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EMDR Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

 P.O. Box 51010, Pacific Grove, CA 93950-6010 (408) 372-3900 **Vol. 2 Issue 1**

STRAY THOUGHTS

Francine Shapiro, Ph.D.
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Questions have arisen about the use of **EMDR in the courts** and the comparison to hypnosis. So far **EMDR** is not well enough known to have been tested in court; it is simply described under the rubric of cognitive-behavioral techniques (as it is for insurance purposes). However, I want to make sure everyone realizes that just because a scene emerges during an **EMDR** session, does not mean that it is "true" in a literal sense. Things can be "truly experienced" without having actually happened.

I remember an experience when I was around eight years old. I was convinced I had brought home a crafts project to show my grandmother. I was so convinced that I started arguing with her later in the day, when she assured me she had not seen it. Finally, distraught, I raced back to the camphouse, only to find the project still on the floor where I had left it. If I had not gone back to check, **EMDR** would undoubtedly have revealed the memory in its original, disturbing, "true and invalid" form.

Please make sure if incest, abuse, or other disturbing memories arise, that you use full clinical judgment and cross- checks to determine actual validity. Present thought on cult abuse reports, for instance, is that in many instances adults use trickery to make the children think cults or large groups are involved. By the same token, individual perpetrators could conceivably fool children into believing that their parents were actually present and approved an abuse. A strong enough suggestion could implant that image in the child, which is subsequently repressed. While **EMDR** may release the repressed "memory," we do not know if it would necessarily reveal the trickery in every instance. All clinical cautions must be in place.

I thought it might be useful to include the **Protocol for Cancer Patients**. This, of course, is not a substitute for appropriate medical care. However, it was successful with one cancer patient I tried it with and was taken up with excellent results by a therapist for self-use after a cancer operation. Having reported on it at the Somatic Disorders section of the **EMDR** Conference, I am also looking forward to feedback from the field. I do not mean to limit the application to only cancer patients, and expect it will be successful with a variety of somatic complaints. Please let us know your results.

With cancer, as with most presenting pathologies, the **EMDR** model requires a search for the touchstone memories, present factors, and fears of the future that may be involved. **EMDR** must be used on all revealed problem areas. A good history may reveal patterns of self-sacrifice and difficulty in dealing with anger. Present factors may include a "no-win" situation that is generating the feelings of helplessness and hopelessness. The future must be dealt with in terms of questions regarding "Who am I without the cancer" and "What do I have to change or confront." If they apply, the memories that laid the groundwork for feelings of low self-esteem and powerlessness must be metabolized. Issues with parents, family, significant others, career, identity crises, and present upsets must be addressed. The question, "Do I want to live," must be explored, along with any negative emotions that arise.

An excellent resource for cancer patients is a book called Getting Well Again by Carl and Stephanie Simonton. As psychologist and radiologist, they received referrals of primarily the terminally ill. They were intrigued by the question of differential survival rates and their analysis revealed that these were often correlated with the attitude of patients and mental imagery they were using. They suggest helping the patient to formulate a mental image of the immune system as powerful and in some way defeating the weak cancer cells.

A good cognitive groundwork is useful here. Assure the client that cancer cells are the weakest in the system.

That is why chemotherapy works; it kills off the cancer cells while the stronger, healthier ones survive. Often, at this point, with **EMDR** you may have to work on some "non-useful" statements made by medical personnel regarding the cancer's potency. It is unfortunate that there are still some physicians who are seemingly ignorant of the findings of psycho-neuroimmunology.

My client had worked with Simonton and had developed an image of electricity coming in through the top of his head and sparking through his entire body, killing all the cancer cells. However, when I first saw him, he reported that he used the imagery only rarely, and the electricity often got "stuck" in certain parts of his body and would not proceed the entire way through.

Working with the **EMDR**, I had my client first formulate a positive cognition to go with the picture. He chose "My immune system heals me." I then had him hold the picture of the electricity together with the positive cognition and added in the eye movements until it strengthened. I then had him close his eyes and imagine the electricity moving throughout his body. Any place it "stuck," we stopped and used the eye movement until it moved freely throughout his body.

The objective is to allow a fluid image of the cancer cells being destroyed and leaving the system. We used the **EMDR** repeatedly in the office on the linked cognition and image until he could access both powerfully and easily. He then chose to rehearse the imagery every time he urinated, with the added thought that the cancer cells would be washed out of his system (i.e., "It will take away all the poison.")

When possible, have the picture and cognition linked and use the eye movements. When that is not possible, for instance, if it is a moving picture and the client has difficulty maintaining a focused attention, then use the eye movements on the positive cognition at the opening and close of the imagery.

The client should log any doubts, resistance, pertinent memories, or current upsets. Fears should be addressed with the **EMDR**, along with all the traumatizing experiences of the cancer, including feelings of "body betrayal," real or perceived callousness or indifference of the medical profession, family, friends, and emotions related to hospital stays, medical tests, operations, etc.

I want to emphasize that I consider most victims of severe illness to be suffering from post-traumatic stress disorder (PTSD). While we can see this clearly in the rape victim, or molest victim, let us not minimize the impact when the perceived perpetrator is the victim's own body or immune system. The sense of powerlessness and self-disgust can be paralyzing. We must be very careful to frame the work as "self-healing" and help restore a sense of power and choice.

Relaxation and pain control techniques, such as those I taught in Level II, can be very helpful to allow a sense of self- efficacy. Also helpful are alternative care approaches such as massage, nutrition, etc., to help encourage a sense of "self- nurturing" and mobilization of resources. Self-care and logging doubts and fears is an on-going process. Of course the **EMDR** treatment is never complete until the client is able to envision him/herself healthy and cancer-free and a body scan reveals no negative sensations. The image is of course strengthened as much as possible. My former client is now adding in the cognition, "I have control of myself—nothing will interfere with my feeling that I can get better," along with using the eye movements at home. I become a resource if a real-life crisis emerges. He is the healer—doing his own healing.

FROM THE EDITOR

David Fenstermaker, Ph.D.
JFK University
San Jose, CA

It has been more than a year since Francine and I, while sipping Sake in a small Japanese restaurant, worked out the basic format for the **EMDR** Newsletter. I had no idea what it would really take to produce a Newsletter, which is probably the best way to undertake a project like this.

There are two groups of contributors I want to thank. The first group is those to whom I turn for editorial help and collaboration in the publication. Robbie Dunton's talented organizing and publicizing ability place shape and guidance to the project. Lois Allen-Byrd and Robbie share the substantial task of fine tuning the Newsletter to conform to the subtleties of the English language. This task is both painstaking and time-consuming, although it is one they perform beyond distinction. A. J. Popky, with his computer graphics ability and down-to-earth common sense, actually produces the Newsletter. I also would like to thank Ron Martinez, Assistant Editor, who writes the "Innovative Uses" column, and Andrew Leeds, Assistant Editor, who writes the Column entitled "Difficult Cases." Both have put their creative intellect to this project. Thanks also goes to Bob Welch, Ph.D., for giving his time as Science and Research Editor.

The second group that I wish to thank are the contributors who have given graciously of their time and clinical knowledge and expertise. The demand for all of us to maintain current information is critical, and, thanks to those who have contributed, we as a group stand closer to the edge of excellence. I know many of you have put up with me saying, "Type that up and send it to me," or Francine saying, "Send that to the Newsletter." If you have items of

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interest that you think others in **EMDR** would benefit from, or questions that you would like to see answered, please put them on a disc and send the disc to me. Your contributions will help keep **EMDR** at the edge of excellence.

The projects that we are planning are exciting, and they will expand the depth and areas of **EMDR** utilization. In the November, 1992 Newsletter the area of concentration will be interventions with children who have suffered traumatic experiences. These experiences can originate from: family violence, chronic or progressive-degenerative illnesses, natural disasters, accidents, or molestations. We have a great deal of expertise in defining the problem and using **EMDR** with adults. We anticipate developing this same expertise with children. To that end we are looking for responses to two questions from those of you who work with children. The first question is, after a clinician decides that **EMDR** would be appropriate for a child, how is this framed for the child; in other words, how is **EMDR** introduced as a relevant mode of treatment? Eventually our experience base will include this particular "how" for each different age group. The second question concerns how the procedure is actually done for a given aged child. Other helpful information to know would be how recent the trauma is, what prior treatment, if any, for the problem has taken place, and what predisposing factors are significant. Thus, the responses should include the following information: age, type of trauma, predisposing factors and prior treatment, presentation of **EMDR**, and the actual use of the procedure.

The Newsletter of January, 1993, will be premiering work with critical incidents. It will be a review of work within the immediate aftermath of a trauma and the role **EMDR** can serve in Critical Incident Stress Debriefing. This brings the role of **EMDR** within the scope of the primary mental health directive in this country, which is to encourage primary prevention and maintenance of positive mental health. This type of primary prevention will have long standing effects on those we treat following a critical incident. There will not be the loss of our humanness from the usual succumbing to the effects of physical illness, nor from the drop into the more long standing effects of PTSD. Excerpts from Roger Solomon's paper from the **EMDR** Conference (April 3, 4, 5, 1992) will be highlighted. Roger is nationally known for his work in critical incident stress debriefing, and the population with whom he works includes: police officers, railroad engineers, firefighters, and paramedics, all of whom during sometime in their careers are exposed to critical incidents. Roger largely deserves the credit for the introduction of **EMDR** into that area of specialization.

The Newsletter has been a great pleasure to produce and it has brought me into contact with some very exceptional people. I look forward to meeting more of you through the network meetings and through my travels with **EMDR**. I also look forward to your participation in the Newsletter. Please send in your articles and case vignettes; putting your thoughts in writing will help you with your own ideas and will enrich others through reading them.
[If possible, please submit material on an IBM floppy disc.]
Thank you,

David Fenstermaker, Editor.

FROM WORTHLESS TO WORKING

Edith Ankersmit, LCSW
Berkeley, CA

Julie, age 40, came to therapy depressed and feeling "stuck." She was married to a verbally, and, at times, physically abusive man, and had recently quit her job. As a child, she had been verbally abused and beaten

by an emotionally removed and critical father. She was intelligent and had basic strength and humor.

After one individual session, she joined my women's group, with one of her main goals being to start working again. She was referred to an agency that does vocational counseling for battered women.

At her eighth group meeting, Julie came in very discouraged. She and her vocational counselor had decided that she was resisting in her work search, and Julie felt that she would need therapy "every day for a long time" to overcome this block. I asked her what was standing in her way, and she said she felt " worthless."

I then asked her if she was willing to do **EMDR**, and she agreed. This was her first and only session of **EMDR**, which lasted approximately twenty minutes. I will describe what transpired. I asked Julie to close her eyes and remember a time in her childhood when she felt worthless. She did this without telling me the incident, but gave it a high SUDS level. As the **EMDR** progressed, her parents became physically smaller and she grew larger. I then asked her to bring herself to a scene with her husband. At first she felt frightened. Then, as the eye movements progressed, she was dancing around the table, running away from her husband, saying "na, na, na." In the next scene she was living alone, feeling peaceful. I then asked her to bring this peaceful feeling to a job interview. She came out of the interview feeling "great." I asked her to take the "great" feeling to the original scene with her parents. She did this, and the session ended with Julie glowing, saying she "hadn't felt this way in years," not since she lived alone before her marriage.

Julie returned to the next group meeting having spent the intervening time intensively searching for a job, and feeling somewhat realistically discouraged by her lack of results. She had also made the decision to have separate friends and to do what she wanted, despite her husband's disapproval. She reported two dreams, which I consider to be continued processing of the **EMDR** procedure. One dream was of a volcano about to erupt. Julie said it wasn't a scary dream, and she saw it as a message that a change was coming in her life. I saw it as her considerable strength and energy beginning to burst through, but did not offer this interpretation. The second dream was very bright, in color, and occurred the night after we did **EMDR**. It was simply of her as a child in her room upstairs over the garage, where her father was always working. She would be nasty and rebellious in an attempt to get his attention. She saw that she used a similar behavior with her huband, and that she goaded him to hit her. She thought she did this so she could have a reason to leave the marriage.

At Julie"s next group meeting, she told us she had several job prospects and might have to leave the group. The following week she did not show up, and I learned by phone that she had found work and had to start immediately. I offered her therapy at another time of day, thinking she still had issues in her marriage to work out. She said she wanted to take a break from therapy for now. Since then, I have heard from another group member that Julie is happy with her job, and she was enjoying the attention she receives from the men she works with.

Thus, Julie ended therapy completing her major goal of finding work after only ten sessions, but only two sessions after one **EMDR** procedure. I consider the extreme brevity of the procedure and the rapidity of the results due, in part, to Julie's underlying strengths. However, without **EMDR**, I am certain she would have been stuck and depressed for quite some time.

TWO BOOK REVIEWS

by Andrew M. Leeds, Ph.D.
Santa Rosa, CA

Memory in Mind and Brain: What Dream Imagery Reveals

by Morton F. Reiser, M.D., Basic Books, 1990

Mindworks: Time and Conscious Experience

by Ernst Poppel, Harcourt Brace Jovanovich, 1988
Originally published as Grenzen des Bewubtseins.

What is the relationship between memory and consciousness? Can Freud's theories coexist with modern neuroscientific knowledge? What is the role of emotion in organizing memory and in recruiting stored images during REM sleep? The book jacket from Morton Reiser's, Memory in Mind and Brain (1990), offers us the lofty promise that the widely acclaimed author of Mind, Brain, Body "once again brilliantly integrates data from neuroscience, psychology, biology, artificial intelligence and psychoanalysis to answer key questions about how the brain works."

In his book, Reiser takes us on a clear if plodding journey through the trenches of Freud's interpretation of dreams to the furthest edges of research on cognitive neuroscience. He takes the position that to unlock "the safe deposit box" containing "the secret of dreams" we need two keys. The first key opens a "file cabinet containing neurobiological and cognitive neuroscientific information about memory." The second key unlocks the file containing clinical psychoanalytic information about memory.

In Section II of Memory in Mind and Brain, depth psychologists, especially

psychoanalytic followers of Freud, are given a detailed review (more than 60 pages) of Freud's "Dream of the Botanical Monograph." The purpose of this lengthy exercise is to present psychoanalytic support for Reiser's central thesis on the organization of memory: "Sensory residues in the mind are organized by affect and arranged as nodal memory networks" (p. 92). Non-analysts are likely to read Section I, with its overview of Reiser's dual-track approach to understanding memory, and then skim through most of Section II.

For those who like their science served open faced, Section III of Memory in Mind and Brain gives us a detailed summary of empirical studies in cognitive neuroscience. This summary focuses on a search for specific evidence to support Reiser's central thesis on affect as an organizing principal of memory. Animal rights activist's should beware; Reiser reviews some painstaking animal research by Mishkin and Appenzeller (Scientific American, 1987) on one trial object recognition. This extensive research project maps out the pathways in the brain by which "imagery units [are] routed, processed, stored, retrieved, reassembled, and reperceived in waking states and in dreaming sleep" (p. 103). This section is an excellent review of how images are processed in the brain and is well worth careful reading .

For those interested in the theoretical model underlying Eye Movement Desensitization and Reprocessing (EMDR), part IV of Reiser's book examines the evolutionary role of REM sleep. Reiser reviews Jonathan Winson's research on REM in the mammalian brain. An article by Winson published in the Scientific American ("The Meaning of Dreams," Scientific American, 11, 1990, pp. 86-96) subsequent to Memory in Mind and Brain was referred to on page 4 of the EMDR Network Newsletter (1991, Vol. 1, No. 1). In this article, Winson presents his thesis that Theta rhythm passing through the limbic system during REM sleep provides a means of efficiently processing and formulating survival information, thereby reducing the amount of cortical tissue needed to a reasonable brain size. Reiser also reviews several other recent theories on REM and the neurological purpose of the dream state.

Reiser is refreshingly careful throughout the book to distinguish between hypothesized nodal memory networks (organized by affect) and their underlying neural nets. He began conceptualizing nodal memory networks in the early 1980s, as a theoretical construct to help integrate psychoanalytical and psychophysiological ideas on anxiety. The platform for these hypothesized nodal memory networks is the involvement of neural nets in the processing of images. These neural nets represent actual biological circuitry. For example, every cell in a neural net of the striate cortex "may be a member of a hundred constellations each consisting of a thousand cells" (p. 163). Reiser's careful discrimination between these conceptual poles helps the reader to retain confidence in the boundary between scientific research and metaphor, which other authors sometimes overlook or deliberately obscure.

Reiser closes with an attempt to revise Freud's model of dreaming and bring it into conformity with the cognitive neuroscience he reviews in the book. In his epilogue, Reiser calls for further interdisciplinary research to carry forward the integration of psychoanalysis and neuroscience. He mentions the work of Shevrin and Dickman to correlate data on unconscious effort with evoked sensory brain potentials as one of the few examples of exploratory work in this exciting area of research. Whether we feel the attempt to revise Freud's theory of memory and dreaming is successful, or is even worth his elaborate toil, Reiser's integrative work is a valuable introduction and reference on the neurophysiology of image processing and advances our understanding of perception, memory, and dreaming in a significant and intelligible way.

Ernst Poppel's Mindworks: Time and Conscious Experience (1988) offers a wide-ranging, but very different exploration of neurophysiology by focusing on our experience of time. Poppel delights in demonstrating that our conscious experience of duration and events is entirely constrained by the physiological limits of perception of which we generally remain completely unaware. Poppel, a vivid and entertaining, strongly dualistic neuroscientist, affiliated both with the Massachusetts Institute of Technology and the Medizinsiche Psychologie in Munich, focuses here on the "temporal illusions" of consciousness.

Poppel's recurrent theme is that the brain consists of various sensory processing mechanisms, only some of which ever reach our consciousness. He believes that the neurologically imposed limits of our conscious perception serve to protect us from a flood of sensory stimulation that would otherwise overwhelm us and leave us incapable of any integration of perceptions into consciousness or organized behavior. Yet Poppel is quick to point out that although some sensory perceptions are excluded from consciousness, they still exert a multitude of influences on the unconscious.

In Chapter 19, "The Unconscious-Grey Area of Consciousness," Poppel expands Freud's simple model of the conscious, unconscious, and preconscious into a three dimensional grid of past, present, and future forms of consciousness, as well as adding terms for five other types of consciousness including infraconscious, paraconscious, and extraconscious. He does not limit his focus to our sense of time; other chapters explore "Pleasure and Pain-Missing Border

to the Emotions," "Is Consciousness Contingent on Language," and "On the Gradual Formation of Ideas in Talking."

Part of the impetus for reviewing Mindworks came from an interesting aside Poppel makes in Chapter 13, "The Limitless Consciousness of Dreams," where he examines Freud's belief that dreams are "the royal road to knowledge of the unconscious" (p. 118). Here Poppel states, "The question is, to be sure, whether one can, or ought, to interpret dreams at all" (p. 118). He then gingerly approaches the thesis that dreams might be meaningless, advancing arguments in support of the notion, but without insisting on it. One of his arguments is that "the phases of sleep in which the dreams occur have a purpose only before birth. After birth, they are superfluous" (p. 118). Poppel's theory is that in the absence of sensory stimulation (especially visual stimulation), REM activity serves to prepare the fetal brain to be fully functional at birth.

Poppel's theory of dreaming as existentially empty will probably leave most psychotherapists unimpressed. His theory of the post-natal dream seems to reflect his deep discomfort with the "irrationality and unreality" of the dream, which perhaps we can forgive in Poppel, the neuroscientist. Yet, his theory of the pre-natal dream as providing "off-line" stimulation for the developing brain seems extremely useful and congruent with observations of lifespan changes in REM activity. Poppel points out that, "The number of the paradoxical sleep phases decreases continuously from [a maximum in] the uterine period, through infancy and childhood, up until adulthood" (pp. 118-119).

Those who have become familiar with Jonathan Winson's research on the evolutionary role of REM in the mammalian brain are likely to discard Poppel's explanation of why dreaming continues after birth: "There was no particular evolutionary reason to delete the phases in which dreaming occurs after birth. They were simply left over, after having accomplished their prenatal task of preparing the brain. They could remain left over, because they did not interfere with anything in particular" (p. 120).

We can kindly set aside Poppel's suggestion that dreaming serves no purpose above the level of stimulating neural circuits and still retain his theory of the pre-natal dream as serving the evolutionary purpose of preparing the visually deprived fetal brain for adequate sensory functioning at birth. Poppel's theory of the pre-natal dream can be accommodated within the same evolutionary perspective that Jonathan Winson proposes for the post-natal dream, that of assisting the brain in processing survival related sensory information.

Mindworks: Time and Conscious Experience, in spite of its dualistic limitations, is a worthwhile explanation of some fascinating research on the neurological basis of perception and the limits of conscious experience. Even if he sheds no light on the meaning of unconscious perceptual processing, as Reiser does in Memory in Mind and Brain, Poppel still reveals and reminds us of the illusions of conscious perceptual reality and gives us an intriguing glimpse of the mechanisms of the mind.

NETWORK UPDATE

Clifford Levin, Ph.D.
National Network Coordinator
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The **EMDR** Conference on April 3rd-5th was an unmitigated success with an attendance of about 160 participants. All of the presentations were of high quality and the primary complaint heard was, "How can I attend two workshops at the same time?" On Friday, Scott Nelson and I presented a full day workshop on the uses of **EMDR** with partners of survivors of incest. Unfortunately, that morning I woke up with absolutely no voice, apparently a case of laryngitis. The hotel was kind enough to equip us with some high quality microphones, so I was able to whisper in an amplified fashion during the morning session. However, I was scheduled to make a two hour presentation in the afternoon. Now you might think that I am about to report that I used **EMDR** on myself and my voice miraculously returned. Well, I cannot admit to this. However, at lunch I had a large portion of Hunan Bean Curd (a very spicy Chinese dish) at a small restaurant near the hotel and the miracle happened. My voice did return enough to complete my presentation. The point of this story is that the whole conference was blessed in this fashion. No matter what the problem, a solution was found and everything ran in an exceptionally smooth manner. The true miracle here was the unbelievable efforts put in by Robbie Dunton, A.J. Popky, and Eirin Gould, who made it all look easy. Thanks a lot guys.

The highlight of the conference was the Keynote speech given by Ron Martinez at the Saturday Banquet Luncheon. Ron is a paraplegic and a guiding light and source of inspiration to all of us who know him. His speech was autobiographical in nature and focused on his recovery from a teenage diving accident which resulted in his paralysis. There was hardly a dry eye in the room by its completion; I know I had a good cry (thanks to Francine for a shoulder to cry on). Our deepest appreciation and gratitude go to you, Ron, for your dignity and character, which puts all of our petty difficulties in perspective. I think we were all changed for the better.

During this year, we are beginning to plan an expansion of the Network

to include regional organizations with quarterly Network meetings, much like those we have here in Northern California. As we get these regional organizations in place, we will be sending videotaped highlights from the Northern California quarterly Network meetings. The Special Interest Groups and Study Groups are putting an incredible amount of work and effort into developing protocols and procedures for a wide variety of DSM III-R diagnostic categories, and it is important to have this information available to other **EMDR** practitioners.

Lastly, I would like all of you to consider writing for this Newsletter. I speak with dozens of **EMDR** trained therapists every month and hear stories about such wide ranging topics as emergency room applications of **EMDR** to formal research studies in the planning stages with PTSD Vietnam veterans with a dual diagnosis of alcohol or substance abuse. You all have something important to say, even if you don't know it. Please send us your articles about **EMDR** successes, mixed results, and failures. We all are anxious to learn.

Thank you for your participation in the EMDR Network. I think that we all have the belief that we are involved in the cutting edge of tomorrow's world of psychotherapy.

VARIATION IN DIRECTION OF EYE MOVEMENTS

Ruth Knowles Grainger, Ph.D.

In working with a young woman with multiple personality disorder, diagonal eye movements brought about almost immediate abreactions. (In fact, the first time that **EMDR** was conducted with this client, two heretofore unknown, cult-induced, alters emerged.) **EMDR** has been used at almost every session, each time with the client-preferred diagonal direction. Sometimes it induces abreactions, and sometimes only anxiety management. For the past two sessions, with the advice, consent, and watchful eyes of 12 already integrated alters who have arranged to be able to talk with the therapist as desired, a change in the direction of eye movements has increased the speed and thoroughness of reprocessing.

One individual, who is trained in kinesiology, described his use of the "infinity sign" and its apparent integrating effect on his clients. I utilized a variation of the "infinity sign" with a multiple personality client. I began with small figure eight hand movements, progressing to larger sweeps (6 feet in length), and then decreased the size of the movements again. The client has reported that this type of eye movement has caused a feeling of greater peace and control in the multiple system, with a sense of speeded up reprocessing toward mental health.

Several clients who have done abreactive work with **EMDR** now use circular or half-arc movements to relax the body and slow the mind in order to fall asleep. This therapist has noted that sleep comes almost immediately when engaging in circular or infinity movements. For example, after one session of **EMDR**, an 83 year old client with life-long insomnia reports awakening briefly only twice during the night as opposed to a history of doing so every 30 to 60 minutes.

Research needs to be conducted on the efficacy of the various directions and shapes of **EMDR** movements as they relate to myriad symptomatology.

DIFFICULT CASES

Andrew M. Leeds, Ph. D.
Petaluma, CA

Have you experienced atypical responses to **EMDR**, lack of progress, even outright therapeutic failures? You are invited to submit your challenging clinical problems to "Difficult Cases." "Difficult Cases" will be a regular column in future **EMDR** Network Newletters. Your proposed solutions are welcome, but are not necessary. Remember, you are not the only one encountering these problems. Please send submissions, which may be anonymous, to:

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[If possible, submit material on an IBM 5.25 floppy in ASCII or MS Word.]

INTERNATIONAL UPDATE

Francine Shapiro, Ph.D.
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Planned presentations for 1992 include three proposals submitted to the International Society for Traumatic Stress Studies (ISTSS) annual conference. One panel would include four Directors of PTSD programs within the Veterans Administration Medical Centers: Neal Daniels, Ph.D., VAMC Philadelphia; Howard Lipke, Ph.D., VAMC North Chicago; Roy Richardson, Ed.D., VAMC Tomah, WI; and Steve Silver, Ph.D., VAMC Coastesville, PA. All staffs are using **EMDR** as the treatment of choice for chronic PTSD with excellent results. Research is planned at

three of these facilities. Dr. Silver is also compiling statistics on the use of **EMDR** throughout the VA system. Joan Barron at Dayton, Ohio, has also inaugerated an **EMDR** electronic mail group on the VA electronic bulletin board, open only to VA personnel who are trained in **EMDR**. Access information is available elsewhere in this issue.

Regardless of what we thought of the Vietnam War, the nineteen-year-olds who were sent to fight it are still suffering today. The first Vet I ever treated taught me that he was suffering because of his nobility, empathy, and compassion. Liberation from his pain was due largely to self-acceptance. I saw him again, over four years later, and he has maintained the **EMDR** treatment effects. Now we just need the research to bear it out in the scientific literature.

Another panel proposed at the ISTSS conference would include Byron McBride, Ph.D., of the L.A. Sheriff's Department psychology staff on critical incident treatment, Nancy Baker, Ph.D., also of the L.A. Sheriff's Department on treatment of sexual harassment stress reactions and the linkage to earlier sexual abuse history, and Scott Nelson, Ph.D., of the Mental Research Institute on the treatment of partners of sexual abuse victims.

Also planned are presentations at the American Psychological Society (Presidential Symposium) and the International Society of Trauma Counselors.

Gerald Puk, Ph.D., gave a presentation entitled, "Using **EMDR** with Motor Vehicle Accident Trauma," at the Eighth Annual Symposium of the American College of Forensic Psychology this April in San Francisco. The presentation was very well received and a number of **EMDR**-trained clinicians in the audience verified his positive reports. It does a great deal to allay scepticism when members of the audience independently confirm efficacy. Thanks to those of you who did.

Alan Goldstein, Ph.D., the Director of the Agoraphobia and Anxiety Treatment Center of the Department of Psychiatry, Temple University, has launched an **EMDR** study on the treatment of panic disorder. He will be presenting preliminary data at the **EMDR** Symposium we are presenting at the Fourth World Congress of Behavior Therapy in Australia this July. Also presenting, besides myself, are Cliff Levin, Ph.D., on the treatment of partners of abuse victims, and Robbie Dunton, M.A., on treatment of learning disabilities. Independently presenting a supporting paper at the conference on **EMDR** for the treatment of PTSD is Kevin Vaughan, Ph.D., of Hornsby Ku-Ring-Gai Hospital of New South Wales. In another exciting event, Jonathan Winson, Ph.D., Department of Neuroscience, Rockefeller University has completed his preliminary research on the brain mechanisms underlying **EMDR**'s effect. An article has been submitted for publica-

EMDR REFERENCES

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tion and we will send copies along as soon as possible.

Dr. Winson recently sent me a copy of an article published in 1954 that he had unearthed, which reported the observation of rhythmical nystagmus in therapy patients and which posited a connection between this eye-movement phenomenon and thought processes. We have included that article, along with Dr. Winson's "The Meaning of Dreams" from Scientific American, in the present packet. Clearly as past and present research dovetails in support of **EMDR**, we come closer to full acceptance.

NIMH has just approved large-scale research of **EMDR** at the Augusta, GA, VAMC. A copy of the pilot data presented to APA was included in the 1991 **EMDR** article packet. The well-respected status of the researchers and positive results of the pilot data were, I am sure, supplemented with the widespread reports of clinical success among the VA system in the field. Many thanks to all of you who have been vocal in your support. As you know, NIMH grant money is hard to come by these days.

On the down-side, there have been a number of published attacks of **EMDR**. You all know of Cory Hammond, Ph.D., and his use of **EMDR** without training on two MPD clients. His attack on **EMDR** as a "California fad" appeared in the newsletter of the American Society for Clinical Hypnosis (ASCH). A copy of his attack, along with the reply from the **EMDR** Professional Issues Committee (EPIC), was sent to all 1991 **EMDR** Network members.

EPIC's reply was printed in the next issue of the ASCH Newsletter, but unfortunately, simultaneously, there appeared an attack by Drs. Metter and Michelson, who reported the same results as Hammond, stating that the effects of **EMDR** were linked to "emphatically" signally "No" to the client through the lateral hand movement, etc., and any successful effects were temporary and the results of "clever manipulations." They also stated that they had been trained by me. In actuality, I had trained them, but it was before I realized exactly what I needed to teach (i.e., guidelines for vulnerability, selection, pacing, rapport, etc.). I also tried to supervise their whole institute by myself, and they only had one experiential trial; therefore, I was unable to observe many of the participants. I have written a response which should appear shortly in the same newsletter. We are sending it, together with the attack, in the present article packet. While the experience has been painful, it has underscored the need for training the way that it is now done, with extensive supervision.

Another attack appeared in the last issue of the Behavior Therapist. In the last **EMDR** Newsletter, I reported to you that I had been invited to give a three-hour workshop at the annual conference of the Association for the Advancement of Behavior Therapy, in which I would be exploring the **EMDR** model. While most participants were, as usual, intrigued and laudatory, a few came with the idea that they would be trained. When I explained that it could not be done in that length of time, and that client safety factors were involved, they insisted, and one person even informed me that client safety factors were secondary to scientific advancement and should not concern me!

While I recognize that there is a lot of pressure to do otherwise, I feel that each of us has a responsibility to uphold the standards of our profession. I fail to see how responsible therapists and researchers can disregard warnings and simultaneously obtain informed consent from their clients and subjects. When EPIC and the majority of clinicians trained in **EMDR** inform me that our training program is unnecessary, I'll listen, but not otherwise. On that note, I would like this to be the last time I mention the issue in the Newsletter. The attack and rebuttal are included in the present packet. Any others will be forwarded to you without comment, as they are received.

If you think we are doing anything incorrectly, I want to hear about it from you. Likewise, if you think we are doing it well, or have suggestions. However, if you see an attack in print you do not agree with, please feel free to respond on your own. Anything I write, at this point, has limited impact.

Once again on the up-side, the first **EMDR** Conference was a huge success. Over 160 people were in attendance and the overall evaluations were sensational. Clinicians were here from practically every state, Canada, and about a half dozen from Australia. I was particularly happy to see the high calibre of the presentations. Each clinician interfaced his/her own area of expertise with **EMDR** and the directions, observations, innovations, and insights for each area covered were extraordinary. Also fruitful were the continued observations from clinicians in the audience. It left me feeling that **EMDR** is indeed in good hands. I floated through the three days repeating, "We have the best people around us." Needless to say, it was personally very gratifying as the culmination of five years of work.

We have included in this Newsletter the **EMDR** areas covered in the conference, the presenters, and access telephone numbers. For anyone interested in pursuing a particular topic, I suggest direct contact. We are planning the next **EMDR** Conference for March 5, 6, 7, 1993, at the Sunnyvale Hilton. I will again hand select the topics and presenters, so suggestions are welcome.

During my final keynote address, I included a list given to me by Dave Wilson, Ph.D. He said that when he

NETWORK MEETINGS

Sandra "SAM" Foster, Ph.D., California Network Coordinator
(415)965-8988

1992 EMDR Network Schedule
Saturday, June 27th
Saturday, September 12th
Saturday, November 14th
9:30am to 4:00pm

The Network meetings are held at the Sunnyvale Hilton, 1250 Lakeside Drive, Sunnyvale, California (408) 738-4888.

SCHEDULE

9:30-10:00am Registration & coffee

10:00-11:30am Special Interest Groups (SIG) meet to share new information.

11:30-1:00pm Lunch [We suggest a second SIG meeting during lunch.]

1:00-4:00pm General meeting. Presentations by SIGs and Francine.

Our 1991 quarterly Network meetings have been a success as a forum for sharing new applications of **EMDR**, learning about the latest research results, and observing talented colleagues demonstrate innovative twists with **EMDR**.

EPIC (EMDR Professional Issues Committee)

The **EMDR** Professional Issues Committee is pleased to announce that our response to the Cory Hammond article was published. Each of you should have received a copy of this response (as well as Cory Hammond's letter) in the packet of articles that were mailed earlier this year.

EPIC has also decided to write a column for each Newsletter that will focus on professional issues, ethical concerns, or unique situations that you may have encountered in your practice. You may submit any of the above (anonymously if you choose) to Lois Allen-Byrd, Ph.D., 555 Middlefield Road, Palo Alto, California 94301.

We continue to meet the second Wednesday of the month and have been considering a number of issues in and out of the committee. Some of the situations that have been brought to our attention include the following: suitable minimum background and training required to participate in the workshops, appropriate supervision and the context within which **EMDR** will be used, informed consent, protocol for **EMDR** presentations, possibility of training and personnel committees, review of ethical complaints that have been dealt with informally, issues of client safety, and when it is appropriate to use **EMDR**.

If you have any professional issues, concerns, or questions, please contact one of the following committee members:

Lois Allen-Byrd, Ph.D.	(415) 326-6465
Joan Fish, MS	(415) 327-2051
Ferol Larsen, Ph.D.	(415) 326-6896
Jennifer Lendl, Ph.D.	(408) 244-7942
Virginia Lewis, Ph.D.	(415) 326-8752
Marguerite McCorkle, Ph.D.	(415) 322-4884
Roger Solomon, Ph.D.	(206) 943-8987

first read it, it reminded him of what we were trying to create. I have been requested by many present at the Conference to include it in the Newsletter, so here it is as well:

LESSONS FROM GEESE

by Milton Olson

1.As each bird flaps its wings, it creates an "uplift" for the bird following. By flying in a "V" formation, the whole flock adds 71% greater flying range than if the bird flew alone.

LESSON

People who share a common direction and sense of community can get where they are going quicker and easier because they are traveling on the thrust of one another.

2.Whenever a goose falls out of formation, it suddenly feels the drag and resistance of trying to fly alone and quickly gets back into formation to take advantage of the "Lifting power" of the bird immediately in front. [F.S.— When I first read this I thought,"What about individuality, inspiration, taking the initiative, etc." Absolutely, and . . .]

LESSON

If we have as much sense as a goose, we will stay in formation with those who are headed where we want to go (and be willing to accept their help as well as give ours to the others).

3.When the lead goose gets tired, it rotates back into the formation and another goose flies at the point position.

LESSON

It pays to take turns doing the hard tasks, and sharing leadership — with people, as with geese, we are interdependent on each other.

[F.S.—The conference was about expanded leadership in proven areas of expertise.]

4.The geese in formation honk from behind to encourage those up front

to keep up their speed.

LESSON

We need to make sure our honking from behind is encouraging — and not something else. [F.S.—Please!!—All suggestions and observations are welcome, but please contact me directly regarding negative judgments or attacks. While misinformation and rumors run rampant, they serve no useful purpose]

5. When a goose gets sick or wounded or shot down, two geese drop out of formation and follow it down to help and protect it. They stay with it until it is able to fly again or dies. Then they launch out on their own, with another formation, or catch up with the flock.

LESSON

If we have as much sense as geese we too will stand by each other in difficult times as well as when we are strong.

And so, as always, we are in a mixture of good times and difficult times. However, the Conference showed me, once again, what good company we are keeping.

WORKING WITH PERPETRATOR-IDENTIFIED EARLY CHILDHOOD ABUSE SURVIVOR

Landry Wildwind, LCSW
Albany, CA

In using EMDR with early childhood abuse survivors, I often find more resistance and denial than with clients who experienced later abuse. Also, the weakened ego of the patient allows for slower progress through intensely affect-laden work.

The technique I have been using seems to help with this kind of patient. I assume that the resistance includes introjects of the perpetrator, as well as the denial and covering mechanisms usually seen. I also assume that fear of abandonment, as actually experienced during sexual abuse, emerges along with the memories, since the memory retrieval negates the internalized image of the perpetrator as a source of positive identification and supplies. This "image destruction" can only take place gradually, using cognitive bridging to avoid overwhelming identity diffusion and anxiety.

Therefore, when the resistance emerges during sets focused on the sexual abuse, and the resistance takes the form of remembering the positive things the perpetrator did for the patient, or the fear of giving up the positive image of the perpetrator, I ask the patient to focus on the positive things exclusively, to see all of them together. In the next set, I ask her/him to make a strong, beautiful container, a box, jar, something safe and pretty, and to see all the positive, loving aspects of the perpetrator placed inside that container. I remind the patient that only those things that the person did that hurt the patient are left outside the container. I can then ask her/him to refocus on those hurtful things that happened and, if angry feelings come up, they are only at the "bad part" of the person who is so loved and needed.

Later, when the person has worked through most of the horror, rage, and sadness, often a sense of inner emptiness emerges. That is when I ask her/him to recall the container, and, this time, to sort through it to see what qualities of the perpetrator now feel positive. After one set, I ask the person to choose those qualities she/he wishes to be like. Often, there are a few that the person can still feel good about. There is often a need to do both cognitive work and EMDR regarding the sense of emptiness and the anxiety that emerges with a shift in identity.

With very early childhood molest, abuse, or abandonment, I have found another kind of resistance. Perhaps the patient has identified very strongly with the perpetrator, or the molest began before there was psychological differentiation from the mother. In cases such as these, I help the patient notice how she/he is different from the perpetrator. A patient with MPD recently repeated during several sets, "She's big, I'm little. She's a woman, I'm a boy." Later he said, "I'm not her!" with great excitement. He then could remember more fully what had occurred and feel more free to feel his anger about it. This has also helped with feelings of shame and guilt that seemed very global.

In general, the issue of identity change seems central to helping people whose earliest identities are merged with those of the people who hurt them most. Often, in working in the area of resistance, feelings of confusion, fear of the work, fear of not recognizing one's self, and fear of ending up permanently damaged by the knowledge gained are all expressions of identity loss anxiety. Helping our patients to contain this anxiety until it is naturally resolved can make a great difference in whether the patient can tolerate complete treatment.

CASE STUDY

Liz Mendoza-Weitman, LCSW
San Jose, CA

A ten year-old Hispanic boy was referred by his mother for outpatient psychotherapy. The mother described her son as having been depressed since the father abandoned the family over five years ago. The depression was now worsening, although the mother could not identify any new stressors. The boy was described as having little or no interest in pleasurable activities, doing poorly academically, experiencing significant weight loss, panicking each morning about leaving home for school, complaining of stomachaches every morning, and having sad affect. Additionally, the mother was distressed that the boy had an intense phobia of eating in public and

1992 ANNUAL EMDR CONFERENCE

Topics and Presenters

CHRONIC DEPRESSION		
Landry Wildwind, MSW	Albany, CA	(510) 527-2286
CREATIVE USE OF METAPHOR		
Carol Erickson, MFCC, BCD	Berkeley, CA	(510) 526-6846
CRITICAL INCIDENT TRAUMA		
Roger Solomon, Ph.D.	Olympia, WA	(206) 586-8492
COMBAT-RELATED PTSD		
Howard Lipke, Ph.D.	N. Chicago, IL	(708) 688-1900
DISSOCIATIVE DISORDERS		
David Fenstermaker, Ph.D.	San Jose, CA	(408) 257-5032
EATING DISORDERS		
Jean Bitter, Ph. D.	Los Gatos, CA	(408) 354-4048
EMDR TARGETS IN SEX THERAPY		
Leonard Loudis, Ed.D.	Denver, CO	(303) 321-4517
LEARNING ISSUES AND CHILDREN		
Robbie Dunton, MA	Pacific Grove, CA	(408) 372-3900
PEAK PERFORMANCE		
"Sam" Foster, Ph.D.	Mt. View, CA	(415) 965-8988
Jennifer Lendl, Ph.D.	San Jose, CA	(408) 244-7942
PARTNERS OF SEXUAL ABUSE SURVIVORS		
Clifford Levin, Ph.D.	Palo Alto, CA	(415) 326-6465
Scott Nelson, Ph.D.	Mill Valley, CA	(415) 383-9254
PRINCIPLES OF GUIDED IMAGERY		
Emmett Miller, Ph.D.	Menlo Park, CA	(415) 328-7171
SEXUAL ABUSE		
Rita Belton, MA	San Rafael, CA	(415) 883-0736
Eirin Gould, MA	San Jose, CA	(408) 985-6858
Brooke Passano, MA	San Rafael, CA	(415) 461-5711
SUBSTANCE ABUSE		
Norva Accornero, MA	Los Gatos, CA	(408) 356-1414
Robert Kitchen, MA	Hayward, CA	(510) 886-6488
Andrew Leeds, Ph.D.	Santa Rosa, CA	(707) 579-9457
Virginia Lewis, Ph.D.	Palo Alto, CA	(415) 326-8752
THEORETICAL CONVERGENCES		
Andrew Sweet, Ph.D.	Aurora, CA	(303) 337-9588
TURNING LOSSES INTO WINS		
Ron Martinez, Ph.D.	Burlingame, CA	(415) 692-4658

IMPORTANT NOTICE!

V.A. NETWORK: An **EMDR** mail group exists on the V.A. electronic bulletin board. It is necessary to have access to FORUM to get to the mail group--this is obtained at your local station. This is open only to V.A. individuals who have completed **EMDR** training. For enrollment, send a copy of training certificate with access name and address to:

JOAN BARRON, MN, RN, CS (118)
V.A. Medical Center
4100 West Third Street
Dayton, Ohio 45428
(513) 268-6511, ext.2678
FTS Phone-950-2678

refused to do so. He complained of "picturing vomit" each time he tried to eat. The boy's stated goal of treatment was "to stop thinking about throwing up." He also asked for help "to not feel sick every morning, even though I'm not really sick." His mother was now threatening to place him out of the home due to the severe restrictions and burdens placed on her for the past five years. The boy was seen in individual therapy and the mother was seen in collateral sessions. **EMDR** was implemented in the standardized procedure. The initial treatment focus was the client's distressing memory of an incident at age five when his brother had vomited on him in a restaurant. He reported that it was this image that intruded on him each time he ate food. The boy identified feeling "very scared" (SUDS 9-10) when imaging this memory. He also held onto his stomach where he felt the anxiety, focused on the picture, and the cognition "I'm scared." By the end of the procedure, he reported no longer feeling fear when recalling this memory. At the start of the second and final **EMDR** session, the boy reported that he was now concerned with a more recent memory of vomiting he had witnessed in a public restroom. (This had not been reported in the first session). The **EMDR** procedure was implemented again. By the end of the session, the boy reported feeling "fine" and no longer scared by this memory. The positive cognition, "It's over. I can feel good now when I eat," was installed. In the subsequent psychotherapy visits, the boy's mother reported the following changes: the boy's affect was brighter, he was spontaneously showing an interest in others, and reporting to his mother that he was now eating at school and at daycare. The boy was also no longer crying in a panic upon awakening or complaining about stomachaches in the morning. The mother also reported that she was no longer considering out of home placement for her son. The boy, in interviews separate from the mother, giggled appropriately, smiled spontaneously, showed a bright affect, boasted of eating in public, denied fear of eating in restaurants, and described himself as "feeling happy." Additionally, his mother shared that the daycare director no longer found the boy to be irritable or fearful, and that he was showing an interest and enthusiasm in helping her set the table to eat and in other activities in the home. Her reported observation to the mother was "he is like a different child."

1992 TRAINING SCHEDULE

LEVEL I BASIC TRAININGS

		Sponsors	
Apr. 11/12	**Philadelphia, PA** Radisson Hotel Philadelphia Airport	Alan Goldstein, Ph.D. Agoraphobia & Anxiety Treatment Center Temple University Medical School	(408) 372-3900
May 30/31	**Honolulu, HI** Hilton Hawaiian Village	Sandra Paulsen, Ph.D. Pacific Institute of Behavioral Medicine	(808) 523-2990
June 5/6	**San Jose, CA** Sunnyvale Hilton	Francine Shapiro, Ph.D.	(408) 372-3900
Sep. 12/13	**Chicago, IL** Holiday Inn Crowne Plaza Northbrook, IL	Howard Lipke, Ph.D. Director, Stress Disorder Treatment Unit N. Chicago Veterans Admin. Medical Center	(708) 688-1900x4675
Sep. 19/20	**New York, NY** Loews New York Hotel	William Zangwill, Ph.D. Gerald Puk, Ph.D.	(212) 663-2989 (914) 635-1300
Sep. 25/26	**San Francisco, CA** Radisson Inn SF Airport	Francine Shapiro, Ph.D.	(408) 372-3900
Oct. 3/4	**Seattle, WA** Radisson Seattle Airport	Roger Solomon, Ph.D. Washington State Patrol	(206) 586-8492
Oct. 9/10	**Los Angeles, CA** Airport Marina Hotel	Ron Doctor, Ph.D. Cal State Univ., Northridge	(818) 885-2827
Oct. 11/12	**Denver, CO** Holiday Inn Denver SE	Andy Sweet, Ph.D.	(303) 337-9588
Oct. 16/17	**Miami, FL** Miami Airport Marriott	Ruth Knowles Grainger, Ph.D.	(305) 595-3399
Nov. 6/7	**San Jose, CA** Sunnyvale Hilton	Francine Shapiro, Ph.D.	(408) 372-3900

LEVEL II TRAININGS

May 15/16	**San Jose, CA** Sunnyvale Hilton
June 19/20	**Santa Ana, CA** Crowne Sterling Suites
July 24/25	**San Jose, CA** Sunnyvale Hilton
Oct. 30/31	**Philadelphia, PA** Temple University Medical School
Dec. 11/12	**San Jose, CA** Sunnyvale, Hilton

History-taking and specified questioning for focused identification of problem areas

Closing down "incomplete" sessions

Axis II applications

Integration of EMDR with cognitive therapy

Dissociative & other major disorders

Abreactive responses and alternative strategies

Working with difficult/resistant clients

Integrating "self-control" techniques

Treatment of Process Phobias

EMDR: Innovative Uses

Ron Martinez, Ph.D., Co-editor
Burlingame, CA

*This section will appear in each Newsletter and will present innovative uses/variations of the **EMDR** procedure that have been discovered by clinicians trained in the method. I would very much appreciate it if any of you who have found new variations on how to use **EMDR**, would write these up and send them to me at the address below, so that I can include them in future Newsletters. Though your write-ups can be informal, I would appreciate inclusion of the specific steps of the technique, the number of people on which it has been successful, any specific outcomes that you have consistently noticed, and any further comments. Please include your name, address, and phone number, so that I can reach you with any questions. Thank you.*

Jessie Rappaport, R.C.S.W. of Eugene, Oregon, sent in this observation: He states, "for clients with persistent negative cognitions such as, 'I don't deserve to be loved', where **EMDR** saccades, cognitive interweave, and all other variations fail to effectively shift the cognition, he tells the client, 'I would like you to notice, if you would, how you feel when I take over the voicing of that belief and say it to you...." [An example of this would be 'you don't deserve to be loved'.] He does this with eye movements induced and often at this point reports that the client will dramatically shift the polarity when the belief has been externalized by his voice. The response is often from the positive polarity, such as, 'I have every right to 'be loved' or 'the heck with you, I'm tired of hearing that', etc. He states that with particularly fragile clients, this intervention must be carefully framed, such as, 'I am taking over the negative voice that is in you'."

Please feel free to try this and send in your responses as to the results you observe.

I'd like to share the results of a case in which I combined **EMDR** and hypnosis in working with a Vietnam vet. The effect was very powerful, and seemed to be impacting the client on an archetypal level.

This 44 year old Vietnam veteran, whom I shall call Tom, was referred to me by the psychiatrist who was his on-going therapist. Both therapist and client had heard of **EMDR** and were hopeful it might help with Tom's sleep disturbance, flashbacks during which he often became enraged and assaultive, and periods of severe depression. He served in the infantry in Vietnam when he was 19 years old, and engaged in extensive combat as a helicopter "doorman." Tom had an uncle, a few years older and "like a brother," who was also in combat in Vietnam. The uncle was killed in the war, unbeknownst to Tom until several months after the fact. Tom described himself as changing "from mean to just plain evil" when he learned of his uncle's death. At this point, he recognized a deep shift in himself, which I conceptualize as archetypal in nature.

Upon his return from the war, he used drugs, attempted suicide, was hospitalized for depression, and spent time in jail for smuggling, theft, and assault. In more recent years, he has married, had children, and worked at jobs that typically last 2 to 3 years. He has assaulted his wife, and has assaulted other men when, during a flashback, he has mistaken them for guerrillas. He described often feeling "swallowed in blackness" (another archetypal reference) and despair. He reported being unable to experience feelings of fear or grief, and wanted help to "humanize" himself.

Because of the nature of the funding source for this case, we had a maximum of 10 sessions available for our work together. After two sessions of using **EMDR** in the conventional way, I began to feel that we would not reach our goals in the time available. Tom would lapse into lengthy stories with each memory that surfaced, and it was difficult to keep him focused on the **EMDR** process. At one point he mentioned that the only time he'd been able to cry about his uncle's death was in a session with a therapist several years ago when he had his eyes closed. Since grieving his uncle's death was something he'd been unable to do and seemed a key issue for him, we decided to try combining hypnosis with **EMDR**.

We met for 90 minutes in each of the next seven sessions. The procedure was as follows—I induced a hypnotic trance by taking Tom to a "special place" where he would be able to safely watch a movie of his life. He watched from a "safe distance" and was in "complete control" of what he saw. I suggested that his arms and legs would be very heavy, and he easily achieved deep states of trance.

I suggested that he run the movie back to something about the war that we needed to work on. He verbally reported what he was experiencing, and when he saw something which was emotionally charged, I instructed him to stay with it and move his eyes back and forth while I tapped the backs of each hand. I then asked him to report what had occurred, either following that image or installing cognitions as in a typical **EMDR** session. In the first session of this combined approach, he came face to face with the "cold eyes" of his 19 year old self. He began grieving his uncle's death and the losses he had suffered from the war. Over the next several sessions, tears streamed down his face throughout much of the process. Imagining his uncle's death, Tom saw his uncle stop him as a 19 year old from running around with a gun, and convinced him to "come home"

to a family reunion he envisioned.

Between sessions, Tom began experiencing longer and longer periods of feeling sad before the familiar rage would return. In one session he experienced intense pain in his body as he grieved his losses — "I was used. I was supposed to help—I wasn't supposed to be this way." In that session, Tom's 19 year old self told him, "We need to settle this once and for all."

It was apparent in the next session that what needed to be settled was "the war, and whether to live." I asked Tom what choices he saw, and he responded, " Staying in the war, being depressed in my room (a severe depression he experienced upon his return from the war, in which he literally stayed in his room for three months), or killing myself." When I asked him to generate another possibility, he saw his grandmother rocking him, removing his uniform and bathing him. The words he used to describe this were "Grandmother's love can heal my grief and pain." I asked him to give his Vietnam experience a shape, color, sound, smell and feeling, and flush it out of his body. He saw guns flushing out from his feet, with his grandmother pouring water over his head. (This archetypal symbol of baptism/rebirth seemed especially important given Tom's background as a Catholic and altar boy.)

In our next session, I instructed Tom to "settle things once and for all" with his 19 year old self. I asked him to concretize his Vietnam experience and flush it out. He saw a dragon emerge from his stomach, enveloping himself and everything else in darkness. (The dragon has been a widely-held symbol of the Vietnam war.) I asked him to find a way to disconnect from it, and he saw his father carrying him away, tending the wound to his belly where he bled from disconnecting the dragon. I suggested he see the dragon in the distance and dematerialize it. He saw it blow up, and knew his 19 year old self was gone also. I suggested he fill the space that had been emptied, and he saw his mother holding him as he became a baby filled with light and a feeling of calm. I instructed him to bring that experience into the present and he saw himself with his wife and the words, "I am more at peace now." As the session ended, I taught him a simple grounding technique to practice as homework to help him stabilize this experience and counteract the light-headedness he reported.

Tom felt "in a fog" for the next several days, reacting with rage only once when he was rear-ended while driving his car. We spent a session compacting and flushing out the remainder of the war, with him experiencing it rushing past so quickly that he saw himself reach out to catch the positives he wished to keep.
I taught him to imagine a "personal space bubble" around him, installing that experience with **EMDR** while he was in trance. As he saw himself inside the bubble, he envisioned his drunk grandfather unable to enter it, but others able to enter at his invitation. As I brought him forward into the present while still inside his bubble, he saw the old familiar blackness reappear. This time, instead of being engulfed in it, he saw himself moving safely through it. (I saw this as progress in his ability to disidentify from that experience.) The question "Who am I?" emerged for him, and the answer that returned was "Peace."

In our final session, Tom reported feeling many internal shifts during the previous week. He frequently saw himself inside his bubble. He noticed a marked decrease in his reacting to situations with hostility, especially while driving. We focused again on the question, "Who am I," and he saw his son telling him "You're my father." (This marked a shift in archetypal identification from the "young warrior" to the "nurturing older man.") We ended with installing, once more, the phrase, "I am more at peace now," with an image emerging of him and his family (those living and dead) together.

In a three-month follow-up contact, Tom reported that he continued to feel that our work together "changed something" on a deep level. He was sleeping more restfully at night, dreaming, and reported having his first "dream" about Vietnam that wasn't a nightmare. He experienced "recollections" about Vietnam, rather than intrusive flashbacks. He had no recurrence of the "blackness" and felt that "bubble" was "still there." In some situations, where he used to be enraged, he said he felt "hurt." He reported being able to experience sadness again. He had begun to meditate (which he had tried several years before, but stopped when memories began overwhelming him), and felt the practice was extremely helpful to him. He recently held a "ritual burial" of his uncle, and felt at peace with his loss.

I believe the combination of **EMDR** and hypnosis in my work with Tom enabled us to accomplish, in a short period, more than we could have achieved with either technique alone. It seemed important for Tom to have his eyes closed in order to move beyond the interference of his conscious mind, allowing him to work on deeper levels. It appeared that we needed to tap his grief in order to defuse his rage. And, in Tom's words, "humanize" him again. As we worked on an archetypal level, I surmised that we needed to restore the ego boundaries of his Self, which were probably weak at best as the 19 year old who went to war. I hoped that this would allow Tom to disidentify from the "blackness" and the archetype of war with which he had identified so completely, and to begin to develop a new identity.

CALIFORNIA EMDR STUDY GROUPS
[Listed Geographically North to South]

REDDING
Dave Wilson (916) 223-2777
Meets once monthly at the Frisbee Mansion on East Street in Redding. Discussions, case presentations, videos, role playing,and "troubleshooting." Open to new members.

SONOMA COUNTY
Kay Caldwell (707) 525-0911
Meets in Santa Rosa at Kay's office the fourth Tuesday 12:30 to 2:00pm. Primarily case discussion with some videos and "troubleshooting" of the **EMDR** procedure. Open to new members.

MARIN COUNTY
Laurel Parnell (415) 454-2084
Contact if interested in monthly Friday afternoon meetings.

EAST BAY
Edith Ankersmit (510) 526-5297
Meets third Friday at 7:30pm. Case discussion only. Group is closed to new members, but Edith will coordinate any new East Bay group.

SAN FRANCISCO
Sylvia Mills (415) 221-3030
Case discussion and group process. Open to new members.

SAN MATEO/BURLINGAME
Ron Martinez (415) 692-4658
Meets second Monday from 7:00 to 8.30 pm. The group is open and conducted as a forum for people to further the understanding and use of **EMDR**. Case consultation and practice sessions are available.

PALO ALTO
Ferol Larsen (415) 326-6896
Meets the first Wednesday at 10:00am in the conference room of Mental Research Institute (MRI), 555 Middlefield Road, Palo Alto. Case discussion. Limited to 10 participants.

LOS ALTOS/PALO ALTO
John Marquis (415) 965-2422
Dewey Lipe (415) 852-2855
Meets ad hoc at Pacific Graduate School of Psychology in Palo Alto. Primarily case discussion. Open to new members.

LOS GATOS/SARATOGA/CAMPBELL/W. SAN JOSE
Jean Bitter (408) 354-4048
Liz Mendoza
Meets the third Thursday of each month, noon to 1:30pm at Good Samaritan Hospital, Room TC2, in San Jose. Open to new members. Agenda to be determined.

SANTA CRUZ
Linda Neider (408) 475-3480
Generally meets once per month on a Friday at 7:00pm. Primarily case discussion. Open to new members.

WOODLAND HILLS/NORTHRIDGE/WESTWOOD
Ron Doctor (818) 992-5071
Is willing to coordinate a new group.

CENTURY CITY/SANTA MONICA
Robert Goldblatt (213) 286-9490
Is willing to coordinate a new group in the 90067 zip code area for West L.A. people.

WEST LOS ANGELES
(Zip Code areas: 90230, 90232, 90265, 90292, 90401, 90406, 90291)
Renee Cote (310) 988-2166
Is willing to coordinate a new group in one of the above zip code areas.

DOWNEY
Pauline Hume (213) 869-0055
10642 Downey Ave, Downey
Is willing to coordinate a new group.

SAN DIEGO
Marcee Sherrill (619) 233-0460
Times to be arranged.

ORANGE COUNTY
Jocelyne Shiromoto (714) 680-0663
Meets one Tuesday a month from 9:00am to 11:00am

Submission Information

Submission of general articles can be sent to David Fenstermaker, Ph.D., 4985 Mitty Ave, San Jose, CA 95129-1849. Articles specific to new and innovative uses can be sent to Ron Martinez, Ph.D., 1515 Trousdale Drive, Suite 215, Burlingame, CA 94010. ***[If possible, articles need to be submitted on an IBM formatted diskette.]*** *The deadline for the next Newsletter will be August 1, 1992.*

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