

[Note: Part Two of this article, appearing in the next issue of the EMDRIA™ Newsletter, will relate each of the above ego state techniques—ego state bridge, ego state shift, and the internal dialogue—to the EMDR process, demonstrating how EMDR procedures are totally congruent with these ego state techniques. Then, using the ego state model to expand EMDR options, a variety of new approaches will be outlined. These approaches are useful with both PTSD and character-disordered patients, and, most particularly, with therapeutic impasses.]

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(Effective Consultation - Continued from page 12)
extending such an invitation, I find out what the client prefers.) In most of my cases, the other therapist has not been present during the EMDR sessions due to the cost and difficulty coordinating schedules.

With some of the more fragile clients, however, I have had the other therapist in the room and it has invariably been a positive experience in a number of ways. The therapist's presence in the room has served as a tremendous source of support for the client. At times, the other therapist has helped interpret a client response that prevented us from getting stuck. The therapist leaves the session much more knowledgeable about EMDR and her client, enabling their follow-up work to be more effective. Seeing how powerful EMDR can be has also served as a stimulus for therapists to get their own training. (This last point brings up an issue that I raise whenever I invite the other therapist to participate. I ask her to agree not to do EMDR on her own without first getting appropriate training.)

5. Follow up

The more communication between EMDR clinician and referring therapist, the more effective the consultation will be. Ongoing contact facilitates maximum client safety. Thus, I contact the therapist after my initial session with the client prior to beginning desensitization and after each EMDR double session. During these contacts, I share my initial impressions and ask for the clinician's help and observations. I remind myself how I felt when I referred my clients for a consultation, and how much I appreciated it when the consultant did not make me feel like an idiot.

While the initial contract is usually for two to three regular sessions and two extended EMDR sessions, I recommend offering at least one follow up session if needed. Sometimes the client needs to say

(Continued on page 28)

POST YOUR EMDR STUDY GROUP IN THE NEXT *EMDRIA™ NEWSLETTER*!

If you have an existing Study Group—or will be starting a Study Group—and want it posted in the next *EMDRIA™ Newsletter*, please submit it to the EMDRIA™ administration office by January 31, 1999. When submitting your Study Group, please provide the following information (by completing and sending this form or providing the information in another format.)

My Name: _____

Study Group Frequency: (Specify monthly, weekly, bimonthly, etc. and day and time group is held.)

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(Please see page 20 of this issue for current postings to the Study Group Listing.)

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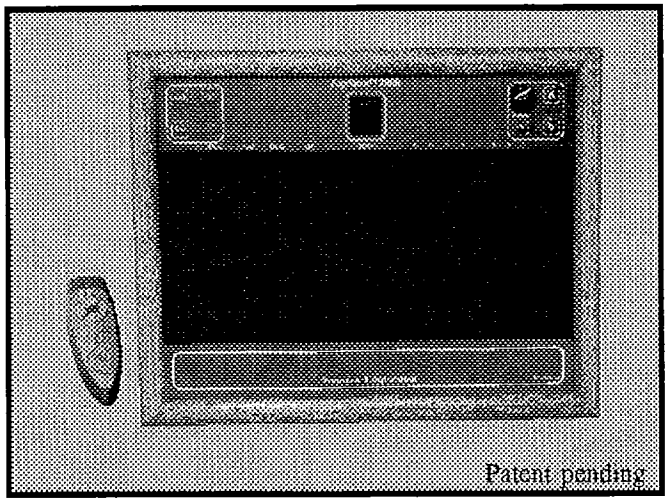

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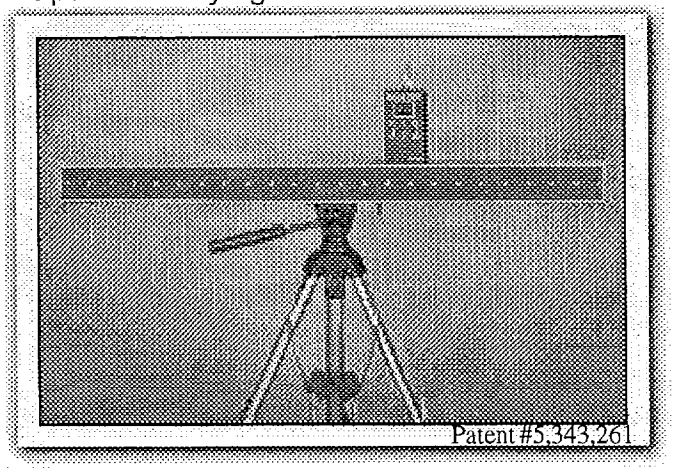

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(Effective Consultation - Continued from page 26)
good-bye and have closure. Other times, the processing has almost finished, but the client may need an additional EMDR session to complete the material. Again, I recommend the EMDR clinician be flexible in this regard. However, this flexibility can also create one of the problems that I shall briefly discuss next.

6. Concerns

While I have found EMDR consultations to be very useful, there have been problems. One of the most important caveats I can give the EMDR clinician considering a consultation is—Beware of Storks! Like the proverbial stork who would deliver the baby and then take off, some therapists, whether consciously or not, want to fly away after they have made the referral. Do not let it happen! It is not fair to you or the client. (In an EMDR Internet communication on October 15, 1998, Peter Barach referred to this as "EMDR as tow truck." The referring therapist wants you to use EMDR as a winch to get the client out of the ditch he is stuck in. And once you have hooked up and gotten them out, the referring therapist wants to take off and let you tow the client in.)

However, as I mentioned above, one of the valid purposes of an EMDR consultation, as I see it, can be to evaluate the effectiveness of the client's current treatment. If, after EMDR, the client wants to discontinue work with the current therapist, a number of issues have to be addressed, For example, what needs to be done to make the separation as constructive as possible? An honest discussion of the limitations of the current work can be valuable for all concerned. A sudden flight from the current work usually is not. What are our professional and ethical responsibilities to our colleagues? Personally, unless I think the client is being mistreated, I refer them to another EMDR therapist after the consultation. I do this for two reasons. First, it feels "less messy." Second, any therapist who gets a reputation for "stealing" other people's clients will not receive many referrals for consultation.

I do not continue ongoing treatment with a referral. While others may have successfully done this, I worry too much about the chances for "splitting," mis-communication, etc., to feel comfortable doing so.

Summary

EMDR consultation with a client engaged in ongoing therapy with another clinician can be an effective way to remove specific blockages, bring new material to the surface, and help the client evaluate the efficacy of her current treatment. It is recommended that the EMDR clinician considering such a referral:

1. Contact all parties involved in treatment.
2. Clarify the goals of the consultation.
3. Educate all concerned as to the scope and content of the consultation.
4. Plan on enough sessions to do an adequate evaluation.
5. Maintain frequent communication with the referring clinician.
6. Be flexible enough to provide adequate follow up, but
7. Be aware of potential conflicts and problems that may emerge.

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To be announced.

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EMDRIA™
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EMDRIA NEWSLETTER ADVERTISING RATES

DISPLAY ADVERTISING

	1 ISSUE		2 ISSUES		3 ISSUES	
	Member	Non-Member	Member	Non-Member	Member	Non-Member
¼-Page	$80	$100	$100	$120	$120	$140
½-Page	$100	$120	$120	$140	$140	$160
Full-Page	$120	$140	$140	$160	$160	$180
Two Page	$175	$200	$200	$225	$225	$250

INSERTS

	Member	Non-Member
Per Issue/Per Sheet	$100	$125

CLASSIFIED ADS: 3-¾" x 2"

	Member	Non-Member
Per Issue	$30	$60

Please refer to the Newsletter Submission Requirements provided on the inside back cover for specific information on drafting, formatting, and submitting ads.

EMDRIA™ NEWSLETTER SUBMISSION INFORMATION

We welcome and encourage your contributions to the Newsletter.
Please note the following guidelines and policies when making submissions:

- **APA Style** - All articles must be submitted in APA style and format.
- **Submissions Other than Advertisements** - Articles, columns, and other non-advertisement submissions must be provided in electronic format. Files may be submitted on 3½-inch diskette or, ideally, via e-mail. WordPerfect 6.1 for Windows or Microsoft WORD 7.0 or earlier versions are the preferred formats, although a standard text format (i.e., ASCII or Rich Text) may be used. *The file format of each contribution should be specified in the accompanying e-mail or on the diskette.*
- **Submission of Advertisements** - In general, advertisements should be submitted in camera-ready format. Exceptions may be made for text-only ad copy. Various requirements and restrictions apply to advertising for legal and other reasons, so please contact the Editor before preparing your advertisement for submission. Also, please note that, due to the Association's legal status, the *Newsletter* cannot publish pricing information for advertised products or services.
- **Fonts and Other Formatting** - Times New Roman is the standard font for *Newsletter* submissions, and text-only submissions should utilize this font whenever possible. In addition, formatting characters such as bolding, italics, graphics, centering and other alignment/justification may not translate properly, so *text should be provided in "plain," unformatted form when possible.*
- **Author's Responsibility** - It is each author's responsibility to ensure that all aspects of submitted articles are correct and in accordance with APA style including: correct spelling and punctuation; accurate quotations that include page numbers, author, and year; and a complete list of references in proper order. (Please refer to the *Publication Manual of the American Psychological Association, 4th Edition*, for specifics.) Contributions should be well-organized and proofread. (It is requested that you make every effort to complete the final draft before submitting your contribution. It may be difficult to incorporate revisions after the editorial process has begun.)
- **Editorial Review** - Please note that all contributions are subject to editorial revision by the Publications Committee and the Editor.
- **Decision to Publish** - The Publications Committee and the Editor cannot guarantee when or if any contribution will be published.

Please submit articles and other contributions to the Editor:

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DEADLINE FOR NEXT *NEWSLETTER*

JANUARY 31, 1999

EMDR International Association
5806 Mesa Drive
Suite 360
Austin, TX 78731

BULK RATE
U.S. POSTAGE
PAID
AUSTIN, TEXAS
PERMIT NO. 336

Time to Renew?

Please note that this is the final issue for those who have not renewed EMDRIA™ memberships for 1999!

Inside this Issue of The *EMDRIA™ Newsletter*:

Calendar

December 31, 1998

Deadline for Submissions to the *EMDRIA™ Register*

January 31, 1999

Deadline for Submissions to the next *EMDRIA™ Newsletter*

March 1, 1999

Deadline for Submissions to special Child and Adolescent edition of the *EMDRIA™ Newsletter*

April 15, 1999

Deadline for Poster Submissions for the 1999 EMDRIA™ International Conference

June 18-20, 1999

1999 Annual EMDR International Association Conference in Las Vegas