

The

# EMDRIA Newsletter

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## From the President: David Wilson, Ph.D. Acknowledgements

In this final column, I want to acknowledge and to remind you that you are part of the first major innovation in psychotherapy in the past 50 years. As a core member of the EMDR community, you have demonstrated the intelligence, insight, and vision to recognize that there is something in EMDR which is truly different, truly a major contribution toward effective psychological treatment. I want also to acknowledge the resistance to EMDR by some members of the academic/research community, and to say a little about that.

Not many new Ph.D. psychologists make a major contribution to the field and establish a name for themselves right out of the gate. In doing so, Dr. Shapiro incited a great deal of professional jealousy and efforts to put her in her place. The rules of the academic/research game are such as to award small, incremental steps, and I think too often petty, if not trivial contributions. Dr. Shapiro's Meteoric success has not set well with some academics who have put in their time and paid their dues, but not contributed very much. Giant steps is not the way the game is played. Yet that is how major contributions are made. And all major contributors - Freud, Rogers, Reich, Perls, Ellis, Wolpe, et al - have met with major resistance in the beginning of their work. Fortunately, for us, many major players in the field, those whose primary commitment is contribution rather than personal reward - Wolpe, van der Kolk, Stickgold, Nathanson, Rossi, et al - have recognized the value of EMDR, and contributed to and supported our work.

*For these folks, I wish to extend our gratitude.*

Finally, in this section, I want to acknowledge the source of EMDR. At conferences, award banquets, and such, after the applause died down, I have heard Dr. Shapiro say a number of times, "If you

were in my position, you would have done exactly what I have done." I appreciate her confidence in us, but I don't think so. True, there are now many of us who have the intelligence and insight to appreciate the potential effect she discovered. There are even some of us who have the creativity and ingenuity to develop the effect into clinical applications. Maybe there is someone else

in the EMDR community who has the commitment and tenacity to carry on in the face of sometimes scathing personal criticism. Possibly, there is someone else out there who has the vision, compassion, and heart which Dr. Shapiro demonstrates. But I do not know of anyone else in the community who has the combination of intelligence and insight, creativity and ingenuity, vision, courage, compassion, and sheer tenacity to do what she has done. Hence, I think it appropriate that all of us continue to acknowledge Dr. Shapiro for the contribution she is, and for making it possible for the rest of us to participate in this journey.

Once again, I note that if we are to give EMDR the audience it deserves, the movement needs your support:

- To hone your skills in EMDR to be the best clinician you can be;
- To present at conferences, conventions, and such, as well as speak out from your personal and clinical experience;
- To produce and/or encourage and support high quality research;
- To support that which supports you by continuing your participation in EMDRIA and the EMDR community.

*Thank you~*

## Highlights

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## The EMDRIA Newsletter

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## From the Desk of the Executive Director

*Carol York, MSSW, LMSW-ACP  
Executive Director  
Conference Chair*

The opposition to EMDR is alive and well! Over the last quarter, EMDRIA has begun to talk to more EMDR clinicians and researchers who are frustrated and angry that the use of EMDR is being blocked in such settings as hospitals, by insurance companies, foster care agencies, etc. Many professionals and consumers are reporting and complaining that other mental health professionals are touting EMDR as ineffective and offers that the research supports these claims. It has been reported that various universities are not supporting students and/or academic professionals in their desire or efforts to do research in the study of EMDR and have even become active in blocking this

type of research in his/her university. EMDRIA had decided to become proactive in this debate and controversy. The Public and Professional Relations Committee has worked diligently in putting together "Ten Compelling Points About EMDR" for dissemination at the APA Conference. This document is an attempt to cite research demonstrating the efficacy of EMDR; to address the issue of whether eye movements are critical to the effectiveness of EMDR; to outline that EMDR is more than eye movements, but an integrated psychotherapy treatment; to promote the need to meet the standards of EMDR training and practice; and last, but not least, a call for respectful dialogue about EMDR.

Recently, I received a phone call from an EMDRIA member desperately needing studies on EMDR that show its effectiveness because the hospital in which he worked was barring the use of EMDR. There was a meeting being held within two days of this phone call and effective studies on EMDR were crucial information. I explained that we had the document which was being prepared for the APA Conference and suggested it might be more informative and helpful to his case. I was quite delighted when I received a fax the following week informing me that the meeting resulted in EMDR being approved as a treatment modality.

If this has happened to you, or if you know of a similar situation, please consider joining EMDRIA in its efforts to speak up. Ask for a forum to allow discussion and help educate others. Be informed, yourself, so you can inform others. Each one of us individually and collectively can make a difference!

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# Administratively Speaking

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*Jennifer Turner, Associate Director  
Newsletter Editor*

The EMDRIA Newsletter is the voice by which EMDR practitioners are heard. Over the past several years, it has been used to apprise clinicians of current trends and findings in EMDR, as well as the growth within EMDRIA itself as it has grown into the successful association we see today. Our membership has nearly quadrupled in the last 3 ½ years! Many factors can account for this; a hard working and loyal staff, a diversely talented and ambitious Board of Directors and Officers, a talented and resourceful Executive Director, and perhaps the most important aspect, a generous and dedicated membership. We have said many times that without you, the membership, there is no EMDRIA. It should also be said that without your help, your generosity, and your dedication to this work, there could be no EMDR. The importance of continued training and education in EMDR can be no better gauged than by the growth of this year's Conference. As this issue goes to print, we have counted 800 attendees, with several weeks still to go. This is a 200 person increase

to date, which is unprecedented growth for any association and a true calculator of the thirst for knowledge that we consistently encounter in the EMDR community. With each person who becomes trained in EMDR, we grow; with each person who becomes Certified, we gain credibility and protect the public; with each person who becomes an Approved Consultant, we support on-going education and growth in EMDR; and with each person who becomes an Approved Instructor, we expand our ability to help others. This is EMDRIA's mission, this is why we are here.

As the association has grown, so has the staff needed to administer it. When the Administrative Office opened in 1997, there were only 3 of us to staff it, and we were all part-time. We had 900 members. By 1998, we had added additional hours to our schedules as well as a full-time Administrative Assistant/Asst. Conference Coordinator, Gayla Turner. We had also doubled our membership to 1800 members. In 1999, we brought in Terri Curtis to

take over the massive amounts of data entry for the membership and conference. Later that year, Sarah Tolino joined us part-time to manage our shipping and orders for the various publications and brochures we were now offering to our members. By the end of 1999, we had grown to nearly 3000 members. In early 2000, Sheila Kulczyk joined our team to take over the telephones and data entry as Terri moved on to work more with Regional Coordinating and the overwhelming response we had to Certification. To date, we have over 3600 members and continue to grow daily. The staff, under the guidance of Carol York, has grown to be talented and diverse in their jobs. They have excelled in their job performances and provided EMDRIA with the ability to consistently and efficiently grow and improve itself. Each staff person is committed to the work done with EMDR, this is why they are here.

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# THE CLINICIANS CLIPBOARD



## EMDR and COMPASSIONATE PSYCHOTHERAPY: A NEW TREATMENT FOR CHRONIC PAIN?

Mark Grant & Ann Just

Since its inception as a treatment for trauma, there have been increasing reports of EMDR being efficacious with pain. (McCann, 1992, Hekmat Groth & Rogers, 1994, Wilson, Becker and Tinker, 1997, Grant 2000). EMDR is an integrative method with many different components. One of these is the therapeutic relationship. Compassion is also an essential element of any effective intervention (Rubins, 1986, Waldman & Waldman, 1996). However, it is often confused with empathy or pity, indicating the need for a definition based on a concept analysis (Just, 1998). Given its importance in the therapeutic process, and the effects of social isolation on chronic pain sufferers, it is remarkable how little consideration is given to this topic.

- Compassion means being responsive to and entering into the "space" of another's suffering.
- Compassion requires a willingness on the part of the therapist to temporarily set aside his or her own fears, prejudices, and needs coupled with a commitment by the therapist to the patient's welfare.
- Compassion is not pity (which has its roots in fear for self).
- Compassion is also impartial; the boundary between therapist and patient is maintained while the therapist supports the patient to find their own answers.

Therapeutically speaking, the compassionate therapist provides a psychological 'container' for the patient's experience. Compassion reduces anxiety and facilitates the

development of safety which are necessary preconditions for the kind of confrontation with pain that an exposure-based approach, such as EMDR, involves. It is the combination of safety and support which gives the patient the motivation and willingness to face what he/she has previously avoided. It is a core element of treatment. As Waldman & Waldman (ibid) have stated, "even when the most sophisticated pain management techniques are utilized, the most effective modality in the care of the patient is the informed, caring and compassionate health professional."

*"It makes me feel like a human being, ...It relieves my fears, it allows me to deal with my pain in a positive and confident manner, gives me confidence and motivation to use treatments which are non-drug related and try to get well again."*

- patient treated with compassion

Compassion would appear to be an important element of EMDR in the treatment of disorders where a lot of suffering has been endured, or where there is shame present. It is certainly a powerful compliment to any therapy, including EMDR. Perhaps it deserves further attention.

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## EMDR CASE STUDY: MICRONESIA

Laura L. Post, MD

As a physician board-certified in Psychiatry, Addiction Medicine, Addiction Psychiatry, Sexology, Traumatology, and with credentials in Massage Therapy, EMDR, and as a Forensic Examiner, I have worked in almost every practice setting imaginable and with a broad variety of patients. Having been based from a hospital, community clinic, halfway-house residence, private office, Veterans Administration Medical Center, training institution, and doing outreach on the streets, I am clinically familiar with the behavioral challenges of children, adolescents, young adults, old adults, couples, families, and groups manifesting acute symptoms and exacerbations of chronic disorders, with and without chemical dependency, physical problems, and sociological impairments. I like to teach trainees, do interactive lectures, travel and experience 'difference.' It is thus that I have found myself a settled homeowner on Saipan, a Manhattan-sized island that, as part of the Commonwealth of the Northern Mariana Islands (U.S.), is the farthest-flung American overseas possession. Always the outsider; here among the various tan tones of complexion found among the indigenous of the western Pacific, I have experimented with several interventional strategies, both to establish rapport and some trust and also to start creating that unique and culturally competent treatment modality that will foster growth among my patients. Cognitive-behavioral approaches generally work better than insight-oriented ones because of the 'here-and-now' mindset of Chamorros, Carolinians, Yapese, Chukese, Pohnpeians, Kosraeans, and Filipinos who comprise the population base here. Let me briefly discuss one fascinating case. Twenty-two year old Chamolinian woman, married and with three young children was involved in a minor motor vehicle accident. This accident was a spinoff of a more serious one primarily involving two other vehicles. In a large truck (Toyota T100), she was not hurt, and the two children riding with her were also unharmed.

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However, the younger of the two children present at the crash, also the youngest of the brood of three offspring, began experiencing nightmares of the crash in which her mother (who was driving) was killed. Ostensibly, the little girl was brought in to see me for treatment, but one two-hour-long session with a sand tray appeared to relieve her subjective trauma residua and to entirely eliminate her nightmares. Upon bringing the child back for a second visit (unnecessary, as it turned out), the suffering mother began to cry and to tell me about her own intrusive recollections and fears of sleep. I briefly introduced EMDR verbally - Micronesians are not principally writing-centered - and she agreed to try it even though it sounded silly to her. Two visits later, this woman, initially recalcitrant, proclaimed that she had anxiously and cautiously driven herself to the appointment, even though she had not been able to direct a car since the incident. Between the second and third visit, my mother passed away unexpectedly on the mainland, and I rushed stateside to collect the rest of my family and take care of arrangements. Of course, this patient was notified of my emergency and her third appointment with me was cancelled. Upon my return, I nonetheless felt bad and guilty for having seemingly abandoned her during an involved part of her therapy. Despite several messages left at her home and a letter written to her address of record, the woman neither re-contacted me to reschedule, nor let me know in any way that she was upset or disappointed in my hasty departure. Around Christmas time of that same year, three months later, I ran into the [former] client at an island-wide fiesta. I had planned on being friendly, but not chatty (entirely avoiding someone is like a public curse in this small community), when, to my astonishment, she approached me. She threw her arms around my neck, kissed both cheeks exuberantly, and whispered that I had helped her so much by waving my hands and that my unplanned exit from her life had, moreover, caused her to see that her problems weren't the worst and forced her to just do it. She blessed me, told me that she had said prayers for my mother while I was away (the island is so small that she knew why I had gone even though no one officially told her), and wanted me to know how happy she was now teaching her eldest child to drive.



Future columns of the *Clinician's Clipboard* would like to highlight different techniques and tips from EMDR Clinicians. The articles are anecdotal in nature and have not been proven with research or controlled studies. If you would like to submit a short case study or technique you have tried, please send your article to Jennifer Turner at [emdriaJT@aol.com](mailto:emdriaJT@aol.com) or by fax at (512) 451-5256.

## From the Public, For the Public: “My Experience”

*The following is taken from an e-mail received by EMDRIA and is reprinted with permission from the author. We often hear feedback from the professional community, but not from those people most affected by EMDR, the client. Janice agreed to have her comments published in the hopes that her voice may reach others. Janice also wished to credit her therapist, Mary Bosley, and her colleague, Timothy Clark, for guiding her through the EMDR process.*

“For Almost two decades I have been trying to put the pieces of a broken childhood into an understandable order. Each attempt would bring me closer to the truth. The last two years of therapy have been the most successful of all, but there was an obstacle that I just could not overcome. My therapist suggested EMDR, and even after I did some searching on the internet, I wasn't sure if it was something that I wanted to try. Since I trusted my therapist 110%, I decided to take the chance. I went into the process with no expectations, and came out of it with no explanation..all I know is that it worked! It would take too long to explain the before and after stories, and there are parts of the process that I am still amazed at. I know that I was in the right place and time in my journey to be receptive to the process. All those freeze frame photos of my past are now just a big long mural, where I can look back at things and put them in their proper perspective, and look to a brighter tomorrow. Thank you for promoting the EMDR process...

**I am a believer!!”**

J. Copley  
Cape Cod, MA

# Accessing Pre-Traumatic Prenatal Experience Using EMDR: Uncovering a Powerful Resource of Equanimity, Integration, and Self-Esteem in the Pre-Traumatized Self

Brian Lynn, MD, B.Sc., M.Sc.,  
Level II, Consultant

This article is a preliminary report on the remarkable results some of my clients and I have been achieving using EMDR to target prenatal trauma, with a focus on the discovery of an experience of the self prior to any trauma occurring and the enormous healing power that derives from revisiting and reactivating this extraordinarily positive pre-traumatic experience. It is with some hesitation that I am reporting my experience with prenatal trauma processing, as I do not wish to be seen as on the fringe or even over the edge by my colleagues. However, I realize that I was able to overcome my prejudices -through examination of the facts- about the nature of prenatal experience, when memory begins, and how it can be accessed. I have found there is a body of scientific investigation and knowledge on prenatal experience and trauma, and that indeed we do experience and are influenced by our environment in the womb. We can learn from such experience, and therefore, can be traumatized prior to birth. The prenatal self can feel and record this experience. I refer the reader to [www.birthpsychology.com/resources/index.html](http://www.birthpsychology.com/resources/index.html) for a list of publications on this matter. The various kinds of pre- and perinatal trauma and the deep healing that results when processed with EMDR will be the object of other articles by myself and Dr. Heather Pearson, who is also investigating this same field. What I intend to focus on here is the discovery of a pre-traumatic experience at the embryonic stage, which I have found to be a remarkably powerful internal resource for healing, already developed and installed, simply requiring reactivation. When I saw the powerful healing results of reactivation of this pre-traumatic experience in a number of relatively “stuck” clients, I felt ethically bound to report this immediately to other clinicians using EMDR so that others may benefit.

To illustrate this phenomenon, I will describe the case of the first person with whom I used this embryonic neural network reactivation (memory retrieval?) technique.

I have been seeing Miss A., a 53 year-

old retired school teacher, for a number of years on a twice weekly basis for chronic depression and generalized anxiety. The pertinent details in her history are as follows. She was the first born to a very anxious and emotionally immature mother and a post WW II-veteran father, who appears to show signs of PTSD. At a very young age, Miss A. took on the role of caretaker of her mother’s and father’s emotional well-being. She subsequently became a mother substitute for the three sisters that followed, and naturally, came to feel excessively responsible for the well-being of everyone around her in later life, at the expense of her own well-being. The entire family was dismissive of feelings of suffering, and when Miss A. was diagnosed with rheumatoid arthritis and fibromyalgia as a young adult, she found little support from her family, who remained her main social contacts. She had been deeply hurt by her father’s focus on himself and the physical beauty of her sisters, and lacked confidence that she could be attractive to a man. In preparation for EMDR treatment, Miss A. could not find a safe place no matter what we tried, and the light stream and other relaxation exercises failed to work. Nonetheless, we targeted numerous traumatic memories from her childhood using EMDR, and she progressed and made many positive changes in her life, including spending less time and energy taking care of her mother and father’s emotional and physical well-being and feeling less guilty about taking care of her own needs. But somehow, the processing never went to complete adaptive resolution, with the SUD never going down below 3, and the positive cognition never going higher than 4 or 5 on the VoC scale, no matter what the target. We tried processing blocking beliefs, with the unfortunate looping of blocking beliefs that block processing of other blocking beliefs. We tried processing feeder memories, including early babyhood targets, but again to less than full resolution. I had discovered through the perinatal psychology literature that some clients’ trauma starts in the womb when maternal anxiety is transmitted via adrenaline (and cortisol) transfer across the placenta to the fetus (producing the equivalent of a panic attack), and I had seen remarkable unblocking and successful deep processing (i.e., symptom resolution) in a number of clients with chronic anxiety, panic, sleep, eating and other disorders when we targeted this prenatal trauma. Miss A. and I found that this prenatal transplacental adrenaline

transfer was indeed the tip of the root of her anxiety, and her sense of neither belonging nor being special, but none of the maneuvers I have been using for other clients, such as the “physical interweave”, worked for Miss A. (see my website [www.voc7.com](http://www.voc7.com) for further elucidation of this and other techniques used). As I reviewed embryology, I noted that before 5 or 6 weeks gestational age, the placenta has not developed a connection between maternal and embryonic circulation that would allow for such transplacental transfer of the molecular mediators of the fight, flight or freeze response. Therefore, I decided to ask her if she would try to go back to the stage prior to placental connection; i.e., to less than 5 weeks gestational age. We started with the light stream exercise (which Miss A. never derives any relaxation from), in combination with computer-generated tactile alternating bilateral stimulation and some suggestions about going back to a time prior to trauma, when the primitive nervous system (we have a brain at end of the fourth week gestational age and about 125,000 neurons in total) presumably stored the experience. Within minutes, to her and my surprise, she experienced deep relaxation, and exclaimed, “This must be *relaxation*, which I have never experienced before!” Indeed, as a chronic pain sufferer, Miss A. has tried virtually every relaxation technique, including deep relaxation exercises, massage, physiotherapy, biofeedback, wax immersion and warm floatation baths, and yet nothing had ever worked. I encouraged her to stay in this new found state of relaxation for the entire appointment, and when I asked for a positive cognition half way through, she said, “I belong” and later, “I am important” with a VoC rating of 7 for each. I was astonished at the knowledge of self worth that she had accessed so quickly through this process. At the time of writing, I have guided her back to that pre-traumatic experience 7 times: each time she is re-experiencing a profound sense of peace and well-being, and the positive cognitions remain completely valid to her. In terms of symptoms, we are seeing a generalizing effect: Miss A. is reporting new

“This must be  
*relaxation*, which I  
have never  
experienced before!”

behaviors that were previously outside of her repertoire due to anxiety, such as spontaneously calling on the neighbors for a visit, and feeling comfortable the whole time. She is reporting **enjoying** -for the first time in her life-activities, such as aquatic fitness, that are centered on self-care, not other-care. She reports feeling more rested and content with her life. She said the other day, "I think I'm happy!" and "I have been thinking about how I am getting all my needs met". These are extraordinary statements from this previously melancholic and pessimistic person.

I have tried this technique with other clients, having them close their eyes and using alternating bilateral tactile and/or audio stimulation (using a "heartbeat" sound for the latter). I have found that *most* clients rapidly experience the same profound sense of equanimity and self-worth. Each reports the experience using their own frame of reference; thus, for example, some report a detailed "spiritual" experience while others report it being like a state of deep meditation or as a remarkable mental clarity. Some cannot get to this state of tranquility, but I have found that the pre-traumatic neural network storing this experience seems to have been activated whether they *feel* it immediately or not. Therefore, when I encourage these clients to let whatever happens happen, I have observed profound unblocking in their healing process (such as the sudden de-repression and successful processing of memories containing blocking beliefs like "I deserve to be punished and therefore not to heal") as if a higher level of self has taken over and is driving their mind towards healing resolution. I have been experimenting with the use of this experience to enhance therapeutic results. I have used it with others in the same way as I have with Miss A.; i.e., simply assisting them to get to this mental state each appointment. I am seeing a generalized effect in each client that I do this with, with reports of positive shifts in day to day functioning occurring. In others, I have started with helping them to get deeply into this state to use it as a resource, as in Andrew Leeds work, and then suggest that they take this positive knowledge and feeling about themselves as we proceed into processing the next trauma targeted. I use Maureen Kitchur's Strategic Developmental Model, targeting traumatic experiences chronologically. Some clients spontaneously move from the positive cognition that comes up for them in the pre-traumatic state along a channel of memories that contain the corresponding negative cognition, processing rapidly and deeply as they go. Some people report a perfectly clear and logical frame of mind in which problem solving becomes

straightforward and efficient. Others report a higher level of creative thinking.

I am describing this phenomenon as activating embryonic neural networks, and therefore, accessing embryonic memory, although there is no way to prove that such is actually the case. It could be argued cogently that what is happening in these clients is due entirely to suggestion. I am leaning towards the explanation that clients are, via suggestion, accessing embryonic neural networks containing actual memory (stored as feelings) with an overlay of adult interpretation of these feelings. The fact that Miss A. was not previously at all responsive to deep relaxation or hypnotic suggestion argue in favor of this conclusion. The fact that single neurons in vitro demonstrate the ability to record experience of stimuli makes plausible the idea that a developing human embryo whose brain and spinal cord contain around 125 thousand neurons can store experience. The idea that we start life with a primordial sense of our worth and power fits with evolutionary survival of the fittest, since the fittest are those with the highest realistic self-esteem. Our abusive or misguided upbringing and other negative experiences may result in a burial of this primordial authentic self under a deep layer of negative self conceptions. While these

questions are being sorted out, I will continue to use this remarkable, powerful, and accessible resource because of the depth of healing that I am seeing in my clients. As is true for EMDR itself, knowledge of the mechanism is not necessary for the achievement of extraordinary results.

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*The theories contained in this article are anecdotal in nature and have not been proven through research or controlled studies. It is the intention of the EMDRIA Newsletter to provide a forum for discussing case studies and theories among EMDR clinicians.*

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**Printer: Insert Shirley-Jean Schmidt Ad Here**



# Your Regional Meeting: Helpful Hints & Tips for a Successful Meeting

Rosalie Thomas, R.N., Ph.D.,  
Chair, Regional Coordinating  
Committee

**T**hank you to all of the Regional Coordinators! You have made a commitment to support the growth of EMDR and EMDR clinicians at the local level. You've provided a range of opportunities for newly trained EMDR practitioners to get to know each other, to review the basic protocol, to venture into incorporating EMDR into their clinical practice, and to feel the support of the EMDR community. You've helped to keep therapists "on the track" (sorry, Francine!) of fidelity to the method. You've provided opportunities to advance the practice of EMDR by providing information on specialty applications, sharing new ideas and research. You've also encouraged the development and exchange of ideas and provided opportunities for your local talented presenters to try their wings before going on to larger meetings or conferences. You've done all of this, while also trying to meet the non-profit criteria, and you've done it on a shoestring. Good work!

Now we want to provide a format for you to share your ideas with each other. Last winter we asked you to complete a survey. We wanted to know more about how you are doing all of these things, what seemed to be working the best, what you've tried that didn't work as well, and any particular interest areas for future development. Here's what you had to say:

*Having a regular meeting time and clear structure seem to contribute the most to successful meetings.* Participants anticipate and plan for the meeting as part of their schedule. They feel more a part of an ongoing supportive community. The frequency of meetings varies a great deal. Some Regions meet monthly, some quarterly, some two or three times per year, and some yearly. Regardless of frequency, those that follow a regular structure seem to have the best attendance. For example, one Regional Meeting occurs on the third Sunday of January, April, and October for three hours. They devote one hour to general discussion of EMDR, current research, or other current

information provided by the participants, one hour to case consultation in a group format, and one hour to a prearranged presentation. Now that participants are interested in EMDRIA Certification, it's also helpful to have a portion of the program approved for EMDRIA Credits. Some meetings encourage additional smaller and more frequent clinically based meetings among participants. The primary pitfall regarding structure was that of either having randomly scheduled meetings, or no clear agenda.

*Along with a consistent schedule and structure, many of you suggested that a consistent location was helpful.* Some meetings are held at local schools or colleges, some at libraries or churches, some at apartment complex clubhouses, and some at offices. While we would encourage everyone to be mindful of special needs on a regular basis, larger presentations require a more formal venue and that the requirements of the Americans with Disabilities Act are met.

*Most Regional Coordinators report that hands-on, practical topics are the most useful.* People like to participate. Devoting time each meeting to an open forum where members can raise issues for group discussion and consultation has been very successful. In addition, a more formal presentation by a member of the group allows participants to more systematically develop their information base. This allows members who are interested in developing their presentation skills to do so in a "user-friendly" environment. New presenters can use the experience as a stepping stone to larger meetings or conferences. Some Regional Meetings have organized a lending library of tapes and other materials to share with members. This can also lead to group discussion of the material. One helpful suggestion was concerning role-playing or live demonstrations. Since these are typically small and close groups, it is better to work in dyads or to show a video to demonstrate skills. Having one group member volunteer for a live demonstration may leave them too vulnerable in a group of peers. The main problem reported in the area of meeting content had to do with presenters and finances.

As you know, there is no start-up money for your first meeting and there may be considerable expense. We've reminded you that because of the not-for-profit status of EMDRIA, and at the advice of EMDRIA's legal and accounting consultants, you must keep your own records and carry the tax liability of the Regional Meetings. That means that first

you should get some advice from a local accountant about the laws in your state. Set up a plan that will minimize your liability and tax risk and that will help you to keep the records necessary for EMDRIA and for your own financial accounting. Contact the EMDRIA office if you have any questions about this. Once you are up and running, it is permissible to carry a balance forward from meeting to meeting as an operating expense. The balance only has to be dispersed if the Regional Meeting is disbanded. At that point, any remaining funds have to be donated to another not-for-profit organization such as HAP or EMDRIA. For all of these reasons, most Regional Coordinators have found it helpful to keep operating expenses at a minimum. Several Regional Coordinators have come up short after making commitments to expenses, usually towards venue or presenters. They have had to provide extra money "up front" until the Meetings are financially able to reimburse them. We wish there were a better way to do this, but haven't found anything to date.

As a part of getting started, the EMDRIA office will help you obtain the mailing labels for those clinicians in your Region trained by the EMDR Institute. At your meetings, you can ask participants to pre-address post cards for notice of future meetings, or you can use email. Either seems to work. We encourage you to update your list regularly through the Institute, and particularly after there has been a Level I or Level II training in your area.

To best handle all of the details and avoid that last minute crunch, it was suggested that you plan ahead, work closely with your support staff at the EMDRIA office, get other group members involved in the program planning and logistics, and develop a meeting structure that works in your area. You won't have to reinvent your wheel or your paperwork with each meeting application.

By now you're probably asking why you would want to do all of this! I'll remind you. It's because you're committed to the mission of the Regional Coordinating Program: To create an opportunity for accessible and on-going education in EMDR at the local level, to provide a format for local providers to become acquainted with the EMDR community, get support, and to share and develop skills and ideas. Besides, you're good at it! Thanks to all of you!



# Healthcare Committee

## Updates:

### Aetna Healthcare: A Brief Saga

Mark Dworkin, CSW, LCSW  
Chair, Healthcare Committee

After our success with Value/Options, The Healthcare Committee is tackling issues with Pacificare, United Behavioral, Magellan, and Aetna/US Healthcare.

I have taken on the task of negotiating with Aetna, myself, and have the following "story" to report to you all:

I contacted their Chief Medical Officer (CMO) and after a cordial dialogue, he was willing to read our information packet. He said that it would take a few weeks to review before a determination was made on whether there was sufficient research to warrant certifying specific EMDR treatment for PTSD. This call was made on November 1, 1999. Jennifer Turner, Associate Director of EMDRIA, has been a great help and support to my committee and deserves great praise. She is the one responsible for the excellent working relationship with my committee.

I re-contacted the CMO on January 21, 2000.

His office acknowledged receipt of all our materials, and his secretary informed me that it had been sent to the CMO for mental health and substance abuse. I was connected to his office and spoke briefly with him. He was cordial, but apologized because there must have been a problem on interoffice communication because his had not received any of our materials. He suggested that we re-send the materials directly to him and he would personally ensure that the review would be "fast tracked" and that we would have an answer within 2 weeks. EMDRIA again sent the materials.

I then called his office 2 weeks later to get a progress report. He was quite abrupt. He said that he had forwarded the materials to the appropriate reviewer and that a decision would take several weeks, after careful study. On Wednesday, April 5<sup>th</sup>, EMDRIA had not received any correspondence from Aetna. Once again I attempted to contact the CMO for mental health. At first, the secretary who answered the call said that this was not his office, and that she did not know of this doctor. She suggested that I be transferred to the operator, which I was. The operator said that she was sorry, but there was no doctor by that name listed. I then asked to be connected to the overall CMO whom I originally spoke with. His secretary gave me the CMO for mental health and substance abuse's number. This was the same number I had originally dialed!

When I explained the

dilemma, she very nicely offered to stay on the line while she transferred me. This time another secretary confirmed that this was the right number, but that the doctor was out of town, and she could not find the materials. I explained the growing saga to her. She was gracious enough to contact the Associate CMO for mental health and substance abuse, who had told her that the CMO had given the materials to someone to review?! The secretary promised to call me on Monday, the 10<sup>th</sup> of April, because the CMO was out of town on business and would return then.

She called me on said day to tell me that a child psychiatrist is reviewing the information. I informed her that EMDR is for the treatment of PTSD and that it is a method of treatment that goes through the life span. She acknowledged what I had told her, and would try to have the material reviewed soon. She suggested that I call back in two weeks. This is fairly typical of MCO's. There has been no response from them to date. Currently, the President of EMDRIA is writing a formal letter to Aetna. This saga is for the benefit of the uninitiated.

**"MY COMMITTEE NEEDS YOUR HELP!"**

### For Successful Regional Meetings:

- Plan ahead
- Develop a clear and consistent structure
- Meet on a regular schedule and at a consistent location
- Update your mailing list as Level I and II Trainings occur
- Work closely with the EMDRIA office and utilize available forms and checklists
- Keep and submit accurate financial records

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# State of the State

David Wilson, Ph.D.

EMDRIA Past President

In my first Newsletter column last September, (Vol. 4 Issue 3), I reviewed the organizational priorities and specific goals established by the Board at the Long Range Planning Meeting last June. In that connection, we have continued to advance our ongoing priorities:

1. Under the leadership of Chair, Curt Rouanzoin, the Standards and Training Committee has established a process for certification and requirements for ongoing Continuing Education which has expanded the framework and expectations for what it means to be “trained in EMDR”.
2. The subset of EMDRIA membership involving research has produced increasingly more systematic, sophisticated, and rigorous research.
3. The Conference and our ongoing publications continue to provide a forum for innovations in psychotherapy derived from EMDR.

***So far as our specific goals for this year are concerned:***

1. We have established a consistent weekend for the Conference on the last weekend in June each year, beginning in 2001.
2. This year’s Conference is organized to provide special interest and student tracks.
3. Under the leadership of Publications Chair, Dan Merlis, with major contributions by Ricky Greenwald, the special issues of the Newsletter represent a major step toward creating a professional journal.
4. We have yet to establish a research library online, but the Research Committee has created a listserv in support of researchers.

Finally, as indicated in my prior members column in June (Vol. 5 Issue 2) as an organization, EMDRIA is hitting on all cylinders. All the organizational structures are in place. We have strong Chairs and Members for our Committees, Chairs who are responsible

and accountable and good for their word, and Committee Members who participate and contribute. All the projects and services we envisioned at the outset are up and running or well in progress.

## ***On the Benefits of Participation in Governance:***

As the Past President of EMDRIA, next year, my primary responsibility will be to Chair the Nominations and Elections Committee. Consequently, I want to start recruiting early by promoting the benefits of participating in the governance of our association, based on my own experience.

Some of the benefits are obvious:

~I have the satisfaction of contributing to something I consider a good cause.

~Although organization was already one of my strong suits, I have become much better at organizing tasks.

~I have become much better at delegating tasks.

~I have become much better at saying “no”.

Some of the personal benefits are not so obvious:

Steve Lazrove, the first President of EMDRIA, described his year in office as a “purification rite.” At the time, I thought he was overstating the matter. At this point, near completion of my term, I believe he was understating the case.

~I have dropped all personal and professional activities which I do not find rewarding or to which I am not fully committed.

~I have dumped all of those projects I am never going to complete.

~I have gotten rid of everything I do not or will not eat, wear, enjoy, or use in some way. My house and grounds are clean, neat, and orderly, including the garage, closets, and drawers.

~My finances are in order for the first time since my 1991 divorce.

~I have lost weight.

~I am taking Monday’s off for paper work and administration, working less, working smarter,

enjoying it more, and making more money.

~I am doing my best therapy I have ever done in 36 years in the field and my practice is flourishing.

~I am spending more time and better quality time with my wife, family, and friends.

~Last, but not least, I have learned how to dance.

If you want to make a big contribution to yourself and others, I recommend that you participate in the governance and administration of EMDRIA. There is no EMDRIA without you!

*“Last, but not least, I have learned how to dance.”*

*~David Wilson*

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# EMDRIA CREDIT SCHEDULE

*As of 8/1/00*

Provider # Program #	Provider Name Title	Contact	Phone No.	Dates Location	Presenter(s)
99003 99003-02	EMDR Institute <b>2000 Vacation Workshop</b>	Staff	831-372-3900	<b>12/4-12/8/2000</b> Whistler, BC Canada	<b>Marcia Whisman, LCSW</b>
99019 99019-07	Andrew Leeds, Ph.D. <b>Strengthening the Self: Creating Successful Treatment Outcomes for Adult Survivors of Neglect &amp; Abuse</b>	Andrew Leeds	707-579-9457	<b>10/28-29/00</b> Denver, CO	<b>Andrew Leeds, Ph.D.</b>
99003 99003-02	EMDR Institute <b>2000 Vacation Workshop</b>	Staff	831-372-3900	<b>10/16-20/00</b> The Sea Ranch, CA	<b>Francine Shapiro, Ph.D.</b>
99019 99019-06	Andrew Leeds, Ph.D. <b>Strengthening the Self: Creating Successful Treatment Outcomes for Adult Survivors of Neglect &amp; Abuse</b>	Andrew Leeds	707-579-9457	<b>10/14-15/00</b> Seattle, WA	<b>Andrew Leeds, Ph.D.</b>
00009 00009-03	Alvarez/Luber Seminars Series <b>Using EMDR for Performance Enhancement in Career &amp; in the Creative and Performing Arts</b>	Elaine Alvarez Marilyn Luber	215-545-8296	<b>10/14/00</b> Philadelphia, PA	<b>Sandra Foster, Ph.D.</b>
99003 99003-02	EMDR Institute <b>2000 Vacation Workshop</b>	Staff	831-372-3900	<b>9/18-22/00</b> Gualala, CA	<b>Francine Shapiro, Ph.D.</b> <b>Bessel van der Kolk, M.D.</b>
RC99023 RC99023-03	Denver EMDRIA Regional Meeting <b>Techniques from Applied Kinesiology in the Service of EMDR</b>	Claudia Christian	303-393-0234	<b>9/16/00</b>	<b>John Hartung, Ph.D.</b>

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## IN THE SPOTLIGHT:

### Ad de Jongh

*Marilyn Luber, Ph.D.*

**A**d de Jongh is a man who wears his many hats with aplomb and great style. I met him in the early '90's during the first EMDR Institute trainings in Europe. These began in the famed Hotel Krasnapolsky in Amsterdam. In the midst of this old world charm, Ad stepped forward from The Netherlands, along with his counterparts Francois Bonnel of France, Arne Hofmann of Germany, Elan Shapiro of Israel, and John Spector of the United Kingdom to translate their interest and enthusiasm for EMDR into a plan to teach this new methodology throughout Europe.

He began by raising his colleagues' interest in EMDR through his professional organizations, encouraging qualified professionals throughout The Netherlands and Europe to learn EMDR by taking seminars in this methodology. As the numbers of interested therapists and academicians grew -and with the assistance of Erik ten Broeke, Ellen Latenstein and Joany Spierings- he began to build The Netherlands' Network of EMDR practitioners. They disseminate the Network Newsletter three times per year, hold educational meetings, and are proud of their 200 members in the organization. Through this concerted effort, EMDR is now considered a mainstream therapy in The Netherlands.

Ad's own development in EMDR began in 1992, when he took his first training seminar in this field. He went on to become a sponsor of trainings in Amsterdam and Utrecht and then became a facilitator for the EMDR Institute. Currently, he is training to be an EMDR Trainer and teach EMDR in the Dutch language.

Ad's interest in having a strong European union evolved over time and resulted, along

with the assistance with many of his colleagues, in the birth of the EMDR European Association (EMDREA) last year. He is on the Board of Directors for this organization and holds the elected post of Treasurer for EMDREA. As a result of his interest in research, he joined the Research Committee of the EMDR International Association (EMDRIA).

Ad's career consists of two distinct professions: dentistry and psychology. The common denominator that he has discovered in these two fields is based on his primary understanding of trauma. It is through his unique way of integrating the traumatic elements of these two professions that he has become one of the world's experts on dental phobia and a well-respected leader in the discipline of Psychotraumatology. Now that he is trained in EMDR, he has incorporated this method into his treatment strategy. Ad's interest in research is extensive. He is a prolific author with more than 80 scientific articles and book chapters on the treatment of dental phobias and fear related to dentistry to his credit. He is a Senior Investigator of The Netherlands Institute for Dental Sciences (IOT) and was involved as a principal investigator in several research projects for this organization. Also, he is on the Scientific Advisory Board of the War Trauma Foundation International (WTFI), Secretary of the Dutch Association for Social Dentistry (NVSST) and a member of the Federation of Dutch Scientific Associations in Dentistry (FTW).

The area of trauma is exciting to Ad and his interest is reflected in his many accomplishments and appointments in this field. He is an Associate Professor in the Department of Behavioral Science at the Academic Centre for Dentistry at the University of Amsterdam, The Netherlands (ACTA), the largest dental school in the world, with 700 students. Here he does research, reviews articles, teaches, and supervises two Ph.D. candidates. He is the only professor at the University who has his appointment in the field of Trauma and one of his jobs is to make EMDR well-known throughout The Netherlands one day a week! Also, he is a faculty member for the Institute for Psychotrauma (IVP) in Zaltbommel.

Ad is the Director of the Centre for Psychotherapy and Psychotrauma in Bilthoven. He opened this Center in 1998, to address the overwhelming demand to assist victims of violence, PTSD, medical phobias, and phobias in general. Also, in 1998, he opened D.O.E.N. (Directe Opvang En Nazorg) in Druten for the employees of shops, banks, and other

companies. The aim of D.O.E.N. is to help victims receive immediate help subsequent to a critical incident, robbery, job-related incident, motor vehicle accident, medical emergency, and/or other traumatic incidents so that they can address their psychological needs and return to work as soon as possible. This is a 24 hour a day facility that employs 20 people to address the needs of employees all over The Netherlands. There are two employees who stand-by for emergencies at all times. The longest distance they have to drive in this small country is 300 Km to reach their patients.

Ad's interest in Dentistry is primarily in addressing the problems of people who have not been to a dentist for a long time. He specializes in treating traumatized individuals. He notes that often his patients are victims of sexual abuse who cannot tolerate the idea of lying down in a dental chair and feeling helpless. He uses EMDR and Exposure Therapy to give his patients a good experience and help build a relationship with them so that they are an active part of the dental process. He begins by building a relationship of trust and then does the dental work in little pieces. If a patient has difficulty because of trauma, he introduces each part of the dental procedure and works with the patient whenever flashbacks, panic, or concerns arise.

He notes that the phobia literature does not make distinctions between a spider and snake phobia and a traumatic phobia that has much more in common with Posttraumatic Stress Disorder. He reports that patients with dental phobias, when tested with the IES (Impact of Event Scale) and other measures of their symptoms 7 days prior to their dental appointment, show that these patients have "full-blown PTSD".

Although Ad admits to enjoying doing many other activities after work, he most enjoys being with his "three women", his wife and two young daughters. He has moved from the lovely university town of Utrecht to the more rural area of Bilthoven which is in the forest. He is a man truly content with his work and his play and an integral part of the EMDR international community.



# Why and How to Use 'In Vivo' Exposure' in EMDR

Ad de Jongh, Ph.D.  
Erik ten Broeke

## Why?

An important feature of PTSD is that it is not very likely that the same traumatic event will ever happen again. Accordingly, if a client has been raped and successfully been treated with EMDR, generally not many clinicians will feel the urge to prepare this client for a next rape. Conversely, in a number of cases (particularly phobic conditions) the client does have to anticipate future situations in which fear evoking stimuli are present; and where he will have to interact with these. For example, if a person who suffered from a dental phobia has been successfully treated for his phobia, it is likely that he will still have to undergo invasive dental work, such as injections, root canal treatments, or extractions. This has implications for treatment. As a result of the successful application of the EMDR basic protocol, the likelihood or severity of the initial threat may have been reappraised, and the incident that initially felt traumatic may have been reattributed to an innocuous event. Yet, it is possible that the client is still not completely convinced of her ability to cope, and therefore, avoids certain activities or situations. In that case, the client should be properly prepared for future encounters with the anxiety provoking objects and situations. One way to prepare the client for such confrontations, is the use of in vivo exposure.

The term 'in vivo exposure' presumes an underlying habituation model. However, in the behavior therapy version of exposure, the client is requested to stick to the troublesome task during the session until anxiety alleviates and under no circumstances to run away. Conversely, in EMDR (e.g., in the phobia protocol) the use of in vivo exposure is an opportunity to test whether the treatment effects are generalized to all associated triggers or aspects of the situation. However, exposure can also be considered in terms of a cognitive change model. Here, exposure is explicitly used to test the predictions the client has about how dangerous a situation is; that is, to gather information that disconfirms client's

dysfunctional erroneous cognitions. In cognitive therapy such a procedure is termed a 'behavioral test'. The encounters with the phobic cues are set up as tests of the clients' catastrophic cognitions so that the client gains an experience where the catastrophe he fears does not occur and that his fear is, therefore, unfounded. In this respect, real-life further strengthens the believability of the positive cognition as the NC, and other still existing assumptions and beliefs, are contradicted by the consequences of acting in new ways. Concomitantly, the encountered situation, gives the client the opportunity to perceive or evoke mastery through observing that no danger exists.

## How?

The in vivo exposure part should be a joint venture of client and therapist. Unforced willingness must be ensured. Some gentle persuasion is certainly permissible, but it must be clear to the client that nothing will happen against his or her will during the confrontation with the phobic stimuli or situation. Unexpected introduction of new fearful material is counterproductive, as this can both damage confidence and lead to a revision of estimates of the likelihood of threat and increased caution. Also, there is a real danger that the client will drop out. The essence of the confrontation is that it is safe. The client is invited to ask questions about the nature and changing quality of their experiences. The task of the therapist is to help the client reinterpret his or her experiences in the framework of normal psychological and physiological processes when and where necessary.

Furthermore, the therapist may help the client to pay attention to features of their experiences that are positive or interesting, to identify negative thought content and to give advice to help the client cope with both the situation and their own mental and bodily sensations. Understanding his or her emotional reactions and knowing what features of a situation arouse them, increases clients' sense of control over these phenomena. All varying stimulus elements within a situation should be explored. Therefore, the eliciting situation should hold the client's attention.

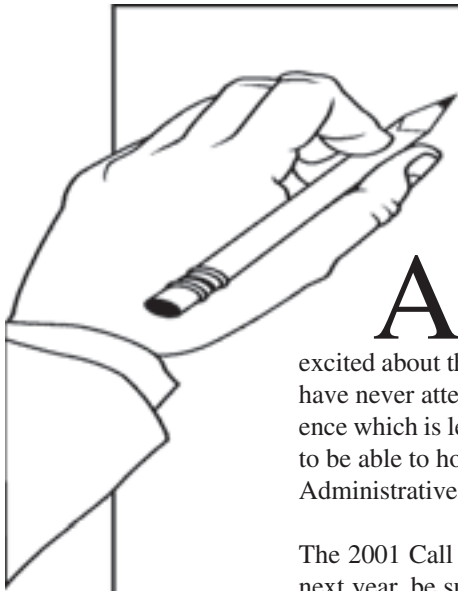
One helpful way to maintain attention to the task is to ask the client to describe the most notable features of the situation. For instance, a person fearful of high places could be encouraged to climb an apartment building that is not too distressful, while paying attention to

what is happening in a street or to certain objects such as trees, cars, and persons. It is our experience that it is helpful to make variations with regard to the stimulus dimensions 'action', 'distance' and 'time'. That is, in a real-life confrontation, for example, with an animal, the animal can be induced to be more or less lively, close or more distant, to be positioned with its head to the client or not, and during a long or a more limited period of time. Make sure that confrontations are repeated so that the reduction in distress is fully consolidated before moving on.

If necessary the therapist can demonstrate to the client how he or she would handle the feared object (e.g., by petting a dog). The therapist should act in such a confident and relaxed manner that the client feels prepared for any eventuality. This helps the client to acquire faith in the notion that his or her anxiety is not physically harmful and that these emotional reactions will subside and fade over time. Thus, it is important that clients expose themselves to the feared stimuli until they have achieved a degree of self-mastery and feel that they are able to handle a certain level of anticipatory anxiety and fear with confidence. Thus, the overall aim of in vivo exposure in EMDR is to foster confidence in a general ability to cope despite variations in circumstances.

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- \* Correspondence to: Ad de Jongh, Department of Social Dentistry and Dental Health Education, Academic Centre for Dentistry Amsterdam, Louwesweg 1, 1066 EA Amsterdam, the Netherlands (E-Mail: info@psycho-trauma.nl)



## The Conference Corner...

*Gayla Turner,  
Conference Coordinator*

**A**s this issue of the Newsletter goes to press, we are hurriedly putting the final touches on what is shaping up to be one of the largest and most successful conferences yet. Attendance, to date, has outnumbered years past, and we are excited about the fact that the majority of registrations we are receiving are coming from those who have never attended an EMDRIA Conference before. We also have our eye on next year's Conference which is less than a year away, being held June 22-24, 2001, in Austin, Texas. It is very exciting to be able to host the Annual Conference in the hometown of the EMDRIA Administrative Office. We would like to personally welcome you all to join us.

The 2001 Call for Papers have already gone out in the mail, so if you're interested in presenting next year, be sure to complete one and send it in by the deadline of October 1, 2000. You will find a copy of the 2001 Call for Papers in your June 2000 issue of the Newsletter. If you need us to send you one, however, please call our office, and we will be happy to get a form to you.

As in years past, we try to make each Conference better than the last, so please plan on joining us in Austin, Texas, next summer. Look for your Conference Brochure to be arriving sometime between late January to February 2001. We are planning some new and exciting things for this one that you will not want to miss!

## **Have you sent in your Call for Papers for the 2001 EMDRIA Conference?**

*If you need a copy of the Call for Papers, please contact the  
Administrative Office and we will be happy to send you one.*

**Remember The Deadline is  
October 1st!**



## Australia

Mark Grant reports that Alex Wolowski, an EMDR therapist from Victoria, has just completed a study on EMDR treatment with children. His work with phobia sufferers using EMDR was recently featured on the television program, "A Current Affair". Mark, himself, has recently completed a paper documenting EMDR treatment of chronic pain with three adult chronic pain sufferers with positive results and has submitted it to a leading journal. Mark and Ana Valenzuela will be presenting a workshop about the use of EMDR and projective techniques in the treatment of trauma and pain in New Zealand in September 2000.

## Ecuador

John Hartung writes about Esly Carvalho's plans for the November trainings with the vision of creating a post-graduate training center in the future with EMDR as a core training element. Trainings are planned for November.

## El Salvador

According to John Hartung, Salvadoreans have taken courses in nearby Guatemala and are planning to host their own EMDR trainings soon. They are hoping for sponsorship from the Catholic University campus there.

## Germany

President-elect of EMDR-Germany, Christine Rost, has given several presentations in Germany on EMDR with Dissociative Identity Disorder Patients and EMDR with Depression.

## Guatemala

John Hartung writes that the first follow-up on the Wilson et al study (an intra-subject design) was conducted in Spanish by AnaMari Andreu and is now being translated into English. AnaMari's work gives an individualized flavor to the impact of EMDR; for example, she

shows how one sexual assault victim remained "normal" on the trait anxiety but had the state anxiety measures rise after she was threatened again by her perpetrator's family during the course of treatment. The Guatemala Brief Therapy Institute continues to sponsor several trainings annually and is becoming a center for EMDR training in Central America.

## Israel

Alan Cohen reports that he, Udi Oren, and Gary Quinn trained 20 senior mental health professionals from the Ministry of Defense (Israeli Army). He notes that "it went very well and I see much future development and cooperation". A large team of Israeli facilitators was part of the EMDR-HAP trainings in Turkey.

## Italy

Isabel Fernandez writes that over the past year, 200 clinicians have been trained by Roger Solomon in the use of EMDR. The Association for EMDR in Italy was founded in May, 1999, and currently there are 130 members! Most workshops take place in Milan, but in 2001, trainings in Palermo, Rome, and Naples are on the schedule. EMDR-Italy has been active in the mass media and articles have appeared in newspapers and magazines throughout Italy. Francine Shapiro's textbook on EMDR has been published in Italian, and EMDR has been gaining support in the universities and scientific community.

## Lebanon

Peggy Moore recently took a trip to Turkey and Lebanon. During this time, she spoke to a group at the American University of Beirut. Dr. Umayya Yarkin arranged for a presentation to students and faculty of the School of Nursing. Her talk was well received and she found a receptive audience at this University. She met with Dr. Ellie Karam, a leading Lebanese psychiatrist, who is familiar with EMDR and has done some research with Bessel van der Kolk on PTSD in Lebanon.

## Mexico

From John Hartung comes news that another beginning seminar is planned for the fall in Mexico. Three new Mexican facilitators will be trained, along with Luchi Weissman, Lalo Barket, and Cielo Falcon. Ignacio & Lucina Jarero remain important contacts who combine EMDR with critical incident stress debriefing throughout natural disaster areas in Latin America.

## Nicaragua

John Hartung reports that trainings continue with Women Against Violence groups. Follow-up is coordinated by Barbara Zelwer, who remains committed to the important aspects of supporting participants after they are first trained. He is hoping to see a university-based graduate course built around EMDR and other innovative therapies.

## Switzerland

Hanne Hummel continues to support the teaching of EMDR in Schaffhausen in the German part of Switzerland. In the fall, there will be continuing education and supervision offered by three facilitators from the EMDR Institute.

## Turkey

The EMDR Institute/ HAP Project in Turkey continues. Fran Yoeli writes that Jim Knipe, John Hartung, and Emre Konuk, the head of the Istanbul Psychological Institute, spearheaded a 16 member team who went to Istanbul to train more Turkish mental health workers in the aftermath of the terrible earthquakes that has devastated the country. Gerry Puk did an advanced training for 48 EMDR trained clinicians from Istanbul and Ankara who had "hundreds of sessions under their belt". Karen Forte and Joanne Morris Smith put together a presentation on traumatized children and EMDR and Fran Yoeli and Jim Knipe presented the Popky Protocol for Addictions. Other facilitators that journeyed to Turkey were Lene Jacobson, Cynthia Kong, Phil Manfield, and Visal Tumani. John Hartung, Udi Oren, and Liz Snyder co-led a beginning training with 58 participants. Brurit Laub presented another format for the safe, secure place or enhanced resource development installation. Other members of the team from Israel included Eva Eshkol and Elan Shapiro.

## United Kingdom

Kamala Muller from Nottingham reports that she recently gave a presentation on EMDR with Children and Adolescents for the Association for Child Psychologists and Psychiatrists (ACPP) for the Leicester Region in April.

## United States

Sheila Bender, Uri Bergmann, Gudrun Lange, and David Grand have a grant from the Violence Institute at the University of Medicine and Dentistry of New Jersey on "Imaging Violence, Posttraumatic Stress Disorder, EMDR and Functional Magnetic Resonance Imaging" and are beginning to write up their findings.

Donna D'Aloia has been working with patients who have post Shingles pain; residual Shingles pain can be life-inhibiting because of its intensity and many people take narcotics to manage their pain. She has been using EMDR successfully in eliminating their pain, and thus, enabling them to quit pain medication. She notes that she has had the same type of success with Asthmatics, especially steroid dependent ones. By using EMDR with patients, she has been able to reduce their need for steroids, decrease their Emergency Room visits, and reduce hospitalizations.

John Hartung, who has provided the excellent update on Central and South American countries for this article, also talks about the future: "Our future plans are to have training in some 20 Spanish-speaking countries within the next five years, and to help to create local training institutes in as many sites as possible – with local facilitators and trainers. We also continue to adapt the training manuals and courses so that they contain the essence of Shapiro's work while being sensitive to the feedback of our Latin American colleagues and the nuances of local psychotherapeutic and educational realities".

In May 2000, Priscilla Marquis reports that John Hartung, Ligia Barascout, Barbara Zelwer, and herself did the first EMDR training in Caracas, Venezuela, at the Catholic University with an excellent reception. She will return to Cuba in

September, and is hoping to set up EMDR workshops then. In the fall, Priscilla and Liz Snyder will be teaching two programs for the EMDR Humanitarian Assistance Program (HAP) in Columbine, CO and Oakland, CA.

Sandra Paulsen writes from California that Sam Foster, Wendy Freitag, and herself will be staffing an EMDRIA booth at the APA Convention in Washington, DC, in August. Sandra will be presenting her workshop, "Healing the Divided Self: Using EMDR within Ego State Therapy with Dissociative and Non-Dissociative Clients" in San Francisco, on November 18, 2000.

Gerald Puk will present on EMDR at the Annual Conference of the New York State Crime Victim's Board in October 2000.

Susan Rogers has been very busy with EMDR related activities. She taught therapists from family agencies in Baton Rouge, LA, for HAP in May 2000 and presented "EMDR Research and Clinical Applications" for the Philadelphia Psychiatric Society in June. Her intern, Melanie Cerme, will present a poster at APA entitled "The EM Component and the Effect of EMDR and Combat-Related Guilt". Currently, Susan has been using EMDR for pain management with combat veterans with good results.

Sandra Wilson writes that she and Bob Tinker just completed a television show on the Discovery Channel called "Medical Alternatives" that is slated to be aired in August or September.

## Venezuela

Barbara Zelwer, Ligia Barrascout de Piedrasanta, Priscilla Marquis, and John Hartung conducted two beginner's trainings in EMDR in Caracas. John notes that there is a strong Venezuela-based EMDR core group, as they were sponsored by the Catholic University. Ligia was professionally filmed conducting EMDR with a university professor so that an excellent (quality and content) video in Spanish now exists.

[www.emdria.org](http://www.emdria.org)

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

- **APA Style** - All articles must be submitted in APA style and format.
- **Submissions Other than Advertisements** - Articles, columns, and other non-advertisement submissions must be provided in electronic (computer) format. Files may be submitted on 3-1/2-inch diskette or, ideally, via e-mail. Microsoft WORD is the preferred format, although a standard text format (i.e., ASCII or Rich Text) may be used. The file format of each contribution should be specified in the accompanying e-mail or on the diskette.
- **Submission of Advertisements** - In general, advertisements should be submitted in camera-ready format. Some exceptions may be made for text-only ad copy. Various requirements and restrictions apply to advertising for legal and other reasons, so please contact the Editor before preparing your advertisement for submission.
- **Fonts and Other Formatting** - Times New Roman is the standard font for *Newsletter* submissions, and text-only submissions should utilize this font whenever possible. In addition, formatting characters such as bolding, italics, graphics, centering and other alignment/justification may not “translate” properly, so text should be provided in “plain,” unformatted form when possible.
- **Author’s Responsibility** - It is each author’s responsibility to ensure all aspects of submitted articles are correct and in accordance with APA style including: correct spelling and punctuation; accurate quotations that include page numbers, author, and year; and a complete list of references in proper order. (Please refer to the Publication Manual of the American Psychological Association, 4th Edition, for specifics.) It is requested that you make every effort to complete the final draft before submitting your contribution. It may be difficult to incorporate revisions after the editorial process has begun.
- **Editorial Review** - Please note that all contributions are subject to revision by the Publications Committee and the Editor.
- **Decision to Publish** - The Publications Committee and the Editor cannot guarantee when or if any contribution will be published.

**Please submit all regular Newsletter columns, EMDR or EMDRIA news items, committee and meeting information, and advertisements to:**

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**DEADLINE FOR NEXT NEWSLETTER:  
OCTOBER 20, 2000**



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# CALL FOR EMDR PAPERS

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The Publications Committee is continuously seeking material on EMDR case studies and clinical experiences, techniques, and protocols for our new clinical publication.

We are also specifically requesting papers related to Resource Development for EMDR clients for a Fall 2000 issue (deadline October 15, 2000) specifically devoted to that topic.

*Please contact the Editor:*

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