EMDRIA™ NEWSLETTER

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In This Issue

Message from the President: A Critical Time Ahead

Daniel T. Merlis, M.S.W.

The past year has seen EMDRIA™ take shape as a true membership organization. In brief, a small band of hardworking EMDR clinicians took the initiative, about three years ago, to form this organization following announcement by the EMDR Institute, a for-profit EMDR training organization, that it intended to divest itself of functions typically maintained by nonprofit professional associations. Those functions included a newsletter, annual practice conference, support of local clinician study groups, credentialing, and public education. In the thirty-plus months since then, EMDRIA™ has made significant strides in providing these services and laying the infrastructure to meet the growing needs of EMDR clinicians worldwide.

We are now incorporated as a member service organization which, in IRS tax lingo, is a 501(c)(6) organization. The earlier entity formed three years ago is a 501(c)(3) and remains as a charitable organization. Membership dues are collected and services provided by the 501(c)(6) organization, EMDRIA™. Charitable contribution can be made to the 501(c)(3), which will be used to support special research and educational projects. While the two organizations are now operationally separate, EMDRIA™ members will be informed of 501(c)(3) activities through the *EMDRIA™ Newsletter*. Those of us who have been involved in this tax reorganization truly appreciate the national call to revamp the Internal Revenue Service!

Feedback from membership indicates that the International Conference held in Baltimore, Maryland this past July 10th through 12th, was our best yet. We would like to acknowledge Carol York, Executive Director; Jennifer Turner, Associate Director; Gayla Brown, Conference Coordinator; and new office staffer, Leslie Edmonds, for their hard work, foresight, and impeccable attention to detail that contributed to the huge success of the Conference. We also would like to acknowledge the contributions made by many of our EMDRIA™ Committees that worked closely with the Administrative Staff to plan and coordinate many aspects of the Conference including presentations, vendorship, publicity, and the awards dinner and cruise. The latter was, by the way, a wonderful experience which we hope to re-create in some form at our next Annual Conference.

Most importantly, we would like to thank the many EMDR clinicians who presented at the Conference. These individuals devoted many hours to the preparation of didactic and clinical material to be shared with

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1998 Conference Report

Carol York, MSSW, LMSW-ACP
Executive Director/
Conference Chairperson

Another Conference year has ended and we are happy to report that the 1998 EMDR International Association Conference, held in Baltimore, Maryland, was a huge success! Conference attendees came from many corners of the world, including Argentina, Australia, Canada, Denmark, Germany, Israel, Japan, Sweden, The Netherlands, and England, to name a few.

Our distinguished guest speakers, Francine Shapiro, Ph.D., Bessel A. van der Kolk, M.D., Donald Nathanson, M.D., Christine Courtois, Ph.D., Jeffrey Young, Ph.D., Robert Stickgold, M.D., Andrew Leeds, Ph.D., William Zangwill, Ph.D., as well as other talented clinicians and researchers, delivered outstanding presentations. The presentations focused on numerous ways to implement EMDR and how to use EMDR with various problems ranging from addictions, grief, complicated PTSD, anger, and others. Conference participants were quite excited about the information they obtained, with comments on Conference Evaluations ranging from "stronger in area of conceptual, theoretical, research data than 1997 Conference" and "higher level of professionalism in presentations and material" to "the presenters were superb."

Each year, our goal has been to improve upon the professionalism of the Conference. This year's attempt to further that goal was to establish an Exhibit Hall, a project coordinated by Wendy Freitag, Ph.D., who did a terrific job of putting together an impressive list of Exhibitors.

It goes without saying that our Conference could not have been successful without all the volunteers who assisted in monitoring workshops and working at the Registration Desk and the EMDRIA™ booth. The EMDRIA™ Board and staff would like to thank all presenters and volunteers who donated their time and their talents to bringing this Conference together and making it successful!

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Continuing Education at the Annual Conference

It seems that there has been some confusion and frustration in the process of attaining Continuing Education certificates at our Annual Conferences. We have tried to make this process as efficient as possible and are still fine-tuning it, while adhering to the guidelines of the Continuing Education accrediting agencies (APA, MCEP, NBCC, etc.).

Because of Continuing Education requirements, certain procedures cannot be changed, such as signing in and out of each individual session to receive credit. Each session is approved separately through the appropriate agencies, so utilizing a single sign in/out sheet for the Conference as a whole or even for each day is not possible. In addition, signing in and out on the same page allows room monitors to easily verify that a given participant attended the entire workshop, as required to receive the Certificate of Completion. Signing out at lunch and back in after lunch for full day sessions is also mandatory.

We realize that the process of signing in and out of these workshops is tedious and time-consuming. Each year, we look for ways to make the process less complicated and frustrating for the participants, and we welcome suggestions that you may have to improve the process—please send your comments/suggestions to the address, fax number, or e-mail address listed below. Next year, we hope to have longer tables to accommodate the numbers of participants and shorten the lines for signing in and out. Having all sign in/out tables located outside the rooms will help as well. Increasing the number of room monitors for the larger sessions is also being considered.

The EMDR International Association would also like to thank those of you who worked at this year's Conference as room monitors. We hope that you will participate in the same way next year, and we encourage anyone else interested in helping out as a room monitor next year to contact our office for more information.

It is our desire to make the Annual Conference as enjoyable and informative an experience as possible for our participants. There is always room for improvement, and we will continue to work hard to lessen the frustration and confusion as much as possible in the years to come.

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(President's Message - Continued from page 1)
attendees. I would like to recognize one of the many fine presenters, Andrew Leeds, Ph.D., for his contributions in multiple workshops at the Conference. Andrew's ability to integrate and synthesize the many threads of EMDR applications has made him one of our most respected EMDR innovators and teachers.

Annual awards were presented this year to three individuals who have been major contributors to EMDR methodology and the teaching of EMDR. The Innovations Award was presented to David Grand, M.S.W., whose explorations in the domain of stimulation methods has been of much interest to EMDR clinicians worldwide. The Research Award was made to Howard Lipke, Ph.D. In addition to contributing to EMDR research himself, he has been a resource to many other EMDR researchers and has participated in many significant debates within the field which relate to EMDR research. The Outstanding Contribution Award was made to Steven Silver, Ph.D., who introduced EMDR treatment into the largest U.S. health care organization, the Department of Veterans Affairs, contributed original comparative research, and assumed responsibility for coordinating trainings for the nonprofit organization, EMDR Humanitarian Assistance Program. All three award recipients demonstrated a strong commitment to increasing our understanding of EMDR and making it accessible to clinicians worldwide.

Representatives from many of our internationally-affiliated EMDR organizations have met as a group with officers of EMDRIA™ and the EMDRIA™ International Committee, with the goal of developing an international structure within which world-wide standards of practice will be established, while at the same time allowing affiliates the independence necessary to meet the unique practice needs and realities of their geographic areas. Consensus was achieved in a number of crucial areas and will be reported on in more detail in future issues of the *Newsletter*.

We have completed the election process and are pleased to announce that the following individuals have been chosen by membership to serve as Officers and/or Board members:

President-elect: David Wilson

Secretary-elect: Darlene Wade

Treasurer-elect: Byron Perkins

Director: Ricky Greenwald

Director: Gary Peterson

Director: Marcia Whisman

We thank all of the candidates for their willingness to serve the membership and know that most of those individuals who were not elected this year will serve the membership in other capacities.

Retiring from the Board of Directors this year are Marilyn Luber, Peggy Moore, and Jocelyne Shiromoto. All have been tireless in their dedication to EMDRIA™ from the earliest days and choose to continue to work with the organization as Committee Chairs for the coming year.

The year ahead is full of challenges, both great and small for the EMDRIA™ organization. We will be working hard to further develop our Committee structure to insure that the organization represents multiple perspectives as we continue to evolve. Note that our Board is a "working Board." This means, in effect, that Directors are expected to participate in committee work and not merely to serve as advisors to the organization.

We encourage EMDRIA™ members to participate in the work of our Committees. We have a number of Committee openings and, in addition, there are always projects available for members interested in contributing to Committee work but unable to commit time on an ongoing basis. Please contact our Committee Chairs, the Executive Director, or myself by e-mail or phone to discuss our current needs and your interests and abilities. We want to help you find ways to participate in the meaningful work of this organization.

In addition to providing an annual clinical conference, EMDRIA™ encourages clinicians to seek continuing education through local study groups, consultation groups, and EMDR workshops. Mechanisms will be developed to make it possible for clinicians who participate in ongoing EMDR educational and consultation activities to have the opportunity to earn continuing education credits necessary for listing in the *EMDRIA Register*.

We soon will be entering the second decade of EMDR practice. Where there once existed only one EMDR training program, the EMDR Institute, Inc., there are now a growing number of university-based programs, and we expect that many for-profit training programs will be established in the months and years ahead. It is crucial that EMDRIA™ works with these programs to establish and promote high standards of training while encouraging innovation in training methods and approaches. To this end, it will be vitally important for EMDRIA™ to remain distinct from the training organizations themselves. We expect all EMDRIA™ Board members, Committee members, and *Newsletter* contributors to maintain an attitude of detachment from proprietary concerns and the resolve to work toward what is best for all members and for present and future EMDR clients. The Board and Officers of EMDRIA™ are committed to ensuring this standard of organizational practice.

This will be a crucial year for us and we solicit your participation at whatever level you are able to commit. Thank you in advance for your willingness to step forward and best wishes to all in meeting the challenges that lie ahead. ⇔

FROM THE INTERNATIONAL SCENE

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

The EMDR International Association Conference of 1998 in Baltimore was a wonderful time for learning, teaching, and fellowship between old and new friends. The International membership was one of the major foci of the Board this season, and we are hoping that this year will expand our Association so that members around the world will participate in all of our committees. We invite you to join an EMDRIA™ committee that interests you and become active in your organization (see the list of Committee Chairs in this *Newsletter*).

We had several International Committee meetings at the Conference and are gearing up for an active new year. We hope to have input from all of our members. . . with the help of the Internet and our e-mail committee meetings. Mark Grant is our secretary and Curt Rouanzoin is our liaison with the EMDRIA™ Board.

Some of the major international issues currently being faced by EMDRIA™ are the following:

How does an entity get approved/connected with EMDRIA™?

How do we best develop an information packet for new member entities?

How do we collate the qualifications for EMDR training in each country so, if a therapist from one country does training in another, credentials can be accurately checked?

How do we encourage members to be heard in the organization by encouraging them to join and participate in Committees?

If you have any ideas, concerns or information you would like the International Committee to address, please contact your local representative so that s/he can represent your opinion in our meetings.

This year, Graciela Rodriguez headed a presentation on cultural differences at the Conference that we think will gain momentum over time as EMDR spreads throughout the world. To convey your thoughts on the matter, please contact the International Committee or Graciela Rodriguez.

The latest from around the world:

- **Armenia:** Edmund Gergerian accomplished the Herculean task of putting together an EMDR training and translating the training materials into Armenian. The training was well received and Dr. Gergerian has continued to maintain contact with the participants through e-mail for follow-up.
- **Australia**: Australia voted to affiliate with EMDRIA™. The EMDR Association of Australia sponsored a debate between an EMDR skeptic/ academic and Francine Shapiro. The debate was videotaped and is being used as a resource by EMDR groups around the country. In the 2-hour video, Dr. Shapiro presents the latest research about EMDR plus a review of all the standard criticisms and her responses to them. Copies are available through EMDR Australia. On another note, the EMDR Association of Australia has offered to send a team of EMDR-trained therapists to help citizens in Papua New Guinea with the Tsunami tragedy that occurred in July.
- **Belgium:** Through the efforts of Marc Van Knippenburg and his team, work is being done on a project to assist traumatized people in Ruanda.
- **Canada:** The Canadian group is organizing its first annual general meeting in Vancouver in the fall and hopes to have a one-day mini-conference. David Hart reported that their membership renewals are coming in!
- **Denmark:** Lene Jacobsen reports that forty people have completed EMDR trainings in Denmark. There will be additional trainings in November, and interest is building in developing an EMDR organization. Lene is running a monthly supervision group in Copenhagen, and Birgit Schulz runs a group in Jutland.
- **Europe:** EMDR-Europe is in the process of ratifying their constitution. They met in Amsterdam in May, and the meeting was well attended by members from all over the continent, Eastern Europe, Israel, and the United Kingdom.
- **Germany**: The team of Arne Hofmann, Gottfried Fischer and Monika Becker-Fischer continue to work to introduce the concept of trauma to German practitioners and to teach them about EMDR. Christof T. Eschenroeder edited the first German book on EMDR in December, 1997, *Eine neue Methode zur Verarbeitung traumatischer*

Erinnerungen. Tuebingen (Germany), dgvt-Verlag.

- **Holland:** Bessel van der Kolk participated in an interesting TV documentary about trauma and EMDR that was produced and aired in Holland. Ad de Jongh presented a pro bono training for Algerian psychologists, after the Algerian psychologists requested the EMDR training to help them deal with the violence and suffering of the people in their country.
- **Israel:** EMDR-Israel is active and enthusiastic. Udi Oren reports that Philip Manfield came to Israel and lectured to the members of the EMDR-IS organization on personality disorders and EMDR. Two Israelis, Alan Cohen and Frances Yoeli are part of the HAP team donating their services in Bangladesh. EMDR-IS made a presentation at the yearly conference of the Mental Health department of the Ministry of Health. First contacts were made with the Israeli Veterans Administration and with AMCHA, the Holocaust survivors' organization.
- **Japan:** Masaya Ichii reports that there have been six EMDR trainings in Japan over the last three years. There is growing interest in EMDR by the Japanese mental health professionals. A Japanese translation of Dr. Shapiro's text on EMDR will appear this fall and the first volume of the *EMDR-Network Japan Newsletter* appeared last spring with a preface by Dr. Shapiro. EMDR was used with survivors of the Kobe Earthquake and with the Tokyo subway victims of terrorism with good results. Case reports are beginning to appear in Japanese journals.
- **Poland:** Barbara Anderson is in the process of planning an EMDR training in Poland.
- **South and Central America:** John Hartung writes that, of 24 Spanish and Portuguese-speaking countries identified as potential EMDR training sites, eight have received trainings and are in some stage of organization (the goal being a local Institute that sponsors training, academic research, study groups, etc.), including Argentina, Brazil, Chile, Colombia, Nicaragua, Guatemala, Mexico, and El Salvador. Additional trainings are planned for Argentina and Mexico. Eight other countries are in some stage of planning for future trainings: Costa Rica, Cuba, Venezuela, Ecuador, Paraguay, Peru, Spain and Spanish-speaking groups in the Southwest U.S. The third group awaits contact persons and includes the following: Bolivia, Dominican Republic, Haiti, Honduras, Panama, Paraguay, Puerto Rico and Portugal. There are two training teams: the first includes Pablo and Raquel Solvey, Graciela Rodriguez, Michael Galvin, Donna Bruzzese and John Hartung.and the second is comprised of Pablo and Raquel, Graciela, Liz Snyker, Priscilla Marquis and Christie Sprowls. Facilitators include Laurel Parnell, Cathy Wickham, Barbara Zelwer, Ligia de Piedra Santa and Luchi Weissman.
- **Sweden:** According to Kerstin Bergh Johannesson, the Swedish EMDRIA™ coordinator, there have been three EMDR trainings in Sweden. Eighty participants have been trained and three more trainings are scheduled to occur in October, 1998. The first national meeting to establish a Swedish organization is scheduled to occur on September 14th.
- **Ukraine:** Alex Bondarenko just sponsored a training in the Ukraine this June.

[*Author's Note:* Please note that I misunderstood a communication by Charlotte Bucheli-Egger and printed that an article had appeared in the Swiss journal, *Schweizerishche Aerztezeitschrift,* and that EMDR was being promoted in the Swiss University Institutes and hospitals. This was wishful thinking on my part and I apologize to Dr. Bucheli-Egger for the misunderstanding.]

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NEW BROCHURE FOR PROFESSIONALS SOON AVAILABLE!

The Public Relations Committee is completing a new brochure about EMDR for mental health practitioners, physicians, and other professionals. The brochure is appropriate for distribution at speaking engagements, grand rounds, and conferences.

Contact the EMDRIA™ office at 512-451-5200 or via e-mail at emdria@aol.com for information.

Becoming a Presenter

Vicky Van Winkle

When I first considered giving a presentation at the 1998 Conference, I was motivated by my awareness that I was using EMDR in some innovative ways, and by a desire to share that work and become better known in the EMDR community. I was first encouraged by a participant at the 1997 Conference during a discussion who asked me why I hadn't given a presentation on an idea I was telling her about. I really didn't have a good reason!

Several factors made me hesitate:

1. I wasn't sure my work really contributed enough to stand out.
2. I didn't know how the selection process worked. Were presenters invited or did they volunteer? Would a less-known professional even be considered?
3. Of course, there was also the daunting task of synthesizing and preparing my material.

I was encouraged by my practice partner to apply. She assured me that the selection process was really open and fair. I also learned that a blind jury, one that doesn't know the identity of the proposed presenter, chooses the presentations.

Once I knew my application would be seriously considered, I had to write a 250-word abstract that could convey the nature of my presentation. Actually, anticipating this task was harder than completing it.

It was when I was selected that I faced the many costs and the unknown benefits. While travel, accommodations and copying expenses were significant, of course the biggest hurdle was the decision to take the time away from my practice.

I moved ahead because I was honored to be chosen and excited about the opportunity to share my work. I also thought the intellectual challenge would be stimulating. It felt very good to be able to offer something to others at the Conference where I had learned so much from others before.

There was considerable time involved in planning the presentation and handout, but I worked for three months on it and by the time of the Conference I felt fairly confident. It helped that I gave several workshops with colleagues that were well received at the local level, so I was not a beginner.

The rewards began as soon as I arrived at the Omni Hotel and registered. I was invited into many new groups of participants simply because I was wearing a Presenter badge. I talked with a number of people about my work with ADD before actually giving my presentation. I had a clear role that served as a bridge for myself and others and didn't feel shy about initiating contact. The visibility was very gratifying.

The pleasure I felt while giving my presentation was intense. I was happy with the appreciative audience response and the continuing positive and interested feedback. I realized I like doing this!

I was very impressed with the way the Conference was organized. Communications flowed smoothly both before and during the Conference, and follow-up was wonderful. (The only request I would make is that the seminar rooms be a little warmer in the future.)

After enjoying the rest of the Conference and especially several other presentations, I returned home to an amazing number of referrals and requests for consultation. While few of them seem directly related to my presentation, I am sure the experience did a lot for my confidence and for my reputation. Now that I have seen the initial results, I am thinking about my next presentation at an EMDR conference.

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U.S. Regional Coordinating Committee Report

Jocelyne R. Shiromoto, M.S.W., L.C.S.W.

As discussed in past columns, the Committee continues to evolve. Some of you may recall that, when this Committee selected "Word Wide Link" as its name, it was in an effort to represent the concept of an "umbrella" of clinician member services that included Regional Meetings, Special Presentations, Speakers Bureau, and the EMDR Library. Due to the enormous work involved in developing and administrating Regional Meetings, it became apparent that this Committee could not effectively oversee all of the above responsibilities.

As we indicated in our article EMDRIA™ World Wide Link (*EMDRIA™ Newsletter*, June 1998), we shifted the responsibilities of the Special Presentations and the Speakers Bureau to the Standards and Training Committee, chaired by Curt Rouanzoin Ph.D. The EMDR Library is no longer under the auspices of our Committee, and the Board will determine how best to proceed with that endeavor. (One recommendation is that the Board develop a committee with a chair with experience in library services, or hire a library consultant to establish the Library.)

As a result of shifting the above responsibilities, this Committee and its objectives have been redefined. One of the major problems was that our previous definition and title (EMDRIA™ World Wide Link Committee) lead the international community to incorrectly believe that the Committee was involved in organizing regional meetings for the non-U.S. countries. The international organizational structure of entities/affiliations (which is different from that in the U.S.) is the responsibility of the International Committee. This became much clearer during the Board's meeting with the international EMDRIA™ leaders at the Conference in Baltimore.

Consequently, this Committee voted unanimously to change the committee name to the EMDRIA™ U.S. Regional Coordinating Committee. We believe that the new name appropriately represents our tasks and objective—to help those interested in developing EMDRIA™ Regional Meetings within the United States and to administrate this endeavor.

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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 November 15, 1998. When submitting your Study Group, please provide the following information (by completing and sending this form or providing the information in another format.)

My Name: _____

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

_____

City: _____ State/Province: _____

Phone: _____ Fax: _____ Email: _____

(Please see page 8 of this issue for current postings to the Study Group Listing.)

STUDY GROUP DIRECTORY

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

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

UNITED STATES

Alaska

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

Arizona

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

California

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

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

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

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

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

Colorado

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

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

Connecticut

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

Delaware

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

Florida

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

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

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

Hawaii

City: Honolulu, HI
Name: Silke Vogelmann-Sine & Larry Sine
Tele: 808-531-1232
Fax: 808-523-9275
E-mail: silke@silke.com -and- sine@sineposta.com

Name: Darlene Wade & Terry Wade
Tele: 808-545-7706
Fax: 808-545-5020
E-mail: wadeandwade@compuserve.com

Illinois

City: Chicago, IL
Name: Howard Lipke
Tele: 847-537-7423
E-mail: HLipke@aol.com

Kansas

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

Kentucky

City: Judith Daniel, Louisville, KY
Tele: (502) 459-7917
E-Mail: JDaniel404@aol.com
Meetings held monthly

Maryland

City: Baltimore, MD
Name: Catherine S. Weber
Tele: 410-744-0869
Fax: 410-448-2005
E-Mail: csweber@erols.com

Michigan

City: Ann Arbor, MI
Name: Zone Scheiner
Tele: 734-572-0888
Fax: 734-663-9789
E-Mail: zonagse@aol.com
Monthly, Fri afternoons

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

City: Bloomfield Hills, MI
Name: Eileen Freedland
Tele: 248-647-0050
Fax: 248-683-7010

Minnesota

City: St. Paul, MN
Name: Chris Baldwin
Tele: 612-825-4407
Fax: 612-825-0768
E-mail: baldwoo2@maroorto.tc.umn.edu

Montana

City: Missoula, MT
Name: Nancy Errebo
Tele: 406-721-4918
E-mail: nerrbo@montana.com
1st Mon each month, 11:15a.m. to 1pm

New Jersey

Name: Barbara Korzun
Tele: 609-895-1070
Fax: 215-862-9370
E-mail: bkorzun@dplus.net
1st Fri each month,9:30-11:30am

New Mexico

Name: Peggy Moore
Tele: 505-255-8682 ext. 145
Fax: 505-255-7890
E-mail: pvmoore@unm.edu

New York

City: Fayetteville, Syracuse
Name: Maudie Ritchie
Tele: 315-251-0909
Fax: 315-637-2643
E-mail: msritchie@aol.com
1st Mon each month, 12-1:30pm

City: Great Neck, NY
Name: Lillian Gross
Ph: 516-466-6360
Fax: 516-466-2763
E-Mail: DRLillian@aol.com

City: New York City, NY
Name: William Zangwill
Tele: 212-663-2989
Fax: 212-663-2989
E-mail: WZANGWILL@aol.com
2nd Fri each month, 11:30am-1pm

City: Southampton, NY
Name: Marcia Schwartz
Tele: 516-287-3758
Monthly on Sat, 11:30am-1:30pm

Ohio

City: Cincinnati, OH
Name: Irene Giessl, Ed.D.
Tele: 513-221-2001
Fax: 513-961-6162
E-Mail: MGCmsac@prodigy.com

Oklahoma

City: Tulsa, OK
Name: G.J. Ann Taylor
Tele: 918-743-6694
Fax: 918-743-6695
E-Mail: ATaylor@busprod.com
Tues, 7:30am

Oregon

City: Bend, OR (Central Oregon)
Name: Karen Forte
Tele: 541-388-0095
E-mail: kforte@bendnet.com
Monthly, Tues, 12:15-2pm

Pennsylvania

City: Bloomsburg, PA
Name: Dorothy Ashman
Tele: 717-387-1832
Fax: 717-387-5103
E-mail: kent@csrlink.net
Monthly on Fri, 9-10am

Tennessee

City: Nashville, TN
Name: Bea Scarlata
Tele: 615-370-9451
Fax: 615-370-4382
E-Mail: BSScarlata@aol.com
Group 1: 1st Tues each month, 9:30-11am
Group 2: 3rd or 4th Fri each month, 6-8pm

Texas

City: Fort Worth, TX
Name: Janet Ragsdale
Tele: 817-336-7925
Fax: 817-336-7925

City: Hurst, TX
Name: William Gumm
Tele: 817-589-1419
Fax: 817-589-7918

City: San Antonio, TX
Name: Shirley Jean Schmidt
Tele: 210-561-9200
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NOTE: To maintain a current Study Group list, PLEASE provide the EMDRIA™ Administrative Office with up-to-date information about your group.

(U.S. Regional Coordinating Committee - Continued from page 7)

At the Conference, we also restructured by adding new Committee Members, while others left for greater and better things (although I can't imagine what they could be). A new listing of members is provided on pages 8 and 9).

If you are interested in being a Coordinator and have not sent or faxed your Regional Coordinators Application, please do so as soon as possible. If you are uncertain about the status of your application, please call the EMDRIA™ office and ask if we received it. I am aware that certain individuals are interested, although their applications have not yet been received.

During the Conference, we held our first U.S. Regional Coordinators Meeting with about 40 members in attendance. I covered and differentiated the responsibilities that EMDRIA™ and the Coordinators will have. A modified transcript of the Coordinators Meeting will be sent to those who attended as well as those who sent an application but could not attend the meeting.

As of this writing, Terms of Agreement are being reviewed by our attorney and, once completed, will be sent to all who apply for Coordinator. For a Coordinator to function under the auspices of EMDRIA™, the Terms of Agreement must be signed. Please do not establish meetings under the EDMRIA™ name until that time. (If you have questions or concerns about this process, please notify me.) After Coordinators have reviewed and signed the Agreements, we will begin listing Regional Meetings in this *Newsletter* and on the EMDRIA™ Website.

If you are aware of Study Groups* that are listed but are not current, please notify Liz Snyker as soon as possible (see listing below). Again, if you have questions, please notify the EMDRIA™ Administration Office or any of the Committee Members below.

Until next time . . .

* *Study Groups are not an affiliation of EMDRIA™ nor does EMDRIA™ bear any responsibility for Study Group activities.*

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Report from the Research Committee

Nancy J. Smyth, PhD, CSW, CASAC, Chair

The Research Committee is beginning some exciting new activities to encourage and support research on EMDR, and two meetings were held at this year's Conference to assist researchers. The first provided information on the status of EMDR research as well as journals that may serve as suitable publications for EMDR research studies. The second meeting focused on encouraging researchers and academics to network and generate ideas related to the work of the Research Committee.

The latter was attended by beginning and experienced researchers from all over the world, including Australia, Japan, The Netherlands, Germany, Northern Ireland, Bermuda, and the United States, and many excellent ideas were exchanged on how to stimulate more research. As a result, a *Directory of Researchers and Academics* interested in EMDR is being compiled; the first edition will include anyone who attended the research meeting on Sunday. Research Interest Groups also were formed on the following topic areas: Children, Violence, Anxiety Disorders, and Physiology.

In addition, participants volunteered for one or more of several task/resource groups:

1. **Writing EMDR Research Reviews:** This group consists of people who will write balanced reviews of EMDR research; this need is especially critical in light of some recently published reviews which both omit and distort important research findings. These reviews are being circulated and have resulted in at least one researcher being denied access to a clinical research population.
2. **Writing up Data with Clinicians for Publication:** This group includes researchers/academics willing to partner with EMDR clinicians who have group or single case data to publish, but lack writing and publishing experience.
3. **Internet Listserve Monitoring/Participation:** This group is comprised of individuals who are knowledgeable about EMDR research and are willing to monitor and participate in key Internet Listserves to ensure that a balanced perspective on EMDR is presented (for the same reasons articulated in Writing EMDR Research Reviews Group above.)
4. **Research Consultants:** This group consists of researchers interested in serving as consultants to beginning EMDR researchers.

Finally, ideas were exchanged on how to encourage more research submissions at the Annual Conference and the possibility of establishing a web-based discussion board. We also are in the process of increasing the membership of the Research Committee and are especially interested in ensuring that our international colleagues are represented.

We are excited about encouraging the development and implementation of more quality research on EMDR and are open to more ideas about how to do so (not to mention people to help!). Volunteers for all of our activities are always needed. If you would like to volunteer, or would like to utilize one of the above resources, please call Nancy J. Smyth, Ph.D. at 716-645-3381 ext. 232 or e-mail her at njsmyth@acsu.buffalo.edu.

Future editions of the *Directory* will provide opportunities to other researchers/academics to be listed. If you would like to be listed, please contact Nancy Smyth.

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BioLateral Sound Recordings: An Effective Alternative to Eye Movements

Invented and Produced by
David Grand, RCSW, EMDR Facilitator

What Are BioLateral Sound Recordings?

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

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

How Were BioLateral Tapes Developed?

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

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

The success of the original tape led to requests for new ones. We accordingly returned to the studio and recorded BioLateral 2–*Going To Wave Lengths*, which combines ocean sounds with a bilateral brush tone and BioLateral 3–*Round the Lake*, which fully integrates the bilateral stimulation into music that sounds both Gaelic and Eastern, and BioLateral 4–*A Simple Progression*, a basic bilateral chorded eight-step progression. Responses to all of the tapes continued to be enthusiastic.

I have also just released a CD, *The Best of* BioLateral, which contains tracks of all four BioLateral melodies, digitally remastered for the highest sound quality possible.

How Is BioLateral Used?

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

How Will My Client's Benefit from BioLateral?

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

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

Health Services Task Group Report

Mark Dworkin CSW, LCSW, BCD
Chair, Health Services Task Group, EMDRIA™
EMDR Institute Facilitator, East Meadow, NY (Long Island)

Efforts of the Task Group

There has been progress!

Efforts of the Health Services Task Group and others are beginning to bear fruit. We are starting to develop friends inside many of the MCOs, and recent anecdotal reports have surfaced that Case Managers are certifying care and even requesting EMDR for some of their subscribers (our patients). One example involves an EMDR therapist who has recently been receiving referrals from Aetna's Tandy Corporation account. It seems that Tandy may have requested that EMDR be viewed as an accepted treatment component, and other corporations and unions may be making these requests as well.

The Task Group's mission is to gain industry-wide acceptance from the health insurance community including HMOs, PPOs, etc,, and we have had some degree of success. Cigna/MCCs Clinical Senate voted to accept EMDR as a preferred practice. Jesse Rappaport and Andrew Leeds influenced Blue Cross/ Blue Shield of Oregon to accept EMDR, and Monica Sudenberg and others have done the same with BC/BS of Kansas. Other corporations are reviewing our research now.

How You Can Help

We are researching the areas of concern of MCOs and are addressing them. We will succeed, but we need your support.

The process is not time-consuming and will have great impact if every EMDRIA™ member helps. To get involved:

- Contact a local, regional, or national MCO and determine who is the best contact person in the organization. The contact may be a Medical Director, a Clinical Director, a Case Management Supervisor, or a Case Manager.
- Identify yourself as a trained EMDR practitioner and a member of EMDRIA™. Inquire as to the status of EMDR as a covered treatment service for PTSD, as well as the status of written policy.

  [If the contact person quotes a policy statement, please ask for a copy and report this to Jennifer Turner at EMDRIA™ at 512-451-5200 or EMDRIA@aol.com.]
- If the MCO reports that EMDR is not a covered treatment service, ask the reasons for the policy, and document and provide the information to EMDRIA™. Then, ask how we can inform their decision-making bodies about the research on EMDR; typically, there is a Committee on Practices and Standards or a Medical Directors Committee that reviews these materials. Inform the contact that EMDRIA™ will send a standard Research package to the appropriate people immediately. Then call the EMDRIA™ office to request that the information be sent, and EMDRIA™ will send the package promptly.
- After a period of two to four weeks, contact the MCO to ensure that the appropriate people have received the materials, and report back to EMDRIA™. Then call each month for an update on the progress of their decision-making and report the results of your efforts to us.

If the company remains reticent, we will implement a second level strategy that involves setting up a meeting with their representatives. At that point, we will send a senior EMDR clinician to meet with them to resolve any difficulties.

Get Involved

Please pitch in—and don't be concerned that someone else may have contacted a particular MCO. The industry is extremely volatile and managed care organizations have known to lose our materials, to be acquired by someone else, to have personnel changes, and so on. We intend to continue the process until we have gained universal acceptance on a policy level.

I have been involved in this process for three years and I like to use the popcorn analogy. Until now, the microwave has been heating the kernels. Some are beginning to pop, and soon the whole bag will be full.

I welcome any constructive ideas that may enhance our efforts. Please join us—and thanks to all who have helped!

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— NOTICE —

The 1999 EMDR International Association Conference location and dates have changed!

NEW LOCATION:

Alexis Park Resort & Spa

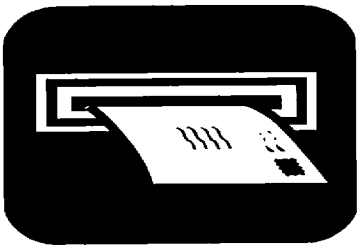
375 E. Harmon

Las Vegas, Nevada 89109

702-796-3300 or 800-453-8000

NEW DATES:

June 18th-20th, 1999



Look for the Conference Brochure in early 1999.

Sleep, Memory, PTSD and EMDR

Robert Stickgold
Dept. of Psychiatry, Harvard Medical School

Several lines of evidence suggest that EMDR may help in the treatment of PTSD by activating memory processing systems normally activated during REM sleep but dysfunctional in the PTSD patient.

Dreams

Normally, people do not have dreams that accurately replay real-life events. Although they may incorporate details from their daily activities, in reading several thousand dream reports we have seen none that were described as replays of events as they occurred in waking. From this, we conclude that the brain mechanisms active during REM sleep, when most dreaming occurs, normally do not have access to the "episodic" memory system located in the hippocampus, a system which is required for waking recall of events. However, one of the DSM-IV criteria of PTSD is the repeated replay of the traumatic event in patients' dreams. Thus, we conclude that the mechanism that normally blocks access to the episodic memory system during REM sleep is malfunctioning in the PTSD sufferer.

Sleep and Memory

Recent studies from several laboratories suggest that the normal processing and "consolidation" of memories may require events that occur specifically during REM and nonREM stages of sleep. Specifically, REM sleep may be necessary for the transfer of information from the forebrain into the hippocampus, while nonREM sleep facilitates transfer in the opposite direction, from the hippocampus to the forebrain. This back-and-forth communication is thought to integrate specific, episodic memories into our more general, semantic store of information. It is through this process that we "see" how events fit into the rest of our lives. Presumably, once this integration is complete, the forebrain can "tell" the hippocampus that there is no longer a need for the detailed memory and its associated affect.

REM Sleep and Memory

Two features of REM sleep seem related to this memory processing mechanism. The first is the massive activation of the acetylcholine neuromodulatory system during REM sleep. Acetylcholine (ACh) is released at high concentrations in the brain during REM sleep. The neurons which respond to ACh directly control the rapid eye movements of REM sleep, and may control the direction of flow of information between the forebrain and hippocampus as well. The second important feature of REM sleep is that the brain seems to preferentially process weakly-related associations during the stage of sleep, in contrast to its normal preference for strongly related associations in waking. Such a preference for weak associations would help integrate new episodic information into a wider network of related information already present in the forebrain.

PTSD and REM Sleep

If this back-and-forth communication within the brain is necessary to cause the hippocampus to reduce the strength of specific (traumatic) memories as well as the strongly associated affect, then the breakdown of the normal REM sleep mechanism in PTSD might be the cause of patients' failure to effectively process memories of traumatic events. Without the increase ACh levels, the preferential activation of weakly associated memories, and the flow of information from forebrain to hippocampus, the patient is unable to "get beyond" the original traumatic memory.

The Role of EMDR

If what I have suggested above is true, then it should be possible to facilitate the processing of traumatic memory in PTSD sufferers by activating these three systems (ACh release, forebrain-to-hippocampus information flow, and preferential activation of weak associations) from outside of REM sleep.

I believe that any alternating, lateralized stimulation regimen, whether eye movements, tapping, or binaural sound, should facilitate the activation of these systems. They would do so by forcing the brain to constantly reorient to new locations in space. This reorientation process: (1) facilitates shifts of attention and should enhance weak associations and (2), at least in the extreme case of stimuli that actually startle subjects, has been shown to induce ACh release.

Putting all of this together, I suggest that EMDR acts to "push-start" the broken-down REM machinery that is required for the brain to effectively process traumatic memories. By starting up these processes while subjects focus on the specific traumatic events and their associated memories, the brain becomes optimally poised for the effective processing of the traumatic memory, which in turn can lead to successful incorporation of the event into the patient's ongoing schemas and to an end to their painful and intrusive replay.

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Multiple Positive Cognitions

Chad Glang
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Conceptual Framework

In Shapiro's (1995) metaphor of EMDR treatment as a train ride, the Positive Cognition (PC) serves as a kind of magnet to draw the train forward. She suggests that, at the beginning, the client can often see only modest potential gains, or "part way down the track." Thus, the PC may contain limitations which are transcended during the session. In such cases, at journey's end, the client is able to identify a more positive cognition, which had previously been beyond his view. The clinician is therefore advised to ask if the original PC still fits, or if there is another statement which is more pertinent. It is possible to further access the client's new vision by encouraging him to identify all the positive self-statements which emerge from the work. Installing these multiple PCs can enhance the effectiveness of EMDR.

Without labeling them as such, many clinicians have discovered the usefulness of multiple PCs as they emerge naturally from processing. For example, Shapiro (1995) suggests that a successfully treated abuse survivor might report, "I'm fine. Mom and Dad really had a problem. I can succeed" (p.211). Although these are referred to as "a cognition," they may be conceptualized as three separate PCs, on the related but distinct dimensions of self-acceptance ("I'm fine"), objective viewing of others ("Mom and Dad really had a problem," which might be restated as "I've healed enough to see Mom and Dad as they really are"), and hope for the future ("I can succeed").

Returning to the train ride metaphor, one can see a symmetry between clarifying the Negative Cognition (NC) at the beginning of the journey, and discovering multiple PCs at the end. Identifying the NC usually involves brainstorming a list of inter-related preliminary NCs (Leeds, 1994). These beliefs are often out of awareness, and tend to underlie the client's experience in a pervasive way. Looking at different aspects of her experience, the client may say: "I screwed up, nobody likes me, I don't have relationship skills, I'll never have any close friends, I have bad judgment, etc." before coming to the statement which feels most deeply negative, e.g. "I'm not good enough." It is as if the preliminary NCs are signposts, scattered around the landscape, pointing the way to the train station. The client moves from a pervasive negative experience to one which is focused intensely by the core belief "I'm not good enough." This NC provides a boarding platform, and the train ride can begin effectively.

We can conceptualize the "other end of the track" in a complementary way. The train arrives, and the PC functions as a platform onto which the client disembarks from the journey. Acknowledging arrival, she affirms: "I am good enough" (original PC), or perhaps "I'm a good person with many wonderful qualities" (improved PC). At this point, eliciting multiple PCs facilitates expansion from this focus, so that the client sees how her new thinking pervades her experience. Whereas the pervasiveness of the NC was part of the problem, the pervasiveness of the PC is a desired outcome of treatment. In effect, the client can be encouraged to leave the train station and explore this new landscape, planting signposts which indicate how to continue her momentum. With the installation of each new PC, she further grounds herself in her new psychological domain.

Case Examples

Deborah, 38, had recently separated from her abusive husband. Processing a scene of domestic violence, her cognitions were "I'm worthless," and "I'm a valuable human being." In addition to the original PC, we installed:

"I am really strong!"

"I'm getting more aware of what's healthy."

"I deserve better than I've given myself."

"I am committed to learning to assert myself."

"I am ready for a healthy relationship."

A year prior to my seeing him, 18-year-old Michael hung himself from his bunk bed. His uncle found him with no vital signs, applied CPR, and brought him back to life. After two hospitalizations, and intermittent outpatient therapy, Michael was functioning reasonably well, but was unable to sleep in his room. Each of the few times he tried, he awoke from a nightmare of the hanging. Targeting the dream, the cognitions were: "I can't go in there, the dream will always get me," and "It was a turnaround; it's behind me." In closing, we installed these PCs:

"I turned it around, and I feel comfortable about my room."

"I'm doing better, and I'm proud of myself."

"I'm more in tune with myself now."

"I am grateful for God's forgiveness."

(Continued on page 18)

(Multiple Positive Cognitions - Continued from page 17)

"My parents forgive and trust me now; I can begin to let that in."

"I can make right choices and trust myself."

"I don't give up that easy—I stick with it!"

"I can change even more."

Joann is a 45-year-old single mother of three. From the ages of eight to ten, she was molested by her optometrist during examinations. The target image was telling her mother, who reacted with self-absorbed panic. Her NC was "I'm different, and that makes me bad;" her PC was "I'm normal." At the end of the session, we installed an improved PC, and several more:

"I'm unique, and I like that."

"I'm strong, and I know when I'm right."

"I'll make sure things are done right, when faced with opposition."

An interweave of seeing one of her children in a similar situation had evoked a clear sense that she would act to protect them; this led to these PCs:

"By loving my kids, I learn to love myself."

"I've always believed that if I do what's right for my kids, it's right for me. Now I know it's true."

"I'm in a great place with my kids."

And finally:

"I'm on a journey, and it's fun!"

"Every day can be exciting, I can learn something."

Clinical Guidelines

New PCs may emerge during processing, after processing is complete, and at either time spontaneously or in response to questions. If a new PC arises during processing, it can be noted for later installation. An example of an unexpected, spontaneous PC occurred when a female client was grieving the death of a favorite aunt. While the main theme was her perceived inability to move beyond despair, midway in the session she experienced an appreciation of the special bond they'd had, saying "I love being a woman!" Sometimes, a new PC marks the "end of a channel," (Shapiro, 1995) in a more predictable way. For example, a man was processing the childhood beatings he'd received from his older brother, who had been beaten by their father. At one point, he realized: "My brother passed on the abuse, but I didn't turn and find another victim." When asked the question often used during case formulation, "And what does that say about you?," he replied "I'm a caring person." In both these cases, after processing was completed, these PCs were installed with others.

At the close of a session, installing one PC may give rise to a stronger statement of the same belief. For example, "I'm acceptable...(EM)...I'm lovable...(EM)...I'm a real catch...(EM)." Such a progression led one client to smile and wonder, "Why settle for happiness, when you can have bliss?"

A variation is the series of PCs which describe one issue from many points of view. Deborah, in the case mentioned above, made several statements about the theme of her growth as a potential intimate partner, viewing it in terms of awareness ("I'm getting more aware of what's healthy"), self-valuing ("I deserve better than I've given myself"), intention ("I am committed to learning to assert myself"), etc. Similarly, a man who was severely depressed by his wife's filing for divorce, claimed a sense of self-efficacy in terms of awareness ("I can see past Diane to the real problem," "I know myself"), and confidence ("When I am focused, I have choice about how I feel," "I can stay in touch with myself," and "I can pull myself out of this pattern when it brings me down").

Finally, clients may be helped to discover new PCs through questions. After the original PC has been affirmed or an improved version identified, it usually suffices to ask, "Are there any other positive statements about yourself that come out of our work today?" Most clients will respond with a series of new cognitions, which can all be noted and then installed. Alternatively, the clinician may obtain one new PC, install it, then ask again. In cases where open-ended questioning draws a blank, and it seems that additional PCs could be just out of reach, one can probe further. This is comparable to the use of cognitive interweave, when processing is stuck. For example, a client could be so pleased with the PC "I'm a caring person," that it doesn't occur to him to look elsewhere. He might be helped by the questions, "Are you getting anything about yourself as a Dad? As a husband? Is there a statement you could make about self-forgiveness? About hopefulness?" Of course, this must be done sensitively, without conveying that there should be more. Based on what clients have expressed spontaneously, here is a tentative list of themes and matching PCs:

1. One might refer back to the preliminary NCs. These "signposts" from the old landscape may suggest analogous PCs, which can lead the client forward. For example, "I don't have relationship skills; I'll never have any close friends," may have led to the NC "I'm not good enough." After installing the PC "I am good enough," the clinician could ask, "What seems true to you now about your relationship skills, and your potential for forming friendships?" This may evoke new PCs such as "I can develop skills" and "I feel solid

enough in myself to risk opening up to friends."

2. Self-awareness ("I am growing in my ability to read my own signals.").
3. Self-acceptance ("I can love myself, even with my faults.").
4. Self-trust ("I will take only reasonable risks in this relationship.").
5. Empowerment/choice ("I can be proactive, rather than reactive.").
6. Self-valuing ("I deserve respect; I'll see that I get it.").
7. Positive attributes or skills ("I'm competent." "I'm a good listener.").
8. Effectiveness in different roles ("I'm a loyal friend." "I'm a good mother.").
9. Confidence/optimism ("I know I can count on myself." "I'm hopeful.").
10. Safety ("I can use my safe place when I need it; it's just a breath away.").
11. Spirituality ("I am aware of the spiritual center in myself and my partner; I'm committed to connecting on that level." "My relationship to God is big enough to contain my anger.").
12. Lessons learned from the process of doing EMDR ("I can find peace with issues that seem overwhelming." "When I face my fears, I grow." "I can know and love myself more fully.").

Conclusion

At a fundamental level, EMDR is an efficient means of asking the question, "What is true for you about this issue?" The client experiences a journey, or "train ride," from a place of disturbing untruth to a place of peaceful truth. In Shapiro's protocol, the NC and PC focus the beginning and ending of the journey, effectively providing loading platforms for the train. Expanding the protocol by eliciting and installing all relevant positive cognitions enhances the client's integration of her truth, by inviting her to fully explore the territory at the other end of the track.

References

Leeds, A. (1994). *Case Formulation. Presentation at Facilitator Training, Level I EMDR Training,* San Francisco.

Shapiro, F. (1995). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures.* New York: Guilford.

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A Client's Poem: EMDR..... Peace of Mind

Events from my past haunt my memory
They hold me prisoner not wanting to let go
When I least expect it, they jump out at me
Hurting, hating, they take my breath

Must I continue to endure this pain?
Please move through and be on your way
Release your hold on me, your grasp is smothering
I am so weary from carrying such great weight

Deep within my soul I gather courage and strength
Even though it appears to be only a faint glimmer
Like a natural spring of water, they will continue to flow
They've been there all along, they are a part of me

Reveal the memories, face them without fear
Change the pictures presenting themselves, I am in control
Nothing worth having does not involve hard work
The reward is priceless and peace of mind.

As I walk away, though tired from such great effort,
I stand tall, the weight is gone
I reach for the stars because I can!
The world is brighter, more beautiful than before.

[*Editor's Note: This poem was submitted by an EMDR therapist whose client was dysthymic at the time the client wrote the poem. The piece was written after two or three EMDR sessions, following the therapist's suggestion to try journaling, and represents the client's first poem. The therapist reports that the client has since been writing prolifically and that the EMDR "allowed her expressive side to come pouring out."*]

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EMDRIA NEWSLETTER ADVERTISING RATES

DISPLAY ADVERTISING

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

INSERTS

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

CLASSIFIED ADS: 3-¾" x 2"

	Member	Non-Member
Per Issue	$30	$60

Please refer to the Newsletter Submission Requirements provided on page 39 for specific information on drafting, formatting, and submitting ads.

THE EMDRIA™ REGISTER

EMDRIA™ is publishing a *Register* of EMDR-trained clinicians. The *Register* is different from our *Membership Directory*. The *Register* differs in that it will independently list licensed/certified mental health professionals who have utilized EMDR in their clinical practice, have pursued ongoing supervision/consultation, and continue to use it in the highest ethical and professional manner. Members and non-members of EMDRIA™ will be listed as long as they meet the criteria.

Purpose of the *EMDRIA™ Register*

The purpose of the *EMDRIA™ Register* is to benefit the general public by providing a convenient, centralized list of EMDR therapists who voluntarily applied and met the criteria for listing in the *Register*, where such criteria are recognized as promoting the integrity of EMDR. To support this purpose, the *EMDRIA™ Register* will be made available to the general public. The public may utilize the *Register* to find an EMDR-trained therapist in their area, and EMDRIA™ plans to publish the *Register* on the Internet as well as in hard bound copy for therapists.

Criteria for Listing

Therapists listed in the *Register* recognize that EMDR is a method of psychotherapy. Consequently, treatment with EMDR should be undertaken only by individuals licensed or certified to practice psychotherapy and who have completed formal training in the clinical use of EMDR. Therapists listed in the *Register* agree to use EMDR according to whatever independent organization's Standards of Practice govern the performance of psychotherapy in their respective disciplines (e.g., American Psychological Association, American Psychiatric Association, National Association of Social Workers, American Association for Marriage and Family Therapy, etc.).

Therapists listed in the *Register* must meet the following criteria:

1. A current license or certification as a mental health professional allowing for the practice of his/her mental health profession.
2. Successful completion of an EMDRIA™-approved training program in the practice of EMDR administered by an independent organization.
3. An affidavit declaring that the therapist has conducted at least 50 EMDR sessions with at least 25 clients and has participated in peer and/or other supervision of at least 10 of their own or others' cases.
4. Completion of a total of 12 hours of EMDRIA™-approved continuing education experience (CEE) in EMDR, administered by EMDRIA™ or other EMDRIA™-approved organizations every two years. NOTE: This requirement will not be in effect until 1999; only 6 hours of CEEs will be required for listing in 1998, 6 hours in 1999 totaling 12 hours by December 31, 1999. The requirement will then be 12 hours at the end of two years, renewing every two years thereafter. (EMDRIA™ will offer approved CEEs at the Annual Conference and other EMDRIA™-approved courses will be accepted.)

EMDRIA™ does not engage in testing and certification of EMDR therapists nor does EMDRIA™ provide a referral service or ethics review. EMDRIA™ does not make guarantees of any kind regarding the competence and proficiency in EMDR of therapists listed in the *EMDRIA™ Register*. The Register merely indicates that each listed therapist sought to be listed and voluntarily provided evidence of meeting the criteria for inclusion in the *Register*.

Application for Listing in the *EMDRIA™ Register:*

For listing, please submit the following:

1. Completed *Register* Application.
2. An affidavit declaring that the applicant has conducted at least 50 EMDR sessions with at least 25 clients and has participated in peer and/or other supervision of at least 10 of the applicant's or others' cases.

3. A photocopy of the applicant's license or certification as a mental health professional (psychologist, psychiatrist, LCSW, MFCC, or equivalent) and proof of successful completion of an EMDRIA™-approved training course administered by an independent organization.
4. Documentation of at least 6 hours of EMDRIA™-approved continuing education experience (CEEs) in EMDR, administered by EMDRIA™ or other EMDRIA™-approved organizations, by December 31, 1998; 6 hours by December 31, 1999; 12 hours every two years thereafter. (EMDRIA™ will offer approved CEEs at the Annual Conference and other EMDRIA™-approved courses will be accepted.)

The EMDRIA™ Board of Directors reserves the right to amend or modify eligibility criteria affecting current or future members in the *EMDRIA™ Register*.

Renewal for Listing in the EMDRIA™ Register

1. A photocopy of applicants current license or certification as a mental health professional (Psychologist, Psychiatrist, LCSW, MFCC, or equivalent)
2. Documentation of at least 6 hours of EMDRIA™ approved continuing education experience (CEE) in EMDR, administrated by EMDRIA™ or other EMDRIA™ approved organizations completed by December 31, 1998. (List of EMDRIA™ approved CEE providers is available in the Administrative office and on the website)

Fees for Listing

Fees for being listed in the *EMDRIA™ Register* are as follows:

New Applicants:

$50 for applicants who are current Members of EMDRIA™ and who meet the criteria.
$100 for applicants who are not current Members of EMDRIA™ and who meet the criteria.

Renewing Applicants:

$25 for listees who are current Members of EMDRIA™ and who meet the criteria.
$50 for listees who are not current Members of EMDRIA™ and who meet the criteria.

Procedures for Removal from Listing in the *Register*

EMDRIA™ reserves the right to remove any therapist from the listing when it has been determined by an independent ethics board or licensing/certification agency that a listed therapist no longer meets licensing/certification requirements, has engaged in professional misconduct, or has engaged in a serious crime.

The *EMDRIA™ Register* is designed to provide a benefit to both the general public and EMDR therapists by providing a convenient, centralized list of EMDR practitioners. To achieve this goal and to be included in the next printing of the *Register*, all mental health professionals who meet the criteria are encouraged to apply or renew for inclusion as soon as possible.

The 1998 *Register* will be issued in the Spring of 1999.

THE EMDRIA™ REGISTER APPLICATION continued

OTHER BOARD CERTIFICATIONS: (e.g., ABPP, AAMFT Approved Supervisor, ACSW, etc.)**(Limit 2)**

_____

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_____

_____

LIST SPECIALTIES: (e.g., PTSD, DD, Sexual Abuse, etc.) **(Limit 4)**

_____

_____

_____

AFFIDAVIT: I declare that I have conducted at least 50 EMDR sessions with at least 25 clients and have participated in peer and/or other supervision/consultation with at least 10 cases of my own or others.

Signature_____Date_____

FEE FOR LISTING

(Deadline for Submission December 31, 1998*)

Please check appropriate box:

- ❑ $50 for Members of EMDRIA™ who meet the criteria for listing
- ❑ $100 for non-Members of EMDRIA™ who meet the criteria for listing
- ❑ $25 Renewal fee for listees who are current Members of EMDRIA™
- ❑ $50 Renewal fee for listees who are not current Members of EMDRIA™

Send Payment to: EMDRIA, PO Box 141925, Austin, TX 78714-1925
Or Fax to: (512) 451-5256

***Applications received after the deadline may be subject to late fees and/or exclusion from The Register.**

THE EMDRIA™ REGISTER APPLICATION

LAST NAME_____ FIRST NAME_____ MI_____

OFFICE ADDRESS_____ STE._____

CITY_____ STATE_____ ZIP_____ COUNTRY_____

TEL_____ FAX_____ E-MAIL_____

ADDITIONAL OFFICE ADDRESS_____

CITY_____ STATE_____ ZIP_____ COUNTRY_____

TEL_____ FAX_____

DEGREE: Highest Degree (M.A., Ph.D., M.D., etc.)_____

Institution where received:_____ DATE_____

LICENSE/CERTIFICATION: License or Certification to practice.

Mental Health Profession_____ ID Number_____

State or Country issued:_____
STATE OR COUNTRY

Please send a copy of your license/certification ❑ (Check box)

EMDRIA™ APPROVED TRAINING: Please send a copy of your certificate of completion for EMDRIA™ approved training (I.E. Level I AND Level II from the EMDR Institute or other EMDRIA™ approved Institutes, -or- have completed a minimum of 18 didactic and 13 supervised hours in an academic institution, etc) (certificate must list total hours and be signed by Instructor)

❑ (Check box)

OTHER EMDR TRAINING: (e.g., Teacher/Trainer/Facilitator for EMDRIA™-approved EMDR Instruction) **(Limit 2)**

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Continued on back

Coordinating Inpatient EMDR in Ongoing Outpatient Treatment

Dennis Balcom, MSW, LICSW
Dbalcom@compuserve.com

[*This is a brief report on a single case of EMDR treatment that focuses on coordinating an inpatient hospitalization and continuing EMDR while hospitalized.*]

The client, Mr. C, age 43, is a professional musician, living with his partner in a long-term stable relationship, and suffering from chronic PTSD. He was sadistically abused sexually and physically by his mother (and others) beginning in infancy, continuing through mid-adolescence when he left home. His mother repeatedly threatened to cut off his penis, approaching him with scissors and knives, making cutting motions. She held him on her lap, stroking his penis and telling him stories of animals she tortured as a child, especially a cat whose tail she had cut off. She smothered his face with her genitals, berated him as bad for being male, and blamed him for her problems.

He was raped by many others during this time period, including an "uncle" (a friend of his parents), a female babysitter, a Catholic priest, and two of his sisters. Interventions were attempted by social services and school personnel on behalf of his sisters, but the boys remained in the home.

During initial assessment (1/97), Mr. C reported multiple signs of PTSD, including nightmares, recurring flashbacks and intrusive thoughts, sleep disorders, panic attacks, dissociative symptoms, and memory loss. He has a long history of anger being harmful to himself and to others. He has not, however, physically harmed others, nor has he committed any sexualized crimes. Against himself, Mr. C has chronic, omnipresent suicidal thoughts. On the Internalized Shame Scale he scored 81 (in the high category), which is correlated with depression as well. During periods of severe depression he ceases eating, has increased difficulty sleeping, is more highly phobic of people, and is unable to continue his part-time work.

Treatment

Mr. C is in weekly individual and group treatment, and in EMDR treatment twice weekly (90-minute sessions) with the author. The primary therapist who

(Continued on page 26)

(Coordinating Inpatient EMDR - Continued from page 25)
referred him for EMDR treatment and the author have an established collaborative/collegial relationship and are in frequent communication on behalf of Mr. C. This format of treatment has been ongoing to the present. In addition, Mr. C has had multiple forms of outpatient and medication treatments over the years, including one previous psychiatric hospitalization for similar concerns.

Mr. C is highly motivated and has utilized outpatient EMDR treatment effectively. He has processed many traumatic experiences, strengthened many of his coping and defense mechanisms, ceased smoking and drug use, and improved his daily life management. Regarding EMDR, we have used the basic protocol as well as developed specific processes to more fully engage his resources.

Need for Hospitalization

One of Mr. C's most persistent and troubling symptoms has been repetitive penile amputation fantasies, accompanied with a fragmented sense of body integrity. Mr. C reported a "bloody stump where my penis ought to be."

Mr. C requested hospitalization to work through the issues behind these troubling intrusive fantasies. Previously during his EMDR work, while working through difficult material, he had scheduled additional appointments, both for EMDR and for psychotherapy. In each instance, this was successful in enabling him to restore a relative sense of safety and well-being. However, every time Mr. C tried to work through the penile amputation fantasies as an outpatient, he reported that he felt so much anger that it could not be contained in the sessions, spilling over into his daily life, damaging some relationships, and jeopardizing others. He felt that if he could find a safe place in which to work through this material he would be able to reduce the amputation fantasies, improve his sense of body integrity, and lower his compulsions to end his life to escape these torturous thoughts.

Pre-admissions Negotiations with the Hospital

Mr. C's hospitalization was initiated in a meeting with his primary psychotherapist. He, his primary therapist, and I agreed that he might benefit from a planned hospitalization, which could provide a safe haven to focus on the actual experiences underlying the intrusive thoughts. We then, with Mr. C's permission and cooperation, researched possible inpatient units that could provide treatment for his traumas. While he knew that EMDR is effective for him, he was open to other possible interventions the hospital trauma team might recommend.

Unfortunately, no local hospital (except perhaps for the VA) have any experience of using EMDR as a form of inpatient treatment. Fortunately, we found a unit specializing in trauma treatment at a nationally-known facility that was willing to allow the author to come into the hospital to continue Mr. C's EMDR treatment. Although this particular hospital unit did not utilize EMDR, the clinical director and staff were familiar with the EMDR method.

To ensure efficacy of the hospitalization, it was necessary for the outpatient and inpatient providers to coordinate their treatment goals for Mr. C. The particular philosophy of treatment for the unit was one of rapid stabilization, with discharge as quickly as safety allowed. Mr. C's request, via the author, was in the opposite direction: to allow him to be in a safe place and to use EMDR to destabilize the specific penile amputation fantasies. Based on my 14-month history with Mr. C, I believed that he would benefit from this arrangement and was able to present to the admissions staff and the Clinical Director our reasons for this plan.

After a few days of hospitalization, the staff agreed to EMDR treatment to specifically target Mr. C's penile amputation fantasies with the understanding that this work could result in a temporary destabilization of his functioning. (A psychiatrist friend of Mr. C's spoke directly to the Clinical Director of the unit in support of this plan, this may have been a determining factor). I was allowed to conduct EMDR with Mr. C, and was asked to communicate with his inpatient therapist following each session to ensure continuity of care.

EMDR During Hospitalization

During a 10-day inpatient stay, Mr. C had five two-hour EMDR sessions. Two impromptu case conferences were also held with his inpatient therapist to discuss a day pass, plans for post-hospital care, and an extension of his hospitalization. Mr. C utilized EMDR as an inpatient as fully as he did as an outpatient. The content and process of the EMDR sessions during the hospitalization replicated the outpatient sessions, although at a greater depth and with easier access to difficult subject matter, according to Mr. C. The only additions made to the usual procedure was additional spent time orienting him to the physical space and increasing the length of each session. Although he did not achieve full closure by the end of each session, he felt that the hospital gave him a safe environment with the knowledge that we could continue EMDR the next day. The hospital staff did not have to employ additional or extraordinary measures

following the EM sessions. Mr. C was granted the usual privileges of "signing out" on hospital grounds, and received day passes on two occasions.

Results

Mr. C was able to access and process through the three primary experiences behind the amputation fantasies. One involved his mother's repeated use of sexual torture as a common disciplinary technique, another was his uncle's repeated threats to bite off his penis if Mr. C cried out while being molested. The third was a literal penial amputation attempt by Mr. C's sister, which he was able to thwart by convincing her that he had already cut it off in his own mind and she therefore would not be able to hurt him.

After processing through these horrific experiences, Mr. C was able to restore his body image to a more whole state, including his genitals, albeit in an infant's rather than an adult size. Additionally, in general, he reported significant changes in the appropriation of blame to the perpetrators. He felt the contributing factors to the success of the inpatient treatment were the safety of the environment, the extra length of the sessions, and his ongoing successful relationships with the EMDR practitioner and primary therapist.

Resumption of Outpatient Treatments

Upon discharge, Mr. C resumed his pre-hospitalization routine of care. He reported a significant diminution of the intrusive thoughts: they were less present, less powerful, and he felt that he had more resources to counteract them. Currently, three months post-hospital, Mr. C reports that the penile amputation fantasies have been reduced by 90 percent.

While reporting delight at the results from the inpatient EMDR work, Mr. C was disappointed in other aspects of the hospitalization, such as the delayed start to actual inpatient use of EMDR, the unit emphasis on sedating medication, a policy against taking psychological histories, staff insistence on its own treatment preferences, the inability of one staff member to believe that Mr. C's reports of his childhood experiences were not exaggerated, and the unavailability of non-medical resources for men (while a mixed gender unit, the population was primarily female).

Discussion

Several concerns became apparent in this unique process of being the first EMDR therapist to be allowed into this specific inpatient trauma unit. Anticipating these concerns can help in smoothing the transitions from outpatient to inpatient to outpatient EMDR treatment.

Of greatest importance is the question of selecting appropriate clients for inpatient EMDR treatment. The crucial question here is whether to do in-depth uncovering work while a client is actively suicidal. The EMDR standard I refer to in these situations is that clients are typically able to process traumatic experiences more quickly utilizing EMDR than conventional psychotherapeutic methods. Thus, for me, the quickest way to resolve Mr. C's crisis (he agreed), was to intensify EMDR to achieve resolution as promptly as possible. Obviously, this abreaction standard would not be appropriate to all clients, therapists, or hospitals. Each therapist and hospital would need to carefully assess the immediate needs with the client.

Clients presenting with psychotic processes, debilitating depression, or those who are unable to utilize the EMDR method would be contraindicated. Another concern is orienting the client to the new setting in which EMDR is conducted. With Mr. C, we moved between three spaces, one of which (his room) we deemed inappropriate. A second was a small conference room and, finally, the best option was his inpatient therapist's office. Because this was a locked psychiatric facility, staff had to visually check on each patient every fifteen minutes, unless the patient was "signed out" either on or off the unit. Signing out, combined with using the inpatient therapist's office, proved to be the best arrangement.

The third concern is coordinating with the inpatient program the pragmatics of scheduling appointments and the length and frequency of sessions. These details can probably best be arranged once the hospitalization has occurred, after the staff is familiar with the patient and has established a working relationship with the EMDR outpatient therapist. Mr. C commented that he believed that he would have found two daily two-hour EMDR sessions helpful.

The final concern is funding. Once admitted to the hospital, Mr. C's insurance covered the hospital costs and reimbursed him for much of the author's time (not including travel, which Mr. C paid himself).

In conclusion, this experience illustrates that EMDR can be effectively utilized on an inpatient basis, when the outpatient therapist has already established a good therapeutic relationship with the patient, and is able to forge a cooperative relationship with the staff of the inpatient facility.

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THOUGHTS ON EMDR AND ARUNDHATI ROY'S NOVEL, *THE GOD OF SMALL THINGS*

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I want to bring Arundhati Roy's remarkable, new novel, *The God of Small Things,* to the attention of psychotherapists, especially EMDR therapists, as we work with people in pain and suffering from serious psychological trauma. Almost every character in the book, like many of our clients, has been traumatized by death, loss, rejection, sexual abuse, gender or caste exploitation, abandonment, violence, deceit, betrayal, inappropriate blaming, shame, rage, guilt, lack of validation, humiliation, fear, and/or terror.

The book vividly presents the truth of life's experience as life is lived—and as our clients and we access it in the consulting room. For experienced EMDR, therapists the book confirms and affirms the richness and complexity of our work. For therapists new to EMDR, this book presents a superlative example of the depth and profundity of the material that the therapist can help the client connect with and resolve. And, in addition, I want to recommend that EMDR therapists read this book because it is beautifully written and wonderful to read as an artistic creation.

Reading the book is like taking a full history and doing an assessment, Phases Two and Three, of the EMDR method, however in this case, in exquisite detail and with superb use of language. There is clear delineation of what could be targets for focused psychotherapeutic work and clear articulation of what many of our clients can barely, or only, sense.

I will point out a number of principles key to the EMDR method, and to psychotherapy, and show how they are exemplified in the book. Let me be clear, though, this book is a novel and neither about psychotherapy nor EMDR.

In *The God of Small Things*, Roy presents a family caught up in the historical, political, religious, and cultural forces of their time and place, as well as caught up in their individual and family dynamics, and in the way all of these forces interact dramatically and cruelly. The time periods are two weeks in December 1969 and twenty-three years later; the place is a small town in Kerala in southern India:

> In the country that she came from, poised forever between the terror of war and the horror of peace, Worse Things kept happening. (p. 19)
>
> . . . it really began in the days when the Love Laws were made. The laws that lay down who should be loved, and how. (p. 33)
>
> They sat there. . .Trapped in the bog of a story that was and wasn't theirs. That had set out with the semblance of order, then bolted like a frightened horse into anarchy. (p. 236)

Roy outlines the main events and presents the main characters in the first chapter, not unlike what we hear in an initial session. Ammu, one of two siblings, comes from a family where both she and her mother, Mammachi, were beaten by her father. Ammu married a man who was alcoholic and not a Syrian Christian, so that after they divorced, she and her twin children are outcasts when she returns home. In December 1969 the twins, age seven, run away, are blamed for the death by drowning of their nine year old half-English cousin, Sophie Mol, and are forced to betray Velutha, a man whom they and Ammu love, violating the tradition of caste. The twins are then separated from each other, and from their mother, until they come together again twenty-three years later.

Our clients, when we first see them, remain stuck in the trauma like these characters, unless the trauma is worked through. And, even with a willingness to do the therapy work, there are often systems issues that go beyond the individual. For Rahel and Estha, the "two-egg twins" (p. 2), time stood still, just like:

> Rahel's toy wristwatch [that] had the time painted on it. Ten to two. (p. 37)

They experienced:

> Not death. Just the end of living. (p. 321)
>
> . . . the Loss of Sophie Mol grew robust and alive. It was always there . . . It ushered Rahel through childhood . . . into womanhood. (p.16)
>
> But anger wasn't available to them and there was no face to put on this Other Thing . . . It wasn't theirs to give away. It would have to be held. Carefully and for ever. (p. 191)

In learning more of the characters' history we learn that:

> Once the quietness arrived, it stayed and spread in Estha. It reached out of his head and enfolded him in its swampy arms . . . hoovering the knolls and dells of his memory . . . It stripped his thoughts of words that described them and left them pared and naked. Unspeakable. Numb . . . Gradually the reason for his silence was hidden away . . . (pp. 11-12)
>
> 'To understand history,we have to go inside and listen to what they're saying. And look at the books and the pictures on the wall. And smell the smells.' (p. 52)

And this is exactly what Roy has us, her readers, and her characters do, and she does it with superb craft and sureness:

> . . . a few dozen hours can affect the outcome of whole lifetimes. And that when they do, those few dozen hours . . . must be resurrected . . . and examined. Preserved. Accounted for.
>
> Little events, ordinary things, smashed and reconstituted. Imbued with new meaning. Suddenly they become the

bleached bones of a story. (pp. 32-33)

Thus, in EMDR terms, developing new and positive self-beliefs and a narrative of the events that can be integrated in a functional way. As we find with our clients, it is hard to deal with a trauma as a whole, before three months or so. At first the memory consists of the discrete sensations and details of the traumatic experience:

> Esthappen and Rahel woke to the shout of sleep surprised by shattered kneecaps.
>
> Screams died in them and floated belly up, like dead fish. Cowering on the floor, rocking between dread and disbelief, they realized that the man being beaten was Velutha. (p. 308)

At the police station, the Inspector:

> . . . sensed the growing incoherence in the children. He noted the dilated pupils. He had seen it all before . . . the human mind's escape valve. Its way of managing trauma . .
>
> Gradually, in a fractured, disjointed fashion, things began to fall into place. (pp. 313-314)

Before starting the reprocessing work, we encourage clients to find a safe place to manage their distress. The twins thought that they had found a safe haven at History House.

When our clients have insufficient ego strength to tolerate the stress of therapeutic work, we will help them develop the needed ego resources. Rahel and Estha, fused psychologically, were each other's resource. Separated from each other, at age seven, for twenty-three years, and from their mother, they barely functioned:

> . . . their mother . . . left them behind, spinning in the dark, with no moorings, in a place with no foundation. (pp. 191-192)

In EMDR work, we encourage our clients to access disturbing incidents in as full a sensory mode as possible. Roy presents the characters' experiences in vivid and rich sensory detail: sights, sounds, smells, tastes and feel, such as, "the oldfood smell" (p. 35) of the hotel in Cochin, or: "the sharp, smoky stink of old urine that permeated the walls and furniture" (p. 7) at the Kottayam police station.

> And so Estha was Returned in a train . . . He had terrible pictures in his head.
>
> Rain. Rushing, inky water. And a smell. Sicksweet. Like old roses on a breeze.
>
> But worst of all, he carried inside him the memory of a young man with an old man's mouth. The memory of a swollen face and a smashed, upside-down smile . . . (p. 32)

Just like the EMDR therapist, Roy even tells the reader to bring up a picture:

> The fisherman had already found Sophie Mol.
>
> Picture him. (p. 258)

We then ask our clients their negative and positive self-beliefs in relation to the trauma:

> . . . Estha . . . thought Two Thoughts:. . .
>
> (a) Anything can happen to Anyone
>
> And
>
> (b) It's best to be prepared. (p. 194)

The twins feel inappropriately guilty and responsible for their behavior as children and have not been able to move beyond the disasters that befell them.

> In the years to come they would replay this scene in their heads. As children. As teenagers. As adults. Had they been deceived into doing what they did? Had they been tricked into condemnation? (p. 318)

Certainly, the issues of responsibility, safety, and choice were as pertinent to them as to many of our clients.

> And what had Estha done? He had looked into that beloved face and said: Yes . . .
>
> The word Estha's octopus couldn't get at: Yes. Hoovering didn't seem to help. It was lodged there, deep inside some fold or furrow, like a mango hair between molars. (p. 32)
>
> It took the twins years to understand Ammu's part in what had happened . . . they saw her swollen eyes, and with the self-centredness of children, held themselves wholly culpable for her grief. (p. 324)

Roy presents her characters' emotions directly and symbolically:

> A cold moth with unusually dense dorsal tufts landed lightly on Rahel's, heart. Where its icy legs touched her, she got goose bumps. . .
>
> A little less her Ammu loved her. (p. 112)
>
> Estha Alone walked weavily to the bathroom. He vomited a clear, bitter, lemony, sparkling, fizzy liquid. The acrid aftertaste of a Little Man's first encounter with Fear. (p. 119)

We ask our clients to say where they feel their distress in their bodies. Roy describes:

> Though the rain washed Mammachi's [Ammu's mother] spit off his face, it didn't stop the feeling that somebody had lifted off his head and vomited into his body. Lumpy vomit dribbling down his insides. Over his heart. His lungs . . . All his organs awash in vomit. (p. 286)

The characters, and our clients, handle time fluidly, moving between past and present, often having a dual focus on both past and present, having the feelings and thoughts as they did at the time of the trauma.

> Twenty-three years later . . .
>
> Estha, sitting very straight, waiting to be arrested . . . (p. 327)

In the present, the twins are the same age as their mother at the time of her death: 'a viable, die-able age. (p. 3)

> . . . Estha - steeped in the smell of old roses, blooded on memories of a broken man -. . . (p.12)

(Continued on page 30)

(The God of Small Things - Continued from page 29)
Baby Kochamma, grand aunt of the twins, feared:

> They might even steal their present back. (p. 29)

Roy is exceptional in being able to present the perspective of children and shows how they often take things literally:

> Rahel knew that Sophie Mol died because she couldn't breathe.
>
> Her funeral killed her. (p. 7)
>
> . . . Ammu sifted through her rage to try to make sense of what had happened . . . The careless words she hadn't meant. '. . . You're the millstones round my neck!'
>
> She couldn't see them crouched against the door...
>
> 'Just go away!' . . .
>
> So they had. (p. 253)

As therapists, we need to be sensitive to our clients responding in child-like ways when they are dealing with trauma from childhood.

The characters, like our clients, have their traumatic memories triggered in the present:

> It had been quiet in Estha's head until Rahel came. But with her she had brought the sound of passing trains, and the light and shade that falls on you if you have a window seat. The world, locked out for years, suddenly flooded in . . . (pp. 14-15)
>
> Years later . . . in upstate New York, on a Sunday train . . . it suddenly came back to Rahel . . .
>
> That hard marble look in Ammu's eyes. The glisten of perspiration on her upper lip. And the chill of that sudden, hurt silence. (p. 72)

EMDR therapists are concerned about clients' use of dissociation at the time of trauma, as well as, in the therapy session. Estha was: "A quiet bubble floating on a sea of noise." (p. 11)

When Velutha was trying to get help:

> His mind, suddenly impossibly old, floated out of his body and hovered high above him in the air, from where it jabbered useless warnings. (p. 285)

I have tried to give you a sense of the language in this novel and of the way experiencing Roy's writing and characters can enrich our thinking about and understanding of EMDR and psychotherapy. I hope that you enjoy reading the book and that it may further inform your practice. Arundhati Roy, a gifted writer, presents the truth, beauty, and horror of life, but, of course, this is just fiction . . .

Reference

Roy, Arundhati.(1997). *The god of small things.* New Delhi:

⇔

EMDR Institute Discussion List

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Andrew Leeds, Ph.D.
List Moderator, EMDR Institute Discussion List

[*Editor's Note: The EMDR Institute Discussion List is operated by the EMDR Institute, Inc. exclusively for individuals who have trained with that organization. (The Discussion list is not operated by EMDRIA™.) For information on the Discussion List, please contact the EMDR Institute, Inc. directly.*]

May marked the two-year anniversary of the establishment of the EMDR Institute Discussion List. The creation of this list was a shared vision of A.J. Popky and myself for several years which finally came to fruition with the generous assistance of Beverly Jamison and the support of St. Johns University.

In the beginning, A.J. and I created a division of labor in which he would do most of the largely invisible management of the technical aspects of the list and I would take care of moderating the online discussion. So, for the last two years, A.J. Popky verified over a thousand subscription requests in the EMDR Institute database showing who was trained, and responded to literally thousands of other e-mail requests for assistance with modifications in e-mail subscriptions. After two years of dedicated volunteer service, A.J. is stepping down from the role of technical liaison. I and the other members of the EMDR Institute Discussion List owe A.J. a debt of gratitude for his patient responsiveness to (sometimes impatient) clinicians eager to get their subscriptions working, changed or canceled. I know A.J. will remain active as a list member and will remain involved as a "quiet" listowner in the transition over the next few weeks.

Thanks A.J. You've done a great job.

New Technical Liaison

The new technical liaison for subscription services for the EMDR Discussion List will be Stacy Bradley. To obtain assistance with changes in your subscription or other technical support questions, please contact her directly:

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Pacific Grove, CA 93950
Phone: (831) 372-3900 ext. 11
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⇔

Introducing the

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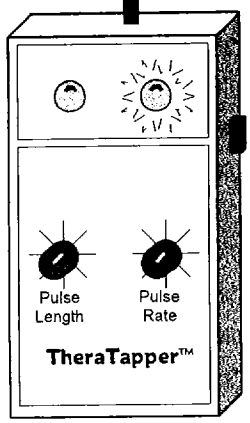
A convenient alternative to manual tapping

The TheraTapper™ consists of a small hand-held control box (with two knobs and two blinking lights) connected to two small canisters by two six-foot wires. The canisters, which fit easily into the client's hands, briefly pulse in an alternating fashion, first one, then the other. Two control knobs adjust the tactile experience to suit each client. The left knob adjusts the pulse length (short to long), and the right knob adjusts the rate of alternating pulses (slow to fast). Two small lights at the top of the TheraTapper™ blink on and off in an alternating fashion with each pulse, giving real-time visual feedback about the length and rate of the stimulations. A power switch on the side operates independently of the two knobs so settings remain fixed when the box is turned off and on between sets. It operates very efficiently with two AA batteries, and is covered by a full one-year replacement warranty. Invented by Shirley Jean Schmidt, an EMDR® therapist, and her really smart husband, Jürgen!



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Patent Pending

TheraTapper™ Benefits ...

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- Passive stimulation; requires no effort from client
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- Safeguards against litigation claiming therapist touch was sexual
- Sets can be very long without strain to client or therapist
- Processing with eyes closed can lead to deeper processing
- Canisters can be placed to suit client, in hands, pockets, socks, etc.
- Client and therapist can easily dialogue during sets
- Many clients report the sensation is reassuring and grounding
- No stress to therapist neck, back, wrists, etc.
- Effective with kids
- Take notes during sets
- Lightweight & portable
- Inexpensive

"I find that 90% of my clients prefer the TheraTapper to EMs. I was initially surprised to find, that in addition to the increased ease and comfort for the client, most reported increased effectiveness in processing with the TheraTapper, and that feedback has continued over the 6 months I've used the device. I find the TheraTapper to be invaluable in my EMDR practice." **Rick Levinson, MSSW**

"Before I bought my TheraTapper I found EMDR with my highly cognitive clients was often ineffective and disappointing. When I started using the TheraTapper I was absolutely amazed. It somehow allowed these clients to break through their over-intellectualizing, allowing safe passage to the painful issues that most needed attention." **Regina Cansler, MA, LMFT**

"I work with kids a lot. I tell them the TheraTapper is a "gizmo." They think of it as a fun electronic device, and take to it quickly. It is much easier for kids to hold the gizmo than to sustain EMs." **John Palmer, LMSW**

"The TheraTapper is an excellent addition to the growing field of EMDR technology. It is the only one which provides bilateral tactile stimulation. It is non-intrusive and highly effective and has my endorsement. It works!"

David Grand, RCSW
EMDR Facilitator

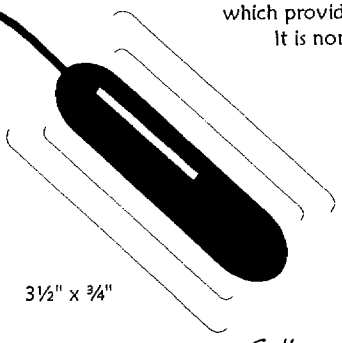
"I like the TheraTapper, it is nice and soothing. It is not abrupt or startling at all for the client. It also gives me a lot of space from the client if they cannot tolerate the closeness EMs require. It saves my arm, can be an additional stimulation other than the eyes, and is generally easy to use and handy." **Susan Thompson, LSCSW**

"I have used my TheraTapper with kids and found it to work effectively." **Carol York, MSSW, LMSW-ACP, EMDR Facilitator**

"I first used my TheraTapper with 4 patients who had been reluctant or unable to respond to EMs or any kind of physical touch – such was the severity of their trauma. The TheraTapper performed its task well. All 4 showed improvement and relief over several sessions. I'm happy with this tool." **Irene R. Mazer, PhD**

"I enjoy the TheraTapper very much in my practice, it is much more convenient than EMs in that I don't have to start and stop - can continue processing as long as is needed, doesn't seem to break the flow. It is relaxing and seems less threatening to clients than EMs. I have seen a lot of progress in many of my clients while using the TheraTapper." **Stephanie Ecke, LPC, LCDC**

"A tool that is kept in the front of a toolbox is simply one that works. Many times I find that the TheraTapper reaches places that eye or ear stimulation do not. That's why I keep my TheraTapper right in the front of my toolbox."
Lawrence Nieters, PhD



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EMDR Cures Kidney Stones?: A Case Report

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When I was teaching EMDR to a small group of professionals last year, I had occasion to demonstrate various portions of EMDR treatment of a medical problem during Day 3 of the course (roughly equivalent to the first half of Level II). The participant was a middle-aged man who had suffered for months with complications related to kidney stones which he failed to eliminate from his system, leading to installation of a shunt and entailing frequent infection. He was barely able to attend class, felt constantly exhausted and ill, and lived on liquids and medications.

In a small-group practicum earlier in the day, the man had an opportunity to work through the events surrounding the ordeal of his diagnosis and medical treatment. Later, he was the patient for a demonstration of installation of a positive future template—in this case, involving sensations of health and vigor as well as renewed ease of strenuous physical activity.

We then focused on what he could do in the present to attain this positive future. He had recently been through a procedure which fractured a large stone which remained, however, in its original shape. His physician had instructed him to drink a lot of water in the hope that the fragments would wash away one at a time. However, if the stone passed as a whole (which was a distinct possibility), the process would be painful and dangerous.

During EMDR, I had him visualize himself drinking the water, seeing the water pass through his system and wash away the fragments one at a time. Each time he ran through this exercise, I also had him "tack on" an image of one of the positive future activities to which he would return with subsequent good health.

Suddenly he cried out, and doubled over in pain. He recovered momentarily, and explained to the class that this is what it felt like when a stone (or fragment) passed, a feeling he experienced every six to eight weeks. He agreed to continue the visualization with eye movements a bit more, and then we went on to other class activities. I also suggested he practice this visualization on a daily basis, with eye movements.

Day 4 of the class was a month later and, of course, we all wanted to know how he was doing. He reported that he had seen his physician for a scheduled appointment several days after the previous class, and learned that he had safely passed 14 fragments and the entire stone had been eliminated from his system. He was able to have the shunt removed, and his health had already recovered considerably. (I offered my services as a guru on the spot, but nobody took me up on it!)

About a month later, we spoke on the phone and he was curiously disinterested in his recent miracle cure. He was more interested in mowing the lawn, working with his clients, and like things, and seemed to consider the kidney stone problem ancient history. Although he had initially expressed enthusiasm for writing up his experience, this desire faded as well, leaving me with the dirty work. Although I was disappointed on that account, I do regard his shift as representing a healthy focus on present and future concerns.

Of course, in a case report of this kind, there is no way to really know what role, if any, EMDR actually played. It does encourage my suspicion that EMDR can enhance the effects of those healing visualizations that focus on physiological processes. Personally, pending further study, I would certainly try this routine again in a similar situation.

Events and Deadlines

Submission of abstracts for the *Call for Papers* for the 1999 EMDR International Conference are due no later than November 1, 1998 (see page 34).

Contributions to the next *EMDRIA Newsletter* are due November 20, 1998. Articles for the following issue should be received by February 15, 1998. Please refer to the Submission Information on page 39 for details.

The deadline for inclusion in *The EMDR Register* is December 31, 1998 (see page 21 for information on *The Register* and page 23 for *The Register* Application).

1999 ANNUAL EMDRIA™ CONFERENCE
CALL FOR PAPERS

EMDR INTERNATIONAL ASSOCIATION CONFERENCE

June 18-20, 1999
Las Vegas, Nevada

SUBMISSION DEADLINE: November 1, 1998

Abstracts are invited for the Annual EMDR International Association Conference. Material should be relevant to the EMDR field and be an original contribution. All presentations should involve participants in a continuing education experience. A variety of innovative and creative programming related to the field of EMDR will be considered. Members and non-members of EMDRIA™ are invited to submit abstracts.

IMPORTANT: The professionals submitting the abstracts for the program are responsible for contacting all co-presenters and for all details, including abstract submission, communication with presenters, presentation format, audio-visual requests and payment of fees. Presenters pay registration fees, at a reduced rate, if attending any portion of the conference other than their own presentation.

Abstracts must be postmarked no later than November 1, 1998. Notification of acceptance will be made by December 15, 1998.

SUBMISSION GUIDELINES AND INFORMATION

ALL ABSTRACTS WILL BE PEER REVIEWED without the name(s) of the author(s). This "blind" review process will help ensure that the evaluation is fair and equitable, and that factors such as gender, ethnicity, and reputation do not play a role in judging the quality of the submission. Therefore, be certain NOT to identify yourself in any way on the abstract portion of this form.

ABSTRACTS MUST BE TYPED AND SUBMITTED WITH THIS FORM. (Duplicate this form for additional submissions.)

SUBMISSIONS MUST INCLUDE: 1) this completed form, **2)** two (2) copies of page three with its attachments, **3)** curriculum vitae or resume for **EACH PRESENTER**, and **4)** a biographical sketch for **EACH PRESENTER** in paragraph format of **100 words or less** (this will be published in the Conference Program). Each submission must be signed by the presenter chair. Incorrect or incomplete submissions will be returned and not considered until submitted properly. For questions, call Gayla Brown at the EMDRIA™ Administrative Office at (512) 451-5200.

Mail to: EMDR International Association
P.O. Box 141925
Austin, TX 78714-1925

Please fill in all information requested below for **all** individuals. Submit any additional pages along with this form in order to provide divisions with complete information on all participating individuals. Information not appearing on this form and its attachments, including degrees and affiliations, will not appear in the Conference Program.

1. Title: _____

2. Format: ____ Symposium ____ Plenary ____ Workshop ____ Conversation Hour ____ Poster Session

3. Length of time requested on program: ____ Conversation hour ____ 90 min ____ Half day (3 hrs. of instruction) ____ Full day (4.5 hrs. of instruction)

4. Category(s): ____ Clinical Adult ____ Clinical Child/Adolescent

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____ Advocacy/Grassroots ____ Research

5. Presenter Listing: List chair's name first. For each presenter, list name, highest educational degree, all licensure numbers and state, address, zip code, phone number, fax numbers, e-mail address and professional affiliation.

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6. Abstract: Limited to 250 words. Please type abstract on separate sheet of paper with ONLY the title of presentation and the abstract itself. You may also submit abstract on disk, 3.5" ASCII formatted disk only. Be as specific as possible about the learning that will take place at your presentation. If your presentation is research-based, only completed research with available results may be submitted for a workshop.

7. Learning Objectives: Please type on separate sheet of paper with ONLY the title of presentation and the objectives. List at least three learner outcome objectives. These objectives should be written so that the learner can assess that they have been accomplished. Objectives must be stated in measurable terms. Please indicate how much time is allotted for each objective in minutes. (This information is now required by some CE-granting organizations.)

8. Quiz: Please type on separate sheet of paper with ONLY the title of presentation and the quiz itself. Quiz must contain a minimum of three questions pertaining to your presentation. This may be done in any format you choose, such as True or False, multiple choice, etc. (This information is now required by some CE-granting organizations.) You may submit answers on a separate page.

9. What is new or unique about this material/topic/presentation? Give an example of how the proposed material has been implemented. (Please avoid using identifying information.) NOTE: If your material is a deviation from the standard EMDR protocols, please submit documentation supporting effectiveness.

10. AudioVisual Needs:

NOTE: Audiovisual equipment must be limited to two (2) items. If additional equipment is necessary, please contact our office for approval.

____ TV Monitor/VCR ____ Overhead Projector ____ Flip Chart ____ Slide Projector

____ White Board ____ No A/V needed ____ Other _____

11. Presentation may be audiotaped: ____ Yes ____ No

12. This presentation is suitable for:

____ Beginning EMDR Clinicians ____ Intermediate EMDR Clinicians ____ Advanced EMDR Clinicians

13. This is my only submission: ____ Yes ____ No Second Submission Title:_____

14. Please check membership status: ____ EMDRIA™ Member ____ EMDRIA™ Associate Member

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15. Describe public speaking experience and expertise with proposed topic: (This information should be submitted for each presenter.)

16. List EMDRIA™ board and committee positions held by each presenter to avoid schedule conflicts with meetings.

PRESENTER AGREEMENT

On behalf of myself and my co-presenters, should this abstract be selected, I/we agree that:

1. Participation in this program does not exempt presenters from paying registration fees if attending other conference sessions.
2. Individual submitting this proposal and signing this form agrees to receive all conference correspondence and accepts responsibility for conveying conference related information to co-presenters.
3. EMDRIA™ may videotape and/or audiotape this entire presentation, including videotape and audiotape excerpts, and distribute the tape for educational purposes with no remuneration or reimbursement to presenter(s).
4. Appropriate "Release of Confidential Information" forms have been obtained for all client materials that will be used or recorded as part of this presentation. The responsibility for protecting client confidentiality rests with the presenter(s).
5. Individuals submitting or included within this proposal have agreed to be present in Las Vegas, Nevada, during the hour and date assigned to this presentation at the 1999 EMDRIA™ Conference, and conduct this proposed presentation according to the conditions listed above.

SIGNATURE_____ **DATE**_____

EMDR International Association Information

The EMDR International Association (EMDRIA™) is a nonprofit, mutual benefit corporation and the professional association for EMDR practitioners. The bylaws state, "The primary objective of EMDRIA™ is to establish, maintain and promote the highest standards of excellence and integrity in Eye Movement Desensitization and Reprocessing (EMDR) practice, research and education...". EMDRIA™ maintains a Register of qualified EMDR clinicians; holds an Annual Conference; publishes a Newsletter; provides World Wide Link which includes regional meetings, special presentations, and library; evaluates training programs and develops practice guidelines for the applications of EMDR in various settings; supports EMDR research, advocates for the use of EMDR with health care organizations; and informs the general public about EMDR.

EMDRIA™ is the ongoing support system for EMDR trained practitioners and provides the mechanism for the continued development of EMDR in a professional manner. Through EMDRIA™, practitioners have access to the latest clinical information and research data on EMDR.

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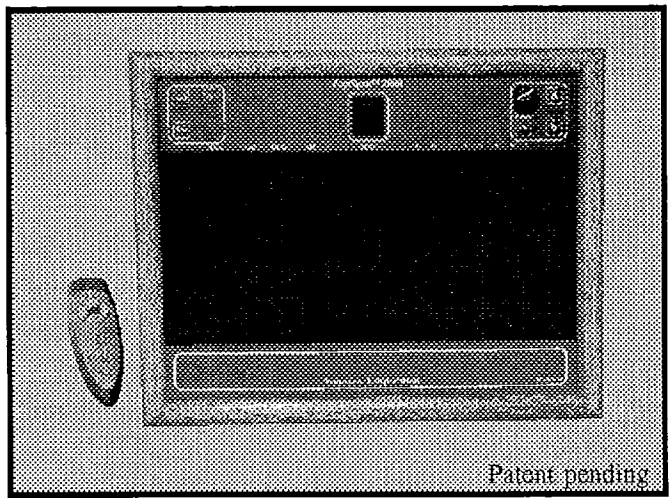

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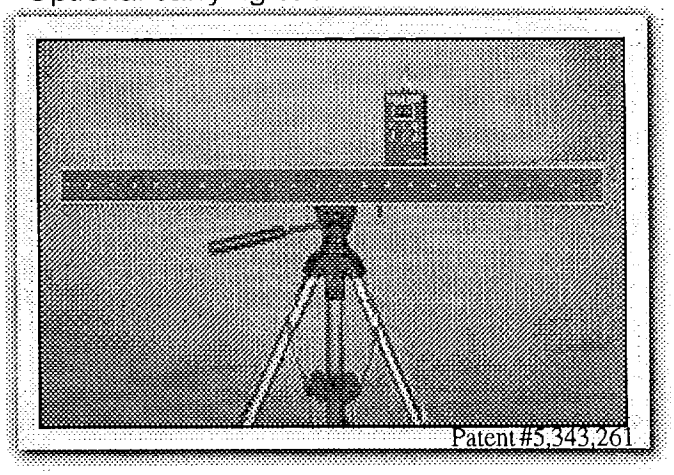

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Please note the following guidelines and policies when making submissions:

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

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DEADLINE FOR NEXT *NEWSLETTER*

NOVEMBER 20, 1998

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

Don't Forget to Mark Your Calendar for the next EMDR International Association Conference in Las Vegas from June 18-20, 1999!

Inside this Issue of The *EMDRIA™ Newsletter*:

Calendar

November 1, 1998

Deadline for Abstracts submitted for the 1999 EMDR International Association Conference

November 20, 1998

Deadline for Submissions to the next *EMDRIA™ Newsletter*

December 31, 1998

Deadline for Submissions to the *EMDRIA™ Register*

June 18-20, 1999

1999 Annual EMDR International Association Conference in Las Vegas