EMDRIA™
NEWSLETTER
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In This Issue

Message from the President: State of the State

David L. Wilson, Ph.D.

Because EMDRIA, as an appropriately chartered C6 professional association, evolved out of and supplanted the old EMDR Network and the C3 educational/charitable association, it is easy to forget that EMDR is a relatively young organization—only eight months into our second year of operation. For the first time, we have all the pieces in place to provide the basic functions and services of a professional association: an Annual Conference, quarterly *Newsletter*, *Membership Directory*, website, process for certification of practitioners and consultants, *Register of Certified Clinicians & Consultants*, Regional Meetings, elected Officers and Board of Directors, an Executive Officer and paid staff, and working committees for internal/organizational issues (Structure, Function and Bylaws, Membership, Finance, Personnel, Nominations and Elections, Awards, and Long-Range Planning) as well as committees for services (Conference, Publications, Training and Standards, Regional Coordinating, Health Care, Public/ Professional Relations, and Research).

From the EMDRIA Long-Range Planning meeting, held before the Conference this year, the Board established three ongoing priorities:

1. To expand the framework and expectation for what it means to be "trained in EMDR." EMDRIA envisions a comprehensive and on-going program of training and education as is represented through certification. This would consist of basic courses through EMDRIA-approved programs, either in a university setting or through private instruction, supervision and consultation, and ongoing continuing education;
2. To support ongoing validation of our work with more systematic, sophisticated, and rigorous research and publication of such; and
3. To continue to provide a forum and encourage innovations in psychotherapy derived from EMDR.

In addition, the Board established the following specific goals and priorities for this year:

1. To establish a consistent weekend for the Annual Conference starting in 2001 (The Conference date for 2000 was set prior to this decision.);

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From the International Scene

Marilyn Luber, Ph.D.
Marluber@aol.com

It was summer when I first met Edmund Gergarian at one of the early EMDR conferences, at the time when they were sponsored by the EMDR Institute. Immediately, I was drawn to his shy, quiet smile, little realizing what a power-house of a scientist, clinician, and educator I had met that day. Over the years, I have come to understand the depth of Edmund's intellect and his dedication to his country Armenia.

Edmund is a physician with a specialty in Psychiatry whose distinguished career began at Cairo University Medical School Faculty of Medicine where he earned his medical degree in 1965. He completed his Internship in Cairo University Hospitals and then won and completed a Pathology Fellowship at Albert Einstein Medical Center in Philadelphia, Pennsylvania. Edmund did another internship at West Jersey Hospital and became a Psychiatric Resident at Thomas Jefferson University before becoming Chief Resident. He won a research Fellowship in Clinical Psychiatry at SUNY Downstate Medical Center in Brooklyn, New York and is licensed to practice Medicine and Surgery in New York, Pennsylvania, and Egypt.

Edmund's career has been an interesting and diverse one. He spent ten years at South Beach Psychiatric Center working as a Unit Psychiatrist before becoming Unit Director. His interest in research earned him the position of Clinical Director and Director of Research during a time when he also served as the Director of the Psychiatric Residency Training Program. In 1984, he moved to the Kingsboro Psychiatric Center and served as Chief Medical Officer of the Secure Care Units. He left Kingsboro in 1987 for the Staten Island Developmental Disabilities Services Office, where he continues to serve as the Chief of Psychiatry. He has also been the Attending Psychiatrist at the Armenian Home for the Aged in Flushing, New York from 1980 to the present.

Edmund's broad research experience reflects his varied interests—the understanding of facial expressions, differentiating Mania from Schizophrenia, emotion theory based on facial expressions, Minimal Brain Dysfunction Scales in Adults, biofeedback treatment of Tardive Dyskinesia, PTSD in Genocide Survivors, and EMDR studies—but Edmund's first priority remains helping people in need. From 1989 to 1990, he undertook two missions of mercy to Soviet Armenia to provide crisis intervention and treatment for the survivors of the Armenian Earthquake in Leminakan, Kirovakan and Spitak. During that time, he worked with 120 school age children and 100 adults using cognitive stress management, biofeedback, and stress inoculation training, teaching these methods to twenty school psychologist at the Leminakan Pedagogic Institute.

In 1994, he was awarded the Humanitarian Assistance Award from the President of the Republic of Armenia, Levon Ter-Petrossian. The following year, he was awarded the Outstanding Achievement Award by the Armenian Behavioral Science Association for outstanding contributions to the behavioral sciences.

Edmund completed his basic training in EMDR in 1993 and, from the moment he understood that EMDR was an excellent treatment for traumatized individuals, focused his sights on bringing EMDR training to clinicians in Armenia. In 1993, Edmund took the trainings offered by Dr. Francine Shapiro of the EMDR Institute in Pacific Grove a second time to study how she taught EMDR. He attended Dr. Shapiro's Special University Course at the 1995 EMDRIA Conference and continued to work on his EMDR presentation skills under the supervision of William Zangwill, Ph.D., an EMDR Institute trainer.

By 1997, Edmund had begun the difficult process of translating the manual from the EMDR Institute into Armenian and forming a team of well-trained, Armenian-speaking EMDR clinicians. To solidify his clinical skills in EMDR, he went on to take Dr. Shapiro's Advanced Clinical Applications and Case Consultation course at Punte Serena in 1998.

Unfortunately, Edmund's plans to train clinicians in Armenia were stalled due to a lack of financial resources. On January 1, 1998, he made a commitment to finance the entire training as soon as he received approval from Dr. Shapiro and the Training and Standards Committee of EMDRIA. Upon their approval, he made plans for the first

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Research Committee Update

Research Committee Members:

Nancy J. Smyth, Ph.D., CSW, Chair.
njsmyth@acsu.buffalo.edu

Ricky Greenwald, Psy.D.
rickygr@childtrauma.com

Ad de Jongh, Ph.D.
adnicole@knoware.nl

Christopher Lee, Ph.D.
Christopher.Lee@health.wa.gov.au

Conference Update

The Research Committee had an important presence at this year's EMDR International Association Conference. We sponsored two panel presentations: "How EMDR Works—What We Know and What We Need to Find Out: Directions for Basic Research" and "The Future of EMDR Clinical Research: Where Are We? Where Do We Next Need to Go?." In addition, we organized the first significant poster session for this year's conference, including nine poster presentations:

1. *Child Trauma Measures for Research and Practice*, Ricky Greenwald, Lihue, Hawaii, United States
2. *A Crisis Response Approach for Suicidal Teens,* Ricky Greenwald, Lihue, Hawaii, United States
3. *Neuropsychological Hypotheses of Eye Movement Desensitization and Reprocessing (EMDR)*, Jennifer Hall, Buffalo, New York, United States
4. *Treatment of PTSD: A Comparison of Stress Inoculation Training with Exposure and EMDR,* Christopher Lee, Cottesoe Western, Australia
5. *Eye Movement Desensitization and Reprocessing: An Evaluation of Single Session Treatment of Test Anxiety,* Louise Maxfield, W. T. Melnyk, Thunder Bay, Ontario, Canada
6. *Group Work with Domestic Violence Offenders Using EMDR*, Mary L. Froning, Washington, D.C., United States
7. *Eye Movement Desensitization and Reprocessing in Battered Women: Alleviation of Post Traumatic Stress Disorder,* Melissa Carpenter, Carol Ummel Lindquist, Laguna Beach, California, United States
8. *Information Processing Group*, Kamala-Maria Muller, Nottingham, United Kingdom
9. *Mastering the Cognitive Interweave*, Roy Kiessling, Montgomery, Ohio, United States

Directory of EMDR Researchers and Academics

We are in the process of compiling the second edition of *EMDR Researchers and Academics*. This directory serves as a valuable resource to those wanting to network with other researchers or those seeking out assistance with research. Forms for inclusion were distributed to attendees of the Research Interest meeting at this year's Conference and to those listed in last year's directory. To request a form, send your mailing address to Nancy Smyth through e-mail (address listed above), fax at 716-645-3456, or by phone at 716-645-3381 ext. 232.

EMDR Practitioner/Client Participants Needed for EMDR QEEG Research

(Researcher Will Travel!)

In addition to providing research consultation to EMDR researchers, we hope to support research in other ways whenever possible. Below is a description of a study in search of participants. If you think you can help, please contact Ray Worthy, the investigator. He is willing to travel if he can identify a group of participants, and is willing to link up with another EMDR research project:

> An EMDR/QEEG doctoral dissertation study is in the process of getting underway in the San Francisco Bay area. The doctoral student researcher, Ray Worthy, is hoping to use a basic experimental design consisting of repeated measures and a delayed treatment control group.

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2000 EMDR International Association Conference

September 8-10, 2000

~ Toronto, Canada ~

at the

Royal York Hotel

100 Front Street West
Toronto, Ontario
Canada M5J 1E3
(416) 368-2511

Please be sure to Mark Your Calendar!

HIGHLIGHTS FROM THE 1999 CONFERENCE IN LAS VEGAS

Bigger and Better

Under the direction of Conference Chair/Executive Director, Carol York, and the Assistant Conference Coordinator, Gayla Brown, our Annual Conferences seem to get bigger and better every year. Once again, we set records for attendance and presentations with more than 600 attendees and 42 presentations. The exhibit hall was also expanded with 12 exhibitors and many "Take One" handouts. Also new this year was the implementation of a Poster Session, with nine Research posters on display.

In the opening Keynote Address, "Does EMDR Facilitate New Growth In The Brain?," Ernest Rossi reviewed the role of immediate early genes in optimizing human potentials, and made a compelling case for EMDR as " . . . the most significant development in psychotherapy over the past 50 years."

Entertainment reigned as the Las Vegas ambiance took hold. The Awards & Recognition Banquet was outstanding, with opera tenor/comedian, Joey Evans, captivating the audience. The EMDR Players were also a big hit as the opening act on Saturday morning. This year's cocktail party was an enjoyable social break followed by the EMDR HAP Benefit Dance, where Sam Foster and Debbie Korn put on a fun show.

From The Annual General Meeting

There was an outstanding turnout for the EMDRIA Annual General Meeting, with more and more members stepping up to own EMDRIA as a membership-driven professional association. At this year's General Meeting members, were updated as to the progress of the committees over the past year:

- EMDRIA Health Committee Chair Mark Dworkin announced that Ian Shaffer, Corporate Medical Director for Value Options, the second largest managed care company behind only Magellan, has removed EMDR from the category of "experimental therapy," thereby making EMDR available to some 25 million members covered by Value Options health plans.
- Under the leadership of Chair Sandra "Sam" Foster, the Public Relations Committee has produced a media packet for the general public and high quality color brochures and presenter packets for mental health professionals.
- Under the leadership of Chair Jocelyne Shiromoto, the Regional Coordinating Committee has developed a structure for a network of Regional Study Groups throughout the United States and the world.
- The International Committee reported that EMDRIA has completed formal affiliations with organizations in Argentina, Australia, and EMDR Europe with EMDRIA Canada in progress, moving us forward as a truly international association.

The new Officers and Board Members were also installed at this meeting: Officers Wendy Freitag (President-elect), Linda Vanderlaan (Secretary-elect), and Jim Gach (Treasurer-elect) and Directors Zona Scheiner, Curt Rouanzoin, and Roger Solomon.

Prior to the start of the Annual Conference, the Board met for its Annual Long-Range Planning Retreat, where they set the top priority: "to expand the framework and expectation for what it means to be 'trained in EMDR.'"

We sincerely hope you will join us in Toronto, Canada for the 2000 EMDR International Association Conference. Next year's theme will be "Inventing the Future."

We look forward to seeing you there!

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GRANDPARENTING FOR EMDRIA CERTIFICATION IN EMDR AND EMDRIA APPROVED CONSULTANTS

Please note that grandparenting period for becoming EMDRIA-Certified in EMDR or an EMDRIA-Approved Consultant is December 31, 1999.

During the grandparenting period, individuals may apply for these designations by providing documentation that they meet the criteria for grandparenting. After 1999, applicants must contact the EMDRIA office to begin the process for achieving Certification or the Approved Consultant status.

Criteria for qualifying for these designations as well as applications and fee information can be found in the March 1999 and June 1999 issues of the *EMDRIA Newsletter.*

(Research Committee Report - Continued from page 3)

The potential for the design to become more ambitious exists, but therapist and research subject recruitment are two present challenges. The study hopes to include highly-trained therapists (consultant, certified, or completed EMDRIA-approved training) in order to minimize potential treatment fidelity problems. With regard to subject recruitment, the study hopes to include individuals with PTSD symptomatology, as well as individuals who have endured some degree of trauma/ difficulty in their lives and for whom varying degrees of anxiety and/or depressive symptoms are present.

This research will take place for roughly the next 15 months and the student is in a position to travel to different locales in the country should viable research subject pools (and therapists) be available. Any information and suggestions can be sent to him at: Ray Worthy, 956 Oak Street San Francisco, CA 94117, Phone: 415-934-0602, Fax: 415-934-0600, E-mail: Rworls@aol.com.

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CALL FOR PAPERS FOR *THE EMDRIA NEWSLETTER*

The EMDRIA Publications Committee is engaged in a continuous process of gathering EMDR-related papers of interest to our membership.

Next deadline for submissions:

October 20, 1999

Please see page 39 of this issue for Submission Guidelines.

EMDRIA REGIONAL MEETINGS DIRECTORY

This directory is designed to provide EMDR clinicians with a listing of Regional Meetings in their areas. These meetings have been designed to enable EMDR clinicians to obtain the latest information about EMDR as well as to continue the pursuit of excellence in EMDR. Many Regional Meetings may be providing "EMDRIA Credits" in order to fulfill the requirement of continuing education for Certification in EMDR.

Please see below for the listings of Regional Meetings in your area as well as whom to contact for more information. If there is not a Regional Meeting in your area and you are interested in developing one, please contact the EMDRIA Office at 512-451-5200.

California

Southern California Regional Meeting
Contact Person 1: Jocelyne Shiromoto
T: 714-764-3419
E-mail: shiroflex@aol.com
Contact Person 2: Liz Snyker
T: 760-942-6347
esnyker@bigfoot.com

Colorado

Boulder EMDRIA Regional Meeting
Contact Person: Keith Andresen
T: (303) 443-5682
E-mail: BolderEMDR@aol.com

Colorado EMDRIA Regional Meeting
Laura Knutson, Jana Marzano, Claudia Christian
Contact Person: Laura Knutson
T: (303) 753-8850
F: (303) 753-4650
E-mail: lauknutson@aol.com

Connecticut

Connecticut EMDRIA Regional Meeting
Contact Person: Leslie Weiss
T: (203) 865-6156
E-mail: lesweiss@tiac.net

Hawaii

Oahu EMDRIA Regional Meeting
Contact Person: Gary Ralston
T: (808) 533-3850
F: (808) 533-3583
E-mail: GR100240@aol.com

Illinois

Chicago EMDRIA Regional Meeting
Contact Person: Howard Lipke
T: (847) 688-1900
E-mail: hlipke@aol.com

Maryland

Greater Baltimore-Washington EMDRIA Regional Meeting
Deany Laliotis, Dan Merlis, Gene Schwartz
Contact Person: Deany Laliotis
T: (301) 718-9700
F: (301) 718-9701
E-mail: dlaliotis@aol.com

Massachusetts

Massachusetts EMDRIA Regional Meeting
Contact Person: Esther Bean
T: (413) 584-9999
E-mail: edbmsw@aol.com

Michigan

Michigan EMDRIA Regional Meeting
Eileen Freedland, Zona Scheiner, Bennet Wolper, Cam Vozar, Harriet Mall
Contact Person 1: Eileen Freedland -Bloomfield Hills
T: (248) 647-0050
F: (248) 683-7010
Contact Person 2: Zona Scheiner -Ann Arbor
T: (734) 572-0882 ext. 3
F: (734)663-9789
E-mail: zonags@aol.com

Missouri

St. Louis EMDRIA Regional Meeting
Marcia Whisman, Sheri Rezak-Irons
Contact Person: Marcia Whisman
T: (314)644-1241
F: (314) 644-6988
E-mail: marwhisman@aol.com

New York

Buffalo EMDRIA Regional Meeting
Contact Person: Nancy Symth
T: (716) 645-3381 x232
F: (716) 645-3456
E-mail: njsmyth@acsu.buffalo.edu

Long Island EMDRIA Regional Meeting
Mark Dworkin, Uri Bergmann, Beverly Wright
Carol Forgash, David Grand
Contact Person: Mark Dworkin
T: (516) 731-7611 F: (516) 579-0171
E-mail: mdwork5144@aol.com

Mid-Hudson Valley EMDRIA Regional Meeting
John Nash, David Sherwood
Contact Person: John Nash
T: (914) 575-3000 x2156
F: (914) 575-3299
E-mail: jwz3@maristb.marist.edu

Syracuse EMDRIA Regional Meeting
Maudie Ritchie, Sandra Kaplan
Contact Person: Maudie Ritchie
T: (315) 251-0909
F: (315) 637-2643
E-mail: msritchie@aol.com

Nevada

Nevada EMDRIA Regional Meeting
Deborah Roberts
Contact Person: Deborah Roberts
T: (702) 458-7774 F: (702) 458-0081
E-mail: jwroberts@net-tek.net

Ohio

Ohio EMDRIA Regional Meeting
Contact Person 1: Irene Giessl
T: (513) 221-2001
F: (513) 961-6162
E:mail: mgcm59c@prodigy.com
Contact Person 2: Barbara Hensley
T: (513) 961-2400
E-mail: bhense14456@aol.com

Pennsylvania

Pennsylvania EMDRIA Regional Meeting
Dorothy Ashman, Sally Eves, William Harrar
Contact Person: Dorothy Ashman
T: (570) 387-1832
F: (570) 387-5103
E-mail: kent@csrlink.net

Texas

Austin EMDRIA Regional Meeting
Contact Person: Barbara Evans
T: (512) 448-4514
F: (512) 448-4954
E-mail: bobbieevans@worldnet.att.net

(International Scene - Continued from page 2)

EMDR training in June 1998 in Yerevan, Republic of Armenia. Due to the undeveloped resources in psychotherapy teaching, training, and practice, he decided to ensure an excellent standard of training by lengthening the training to five days to allow time for personal practicum supervision as well as supervision for patients. He also incorporated e-mail support as follow-up to facilitate supervision after the training.

At that time, Edmund's dream was "to provide these trainings on a yearly basis until an Armenian EMDRIA Chapter [was] formed in Armenia." For his first approved training, Edmund and his Armenian-speaking colleagues, Meline Karakashian, Ph.D., and Liza Papazian, M.S., C.S.W., trained 21 clinicians in Armenia.

During 1999, Edmund put the finishing touches on the translation of the second part of his EMDR training for Armenia clinicians, an advanced training he will be providing to the 21 clinicians who finished this year's training in July. Additionally, Edmund and his assistant, Liza Papazian, will train 18 to twenty new clinicians using last year's format, which includes at least three practica, a training that will be partially underwritten by the Humanitarian Assistance Program of the EMDR Institute and by Edmund himself.

Edmund Gergarian has my nomination for a truly splendid soul and all-around humanitarian. Thank you, Edmund, for all you have done in the world and for upholding a high standard of the practice of EMDR.

News from Around the World

- **Australia:** The Australian Association is delighted to at last be affiliated with EMDRIA and is looking forward to a closer relationship and sharing and contributing to the on-going developments in EMDR here and around the world. Our Australian colleagues are planning an EMDR conference in the year 2000 that will coincide with the Olympic games and will provide more information as plans are formalized. In the last 12 months following the visit of Dr. Shapiro in 1998, there have been a

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

If you have an existing Study Group—or will be starting a Study Group—and want it posted in the next *EMDRIA Newsletter*, please submit it to the EMDRIA administration office by October 20, 1999. When submitting your Study Group, please provide the following information by mailing/faxing this form to the EMDRIA office or e-mailing the information to the *Newsletter* Editor at superVisns@aol.com.

[Please note: You must be a current member of EMDRIA to have your Study Group listed.]

Contact Name: _____

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

_____

City: _____ State/Province: _____

Phone: _____ Fax: _____ E-mail: _____

[Please see page 36 of this issue for current postings to the Study Group Listing.]

number of EMDR trainings from several new EMDR Institute trainers as well as two non-EMDR Institute trainers.

Mark Grant has been conducting specialty workshops concerning the application of EMDR to pain. He will also be presenting this material at the EMDRAC Conference in Toronto in October 1999 followed by presentations in San Francisco, Los Angeles, and possibly Philadelphia in November 1999.

- **Germany:** Marilyn Luber presented a training, specifically developed for Germany, to ten psychotherapists from throughout Germany and one psychotherapist from Luxembourg who are preparing to become supervisors of EMDR-trained clinicians.

- **Israel:** Alan Cohen reported that Kiryat Shmona was once again the target of rocket fire, with the psychological toll worse than ever. He is thankful for being able to use EMDR as part of his work with survivors.

  The Gilbert Luber Memorial Fund was established under the auspices of the Humanitarian Assistance Program to support a program to train Israeli and Palestinian psychotherapists in the use of EMDR.

- **Poland:** Barbara Anderson continues to plan for trainings in Poland and has applied for financial aid to train clinicians in Warsaw and Cracow.

- **South and Central America:** John Hartung will present EMDR trainings in Guatemala City with Ligia Piedrasanta, who is in training to become a trainer, assisting him. With Barbara Zelwer, they will travel to Managua, Nicaragua to train clinicians.

  John and Michael Galvin will teach EMDR in Mexico City early next year. Priscilla Marquis reports that Christie Sprowls and Graciela Rodriguez trained clinicians in an advanced level in Mexico City. Priscilla is in the process of organizing trainings in Central America under the auspices of HAP for survivors of Hurricane Mitch.

Please continue to send me the news of your work and accomplishments at marluber@aol.com.

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(Message from the President - Continued from page 1)

2. To create a research library online;
3. To develop special interest and student tracks at the Conferences;
4. To provide additional member benefits;
5. To develop a professional journal (as distinct from a trade publication like the current *Newsletter*)
6. To support the development of localized emergency response teams as a public service; and
7. To develop a Scientific Advisory Board.

Finally, each year EMDRIA establishes a theme for the year and the next Conference. In EMDR we have a powerful means for putting the past in the past and creating an opening for possibility, for new ways of being. In my view, we need to couple this with a powerful ideology: specifically, a commitment to promote greater understanding, compassion, kindness, and love in the world. Toward this purpose, the Board thought it appropriate as we enter the next millennium to set as Conference theme for the year 2000: "Inventing the Future."

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OUR APOLOGIES . . .

We would like to express our apologies to the EMDR Institute for the ad run in the 1999 EMDRIA Conference Exhibitor Directory on the front inside cover.

Due to a computer error at our printer, there were numerous typographical errors in the ad.

These errors were not on the part of the EMDR Institute.

—The EMDR International Association

Health Care Committee Report

Mark Dworkin CSW, LCSW
EMDR Institute Facilitator
EMDRIA Chair, Health Care Committee
mdwork5144@aol.com

Progress with the MCOs

This past April 28th, after four years of effort, we were invited to make a telephone presentation to the Medical Directors' meeting at Value Options, the decision-making body of the managed care organization (MCO) that determines whether there is sufficient research and credibility of a "new" treatment method to warrant the removal of the treatment from their "Experimental Treatment List."

Sue Rogers, Ph.D., Byron Perkins, Ph.D., and I presented on three issues:

1. Research
2. Credentialing
3. How EMDR can be used in the world of managed care.

We received notice from Value Options that they have indeed decide to stop "red flagging" EMDR. In other words, it is now an accepted treatment methodology—a nice breakthrough for us.

Your Help Is Needed

In the past, we were rejected by a number of large MCOs (e.g., Magellan) for reasons that are difficult to accept. We will continue to proceed until the job is done, but it is important to note that there is a change in strategy. To streamline the process, we will be sending the efficacy report which consolidates all our research findings to the MCOs.

We encourage any and all interested therapists to continue to try to locate which decision-making bodies in HMOs, MCOs, and similar organizations make determinations to reject EMDR as a viable treatment method. Provide us with contact information, and we will then make the appropriate contact and presentation which should sway their thinking.

We appreciate the support of the EMDR community in this effort.

EMDR at the ISSD Fall Conference

The International Society for the Study of Dissociation (ISSD) is pleased to invite EMDRIA members to attend the 16th International Fall Conference, to be held in Miami, Florida, November 11-13, 1999. The theme of this year's conference is "Integrating Dissociation Theory into Clinical Practice and Psychological Research" and there will be many workshops and paper sessions which reflect the growing interest in the dissociation field in other clinical and research fields. There will be two workshops on the use of EMDR in treating dissociative disorders (Fine and Berkowitz: "The combined use of EMDR and hypnosis in the treatment of DID: The Wreathing Protocol" and Bergmann and Forgash: "Deepening EMDR Treatment Effects in the Clinical Treatment of Dissociative Disorders: Integrating EMDR Techniques, Ego-state Therapy, and Developmental Blueprinting") as well as a paper on EMDR. While this may not seem like much to those accustomed to EMDR conferences, it is indicative of the growing interest and cooperation in the two areas.

There will be more than 40 papers, 20 workshops, conversation hours, symposia, as well as four plenary addresses. The plenary speakers are Frank Putnam, M.D., speaking on "Developmental Antecedents of Pathological Dissociation," Peter Barach, Ph.D., on "A Threshold-of-Vulnerability Model for Dissociation—Etiological and Treatment Considerations," Christine Courtois, Ph.D., on "The Scientifically-Based Treatment of Memories of Trauma" and Ross Cheit, Ph.D., J.D., on "Junk Skepticism and Recovered Memory." The program co-chairs, Su Baker, M.Ed. and Etzel Cardeña invite members of EMDRIA to take advantage of this opportunity to further their understanding of dissociation and dissociative disorders to bring the most up-to-date information and treatment strategies to patients suffering from a dissociative or trauma disorder. With such a rich and varied program, there will be much of interest for everyone.

Information and registration applications may be obtained from ISSD, 60 Revere Dr., Suite 500, Northbrook, IL 60062, telephone: 847-480-0899 or via the World Wide Web <http://www.issdorg>. We look forward to meeting many of you there.

Utilization of EMDR in Crisis Intervention

Roger M. Solomon, Ph.D.

[Editor's Note: This article is re-printed from Crisis Intervention, 1998, Vol. 4(2-3) with permission from Harwood Academic Publishers.]

A crisis or traumatic situation occurs when a person is involved in a situation that results in an overwhelming sense of vulnerability and/or lack of control (Solomon, 1995). These situations can shatter basic assumptions about how the world works, interfering with the victim's ability to assimilate and accommodate the event (Janoff-Bulman, 1992). Three major themes that commonly need to be addressed by victims of critical incidents are 1) responsibility for the event 2) personal vulnerability and lack of safety, and 3) issues of control and self-efficacy (Shapiro, 1995).

Issues of responsibility and self-blame are often central following a tragedy (Janoff-Bulman, 1992; Herman, 1992). Victims of a critical incident often take excessive responsibility and blame themselves for outcomes beyond their control. Many people hold a core belief that they have control over what happens to them (Bulman, 1992). Consequently, a person may irrationally believe that he or she did something wrong to cause the tragedy. Such thinking often proceeds, "Because of what I did (or did not do), this happened . . . If I had done something differently . . . it would not have happened." Such thinking results in feelings of guilt, depression, inadequacy, and low self-efficacy.

Issues of personal safety may dominate the clinical picture following a critical incident. A person may intellectually know that he or she could get hurt or killed, or that it could happen to someone they love. However, a person may hold a core belief that "it won't happen to me" (Bulman, 1992). In the aftermath of a critical incident a person may come face to face with his or her sense of mortality. Intense feelings of vulnerability arise not only when a person's sense of safety is threatened, but also after witnessing tragedy or experiencing a significant loss (Rando, 1993).

Issues of control and self-efficacy may be paramount after a crisis. The realization that one has no control over the occurrence of tragedy can leave one feeling helpless and powerless. A crucial element of recovery is recapturing a sense of efficacy and empowerment. People may not be able to control what goes on around them, but they can control their response to it. In other words, they have choices.

Eye Movement Desensitization and Reprocessing (EMDR) is a treatment method for psychological trauma that can be effectively applied within a framework of crisis intervention and brief therapy following a traumatic event. The theoretical model underlying EMDR is the Accelerated Information Processing model (Shapiro, 1991, 1992, 1993, 1994, 1995). This model posits an innate information-processing system that is physiologically configured to facilitate mental health in much the same way the rest of the body is designed to heal itself when injured (Shapiro, 1995). When operating appropriately, this system takes the perceptual information from a traumatic event to an adaptive resolution -useful information is stored with appropriate affect and is available for future use. The physiological and emotional arousal stemming from a crisis may disrupt the information processing mechanism. This can result in the information taken in during the time of the trauma (e.g., disturbing images, thoughts, sensations, beliefs, and the like) becoming stored in disturbing, excitatory, state-specific form. The blocked processing prevents the traumatic information from progressing through the normal steps of adaptive integration. Nightmares, flashbacks, intrusive thoughts and sensory imagery, and other symptoms may result from continual activation of this dysfunctionally stored information by internal or external stimuli, or perhaps because of repeated unsuccessful attempts of the information-processing mechanism to complete its own processing.

EMDR appears to stimulate the information-processing system so it can metabolize and integrate the dysfunctional information. Rebalancing the information processing system enables the client to progress through the appropriate stages of affect and insight regarding issues of responsibility, present safety, and the availability of future choices. (See Dr. Shapiro's article for a description of the method and supporting research.)

EMDR is not a short-cut to resolution. After a traumatic incident, including significant loss, people have been found to go through a recovery process that has been conceptualized as taking place in stages or phases (Herman, 1992, Rando, 1992). Clinical observations and the experience of hundreds of therapists show that the EMDR client goes through the same phases of recovery, but at an accelerated rate. Dysfunctionally stored information that is unable to process is at the core of trauma symptoms (van der Kolk, 1996; Herman, 1992). By processing the dysfunctionally stored information, EMDR allows the information to move toward adaptive resolution. Hence, rather than skipping recovery stages, EMDR enables a natural progression.

EMDR is not a "stand alone" method. Following a critical incident, EMDR should be integrated within an overall crisis intervention framework. Dealing with safety and security needs; therapeutic procedures to enable emotional and physiological stabilization; appropriate

(Continued on page 13)

Floatback and Float-Forward: Techniques for Linking Past, Present and Future

Cindy Browning, MSW, LCSW
Private Practice
Montclair, New Jersey

The standard EMDR protocol calls for targeting the past origins of a disturbance, present day triggers and creating templates for appropriate behavior in the future (Shapiro, 1995). Some clients, however, may have difficulty connecting their current problems to past events. Similarly, other clients may have difficulty creating positive future templates, especially if the client is anxious about trying new behavior. For these problems the Floatback and Float-forward Techniques, developed by EMDR Institute Trainer, William Zangwill, Ph.D., are effective methods for linking past, present and future in the clinical setting and providing the therapist with tools for competently addressing both of these issues.

The Floatback Technique

Addressing earlier memories associated with disturbing material is fundamental to EMDR. Shapiro states that helping the client to find an earlier memory "...should be one of the first options considered by the clinician..." (Shapiro, 1995 p. 185). The Floatback Technique is a powerful and efficient means to this end, allowing the therapist to assist the client to make his or her own associations to past events. It is highly appropriate for use when the client is experiencing a disturbance in the present that the therapist suspects is rooted in past experiences, especially when direct questions such as, "What is your earliest memory of feeling this way?" have not succeeded in helping the client make a connection to past events. Also, when a client presents a theme or recurring experience, the Floatback Technique is ideal for helping the client to identify a salient target for reprocessing. Many clients find it relatively easy to get in touch with current problems. For example, a client who complains that she feel abandoned when her husband leaves briefly on a business trip can probably be asked to bring up the most recent of these events with relative ease. The therapist can then apply the Floatback Technique to help the client make the association to an earlier event rapidly and efficiently.

To use the Floatback Technique, set up the present disturbance using the procedural steps listed in the Level I and Level II training manuals (Shapiro, 1994; Shapiro, 1996) including image, negative cognition (NC), positive cognition (PC), validity of cognition (VoC), emotions, subjective units of disturbance (SUDs), and location of body sensation. However, do not initiate processing (i.e., eye movements or other stimulation) at this point. Instead, say to your client, "Please bring up that picture of _____ and those words _____, (repeat client's disturbing image and negative cognition), notice what feelings are coming up for you, and where you are feeling them in your body. Now close your eyes and let your mind float back to an earlier time in your life. Don't search for anything, just allow your mind to drift back to a time when you had similar thoughts of _____ (repeat negative cognition), and feelings of _____ (repeat emotions above), in your _____ (repeat places in the body where they reported sensation. And when you're ready, open your eyes and tell me the first thing that comes to your mind."

Set up this earlier experience as a target complete with image, NC, PC, VoC, emotions, SUDs and location of body sensation, and, start processing with eye movements or other stimulation. Once this earlier material is reprocessed, go back and check the original present-day target. Often the work on the earlier material will generalize and may render the processing of the present-day target unnecessary.

It is important to use general language when guiding the client through the floatback instructions, i.e., to ask for *earlier* rather than *earliest* memories. There are several reasons for this. Firstly, it is often the worst rather than the first memory that makes the most salient target for reprocessing. Also, using general language is helpful to the more compulsive and perfectionistic clients who may otherwise be overly concerned about doing it correctly and finding exactly the first association. Finally, the flexibility allowed by general rather than specific language maximizes the client's chances for success in making an association to the past, which is the goal of this technique.

The essential feature of the Floatback Technique is using the EMDR procedural questions to connect present problems with past events. Asking the questions as developed by Shapiro is a potent method for helping clients to tune into all aspects of their experience of the problem. The upsetting material becomes more vivid and present for the client and sets the stage for recalling similar experiences. Fully delineating the present-day target by using the procedural questions is hypothesized to stimulate the neural network of associations, making it possible, and often nearly effortless, to "float back" to

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(Crisis Intervention - Continued from page 11)

physical, psychological, and social supports; and so on; are essential elements in working through a crisis (van der Kolk and Fisler, 1995; Everly, 1995; Herman, 1992). In all of its clinical applications EMDR is not considered to be one-session therapy, but rather an approach to be used as part of a comprehensive, integrated treatment plan.

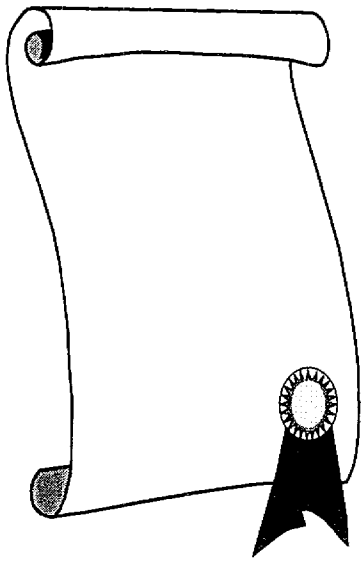
The timing of the integration of EMDR in the therapeutic process must be appropriate to the client. For example, EMDR may not be helpful in the immediate aftermath of a critical incident if a person is in a dissociated, numb state. Psychological defenses utilized during and immediately following a traumatic incident need to be respected. EMDR is best utilized after the emotional impact of the event hits, when the signs and signals of dysfunctionally stored information can be assessed. The emotional impact, as evidenced by intrusive and arousal symptoms, may begin to be experienced within several hours or several days of the event. Clinical experience has shown that EMDR, within a crisis intervention framework, can be effectively applied in the days and weeks following a traumatic incident to alleviate severe symptoms that disrupt functioning, as seen in the following case examples.

Issues of Responsibility

Traumatized people often take undue responsibility for events and blame themselves for outcomes beyond their control. EMDR can help a person attain an awareness of appropriate responsibility and resolve irrational feelings of guilt, as illustrated below. In a major explosion that involved many deaths, a rescue worker felt guilty over not being able to find all the body parts of a victim. Because there were missing limbs, he felt that he did not complete his mission. He also felt guilty that it took several days to recover a body that was visible but inaccessible. He experienced intrusive images of the scenes which evoked significant distress. The worker was given debriefings and counseling, but intrusive images and feelings of guilt persisted. Two months after the incident, the rescue worker received EMDR. The image of the first dead body was targeted along with his feelings of guilt and failure. In the course of EMDR he realized that nobody ever found the missing body parts, and that he indeed had done all he could. EMDR was also applied to the second situation involving the delayed recovery. Starting with the image of the dead person and feelings of guilt and failure, the rescue worker realized the person was dead, not calling for help, and the rescuers had other priorities. He then verbalized that not only did he do the best he could, that he and his fellow rescuers had done a good job. His guilt was alleviated.

EMDR does not absolve a person from responsibility. It results in a person being able to attribute appropriate responsibility and discard irrational self-blame and guilt. In the present case reprocessing the situations enabled the worker to differentiate what was under his control from what was beyond his control, understand the rationale for decisions that were made, and resolve his guilt. Being able to view his role in the situation more realistically resulted in the perception that he did the best he could, which restored feelings of efficacy.

(Continued on page 14)



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(Crisis Intervention - Continued from page 13)

Issues of Present Safety

A traumatic incident may result in the experiencing of intense feelings of vulnerability that can permeate the present and the anticipation of the future. EMDR, in facilitating integration of the event, can help restore a person's sense of present safety.

A police officer responded to a situation involving a suicidal man with a rifle who had left his house and was walking around the neighborhood. The police officer knew this individual and had dealt with him successfully several times before. The officer found the man, got out of his car, and called to the man. The man fired a shot at the officer, shouting at the officer to shoot him. The officer, not wanting to shoot the man, ducked in the car. More shots were fired, hitting the police car. The officer backed the car away from the scene, and called for more help. The man later gave himself up and was admitted to a psychiatric hospital. The officer was quite shaken by the incident because he could have been killed. Further, he was distressed because of the violation of his belief that a person who knew him would not try to hurt him. He also was being second guessed by fellow officers for his decision not to shoot at the man and was second guessing himself. He was seen by a psychologist three days following the incident. He was having difficulty sleeping, experiencing repetitive intrusive imagery of the man firing at him, could not reconcile that someone who knew him would try to kill him, and was second guessing himself for not shooting despite feeling glad that he did not have to kill the man.

After going through the situation "frame by frame," EMDR was utilized with the initial target being the intrusive image of the man firing at him. At this moment he believed he was going to die and experienced extreme fear, vulnerability, and helplessness. After a few sets of eye movement the image started to fade. He realized people he knew could harm him. He had known this intellectually before but it did not feel valid; it was not supposed to be this way. Now he could emotionally accept the reality. He then verbalized he did not shoot because he did not want to be the instrument of the man's suicide and he had the option of ducking back into his car and backing away from the scene. However, he knew he could have shot had there not been the availability of the car for cover. By the end of the session, the image was more distant, he felt he had made an appropriate decision, and had exercised control by ducking in the car and removing himself from danger. Now the incident felt over and in the past. For the future, knowing that someone who knew him could still put him in jeopardy, he would modify his tactics should a similar situation arise. After the session, he was able to sleep. Follow up showed treatment gains to be stable over time.

In the above case, the officer was experiencing significant vulnerability and intrusive imagery as a result of a life threatening experience. A core assumption—people who know you will not harm you—was violated. With the processing of the situation, he was able to assimilate and accommodate the information. Integrating the information led the officer to a new awareness of safety parameters, resulting in the availability of different choices for future behavior.

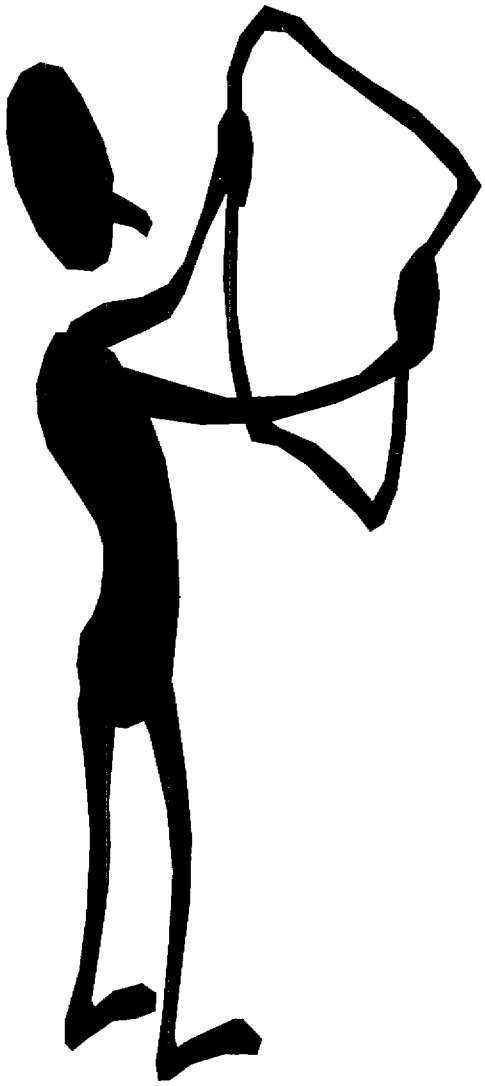
With the event reprocessed, it felt over and in the past. Clinical observation and experience have indicated this is a common pattern of resolution when EMDR is used to treat acute feelings of vulnerability. People involved in traumatic situations are often fixated on the worst moments. The moments of terror can be dysfunctionally stored in the brain, unable to process. When the person thinks of the incident, or is reminded of it, feelings of vulnerability are stimulated and permeate present consciousness, and the world appears unsafe (Foa and Riggs, 1994). EMDR facilitates the processing of the moments of vulnerability, enabling the person to focus on what happened afterwards (e.g. "I survived"). The client can now feel the event is over, place the event in the past, and experience a sense of present safety.

(Continued on page 31)

Brochure for Professionals Available

The Professional and Public Relations Committee has completed a brochure about EMDR for mental health practitioners, physicians, and other professionals—appropriate for distribution at speaking engagements, grand rounds, and conferences.

Please contact the EMDRIA office at 512-451-5200 or emdria@aol.com for information.



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She was trained in EMDR in 1990, 1991 and 1992. She served as a facilitator from 1990 to 1995, and participated in trainer training for three years with the EMDR Institute. She gave her first EMDR International Conference presentation in 1993 on depression and resistance, with further Conference presentations in 1994, 1995 and 1998. The 1996 workshop video represents six years of development and experience in this specialty area.

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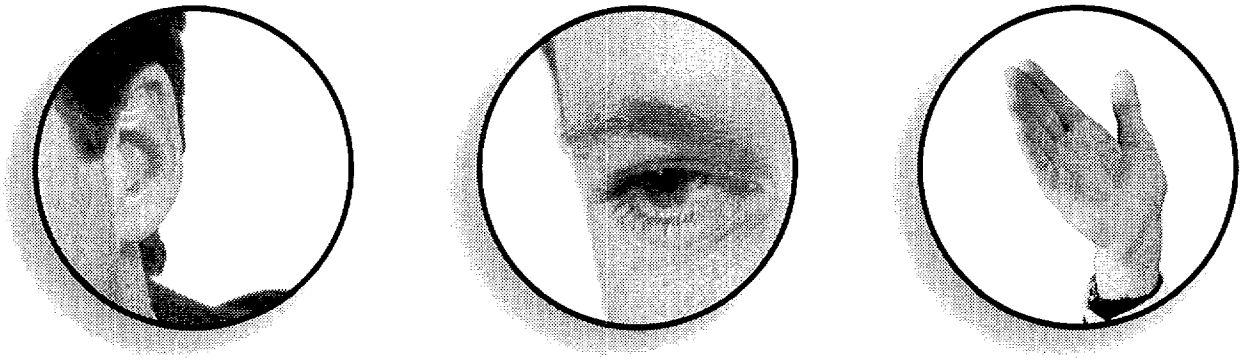

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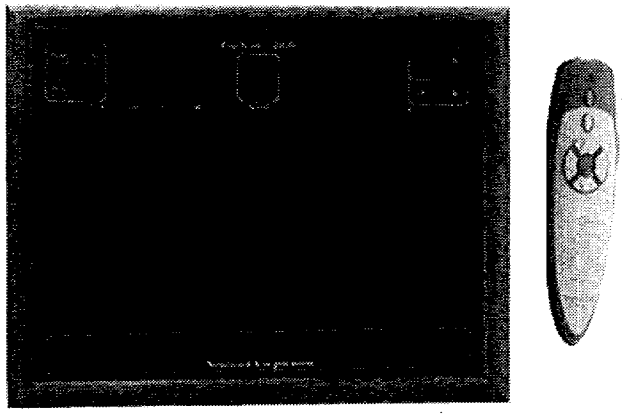

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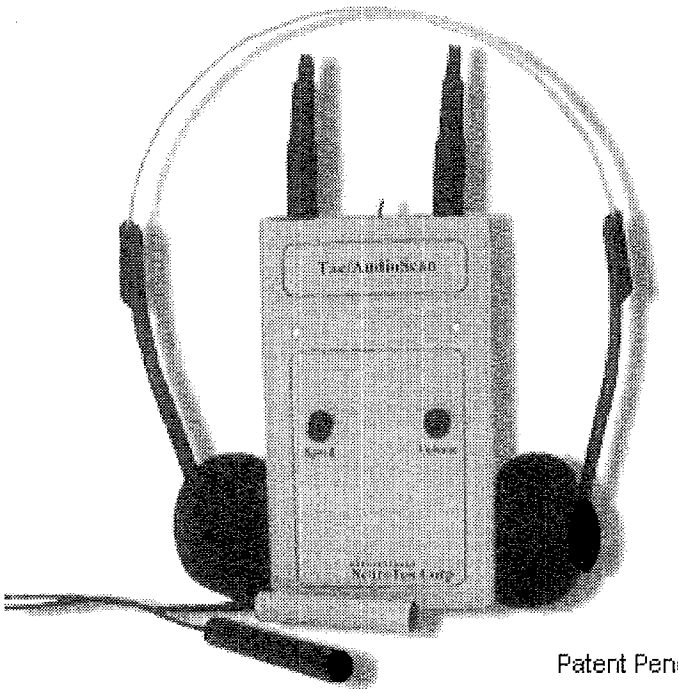

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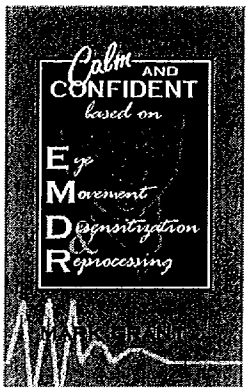

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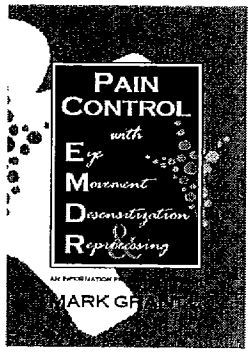

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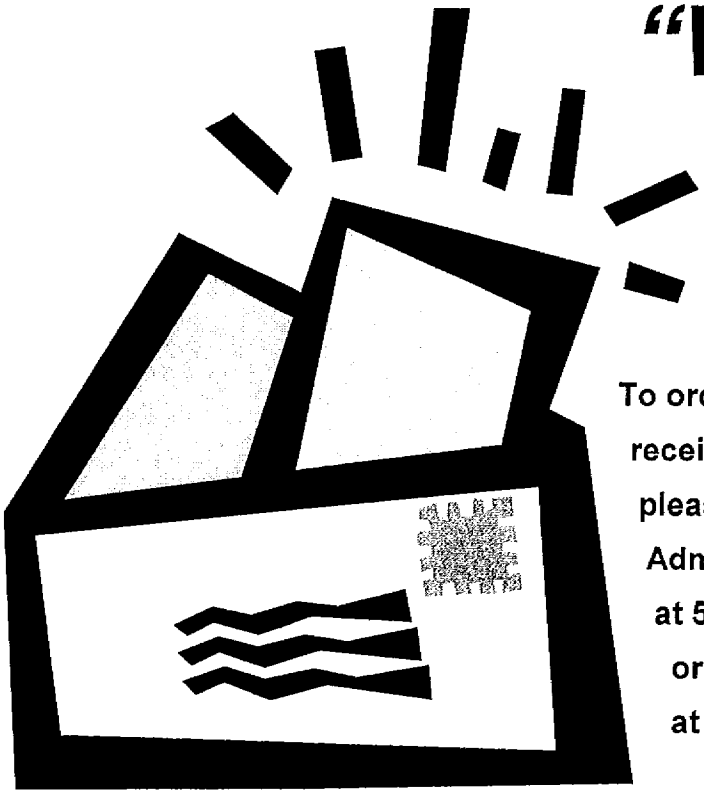

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The processing led to resolution of issues of responsibility (e.g., self second-guessing) with the officer attaining a clearer understanding and acceptance of why he did not shoot. Control issues were also resolved. The officer realized that he was not helpless in the situation, but had made decisions and taken action that saved his life and the life of the suicidal man, re-establishing his sense of efficacy.

Issues of Powerlessness / Lack of Control

A critical incident can result in feelings of helplessness, powerlessness and lack of control. Frequently, feelings of vulnerability are triggered by issues of powerlessness as the person realizes that he or she has little or no control over the occurrence of future tragedy. The next example illustrates such dynamics, with the client's presenting issue centering on helplessness. Along with facilitating a sense of present safety, EMDR can help a person regain a sense of control, efficacy, safety, and confidence in their ability to make constructive choices.

A train conductor was on the head engine with the engineer when a truck tried to beat them across an intersection. The engineer applied the emergency brakes, it was too late. The train hit the truck, which exploded. The truck driver was killed. The trainmen, holding on for dear life, survived without injury. What was most distressing to the conductor were his feelings of powerlessness. He realized he could have been killed, but survived this time. However if there was another collision in the future, he felt like a "sitting duck," with nothing he could do.

One month later, in the context of a two day workshop on critical incident trauma and peer support, the conductor had an opportunity to discuss his incident with his peers. He also received EMDR to process the accident. A few minutes into the process he experienced the strong sense of powerlessness, helplessness and fear that he had felt immediately preceding and during the impact. He then became aware that he had managed to go to a protected area behind his seat and brace himself. He started calming down as he realized he was not totally helpless, but was able to do something that helped him survive. With the awareness that he did do something came the realization he could take similar action in the future. Although he could not control an accident, he could control his response to it. He was asked to imagine a future similar situation, and, with eye movement, rehearse taking safety measures. He then realized that he could come up with a safety plan at the beginning of each train trip as to what to do should there be another collision. Being able to anticipate the future with some control greatly decreased his distress.

Following the workshop, he would begin each train trip by coming up with a plan of what he would do if there was another collision. He also would go over his plan with the other trainmen so if there was a dangerous situation, they would not get into each other's way. Several months following the workshop, the conductor was involved in another train accident. During the incident, he found himself acting in accordance with his previously rehearsed plan. It was an upsetting, distressing experience to again be involved in an accident. However, it was not traumatic. He felt more in control this time.

In the above example, once the dysfunctionally held information was processed, he could move from feelings of helplessness to the realization that he made decisions and took action that helped his survival. In recapturing his sense of efficacy, he was able to come up with and implement adaptive strategies to deal with anticipated danger. EMDR can be utilized to reinforce a positive future template for adaptive behavior. In the above case, EMDR was used in conjunction with mental rehearsal techniques to prepare for future incidents.

Application to Traumatic Grief

Another way blocked information processing is manifested following a traumatic event is the encoding of the traumatic information in the form of vivid sensations and images (Herman, 1992, van der Kolk, 1996). These sensory impressions may repetitively intrude causing significant distress and impairment in functioning. As illustrated in the above case examples, EMDR can facilitate the processing of the blocked information and reduce intrusive sensory experiences.

After a traumatic loss, the blocked information may be manifested by the bereaved only being able to experience negative, distressing images of the loved one (Shapiro, 1995). The bereaved, in identifying with the loved one and trying to comprehend what happened, may imagine horrible images so vivid that they interfere with, and prolong , the grieving process. EMDR can be helpful in relieving the painful negative images and facilitating access to positive memories, as the following example illustrates.

A man's fiancée was killed in an auto accident. He could only imagine what she must have experienced when she died and vicariously identified with the pain

(Continued on page 32)

(Crisis Intervention - Continued from page 31)

and suffering she must have gone through. He experienced very distressing negative vicarious images of the fiancée being killed, and also imagined a similar accident happening to him. He also experienced significant distress when he thought of places they went together or things they did together, because she was no longer here. In other words, he was unable to retrieve any positive thoughts or memories of her. He was very depressed, lost his appetite, and found it difficult to sleep. He started seeing a therapist several days after the incident because of his acute distress. Symptoms did not abate in the next three weeks despite twice weekly sessions. The client was referred for EMDR. While some therapists may not think that any therapy should be used following such a tragedy, clinical experience has shown that EMDR will not take away anything the client needs. Th vicarious image of his fiancée and associated cognitions and affect was first targeted. After forty emotional minutes, the vivid vicarious images seemed far away, and more neutral and positive images and memories of the fiancée started to emerge. With continued processing the client was able to emotionally connect to the memories with positive affect. Places where they had visited and things they had done together now were remembered with positive emotions instead of distress. After the session he could think of the fiancée with feelings of love and without negative vicarious imagery. In the next months, he continued therapy to help him cope with the loss.

In the above situation, the traumatic circumstances of the loss resulted in intrusive negative vicarious imagery and blocked any association to positive imagery or affect. According to the Accelerated Information Processing model, the negative information is held in dysfunctional, excitatory form. As a consequence, the negative information is more likely to be stimulated than other associations, thereby blocking access to positive memories and feelings. When the disturbing imagery association and events have been processed into a more neutral form, positive memories can then emerge with associated positive affect. EMDR is not a shortcut. The client still had to go through normal grief recovery phases (Rando, 1992), and benefited from continued therapy. However, recovery could now proceed unimpeded by the compounding effects of vicarious negative imagery.

(Continued from page 32)

A Word of Caution

The appropriateness of EMDR needs to be evaluated prior to implementation. If someone with many psychological vulnerabilities is involved in a crisis, many unresolved issues may arise, producing significant impairment in functioning. For example, a person with a borderline personality disorder or dissociative disorder, who is coping marginally, may be thrown into an even more dysfunctional state by a crisis. Initially, treatment would consist of stabilization procedures rather than EMDR, which could further open up a person to distressing emotions they are not ready to handle. It is important that the clinician have training in EMDR, as well as knowledge and clinical experience with crises and trauma, before utilizing it with critical incidents.

EMDR is not a "quick fix" and needs to be implemented within an overall treatment context. Sometimes an unrealistic core assumption is contradicted by a traumatic event (e.g., "I am always supposed to be in control") leaving the victim with no system within which to integrate the experience (Shapiro and Solomon, 1995). Longer term therapy may be needed to help the client create a new, more adaptive world view that can assimilate the event. EMDR can be helpful in such a case, but within an overall treatment plan that utilizes a combination of treatment methods and approaches.

Conclusion

EMDR facilitates recovery by accelerating the processing of dysfunctionally stored information, enabling the client to progress through appropriate stages of affect and insight, regarding such issues as 1) appropriate levels of responsibility, 2) present safety, and 3) availability of future choices. It is important that EMDR be implemented within an overall clinical framework. EMDR does not skip the phases of recovery. Rather, by accelerating the processing of dysfunctionally stored traumatic information, EMDR removes the obstacles that interfere with recovery, allowing the client to proceed naturally through phases of recovery.

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⇔

(Float-forward and Floatback - Continued from page 12)

the earlier association.

Additionally, the client-therapist bond is enhanced since the clinician can validate the client's experience (the present-day disturbance) by starting where the client is. The associations made come from the client, thus eliminating the issue of resistance to ideas or interpretations introduced by the therapist. The client comes to experientially *know* the connection of present to past using the Floatback Technique, again sidestepping avoidance and other defenses.

The Float-Forward Technique

While the Floatback Technique often enables clients to see and feel the connection between present problems and past events, the Float-forward Technique allows clients to identify and reprocess anticipatory anxiety and create positive future templates. It is a method that can be used at any time during the therapy process to address blocks, reluctance and, in some cases, resistance or secondary gain/loss issues. It is especially useful for targeting the client's fear of doing EMDR and should be considered before assigning tasks.

To use it, first ask the client to imagine the worst thing that could happen if they did "X" (e.g., try a new behavior, test a new skill, or pursue a new experience). What is the worst thing that could happen if you do EMDR? What is the worst thing that could happen if you got rid of this problem? What is the worst thing that could happen if you set limits with your boss about her expectations for your workload? The client may need help to identify the worst case scenario. Some suggestions include fear of losing control of their emotions, fear of losing control of bodily functions such as bowel or bladder control, having a panic attack, and not being able to manage their emotional life between appointments.

Once the client has identified it, set up the worst case scenario as an EMDR target by asking the standard procedural questions with a slight modification: Ask for an *image* that represents *the worst part of the worst case scenario,* e.g., "As you bring up a picture of doing ____, what is the worst thing that could happen?" Then proceed with the remainder of the questions along standard lines, i.e., NC, PC, VoC, emotions, SUDs and location of body sensation. Facilitate the client's processing of the target using eye movements or other stimulation.

If developing the client's worst case scenario elicits a fear that is rational, then practical measures may be needed to address these concerns. For example, using the Float-forward technique with a 13-year old boy in foster care elicited a worst case scenario of "I will be returned to the shelter if my current placement doesn't work out." During processing, his SUDs were reduced from 8 to 3 rather quickly but would not move lower. The client observed that it could not go lower because this "worst case scenario" could actually happen to him and had happened in the past. We discontinued the eye movements, debriefed, and made a plan for a) a session with his foster parents to discuss the permanence of the placement and b) a conference call with his legal advisor to clarify his rights and options. Returning to the target afterwards, he was able to reduce his SUDs to "1" with just a few sets of eye movements.

Using the Float-forward Technique to reprocess the worst case scenario, the client is given an opportunity to resolve the anticipatory anxiety. During the installation of the PC, the client is essentially creating positive templates for future action. A woman whose brother was verbally abusive in childhood and intimidating in the present day had a "worst case scenario" of "He'll be just as verbally abusive when I see him next time." The client had done a great deal of EMDR, reprocessing childhood incidents involving her brother's verbal abuse. However, without a positive experiential reference, she remained mildly anxious about interacting with him. Asking her to "float forward" and use EMDR to address the worst case scenario relieved her lingering anxiety about a pending family gathering. Installing a PC of "I'm stronger now" allowed her to create an image of herself handling her brother with humor and feeling confident.

By applying the Floatback and Float-forward Techniques, and therefore addressing *past, present and future*, EMDR clinicians can facilitate more thorough healing for their clients. Further, the Floatback and Float-forward Techniques are EMDR-based. Since both incorporate the use of the standard procedural questions, employing the techniques has the added advantage of giving the therapist and client another opportunity to become more fluid with the protocol.

[Many thanks to William Zangwill, Ph.D., for his development of these techniques and for his helpful comments on this article and the worksheet that appears on the next page.]

References

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Shapiro, F. (1996). *Eye Movement Desensitization and Reprocessing Level II Training Manual.* California: EMDR Institute, Inc.

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Floatback Worksheet

1. Target the presenting issue using the procedural questions as follows:

Issue/Memory: (*What issue or memory would you like to work on today?)*

Image: (*What image represents the worst part of that?)*

NC: *(What words go with that image/incident that best describe your negative belief about yourself now?)*

PC: *(What would you rather believe about yourself now when you look at that image?)*

VoC: *(When you look at that image_____, how true does the statement_____ (Please repeat PC from above) feel to you now on a gut level from 1 to 7 where 1 feels totally false and 7 feels totally true?)*

1 2 3 4 5 6 7

Emotions: *(And when you bring up that image_____ & those words_____ (Please repeat the image & NC), what emotions go with it now?)*

SUDS: *(On a scale of 0-10, where 0 is no disturbance or neutral, and 10 is the highest disturbance you can imagine, how disturbing does the incident/memory feel to you now?)*

0 1 2 3 4 5 6 7 8 9 10

Body: *(And where do you feel it in your body?)*

2. Link present issue to past event/s using the "Floatback" instructions:

"Now, please bring up that picture of ____ and those words ____, (please repeat client's disturbing image and negative cognition), notice what feelings are coming up for you, and where you are feeling them in your body. Now close your eyes and let your mind float back to an earlier time in your life. Don't search for anything, just allow your mind to drift back to a time when you had similar:

thoughts of _____ (repeat negative cognition)
feelings of _____ (repeat emotions above)
in your _____ (repeat places in body the where they reported sensation).

And when you're ready, open your eyes and tell me the first thing that comes to your mind."

3. Write the client's response here:

4. Target the earlier memory using the procedural questions:

Image: *(What image represents the worst part of this earlier memory ?)*

NC: *(What words go with that image/incident that best describe your negative belief about yourself now?)*

PC: *(What would you rather believe about yourself now when you look at that image?)*

VoC: *(When you look at that image_____, how true does the statement_____ (Please repeat PC from above) feel to you now on a gut level from 1 to 7 where 1 feels totally false and 7 feels totally true?)*

1 2 3 4 5 6 7

Emotions: *(And when you bring up that image_____ & those words_____ (Please repeat the image & NC), what emotions go with it now?)*

SUDS: *(On a scale of 0-10, where 0 is no disturbance or neutral, and 10 is the highest disturbance you can imagine, how disturbing does the incident/memory feel to you now?)*

0 1 2 3 4 5 6 7 8 9 10

Body: (And where do you feel it in your body?)

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This Directory is provided to give EMDR-trained clinicians an opportunity to join a Study Group in their area. These are "no fee" discussion meetings. If you would like to join a Study Group, please contact the group leader in your area. *[Please Note: Although Study Groups are listed in this EMDRIA™ Newsletter, these groups are not an affiliation of EMDRIA, nor does EMDRIA warrant or otherwise assume responsibility for content of meetings nor competency of group leaders.]*

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It's Not Too Early . . .

to begin making your plans to attend the 2000 EMDR International Association Conference in Toronto, Canada from September 8-10, 2000.

Inside this Issue of *The EMDRIA Newsletter*:

Events and Deadlines

October 20, 1999

Deadline for submissions for December 1999 issue of *The EMDRIA Newsletter*

December 1, 1999

Deadline for Call for Papers for the 2000 EMDR International Association Conference

November 11-13, 1999

16th Fall Conference of the International Society for the Study of Dissociation in Miami, Florida

September 8-10, 2000

2000 Annual EMDR International Association Conference in Toronto, Canada.