INTERNATIONAL EMDRIA ASSOCIATION™

EMDRIA NEWSLETTER

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PRESIDENT'S COLUMN

Deadline For Next Newsletter

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What is EMDRIA?

Steve Lazrove, MD

In the beginning, there was only EMDR, and it was good. Francine said, "Let there be training in this complex methodology so that licensed therapists everywhere may learn how to practice EMDR correctly." So it came to pass that there was an EMDR Institute with Level I and Level II trainings and it, too, was good. Then Francine said, "Why don't we have a Humanitarian Assistance Program for EMDR to help relieve suffering worldwide?" Thus, it was that EMDR-HAP was born, with projects in the Balkans, Oklahoma City, and Columbia, to name a few. EMDR-HAP was pretty good, too, except that funding was scarce. Finally, Francine said, "What we really need is a professional association for EMDR to do all the things that professional associations do." So it was that almost 800 therapists from six continents plopped down their hard-earned money to become members of EMDRIA, and when they had done this they asked, "What *is* this professional association that we have joined, anyway?"

Of all the tasks facing our Association, none is more urgent than finding a clear and concise answer to the question, "What is EMDRIA?" How we define ourself will determine what we do and establish our sphere of operation. No unambiguous answer exists yet because EMDRIA is a work-in-progress. Nevertheless, I would like to use this column to bring you up-to-date on where we stand in the evolution of our Association.

As my tongue-in-cheek introduction suggests, EMDRIA was created because the growth of EMDR has outstripped both the capacity of the Institute to exploit EMDR's full potential and its ability to meet the needs of EMDR-trained therapists. EMDRIA's by-laws state, "The primary objective of EMDRIA is to establish, maintain, and promote the highest standard of excellence and integrity in Eye Movement Desensitization and Reprocessing practice, research, and education..." Let me focus on the practice component for now.

EMDR therapists' greatest need is having the tools to practice EMDR competently. This means that therapists must receive adequate training in the method and have access to some mechanism for refining and updating their skills. With the publication of Francine's book and the abolition of the nondisclosure statement, we can expect a number of training programs to appear. Some will be good, some will be, umm, less good. EMDRIA will develop minimum standards for training, as opposed to providing actual training, and anyone teaching EMDR, whether for-profit or as part of a professional program, will be encouraged to submit his or her curriculum to EMDRIA for evaluation. We currently are investigating the possibility of credentialing EMDR therapists in some way. The legal/tax issues make this project very complicated, but we have to start. In my mind, there is nothing we can do that will better assure the integrity of EMDR than to establish comprehensive standards for clinical practice which include elements of both proficiency and continuing education. Such a certification process would allow health care providers and consumers to help identify clinicians who are competent to use EMDR. We also are working to reanimate the Network, now called the Worldwide Network. We hope that local chapters will serve as another educational venue via discussion groups and speciality trainings. Finally, EMDRIA will continue to sponsor an Annual Conference. This year's meeting was a huge success, with 530 attendees. The Conference is an opportunity to hear about the latest research into EMDR, learn new protocols, refine your practice, and network with other EMDR clinicians.

These are just a few of the many directions in which EMDRIA is growing. Much work has been done, but so much more remains. For EMDRIA to fulfill its mission, it must have the active support of its members. I encourage all of you who have the time and ability to contribute to do so within your area of interest. Similarly, I urge anyone who has ideas about how EMDRIA can better meet the needs of its members to please let me know. There is much that can be done to help ourselves as long as we are not waiting for "someone else" to do it. Carpe diem!

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EMDRIA NEWSLETTER SUBMISSION INFORMATION

The following are guidelines/policies for submitting articles to the EMDRIA Newsletter:

* **ALL ARTICLES MUST BE IN APA STYLE AND FORMAT**

* **As author, it is your responsibility to ensure that all aspects of your paper are correct and in accordance with APA style, e.g., spelling and punctuation are correct; quotations are accurate and include the page numbers, author, and year; the paper is well organized; the list of references is complete and in proper order; the paper is proofread with all corrections, revisions, changes being made before submission to the Newletter; etc.**

  * **Refer to the Publication Manual of the American Psychological Association, 4th Edition, for specifics.**

* **Submit only the final draft--once the article is received, revisions to it will not be accepted unless the editor has requested them or you have a prior, agreed upon arrangement with the editor.**

* **All articles are subject to editorial revisions.**

* **The editor cannot guarantee when, or if, an article will be published.**

* **Articles should be submitted on disk with a hard copy included and sent to:**

EMDRIA
3900 E. Camelback Road #200
Phoenix, AZ 85018

From the Editor

Lois Allen-Byrd, PhD

The first EMDR International Conference was a resounding success. We had over 500 attendees and more than 75 presenters covering a wide range of topics in 40 sessions. Because of the breadth and depth of this event, this issue of the EMDRIA Newsletter is devoted to the conference. You will find among these pages brief workshop summaries which are meant to provide you with an overview of the particular presentation. You will also find an order form should you to decide to purchase any audio tapes of conference.

I want to take this opportunity to express gratitude to Carol York and her committee for their tireless efforts in putting this conference together. It was truly a remarkable event.

I would also like to thank the presenters for both taking the time to participate in the conference and to contribute to the Newsletter.

For those of you who did attend, it was wonderful to see such interest and support. For those of you who could not be there, your presence was missed.

Finally, a debt of gratitude to Francine Shapiro for without her vision and courage, we would not be.

International Update

Francine Shapiro, PhD

The first EMDR International Conference put on by EMDRIA was a wonderful success. The lion's share of the work was coordinated by Carol York who did a splendid job. The diversity of the program, including a wide variety of clinical applications and research reports, clearly shows that the international association is fully capable of providing high caliber professional services to the EMDR community. It was an extraordinary event.

The EMDR Humanitarian Assistance Program (EMDR-HAP) gave awards to a number of people for their services. We salute their willingness to provide services, gratis, to people who are suffering. We salute their willingness to drop their day-to-day obligations and go into areas of actual physical danger to serve others in need. The following people were honored at the EMDR Humanitarian Assistance Programs banquet:

Balkans Intervention — Gerald Puk, Susan Rogers, Steven Silver, Geoffrey White
Columbia Intervention — John Hartung, Graciela Rodriquez, Pablo Solvey, Linda Vanderlaan
Rwanda Intervention — Roger Solomon, Robert Tinker

I would also like to solicit assistance in helping to evaluate all the EMDR-HAP programs and services to determine the quality of their success in regards to how many people have actually been helped, and how many clinicians are able to use EMDR effectively after a pro bono training in a disaster area. We need to use our resources well. Any individuals who have experience in this type of research, please step forward. In addition, more donations are needed to thoroughly service the world-wide disaster areas in need. There are now requests for services from all over the globe. In addition, the excellent reports from at least six sources in the US and Canada indicate that EMDR is showing a high level of effectiveness with prison inmates, adolescents in high

risk populations, and institutionalized adolescent offenders. EMDR treatment seems to be preventing relapse into problem behaviors. In consequence, Elaine Alvarez is currently the chair of the Special Projects/Prevention Program and will help to coordinate research in this important area. Please contact her if you can assist in any way.

The Ron Martinez Memorial Award was given to Steve Silver for his outstanding contribution to EMDR over the past many years. With over 30 publications to his name, and having won a VA award for his outstanding contributions as the director of an inpatient unit in the VA system, Steve was extremely vocal in the early days of EMDR in the attempt to win EMDR a place in the treatment of combat veterans. In addition to putting his already established reputation on the line, he authored one of the early research studies, and helped innumerable others prepare similar projects. He also helped to coordinate a pro bono training program for VA personnel working in the outpatient and outreach programs, and ran dozens of free EMDR trainings for them. In recent years, he was the founding programs chair of the EMDR Humanitarian Assistance Programs. He led the team into Zagreb for the first international disaster training, and then repeated the efforts in Sarajevo under war-time conditions. Currently, he is chair of the HAP disaster response training program and has been active all year in helping coordinate its efforts. I believe his dedication to the alleviation of suffering on both local and global levels provides an outstanding model for all of us.

We also presented three research awards this year at the closing ceremony. One went to Margaret Scheck for her comparative study with high-risk behavior females. These results are extremely important in the potential development of prevention programs nationwide. Another went to Stephen Marcus for his large scale study comparing EMDR to standard Kaiser care. These results will have a tremendous impact on the managed care community. A third went to Tonya Edmond for her comparative study with adult survivors of childhood sexual abuse. The wide range of symptoms covered and the internal analyses of comparative effectiveness will make an excellent addition to the evaluation of EMDR in clinical practice. Not present at the closing ceremony, but with research no less important to mention, are the comparative study of combat veterans with Jac Carlson as principal investigator, and a study of rape victims by Barbara Rothbaum. Both are very important additions to the EMDR research. There are now sufficient comparative studies to have EMDR receive well-established efficacy status on the APA Empirically Validated list as soon as they are accepted for publication. It is sincerely hoped that this will occur before the end of the year.

I want to thank all of the participants of this year's conference. The presentations were of the highest caliber. It is clear that the evolution of EMDR theory, practice, and research is in good hands.

Efficacy of EMDR for Trauma Survivors as Measured by the Rorschach

Elizabeth Call, PsyD, Nancy Errebo, PsyD, and Patti Levin, PsyD

Preliminary findings on shifts in Rorschach response patterns in five trauma survivors after three sessions of EMDR were presented. The Rorschach is a test of perception and as such, is an ideal instrument for measuring treatment effects of EMDR which often alters perceptions of self, others, events, and the world. Unlike self-report measures, the Rorschach produces a protocol with multiple indices including many domains affected by PTSD—cognitive functioning, perceptual accuracy, affect regulation, self-image, interpersonal attitudes, coping style, hypervigilance, depression, and suicidality. The Rorschach also has the advantage of indicating gradations along most of its dimensions rather than a simple cutting score. In short, the Rorschach is capable of capturing the depth and breadth of the changes we observe clinically with EMDR. Like EMDR, the Rorschach seems magical and mysterious to some people and so is frequently misunderstood and falsely maligned. In fact, when administered correctly, scored accurately, and interpreted systematically and with restraint, the Rorschach is a valid instrument supported by a rich body of literature. The Exner system of scoring and interpretation used in this study is empirically-based, has very good inter-rater reliability, and lends itself to statistical analysis.

Subjects were interviewed by an EMDR clinician (either Dr. Call or Dr. Errebo), were administered a Rorschach by a graduate student, had three sessions of EMDR, and were administered a Rorschach by a different graduate student. Rorschachs were scored and interpreted by Dr. Levin. The presentation focused on one subject, a Vietnam veteran. Video clips of EMDR sessions were shown, several Rorschach responses were read, and pre- and post-Rorschachs were discussed. The content of Rorschach responses corresponded markedly with material which emerged in EMDR reprocessing. For instance, he saw a "hooded character" in two of the inkblots. In the EMDR session, he experienced sensations in his head and arms, which he characterized as a "hooded character," a part of himself which had "dragged" him through Vietnam. He also perceived one of the inkblots as "hollow," and reported feeling "hollowness in (his) core."

The self-perceptions described by the Vietnam veteran changed dramatically in the sessions with the changes being reflected in the post-EMDR Rorschach. The data are complex and have not been fully analyzed, but initial analysis yielded exciting results. The post-Rorschach showed that the subject had a capacity to reach out for help which had been absent in the pre-EMDR Rorschach. This is a remarkable finding as Exner's norms indicate that it takes about nine months of therapy to develop this capacity. Other findings included marked improvements in affect regulation, capacity for insight, and coping style. Only one finding was negative—he looked more depressed on the second Rorschach than on the first. The Rorschach depression scale is complex; preliminary analysis suggests the depression was characterized by dysphoric thoughts. We hypothesize that the improvements on the other dimensions increased his tolerance for thinking about his war experiences. This man entered therapy after the EMDR sessions. At nine-months follow-up, he stated that he has maintained the positive effects of EMDR.

We plan to analyze our data statistically and to add more subjects, some of whom will also be subjects for the brain-imaging study Drs. Call and Levin are working on with Bessel van der Kolk, MD. We hope to present further findings at ISTSS in the fall and eventually submit the study for publication.

Scientific Investigations into EMDR (Part II):

Evaluating the Effectiveness of EMDR in Reducing Trauma Symptoms in Adult Survivors of Childhood Sexual Abuse

Tonya Edmond, MSSW, and Allen Rubin, PhD

Ms. Edmond and her dissertation chair, Dr. Rubin, presented the results of her research study. The purpose of the study was to evaluate the effectiveness of EMDR in reducing trauma symptoms in adult female survivers of childhood sexual abuse. The effectiveness of EMDR was evaluated through the use of a randomized experimental design which included a comparison treatment and a control group. Survivors selected for this study had to meet the following criteria: no previous exposure to EMDR, no contraindications for use of EMDR, and no concurrent psychotherapy. Fifty-nine survivors were randomly assigned to one of three treatment conditions: (1) EMDR, (2) eclectic therapy, or (3) delayed therapy control group. (Eclectic therapy in this study was defined as a variety of methods, techniques, and theories incorporated into a treatment approach designed to resolve sexual abuse trauma.) Each subject received six, 90 minute individual sessions of EMDR or eclectic therapy, focused on resolving a specific issue or memory related to the sexual abuse. Pre-test, post-test, and three month follow-up data were collected using several objective and subject measures. Four standard objective instruments were used to measure specific aspects of the survivors trauma symptomatology: the State-Trait Anxiety Inventory (STAI), which contains a scale that measures state anxiety; the Impact of Event Scale (IES) which measures stress that is associated with traumatic events; the Beck Depression Inventory (BDI) brief form; and the Belief Inventory (BI) which identifies and measures common distorted beliefs held among adult survivors of childhood sexual abuse. The principal investigator collected the data on the objective measures at pre-test, post-test, and follow-up. The subjective instruments used included the Subjective Units of Distress scale (SUDs) and the Validity of Cognition Scale (VoC). These instruments were considered process measures and were recorded by the study therapists for the EMDR and eclectic therapy subjects. The therapists were instructed to obtain SUDs and VoC ratings at least 3 to 4 times a session with the eclectic therapy subjects to address potential demand characteristics concerns that have been raised in other EMDR research.

All participating therapists and the principal investigator had completed Level II EMDR training prior to implementing the study, and had access to an EMDR facilitator for consultation throughout the course of the study. The principal investigator did not provide any of the treatments. Fidelity checks were conducted by an EMDR facilitator and the therapists' administration of EMDR was found to be adequate. Three of the four therapists had no prior knowledge of EMDR before agreeing to participate in the study. The therapist with prior knowledge of EMDR came into the study believing EMDR to be very effective and was thus positively biased toward the method. Of the remaining therapists, after learning about EMDR, one was extremely skeptical to the point of being negatively biased against the method, and the other two therapists were cautiously open-minded and therefore viewed as neutral. The fidelity checks found that the skeptical therapist had the highest rating for accurately administering the method, followed by one of the neutral therapists. The positively biased therapist and the other neutral therapist had lower, but acceptable, scores on the fidelity scale. Analysis of the date collected at post-test and the three month follow-up found no significant differences in outcomes based on therapist assignment. Therefore, the therapists' expectations, as well as their differing degrees of clinical experience, did not seem to have an effect on the outcome of the study. The therapists were each assigned ten subjects, five of whom received EMDR and five of whom received eclectic therapy. The delayed therapy control group subjects received therapy from other therapists in the community after a six week wait. No attrition occurred during the pre- and post-test phase of the study, and three month follow-up data were collected for 52 subjects.

Multivariate analysis of variance (MANOVA) was used to obtain the results of the study. At pre-test, there were no significant differences between the three treatment conditions on any of the demographic and abuse-specific variables, or on the objective and subjective measures. There also were no significant differences on any of those variables by therapist assignment. At post-test, however, both EMDR and eclectic therapy were significantly different than the control group ($p. < .01$) on the objective and subjective measures. While the control group subjects' clinically significant levels of anxiety, depression, stress, and negative beliefs about their abuse were virtually unchanged from pre-test to post-test, the EMDR and eclectic subjects experienced significant reductions in trauma symptoms. The results indicated that both treatments were effective, and when compared to the control group, generated relatively large effect sizes. EMDR produced a composite effect size of 1.46 on the standardized measures. Calculating each measure separately, the following EMDR effect sizes were derived: .75 (BDI), 1.01 (BI), 1.09 (IES), and 1.35 (STAI). The effect sizes from eclectic therapy were .67 (BI), .01 (STAI), and 1.23 (IES). (There was not a significant difference between eclectic therapy and the control group on the BDI, so an effect size was not calculated for that measure.) There were no statistically significant differences on the standardized measures between EMDR and eclectic therapy at post-test. However, a clinically significant trend was observed with the EMDR group having lower mean scores (fewer trauma symptoms) than the eclectic group on the STAI, BDI, and BI. A statistically significant difference ($p. < .001$) was found between EMDR and eclectic therapy at post-test on the SUDs and VoC measures with a composite effect size of 1.36. Furthermore, 65% of the EMDR group versus 25% of the eclectic group had obtained a SUDs rating of 0 to 1 and a VoC of 6 to 7 on the original target by the end of treatment. Thus, based on the data from the subjective measures, a significantly ($p. < .05$) higher number of EMDR subjects than eclectic subjects resolved their target memories or issues.

Several subjects in the study obtained EMDR between post-test and follow-up creating a potential for comparing EMDR to itself. Those subjects, as well as the rest of the control subjects, were excluded from the follow-up analysis so that EMDR and eclectic therapy could be more fairly compared to determine how well each maintained therapeutic gains. Multivariate analysis of the standardized measures revealed that at the three month follow-up, EMDR was significantly better at maintaining therapeutic gains, or further reducing trauma symptoms, than was eclectic therapy ($p. < .05$). The mean scores for the EMDR group were lower than they had been at post-test on all four standardized measures (STAI, BDI, IES, and BI) reflecting that trauma symptoms had been further diminished. Conversely, the eclectic group experienced an increase in mean scores on the STAI and the IES with only slight decreases found on the BDI and the BI. In fact, while the EMDR group mean scores indicated virtually no clinically significant levels of trauma symptoms present at follow-up, the eclectic group mean scores showed clinically significant levels of depression, anxiety, stress, and negative cognitions about the sexual abuse. Analysis of the SUDs and VoC ratings at follow-up also revealed a significant difference ($p. < .001$) between EMDR and eclectic therapy. The composite effect size comparing EMDR to eclectic therapy at follow-up was 1.08 for the standardized measures and 1.38 for the SUDs and VoC. Additionally, the SUDs and VoC measures indicated that while 61% of the EMDR group still had resolution of the original target 3 months after completing the study treatment, this was true for only 12.5% of the eclectic group. Thus, not only is EMDR effective at reducing trauma symptoms in adult survivors of childhood sexual abuse, the therapeutic gains achieved through EMDR appear more stable over time than do those obtained through eclectic therapy.

Process Research in EMDR

Judith Flaxman, PhD

The research group at the Illinois School of Professional Psychology-Chicago Campus presented the following three papers: 1) Affective Information Processing of Traumatic Memories: A Process Analytic Investigation, by Kenneth G. Celiano and Judith Flaxman; 2) Somaticizers and Eye Movement Desensitization and Reprocessing: A Distinctive Processing Style? by Catherine S. Wilson and Judith Flaxman; and 3) Process Research: Future Directions, by Patricia P. Flaherty and Judith Flaxman.

The Celiano and Flaxman paper was a discovery-oriented, process analytic approach to the data analysis of therapy transcripts from a single subject who met many of the criteria for PTSD. Raters were used to code therapy transcripts. The pattern of cognitive/affective processing in successful (Subjective Units of Disturbance Scale—SUDs—shift of 7 points or more) sessions was compared to the pattern in unsuccessful (SUDs shift of less than 3 points) sessions. Successful sessions occurred at times when the client came into therapy with higher Impact of Event scores, suggesting that for this client, more emotional change occurred when the intrusiveness of traumatic material was heightened. Ratings showed that successful sessions involved higher use of the re-evaluation and integration categories of Toukmanian's (1990) Level of Client Perceptual Processing Scale. In unsuccessful sessions, processing remained automatic, tight, and superficial. In successful sessions, a greater decrease in negative emotions and increase in positive emotions occurred over time. Finally, successful sessions were longer than unsuccessful sessions.

Thus, this study found that a higher level of intrusive imagery prior to the session may be needed to catalyze the process, and sufficient time must be available for processing to occur. Also, raters were able to reliably determine that successful sessions were characterized by thoughts involving re-evaluation and integration, and by the development of positive emotions over the course of the session.

The paper by Wilson and Flaxman looked at the second EMDR session for 18 subjects whose level of somatization had been measured using the Somatization Scale of the SCL-90-R. High and low somaticizers were compared on SUDs and Validity of Cognition (VoC) scores, and Body Distress, a measure introduced into the EMDR protocol for this study. Results of this study included an interaction between the Somatization Group and Time on SUDS ($p. < .04$), such that SUDs levels for the high somatization group did not decrease by the end of the session as much as they did for the low somatization group. In addition, high somaticizers showed higher scores on the VoC Scale than low somaticizers at the end of treatment ($p. < .02$). No significant difference was obtained on the Body Distress Scale between the two groups. This study suggests that subjects change more slowly in the modality which is primary to them. For high somaticizers, this modality is probably represented by the SUDs, and for low somaticizers by the VoC. If therapists are aware of these individuals differences in their clients, they can adjust their focus in EMDR accordingly.

The paper by Flaherty and Flaxman reviewed the components of the EMDR procedure which promote recall. Suggestions for future research included a comparison of the recall-enhancing capabilities of EMDR and hypnosis, as well as consideration of research aimed at individualizing and heightening the effectiveness of EMDR. Individual differences in field dependence, cognitive flexibility, and representational system were offered as areas to be explored. Research to determine the optimal level of arousal for recall during the EMDR procedure was proposed.

Brief Psychological Intervention with High-Risk Females: *A Comparison of Eye Movement Desensitization and Reprocessing With Reflective Listening*

Margaret M. Scheck, Judith Schaeffer, and Craig Gillette

Mental health professionals continue to grapple with how to address the needs of young women who engage in high-risk behaviors. The casualties that can arise from the choices made during these formative years raise concerns about life-long consequences.

We believed that Post-Traumatic Stress Disorder is a major factor in the dysfunction of these young women. While simple casual factors for this constellation of behaviors are unlikely, and interactions of neurological, temperamental, developmental, and sociocultural factors are expected; trauma based casual links are too common to overlook.

Sixty females between the ages of 16 and 25, screened for high-risk behavior and traumatic memory, were randomly assigned to two sessions of either EMDR or an active listening control (AL). Inspection of factorial ANOVA interaction effects and simple main effects indicated: (1) significant improvement for both EMDR and AL groups and (2) significantly greater improvement for EMDR treated participants than AL treated participants for five outcome measures (Beck Depression Inventory, State-Trait Anxiety Inventory, Penn Inventory for Post-Traumatic Stress Disorder, Impact of Event Scale, Tennessee Self-Concept Scale). Pre-post effect sizes for the EMDR group averaged 1.56 compared to a pre-post effect size average of 0.65 for the AL group. Despite the brief nature of the treatment, the post-treatment outcome variable means of EMDR treated participants compared favorably (within the first standard deviation) with non-patient or successfully treated norm groups for all five measures.

What we believe this study demonstrates is that EMDR can produce impressive results in reducing a psychological dysfunction associated with traumatic stress in a very brief time with a needy population. Certainly, EMDR holds an alluring opportunity to benefit at risk young women and possibly the change to influence an individual's entire life course and thus, the future of our world.

Advanced Case Consultation on EMDR Applications to the Workplace: *Enhancing Career Performance*

Sandra Foster, PhD, and Jennifer Lendl, PhD

This workshop was designed for practitioners who had previously attended a Foster-Lendl Peak Performance presentation, or who had been exploring EMDR with employee/clients. The presenters' intent was to provide case consultation, and to assist participants with challenging client issues related to their functioning at work.

Drs. Foster and Lendl addressed such questions as, "What do I do when the processing doesn't seem to work?" "How do I break free of a managed care practice to develop a specialty in performance enhancement?" "How do I market myself to corporate clients?"

The presenters discussed ways in which the participants could teach their employee/clients how to increase focus, concentration, and productivity at work.

NOTICE

It has come to my attention that there are EMDR trained clinicians who are describing themselves as "EMDR certified." Please be advised that currently, there is no such designation. As mentioned in the "President's Column," there is some thought being given to certifying therapists; however, it does not currently exist.

This issue has been raised in a previous Newsletter. Please remember that when a therapist identifies him or herself as "EMDR certified," it is at best misleading to the public, and to other professionals who have no, or limited, knowledge about this issue as it implies a recognized level of competence.

Using Internal Dialogue to Achieve Maximal EMDR Results

Sandra Paulsen, PhD

This presentation discussed: (1) the normal role of ambivalence in human functioning, (2) the role of EMDR in catalyzing the resolution of ambivalence, (3) the problem of "stuck" EMDR processing as a function of diverging ego states, and (4) how to use internal dialogue to mediate internal conflict and achieve an adaptive resolution. Internal dialogue was compared and contrasted with dissociative disorders, and cautions were offered about under diagnosing or over diagnosing dissociative disorders.

EMDR in Executive Coaching for Leadership Skills Development and Strategic Visioning

Sandra Paulson, PhD

This presentation described the use of EMDR for performance enhancement in executives, with case examples of various applications including: reducing public speaking concerns, delivering tough messages, increasing leadership confidence, and creating visions and strategies to support those visions. The presentation also addressed ethical issues related to EMDR in organizational work, and cautioned against trying to export a clinical paradigm to executive coaching.

Using EMDR in the Treatment of Veterans

Howard Lipke, PhD

This presentation focused on the role of EMDR in the treatment of veterans, especially those with combat related psychological problems. The presenter drew from his experience providing both in- and outpatient EMDR treatment over the past six years. Issues addressed included identifying therapeutic issues more common in veterans than other clients, discussion of the effects of doing therapy in DVA treatment centers, specific recommendations for the use of EMDR with veterans, and the conceptual and practical integration of EMDR with other methods. Recommendations for helping in the resolution of resistance to treatment were highlighted. Clinical questions and comments from the participants encouraged and forthcoming.

As part of the discussion of the integration of EMDR with other methods, the presenter offered his four activity information processing model of psychotherapy based on Shapiro's concept of accelerated information processing. These activities are: 1) Accessing of present information, 2) Introduction of new information, 3) Facilitation of the processing of information on, and 4) Inhibition of information accessing. (This model is elaborated on in the electronic journal Traumatology, March, 1996.)

A Controlled Study of Eye Movement Desensitization and Reprocessing (EMDR) for Combat-Related Post-Traumatic Stress Disorders (PTSD)

J.G. Carlson, C. M. Chemtob, K. Rusnak, N. L. Hedlund, and M.Y. Muraoka

Despite the clinical and social impact of post-traumatic stress disorder (PTSD), there are few controlled studies investigating its treatment. In this investigation, we compared the effectiveness of two psychotherapeutic interventions for PTSD using a randomized controlled outcome group design. Thirty-five combat veterans diagnosed with combat-related PTSD were treated with either: (a) 12 sessions of Eye Movement Desensitization and Reprocessing (EMDR) (N=10); (b) 12 sessions of biofeedback-assisted relaxation (N=13); or (c) routine clinical care, serving as a control (N = 12). Compared with the other conditions, clinically and statistically significant treatment effects in the EMDR condition were obtained at post-treatment on a number of self-report, psychometric, and standardized interview measures. Relative to the other treatment group, these effects were

generally maintained at three-month follow-up. Psychophysiological measures were not differentially affected by treatment condition.

Body Processing: Innovative Applications of EMDR to the Somatic Experience

David Grand, RCSW, BCD

Bodily sensations, which can be activated by attending to a traumatic memory, may be a component of the sensory experience of the target trauma itself (i.e., an accident or an attack) and are additionally elicited by the resonance of the negative cognition. Accordingly, body sensations are invaluable focal points for EMDR processing. The clear body scan is a fundamental criterion used to determine the completion of a treatment protocol. Significant somatic involvement in EMDR is also demonstrated by the use of hand tapping as an alternative to eye movements as a method of bi-hemispheric activation.

This presentation elaborated and expanded the concepts and practices of processing physical sensations, designated as "body processing," as well as proposed innovative technical applications of bilateral tactile stimulation. The seminar explored the benefits of deliberately targeting body sensations for processing in selected situations despite the availability of images, cognitions, and affective material. Focused targeting of body sensations was examined as a technique to facilitate processing with reduced agitation for clients. The particular efficacy of body processing was also investigated in relation to the treatment of somatically charged conditions such as hypochondriasis, panic disorders, OCD, character pathology (armor), addictions, and chronic pain (i.e., TMJ, muscle spasms, headaches, irritable bowel syndrome, and chronic fatigue). The rationale for, and application of, the symbolic imaging of physical perceptions, repeated returns to body target, and phenomena of fluxing, traveling, and the metamorphosis of body sensations was discussed.

The advantages of alternative (tactile and auditory) methods of bilateral activation including hand, foot, and shoulder tapping, as well as tympanic stimulation, was contrasted with eye movements in terms of the effect of processing with closed eyes, passive inducement, increased saccadic pace, and higher repetitions. The direct neurological pathways between the brain and the rest of the body was also explored in order to conceptualize body processing both physiologically and psychologically. Particular attention was devoted to the innovative technique of alternating hand pressure on lines of meridian and accupressure points. Additionally, case material and two videotaped sessions were presented to illustrate the conceptual and technical aspects of body processing and the various methods of bilateral tactile and auditory stimulation. Those in attendance participated actively with questions, case vignettes, and hands on learning of the alternating hand pressure technique.

Protocol and Strategies for Using EMDR when Treating Somatic Complaints

Adrianne B. Casadaban, PhD

This presentation provided a protocol for using EMDR as part of psychotherapy treatment for a large variety of somatic conditions--from single, circumscribed symptoms or behaviors to physical injury, disability, acute and chronic/genetic disease, and reproductive/sexual dysfunction to reaction to medical procedures. The protocol was derived from the clinical experiences of myself and Phyllis Klaus, MFCC, as well as the rest of the EMDR Medical Committee, Joan Lovett, MD, and Robert Gilden, PhD.

Seeing with the "third" eye, hearing with the literal "third" ear, the protocol guides the clinician in comprehensive history taking to notice clues to meaning, associated trauma, and function of the "somatic issue" in the client's past and current inner and outer (system) life, including attachment themes. This is crucial regardless of the presumed physical or psychological etiology of the condition. Psychotherapeutic intervention is always coordinated with appropriate medical investigation and treatment. All cautions and safety factors elaborated in Shapiro (1995) are respected and addressed.

It was described and illustrated how the clinician makes hypotheses or "best guesses" about the possible psychosocial "fuel" that causes, exacerbates, or maintains the somatic condition or its triggers or distress context. The nature of the hypotheses developed leads to formulating treatment strategies. I found that planning interventions, including EMDR, for successful somatic symptom relief was aided by conceptualizing three levels of intervention. First level work is with somatic symptoms fueled by distress as well as positive states. Level one work can be completely successful all by itself, or can quickly transform into level two or three work. Second level EMDR work is healing specific traumas and anxieties "a la" the standard and specialized treatment protocols described in Shapiro (1995).

Frequently, to achieve symptom relief, third level work is essential. This necessitates generously combining other methods with EMDR and/or attending to the client-therapist relationship. In these cases, somatic conditions or additional accompanying distress are being "fueled" by social-cognitive-affective material which is complicated or hidden. The clinician's challenge in these cases can range from: (1) uncovering unrecognized or dissociated discrete or global traumatizing experiences to (2) apriori enabling the client to achieve greater "ego strength" or to change a core belief (schema) to (3) delicately addressing current (systems work) or past attach-

ments or facilitating developmental mastery (including individuation). Examples, case studies, and specifics of EMDR components were elaborated. This developing study will be described and illustrated in greater detail, both practically and conceptually, at the Northern California EMDRIA Network meeting in Spring, 1997.

References

Shapiro, F. (1995). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures, NY: The Guilford Press.

Integrating EMDR with Marital and Family Therapy

Chad Glang, PhD, and Craig Penner, MFCC

EMDR has broadened the therapeutic interplay between individual and systemic issues. The ability to work more effectively and efficiently in fewer sessions gives us the option to target individual issues without crystallizing any person's role as the "identified patient" in the couple or family. Thus, we have been more flexible about moving between individual and couples/family work, with benefits resulting in both areas. For example, we have found it easier to focus briefly on an individual parental issue, which appears to be creating an impasse, as part of therapy when the presenting problem is a child's difficulty.

We have observed differences in clients' EMDR processing which may be diagnostic indicators of differentials between "blocking beliefs" and "current systemic blocks." Impasses caused by present limitations of one's family or environment may not be amenable to change through EMDR because (despite their dysfunction) the problems may be ecological within that system. Thus, a good assessment before attempting EMDR, as well as keen observation of the processing itself, can help the therapist to make appropriate choices between individual and family work at different points in the treatment.

There are numerous important considerations regarding who should be in the room during an EMDR session, e.g., whether the "client" is a child in family therapy, or a spouse in couples' therapy. Since material that emerges during EMDR sessions is unpredictable, "informed consent" to have others present is difficult for those who have not experienced EMDR. The therapist must consider issues of trust, safety, support, flexibility, power, and loyalty when helping to decide who is to be present. In cases where EMDR is done individually, we have found it useful to have the client inform the family of any changes or insights that will affect the system. This creates an opportunity for the family to experience the client's competency, increase their level of empathy, see change as possible, and support changes at home.

During EMDR sessions with adults, whether within the context of a family therapy or not, developing cognitive interweaves that expand the focus to include considerations of larger systemic issues can help the client to clarify impasses, generalize growth, and often create more concrete steps for integrating changes into daily life. For example: resolution of a work-related issue may help a person improve relations with the family; treatment of a past trauma may lead to a commitment to do things differently now with one's own children; or targeting a current issue regarding one's child may link with how it was for the client at that age, or with that issue. If these connections do not arise spontaneously, the therapist can use cognitive interweaves to elicit them.

Integrating EMDR and Family Therapy

Frances R. Klaff

Therapists working with children and adolescents within a family therapy model often wonder how to apply EMDR, which is an individually based protocol. This workshop approached the issue in order to: 1) Explore integration of individual and systematic theories and methods of treatment and limitations of each; 2) identify whether the family is appropriate for an integrated treatment and if so, select appropriate individual targets for EMDR; 3) suggest ways of presenting the notion to the family without victimization; 4) make the decision as to who should be present in the EMDR session; 5) evaluate how to integrate material revealed in EMDR into the family work; and 6) explore dilemmas of therapeutic alliances, boundaries, confidentiality, secrets, and limitations imposed by managed care.

EMDR and Family Therapy

Peggy Moore, MSW, ACSW, LISW, and Maurine Renville, MEd, MSW

Peggy Moore and Maurine Renville gave a two hour presentation on theoretical approaches to using EMDR with families and discussed several cases to exemplify their work. One theoretical approach for the use of EMDR with families is based on the work of George Brown, a pioneer researcher in the social and family influences on exacerbations of psychosis in schizophrenic patients. His research resulted in the concept of Expressed Emotion (EE) which was found to positively correlate with exacerbations of psychosis. (Later research linked it with other illnesses such as depression and childhood asthma.) EE research showed that critical comments, emotional overinvolvement, and hostility were key factors in relapse. The presenters hypothesized that EMDR could be successfully used with the family member who rates high in EE, targeting issues of hostility, critical and judgmental communication, and emotional overinvolvement. It is important to remember the family context of our clients.

Rachel Yehuda's research on intergenerational trauma formed a second theoretical framework for looking at the use of EMDR with families. Yehuda found that 23% of the children of Holocaust survivors suffered from PTSD at some time in their lives. The presenters suggested that families incorporate into their belief and value systems cognitions resulting from individually experienced or cultural trauma. These beliefs often form a basis for personal identity and connection within the family. It is most efficacious if the family system is included in therapy when the individual suffering from PTSD is part of a traumatized family. Without the permission of the family, the identified patient will have great difficulty making real and sustainable change. The younger the identified patient, the more essential it is to involve the family.

Guidelines for the use of EMDR as part of family therapy were disseminated to the attendees. The following is a synopsis of these guidelines:

1) You must be a trained and experienced family therapist prior to integrating the use of EMDR into your work with families. Follow normal EDMR protocol for introducing EMDR.

2) When to use EMDR. EMDR can be a useful element of family therapy when the contemporary family process is based on schema that are destructive to the family unit and/or individuals within the family. It is particularly useful when a member or members of the family system have been traumatized within or outside of the family.

3) Who is chosen for EMDR. EMDR is most frequently used with a member of the family in a one-on-one session with the therapist. Occasionally, situations may arise within the family therapy session in which a few saccades might help calm a volatile or acting-out family member and allow him or her to join in the therapy. The therapist may join the family by addressing the problems of the child who is identified as the patient. However, it might be most useful to focus on the parents by addressing their cognitions and behaviors that result in the problematic behavior of the child, using EMDR to target and process the parent's experiences which created the destructive cognitions and/or behaviors.

4) Look for intergenerational and cultural cognitions.

5) Issues of secondary gain are more appropriately addressed as unfathomable loss for the identified patient when family membership is tied to identity as a victim or other self-destructive schema. For a family member to change the cognitions could mean loss of family identity and support, and possibly result in becoming the family scapegoat.

Creative Approaches to EMDR with Children

Joan Lovett, MD

I presented my protocol for working with children ages 2 to 6 years who have experienced a critical incident. My approach involves interviewing parents for information about their child's traumatic experience, negative cognitions they imagine their child has, developmental strengths this child has demonstrated, and positive cognitions they would like for their child to have. It involves exploring beliefs about what and who keep the child safe, and what the child can learn to keep as safe as possible. The parents are instructed to write a story about their child's experience. In subsequent visits, the parents read the story to their child while the clinician carries out EMDR to desensitize everything the child saw, heard, smelled, felt, or imagined at the time of the trauma.

Standard cognitive interweave that facilitates processing for adults is not appropriate for young children who must continue to depend on adults for protection and who have limited experience in making informed choices about their behavior. It is more useful to teach young children to rely on adults, to use their voices to call for help, to count on their ability to run or hide, or to evoke "the rules" when threatened. A child should also be taught to trust the ability of his or her own body and spirit to get over the trauma. These principles can be reinforced and practiced during EMDR. This method appears to empower children while also helping their parents get over the trauma.

A Treatment Outcome Study of EMDR with Traumatized Children

Marian K. Puffer, PhD, Ricky Greenwald, PsyD, and Douglas E. Elrod, PhD

We presented the first controlled study (as far as we know) of EMDR for traumatized children and adolescents. Twenty participants were treated for a single traumatic memory with a single session of EMDR. Treatment was delayed 1 month for half the group. Over one-half of the 20 participants moved from Clinical to Normal levels on the Impact of Events Scale, and all but 3 showed at least partial symptom relief on several measures at 1 to 3 months following a single EMDR session. Results should be interpreted with caution, but were positive and essentially consistent with analogous findings of EMDR with adults. Further research with traumatized children and adolescents, using better measures and controls, is urgently needed.

We also discussed the design features which should be taken into consideration in subsequent studies of this kind. The main points are:

Choice of population. Critical issues are researcher access and power. It is very difficult to gain access to traumatized children as the responsible adults tend to be both protective and reactive. Access is enhanced by prior relationships in the community. Power refers to the likelihood that a real treatment effect will be considered statistically significant. Power can be increased by having a strong treatment effect, such as can be expected when using EMDR to treat children traumatized by a single event. Power can also be enhanced by using a homogeneous population; you can measure a specific syndrome more sensitively than a hodgepodge.

Treatment fidelity. Therapists should have Level II or equivalent training, and be familiar with Using EMDR With Children (Greenwald, 1993, available from EMDR Institute). Any specialized protocol should be manualized. If possible, film sessions and have them reviewed by independent raters for treatment and fidelity.

Control. Although it is desirable to include an alternate treatment group in a study design, for ethical reasons, a delay group may be preferable. In this case, effect size can be compared to those found in the literature.

Assessment. Assessment should be blind, independent, and standardized/validated. Measures should be trauma-focused, multi-source (especially parent and child), and include objective scoring and behavioral observation when possible.

Presentation. Given the current political climate, it is important not to overstate conclusions. It is also important to present results beyond the EMDR community.

EMDR for Adolescents with Disruptive Behavior Disorders

Ricky Greenwald, PsyD

In this clinical skills workshop, I presented a protocol that I have developed for use with adolescents with conduct and oppositional disorders--many of whom also have ADHD. EMDR is integral to many elements of treatment including motivation, insight, and cognitive-behavioral training in addition to possible trauma work. The protocol includes the following steps: structuring the initial interview to develop rapport and motivation for treatment, and to "set up" later interventions; fostering emotional investment in long-term goals; developing and practicing impulse-control skills; addressing issues such as anger and stress build-up; reducing reactivity to teasing and other provocation; trauma work; and problem-solving. I am currently preparing a paper which describes this protocol in detail.

The Future of EMDR for Children and Adolescents

Chair: Ricky Greenwald, PsyD, Panel: Michael Abruzzese, PhD, Ann Godwin, MA, Joan Lovett, MD, Robert Tinker, PhD, and Carol York, LMSW-ACP.

This was a meeting to promote the development of EMDR for children and adolescents. We formed a committee for this purpose, and invite you to join us. Here are some of the goals and plans we discussed.

I. Research and Publications
- A. Help to create a body of literature on the efficacy of EMDR for children and adolescents.
- B. Maintain an updated literature review to be used by those writing articles.
- C. Offer an informal peer review/support system to help people develop effective research projects.
- D. Offer an informal peer review/support system to help people write cases and publish them.

II. Schools
- A. Promote EMDR training to school mental health professionals.
- B. Educate school personnel and parents about the effects of trauma and the benefits of EMDR.
- C. Provide referral lists of EMDR-trained child therapists to schools.

III. International
- A. Consciousness-raising re: child trauma and EMDR.
- B. Prevention, education, networking.
- C. Begin by working with existing groups.

IV. Medical
- A. Gain acceptance for EMDR in the medical community.
- B. Develop and validate protocols for medical conditions such as encopresis, enuresis, and asthma.
- C. EMDRIA apply for CME credits for physicians.
- D. Educational presentations and materials for parents, physicians, etc. on EMDR.

V. Clinical
- A. Develop protocols for different populations.
- B. Develop diagnostic and screening tools for EMDR appropriateness.
- C. Create local study groups that are child-focused.

VI. Training
- A. Increase the focus on child EMDR skills in the standard training.
- B. Offer a day-long advanced training on working with children, perhaps as a pre-conference presentation.
- C. Establish standards of training for child/adolescent specialty.

Several themes came up consistently across areas of interest. First was the need to educate professionals, as well as the general public, about the prevalence and consequences of child trauma. Another was recognition of the necessity of additional child-oriented EMDR training. Of course, we agreed on the great importance of publishing case and controlled studies supporting EMDR's efficacy in various applications. What was striking was the widespread belief that this can be accomplished on a grassroots basis. For example, many clinicians have access to special populations, and can write a case study, or be part of a multi-site study. This committee hopes to provide the support and collaborative opportunities to turn your various interests, skills, and resources into important contributions.

We hope that many of you will contribute to this group's development and take advantage of its resources. For more information, please contact Ricky Greenwald, Psy.D., P.O. Box 575, Trumansburg, NY 14886, (800) 758-2193.

Assessing for EMDR Appropriateness and Readiness and Determining EMDR Targets

Larry F. Sine, PhD, CSAC and Silke Vogelmann-Sine, PhD, CSAC, NCAC II

This workshop discussed: (1) assessing for the appropriateness of, and client readiness for, EMDR; (2) determining specific areas of nonreadiness for EMDR; (3) intervening with deficit areas inhibiting readiness for EMDR when appropriate; and (4) assessing negative self-perceptions and associated present and past experiences for EMDR intervention.

The workshop started with a generic intake interview which, for the EMDR therapist, serves to: (1) collect comprehensive intake information including a psychosocial history and mental status in order to begin identifying dysfunctional behaviors which are driven by unresolved traumatic experiences; (2) begin the assessment of the individual's readiness for EMDR treatment; (3) provide initial education regarding connections between current difficulties and earlier traumatic experiences; and (4) increase the individual's readiness for EMDR treatment by identifying themes of negative beliefs and associated experiences, feelings, and sensations. A case example was provided as to how information is collected and how it relates to dysfunctional behaviors, EMDR readiness, and education. Clients are also encouraged to read the "Wounded Child" article by John Bradshaw which serves to reinforce links between the present and the past, as well as to stimulate the client to make further connections between the present and the past.

With the client's increased awareness of how the present links to past experience, the workshop next focused on the content of the session which introduces EMDR. There is a need to tailor the presentation to each individual. Areas covered include: we all carry the past with us as the interwoven fabric of self-perceptions through charged experiences; personal difficulties as skill vs. motivational/emotional deficits; the initial EMDR study; the effects of the past generally being more subtle for those without PTSD, that is, without the "benefit" of the visual flashbacks of traumatic scenes; EMDR growth; EMDR components—eye movement, desensitization, and reprocessing; experiences between sessions; and EMDR as a process of peeling away layers of an onion.

Although providing valuable information, the initial structured interview generally falls short of providing an adequate assessment of dissociation, EMDR appropriateness and readiness, and potential EMDR targets. Consequently, several questionnaires discussed below have been developed and were presented. These questionnaires, along with the Dissociative Experiences Scale by Carlson and Putnam, are generally given as homework to the client. The CSDDQ (Clinical Signs for Dissociative Disorders Questionnaire), developed by Vogelmann-Sine, Sine, Wade, and Wade, is a 19 item, Yes - No questionnaire adapted from Puk's clinical signs for dissociative disorders. The ERQ (EMDR Readiness Questionnaire) developed by Sine, Vogelmann-Sine, Wade, and Wade is a 12 dimension, multi-item questionnaire. The first nine dimensions cover Basic Needs (BN), Social Support (SS), Feelings (F), Emotional Lability (EL), Rigidity (R), Ego Strength (ES), Openness (O), Dissociation (D), and Alcohol/Drugs (A/D) with responses to individual items being on a 5 point scale--Not at All, Rarely, Sometimes, Often, and Always. The last three dimensions include Serious Mental Illness (SMI), Medical (M), and Legal (L) with responses to individual items being Yes or No. The client's response pattern in combination with the clinical interview information assist in determining EMDR appropriateness, and if appropriate, possible deficit areas inhibiting readiness. Some possible interventions were presented to address deficit areas inhibiting readiness.

The NCQ (Negative Cognition Questionnaire), developed by Sine and Vogelmann-Sine, is based on the premise that negative self-perceptions are charged by underlying historical negative experiences. Consequently, possible EMDR targets can be identified by having the individual first rate on a 7 point scale how true each of 38 negative "I" statements feels at a gut level. For the 6 cognitions with the highest ratings, the individual identifies a recent incident and an earlier incident which capture feeling that way. Then for each incident, the individual further identifies the associated emotions/feelings, intensity of disturbance, and location of body sensation. This approach of mapping the strongest negative beliefs operating in an individual's life and using these self-statements to derive negative experiences

has been found to facilitate identification of underlying material.

Several examples of completed questionnaires were presented. Cautions and limitations of the questionnaires were discussed, e.g., these questionnaires facilitate the successful implementation of EMDR, but do not replace, however, standard clinical assessment.

Addictions: An Integrative Approach and Research Design To Evaluate EMDR Efficacy

A. J. Popky, MA, Silke Vogelmann-Sine, PhD, CSAC, NCAC II, John G. Carlson, PhD, Larry F. Sine, PhD, CSAC

This workshop was aimed at EMDR trained clinicians working with the addictive population and who are interested in participating in a multisite research study. Data collected at various sites will be pooled and statistically analyzed by Dr. J. G. Carlson at the University of Hawaii. The goal of the study is to evaluate two EMDR treatment approaches to addiction. The first treatment approach consists of the Integrative EMDR Addiction Treatment Model developed by A. J. Popky. The second treatment approach consists of the Modified Standard EMDR Chemical Dependency Treatment Protocol developed by Vogelmann-Sine and Sine. (See Journal of Psychoactive Drugs, 1994; Vol. 26 (4), pp. 379-3910.)

Mr. Popky's Integrative EMDR Addiction Treatment Model consists of a specific treatment protocol **targeting triggers that activate urges to use**. It is assumed that by targeting, desensitizing, and then linking these triggers to the positive treatment goal, such triggers become less powerful and exert less control over the addictive behavior, i.e., using drugs, smoking. This protocol requires individuals to identify a positive achievable goal of coping and functioning successfully in life, free from using. The focus is on neutralizing triggers activating urges, thereby enabling individuals to achieve more control over their lives and functioning successfully. The protocol does not necessarily require abstinence, but only the desire of clients to achieve their treatment goals. If programs require abstinence, the protocol can be used. The focus of treatment still consists of developing a positive goal the client wants to achieve, discovering and neutralizing triggers, and on establishing a collaborative relationship with the client to desensitize early related, emerging traumas. It is expected that by targeting triggers activating the urge to use, underlying traumatic material becomes available to be reprocessed. Once the underlying traumas have been reprocessed, the triggers no longer carry the urges.

Vogelmann-Sine and Sine's Modified Standard EMDR Chemical Dependency Treatment Protocol adheres more strictly to Dr. Shapiro's original protocol. The treatment protocol aims at arriving at a formulation as to how earlier traumas and an inability to cope with painful emotional states, including low self-esteem, drive current and past disturbances including substance use. The client's adaptation to the effects of earlier traumas needs to be understood including how traumatic experiences are avoided and re-stimulated. Barriers to recovery are seen as manifestations of unresolved painful material. Clients are assessed in terms of existing barriers to recovery. Issues causing clients to feel overwhelmed by negative cognitions and affect are targeted selectively to improve functioning. If clients experience urges to use, these urges are targeted using negative cognitions, emotional discomfort, and physical sensations. Considerable emphasis is placed on installing future templates assisting clients to view themselves as coping effectively in problematic situations. Frequently, targets selected for processing are **current disturbances** and underlying traumatic memories are accesssed as they become available to the client. **Underlying traumatic material is processed gradually** as the client becomes more capable of integrating these experiences.

Research sites need to determine which protocol to utilize with their clients. **Only one type of protocol** at a specific research site can be used during the study to evaluate its effectiveness.

The experimental design consists of randomly assigning individuals to one of three groups: (1) the chosen EMDR treatment condition, (2) an attention/delayed EMDR treatment in which individuals will receive cognitive behavioral coping skills training (adapted from Project MATCH) and later EMDR treatment, and (3) a routine clinical care condition only. The first two groups will also receive routine clinical care. Clients in the routine clinical care condition will be offered EMDR treatment after follow-up assessment is completed. All participants will be assessed on a range of instruments including the following: Addiction Severity Index, Brief Readiness for Treatment Scale, Childhood Trauma Questionnaire, Trauma Symptom Inventory, Spielberger State Trait Personality Inventory, SCL-90-R, Dissociative Experiences Scale, Life Orientation Test, and additional substance use measures.

Relative to pre-treatment, it is expected that at post-treatment and follow-up relative to routine clinical care and the attention-control treatment, significant differences in scores should be obtained. In particular, a **decrease** is expected on all measures indicating use of substances, as well as urges to use. A significant **decrease** is also predicted in the severity of overall PTSD symptomatology; scales measuring clinical symptoms of anxiety, depression, hostility, and interpersonal sensitivity assessed by the SCL-90-R; and negative emotional trait indicators as assessed by the Spielberger State Trait Personality Inventory. A significant **increase** is expected in both positive emotional trait indicators and indicators of social functioning.

Currently, the protocols are being finalized to involve individual practitioners in addition to residential and outpatient treatment centers. A maximum of three pilot sites will participate in late 1996 to allow for finalizing the protocols. It is intended that the full study will take place later in 1997. Further training will be necessary to ensure treatment integrity. Interested parties should contact either: A. J. Popky, MA, 17641 Pleasant View Avenue, Monte Sereno, CA 95030; Phone: (408) 395-8541; FAX: (408) 395-0846; E-mail: ajpopky@emdr.org or Silke Vogelmann-Sine, PhD, 700 Richards Street, Suite 1502, Honolulu, Hawaii 96813; Phone: (808) 531-1232; FAX: (808) 523-9375; email: larsilke@pixi.com.

CLARIFICATION

Janice Harris Lords and Francine Shapiro, PhD

A previous issue of The Networker mistakenly gave the impression that MADD actively supports the use of EMDR for victims of drunk driving. This is not the case. MADD does not, and cannot, support or endorse any one particular therapy, including EMDR. The article more accurately should have noted that MADD has included presentations on EMDR in some of its Advanced Victim Training Institutes to increase awareness about EMDR among victim advocates. The proper role for EMDR therapists interested in working with victim advocates is to continue the work of providing the public with information about PTSD and EMDR, and be accessible when assistance is requested. Dr. Patti Levin (Tel: (617) 227-2008; Fax: (617) 227-8885; E-mail: plevin@warren.med.harvard.edu) is helping to coordinate the efforts of therapists interested in working with victim advocate groups.

Humanitarian Assistance: Sarajevo

Steven M. Silver, PhD, Susan Rogers, PhD, and Gerry Puk, PhD

In December 1995, a small team of EMDR clinicians--Drs. Gerry Puk, Susan Rogers, and Geoffry White--were invited to Sarajevo, Bosnia–Hercegovina, to conduct two EMDR Level I trainings. This invitation came about as a result of a successful training conducted in Zagreg, Croatia the previous March. Working in winter conditions (24 inches of snow fell) with the political situation around Sarajevo still not fully resolved (the Dayton peace accords were signed while the team was there and gunfire still echoed across the hills each night), and with the infrastucture almost totally destroyed (electricity, natural gas, and water were only intermittently available), the team nonetheless was able to train about 40 clinicians.

As expected, the training participants themselves had been under tremendous stress, with the most common experiences being focused on the war itself, separation from their children, and traffic accidents resulting from efforts to avoid snipers. Despite their experiences, participants showed a strong commitment to get the training, frequently walking for hours through the snow and at night. The presentation emphasized the need to address clinician traumatization, as well as the impact of such surroundings on the training team.

Follow–up via fax and e–mail indicates that the Bosnian clinicians are successfully using EMDR. Plans are being developed to return to Bosnia to do additional trainings and perhaps conduct a Level II training for the Balkan nations.

The training was sponsored by Catholic Relief Services and EMDR–HAP with support from the US Department of Veterans Affairs.

Multiple Positive Cognitions

Chad Glang, PhD

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 or her 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 or her to identify *all* the positive self–statements which emerge from the work. Eliciting and installing multiple PCs can enhance the effectiveness of EMDR.

Expanding 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 his or 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 judgement, 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, he or 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 his or her new thinking pervades his or her experience. Whereas the pervasiveness of the NC was part of the problem, the pervasiveness of the PC is a desired outcome 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 his or her momentum. With the installation of each new PC, he or she further grounds him or herself in his or her new psychological domain.

Case Example

Deborah, thirty–eight, had recently separated from her abusive husband. Processing a scene of domestic violence, her NC was "I'm worthless," and her original PC was "I'm a valuable human being." In addition to the original, we installed these new PCs:

"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."

References

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The Basics and Beyond: Conceptual Issues and Advances in Using EMDR

William M. Zangwill, PhD

This workshop was designed to review the basics of using EMDR and to discuss the importance of developing a conceptual framework in which to view the patient and his or her life experiences.

During the first half of the workshop, we covered my outline on Problems and Pitfalls in Using EMDR (3rd ed.). For the conceptual part, Young's book, Cognitive Therapy for Personality Disorders: A Schema–Focused Approach (Professional Resource Exchange, Sarasota, FL, (813) 366–7913) was used. The first half of the workshop also covered the common mistakes--of omission and commission--that therapists often use in applying EMDR. The second half presented an overview of how I see case conceptualization enhancing the effectiveness of EMDR. Participants were asked to share case experiences using either the framework of Young or someone else.

Why conceptualize the case? Why not just treat the trauma directly? I assume that it is the interaction of the events a person has experienced AND the way in which he or she has interpreted, experienced, and stored them that is most important in determining the amount and kind of pain that remains. If you took a group of 100 people who had been in serious accidents, were assaulted, etc., they will not respond the same to the experience. Thus, I think that it is vitally important to "map" each patient's own idiosyncratic set of vulnerabilities, schemas, or life themes.

In Young's system, such issues as Emotional Deprivation, Abandonment, Mistrust/Abuse, Defectiveness, Vulnerability, Subjugation, Entitlement, etc., are assumed to be organizing themes around which memories and experiences are stored.

Once you have identified these underlying vulnerabilities and life themes, educating patients as to the role of these early maladaptive schemas in their present life difficulties is quite useful in a variety of ways. First is its explanatory power. One of the problems clients often present is the pain of the event itself AND their subsequent reactions. How many of us have heard from our clients variations on the theme of "What's wrong with me that this is still bothering me? It happened years ago; how come I'm still overreacting?" Explaining that often, the event was/is so painful because it taps into a whole series of memories (the childhood file folders that Francine talks about in Level I), frequently increases clients' ability to understand their emotional reactions and reduces their tendency to blame themselves. Second, it alerts you and the client to look for other examples in the past that might be thematically connected and to be aware of situations in the future that might be troublesome. For example, imagine a client who suffered a tremendous loss as a child through the death of a parent, divorce, etc. Through your interviews and data collection, you realize that the issue of Abandonment is a very powerful one for him or her. Naturally, you would want to use EMDR to clean out any past experiences connected to Abandonment. However, you should anticipate that situations involving future separation will need to be addressed. For example, how will he or she react when his or her spouse goes on a business trip? The conceptualization around this theme alerts you and the client to be aware of these issues. The combination of case conceptualization with effective EMDR implementation enhances our ability to help our clients.

Integrating Schema-Focused Therapy with EMDR

Jeffrey Young, PhD, and William M. Zangwill, PhD

EMDR has always assumed that each clinician would integrate EMDR with his or her own therapeutic model. While many different models can be synthesized within the EMDR rubric, Dr. Young has developed a model that seems particularly appropriate. Designed especially for working with characterological disorders, including borderline and narcissistic, this integrative model also incorporates several features designed to overcome many of the limitations of short– term cognitive behavior therapy.

According to the theory proposed, eighteen Early Maladaptive Schemas (EMS) are at the core of personality disorders. An EMS is defined as an extremely broad, pervasive theme regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree. Shapiro's concept of childhood file folders would be analogous to the concept of schemas. These eighteen schemas are primarily unconscious, but can be brought to awareness through various strategies, especially EMDR.

Three schema processes are hypothesized: Maintenance, Avoidance, and Compensation. These processes (which overlap with the psychoanalytic concepts of resistance and defense mechanisms, and with such EMDR processes as blocking beliefs) determine, in part, how easily an individual patient can bring his or her schemas into awareness and change them.

This presentation demonstrated how to integrate the use of Schema–Focused therapy with EMDR. In this adaptation of Young's model, Schema–Focused therapy serves as the primary conceptual framework for working with the client, while EMDR is seen as the primary change technique.

The first step in this process is a thorough history taking, looking for both traumatic life events and the client's underlying vulnerabilities, schemas, and coping styles. History taking is accomplished both through client interviews and the use of Lazarus' Multimodal Life History Questionnaire. The Schema Questionnaire and the Parenting Inventory developed by Young are given and scored. Throughout this collection of information, the therapist is looking for specific memories of traumatic experiences and for specific schemas.

As part of this process, the therapist attempts to help the client discriminate memories representing primary trauma versus memories that represent lifelong issues. The EMDR model of eliciting information--asking the client about specific events and problems, then obtaining images, negative and positive cognitions, affect and body sensations, as well as SUDs and VoC ratings--is used as soon as the client is comfortable. Collecting information this way, without the use of eye movements, has been shown to be a very effective means of tapping into the neural network where related memories are stored. The grouping of these memories often appears to be along such schema lines as vulnerability, defectiveness, abandonment, etc.

As the therapeutic relationship develops, clients are educated about EMDR and Schemas. The last part of this assessment process is the case conceptualization. This involves putting together the information from history taking, the Schema Questionnaire, the Parenting Inventory, and the client's in–session behavior to formulate a useful picture of client problems, likely problem origins, and recommended change techniques. Knowing what issues/themes your client is sensitive to tells you where to start your EMDR exploration. It also helps suggests where to probe when processing stops, i.e., what blocking beliefs may be present, what type of cognitive interweaves to use, etc.

Once the case conceptualization is complete, EMDR is used as always. However, the use of Schema–Focused therapy with EMDR broadens the scope of EMDR. It does this by addressing therapist variables when using EMDR, and by systematically integrating cognitive and behavioral change techniques to consolidate and extend the gains achieved in session.

Ground Breaking Results: PTSD and EMDR One Year Later

Sandra A. Wilson, PhD

A dramatic drop in PTSD diagnosis and symptoms were reported by 82% of the participants (n = 66) responding to a follow–up study of EMDR one year later (Wilson, Becker, Tinker, submitted for publication). The results of the follow–up indicate continued treatment benefit in addition to some intriguing changes in behavior, thoughts, and feelings.

In the original study, 80 people (40 men and 40 women) received three 90–minute sessions of EMDR treatment for a single traumatic memory (Wilson, Becker, & Tinker, 1995). In that study, significant improvement was found on the SUDs; the Impact of Events Avoidance and Intrusion Scales; the Spielberger State and Trait Anxiety scales; and the Anxiety, Depression, Interpersonal Sensitivity, and Somatization Scales on the Symptom Checklist (SCL90R). Participants randomly assigned to the delayed treatment condition showed no improvement during the 30 days prior to treatment. However, after receiving EMDR treatment, the delayed group showed the same statistical and clinical significance as the treatment group. These results were maintained at the 90 day follow–up for both groups.

The PTSD literature indicates that only one other study reports one year follow–up data, and this is the only EMDR study to report one year follow–up data. Several unexpected findings were reported by participants concerning positive cognitions, retraumatization, continued therapy, behavioral changes, relationship difficulties, original memory affect, and so forth. Reports of the clinical and statistical data were discussed.

EMDR in the Treatment of Offenders

John Hartung, PhD, and Peter Philbrick, PhD

Psychotherapists have traditionally been reluctant to work with offenders. This may be because offenders are not typical clients. For example, the undereducated, the poor, the less successful, and ethnic minority groups are over represented in the offender population. Even when therapy is attempted, the work is often difficult and the results modest. This is an unfortunate circumstance since one–third of certain demographic groups will appear before the criminal courts. We described a model for offender treatment in which the goals are to reduce recidivism while clients become psychologically healthier. We have developed this over a three–year period at the residential community corrections program (COMCOR) in Colorado Springs, Colorado. Empirical data are used in assessing clients' needs, and clinical tools are borrowed from "Motivational Interviewing," cognitive–behavioral theory, and EMDR.

Client factors in need of assessment begin with 14 criminogenic causes of crime. Most of these appear to be treatable with a form of EMDR, namely: traumatic history; affective disorders; relationship problems, including marriage and family; substance abuse; and personality disorders. The latter are translated into cognitive terms (negative cognitions, blocking beliefs) which allow for interventions using cognitive interweaves. Resources in addition to EMDR are necessary for assisting with clients' basic needs, education, employment, and skill deficits. "Client resistance" has been redefined as a continuum between external and internal motivation, with implications for how treatment is initiated, how directive the therapist must be, and how progress is best monitored.

Therapist factors requiring attention begin with complex countertransference issues--by framing personality disorders essentially as attempts at self-protection, the stereotypically "tough" client becomes more human, the therapist potentially more optimistic. In the process, the offender-client becomes better understood as a vulnerable person, one who becomes even more fragile as the offender role begins to fade away. The potential for self-destructive behavior following an otherwise successful EMDR session will test the clinical skills of the most qualified and experienced Level II-trained EMDR practitioner. In addition, clinicians must be comfortable working with clients who are externally motivated or coerced, and without usual protections of confidentiality.

Future plans are to: 1) develop a training manual for therapists using EMDR with offenders; 2) conduct pilot studies with this team of therapists; 3) to rewrite the original manual as a clearer picture of treatment strategies and precautions appears; 4) conduct controlled research of specific variables (e.g., the efficacy of employing specific cognitive interweaves with specified personality disorder types, or EMDR as an adjunctive tool in group treatment of sex offenders, etc.); and 5) ultimately use the findings to train others. We believe the goal of reducing recidivism while helping clients to become psychologically healthier has become more realistic since the advent of EMDR. For more information, please contact John Hartung, 1414 N. Nevada Avenue, Colorado Springs, CO 80907, Phone: (719) 475-8038, Fax: (719) 475-0993.

Enhancement of Victim Empathy Along with Reduction in Anxiety and Increase of Positive Cognition of Sex Offenders After Treatment with Eye Movement Desensitization and Reprocessing (EMDR)

Puma C. Datta, PhD, and Jack W. Wallace, LCSW

Treatment of sex offenders, who had been themselves sexually abused in their childhood, offers a challenge that may baffle many expert therapists. Even though the issue of one's own victimization may not be directly related to offending/victimizing others, the traumas related to the abuse are unique to the individual offender and need to be addressed to enhance self-esteem and develop full victim empathy. The theory that dissociation takes place for a significant traumatic experience in an individual's life further explains how emotions and feelings associated with the trauma are also repressed. It has been hypothesized that suppression of one's own feelings and being unable to experience the pain of one's own traumas may make it almost impossible for an offender to feel for the victim (i.e., unable to empathize with the victim). He or she may talk about the feelings and sufferings of the victim (suffering caused by the offense), but is unable to experience the pain and sufferings that the victim experienced. When the traumatic memories of the sexually abused offender are released under treatment, the associated emotions are also released, often causing emotional abreactions observed during a treatment session using EMDR. Being able to experience one's own emotions related to traumas opens up the door of experiencing/recognizing feelings in general and thus making it easier for offenders to enhance their victim empathy.

Treatment of a group of sexually abused adolescent sex offenders was reported using EMDR at a residential facility of the California Youth Authority. The treatment sessions reduced the Wards' anxiety level related to their traumas and increased their positive cognitions and cognitive control on their emotional feelings (pre– and post–test sessions). A pre– and post– treatment evaluation using the Datta Empathy Scale (DES which is currently in the process of standardization) after an average of 3 sessions showed a significant increase in empathy for their respective victims.

The differences between the pre– and post–treatment evaluations on the DES scores showed an increase of empathy for victims ranging from 4% to 37%. The improvement in empathy was observed to be significant when the DES scores were compared with other Institutionalized adolescents and adolescents in the community. The two control groups also received group therapy and individual sessions, but did not receive EMDR treatment. The improvement remained sustained in the same adolescents over a period of one year (after 3 sessions of EMDR). The sustaining effects of EMDR on decreasing anxiety and enhancing victim empathy after one year established a permanent effect of EMDR on victim empathy. The treatment is expected to expand for more sexually abused sex offenders in the institution, and future research is expected to establish a relationship between the enhancement of victim empathy (after EMDR) and post–parole re–offense.

The Use of EMDR in Complicated Bereavement

Steve Lazrove, MD

Grief is the normal, healthy reaction to death. Occasionally, grief is prolonged or is unusually severe; a pattern which is referred to as "complicated bereavement." A three–phase model for using EMDR in patients with complicated bereavement was presented: 1) processing the memory of the death, 2) acceptance and/or meaning–making of the death, and 3) imagining life without the deceased. The premise is that the details surrounding the physical death must be processed before the patient can accept the reality that the loved one is gone without any possibility of return. Once the reality of the death has been accepted, EMDR can be used to help develop a future template, making the best of what realistic alternatives exist.

Cognitive distortions are common obstacles in complicated bereavement; the source of which is often related to the fear that loss of the painful memories will mean the loss of all of the memories, i.e., that the deceased will be forgotten. This issue is addressed explicitly during processing by asking the patient (in relation to the death), "What do you need to hold on to, and what do you want to let go of?" This question reassures the patient by averring that everything will not be forgotten, implying specifically that the good will not be forgotten along with the bad. This question also empowers the patient by allowing him or her to make his or her own choice. All of us have strong feelings about death, and the therapist must take care not to introduce his or her own bias into treatment. One example might be the therapist who believes that no one could ever get over the death of a child, and reinforces this belief in the patient. While it is true that the child will never be forgotten and the memory will always be bittersweet, it is equally true that a great deal of the pain associated with the loss can be alleviated. Such processing helps the patient remember the "good times" rather than the "bad."

Basic CISD Program for EMDR Therapists

Roger M. Solomon, PhD

This course was specifically designed for EMDR therapists who wanted to learn about critical incident stress debriefing (CISD), and the application of EMDR to critical incidents and CISD. Participants received an accelerated curriculum that is approved by the International Critical Incident Stress Foundation (ICISF), as well as a certificate of completion from ICISF.

This course prepared participants to provide a variety of crisis services for distressed individuals with an emphasis on emergency service personnel. The services described in the training included pre–incident education, defusings, demobilizations, significant other support, and debriefings.

A framework for understanding and treating critical incident stress was presented. The phenomena that accompany a traumatic incident, the phases of the emotional aftermath, "normal reactions to abnormal situations," and treatment strategies were discussed. The utilization and integration of EMDR with critical incident stress debriefings and an overall treatment plan for trauma were presented.

Love in the Face of Violence: Self–relations Psychotherapy, Ericksonian Hypnosis, and EMDR

Stephen Gilligan, PhD

A number of contemporary approaches to therapy converge around the principle of "life moves through you, except when it doesn't." The idea is that a procession of experiences moves through each nervous system, bringing learning, changes, and developmental growth. If these experiences are perceived as overwhelming or threatening, a person may deliberately or automatically engage in "neuro–muscular lock" in which experience is

arrested and held for later processing. If effective opportunities for processing are not present, symptoms and pathology may result.

This workshop examined a model for describing how this may happen and also presented a model for resolving symptomatic experience. The relevance of principles and practices of Ericksonian hypnosis, Self–relations psychotherapy, and aikido to EMDR theory and practice was highlighted.

Eye Movement Desensitization and Reprocessing (EMDR) with Victims of Jerusalem's Wave of Suicide Bus Bombings and Terrorist Attacks

G. Quinn, S. Gross, and Y. Arnowitz

Tragically, Jerusalem, "the City of Peace," suffers a long history of terror. Recent indiscriminate and overwhelming acts of violence against Jerusalem's civilian population have left hundreds of dead, physically disabled, and psychologically traumatized citizens. Various pervasive and debilitating symptoms consistent with Post–Traumatic Stress Disorder were generally experienced by the survivors including: flashbacks, hypervigilance, avoidance phenomena, emotional lability, social withdrawal, helplessness, memory and concentration impairment, fatalism, irritability, guilt and shame, phobias, depressed motivation, startle response, sleep disturbance, and somatic involvement. Eye Movement Desensitization and Reprocessing (EMDR) was applied to nine post–traumatic victims of suicide bus bombing and terrorist attacks. The case presentations included clinical histories, treatment procedure, outcomes, and recommendations regarding the choice and efficacy of this treatment modality with the given population.

Eye Movement Desensitization and Reprocessing: A Clinical Outcome Study for Post–Traumatic Stress Disorder

Steven Marcus, PhD, Priscilla Marquis, PhD, and Caroline Sakai, PhD,

Sixty–seven individuals diagnosed with Post–Traumatic Stress Disorder (PTSD) were randomly assigned to either Eye Movement Desensitization and Reprocessing (EMDR) treatment or Standard Care Treatment (SC). Participants were assessed pre–treatment, after three sessions, and post–treatment. The individuals in the EMDR treatment group improved significantly on measures of depression, PTSD, psychological symptoms, and anxiety, as compared with those in the Standard Care group. Participants who received EMDR treatment used fewer psychotherapy appointments and fewer medication appointments for their psychological symptoms.

The Use of EMDR in Patients with DID

Catherine G. Fine, PhD, and Steven Lazrove, MD

EMDR is conceptualized as a method of doing trauma work within the context of the tactical integrationalist model for treating DID. Trauma work should not be considered until the initial phases of stabilization have been completed, and the patient has sufficient ego strength to tolerate the strong affect that may arise during EMDR. It is important that the principle of fractionated trauma work (fractionated abreaction) is adhered to so that the patient is not overwhelmed during EMDR. In this, the protocol for working with DID patients differs from the standard protocol in that it is expected that traumatic events will not be processed to completion during a single session.

Different associations to a traumatic event may be associated with different alter personalities, each of whom may have his or her own belief system. Thus, one way to approach the trauma work is to do EMDR with the different alter personalities associated with the traumatic event. Often the different belief systems identify different "channels" for processing. Specific technical considerations involving work with this patient population were discussed, such as how to handle physical proximity during EMDR, the use of the safe place, and the number of saccades per set.

LEGAL ABUSE in FAMILY LAW COURT/Rx: EMDR + ...

Barbara Parrett, RN, MS

The purpose of this presentation was to inform participants of an insidious, tragic violence that is destroying unsuspecting families in the **Family Court System**. Fifty percent of marriages end up in divorce. Issues of custody and sexual and/or physical abuse by one parent are common. The adversarial stance and non–accountability of attorneys, coupled with a seemingly gender–biased court, is legally, physically, emotionally, and financially ripping women, their children, and extended families apart. **PARENTAL ALIENATION SYNDROME** was discussed as the worst abusive attack against women and children in this setting.

Critical concerns regarding due process, constitutional, and basic human rights were identified. Case examples were presented in a thought–provoking discussion. A brief review of the anatomy and physiology of the nervous system was presented and linked to EMDR theory. Coping mechanisms for this overwhelming and unpopular problem included EMDR, Critical Incident Stress Debriefing, nutrition considerations,

relaxation/meditation techniques, and the concept of a consumer advocacy/watch-dog group.

This group, known as JUSTICE FOR WOMEN, was introduced as a vehicle for the empowerment of these families, as well as a medium for change. This presentation concluded with the hope that JUSTICE FOR WOMEN will grow and be able to be instrumental in the correction of these severe injustices occurring daily in the **Family Court Legal System**.

Teaching EMDR in Graduate School Programs

Laurel Parnell, PhD, and Curt Rouanzoin, PhD

Until Fall 1995, EMDR was only taught by EMDR Institute staff in a weekend workshop format. With the publication of Dr. Francine Shapiro's textbook *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (1995), EMDR trained clinicians were freed to teach EMDR in graduate schools. The teaching of EMDR in graduate schools presents special problems and advantages when compared to the weekend workshop format.

In this workshop, Laurel Parnell, PhD, and Curt Rouanzoin, PhD, both of whom taught EMDR in graduate programs in the Fall of 1995, discussed how they adapted the training to these settings. They each presented how they structured their courses, the settings in which they taught, and their syllabi. They discussed what worked and what did not in their courses, and offered suggestions for future courses. Issues that come up in graduate school programs such as how to structure the practica, teaching abreactions, and issues of dual relationships were discussed and recommendations for addressing those issues were offered by the presenters. The pros and cons of teaching EMDR in graduate settings was discussed. After the initial presentations, the workshop was open to questions and answers and feedback from the participants. This was an information gathering session in which a lively exchange of ideas was welcomed.

Laurel Parnell, PhD, is a senior EMDR facilitator who taught EMDR in the Fall of 1995 in the psychology doctoral program at California Institute of Integral Studies. In her presentation, she discussed how she adapted the teaching of EMDR to a three unit quarter class which had twelve, two-and-a-half hour classes. The class of thirteen students met once a week in a graduate school setting. She explained the prerequisites for taking the class and the syllabus she used. She presented the assessment tools which included a midterm exam, a 15 to 20 page paper, and a final exam. She discussed how the practicum was integrated into the classes, as well as her recommendations for future classes. Additional topics included: student anxiety about self-disclosure and vulnerability during EMDR practicum, dual relationship issues, student absences on practicum days, how to teach abreactions in a classroom setting, and covering Level I and Level II material. What worked well in the course, as well as what did not work, were presented along with recommendations for improvement gathered from student evaluations and the instructor's observations.

Curtis Rouanzoin, PhD, is a senior EMDR facilitator and is a Professor and Chair of the Department of Psychology at Pacific Christian College where he directs the MA Program in Marriage, Family, and Child Counseling. In the Fall of 1995, he taught a fifteen week course on EMDR for second year master's students which covered Level I and Level II material. The class met for four hours each week with the practicum built into the regular class meetings. Dr. Rouanzoin presented the syllabus and assessment tools he used for his course. Recommendations were offered for adapting the teaching of EMDR to graduate school settings based on his experience.

Beyond the Cognitive Interweave: The Use of Metaphors, Dreams, Art, and Imagery in EMDR

John Thompson, MA, Linda Cohn, MA, and Laurel Parnell, PhD

This presentation covered the use of the right brain creative process in setting up interweaves for EMDR. In the EMDR Level II training, the cognitive (i.e., left brain) interweave is taught as a means of moving clients past particular blocks. These blocks can be characterized by cognitive or emotional looping, insufficient information, or inability to generalize on the part of the client.

By using the right brain in the interweave process, another part of the neural network is activated. The process involves going from the cognitive to the symbolic and can capture the power of imagery. The structure of the interweave process was discussed and demonstrated by the presenters using three completely different therapeutic styles.

Linda Cohn used art as the means to develop the interweave setup that continued beyond the session. She used slides showing how various art forms activate internal traumatic memories and bring them to the surface. She presented case studies with graphic evidence showing how clients processed disturbing material over various time frames.

John Thompson presented several types of approaches using interweaves through metaphors, dreams, and symbols. He discussed the characteristics of metaphors and how they can be used in nonthreatening, multi-level communication. Metaphors can be used in reframing to activate action. Case studies depicted types of dreams generated by EMDR and illustrated how dreams can be

used in interweaves. Thompson also presented a case study showing how symbols can be used in the interweave process.

Laurell Parnell, who specializes in inner child work, described how she integrates EMDR with the inner child in using the interweave process. She presented case studies where she brought the adult back to the period of trauma for the child and integrated the experience from the adult perspective. In all these therapeutic styles, Thompson, Cohn, and Parnell were able to show how right brain creative interweaves could be used effectively with EMDR.

Using EMDR to Enhance Learning with Adults Who Have Learning Disabilities

Laurel Weisel, PhD

This study was designed to explore the applicability of EMDR with adults who have learning disabilities and who are currently involved in an adult reading program--a relatively new area of application for EMDR. The literature notes that for a variety of reasons, neither traditional nor non–traditional attempts to improve reading skills have significantly impacted this population. Previous educational experiences for this group have been highly problematic and this created dynamics that stand in the way of moving forward educationally.

In this study, a treatment group and a comparison group were incorporated to test for EMDR's affects. Between one and three EMDR sessions were given to members of the treatment group. Pre–test and post–test data were collected for four variables for both groups. Trends in the data were consistent with the study hypotheses. Additionally, trends in the data were consistent with the clinical observations of the psychologist using EMDR with study participants.

Retention of learning disabled adults literacy programs has been a major problem. Perhaps the most interesting finding of this study is that the attrition rate of the comparison group was much higher than that of the treatment group. General findings are sufficiently encouraging to warrant additional, more systematic research in this area.

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EMDR in the Treatment of Panic, Phobia, and Obsessive Compulsive Disorders

Marcia Whisman, LCSW

This presentation focused on the importance of preparing the anxiety disordered client before beginning EMDR. For example, doing a detailed assessment in order to make the correct diagnosis; beginning to locate EMDR targets; providing education, including a thorough explanation of the client's disorder; and presenting models to aid understanding of the "continual loop" of fear, as well as management techniques (teach, tape, practice). It is also important to take time to answer questions, give accurate information, correct distortions, etc.

After assessment (in EMDR terms), education and anxiety management can be thought of as "building in" positive information to be extracted later as positive cognitions. Anxiety disordered clients cannot state the positive cognition of (PC) of "I am just experiencing adrenalin," rather than the PC of "Maybe I will live through this impending heart attack," unless that distorted belief has an alternative, correct belief associated with it and ready to reprocess. Looping often occurs because there is no positive associated belief with which to link.

The second focus of this presentation was targeting for EMDR treatment. The following suggestions were offered: Panic--Target the "Imaginary Fears" first; for example, major medical crisis (i.e., heart attack, death); mental illness (i.e., crazy, humiliation), etc. When desensitization is complete, target fear of fear (i.e., "I am not strong enough to withstand these feelings) and first exposure and emotions that arise in response to performing exposures (i.e., "I am not capable of remembering what I need to do" or "I am a child again"). For phobias, when the client is ready to enter the feared situation, rehearse using the Peak Performance Protocol originated by (Lendl & Foster). Caution was urged in performing eye movements while conducting exposure.

The last focus of this presentation was Obsessive Compulsive Disorde (OCD) Again, assessment, accurate diagnosis, education with explanatory model of the disorder, anxiety management, and targeting were stressed. The complexity of this disorder dictates a categorical, hierarchical, and very different approach to eliciting a representative picture and negative cognition. As with Panic with and without Agoraphobia and Social Phobia, EMDR appears to be accelerating the process of desensitization and information change in the treatment of OCD.

Integrative Psychotherapy: Combining Ego State Therapy, Clinical Hypnosis, and Eye Movement Desensitization and Reprocessing (EMDR) in a Psychosocial Developmental Context

Darlene K. Wade, MSW, and Terence C. Wade, PhD

It seems to be impossible to do psychotherapy without using hypnosis (e.g., suggestion or influence) which

includes EMDR. Indeed, asking a client to recall the first time he or she had a particular feeling is an "affect bridge," presented in 1971 by John G. Watkins as a hypnoanalytic technique. Likewise, a framework such as EMDR that proposes current disturbances are caused by earlier traumas is inherently suggestive. Hypnotizability, and hence suggestibility, whether or not formal hypnosis is used, becomes a liability concern. One purpose of this basic workshop is to encourage therapists to use hypnosis consciously, with appropriate applications and safeguards, including informed consent and measures of hypnotizability. Since a major use of hypnosis is to access information, including what is unconscious, and then utilize the information in new ways, the possibilities for combining hypnosis with EMDR to accelerate the processing of information are limited only by the therapist's imagination. Age progression to a time when a client will have developed new skills, obtained important goals, or overcome physical, emotional, or environmental limitations provides a multitude of EMDR applications. Age regression can access resources and empowering experiences, as well as memories of disturbing events that can be enhanced with EMDR. Post–hypnotic suggestions combined with EMDR can be added to every intervention. Self–hypnosis combined with EMDR provides a flexible method clients can use to devise their own intervention strategies as needs arise.

Ego state therapy provides a framework for focusing interventions on the specific area of personality (or part of the self) that needs to change for the client to become more functional. Psychosocial development then expands the context for understanding disruptions embodied in aspects of the self that cause continuing vulnerabilities and dysfunction. Ego state therapy, clinical hypnosis, and EMDR with age regression and progression provide corrective developmental experiences that can readily be extended to desired future functioning.

Emphasis is on brief therapy focused on matching interventions to the client's stage of change, addressing *how* problems are maintained prior to *why* they developed, changing *patterns* rather than *issues*, modifying *process* rather then *content,* and enhancing *capabilities* prior to eliminating *vulnerabilities*. Case examples included applications of this integrative psychotherapy to depression, grief, trauma, substance use, psychophysiological, and dissociative disorders.

COMMITTEE UPDATES

Membership
Darlene K. Wade, MSW Chair

EMDRIA is continuing to grow into a large extended family consisting of 827 members representing fourteen countries. Full Members total 730, of which 471 hold Charter Membership. Other member categories include 75 Associate, 2 Affiliate, 16 Student, 3 Life, and One Honorary.

At the Denver conference, Lifetime Charter Memberships were awarded to Dr. Francine Shapiro, Robbie Dunton, M.A., and A. J. Popky, M.A. Ellie Ryan was awarded Honorary Lifetime Member for her support and contributions to EMDR.

Quality EMDRIA T–shirts with a $2^{1/2}$ inch breast logo are available for purchase at $12.00 each plus $3.00 shipping and handling. Please add an additional $2.50 S/H for each additional T–shirt. Charter Members may take a $2.00 discount. Please state size Large or X–large. Make checks payable to EMDRIA and mail request to: Darlene Wade, MSW, 1188 Bishop Street, Suite 3205, Honolulu, HI 96813–3313.

Research Committee

David Baldwin, PhD, Co–Chair

The research committee consists of: Lee Becker, PhD, myself, and Steve Lazrove, MD The committee is focusing on several important aspects of research regarding EMDR, with particular emphasis on including methodological issues. A fundamental piece of this is a "meta" look at the process by which any innovative new theory, idea, or clinical method is tested experimentally and becomes accepted (or not) as a significant new contribution to its discipline.

Some important specific questions within this meta view are: "How can we best encourage controlled clinical trials using EMDR?" "What are the relative advantages and disadvantages of various measures, controls, or comparison treatments, and experimental designs used in clinical outcome research for different patient populations (PTSD, etc.)?" "How can we tell that an effective treatment is (or is not) just a placebo effect?" (This turns out to be less straight forward than it first appears, but it is an important and recurring question in clinical science.) "How can we best assist clinicians who want to prepare and conduct EMDR treatment efficacy studies for journal publication?"

Overall, the objective of our focus is to encourage methodologically sound clinical research and to assist the ongoing process as EMDR is scrutinized by the scientific and academic communities.

Professional Issues Committee

Michael Galven, PhD, Chair

The Committee will review questions regarding the professional practice of EMDR and perform an educative function on the appropriate application of the method for members and non-members of EMDRIA. Reports of questionable practice are solicited.

Committee members are Sheila Bender, PhD, in New Jersey; Sherwin Cotler, PhD, in Washington State; and

James Knipe, PhD, in Colorado. We would like to include a member from outside the US; please contact me if you are interested: Michael D. Galvin, PhD, 315 East San Rafael, Colorado Springs, CO, 80903-2405, 719-634-4444, mgalvin@mail.uccs.edu.

was annihilated. A result of this experience, one totally unpredictable at the time, was the United States of America and western democracy.

The connections follow thus: when the plague passed, one of the problems facing the survivors and the

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