EMDRIA

June 2013 The Information Resource for EMDR Therapists Vol 18 Issue 2

Why will EMDRIA exist in the future? Where is EMDRIA going?

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A word from the President...

Kate Wheeler, Ph.D., APRN, FAAN
EMDRIA President

The EMDRIA Board of Directors met in February 2013 for two days to develop a strategic plan for EMDRIA with an eye to the future and a deep appreciation for past Board leadership that has provided the strong foundation so EMDRIA can move forward. A strategic plan is the result of "strategic thinking" and serves as roadmap for change to provide direction and focus that guides the allocation of resources, decision-making and choices for involvement for an organization. Stepping back and reflecting on where we are now, where we want to be, and how to get there is crucial at this stage in EMDRIA's development so together we can meet future challenges and shape our preferred future.

The process was thoughtful, deliberate, inclusive and transparent. The following is a summary of the steps the Board took to assure input by all EMDRIA members into the development of this plan.

The Board began discussing the idea of a strategic plan in 2011 and voted in 2012 to hire a consultant in order to develop a plan. Several teleconference calls were held with potential consultants before a final consultant was vetted. A survey of Board members was then conducted by the consultant regarding our visions and future challenges for EMDRIA. Crucial to the success of the plan was input from our members. The Board sent a survey to all members that asked the following 3 questions:

1. What are the three things that you want from EMDRIA that you cannot get easily from other sources?
2. If EMDRIA could only do one thing, what should it be?
3. State what you would like members of the Board to know as we enter the strategic planning process.

In addition to the member survey, teleconferences conducted by the Board with Administrative Committee chairs, SIG chairs, trainers, and members of the Regional Coordinator Committee yielded further information. A quantitative and qualitative analysis of the data identified the key issues from respondents. The needs and concerns voiced by our EMDRIA members served as the basis on which our strategic plan was developed.

After reviewing results from the data gathered, the Board reviewed and discussed the core purpose, guiding principles, and core values of EMDRIA. Once the Board agreed on the core purpose of EMDRIA and core values, strategic goals were developed.

EMDRIA's core purpose is highlighted below:

To advance the education, practice, and science of EMDR

- To establish and uphold standards of practice, training, certification, and research
- To provide information, education, and advocacy
- To assist practitioners in fulfilling their responsibilities to the public

The core values represent the guiding principles for how we wish to conduct ourselves as professional members of EMDR International Association and include the following:

Promotion of EMDR
Integrity, Professionalism & Ethics
Service
Dedication to Member Concerns
Inclusivity & Diversity
Leadership
Excellence
Teamwork, Collaboration & Cooperation
Change

Continued on page 4...

The strategic plan was approved by the Board in their April meeting with the following 3-5 Year strategic plan goals listed in order of priority set by the Board:

1. EMDRIA will increase membership.
2. EMDRIA will be the indispensable resource for member networking and professional development.
3. EMDRIA will advocate for EMDR practice and research.
4. EMDRIA will promote the advancement and knowledge of EMDR to consumers.
5. EMDRIA will achieve and maintain the relevance of EMDR in a culturally diverse and evolving world.

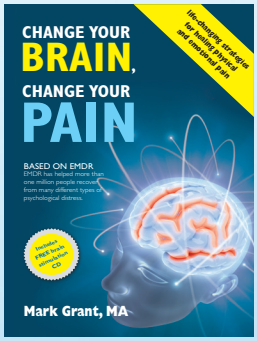
Strategies to meet these goals with indicators of achievement were identified and discussed. However, since these initiatives and benchmarks largely fall under Administrative responsibilities according to our policy governance model, implementation and operationalizing these are under the purview of our Executive Director, Mark Doherty. Benchmarks will be set by Mark in collaboration with the Board so that outcomes are measureable with specific timeframes.

This plan is an opportunity that allows for a special moment of communal reflection that allows every member of our community to take personal ownership in a vision that conveys clarity and continuity. Clarity implies that the strategic plan is visible to and understandable by all members of our community and continuity implies that there is a commitment to the plan that does not abdicate to short-term exigencies. The success of this plan depends on active involvement of our members. We are thankful to all members who contributed their ideas and look forward to working with you to ensure success in meeting our goals. Stayed tuned to future columns that will keep you abreast of this ongoing process and accomplishments. ❖

EMDR Resources by Mark Grant

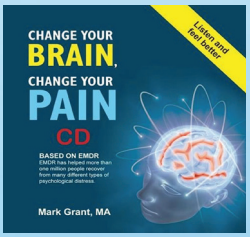
The following books and CD's are designed to help EMDR therapists and clients maximize the benefits of this method when treating stress, trauma, anxiety and pain. I am particularly excited to announce the release of a new CD, 'Anxiety Release' which will also be available as an App.

Change Your Brain Change Your Pain (book & CD) $30.00
Designed for anybody who is suffering from some combination of physical and emotional pain, this book summarizes the research regarding the overlap between physical and emotional pain and provides a phased-oriented approach to stabilizing and overcoming pain. Comes with CD.



"A paradigm shift.. a worthy contribution to the field." Psychotherapy in Australia

Change Your Brain Change Your Pain (CD only) $16.95
Stand-alone version of the CD from the book; consists of 2 x 20 minute sessions of guided pain-management (including resource installation), Healing Music and a 10 minute Bilateral Stimulation track.

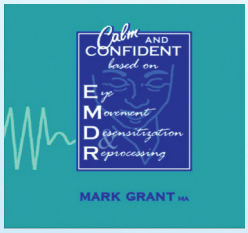


The CD transported into the deepest hypnotic state I've experienced in many years, and my fibromyalgia pain was totally gone…Thanks for a fabulous tool I can now use with confidence for myself and my patients! - Chris DeHaan, Ph.D.

Pain Control with EMDR (Treatment manual – 4th revised edition)$29.95
Describes how to use EMDR in the treatment of chronic pain including pain protocol, 5 key variations from trauma protocol, case examples, and detailed guidelines for preparation and assessment stages, plus 20 pages of therapist and client resources.

"Well written – an elegant and practical tool." Harrison Whitecloud, Australia.

Calm and Confident based on EMDR (CD) $16.95
2 x 28 minute sessions of ericksonian hypnosis, evocatie music and Bls.



"The most effective relaxation training I have heard from any audio library" – Dr Scott Borelli, UK.

Pain Control based on EMDR (CD) $16.95
2 x 28 minute sessions incorporating of Ericksonian hypnotic suggestions, music and dual-attention/bilateral stimulation (DAS/Bls).

'I have severe chronic pain, and use this CD all the time. It is awesome!' Jesi, USA

Anxiety Release, with Bilateral Stimulation, (CD and App) NEW! $16.95
CD consists of four sessions including 1 x Brain Training session, 3 x anxiety management sessions, (includes 1 x Bls only track) and 1 x safe-place session.The unique 'Brain Training session' is designed to reverse the negative effects of anxiety on attention and prepare the user for self-use of Bls.The Anxiety Release sessions show the user how to have more control over their anxiety by changing their experience of it via focused attention and Bls.

App version includes; stunning Bls brain visual with simulated fMRI neurofeedback and a progress Log. Suitable for both clients and therapists, this App turns your iphone into a bilateral stimulation device! (iTunes store only – from July 2013). **Special Introductory price: Only $4.99**

"This App gives me control over my stress and anxiety – the Bls visual is amazing – it really enhances the auditory effect. Thanks!" Lorraine, Australia

Available from:
Mentor Books
www.mentorbooks.com/hap-resources
EMDRResources
www.emdrresources.com
Amazon
www.amazon.com

All audio also available as downloads from voltahealth.com, iTunes

Announcements

Your Vote Counts

The EMDRIA Board of Directors Online Election is now open. You should have received an email containing a link to the ballot. All Full Members who renewed or joined by May 31, 2013 are eligible to vote. You can access the ballot directly from the link in the email or by visiting the Members Only Area of the EMDRIA website and clicking "Vote Now". You will also have the option to call EMDRIA and request a paper ballot be mailed to you if you prefer to vote by mail. If you have not provided an email address to EMDRIA, a paper ballot will be sent to you automatically.

Online Version of the Journal Now Available

Volume 7, Number 2 of the Journal of EMDR Practice and Research is now available online. To access the Journal online at any time, just login to the Members Only Area of the website. Hard copies of the Journal were mailed at the beginning of the month.

Memorial Scholarship Fund

EMDRIA is seeking contributions for this year's Memorial Scholarship Fund. The Memorial Scholarship Fund was established in 2004, in memory of long time EMDRIA member Elizabeth Snyker, for the purpose of expanding professional development opportunities for those who would otherwise not be able to attend the annual EMDRIA Conference. Since 2004, this Fund has provided assistance to more than 65 EMDR clinicians. To donate, please click on the link on the homepage at www.emdria.org.

New EMDRIA Credit Materials Now Available

The EMDRIA Credit (EC) Materials for advanced workshops – including the Provider Application, Program Application, Guidelines and Requirements – have been revised and updated. Please be sure to use the new EC materials as the old version of the provider and program application will no longer be accepted. To access all of the available EC materials, please click on "EMDRIA Credits" under the Training and Certification tab on the EMDRIA website. Be sure to click on the EMDRIA Credits links on the left hand side of the page as they will take you to other pages where that specific information can be found.

EMDR Conferences Around the World

EMDR Asia will hold its 2nd Annual EMDRIA Asia Conference in Maila, Philippines from January 9-11, 2014. For more information, visit www.emdr-asia.org/conferences-meetings/.

EMDR Europe will hold its 15th Annual EMDR European Association Conference in Edinburgh, Scotland from June 26-29, 2014. For more information, visit www.emdr2014.com.

EMDRIA Office Closed

Please note that the EMDRIA office will be closed July 4th for Independence Day.

Executive Director's Message

Mark G. Doherty, CAE
EMDRIA Executive Director

An important function of a board of directors of a professional association is to provide a vision that guides the organization into the future. The strategic planning process that EMDRIA President Kate Wheeler wrote about in her column is a good example of a board taking this responsibility seriously. The core ideology, our core purpose and core values, describes our identity that transcends changes in the environment. Our reason for being (core purpose) and the enduring principles (core values) that guide the behavior of our organization establish a basis for what we do going forward. We then can envision what EMDRIA should become in the longer term 10+ years out and formulate indicators of achievement to measure our progress.

Achieving our vision requires shorter term goals of three to five years that are intended to guide and measure EMDRIA's progress and future success. While all the goals are important, we have to prioritize them due to limited resources in terms of money and staff/volunteer time. What has emerged from board discussion is that increasing membership, enhancing member networking and professional development, and advocating for EMDR practice and research are priorities. However, we won't forget about promoting EMDR to consumers and achieving cultural diversity.

To achieve our goals, we need strategies and tactics. Increasing membership is important to grow revenue, procure needed resources, and increase staff to enhance member benefits and advance EMDR. What if part of our vision is to have 20,000+ members ten years from now? That's a 16 percent per year growth rate! So, let's focus on increasing membership. One approach is to be more proactive in working with those engaged in conducting EMDR basic trainings. Perhaps providing trainers with better membership recruitment materials, engaging Regional Coordinators to talk about joining EMDRIA, and reducing dues for those newly trained would be helpful. We could incent trainers by offering a free EMDRIA membership or even a free conference registration for bringing in specified numbers of newly trained members. The same offer could be made to members who don't conduct basic trainings. Increasing and enhancing current member benefits will also attract and retain members. We need to think differently about how to grow our membership and utilize our members to bring those newly trained into our community.

A second important goal is to enhance member networking and professional development. Increasing online EMDRIA Credits and ramping up our technology to enhance member communication through discussion forums are two ideas considered. Other possible undertakings include developing EMDR curricula in universities with introductory materials/coursework and basic training programs; and streamlining basic training requirements to address cost, time requirements, and accessibility. It is also important to increase the number of EMDRIA Certified Therapists and Approved Consultants to mentor newly trained clinicians and help them find the resources they need to enhance their practices using EMDR. We want EMDR therapists more invested in the community and ultimately EMDRIA.

These thoughts are just some activities that we are beginning to explore now that the board is completing the strategic planning process. As your executive director, I sometimes feel like a bus driver who wants to know where to drive and whether the short cut or scenic route is desired. The staff and I are grateful that the board is providing a clear direction for EMDRIA and for ideas they generated on potential strategies. Professional associations work well when the leadership and staff can brainstorm concepts while recognizing the resource limitations that exist. The execution of a strategic plan focuses our efforts on achieving a perceived end by marshaling resources to attain that vision. We want to be a team moving in one direction. Ideas that the members have to offer are more than welcome. Feel free to contact me at mdoherty@emdria.org .

Part of the implementation of the strategic plan entails coaching the staff and helping them understand their roles in the plan. What we do needs to align with what the goals are. Tasks that don't contribute to the vision of EMDRIA will cease and activities that move us ahead will be supported. We will have to evaluate our staff skills sets and determine what additional needs we have. Implementing a strategic plan will be a challenge and we are excited about tackling it. ❖

Conference Corner

Excitement is growing for the 2013 EMDRIA Conference: "EMDR: Where Science & Research Meet Practice". Come and be a part of the largest and most anticipated EMDR event in the United States. Join us September 26-29, 2013 at the Renaissance Austin Hotel in Austin, Texas.

The schedule of events, speaker biographies, workshop descriptions, hotel information and sponsorship and exhibitor opportunities are available on our Conference website. Visit www.emdriaconference.com today!

2013 EMDRIA Conference
September 26th-29th | Austin, Texas

Registration Information

Registration is now open! Here are two good reasons why you should register today:

1) Get the workshops you want! Workshops are assigned according to the date registrations are received and meeting space may be limited.

2) Save money! If you register by August 1st you will receive the Early Bird registration fee. Fees will go up after August 1st and if you wait to register on-site, there is an additional $25 fee.

Your registration includes: Attendance at all plenaries, workshops, continental breakfast each day, two coffee breaks each day, dinner (Friday only), opening reception, networking reception and access to the Exhibit Hall.

Visit www.emdriaconference.com to register online or to download the printable registration form. In addition to this you should have also received the printed Conference brochure in the mail. For more information or questions regarding Conference registration, please contact Jennifer Olson at jolson@emdria.org.

Hotel Information

This year's Conference will be held at the Renaissance Austin Hotel. EMDRIA has a secured a special group rate at the Renaissance of **$168/single/double** for EMDRIA Conference attendees. It is not too early to book your reservation! To book your reservation online, please visit our Conference website at www.emdriaconference.com or give them a call at 800.468.3571 and ask for the EMDRIA rate! The Group Code is **emdemda**.

As in years past, we are helping to match up attendees who are staying at the Renaissance Austin Hotel as roommates at the Conference. If you are interested in finding a roommate, go the EMDRIA Conference website and go to the "Hotel & Travel" tab and click on the Find a Roommate link, and add yourself to the roommate list.

Air Travel Information

Delta Airlines

Delta is offering discounts (5% restricted flights – no upgrades and 10% non-restricted – this includes first class and business class) to EMDRIA Conference attendees for travel to Austin-Bergstrom International Airport (AUS) between September 19 and October 7, 2013. Miles may be earned. SkyMiles travel award options are not permitted. The meeting event code is NMFZY. Reservations and ticketing is available via www.delta.com or by calling the Delta Meeting Network Reservations at 800.328.1111. Please note that a Direct Ticketing Charge will apply for booking by phone. When booking online, select Meeting Event Code and enter the meeting event code listed above in the box provided on the Search Flight page. You must search by "Fare Class" and not "Cabin". This discount does not apply toward U, L and T class fares. Select Economy E (or higher) to view the lowest price available.

American Airlines

American Airlines is offering a 5% discount to EMDRIA Conference attendees for travel to Austin-Bergstrom International Airport (AUS) between September 20 and October 7, 2013. Mileage members can receive credit for all American miles flown to attend this Conference. The promotional code you will need to us is: 6993BK. To book your discounted ticket online go to www.aa.com and use the discount reference number above as the aa.com promotion code. Itineraries involving any Oneworld or codeshare partner airline must be booked through the AA Meeting Services Department at 800.433.1790 if calling from the US and Canada. International attendees should call their local American Airlines reservations number with the above Promotion code. A service charge of $25.00 USD per ticket will apply for tickets purchased through American Airlines Reservations.

Memorial Scholarship

The Memorial Scholarship Application is available. Visit our website and download the application form if you would like to be considered for a scholarship to help with funds to attend the Conference. The deadline to submit the scholarship application is June 30, 2013.

Want to get noticed? Exhibit, Sponsor or Advertise!

Don't sit on the sidelines...be a part of the buzz! Sign up to be an exhibitor, sponsor or advertiser. This is a great way to get your message in front of EMDR therapists! EMDRIA offers a wide variety of Exhibit and Sponsorship opportunities that are all designed to help you promote your product or service to EMDR therapists.

Exhibit Booth Space

Reserve your booth space and enjoy more value-added exhibitor benefits. Strengthen your existing relationships, increase your product awareness and generate new sales. All Booths include: Standard Single Booth (10' x 10'), 8' background drape, 3' side drape, Draped 6' table, 17" x 44" ID sign for booth display and Wastebasket.

All Exhibitors receive:

- Company logo, a 50-word description and contact information included in the on-site Conference Program
- Company logo, link and 50-word description on the EMDRIA Conference website
- One complimentary Conference Registration
- Two complimentary Exhibitor badges per booth
- Pre- and Post-Conference registration mailing lists to promote your company

Sponsorships

EMDRIA's wide variety of Sponsorship opportunities are all designed to help you spread your message to EMDR therapists. Most of the sponsorship opportunities include Exhibit Booth space, allowing you to get the most advertising value for your dollar.

Spotlight your company's message and reach prospective clients by participating in one or more of the following EMDRIA Conference Sponsorships.

Free Wi-Fi
Relaxation Station
Conference USB's
Conference Mobile App
Hotel Key Cards

Hotel Room Drop
Opening Reception
Conference Bag
Networking Reception
Lanyards
Plenary Workshops

Coffee Breaks
Full Day Workshops
Notepads
Breakfasts
Participant Pencils

To find out more information on exhibiting, sponsoring or advertising and guarantee your visibility, contant Lisa Gallo, CMP at 512.651.3547 or lisa.gallo@horizonmeetings.com for more information or questions. ❖

EMDRIA Memorial Scholarship Fund

Donate Now to provide development opportunities to EMDRIA members and help them attend the 2013 EMDRIA Conference.

Donations can be sent to:
EMDR International Association
Attn: Memorial Scholarship Fund
5806 Mesa Drive, Suite 360
Austin, TX 78731

EMDR RESEARCH FOUNDATION

BY WENDY J. FREITAG, PH.D. *- PRESIDENT, EMDR RESEARCH FOUNDATION*

The EMDR Research Foundation is not a part of EMDRIA; this article is published as a service to EMDRIA members.

Progress…One Accomplishment At A Time

The EMDR Research Foundation (ERF) Board has had a busy Spring! We continue our ongoing fundraising efforts, along with looking into new possibilities, working with a grant writer and looking for opportunities to partner with other funding organization with similar missions. Given those tasks are in motion, we are now focusing our attention to the other goals set forth in our 2011 Strategic Plan.

One of those goals is to reach at least 10,000 clinicians with information on clinically relevant EMDR research. In January we launched our monthly e-newsletter and in early March, we introduced the first of our mini-monthly newsletter that focuses on our colleagues who have been trained to treat military personnel, veterans and their families. EMDR and the Military in Action is designed to promote continued interest and education in EMDR and to show our support for those clinicians who deal daily with this growing population of traumatized individuals. One of the monthly highlights of the newsletter is a featured article related to past or current research literature pertaining to work with these clinical populations. The ERF is aware that military and veteran families face a unique set of stressors that may negatively affect their health and well-being and that the clinicians who treat them encounter a different set of challenges as well. It is our hope that the monthly newsletter is informative, offers support to our colleagues and provides a means of staying connected with EMDR community. We hope the newsletter helps to stimulate conversation and creative treatment ideas amongst our EMDR-trained military colleagues, and potentially fosters new research on the efficacy of EMDR in the treatment of military personnel and their families. Anyone interested in receiving the EMDR and the Military in Action monthly newsletter, is welcome to sign up on our website. Thanks to our Board members, Barb Hensley and Rosalie Thomas, and to our colleague, Camille Zeiter, LICSW, at Joint Base Lewis-McChord (JBLM) who were responsible for getting this project off the ground.

Another way the ERF continues to reach out to EMDR clinicians is through the "Translating Research into Practice" (TRIP) column in the Journal of EMDR Research and Practice. This column is edited by the ERF and provides a link between research findings and their implications on clinical work. It also provides clinicians the opportunity to share how a particular research finding has impacted their work with clients. We are very interested in hearing from all EMDR clinicians whose clinical work has been impacted by a research article or finding. Our Board member and Education Committee Chair, Katy Murray (katymurraymsw@comcast.net) is actively looking for volunteers willing to write up their experiences and share their insights. Please contact Katy to find out more information about how you can be a part of this effort.

Also in March, to continue our outreach to clinicians Board member, Jim Gach staffed our exhibit booth at the Psychotherapy Networker Symposium held in Washington D.C. I want to make a special note to acknowledge and thank Gene Schwartz, one of our generous donors, who shared these responsibilities with Jim. They both took time from their practices and families to spread the word about the ERF. Our goals for this venture were to promote awareness of the ERF and our mission, increase the opportunities for future high quality research proposals as well as promote new donor interest. Our booth was very busy, due in part to the complementary sponsorship opportunity offered by Mike McKenna, Networker Exhibitor Director. Jim and Gene fielded many questions about EMDR, trainings, EMDRIA and the ERF; therefore, our presence not only promoted the ERF, but EMDR in general.

Another of our goals in the 2011 Strategic Plan is to provide non-monetary research resources for current and potential EMDR researchers. We are very excited to announce the launch of the ERF's "Research Resource Directory" on our new website. This was a combined effort by Board members, but I want to acknowledge Katy Murray, Barb Hensley and Tonya Edmond for their time, effort and tenacity in the development of the Directory. This is a compilation of various research resources to support practitioners and provide access to information to guide the development of research projects as well as to inform clinical practice. It was developed in response to numerous inquiries from EMDR practitioners about how to access databases, empirical articles, non-university based Internal Review Boards, measurement tools, and other resources. Some of these resources require a fee for use, but many of them are free to the public. We encourage you to explore the Directory on the Resource and Grants page of our website. We also ask that you share with us any additional resources you know of or discover that could be helpful to others.

In regards to funding research, the newest recipient of the ERF funds is the research team of Michael Blair, Ph.D. and Kathy Harms, Ph.D., at the Crittenton Children's Center in Kansas City, Missouri. Their research project is entitled "Children and Adolescents in an Inpatient Setting" and is the first study seeking to verify the efficacy of the use of EMDR with children and adolescents (ages 5-18) admitted to an inpatient acute psychiatric hospital. In this study, they will compare EMDR to Skills-Based Cognitive-Behavioral Therapy. Congratulations to Drs. Blair and Harms and their research team and we look forward to these important research findings.

As I mentioned, the ERF's new website is up and functional. In the process of making this important change, we have updated our online donation system to allow donors to make one-time and recurrent donations online. Given this is a new and updated donation system we will need to integrate all our current Visionary Alliance members into it. All members received a personal email from us in the last few weeks, instructing you how to register your membership on your own. If you have not done so, we ask that you take a few moments to do so at your earliest convenience. If not, someone from the ERF office will be contacting you by phone to assist you in setting up your account. Or if you have any questions, please feel free to contact Angie Schlanger at 512.571.3637. We want to thank you for your support and patience during this important transition.

As always, I end with a note of gratitude for your sustained financial support of the ERF. I recognize and want to acknowledge how vital your contributions are to our success and continued achievements.

"We cannot seek achievement for ourselves and forget about progress and prosperity for our community… Our ambitions must be broad enough to include the aspirations and needs of others, for their sakes and for our own." ~Cesar Chavez ❖

In the Spotlight: Mark Russell

BY MARILYN LUBER, PH.D.

A Warning

"The importance of Institutional Military Medicine's (Veterans Administration [VA] and Department of Defense [DoD]) 'anything but EMDR' research ban cannot be overstated in terms of the future of EMDR and mental healthcare. Historically, when it comes to mental health, 'as goes the military, so goes the nation,' in reference to the influence of lessons of war trauma, even if those lessons are faulty." -Mark Russell

Mark C. Russell strikes a somber note whenever he speaks about the Military, EMDR and the future of EMDR in the military and private sectors. It is a message that we would do well to heed as it speaks to the core of the work that we do. It is a warning to the EMDR community about the necessity of conducting randomized controlled trials (RCT), the gold standard for clinical trials, to test the efficacy and/or effectiveness of EMDR intervention with a patient population. Without RCTs, we will be relegating ourselves to a minor role in the history of psychotherapy.

As a military spokesperson, Mark Russell has impeccable credentials from the circumstances of his birth into a military family, his upbringing on military bases nationwide, his experience as a Marine and later a U.S. Navy commander and experience as a board-certified clinical psychologist. His father, Charles Marion Russell, was born in the Great Lakes region of Montana. He enlisted in the Marine Corps in 1948 and was a veteran of the Korean and Vietnam Wars. His mother, Yvonne Dionne, was French Canadian and was volunteering in San Francisco at a USO event when she met Charles. They corresponded during his Korea deployment and married when he returned in 1952. They had six children: Vivian, David, Mark, James, Brian and Robert. David, James and Brian all served in the Air Force.

During the early years, the Russell family moved every three years. While Charles was in Korea and later Vietnam, they moved two/three times per year. For Mark, this was a lesson of learning to adapt to change. The downside was that he also learned not to put down roots or get close to people because, after a short while, he would move and never see them again.

As a child living on a military base during wartime, Mark saw firsthand the vicissitudes of war. It was the custom during the Vietnam War at military base schools to announce the names of parents who were killed over the loudspeaker. He remembered that the other students were asked to put their heads on their desks, while the child whose parent had died would be greeted at the door by a group of adults. Mark would peek and see the look of concern on his teacher's face and know that something was not right. One time, it was his best friend who was called and was soon taken away as the big trucks came to move the child's family. These types of experiences impacted Mark deeply and created a rationale to work with children when he chose his career.

Living on bases during times of war and peace, Mark saw the effect on the troops. When his father would come back from war, he did not look the same as he did before his departure. His father did not drink, or get angry or have difficulty at work, but Mark noticed that he seemed detached and that his mind was off somewhere else. From a child's perspective, he thought he might have had something to do with it and his father's detachment saddened and confused him. It also helped form his decision to go into the military and work with soldiers who had been subjected to war stress.

Mark's dream from a young boy, and into college, was to be a baseball player. He had a partial scholarship to Pepperdine University, but when he got there he found out that there were others who could hit and throw much better than he could. He got distracted from his studies by the novelties presented to him while on his own and, in 1979, dropped out of school and enlisted in the Marines. He was struck by the issues of the time: the effect of Vietnam on his instructors; the race riots; and the attempt to integrate women into the military and the sexual harassment that they endured. His first encounter with trauma was when two pilots from his squadron landed their plane on wet ground, one was decapitated and the other survived. He could see the effect of this trauma on the survivor. When he tried to get back into his aircraft, his knees buckled and he would start trembling. No one would have said that this man was predisposed to be like this, but in 1980 there was nothing published and the military did not recognize Posttraumatic Stress Disorder (PTSD) as a diagnosis. Mark's first-hand experience with trauma convinced him of its existence.

During his 10 years in the Marines, he served in the Philippines during President Marcos' years, at the Marine Barracks in Lebanon,in Japan where he met his first wife, and in California where he continued his education. He resonated with David Viscott's "The Making of a Psychiatrist" and started taking courses in Psychology. His superiors supported his studying for his degrees and in 1984 he got his BA in Psychology from Chapman College and started his MA in Counseling Psychology. He decided to leave the Marines in 1989 to finish his MA and do his Ph.D. in Clinical Psychology at the Pacific Graduate School of Psychology. In 1991, he received his MS in Clinical Psychology from the same school. His ever-present goal was to work as a psychologist in the military assisting troops and their family.

On completing his MA in Counseling Psychology, Mark and his family moved to Palo Alto for his doctorate. He began working at the Mental Research Institute (MRI). Mark was deeply rooted in Cognitive Behavioral Therapy (CBT) so he was skeptical when he saw a flyer for EMD that offered trauma treatment in a single session. However, when he viewed Francine Shapiro's videos, after seeing a presentation at MRI, he observed that it was an effective way to treat trauma and that she was getting profound results in a short period of time. He wondered if it was too good to be true and if it would stand the test of time. He decided to ask Francine if he could be her Research Assistant so that he could find out for himself, learn more about it and be in the forefront of something new and groundbreaking. She agreed. His duties involved the design, implementation and analyses of her research on utilizing Eye Movement Desensitization and Reprocessing (EMDR) procedure for the treatment of psychological trauma. He enjoyed trying to piece together the puzzle. To him, it was obvious that it worked but not why it worked. He appreciated that her synclectic theory tried to describe what was happening from different perspectives. However, what was most compelling about EMDR was that it was a treatment method that was amenable to military culture and the warrior class because it was quick, low-tech, portable, effective and did not require much talking or disclosure of detail. He was excited about taking EMDR into his military career. He was Francine's Research Assistant for two years and then became a Clinical Psychology Intern and Staff member at the Department of Psychology, Naval Medical Center in Portsmouth, VA. There he completed his APA approved pre-doctoral internship involving inpatient, outpatient, consultation, behavioral medicine and psychological assessment for diverse clinical populations.

Mark's dissertation was on "Attentional Focus and State-of-Mind in Post-Traumatic Stress Disorder Among Vietnam Combat Veterans". This began a journey of understanding that went beyond academic knowledge. Through his conversations with his father, he developed an understanding about the father he had as a child. His father's willingness to discuss how he was affected by his Vietnam experience helped Mark understand the ripple effect of how his father had related to all of his family members and helped him heal the chasm that had built up between them so many years before that. His father's links to vet agencies assisted him in interviewing hundreds of vets and was instrumental in Mark's understanding of the repetitive nature of this problem across generations. At this time, he vowed to dedicate his life to stopping this discarding of the men and women who serve their country.

Mark was the first Navy Psychology Intern selected for a post-doctoral fellowship in 1984. From 1994-1995, he received a Medical School Post-Doctoral Fellowship in Clinical Psychology in the Department of General Pediatrics at Children's Hospital at Harvard. There he received extensive specialized training, supervision and experience performing neurodevelopmental, neuropsychological and psychological evaluations for children in infancy through 18 years and their family members.

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In 1995, Mark went from being a Marine to joining the Navy and becoming a "squid", as there were no medical facilities in the Marines. It was a shock to go from the clean-cut appearance of the Marines to seeing sailors wearing beards and looking like pirates! His first post as a Staff Adult and Child Clinical Psychologist was at the Director of the Educational and Developmental Intervention Services (EDIS) at the Naval Hospital in Yokosuka, Japan where he was responsible for a multidisciplinary staff of 65. He was charged with providing a full range of mental health services to active duty adults and their families. He also was involved with policy and procedures for special needs programs and community response to child and adult sexual assault victims in Japan and managed the Substance Abuse Rehabilitation Programs. After the Kobe earthquake, the Department of Psychiatry at Waseda University asked him to train 100 clinicians about PTSD as well as conduct six workshops at Tokyo University for Japanese psychiatrists on trauma treatment. For his work, he was awarded Navy Commendation Medals. He also published a research article on combat PTSD in a peer-reviewed journal. During this time, he was teaching undergraduate and graduate courses at the University of Maryland's Japan branch on subjects related to clinical psychology. Mark felt that he had come full circle from being a child on the base to being the Director of EDIS where he could make a difference for the children in his charge and also tend to the repair of his own early experience where no one recognized the suffering of military-born children.

Mark found that his warrior class teachings of respect for the colors and those who came before him resonated with the Japanese culture whose members also honored their ancestors and the old traditions. There were times that he felt the stigma of being an American when he was not allowed to go into certain bars or restaurants. Ga-jin (foreigners) were not allowed and he felt different. Since the bombings during WWII and the subsequent occupation by American forces, Japan has been submitted to an American footprint. During his experience in Japan, Mark's eyes opened to the cultural differences and the difficulties of raising a bi-cultural family where one foot is in and the other out of the culture.

In 2000, his beloved wife, Masai died from cancer. In 2001, Mark brought his boys back to Washington where he was the Staff Adult and Pediatric Clinical Psychologist and Head of the Adult and Pediatric Mental Health, Neurology and Substance Abuse Rehabilitation Program Departments at the Naval Hospital in Bremerton. He returned on the eve of 9/11 and assisted the military in mobilizing for war. During this time, he met his second wife, Mika, and after a short time together, he deployed to Rota, Spain, to serve as the Head for Mental Health for Fleet Hospital Eight deployed in support of Operations Enduring and Iraqi Freedom. During this time, Mark developed an innovative combat-stress management program resulting in proactively screening 96% of the 1,341 medical evacuees for war stress injuries; conducted post-deployment briefings for 942 evacuees; established a Reconditioning Unit returning 63% of the evacuees back to full-duty and thereby exceeding the 10% expected; conducted the first-ever military PTSD training survey that identified 90% of the 110 clinicians had received no training on evidence-based treatments per the DVA/DoD 2004 practice guidelines as cited by the 2007 DoD Task Force on Mental Health; and developed, organized and conducted a joint DoD/VA regional training program that resulted in 250 clinicians trained within six months on evidence-based PTSD therapy (EMDR) with savings of over $250,000. These accomplishments were in addition to the work that he was doing in support of assessing children with serious developmental, emotional and behavioral problems, his work on the Child and Spouse Case Review Committee for childhood abuse and domestic violence, the development of a Provider Wellness Program and publishing two research articles on combat –related mental health interventions.

On August 26, 2005, Mark was awarded the Meritorious Service Medal by the President of the United States, George W. Bush: "Widely recognized as a national expert in the area of PTSD and therapeutic technique of EMDR, Commander Russell's most far-reaching impact has been through his tireless efforts to address combat-related trauma."

It was at this time that Mark slammed into the ten-generation cycle of the institutional barriers that would prevent, and have been preventing, the military from treating war stress injuries. The first hint came as they were preparing to deploy and went into training to simulate mass casualties and gunfire overhead. His team was to treat a female corporal who was dressed in a "costume", not representing anything that would convey the seriousness of the situation. The next clue was being told by the Medical Director, one month prior to deployment to Spain, that they did not know why mental health providers were being deployed. However, the tip-off was after creating an innovative stress screening for evacuees that allowed for the troops to return to their posts at significantly higher numbers than ever seen before. They proudly presented the results of their field hospital's work to the Navy's Surgeon General. He then told them, "This is very impressive. Unfortunately, it will all be forgotten."

At that moment, everything came together for Mark. The interviews that he had done with WWII, Korea and Vietnam vets on the neglect of their traumatic stress injuries, the lack of training in preparation for his team's deployment to Spain to the point of offensiveness and his superior officer's dismissive comment concerning all that his service had done to care for the troops. This was the moment that Mark became the whistle blower on the military's dereliction of duty in caring for their own.

In 2003, Mark submitted his first Official Report to the Bureau of Surgery and Medicine on the "Standardization of Navy Medicine management of combat-related stress and utilization of mental health assets during fleet hospital and other operational deployments".

This was followed in 2005 by a survey on DoD mental health treatment that was submitted to the Bureau of Surgery and Medicine mental health specialty leaders. In this survey, 110 military mental health providers indicated that 95% had not received any training or supervision on any of evidence-based PTSD treatments "highly recommended" by the Department of Veterans' Affairs (DVA) and DoD (2004) Clinical Practice Guidelines for Treatment of Post-traumatic Stress Disorders. Later that year, he sent an Official Memorandum to the Assistant Secretary of Defense for Health Affairs for additional recommendations to prevent a mental health crisis that included: Creation of regional research, training and treatment centers in DoD specializing in the full-spectrum of war stress injury. He also recommended a significant increase in mental health staffing levels and retention bonuses, improved tracking methods, ramped up research funding and the development of standardized assessment protocols.

In 2005, Mark returned to Japan to be the Staff Adult and Child Clinical Psychologist for family members and children from birth through 21 years old. He was given the following responsibilities: provide mental health and deployment-related services to a base population of approximately 5500; conduct the assessment of special needs children; train psychologists; teach the Japanese community about early intervention; and improve post-deployment services and enhanced public awareness and community support for deployed personnel and teaching about PTSD and EMDR in the Pacific region. He also published eight research articles on war-related training and treatment and was awarded the Distinguished Psychologist Award by Washington State Psychological Association.

In 2006, Mark and Mika made a joint decision to speak out despite the possibility of reprisal and that his career could be grievously affected by his actions. They decided that they could no longer be complicit and morally live with themselves. This was the only option they had left. Mark submitted a grievance to the Navy Inspector's General Office calling for the investigation of inaction by military leaders on his previous official reports and memoranda. In 2006, Mark was invited to testify before the Congressionally-mandated, Department of Defense Task Force on Mental Health where he gave solutions to address the current mental health crisis and to prevent future failure to meet mental health needs. By 2007, he was tasked to develop a Navy Medicine PTSD training program that was successfully pilot tested but the recommendations were not acted upon.

In May 2007, Mark filed an official grievance against the United States Navy for unlawful reprisal under the Military Whistleblower Protection Act. He asked the DoD to investigate the inaction of military leaders to prevent or mitigate mental health crises needing significant increases in staffing and retention, research, assessment, training, tracking, treatment access and creation of regional centers. He filed several more requests for the unresolved grievances with no success.

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Despite his work accomplishments in the field, his publications, his presentations, his teaching about PTSD to his colleagues, his documented expertise in war trauma, his military lineage, the media attention, the Meritorious Service Medal from the President of the US and all of Mark's other efforts, he could barely budge the institution. Eventually, Congress passed the Wounded Warrior Act and created new legislation. As Mark reflected, "It takes an act of Congress or a Presidential decree to make the medical profession to do what it needs to do, despite an epidemic of lives destroyed and nothing done. The shame of this situation is in every generation –each crisis- the post war lessons learned are part of the official record. It is a cycle that repeats itself: we knew better, we did not plan, we did not train and there has never been a single inquiry through the centuries by Congress or the media to question, 'Why?'"

By 2008, Mark had his own experience with trauma and/or compassion fatigue. He was at home when suddenly his eyes fixated, his visual field blackened, he became mute and could not move. It took several hours for his symptoms to pass and he learned the true meaning of trauma from the inside of a stress injury. At the time, he was living in Japan and the only Clinical Psychologist responsible for approximately 6,000 people who were coming out of the war zone, landing in Japan with no debriefing and quickly falling apart. By 2009, he went from being one of the highest performing Commanders in the Navy to the lowest.

In July, 2009, Mark transitioned into civilian life. He returned to Washington state where he is currently the Chair of the Psy.D. Program and core Psy.D. Faculty at the School of Applied Psychology Counseling and Family Therapy at Antioch University in Seattle. He continues to teach, sit on the Institutional Review Board and conducts colloquia on compassion fatigue. He established the first-ever Institute of War Stress Injuries and Social Justice to investigate and end cyclic failures in meeting military mental health needs.

To the EMDR Community, Mark has this to say:

> *In the 21st century war generation, billions of dollars have been spent by VA/DoD PTSD researching mainstream CBT (e.g., CPT, PE) and psychopharmacology (e.g., Ecstasy), as well as a host of alternative approaches (e.g., Reiki massage). The controversial findings from a 2010 Institute of Medicine review of PTSD treatments and VA meta-analysis of psychotherapy re search on combat-PTSD (e.g., Albright et al., 2010), reveals a telling trend toward evaluating the evidence of therapies specific to type of trauma (e.g., war, rape, etc.), and concluding that EMDR lacks sufficient empirical support-which is tragically an accurate statement. Keeping the specificity trend in mind, aside from Carlson et. al's (1998) randomized controlled trial showing 77% of Vietnam veterans no longer met PTSD criteria, the last VA sponsored EMDR research, and only 1 of 2 funded trials by NIMH (the other being van der Kolk et al's 2007 blind, placebo control favorably comparing EMDR over Prozac), the VA/DoD policy banning EMDR research over the past 12 war years, ensures future revision of the VA/DoD (2010) clinical practice guidelines AND probably every other practice guideline, will reach the conclusion that there is inadequate empirical support of EMDR efficacy in combat-related PTSD. This will profoundly impact the future availability of EMDR training and treatment access in military populations. The circularity of the logic to exclude EMDR in VA/DoD is blatant and never challenged by IOM or the Government Accountability Office (2011). The very federal agencies responsible for researching PTSD treatments like EMDR (VA, DoD, NIMH), cite justification for excluding EMDR based on the paucity of research. Already, the VA has justified its exclusion of EMDR research, training and access via its (2008) Handbook of PTSD treatments with impunity (e.g., GAO, 2011).*
>
> *How does all of this affect the future of EMDR? The diagnostic construct of "PTSD" was legitimized by the APA (1980) primarily due to war trauma. The American government is primarily concerned about PTSD from war, than any other trauma type because of the exorbitant costs involved with disability pensions. Therefore, the federal government's investment and conclusions of PTSD treatment research ultimately determines the credibility and proliferation of those treatments. In short, the absence of EMDR research in VA/DoD (and NIMH), will serve to condemn EMDR to permanent secondary or tertiary status within federal agencies and academia. Inevitably, the absence of EMDR research will lead DoD to adopt the VA's Handbook of PTSD treatment, and EMDR trainings will cease.*
>
> *What should concerned others do? Contact congressional representatives and demand EMDR research by VA, DoD, and NIMH, as well as contact national news media and documentary film crews about a national scandal. Those who truly care about the future viability of EMDR must make their voices heard NOW before the American war ends in late 2014. By-stander effect guarantees a bleak future for EMDR and mental healthcare. Speak up"!*

Mark has published 13 research articles in peer-referenced journals, three book chapters on war and stress and co-authored, "Treating Traumatic Stress Injuries in Military Personnel; An EMDR Practitioner's Guide" with Charles Figley. He often writes for the Huffington Post on military issues and the mental health crisis. He is an EMDR Institute Trainer and Consultant for the Department of Defense. He is a frequent presenter at conferences speaking about compassion fatigue, traumatic stress injuries, mental healthcare and the DoD, parenting, using EMDR with children and the assessment and treatment of PTSD. He has been interviewed on TV and for newspapers. He also sits on the Editorial Board of the Journal of EMDR Practice and Research and reviews articles for other trauma-focused journals.

Mark noted that he does have a life outside of EMDR and the Military. He continues his passion for baseball and sports in general. He enjoys music, watching movies, science, astronomy, paleontology, microscoping and anything he does with his wife and kids. He has three children in the Navy and the Marines on active duty.

Mark's dedication to the healing of traumatic stress injuries is deeply rooted in his psyche and will not let him cease until he finds an answer. It is time that we join with him to move his vision forward and accomplish the task of healing our wounded warriors – whomever and wherever they may be. ❖

headstrong PROJECT

To heal the hidden wounds of war

The Headstrong Project is committed to helping veterans recover from the hidden wounds of war in order to lead full and meaningful lives. This is done by providing completely confidential, cost free, and bureaucracy free state of the art treatment.

Headstrong Executive Director and military veteran, Zach Iscol and co-founders David Petrucco and Al Rabil, came together to create something that would fight the stigma associated with mental health and getting treatment. Zach contacted staff members at Cornell University, which he attended, and began talking with them about what they could do to help the veterans in New York City and what they could do to build a scalable program nationwide. Together they raised a small amount of money to put together the program at Cornell Medical Center and to start treating veterans.

This program brings together leading research scientists and clinicians in PTSD to develop a manual, treatment program, curriculum, and certification program to train, develop, implement, and fund a nationwide network of mental healthcare providers who can treat Iraq and Afghanistan veterans especially in rural areas outside the reach of the VA. Concurrently, through partnerships with Iraq and Afghanistan Veteran Service organizations, they are recruiting veterans and active duty and reserve service members in need to receive care free of charge.

Role of EMDR

On May 8th, 2013 The Headstrong Project hosted its first *Words of War* benefit in New York City, which raised money for comprehensive psychological help. Actor Jake Gyllenhaal, a friend of chairman and Executive Director Zach Iscol, read a poem by World War I poet Wilfred Owen and gave a $5,000 donation to go toward training specifically in EMDR. The cause and therapy is likely one close to Jake's heart after starring in Sam Mendes' 2005 war drama 'Jarhead', which is based on the real life experiences of US Marine Anthony Swofford.

Zach Iscol had this to say about the role of EMDR treatment at The Headstrong Project:

"At first our team at Cornell was skeptical of EMDR treatment. After training and implementation that has changed and we have had positive results with the treatment."

How to Get Involved.

Currently, The Headstrong Project is operating out of New York City and treating veterans in the Tri-State area. When the organization expands nationwide, they will be looking for a team of providers to help with treatments. If you are interested in volunteering your services, please contact them at info@getheadstrong.org.

If a veteran you know needs care, please reach out to this group. They will work with leading experts at Cornell Medical Center and develop an individually tailored treatment that designed just for them - for free. When a referral comes to them, through a family member, friend or directly from a veteran themselves, someone will get back to them within a few hours.

For more information, please visit www.getheadstrong.org.

Executive Director Zach Iscol (left) and Jake Gyllenhaal

Recent Articles on EMDR

This regular column appears in each quarterly issue of the EMDRIA Newsletter and the EMDR Europe Newsletter. It lists citations, abstracts, and preprint/reprint information—when available—on all EMDR related journal articles. The listings include peer reviewed research reports and case studies directly related to EMDR—whether favorable or not—including original studies, review articles and meta-analyses accepted for publication or that have appeared in the previous six months in scholarly journals. Authors and others aware of articles accepted for publication are invited to submit pre-press or reprint information. Listings in this column will exclude: published comments and most letters to the editor, non-peer reviewed articles, non-English articles unless the abstract is in English, dissertations, and conference presentations, as well as books, book chapters, tapes, CDs, and videos. Please send submissions and corrections to: aleeds@theLeeds.net.

Balibey, H., & Balikçi, A. (2013). Eye movement desensitization and reprocessing (EMDR) treatment at a patient diagnosed with post-traumatic stress disorder: Case report. Düşünen Adam: *The Journal of Psychiatry and Neurological Sciences*, 26(1), 96-101.

Hakan Balıbey, Ankara Mevki Asker Hastanesi Psikiyatri Klinigi Dıskapı, Ankara – Turkiye. E-mail: hbalibey@gmail.com

ABSTRACT

Post-traumatic stress disorder (PTSD) is a psychiatric disorder that is characterised with autonomic, dysphoric and cognitive signs together with affective numbing, distressed reexperiencing and avoidance from previous traumatic events at a person who has encountered, lived or heard an excessive traumatic event. EMDR is a psychological method which has proven to be effective and it brings together elements of well established approaches such as psychodynamic, cognitive, behavioral and client-centered approaches. In this paper treatment process with Eye Movement Desensitization and Reprocessing (EMDR) of a case who shows signs of post-traumatic stress disorder after a car accident and the need for using this method by clinicians more frequent and widespread at post-traumatic stress disorder patients will be discussed.

Draijer, N., & Van Zon, P. (2013). Transference-Focused psychotherapy with former child soldiers: Meeting the murderous self. *Journal of Trauma & Dissociation*, 14(2), 170–183. doi:10.1080/15299732.2013.724339

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ABSTRACT

This article describes the application of transference-focused psychotherapy (TFP) to the treatment of former child soldiers suffering from dissociative identity disorder. It focuses on the problems with aggression faced in psychotherapy. TFP provides a psychodynamic, object relations model to understand the aggression arising in psychotherapy, focusing on the transference and countertransference in the here and now of the therapeutic relationship. Aggression is considered an essential and vital inner dynamic aimed at autonomy, distancing, and the prevention of injury and dependency. In extremely traumatized patients there may be aggressive and oppressive inner parts that want total control—identifying with childhood aggressors—thus avoiding vulnerability. According to TFP it is vital that this aggression is addressed as belonging to the patients themselves in order to reach some form of integration, balance, and health. This is illustrated in a case description.

Farrell, D., & Keenan, P. (2013). Participants' experiences of EMDR training in the United Kingdom and Ireland. *Journal of EMDR Practice and Research*, 7(1), 2-16. doi:10.1891/1933-3196.7.1.2

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ABSTRACT

This research projects spans a 6-year period surveying 485 participants' experiences of eye movement desensitization and reprocessing (EMDR) training in the United Kingdom and Ireland between the periods of 2005 and 2011. This research used a mixed research methodology exploring EMDR training participants' application of EMDR within their current clinical practice. The rationale was to explore potential differences between EMDR-accredited and EMDR-nonaccredited clinicians in relation to retrospective reports of treatment. Results indicate that EMDR-accredited clinicians report better treatment outcomes. An argument is presented that EMDR has progressed from a convergent technique to a divergent psychotherapeutic approach. Consequently, the research explored whether current EMDR training is "fit for purpose. A comprehensive model for EMDR training is outlined, proposing the importance of developing more EMDR training in academic institutions.

Forgash, C., Leeds, A. M., Stramrood, C. A. I., & Robbins, A. (2013). Case consultation: Traumatized pregnant woman.

Journal of EMDR Practice and Research, 7(1), 45-49. doi:10.1891/1933-3196.7.1.45

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ABSTRACT

Case consultation is a new regular feature in the *Journal of EMDR Practice and Research* in which a therapist requests assistance regarding a challenging case and responses are written by three experts. In this article, Amy Robbins, a certified eye movement desensitization and reprocessing (EMDR) therapist from Atlanta, Georgia, briefly describes a challenging case in which a pregnant woman seeks treatment for trauma suffered in a tornado. The clinician asks if it is advisable to provide EMDR treatment and what concerns she should be aware of. The first expert, Carol Forgash, provides some general information about pregnancy and psychotherapy and outlines considerations, concerns, and contraindications for proceeding with EMDR. She recommends that if treatment is chosen, the therapist proceed with a recent trauma protocol to specifically target the traumatic memories of the recent tornado. The second expert, Andrew Leeds, comments on the absence of randomized controlled trials (RCTs) or other scientific reports exploring the safety of EMDR treatment of pregnant women. He states that pregnant women with symptoms of posttraumatic stress should understand that there is a high probability that EMDR will improve maternal quality of life and that the risks of adverse effects on stability of pregnancy are probably low, but that these remain unknown. The third expert, Claire Stramrood, explains that the few case studies that evaluated EMDR during pregnancy have found positive effects but pertained to women with posttraumatic stress disorder (PTSD) following childbirth. She asserts that once obstetricians have been consulted, women have been informed about possible risks and benefits, and, given their informed consent, they should be able to choose to commence EMDR therapy during pregnancy.

Forman-Hoffman, V. L., Zolotor, A. J., McKeeman, J. L., Blanco, R., Knauer, S. R., Lloyd, S. W., . . . Viswanathan, M. (2013). Comparative effectiveness of interventions for children exposed to nonrelational traumatic events. *Pediatrics*. doi:10.1542/peds.2012-3846

Valerie L. Forman-Hoffman, PhD, MPH, RTI International, Research Triangle Park, North Carolina.

ABSTRACT

OBJECTIVES: To assess the effectiveness of interventions targeting traumatic stress among children exposed to nonrelational traumatic events (eg, accidents, natural disasters, war).

METHODS: We assessed research on psychological and pharmacological therapy as part of an Agency for Healthcare Research and Quality–commissioned comparative effectiveness review. We conducted focused searches of Medline, Cochrane Library, Embase, PsycINFO, Cumulative Index to Nursing and Allied Health Literature, International Pharmaceutical Abstracts, and Web of Science. Two trained reviewers independently selected, extracted data from, and rated the risk of bias of relevant trials and systematic reviews. We used qualitative rather than quantitative analysis methods because of statistical heterogeneity, insufficient numbers of similar studies, and variation in outcome reporting. RESULTS: We found a total of 21 trials and 1 cohort study of medium or low risk of bias from our review of 6647 unduplicated abstracts. We generally did not find studies that attempted to replicate findings of effective interventions. In the short term, no pharmacotherapy intervention demonstrated efficacy, and only a few psychological treatments (each with elements of cognitive behavioral therapy) showed benefit. The body of evidence provides little insight into how interventions to treat children exposed to trauma might influence healthy long-term development. CONCLUSIONS: Our findings serve as a call to action: Psychotherapeutic intervention may be beneficial relative to no treatment in children exposed to traumatic events. Definitive guidance, however, requires far more research on the comparative effectiveness of interventions targeting children exposed to nonrelational traumatic events.

George, A., Thilly, N., Rydberg, J. A., Luz, R., & Spitz, E. (2013). Effectiveness of EMDR treatment in PTSD after childbirth: A randomized controlled trial protocol. *Acta Obstetricia Et Gynecologica Scandinavica*. doi:10.1111/aogs.12132

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ABSTRACT

A traumatic experience of childbirth is an important public health issue (1; 2). Approximately 1-2% of women suffer from post-traumatic stress disorder (PTSD) following childbirth (3). To date, no large research project has attempted to evaluate psychotherapeutic interventions for women suffering from PTSD after childbirth in a randomized controlled trial (4). Qualitative pilot studies and clinical expertise suggest that eye movement desensitization and reprocessing (EMDR) treatment is a highly successful psychotherapy for women suffering from traumatic birth.

James, S., Alemi, Q., & Zepeda, V. (2013). Effectiveness and implementation of evidence-based practices in residential care settings. *Children and Youth Services Review*, 35(4), 642-656. doi:10.1016/j.childyouth.2013.01.007

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ABSTRACT

Purpose: Prompted by calls to implement evidence-based practices (EBPs) into residential care settings (RCS), this review addresses three questions: (1) Which EBPs have been tested with children and youth within the context of RCS? (2) What is the evidence for their effectiveness within such settings? (3) What implementation issues arise when transporting EBPs into RCS?

Methods: Evidence-based psychosocial interventions and respective outcome studies, published from 1990-2012, were identified through a multi-phase search process, involving the review of four major clearinghouse websites and relevant electronic databases. To be included, effectiveness had to have been previously established through a comparison group design regardless of the setting, and interventions tested subsequently with youth in RCS. All outcome studies were evaluated for quality and bias using a structured appraisal tool.

Results: Ten interventions matching a priori criteria were identified: Adolescent Community Reinforcement Approach, Aggression Replacement Training, Dialectical Behavioral Therapy, Ecologically-Based Family Therapy, Eye Movement and Desensitization Therapy, Functional Family Therapy, Multimodal Substance Abuse Prevention, Residential Student Assistance Program, Solution-Focused Brief Therapy, and Trauma Intervention Program for Adjudicated and At-Risk Youth. Interventions were tested in 13 studies, which were conducted in different types of RCS, using a variety of study methods. Outcomes were generally positive, establishing the relative effectiveness of the interventions with youth in RCS across a range of psychosocial outcomes. However, concerns about methodological bias and confounding factors remain. Most studies addressed implementation issues, reporting on treatment adaptations, training and supervision, treatment fidelity and implementation barriers.

Conclusion: The review unearthed a small but important body of knowledge that demonstrates that EBPs can be implemented in RCS with encouraging results.

Jarero, I., Roque-Lopez, S., & Gomez, J. (2013). The provision of an EMDR-based multicomponent trauma treatment with child victims of severe interpersonal trauma. *Journal of EMDR Practice and Research*, 7(1), 17-28. doi:10.1891/1933-3196.7.1.17

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ABSTRACT

This study evaluated a multicomponent phase-based trauma treatment approach for 34 children who were victims of severe interpersonal trauma (e.g., rape, sexual abuse, physical and emotional violence, neglect, abandonment). the children attended a week-long residential psychological recovery camp, which provided resource building experiences, the eye movement desensitization and reprocessing integrative group treatment protocol (EMDR-IGTP), and one-on-one EMDR intervention for the resolution of traumatic memories. the individual EMDR sessions were provided for 26 children who still had some distress about their targeted memory following the EMDR-IGTP. results showed significant improvement for all the participants on the child's reaction to traumatic events scale (CRTES) and the short PTSD rating interview (sprint), with treatment results maintained at follow-up. more research is needed to assess the EMDR-IGTP and the one-on-one EMDR intervention effects as part of a multimodal approach with children who have suffered severe interpersonal trauma.

Imel, Z. E., Laska, K., Jakupcak, M., & Simpson, T. L. (2013). Meta-Analysis of dropout in treatments for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*. doi:10.1037/a0031474

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ABSTRACT

Objective: Many patients drop out of treatments for posttraumatic stress disorder (PTSD); some clinicians believe that trauma-focused treatments increase dropout.

Method: We conducted a meta-analysis of dropout among active treatments in clinical trials for PTSD (42 studies; 17 direct comparisons).

Results: The average dropout rate was 18%, but it varied significantly across studies. Group modality and greater number of sessions, but not trauma focus, predicted increased dropout. When the meta-analysis was restricted to direct comparisons of active treatments, there were no differences in dropout. Differences in trauma focus between treatments in the same study did not predict dropout. However, trauma-focused treatments resulted in higher dropout compared with present-centered therapy (PCT), a treatment originally designed as a control but now listed as a research-supported intervention for PTSD.

Conclusion: Dropout varies between active interventions for PTSD across studies, but variability is primarily driven by differences between studies. There do not appear to be systematic differences across active interventions when they are directly compared in the same study. The degree of clinical attention placed on the traumatic event does not appear to be a primary cause of dropout from active treatments. However, comparisons of PCT may be an exception to this general pattern, perhaps because of a restriction of variability in trauma focus among comparisons of active treatments. More research is needed comparing trauma-focused interventions to trauma-avoidant treatments such as PCT.

James, S., Alemi, Q., & Zepeda, V. (2013). Effectiveness and implementation of evidence-based practices in residential care settings. *Children and Youth Services Review*. doi:10.1016/j.childyouth.2013.01.007

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ABSTRACT

Purpose: Prompted by calls to implement evidence-based practices (EBPs) into residential care settings (RCS), this review addresses three questions: (1) Which EBPs have been tested with children and youth within the context of RCS? (2) What is the evidence for their effectiveness within such settings? (3) What implementation issues arise when transporting EBPs into RCS?

Methods: Evidence-based psychosocial interventions and respective outcome studies, published from 1990–2012, were identified through a multi-phase search process, involving the review of four major clearinghouse websites and relevant electronic databases. To be included, effectiveness had to have been previously established through a comparison group design regardless of the setting, and interventions tested subsequently with youth in RCS. All outcome studies were evaluated for quality and bias using a structured appraisal tool.

Results: Ten interventions matching a priori criteria were identified: Adolescent Community Reinforcement Approach, Aggression Replacement Training, Dialectical Behavioral Therapy, Ecologically-Based Family Therapy, Eye Movement and Desensitization Therapy, Functional Family Therapy, Multimodal Substance Abuse Prevention, Residential Student Assistance Program, Solution-Focused Brief Therapy, and Trauma Intervention Program for Adjudicated and At-Risk Youth. Interventions were tested in 13 studies, which were conducted in different types of RCS, using a variety of study methods. Outcomes were generally positive, establishing the relative effectiveness of the interventions with youth in RCS across a range of psychosocial outcomes. However, concerns about methodological bias and confounding factors remain. Most studies addressed implementation issues, reporting on treatment adaptations, training and supervision, treatment fidelity and implementation barriers.

Conclusion: The review unearthed a small but important body of knowledge that demonstrates that EBPs can be implemented in RCS with encouraging results.

Joseph, S., & Murphy, D. (2013). Trauma: A unifying concept for social work. *British Journal of Social Work*. doi:10.1093/bjsw/bcs207

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ABSTRACT

The aim is to show how traumatic stress provides a unifying concept for social work. In the last ten years, there have been significant changes in the nature of organisations that provide social care for people in the UK, with social work practice no longer confined to traditional local authority services. Increasingly, social workers are taking up posts in a variety of settings and sectors demanding new knowledge and skills. The field of traumatic stress is not currently viewed as a social work discipline. However, trauma cuts across a range of contexts and client groups and, as such, needs to be a core component of education and training in social work. The concept of trauma and recent developments in post-traumatic growth offer a new way of thinking that necessitates the development of genuinely psycho-social and relationship-based help and support for individuals, families, groups, communities and organisations affected by adversity.

Laker, M. (2013). Specific phobia: Flight. *ANS: The Journal for Neurocognitive Research*, 54(3-4).

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ABSTRACT

The practice of air travel holds a unique place in modern human life. With the continually shrinking and interconnected world, full global mobility becomes increasingly important for a fully functional life for continually increasing numbers of people. However, while prevalence estimates vary it is undeniable that the fear of flying affects a very large number of people with consequences that are

personal, professional, and aggregate economical. Although effective treatments do exist, the disorder's high prevalence in both clinical and sub-clinical forms, "diagnostic trickiness", and requirement for time-consuming treatments make the disorder Aviophobia a continuing challenge.

Landin-Romero, R., Novo, P., Vicens, V., McKenna, P. J., Santed, A., Pomarol-Clotet, E., . . . Amann, B. L. (2013). EMDR therapy modulates the default mode network in a subsyndromal, traumatized bipolar patient. *Neuropsychobiology*, 67(3), 181-4. doi:10.1159/000346654

FIDMAG Research Foundation Germanes Hospitalàries, Barcelona, Spain.

ABSTRACT

Background: Some functional imaging abnormalities found in bipolar disorder are state related, whereas others persist into euthymia. It is uncertain to what extent these latter changes may reflect continuing subsyndromal affective fluctuations and whether those can be modulated by therapeutic interventions.

Method: We report functional magnetic resonance imaging (fMRI) findings during performance of the n-back working memory task in a bipolar patient who showed a marked improvement in subsyndromal affective symptoms after receiving eye movement desensitization and reprocessing (EMDR) therapy in the context of a clinical trial.

Results: The patient's clinical improvement was accompanied by marked changes in functional imaging, as compared to 30 healthy subjects. fMRI changes were noted particularly in deactivation, with failure of deactivation in the medial frontal cortex partially normalizing after treatment.

Conclusions: This case supports the potential therapeutic overall benefit of EMDR in traumatized bipolar patients and suggests a possible neurobiological mechanism of action: normalization of default mode network dysfunction.

Mabey, L., & van Servellen, G. (2013). Treatment of posttraumatic stress disorder in patients with severe mental illness: A review. *International Journal of Mental Health Nursing*. doi:10.1111/inm.12007

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ABSTRACT

Although the prevalence of post-traumatic stress disorder (PTSD) is high among those with severe mental illness, little is known about the use of interventions to lessen the burden of PTSD in this population. Currently, there are limited data about safe and effective interventions to treat these individuals. This systematic published work review presents the scientific published work reporting studies of psychological treatment approaches for individuals with comorbid PTSD and severe mental illness. A secondary aim of this study was to identify the specific models implemented and tested, and their impact upon patient outcomes. A review of the published work from January 2001 through January 2012 of English-language publications retrieved from the Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE, and the American Psychological Association generated abstracts (PsycINFO) databases was conducted. Six studies met the inclusion criteria for the review. The treatment programs described were cognitive-behavioural therapy, psychoeducation, exposure-based cognitive-behavioural therapy, and eye movement desensitization and reprocessing. Evidence of the effectiveness of these programs is examined. Data to support the use of these interventions are limited, indicating the need for further research and efficacy trials. Future areas of research and implications for nursing are discussed.

Norgate, K. (2012). EMDR for post-traumatic stress and other psychological trauma. *Nursing Times*, 108(44), 24-6.

Child and Adolescent Mental Health Service, Central Manchester University Hospitals Foundation Trust.

ABSTRACT

The practice of air travel holds a unique place in modern human life. With the continually shrinking and interconnected world, full global mobility becomes increasingly important for a fully functional life for continually increasing numbers of people. However, while prevalence estimates vary it is undeniable that the fear of flying affects a very large number of people with consequences that are personal, professional, and aggregate economical. Although effective treatments do exist, the disorder's high prevalence in both clinical and sub-clinical forms, "diagnostic trickiness", and requirement for time-consuming treatments make the disorder Aviophobia a continuing challenge.

Pagani, M., Hogberg, G., Fernandez, I., & Siracusano, A. (2013). Correlates of EMDR therapy in functional and structural neuroimaging: A critical summary of recent findings. *Journal of EMDR Practice and Research*, 7(1), 29-38. doi:10.1891/1933-3196.7.1.29

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ABSTRACT

Neuroimaging investigations of the effects of psychotherapies treating posttraumatic stress disorder (PTSD), including eye movement desensitization and reprocessing (EMDR), have reported findings consistent with modifications in cerebral blood flow (CBF; single photon emission computed tomography [SPECT]), in neuronal volume and density (magnetic resonance imaging

[MRI]), and more recently in brain electric signal (electroencephalography [EEG]). Additionally in the recent past, EMDR-related neurobiological changes were monitored by EEG during therapy itself and showed a shift of the maximal activation from emotional limbic to cortical cognitive brain regions. This was the first time in which neurobiological changes occurring during any psychotherapy session have been reported, making EMDR the first psychotherapy with a proven neurobiological effect. The purpose of this article was to review the results of functional and structural changes taking place at PTSD treatment and presented during the period of 1999-2012 by various research groups. The reported pathophysiological changes are presented by neuropsychological technique and implemented methodology and critically analyzed.

Park, S. C., Park, Y. C., Lee, M. S., & Chang, H. S. (2012). Plasma brain-derived neurotrophic factor level may contribute to the therapeutic response to eye movement desensitisation and reprocessing in complex post-traumatic stress disorder: A pilot study. *Acta Neuropsychiatrica,* 24(6), 384-386. doi:10.1111/j.1601-5215.2011.00623.x

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ABSTRACT

This study assessed the potential of levels of brain-derived neurotrophic factor (BDNF) and nerve growth factor (NGF) as biological predictors of eye movement desensitization and reprocessing (EMDR) responses in complex post-traumatic stress disorder (PTSD). Before and after eight-session EMDR, plasma levels of BDNF and NGF were obtained for eight men with complex PTSD. The results suggest that plasma BDNF levels, which are implicated in vulnerability to depression, may contribute to the therapeutic response to EMDR. The authors concluded that BDNF level might contribute to the therapeutic responsiveness to EMDR in complex PTSD.

Rauch, S. A. M., Eftekhari, A., & Ruzek, J. I. (2012). Review of exposure therapy: A gold standard for PTSD treatment. *Journal of Rehabilitation Research and Development*, 49(5), 679-688. doi:10.1682/JRRD.2011.08.0152

Full text available at: http://www.rehab.research.va.gov/jour/2012/495/pdf/rauch495.pdf

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ABSTRACT

Prolonged exposure (PE) is an effective first-line treatment for posttraumatic stress disorder (PTSD), regardless of the type of trauma, for Veterans and military personnel. Extensive research and clinical practice guidelines from various organizations support this conclusion. PE is effective in reducing PTSD symptoms and has also demonstrated efficacy in reducing comorbid issues such as anger, guilt, negative health perceptions, and depression. PE has demonstrated efficacy in diagnostically complex populations and survivors of single- and multiple-incident traumas. The PE protocol includes four main therapeutic components (i.e., psychoeducation, in vivo exposure, imaginal exposure, and emotional processing). In light of PE's efficacy, the Veterans Health Administration designed and supported a PE training program for mental health professionals that has trained over 1,300 providers. Research examining the mechanisms involved in PE and working to improve its acceptability, efficacy, and efficiency is underway with promising results.

Regehr, C., Alaggia, R., Dennis, J., Pitts, A., & Saini, M. (2013). Interventions to reduce distress in adult victims of rape and sexual violence: A systematic review. *Research on Social Work Practice*. doi:10.1177/1049731512474103

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ABSTRACT

Objectives: This article presents a systematic evaluation of the effectiveness of interventions aimed at reducing distress in adult victims of rape and sexual violence.

Method: Studies were eligible for the review if the assignment of study participants to experimental or control groups was by random allocation or parallel cohort design.

Results: Six studies including 405 participants met eligibility criteria. Meta-analyses revealed that specific cognitive and behavioral interventions (cognitive-processing therapy, prolonged exposure therapy, and eye movement desensitization reprocessing) had a statistically significant effect on posttraumatic stress disorder and depression symptoms in comparison to the control groups. Other outcomes that had demonstrated improvement included anxiety, guilt, and dissociation.

Conclusion: Many studies assessing the effectiveness of interventions for decreasing trauma symptoms combine victims of sexual violence in adulthood with other trauma-based samples despite the profound differences in these experiences. This review again points to the need for increased research that focuses specifically on the effectiveness of treatment models for adult victims of sexual violence.

Regourd-Laizeau, M., Martin-Krumm, C., & Tarquinio, C. (2012). Interventions dans le domaine du sport: Le protocole d'optimisme. [Interventions in the field of sport: Protocol of optimism.]. *Pratiques Psychologiques*. doi:10.1016/j.prps.2012.02.001

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ABSTRACT

Optimism can be envisaged according to various approaches. It is possible to envisage it according to a direct point of view as, for example, the proposition of Carver and Scheier (1982) and the concept of dispositional optimism. It is also possible to envisage an indirect point of view as Abramson et al. (1978) and the concept of optimistic explanatory style. Whatever is the reserved option, the optimism is mainly associated with beneficial effects, and what whatever the contexts are: health, workplace, school, or sports performance. Consequently, techniques intended to increase the level of optimism became crucial in various domains and have been finalized. The main contribution of this article is to present some of these techniques and to develop more precisely the contribution of the eye movement desensitization and reprocessing (EMDR) in the development of an optimistic explanatory style in the field of sports. Limits but also promising perspectives are discussed.

Rooijmans, J., Rosenkamp, N. H. G., Verholt, P., & Visscher, R. A. (2012). The effect of eye movements on craving, pleasantness and vividness in smokers. *Social Cosmos*, 3(2), 200-214.

Full text available at: http://socialcosmos.library.uu.nl/index.php/sc/article/view/62

ABSTRACT

The presence of craving is an important factor in continuing smoking. Following the Elaborated Intrusion (EI) theory of Desire, craving is effective through the formation of smoking-related mental images. In the current study, craving was generated through theuse of a future personal smoking-related image. Eye movements were observed in accordance with the Eye Movement Desensitization Reprocessing (EMDR) intervention. The effect of these eye movements on craving was investigated. In addition, the effect of eye movements on the pleasantness and vividness of the image was examined. 36 participants took part in a within- subjects design with repeated measures. In line with expectations, perceived craving decreased immediately after the experimental condition (eye movements) was experienced. This decrease was not found in the control condition (fixation on a plain wall). After recall of the smoking-related image, the extra measurement showed that the decrease was temporary. Contrary to expectations, the degree of pleasantness and vividness did not decrease after eye movements. In conclusion, the eye movements were found to have only a temporary effect on craving for cigarettes, and did not result in desensitization of the pleasantness and vividness of the personal smoking-related images.

Schoenfeld, F. B., DeViva, J. C., & Manber, R. (2012). Treatment of sleep disturbances in posttraumatic stress disorder: A review. *J Rehabil Res Dev*, 49(5), 729-52. doi:10.1682/JRRD.2011.09.0164

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ABSTRACT

Sleep disturbances are among the most commonly reported posttraumatic stress disorder (PTSD) symptoms. It is essential to conduct a careful assessment of the presenting sleep disturbance to select the optimal available treatment. Cognitive- behavioral therapies (CBTs) are at least as effective as pharmacologic treatment in the short-term and more enduring in their beneficial effects. Cognitive-behavioral treatment for insomnia and imagery rehearsal therapy have been developed to specifically treat insomnia and nightmares and offer promise for more effective relief of these very distressing symptoms. Pharmacotherapy continues to be an important treatment choice for PTSD sleep disturbances as an adjunct to CBT, when CBT is ineffective or not available, or when the patient declines CBT. Great need exists for more investigation into the effectiveness of specific pharmacologic agents for PTSD sleep disturbances and the dissemination of the findings to prescribers. The studies of prazosin and the findings of its effectiveness for PTSD sleep disturbance are examples of studies of pharmacologic agents needed in this area. Despite the progress made in developing more specific treatments for sleep disturbances in PTSD, insomnia and nightmares may not fully resolve.

Shapiro, R., Hofmann, A., & Grey, E. (2013). Case consultation: Unremitting depression. *Journal of EMDR Practice and Research*, 7(1), 39-44. doi:10.1891/1933-3196.7.1.39

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ABSTRACT

Case Consultation is a new regular feature in the *Journal of EMDR Practice and Research.* In this article, an eye movement desensitization and reprocessing (EMDR) clinician briefly describes a challenging case in which a man, "George," was referred for EMDR for treatment of a depression that began more than 2 years previously. After all his reported traumatic memories were completely processed with EMDR, George remains severely depressed and the therapist asks how to proceed effectively with treatment. Responses are written by three experts. The first expert, Robin Shapiro, describes a comprehensive list of possible etiologies, including attachment, early trauma, genetic, and other biological causes and their appropriate EMDR, ego state, or medical treatments. The second expert, Arne Hofmann, reviews the treatment that was provided and makes suggestions for alternate treatment targets, suggesting that the therapist could address the client's belief that "nothing will change" and try the EMDR inverted protocol. The third expert, Earl Grey, recommends that the clinician focus on addressing small "t" traumas, even if the client indicates that he or she has little to no disturbance and explains how to develop and implement a "restorative life span target sequence."

Shapiro, F. (2013). The case: Treating Jared through Eye Movement Desensitization and Reprocessing therapy. *Journal of Clinical Psychology*. doi:10.1002/jclp.21986

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ABSTRACT

No abstract was available for this article.

Smith, P., Perrin, S., Dalgleish, T., Meiser-Stedman, R., Clark, D. M., & Yule, W. (2013). Treatment of posttraumatic stress disorder in children and adolescents. *Current Opinion in Psychiatry*, 26(1), 66-72. doi:10.1097/YCO.0b013e32835b2c01

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ABSTRACT

Purpose of review: We review recent evidence regarding risk factors for childhood posttraumatic stress disorder (PTSD) and treatment outcome studies from 2010 to 2012 including dissemination studies, early intervention studies and studies involving preschool children.

Recent findings: Recent large-scale epidemiological surveys confirm that PTSD occurs in a minority of children and young people exposed to trauma. Detailed follow-up studies of trauma-exposed young people have investigated factors that distinguish those who develop a chronic PTSD from those who do not, with recent studies highlighting the importance of cognitive (thoughts, beliefs and memories) and social factors. Such findings are informative in developing treatments for young people with PTSD. Recent randomized controlled trials (RCTs) confirm that trauma-focused cognitive behaviour therapy (TF-CBT) is a highly efficacious treatment for PTSD, although questions remain about effective treatment components. A small number of dissemination studies indicate that TF-CBT can be effective when delivered in school and community settings. One recent RCT shows that TF-CBT is feasible and highly beneficial for very young preschool children. Studies of early intervention show mixed findings.

Summary: Various forms of theory-based TF-CBT are highly effective in the treatment of children and adolescents with PTSD. Further work is needed to replicate and extend initial promising outcomes of TF-CBT for very young children. Dissemination studies and early intervention studies show mixed findings and further work is needed.

Spence, J., Titov, N., Johnston, L., Dear, B. F., Wootton, B., Terides, M., & Zou, J. (2013). Internet-delivered eye movement desensitization and reprocessing (iEMDR): An open trial. *F1000Research*, 2.

Full text available at: http://f1000research.com/articles/2-79

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ABSTRACT

Recent research indicates internet-delivered cognitive behavioural therapy (iCBT) can reduce symptoms of post traumatic stress disorder (PTSD). This study examined the efficacy of an internet-delivered treatment protocol that combined iCBT and internet-delivered eye movement desensitization and reprocessing (iEMDR), in an uncontrolled trial. Eleven of the 15 participants completed post-treatment questionnaires. Large effect sizes were found from pre-treatment to 3-month follow-up (d = 1.03 – 1.61) on clinician-assessed and self-reported measures of PTSD, anxiety and distress, with moderate effect sizes (d = 0.59 – 0.70) found on measures of depression and disability. At post-treatment, 55% of the participants no longer met criteria for PTSD and this was sustained at follow-up. Symptom worsening occurred in 3 of 15 (20%) of the sample from pre- to post-treatment; however, these participants reported overall symptom improvement by follow-up. Future research directions for iEMDR are discussed.

Zarghi, A., Zali, A., & Tehranidost, M. (2013). Eye movement desensitization and reprocessing (EMDR) as a neurorehabilitation method. *Basic and Clinical Neuroscience*, 4(1), 19-20.

ABSTRACT

A variety of nervous system components such as medulla, pons, midbrain, cerebellum, basal ganglia, parietal, frontal and occipital lobes have role in Eye Movement Desensitization and Reprocessing (EMDR) processes. The eye movement is done simultaneously for attracting client's attention to an external stimulus while concentrating on a certain internal subject. Eye movement guided by therapist is the most common attention stimulus. The role of eye movement has been documented previously in relation with cognitive processing mechanisms. A series of systemic experiments have shown that the eyes' spontaneous movement is associated with emotional and cognitive changes and results in decreased excitement, flexibility in attention, memory processing, and enhanced semantic recalling. Eye movement also decreases the memory's image clarity and the accompanying excitement. By using EMDR, we can reach some parts of memory which were inaccessible before and also emotionally intolerable. Various researches emphasize on the effectiveness of EMDR in treating and curing phobias, pains, and dependent personality disorders. Consequently, due to the involvement of multiple neural system components, this palliative method of treatment can also help to rehabilitate the neuro-cognitive system.

Thomaes, K., Dorrepaal, E., Draijer, N., de Ruiter, M. B., Elzinga, B. M., van Balkom, A. J., . . . Veltman, D. J. (2012). Treatment effects on insular and anterior cingulate cortex activation during classic and emotional stroop interference in child abuse-related complex post-traumatic stress disorder. *Psychological Medicine*, 1-13. doi:10.1017/S0033291712000499

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ABSTRACT

Background: Functional neuroimaging studies have shown increased Stroop interference coupled with altered anterior cingulate cortex (ACC) and insula activation in post-traumatic stress disorder (PTSD). These brain areas are associated with error detection and emotional arousal. There is some evidence that treatment can normalize these activation patterns.

Method: At baseline, we compared classic and emotional Stroop performance and blood oxygenation level-dependent responses (functional magnetic resonance imaging) of 29 child abuse-related complex PTSD patients with 22 non-trauma-exposed healthy controls. In 16 of these patients, we studied treatment effects of psycho-educational and cognitive behavioural stabilizing group treatment (experimental treatment; EXP) added to treatment as usual (TAU) versus TAU only, and correlations with clinical improvement.

Results: At baseline, complex PTSD patients showed a trend for increased left anterior insula and dorsal ACC activation in the classic Stroop task. Only EXP patients showed decreased dorsal ACC and left anterior insula activation after treatment. In the emotional Stroop contrasts, clinical improvement was associated with decreased dorsal ACC activation and decreased left anterior insula activation.

Conclusions: We found further evidence that successful treatment in child abuse-related complex PTSD is associated with functional changes in the ACC and insula, which may be due to improved selective attention and lower emotional arousal, indicating greater cognitive control over PTSD symptoms

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Tynes, L. L., & Spiegel, J. C. (2013). Considerations in comorbid irritable bowel syndrome and fibromyalgia: A case report and review. *University of Toronto Medical Journal*, 90(2), 40-42.

Full text available from: http://utmj.org/ojs/index.php/UTMJ/article/view/1483/1289

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ABSTRACT

Medically unexplained physical symptoms (MUPS) are those without relevant organic pathology and are commonplace in primary care and specialty medical care settings. MUPS disorders include fibromyalgia (FM), irritable bowel syndrome (IBS), multiple chemical sensitivity, chronic fatigue syndrome, and others. The etiologies of FM and IBS are poorly understood and are likely multifactorial and complex. Common factors include symptom hypersensitivity or amplification, hypothalamic-pituitary-adrenal axis perturbation, and genetic vulnerability. A sexual abuse history may play a role as well. Significant comorbidity exists between IBS and FM. Patients with both disorders have more physical and psychiatric symptoms than those with only one disorder. FM and IBS can generally be diagnosed with a careful history and physical exam combined with judicious use of laboratory studies. Treatment is symptomatic and includes addressing psychiatric issues with medications, nonmedication therapies, and supportive, caring attitudes.

Udo, I., & Gash, A. (2012). Challenges in management of complex panic disorder in a palliative care setting. *BMJ Case Reports*, 2012. doi:10.1136/bcr-2012-006800

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ABSTRACT

This is a complex case of post-traumatic stress disorder (PTSD) with comorbid panic disorder occurring in a woman in her mid-60s, with a family history of neurotic illness. PTSD arose in the context

of treatment for terminal lung cancer. This patient who had been close to her father watched him die of cancer, when he was about her age. Her diagnosis and treatment prompted traumatic recollections of her father's illness and death that resulted in her voluntary withdrawal from cancer treatment. The goals of treatment were to promptly reduce anxiety, minimise use of sedating pharmacotherapy, promote lucidity and prolong anxiety-free state thereby allowing time for important family interactions. Prompt, sustained relief of severe anxiety was necessary to achieve comfort at the end of life. Skilled additions of psychological therapies (eye movement desensitisation reprocessing, clinical hypnosis and breathing exercises) with combined pharmacotherapy (mirtazepine and quetiapine) led to control of anxiety and reduction of post-traumatic stress.

Wright, S. A., & Russell, M. C. (2012). Treating violent impulses: A case study utilizing eye movement desensitization and reprocessing with a military client. *Clinical Case Studies*. doi:10.1177/1534650112469461

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ABSTRACT

The growing attention to acts of interpersonal violence and misconduct among military members has accompanied a host of research investigating the nature and causes associated with these behaviors. As such, a robust body of literature exists lending insight into risk factors and clinical presentations associated with anger and aggression; however, such factors are multidimensional and complex, particularly for those suffering with war stress injuries. Furthermore, mental health stigma and treatment compliance with exposure and cognitive-based models, particularly in clients with aggressive presentations, can impact successful outcomes. One active-duty marine was referred to an outpatient mental health clinic for the treatment of posttraumatic stress disorder (PTSD). Four sessions of eye movement desensitization and reprocessing (EMDR) were used to significantly reduce obsessive violent impulses, traumatic grief, and depression. The benefit of EMDR therapy as a treatment for violent impulses is explored. The results are promising, but more research is needed.

Zantvoord, J. B., Diehle, J., & Lindauer, R. J. (2013). Using neurobiological measures to predict and assess treatment outcome of psychotherapy in posttraumatic stress disorder: Systematic review. *Psychotherapy and Psychosomatics*, 82(3), 142-151. doi:10.1159/000343258

Department of Child and Adolescent Psychiatry, Academic Medical Centre, University of Amsterdam and the Bascule Academic Centre for Child and Adolescent Psychiatry, Amsterdam, The Netherlands.

ABSTRACT

Background: Trauma-focused cognitive-behavioral therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR) are effective treatments for posttraumatic stress disorder. However, little is known about their neurobiological effects. The usefulness of neurobiological measures to predict the treatment outcome of psychotherapy also has yet to be determined. Methods: Systematic review of randomized controlled trials (RCTs) focused on neurobiological treatment effects of TF-CBT or EMDR and trials with neurobiological measures as predictors of treatment response. Results: We included 23 publications reporting on 16 separate trials. TF-CBT was compared with a waitlist in most trials. TF-CBT was associated with a decrease in heart rate and blood pressure and changes in activity but not in volume of frontal brain structures and the amygdala. Neurobiological changes correlated with changes in symptom severity. EMDR was only tested against other active treatments in included trials. We did not find a difference in neurobiological treatment effects between EMDR and other treatments. Publications on neurobiological predictors of treatment response showed ambiguous results. Conclusion: TF-CBT was associated with a reduction of physiological reactivity. There is some preliminary evidence that TF-CBT influences brain regions involved in fear conditioning, extinction learning and possibly working memory and attention regulation; however, these effects could be nonspecific psychotherapeutic effects. Future trials should use paradigms aimed specifically at these brain regions and physiological reactivity. There are concerns regarding the risk of bias in some of the RCTs, indicating that methodologically more rigorous trials are required. Trials with neurobiological measures as predictors of treatment outcome render insufficient results to be useful in clinical practice.

Taghva, A., Oluigbo, C., Corrigan, J., & Rezai, R. (2013). Posttraumatic stress disorder: Neurocircuitry and implications for potential deep brain stimulation. Stereotactic and Functional Neurosurgery, 91(4), 207-219. doi:10.1159/000343148

Full text or PDF available at: http://www.karger.com/Article/Fulltext/343148#SA4

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ABSTRACT

Posttraumatic stress disorder (PTSD) is a prevalent and highly disabling psychiatric disorder that is notoriously difficult to treat. At some point in their lifetimes, 5-8% of men, 10-14% of women, and up to a quarter of combat veterans carry this diagnosis. Despite pharmacological and behavioral therapies, up to 30% of patients are still symptomatic 10 years after initial diagnosis. Recent advances in imaging have implicated changes in the limbic and autonomic corticostriatopallidothalamocortical (CSPTC) circuitry in the pathogenesis of this disease. Deep brain stimulation modulates CSPTC circuits in movement and other neuropsychiatric disorders. In this review, we discuss the salient clinical features and neurocircuitry of PTSD and propose a neuromodulation strategy for the disorder. ❖

ARGENTINA

Maria Elena Aduriz reports: "EMDR Iberoamerica Argentina is developing EMDR trainings in different cities of the country. They are getting more successful with each passing year. In August, there will be an International Conference about "Trauma and EMDR" in Salta City. The Journal of EMDR Practice and Research is publishing an article by Silvia Gauvry, the President of EMDR Iberoamerica Argentina."

Silvia Gauvry reports: "Since last December EMDR Iberoamérica Argentina has a new Board of Directors and as its President, I want to share with you our projects for 2013. As our purpose is to respect the guidelines of EMDR Iberoamérica and EMDRIA, we have scheduled continuing education that will be taught in the classroom and online to reach more clinicians in our country and abroad. These courses are on the following: Self-Care of the Therapist, Psychotraumatology, Trauma in Children and EMDR (María Elena Adúriz), and EMDR in Special Populations (Uri Bergmann). As a credit provider, our group accredits EMDR practitioners and Supervisors/Consultants. We also sponsor EMDR Basic Trainings performed by Maria Elena. This year one of them will be a University Postgraduate EMDR Basic Training at the University Institute of the Italian Hospital of Buenos Aires. It will be the first time that EMDR will be taught in this way in Argentina to promote University EMDR academic training program. EMDR Iberoamérica Argentina co-organizes an International Congress on Psychological Trauma and sponsors the World Congress of Mental Health 2013 in Buenos Aires. We offer economic assistance to our affiliates to spread the EMDR model in scientific events. Please visit our website www.emdribargentina.com."

ASIA

Sushma Mehrotra reports: "The Board Members of EMDR Asia met in March 2013 at Luzon, Clark, the Philippines. Board members came from China, Japan, Indonesia, India, Australia, Cambodia, Thailand, Singapore and the Philippines to attend the meeting. We had discussions on EMDR Standards for Training for Asian countries, the Memorandum of Understanding (MoU) for the establishment of EMDR Asia, and the preparations for the next EMDR Asia Conference in Manila from January 9-11, 2014."

AUSTRALIA

Pamela Brown reports: "EMDR Australia has implemented an accreditation program for our members consistent with international standards. We selected 20 members of longstanding to undertake group training with Sandi Richman from the United Kingdom in August of 2012. Sandi was in the region completing EMDR training for 60 New Zealand clinicians as a UK HAP response to the New Zealand earthquakes in Christchurch. Our EMDR Special Interest Group has coordinated many webinar trainings with Jim Knipe, Phil Manfield and others. We had a two-day training with Carol Forgash in 2012 and are looking forward to a training in this month with Robbie Adler-Tapia. Roger Solomon will again be presenting a number of workshops this year."

BELGIUM

Ludwig Cornil reports: "A few weeks ago the Dutch translation of Francine Shapiro's book was published. The Belgian EMDR Association decided to take on the responsibility for translating the book to make it accessible for therapists and patients in the Dutch-speaking countries. After translating Francine's 1995 book myself in 2005, this time it was my 22 year old son, Jonathan, who spent the whole summer of 2012 with headphones on, dictating the translation to his computer. I again wrote the Foreword.

I presented at the Dutch National EMDR Conference in Nijmegen in April to support the 10th anniversary of the Dutch EMDR Association. I presented on "The Power of Now in EMDR" and it was well received. The Dutch Association published a book about their 10-year history, in which a picture appears of me and Richard Mitchell, being acknowledged to have been very important to the development of EMDR in Europe!"

BRAZIL

Esly Carvalho reports: "It is exciting to share my book, Healing the Folks Who Live Inside: How EMDR Can Heal our Inner Gallery of Roles, now that it has come out in English (Amazon). It

is a bestseller in Portuguese and Spanish and it is a first for an EMDR Latin American author. I was trained originally in Psychodrama and Group Therapy and show how EMDR can be applied as role therapy: healing the inner roles, the "folks" all of us have inside. There are many examples from my practice that illustrate how to map out the inner roles and use EMDR to heal and integrate them into the Adult self. I have presented workshops in Ecuador and Brazil on how to develop these clinical strategies.

Preparations are in full swing for the 3rd Ibero-American EMDR Conference to be held in San José, Costa Rica, October 31 – November 2, 2013. Presenters include Francine Shapiro, Robert Stickgold, Debbie Korn, Ana Gomez, John Hartung, Santiago Jácome and myself. More information can be found at www.congresoemdr2013.com. The official languages are Spanish and Portuguese." Mark Nickerson will be presenting in Brasilia, Brazil in September on dealing with hostile behaviors."

CHILE

Santiago Jacome reports: "Mutual security in Chile ("mutuales de seguridad") are private non-profit institutions responsible for the actions of risk prevention and treatment services of occupational accidents and occupational diseases. There are only three in the country. Mutual de Seguridad has one of the most important hospitals specializing in trauma. In 1966, the Chilean Chamber for Construction created it to take care of workers after accidents and their families, in order to avoid the consequent social and economic costs. In this way, the institution started several prevention and intervention programs. Eight years ago, the "Immediate Response Critical Incident Team" (ERIC in Spanish) was created by Mutual de Seguridad in response to critical incidents and occupational accidents (assaults suffered by bank employees, metro incidents, road accidents, etc.). The technical skills required for professional psychologists and psychiatrists who are members of the ERIC team include EMDR Basic Training, Crisis Intervention Training, knowledge of ICD - 10 and Relaxation Techniques Management. For these reasons, this institution has the largest professional staff trained in EMDR in Chile from Arica in the north, to Punta Arenas in the south. EMDR IBEROAMERICA (EMDRIBA) supported trainers led by myself and EMDRIBA staff from Uruguay (Miriam Calero) and Argentina (Susana Balsamo). Currently, the Mutual de Seguridad includes certification in EMDR for all its mental health professionals. A certification process has begun and it will benefit Chilean workers giving them a better quality of trauma care and management."

LEBANON

Lina Ibrahim reports: "I'm delighted to announce the birth of the EMDR Lebanon Association (April 2, 2013). There are 8 founding members: Lina Ibrahim (President), Jean Daoud (Vice President), Maral Boyadjian (Secretary), Noel Roukoz (Treasurer), Carla Sarkis (Accountant), Therese Bou Jaoude (Board member), Chantal Mansour (Board member) and Sabah Saliba (Board member). Our association would not have come into being without the encouragement and help of EMDR people around the world. We want to give our special thanks to all those who have trained us and were our consultants: Peggy Moore, Pauline Guillerd, Anne Dewailly, Emre Konuk, Martine Iracane Blanco, Mona Zaghrout, and Sandra Kaplan. They are a big resource and source of support and will continue to be so. Our association's constitution follows the main guidelines that are set internationally by EMDRIA and EMDR Europe. Thanks to the EMDRIA staff - Mark Doherty who sent us the guidelines for international associations and Sarah Tolino and Lynn Simpson for their prompt responses and constant help. Thanks to EMDR Europe and its board members for encouraging us to create the association and to consider joining them. And, mostly, a million thanks to Emre Konuk for translating the constitution of the EMDR Turkey Association into English, and for working with us step-by-step on the details of our constitution. One of our association's purposes is to establish a network of communication and cooperation with different EMDR associations and organizations around the world. With everybody's help and willingness, it is easy do that."

SINGAPORE

Gary Quinn reports: "We just completed the EMDR Basic Training in Singapore, April 8-13, 2013. Thirty-two participants attended Part 1 and 20 attended Part 2. Atara Sivan (Hong Kong) and Sushma Mehrotra (India), both trainers-in-training, served as facilitators and contributed enormously to the success of the training."

UNITED STATES

Arizona

Beverlee Laidlaw Chasse reports: "Julie Miller and I presented at the EMDR Canada Conference in May on, "Preventing PTSD with Early EMDR Intervention." As Elan Shapiro and Brurit Laub, Recent Trauma Episode Protocol (R-TEP) originators say, 'A stitch in time saves nine!' Three years ago, the Arizona Trauma Response and Recovery Network (AETR2N), was started with a handful of people and has built up its membership to about 90 members. In the aftermath of a shooting at a busy office building in Phoenix where two people were murdered and one injured, several members provided 6-12 hours of pro bono, Early EMDR Intervention to secondary victims of this critical incident. The network volunteers had the option of using early intervention protocols such as Recent Event Protocol, R-TEP, and/or EMDR-PRECI that they had reviewed or learned in trainings provided to them over the last year. They were ready to provide recent incident treatment immediately to those suffering with Acute Stress Symptoms, i.e., children were having difficulty returning to their pre-shooting functioning, with fantastic results. We continue to work diligently to get the word out to the disaster response and recovery

community that EMDR can be utilized effectively in the continuum of care immediately following a critical incident or disaster.

AETR2N has been accepted as a Medical Reserve Corps (MRC) Unit for Maricopa County and we are listed in their national registry. MRC is organized under the Surgeon General's office and the Office of the Assistant Secretary of Health. It is a national network of local volunteer groups committed to improving the public health, emergency response and the resiliency of their communities. Also, we were awarded a $4,000 non-competitive grant from the National Association of County and City Health Officials (NACCHO) to provide our volunteers with training in Disaster Response and Recovery and Early EMDR Intervention. We would like to give a big thank-you to EMDR HAP for their assistance in procuring this grant and helping us to provide training for our volunteers."

California

Merrill Powers reports: "Our most recent news is that on April 12, Dana Terrell of San Diego was a guest presenter at our monthly EMDRIA Regional Networking Group for Greater Sacramento. She provided a condensed workshop on "Integrated Bowen and EMDR Therapy," with a practicum using EMDR to process "triangling" as an anxiety-managing strategy. The meeting was very well attended. Last January we changed the format of our meetings to serve more members. We now alternate locations and Fridays/Saturdays, so that one month we meet on Fridays in Elk Grove, south of Sacramento, and the alternate month we meet on Saturdays in Roseville, north of Sacramento. Our last EMDRIA Regional Meeting was in May and our guest speaker was Shelby Schwartz, representing Sierra Tucson, who explained how EMDR is integrated into a comprehensive addictions treatment program."

Connecticut

Karen Alter-Reid reports: "The Fairfield County Trauma Recovery Network continues to provide treatment to Newtown/Sandy Hook teachers, first responders and families. The team also conducted workshops about EMDR treatment at Newtown Parent and Community Forums and first responder meetings. TRN co-coordinators, Michael Crouch and I presented a workshop at NASW/CT's State conference entitled, "Building Resilience through EMDR Therapy."

Florida

Regina Morrow reports: "The Greater Orlando EMDRIA Regional Network is off to a busy start in 2013. EMDR HAP kicked off the year with a Basic Training at Rollins College. Four local EMDR therapists who attended EMDRIA's 2012 Annual Conference in Washington D.C. presented one of their favorite workshops: "The Feeling-State and the Impulse-Control Disorder Protocol (Robert Miller)" shared by Claire Mauer; "Borderline Personality Disorder (Andrew Leeds)" shared by Julie Pope Dantzler; "EMDR-Family Therapy Integrative Team Approach for Healing Attachment Trauma in Children (Debra Wesselmann and Cathy Schweitzer)" shared by Liz Lester Dumville; "Moment-to-Moment Decision-Making: Broadening the Possibilities (Deany Laliotis and Deborah Korn)" shared by me." An EMDR Institute Basic Part 2 training was held with Deany Laliotis as the trainer, Carl Nickeson, Claire Mauer and I as the facilitators. March was kicked off with a two day intensive with Katie O'Shea teaching an enthusiastic crowd about "The Early Trauma Protocol." No one left early and stayed as long as Katie kept talking. Great reviews! Ahead for Orlando is a thrilling 2 for 1 day. Reg Morrow will be presenting on "Treating Recent Incidents with EMDR" and Roy Kiessling will be presenting his model, "EMDR from the Belief Schema Perspective." To learn more go to www.windermerecounseling.com. Finally, Lynda Ruf and I are offering small intensive Basic Trainings in the Orlando area and on the beautiful Itchnetucknee River outside of Gainesville, FL and in Orange City, FL north of Orlando. The Trauma Recovery Network (TRN) is growing and all local EMDR therapists who have completed the Basic Training are encouraged to become involved. The Regional Network and TRN are looking for volunteers to help us grow. Consider volunteering and get a chance to develop deeper relationships with some awesome EMDR people. Contact Reg Morrow at reg@cfl.rr.com to become involved."

Ohio

Barbara Hensley reports: "The Francine Shapiro Library (FSL) is being refined as a compendium of citations rather than a repository. Users are under the impression that the FSL will provide copies of everything when in reality we are providing only those already in the public domain. Otherwise, we would violate copyright laws, both nationally and internationally. Also, we are in the process of providing a Military Page at Northern Kentucky University's request to provide resources to EMDR clinicians and veterans in general. The FSL is a work in progress. What most do not know is that the FSL is at no cost to the user. All website design has been completed by the College of Nursing and now the College of Informatics. Citation editing is out of the Steely Library and I do all the inputting of data. All time is donated. I spend anywhere from 5 to 20 hours a week on it. We're hoping that the FSL will becomr more user-friendly and that the users will be inclined to use it for more than just searching for citations."

Massachusetts

Mark Nickerson reports: "Over 200 EMDR clinicians from the Northeast attended the EMDRIA Western Massachusetts Regional Network's 9th annual spring conference with the theme, State of the Art EMDR 2013: Enhancing Clinical Practice. Denise Gelinas presented the morning plenary titled, Smoke and Mirrors: Procedures to Manage Dissociation. After a banquet lunch on the 10th floor overlooking the valley, participants chose from an array of afternoon workshops geared toward providing practical EMDR skills that could be put to use "on Monday morning." This volunteer-organized conference donates proceeds to EMDR HAP. Now a tradition, activities and resource tables keep people abreast of cutting edge EMDR issues while building a warm sense of collegiality. The cumulative results of our one-step-at-a-time community building strategy can be seen at our www.wmassemdria.com website which features our

online find-a-clinician search engine, information about our local Trauma Response Network and other news of interest to our local EMDR clinicians. Our progress as a region has been built through a combination of deep commitment to the value of EMDR work and the rewards of building colleagues/friendships along the way. We have an active steering committee of eight people that meet monthly. Each person has specific responsibilities though we make decisions as a group. We laugh a lot."

Montana

Nancy Errebo reports: "Vet Center counselors across the country are trained in EMDR and are using it to help our brave veterans. Patsy Ferrell, LCSW, Team Leader of the Kona, Hawaii, Vet Center, has pioneered EMDR consultation via Telehealth. She does an EMDR session in Hawaii, and I watch from Montana, adding feedback to Patsy and the veteran from time to time. This provides extra support to a veteran who has had a hard time of it during and after the war."

EMDRIA Credit Programs

To view the full list of EMDRIA Approved Distance Learning Workshops, please visit www.emdria.org and click on Calendar of Events under the Get Involved tab.

PROGRAM # / EMDRIA CREDITS / TITLE	PROVIDER NAME / PRESENTERS	CONTACT	PHONE	DATES / LOCATION
99003-88 14 Credits *EMDR in the Treatment of Complex Trauma with Symptoms of Addictive & Compulsive Behaviors*	EMDR Institute Susan Brown, LCSW, BCD	EMDR Institute	831.761.1040	June 21-22, 2013 Albuquerque, NM
13007-02 13 Credits *Treating Headaches with EMDR*	Steven Marcus, Ph.D. Patricia Thatcher, LICSW	Steven Marcus	650.962.1987	June 20-21, 2013 Costa Mesa, CA
12002-10 13 Credits *The Feeling-State Theory of Behavioral and Substance Addiction and the FSAP*	Robert Miller, Ph.D. Robert Miller, Ph.D.	Robert Miller	626.429.4945	June 22-23, 2013 Mt. Kisco, NY
12005-04 6 Credits *Using EMDR in the Treatment of Chemical Dependency and Impulse Disorders*	Hope Payson, LCSW, LADC Hope Payson, LCSW, LADC	Hope Payson	860.830.6439	June 28, 2013 Barkhamsted, CT
03002-21 12 Credits *EMDR Toolkit for Complex PTSD*	Maiberger Institute Barb Maiberger, MA, LPC and Kate Asmus, MA, LPC	Barb Maiberger	303.875.4033	June 29-30, 2013 Boulder, CO
12012-02 3 Credits *Haunted: EMDR for First Responders & Professionals in the Trenches*	Karen Alter-Reid, Ph.D. Robbie Adler-Tapia, Ph.D.	Karen Alter-Reid	203.329.2701	July 12-13, 2013 Stamford, CT
12001-05 14 Credits *EMDR for Complex Trauma Found in Personality, Addictive and Dissociative Disorders*	Diane Clayton, LCSW Diane Clayton, LCSW	Jane Dunham	239.415.0823	July 12-13, 2013 West Palm Beach, FL
99003-82 13 Credits *The Neurobiology of EMDR: A Glimpse Inside the Brain*	EMDR Institute Uri Bergmann, Ph.D.	EMDR Institute	831.761.1040	July 20-21, 2013 Seattle, WA
12002-12 13 Credits *The Feeling-State Theory of Behavioral and Substance Addiction and the FSAP*	Robert Miller, Ph.D. Robert Miller, Ph.D.	Robert Miller	626.429.4945	July 20-21, 2013 Sacramento, CA

EMDRIA Credit Programs

PROGRAM # / EMDRIA CREDITS / TITLE	PROVIDER NAME / PRESENTERS	CONTACT	PHONE	DATES / LOCATION
99010-18 14 Credits *EMDR Treatment for Problematic Anger, Hostility & Related Behaviors*	Bender-Britt Seminars Mark Nickerson, LICSW	Bender-Britt Seminars	973.746.5959	July 20-21, 2013 Iselin, NJ
99003-83 14 Credits *Complex PTSD, Attachment and Dissociative Symptoms: Treating Children with Pervasive Emotion Dysregulation Using EMDR Therapy and Adjunctive Approaches*	EMDR Institute Ana Gomez, MC, LPC	EMDR Institute	831.761.1040	July 27-28, 2013 Charlotte, NC
06005-13 14 Credits *Looking Through the Eyes: EMDR and Ego State Therapy Across the Dissociative Continuum*	Jill Strunk, Ed.D. L.P. Sandra Paulsen, Ph.D.	Jill Strunk	952.936.7547	July 27-28, 2013 Minnetonka, MN
12001-06 14 Credits *EMDR for Complex Trauma Found in Personality, Addictive and Dissociative Disorders*	Diane Clayton, LCSW Diane Clayton, LCSW	Jane Dunham	239.415.0823	July 27-28, 2013 Nashville, TN
RC12103-04 2 Credits *Integrating Neurobiology & EMDR: Part 3 (DVD Presentation)*	Central Texas EMDRIA Regional Network Dean Dickerson - DVD	Carol York	512.451.0381	August 2, 2013 Austin, TX
01018-53 7 Credits *Module 6 - Special Issues & Integration in Complex Developmental Trauma Disorders*	Carol J. Crow, LMHC Katherine Steele, MN, CS and Carol Crow, LHMC	Insight Counselors	813.915.1038 x1	August 2-3, 2013 Tampa, FL
12002-13 13 Credits *The Feeling-State Theory of Behavioral and Substance Addiction and the FSAP*	Robert Miller, Ph.D. Robert Miller, Ph.D	Robert Miller	626.429.4945	August 3-4, 2013 Greenwood Village, CO
13007-03 13 Credits *Treating Headaches with EMDR*	Steven Marcus, Ph.D. Steven Marcus, Ph.D.	Steven Marcus	650.962.1987	August 9-10, 2013 San Jose, CA
01008-63 12 Credits *Child & Adolescent Trauma Treatment Intensive*	Trauma Institute/Child Trauma Institute Denise Houston, LPC	Denise Houston	678.431.1339	August 12-16, 2013 Atlanta, GA
RC12102-09 2 Credits *Integrating Neurobiology & EMDR: Part 2 (DVD Presentation)*	Chico California EMDRIA Regional Network Dean Dickerson (DVD)	Pennisue Hignell	530.891.6767	August 24, 2013 Chico, CA
99003-89 12 Credits *EMDR and the Art of Psychotherapy with Children*	EMDR Institute Carolyn Settle, LCSW	EMDR Institute	831.761.1040	August 24-25, 2013 Burlingame, CA
03002-22 12 Credits *Somatic Interventions and EMDR*	Maiberger Institute Barb Maiberger, MA, LPC	Barb Maiberger	303.875.4033	August 24-25, 2013 Boulder, CO
07003-08 14 Credits *Treatment of Attachment Trauma & the Dissociative Sequelae through the Life Span: EMDR & Case Conceptualization*	Farnsworth Lobenstine, LICSW Robbie Adler-Tapia, Ph.D.	Farnsworth Lobenstine	413.256.3637	October 5-6, 2013 Northampton, MA
09008-04 14 Credits *EMDR Toolbox: Using the EMDR AIP Model for Treating Adult Clients with Complex PTSD*	Jim Knipe, Ph.D. Jim Knipe, Ph.D.	Sue Anne Wrenn	704.527.3077	October 5-6, 2013 Charlotte, NC

PROGRAM # EMDRIA CREDITS TITLE	PROVIDER NAME PRESENTERS	CONTACT	PHONE	DATES LOCATION
06003-43 20 Credits *The Art of EMDR*	Kathleen Martin, LCSW Roger Solomon, Ph.D.	Kathleen Martin	585.476.2119	Oct 18-21, 2013 Albuquerque, NM
RC12103-05 2 Credits *Integrating Neurobiology & EMDR: Part 3 (DVD Presentation)*	Chico CA EMDRIA Regional Network Dean Dickerson - DVD	Pennisue Hignell	530.891.6767	October 26, 2013 Chico, CA
99003-84 13 Credits *The Neurobiology of EMDR: A Glimpse Inside the Brain*	EMDR Institute Uri Bergmann, Ph.D.	EMDR Institute	831.761.1040	Oct 26-27, 2013 Rosemont, IL
12002-11 13 Credits *The Feeling-State Theory of Behavioral and Substance Addiction and the FSAP*	Robert Miller, Ph.D. Robert Miller, Ph.D.	Robert Miller	626.429.4945	Oct 26-27, 2013 San Diego, CA
RC12104-04 2 Credits *Integrating Neurobiology & EMDR: Part 4 (DVD Presentation)*	Central Texas EMDRIA Regional Network Dean Dickerson - DVD	Carol York	512.451.0381	November 1, 2013 Austin, TX
99003-85 14 Credits *Using the EMDR AIP Model for Treating Adult Clients with Complex PTSD*	EMDR Institute Jim Knipe, Ph.D.	EMDR Institute	831.761.1040	Nov 1-2, 2013 Orlando, FL
01016-13 14 Credits *When There Are No Words: EMDR for Trauma & Neglect Held in Implicit Memory*	EMDR Resource Center of Michigan Katie O'Shea, LMSW	Zon Scheiner	734.572.0882 x3	Nov 1-2, 2013 Ypsilanti, MI
03002-24 12 Credits *Self-Care for Therapists*	Maiberger Institute Barb Maiberger, MA, LPC and Katie Asmus, MA, LPC	Barb Maiberger	303.875.4033	Nov 16-17 2013 Boulder, CO

EMDRIA Regional Meetings

LOCATION REGIONAL NETWORK	2013 DATES	REGIONAL COORDINATOR CONTACT INFORMATION
ARIZONA Southern Arizona	June 20, September 19, October 17, November 21, December 19	Linda Bowers | 520.326.5980
CALIFORNIA Chico	August 24, October 26	Pennisue Hignell | 530.891.6767
OREGON Central Oregon	September 10, October 8, November 12, December 10	Karen Forte | 541.388.0095
TEXAS Central Texas	August 2, November 1	Carol York | 512.451.0381
WASHINGTON SW Washington	November 2	Katy Murray | 360.438.0306 Susan Kravit | 360.556.6789

Welcome New EMDRIA Members

Cynthia Anne Abry, MS, LPC
AAsa Rosen Aldin, Psychotherapeut
Keith L Allen, Ph.D.
Pamela D Allen
Tamaki Amano
Caroline Angiello, LCSW-R
Stanley D. Arnold, LMFT, MS, M.Div.
Andrea Barbour, MA-MFT In progress
John A Basie, LPC
Patricia J. Bastani, LPC
Anne (Kate) K Becker, L.C.S.W.
Allison Victoria Bennett, MSW, LCSW-C
Patricia P. Benzien, LISW-CP
Teresa Bertoncin, LPCC, LMFT
Yvonne A Beyer, MFT
Anne Boland, Ph.D.
Amy L Borgman, PhD
Phylis Brancaleoni T Brancaleoni, LMSW
Bill Bray, LPC
Pamela Anne Brigham, LICSW
Monique K Brown, LMHCA, PsyD Candidate
Catherine Bukovitz, Ed.D., LMHC, NCC, NCGC-II
Jody Butler, LCSW
David A Byron, DEdPsy; MA; MEd;BAHons; Cert. Ed.
Kathy S Campbell, MFT
Teresa Cangemi, B.A., B.Soc. Wk
Carolyn Carrier, M.Ed. Counselling Psychology
Katharine A Casey
Poling C. Chan, MSW, LCSW
Elia Heidiann Charles, LICSW
HouKai Chen, M.S., LMFT
Frank J Crane, MA, LMHC
Kathleen (Kate) L Cross, MA, LMHC
Dori A Dalton, MSW, LISW-S
Heidi J Dalzell, PsyD
Valerie C. Davis, LCSW
Virginie Maria Davis, MAC/CMHC
Molly R. Dean, MSW, LCSW
Terri L. Dempsey, MA, LPC
Cherisse Desrosiers
Roger S Duke, MA, LMFT
Mark Dunn, MA, LPC, CPC, NBCCH
Sherri K Eason, LMFT
Jill M Edelstein, MSW, LCSW
Jay Edwards, MFT
Elisabeth Cavin Eilers, MA, MS, MFT
Kate S Evans, MA, LCPC
Kelly C. Evans, LPC
Angelo M Farenga, MA,LPC
Gwendolyn Feldman, LCSW
Joanie M Fellows, MA. MFC 48224
Kelly S Fisher, MS, LPC
Robert C Flinn, MA, LPC
Charlotte L. Forrest, LCSW
Johnie Fredman, MEd, LPC
Susan Fredrickson, LMFT
John P. Gallagher, LMHC
Paul L. Geiger, M.S. LPC/I
Reem Glasco, LPC
Jodie E. Goldberg, Psy.D.
Gary M. Goldetsky, Psy.D.
Irit Goldman, Psy.D., LMFT
Karen A Haggard, MSW, LCSW
Seth Haney, LPC
Patricia M Hanley, MSW, LICSW, LCSW
Kathleen Waldron Hayward, LCPC-C
Jaquelyn A Hoppe, MA LMHC
Angela K House, MS; Licensed Clinical Professional Counselor
Heather E Hruby, PLMHP, NCC, PLADC
Kimberly A Hubeck, LICSW, LADC
Tanya K. Hull, LPC
Kian F Jacobs, msw. LCSW
Lisa R Johnson, LCPC
James S Jones, LCSW LCAC
Catherine L Kestle, MSW, LICSW
Eileen M Lawlor, LICSW, LADC, BCD
Mary E LeBeuf, LCSW
Beth Lee, LCSW
Marsha LeGrand, RN, LPC-S
Theresa Linville, LCSW
Philip Lister, M.D.
Anita L. Lloyd, LCPC
Joan S Lompart, MA,LMFT
Wendy J Lonn, MA LP
Julie Lopez, PhD, LiCSW
Kelly Maas, MSE, LPC, SAS
Nancy Maguire, Psy.D.
Kimberly A Mahr, MSC, LAC, NCC
Jennifer Manning Plassnig, MSW, LCSW-C, BCD, ACHt
Dana L Martinez, Psy.D.
Barbara J Mashak, LPC
Theresa “Tora” Massey, LMFT
Laurie Mastrianna, LCSW
Wendy Maurer, MA, LMHC
Mark E. Mayhugh, LPC
Joi McNeley-Phelps, Ph.D.
Ken Meyer, PsyD
Leslie J Meyer, MA, LP
Twana Miller, Licensed Clinical Social Worker
Felix Raymond Montez, MS, LPCC, LADC
Mary Ann D. Morgan, M.A., NCC, LPC, LCPC
Catherine S Morton, Ph.D.
Ruby Kam Seung Mui, Psy.D.
Keith J Myers, MA, LPC
Dena Nelson, MFT
Nancy C. Norman, LCSW
Monica A O’Connell
Susan L ODell, PhD
Paul T O’Donnell, MS, LMFT
Susan L Osborne, LCSW
Melissa (Lesa) Paulison, LPC
Kathleen Pearce McGowan, MSW, LGSW
Allison J Perks, LCSW
Carol A Poston, D. Min. MFTA
Cheryl Dawn Pratt, BA Dip Ed Master Human Services (Coun)
Vicky Primer, Ph.D.
Sarah E Reimer, Ph.D.
Angela Rhodes, LMFT
MIRIAM RIVAS de MADRID, LPCC, LPC-S
Eileen P Robbins, MS in Ed, LMFT
Amy Roberts
Victoria L. Rosario, M.A., LMFT
Traci Ruble, MA
Rachel S Saboski, Psy.D.
Phyllis Yedida Sachs, L.C.S.W.-R
Nancy “Sundari” Salman, LCSW
Janet F. Sandell, LPC
Trish Sanders, LPC/MHSP
Kris SantaMaria, LCSW
June Santon, M.A., CAC III, LPC
Jasmine Savio, LCSW
Diana S Schaefer, LCSW
Paul J. Schellenberg, MA, LCPC
Josephine Schiff, MSW, LCSW
Suzanne Beth Schimmel, Ph.D.
Julia Rose Schopp, MA/PLPC
Debbie Schwartz, LICSW
Linda A Seppanen, M.A., C.Psych
Paula J Siegel, MFT
Joanne Coral Smart, BA, BCounselling, GradDipAddiction & Mental Health
Adelaide S. Smith, LICSW, BCD
Jeanna M. Smith, MS Professional Counseling
Corinne E Soares, LCSW
John M Spiesman, Ed.D., MSW, LSW
Debra L. Spranger, MS, LCSW
Diana Stafford, MS
Max Stager, MA, LPC, NCC
Mary R Stanley, MS
Sarah K Steenblock, MA
Robyn D Stewart, MA, LPC
Andrea Stoery, MS/LPC
Alicia Stoner, MSW, LISW-S
Alice R. Stricklin, LMFT
Gretchen Sullivan, MA, LMHC
David G Szmak, Psy.D.
Debra L Tasci, Psy.D., ABPP
Susan C Taylor, LCSW
J. Delaine Taylor, MSSW, LCSW
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Case studies
- Assess the applicability of EMDR for a client(s) with a specific disorder or challenging presentation
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Research studies
- Investigate outcome, by using randomized clinical trials
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- Discussion of the impact of ethnicity and culture
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