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EMDR Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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 [Excerpt]

Stray Thoughts

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As I have mentioned in the workshops, I feel that there is an experiential base to most existing pathologies. One of the beauties of EMDR is the ability to metabolize quickly the dysfunctional residue of the past and shift the material into something useful and fruitful. In the Intermediate Training (now the Level II Training), I cover ways of rapidly accessing this painful information so that it can be more easily assimilated into a functional superstructure. (In the following material, I am assuming the reader has taken the Level II Training.)

I would like to underline that a useful interpretation of these EMDR effects is that the dysfunctional material is held in a neural network in state-specific form; this can be interpreted as the "child" perspective. The client is obviously in your office because of his/her belief that something needs to be changed. This accumulation of later information and more functional judgments is also encapsulated in another neural network – the so-called "adult" perspective. The result of an EMDR session may be the link-up of the two networks and an assimilation of the painful material into its proper place, historically – the past – along with a generalization of adaptive cognitions through the hitherto isolated material. The client is now able to bring up old memories that are fully integrated into a more adaptive perspective.

It has been my observation that the major issues confronting many clients are (1) responsibility, (2) safety, and (3) choice. Specifically, using the cognitive interweave variation on these points, in the order given, can dramatically reduce the therapy time. The primary objectives are to get clients to recognize and attribute appropriate responsibility, and to relinquish the guilt and self-blame that have undercut their feelings of self-esteem and self-efficacy. Once these are accomplished, it is easier for them to recognize that they are no longer threatened and are able to choose safely and appropriately their associates and their actions.

In accomplishing this, it is often useful to urge clients to voice to the parent their anger/blame/pain; e.g., "It was your fault that it happened; you shouldn't have treated me that way." I suggest doing this even without perceiving the body signals I have mentioned in the training (e.g., tension in throat or jaw). Time and again, I have seen clients who have been urged to express themselves during the eye movements, give a declaration of independence to the parent. The eye movements are continued as clients are urged to elaborate or repeat their words until their voice is firm, confident and steady. The resultant feeling is often described in terms denoting emancipation and adulthood.

A good clinical ear is necessary, however, for the appropriate timing of these verbal promptings. Make sure there is first a cognitive understanding before proceeding. You should also be very nurturing and reinforcing of the client regarding whatever visual or auditory depictions of violence that occur. Anger untapped for an entire lifetime can be extremely frightening to the client. Give reassurance that it, too, is "just the scenery, while they are on the train."

In the Level I Basic Training, I have often remarked that EMDR appears to me to be almost a window into the brain. Because of the unique opportunity afforded us by the rapid treatment effects, there are many avenues of information processes open for investigation. There are a number of areas that I hope many of us find fascinating, and it would be useful if we could begin to collect some data on them.

For instance, during the Level I Basic Training I speak about the **difference between treating a recent and a more distant trauma.** It was my observation from the Loma Prieta earthquake that patients suffering from stress reactions within a month after the quake had to be treated with each separate sense experience as a separate "node." In other words, while an older trauma could be treated by having the patient concentrate on only the most upsetting part of it – and a generalization effect would ensue – no such general desensitization to the entire event would occur with the recent trauma. It appears as if, on some level of information pro-

cessing, not enough time had passed for a consolidation of the entire memory to take place. This indicated multiple levels of memory consolidation, since the client could give a serial account of the earthquake; however, the differential treatment effect was clear and consistent.

To treat recent memories, it appears necessary to ask the client to give a full narrative of the experience and for the clinician to copy it down. Every distinct phrase, such as: "(a) I heard the bureau fall, and then (b) I rocked from side to side against the door and (c) I heard my baby cry . . . " has to be concentrated on separately and reprocessed with a concluding positive cognition installed. No single reprocessed scene seems to have a profound effect on any of the other remembered material. After all the narrated events are singly reprocessed, the client is asked to "run the earthquake like a movie from start to finish and stop if anything becomes upsetting." At that time, new material will emerge that must be separately reprocessed. This is continued until the patient can review the entire episode without discomfort. Then the entire episode is replayed with the eye movements and the positive cognition in mind.

It would be useful if we could ascertain at what point in time the memory "consolidation" occurs. That is, at what point can a single picture be reprocessed and be expected to generalize to the entire event. My guess is two to three months, but I would appreciate your input. How recent a trauma have you been able to process by concentrating on only one aspect of the event?

The next subject of interest may be the treatment of OCD. The protocol I suggested in the Intermediate (Level II) Training has been successfully used by a number of clinicians, but some OCD clients have remained intractable. One clinician suggested that the subcategory of pure obsessives (e.g., those structured around number repetition, etc., without a physical ritual) may be particularly difficult to treat. Barbara Olasov Rothbaum, Ph.D., at the Emory Clinic, recently submitted a letter to the editor of the Behavior Therapist indicating that cocaine addicts, schizophrenics and OCD clients have all been found to have abnormalities in the orbitofrontal cortex (which has already been linked to visual tracking deficits in schizophrenics), which she conjectures may help us explain the EMDR effects, "by knowing when it does not work." It would be useful if those of you who have treated any of these three categories with EMDR send me a tabulation of: (1) numbers treated, (2) successes, (3) partial successes, and (4) failures—compared to other categories like PTSD, panic, simple anxieties, etc. While outcome studies must eventually rigorously test the efficacy of EMDR with any population, our clinical observations can be invaluable during these initial stages. Our pool of trained clinicians have a wealth of data that can help formulate the future directions of EMDR.

Another potentially fruitful area of investigation may be the use of other stimuli such as hand- or finger-tapping during sessions. The EMDR model suggests that possibly the electrical stimulation generated by the eye movements catalyzes the information-processing system. It is reasonable that other movements could have a similar effect. Initial reports of Dave Wilson's study are that exposure without eye movement caused an increase in anxiety, eye movement showed a decrease, and finger- tapping maintained the level of anxiety. The fact that the anxiety did not increase shows that there is some beneficial effect of finger-tapping.

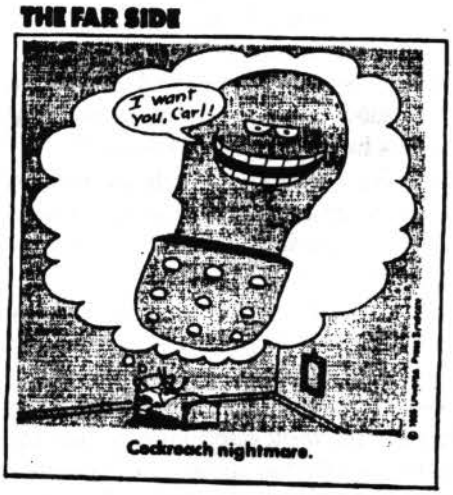
A number of practitioners have been using hand-tapping when the client is, organically or emotionally, unable to visually track. Robbie Dunton, MA, who treats primarily children with learning deficits, has been using this variation for over a year-and-a-half. She asks the child to hold palms upward and rhythmically, alternately taps each palm. She has been very successful in getting desensitizations of primary incidents, however generalization effects are unclear. Gary Flint, Ph.D., and Priscilla Marquis, MS, have also reported positive results with the hand variation, while other clinicians have found that clients who have compared both of these methods report that the "hand" results are not as "powerful" and do not go as "deep." Some clinicians have reported a temporary effect and later recurrence. Differential effects may have to do with age, severity, longevity or kind of target.

For now, therefore, consider using the hand-tapping when the client cannot visually track and then switch to the eye movement when possible. This may prove particularly useful in abreaction work when the client cannot keep the eyes open. If you are able to set up full session comparisons with volunteers, it would be useful to get your reports regarding (1) decreases in SUDs levels, (2) shifts of cognitive structures, including pictures and insights, and (3) maintenance of treatment effects.

Please remember that EMDR did not launch from a theoretical basis. The REM hypothesis was advanced as an attempt to explain the treatment effects of the eye movements, and in no way contraindicates the possible effects of other stimuli. Clearly, if the treatment effects do prove to be linked with REM, it does not discount other possibilities in the waking state just because the body in sleep is not capable of manufacturing external auditory tones, lights, or hand-taps.

The article, in your packet, published in the Behavior Therapist gives a long list of possible explanations for EMDR treatment effects, and there is undoubtedly an interaction of many factors. As a total treatment modality, the accent in EMDR is on the reprocessing of dysfunctional information. While the model has proved predictive, it is subject to alteration. While

the eye movement is obviously effective, it is subject to augmentation by other stimuli. While the format is effective, it is subject to improvement. In other words, the accent is on change.



Hopefully, some of you will remember that in the Level I Basic Training there is a history-taking video; the transcript is contained in the back of your manual. During the subsequent EMDR treatment, the subject goes "bipolar" and, from thoughts of "I'm different in social situations," starts remembering a recent occasion where he is "fine in social situations." He talks of a Far Side cartoon that he found particularly funny: "A cockroach having a nightmare." This appears to be the one. Symbol analysis anyone?

Relapse Therapy

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Most therapists who treat Drug/Alcohol addicted clients have experienced the frustration of client relapse when therapy appeared to be working. Chronic relapse can occur even when the client is fully committed to an abstinent life. Chronic relapsers, and many recovering addicts to some extent, suffer from what Terry Gorski, MA, describes as Post Acute Withdrawal or "PAW." His premise, supported by an analytical study of a group of chronic relapse clients in 1974, identified the thirty-seven warning signs that were predictive of possible relapse. (For those who wish further information, these warning signs were first outlined in his book, Counseling For Relapse Prevention (T. Gorski, 1982).

Many recovering addicts will demonstrate some of these symptoms, to a greater or lesser extent, in the course of their recovery process. Their symptoms will normally begin to appear at six to eighteen months into the recovery process. Of the recovering population, about one third will manage the symptoms with little difficulty. The second third will eventually recover after one or two abortive attempts. However, the relapsers, the final third, will find long term sobriety elusive. Relapser's PAW symptoms will surface during any period of increased personal stress which can occur even after long periods of sobriety and relative comfort. Relapsers will usually experience a greater number of the warning signs that Gorski has identified, and the subjective magnitude of the discomfort they experience will be much greater than others in recovery.

Clients report the following six symptoms most often. These symptoms, particularly the mood swings, can be so overwhelming that these clients will opt to return to their "using" behavior rather than tolerate the pain.

(1) Inability to think clearly
(2) Memory problems
(3) Emotional over-reactions or numbness
(4) Sleep disturbances
(5) Physical coordination problems
(6) Stress sensitivity

Generally, the criteria for diagnosis is that the client has had at least one or more previous residential drug treatments, has had one or more periods of complete abstinence from drug use subsequently, and has been unable to remain sober on a permanent basis, although committed to that life-style. Clients historically have been recycled repeatedly through the same failed treatment modalities. The rational was that "they didn't get it the first time." Those who provided treatment blamed the client for treatment failure. What we call client resistance!

Certified Relapse Prevention Specialists, or CRPS, can help the client learn to manage the symptoms in more than 80% of these cases. This is the 80% that was formerly considered hopeless by the Drug-Alcohol treatment industry, although this belief was seldom acknowledged openly.

Since Gorski began his treatment regimen in the eighties, there has been a breakthrough in knowledge that is of particular interest to those who treat chronic relapsers in their practices. The discovery is that there is a direct correlation between chronic relapse and PTSD. Cynthia Downing, Ph.D., determined in late 1990 that 97.5% of chronic relapse clients had experienced a life threatening experience wherein they perceived their imminent death and could do nothing to prevent it. They subsequently generalized the feeling of being powerless to effect their world in any significant way. Downing's work was a blind study using some hundred odd relapse prone clients and an equal number of normals in the control group. The life threatening/powerlessness dynamic was found to be true consistently, with or without the presence of a history of the other psychic trauma that we have come to expect with the addict population. It is important to note that the presence of the various forms of child abuse per se were not predictive of being relapse prone. Only the client's conviction that death was imminent and that he was powerless to prevent it seems to be the deciding factor.

Extreme violence may be a part of a client's past and is frequently perceived as a life threatening experience. Of course, there are other client experiences that can be construed as life threatening, and it is important to be aware that it is the client's evaluation of the experience that is the deciding

factor. Therapists sometimes may ignore the life threatening experiences, expecting that the abuse experiences are really the underlying causes of relapse behavior. Downing's study strongly suggests that these life threatening experiences absolutely must be addressed for long term sobriety.

The Post Traumatic Stress Disorder symptoms which manifest from these life-threatening experiences are the motor driving the PAW symptoms to client overload. Empirically, from personal experience, I have found this to be true in the relapse clients that I have successfully treated this year using EMDR. Each of these clients had the life threatening experience that Downing identified, and all responded well to EMDR intervention. That is, there was a substantial reduction of anxiety as measured on the SUDs scale and the sense that the experience was now history. "It should never have happened, but it's now history" is the common self-report after one or two sessions using EMDR. This response is particularly important with chronic relapse clients because they have self-medicated in the past to keep from experiencing these feelings in their "flashbacks."

As an example, I successfully used EMDR with a client who had been trapped on a ledge in Yosemite as a teenager. This client was a member of a relapse group that I facilitated in a residential treatment program this past spring. He was non-communicative, depressed, and not able to tolerate the group process. His treatment was almost non-existent, although he said he was desperately seeking to stop using drugs. His drugs of choice were crack-cocaine and alcohol. He said that the group brought up overwhelming feelings of mistrust and fear, so he just "numbed out" in group. I suggested to him that we try EMDR and explained the procedure to him. His initial response was that there really was not anything that bothered him, like sex or physical abuse, but he was willing to try the procedure. I did an assessment and the incident at Yosemite came up. He was sixteen years old when it happened. His verbal description depicted it as a relatively minor incident from a long time ago.

The initial SUDs was a body feeling centered in his stomach that he identified as an eight. The number came from his "subconscious" and "seemed right" to him.

It was necessary to do the EMDR sets for about twenty minutes before there was an opening up of his processes. Body language encouraged me to continue with the client even though he reported no change during these twenty minutes of EMDR passes.

Periodically, during this phase we stopped and talked in generalities about what he was feeling. My take was that this very distrusting individual was making some kind of internal assessment as to whether this was a good thing for him to do. When we broke through the block, the rest was relatively easy. The initial blocked feeling was around the perception of his impending death. He knew that he was going to die because he was losing his grip on the rock that he was holding onto to keep from slipping off the mountain. When he started into the abreaction, I assured him throughout that he was just passing through an old experience, that he had survived it, it was in the past, and that he was now safe. I encouraged him to stick with the experience so that he could finally get through the pain and not get stuck in it again. He had some difficulty staying with it, and we had to stop several times for him to regroup. Each time was a little less difficult for him until he suddenly said, "My father's an asshole."

He stopped the process at that point and told me that he had forgotten that part of the incident when his father came on the scene. Two adults had been watching him and made no effort to help him. Instead, they told him what a stupid fool he was. He knew he was going to die and nobody cared. His younger brother risked his own life to pull him to safety, while the adults continued to berate him. His father soon arrived on the scene and the client's expectation was that the father would comfort him and get the two "big mouths" off his back. Initially, the father showed concern, but then sided with the others. This rejection, on top of the life threatening experience, was encoded and afterward repressed. During the next series of passes he said, "My father never was there for me and that's when I realized it. What an asshole." During the next series he started in a polarization sequence. He vacillated between what a good man his father was because he took the family so many places and that he's an asshole. During a rest period dialogue he observed that his father only took him to places that the father wanted to go to. In the subsequent polarization sequence I fed this information back to him. That is, that his father was never there for him and only went to places that pleased the father. This interject [taught in the Level II trainings] ended the polarization sequence.

I also interjected that he was now an adult and capable of taking care of himself and making mature decisions about the safety of situations. He now had information available that was not available as a youth. This final interject was reinforced with EMDR.

The combination of the life threatening experience and psychological abandonment by his father were the driving forces of the relapse dynamics. This resolution brought about an immediate change, within hours, of the way he related to his peers. Some of them asked, "What kind of miracle happened in there?" Of course it was no miracle. Only a letting go of the past.

Prior to EMDR intervention, this extremely depressed, middle-aged adult could not participate in the group process at all; this was his third treatment attempt. He could not trust his peer group, and did not feel safe anywhere. He reported that the feeling of not

being safe disappeared and his ability to trust increased significantly. Prior to EMDR, his longest period of sobriety was approximately three weeks. He has been sober for seven months and has not relapsed to date. I believe his prognosis is now good for long term sobriety, and there has been no return of his depression.

I have consistently had the same result with clients who were physically beaten by "crazy" parents until they thought they were going to be killed. I also treated a case of forced oral copulation where the perpetrator literally cut off the boy's air supply and brought him near death.

In conclusion, I think that EMDR therapy is an extremely useful tool for those working with the addict population and particularly with relapse prone clients. I have found that EMDR can be used effectively at any time with addicts, unlike some of the other treatment modalities. I have used it very early in treatment on both residential and out-patients with no ill effects so far. Admittedly, my sample is small, so I would advise caution. When treating the relapse prone, the therapist needs to look for the life threatening experience that is almost certain to be there and resolve the attendant feelings of powerlessness with EMDR.

Also, my personal experience using the procedure has taught me to be patient with it and not expect instant responses from my efforts. Each client has his/her own blocking mechanisms, and we must work within that agenda and not necessarily our own.

Autonomic Correlates of EMDR

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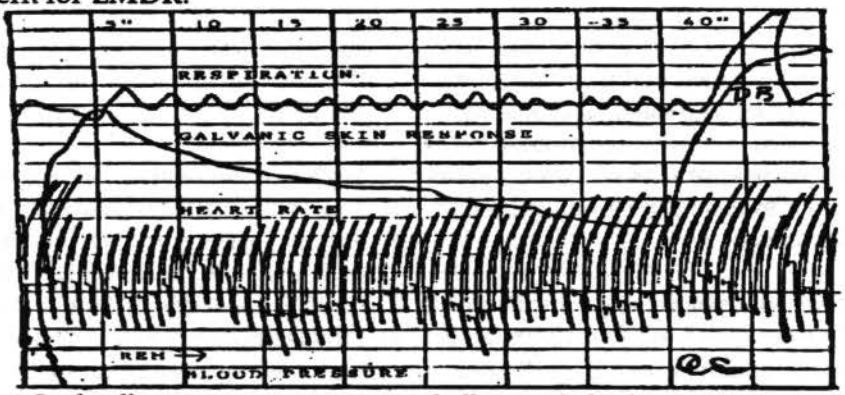
The purpose of this study was to identify autonomic correlates of EMDR as sampled by common measures of physiological functioning: respiration, heart rate, blood pressure, and the galvanic skin response. The study focused on six volunteers with complaints related to memories of traumatic events. Shapiro's procedures for EMDR were followed as closely as possible. Dependent variables were: (a) anxiety level, (b) validity of a positive statement/assessment of outcome, (c) subjective complaints, and (d) measures of autonomic functioning, as noted above. Anxiety level, Validity of Cognitions (VoC), and complaints were measured during the experimental sessions and reassessed at three months. Self-report results were consistent with those reported by Shapiro, and indicated that a single session of EMDR desensitized subjects' memories of traumatic events and dramatically altered cognitive assessments with such effects being maintained at a three month follow-up.

Autonomic measures showed the following distinct, profound changes during EMDR: 1)respiration tracked and matched the rhythm of the saccades in a shallow, regular pattern;2)heart rate, which did not show significant increase or decrease during any given set, slowed significantly overall; 3)blood pressure, which increased during early sets, but decreased in later sets, invariably fell during abreactions, and decreased overall; and 4)the galvanic skin response consistently decreased in a clear "relaxation response."

The following illustration from a polygraph chart shows a "signature" pattern for EMDR.



In the illustration, respiration is shallow and rhythmic AND synchronized with the rhythm of the saccades. Heart rate is stable. The GSR (a measure of sympathetic nervous system arousal) rises as the client is present to a troubling memory, then falls steadily until s/he is instructed to close his/her eyes and take a deep breath. This overall picture—shallow and rhythmic breathing, steady heart rate, and decrease in the GSR—is characteristic of an EMDR set, occurring with minor variations in 80% of EMDR sets. The only significant variations include apneas (holding one's breath) and abreactions. During abreactions, the physiological measures are extremely unstable.

The relaxing effects of saccades indicate that at least one of the mechanisms operating during EMDR is desensitization by reciprocal inhibition, i.e., pairing of emotional distress with a "compelled" relaxation response. In contrast to systematic desensitization, which requires teaching some mode of relaxation, or flooding, which requires repeated exposure to high levels of distress without immediate relief, EMDR utilizes mechanisms producing an unlearned relaxation response.

EMDR: Innovative Uses

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First of all, let me begin by stating that Francine's statement that EMDR "is not a cookie cutter" is beginning to look
more true all the time. Each client/ patient seems to have a great deal of variability of response and, for that reason, the more that we have a forum in which to discuss variations on the technique the better. Gary Flint, Ph.D., recently sent me a several page letter with many observations on his use of EMDR, and I would like to include a few of them here.

First, when dealing with an individual whose initial picture of the trauma was too intense to hold in consciousness, [as suggested in Level II training] Gary asked that she "move the picture away from her until it was less painful." He then did the EMDR procedure, and the visual image spontaneously moved "closer," with repetition of the process, as it began to metabolize. Second, he found that making a simple statement like, "Adjust the color, sound and feeling to obtain the strongest representation of the picture you can," often assists people in developing an optimal visual image.

Rather than attempting to intuit which is the best speed, eye focus level, angle, etc., at which to use EMDR with a given person, Gary simply asks the client which one feels best and then proceeds based on his/her verbal feedback.
[These innovations were presented at the Dec. Network meeting.]

I have developed two further uses, one of which resulted from Francine's observation that you cannot "install" a negative or take anything positive out of the system. Based on that, when I was particularly stuck in working with a gentleman on his fear of authority figures, I asked him to contemplate a time when he felt the most strong and competent. When he brought up a memory of that time, I used EMDR to "lock it in" more and more powerfully until we reached the ceiling of intensity. I then had him hold the memory of that time as vividly as he could in his awareness, alongside the inner representation of fear of authority figures. I asked him to either juxtapose the strong memory and negative representation (hold them side by side like two photographs) or superimpose them (imagine them like a double exposure, one over the other). Then, when he was holding both the positive and the negative representations internally, I began doing EMDR. As predicted by the model, the more positive representation continued to strengthen and become more vivid, while the more negative representation began to fade and become less relevant.

The final discovery I have made is that for some people who seem to "circle" through endless visual representations or through ongoing sequences of physiological responses, there is often a negative cognition that occurs spontaneously during the EMDR.

With one gentleman, the cognition was "You've always been a screwup, and you always will be." With the part that felt the need to express itself, I used the cognitive behavioral technique of asking him to hear that message repeated in Donald Duck's voice while we were doing the EMDR on the representation we were working with. Hearing the negative cognition in Donald Duck's voice seemed to depotentiate it and take away its meaningfulness, which then allowed the visual and physiological aspects of the inner representation to process through. It is important to understand that hearing the negative cognition in Donald Duck's voice in a normal conscious ~~awareness [as suggested in the Level~~ II training] is different from what I am referring to here. Specifically, the Donald Duck voice presenting the negative cognition is to be invoked during the EMDR processing of the issue on which the negative cognition spontaneously arises. I have no idea whether the depotentiation takes place because Donald Duck's voice represents someone silly, or because it simply is different from the original voice speaking the cognition, but I have found it to work on several occasions. I invite you to try all of the above techniques and get back to me on your findings.

LEVEL II TRAINING

Please note the change in training format. The Level II Training is an update of and replaces the Intermediate Training. The consensus of the previous participants of the Intermediate Training and EPIC is that the second two-day workshop is necessary for a full understanding of the therapeutic utilization and myriad applications of EMDR. Therefore, starting in 1992, graduates of the Level I Basic Training will receive a Certificate of Attendance, and the Certificate of Completion will be issued only after participation in Level II. It is recommended that 4 to 6 weeks of clinical practice with EMDR be completed before registering for Level II. Intermediate graduates may attend at half price. **ALL BASIC TRAINING GRADUATES ARE URGED TO ATTEND TO INCREASE THEIR THERAPEUTIC EFFECTIVENESS AND RANGE OF APPLICATION.**

EMDR Used As A Treatment In Chronic Pain

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My wife Carol returned from the EMDR Level I Basic Training and posed a question regarding the effectiveness of EMDR on chronic pain. It seems that if we believe that the eye movements in

EMDR produce something that assists or facilitates the brain to reprocess thought, memory, and emotions, then we can speculate or hypothesize that the same procedure could effect how the brain processes chronic pain.

It is understood that pain normally indicates that there is a problem and that the person must do something about the cause; however, chronic pain is "just there." For some reason, that part of the body sends a constant or near constant message of pain to the brain creating a chronic pain path.

Pain clinics use a variety of approaches to help the individual live with the pain. These include, but are not restricted to, relaxation and self-hypnosis. If the pain reduction and control techniques do not work, the individual may either take medication or may have to resort to injection of chemicals to deaden the nerves.

Is it appropriate then to use EMDR with chronic pain? We feel that the answer is "YES!" If, in fact, EMDR is tapping into the body's capability to heal itself, then it is not only appropriate to allow the body to apply that capability to chronic pain, but it could be considered unethical if the clinician did not allow the individual the opportunity to benefit from the procedure.

For purposes of this paper, EMDR has been used with a sample of ten (10) individuals ranging in age from 40 to 85 years who experienced chronic pain. The pain was located in various areas, e.g., lower back, knee and hand joints, a wound caused by shrapnel in Vietnam, and others. The duration of the pain in the case of the 85 year-old was 40 years of lower back pain and 10 years for the individual with joint pains.

In a number of the cases, the individual had modified his or her body posture to compensate for the pain in the best way he or she could. In some cases, the body posture itself added to or became part of the problem. Thus, it was necessary after the application of EMDR to encourage the individual to modify his or her posture to minimize the possibility of re-establishing the same path of pain (as Francine says, "the tracks are there"). One case reported that while working in her garden, she re-established some of the chronic pain due to overwork. EMDR was immediately applied and the pain was reduced to an appropriate level for the situation (work she was not accustomed to doing). When we discussed the procedure and what happened when EMDR was applied she described it this way, "It was necessary to get rid of the memory of the chronic pain again." Once the memory of the pain was again reprocessed, it left the natural soreness that was appropriate.

With the understanding that it is possible to re-establish the old path of pain, we have included in our procedure a brief protocol for SELF-EMDR for those occasions when there is an activity that re-establishes the old path. The client is also cautioned to use the procedure only when attempting to deal with the re-established path and not to attempt to use it on new areas.

All clinicians must be concerned with the effects on the individual when he/she is suddenly without pain. Working with chronic pain is no different from dealing with emotional pain in that we must look at secondary gains and the stability of the individual in order to assist him/her in preparing for the new experience of being pain free.

PROTOCOL

A. Have the client move or arrange his/her body in a position that maximizes the pain. As when working with emotional issues, it is helpful for the client to visualize those memories he/she wishes to reprocess.

B. Begin the eye movements, keeping in mind that you as the clinician will need to adjust with the client so that he/she can keep the pain at the maximum and still continue doing the eye movements.

NOTE: The eye movements are continued in that position until the pain reaches a low level or is completely gone.

C. You then have the client identify the next point of pain. You may find that the pain moves to a new location in the body and you seem to be chasing it. In both cases, the same pain apparently moving to a new location or another chronic area, you continue as in step B.

Winson, Jonathan (1990)
The Meaning of Dreams
Scientific American 11,86-96
Andrew Sweet, PsyD
Behavior Therapy Institute
Aurora, CO

Dr. Winson is a neuroscientist at Rockefeller University studying memory processing and specifically sleep related processing.

After a brief overview of the history of dreams and their supposed origins, he sets forth his theory that dreaming is a pivotal aspect in the processing of memory, specifically memory that may have survival value for the organism. Using his research on subprimate animals, Dr. Winson believes that he has isolated a brain wave (theta) that is the electrochemical marker for the processing of survival information in the brain. He further reports that in these lower organisms, the only other time this brain wave is present (other than in foraging, escaping, sexual behavior, predating, etc.) is during REM sleep. Using several data bases he makes a convincing case that REM sleep may be the brain's way of organizing, selecting, and filing/processing the abundance of information from the preceding day. The data summarized is indeed impressive, leading the reader to link these theta rhythms with brain activation in those areas of the brain

believed to be associated with memory processing and storage. He even states that the evolutionary value of REM sleep may have been vital in the development of survivability for higher organisms. He likens it to an "off line" method of processing and sorting centrally important information. The next step (in this author's opinion, a fairly large leap) is to state that human dreams reflect an individual's strategy for survival. Dr. Winson cites one interesting data set suggesting that dreams and their associations are frequently linked to childhood themes and patterns. He also aptly points out that theta rhythms have not been found in primates or higher organisms and much more research is needed.

The implications of this article for EMDR are fascinating. Clearly if stimuli are "locked" in the brain, and both EMDR and REM seem to release these fragments, then Dr. Winson's thesis may have merit. I am particularly intrigued with the PTSD population which often (though not always) has as part of their history a near-death, or close - call aspect which has, in essence, "imprinted" an image in their minds. It is also tempting to link the

Treating The Unknown

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Maybe it is a sacrilege, but sometimes I yearn for the clarity of the medical model. How simple our lives would be if we need only assess a client for discernible, measurable symptoms and then refer to a diagnostic "cookbook" for treatment re-commendations. However, our lives as psychotherapists are rarely so uncomplicated.

Consider a case I treated approximately eighteen months ago. I had been individually seeing a man in his mid-30's in preparation for marital counseling. The therapy focused on issues related to his alcoholism (he was one year sober at the time) and work difficulties with a male superior. About three months into treatment, he complained of a nagging image that he found most disturbing.

He described a scene wherein he was at his grandparents' house in the desert. He was standing in front of a picture window looking out onto a ribbon of highway lazily winding itself into the distant mountains with the sky painted red as the sun slowly set. He was terrified and longing for the return of his parents who were in the habit of leaving him with the grandparents while they took off together.

After the appropriate history taking and explanations, I scheduled a double session for an EMDR treatment. Soon after we began, the client grabbed his right thigh in the hamstring area with both hands and cried out, "Ouch, it hurts," and began writhing in the chair in considerable pain. Tears were rolling down his cheeks and I had to stand up in an effort to have his eyes continue to follow my fingers. After about a minute, with the pain apparently increasing and not subsiding as I had anticipated, I stopped the eye movements and asked him if there was a physical cramping that we could stretch out. He said no, and that the pain was familiar and had been with him every day of his life since his earliest childhood recollections. A host of medical specialists had treated him, albeit unsuccessfully. Reassured that the pain was of psychogenetic origin, we forged ahead. Various childhood images floated to the surface, usually pertaining to important male figures in his life – all cloaked by his writhing response to the obviously intense pain. Our macabre "dance" continued for approximately 70 minutes, when out of nowhere he screamed, "Oh, that's it!" We stopped.

The client then recalled an infantile memory. His grandfather was pinning him to the changing table, holding him firmly, maybe even savagely, by the right thigh with his left hand while his right hand played with his genitals and penetrated his anus.

The pain stopped in my office and it appears that EMDR allowed me to successfully treat a "physical" symptom. I am still in touch with this client and the pain has not returned to this day.

International Update

Francine Shapiro, Ph.D.
Mental Research Institute

Trainings are scheduled this coming year in Australia and in Germany, as well as throughout the U.S.

Research is underway at many facilities, including:

1. Temple University on the treatment of panic disorder and agoraphobia – headed by Alan Goldstein, Ph.D.

2. Harvard University on PTSD and chronic combat veterans – headed by Roger Pitman, M.D.3. Augusta, GAV.A. on PTSD and chronic combat veterans – headed by Pat Boudewyns, Ph.D. This group just submitted a paper for publication on a small pilot study completed on EMDR. While physiological measures showed no change, the self-report and therapist observational measures were so positive that they have requested further funding from NIMH for a full-scale investigation. (You have an early report of this data in your packet)

4. Rockefeller University on the neuroscientific explanations for the effects of EMDR – conducted by Jonathan Winson, Ph.D.

5. Philadelphia V.A. on PTSD and veterans – headed by Neal Daniels, Ph.D.

I chaired a symposium at the 1991 annual conference of the International Society for Traumatic Stress Studies. Appearing were Roger Solomon, Ph.D., and Tim Kaufman, Ph.D., head of the personnel division of Union Pacific Railroad which deals with treatment for critical incidents. Kaufman stated unequivocally to the audience that as the head of a department of "a very conservative company," he is convinced that "nothing even holds the promise of what EMDR has already delivered." It was a very moving and eloquent presen- tation and included very disturbing case material (e.g., an engineer at the throttle when the train hit and killed his entire family). We have audio cassette copies of the symposium available through the office at a nominal fee. It is also very useful for those of you wishing to make professional presentations.

An interview of me solicited by the BBC representatives who attended the conference precipitated a call by what appears to be the British equivalent of NASA. The caller said they were intrigued by the interview because they had started recently investigating eye movements for the effect on "iconic images" that detracted from the performance of their pilots. We hope to have more information by the next Newsletter.

The four presentations at the 1991 annual conference of the Association for the Advancement of Behavior Therapy were "standing room only." At the symposium, Alan Goldstein, Ph.D., presented new pilot data on EMDR treatment for agoraphobia and panic disorder which was quite impressive. Likewise, Howard Lipke, Ph.D., of the North Chicago V.A. presented some new findings which, among other things, clearly indicated that EMDR can be considered a culture-free treatment for PTSD. Hopefully this will spur the National Centers of PTSD towards a more rapid inclusion of EMDR as a treatment modality. So far the response has been "spotty"; there has been much enthusiasm among those who have tried EMDR and skepticism from those who have not.

I also gave presentations at the annual conference of the International Association of Chiefs of Police, and a variety of universities, hospitals, and V.A. facilities. These will hopefully yield more research interest in the coming year.

Karen Anderson, Ph.D., presented at the Eighth International Conference on Multiple Personality/Dissociative States. She was very well received. The article you received in your packet by Cory Hammond does not seem to be taken too seriously. However, it is an indication of how misinformed some people may be. We are particularly concerned with his suggestions that EMDR be done by the spouse on an agitated MPD client. You have the response of EPIC (EMDR Professional Issues Committee) also in your packet. We have not yet received word whether or not EPIC's response will be published.

I have completed the chapter on EMDR to be included in the volume on PTSD treatments edited by Lee Hyer, Ph.D., at the Augusta, Georgia V.A. This next year I hope to complete the first of two books on EMDR, to be published by Guilford Press. As more of the research is completed and published to substantiate the efficacy of EMDR, the hope is that EMDR courses can be moved into the universities with an appropriate training text to draw upon.

Once again I would like to ask all of you with any research or writing background to consider applying yourselves to publishable material on EMDR. Journals are apparently quite receptive to brief reports, clinical cases, and preliminary research on EMDR at this time. There are three manuscripts that I know of under preparation and three submitted for publication. Howard Lipke, Ph.D., had his article on the first five cases he treated with EMDR accepted by Psychotherapy. Much more is needed, however. Please remember your skills in graduate school and do not minimize your ability to contribute. It really is the ground floor.

As for 1992, next year's California Psychology Association annual conference symposium on EMDR will be chaired by "Sam" Foster, Ph.D., with Jennifer Lendl, Ph.D., and David Wilson, Ph.D. I would like to encourage you to give presentations at your own local and regional chapters. There are still many clinicians who have never heard of EMDR.

Also already scheduled for my 1992 calendar are invited presentations at (a) the Fifth International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy (I expect that there will be a number of dialogues and symposia comparing approaches for the treatment of trauma), (b) the annual conference of the Association for Applied Psychophysiology and Biofeedback (a panel on new and traditional treatments of stress), (c) the inaugural conference of the International Association of Trauma Counselors, and (d) Gordon Bower, Ph.D. requested that I be one of four speakers at the presidential symposium plenary session of the American Psychological Society. Hopefully, this will spur needed research.

Please notify us of any presentations you are planning at major conferences. We will do everything possible to support you.

So at the close of another year, I would like to thank all of you who have given so fully to assist in the growth and expansion of EMDR. All of the participants are on data-base, and referral requests for clinicians from around the country are filled regularly. The Network has continued to grow nationwide, and while clinical reports of "miracles" are commonplace, they never fail to remind us of what it is all about. *[Continued]*

Creating Positive Cognitions

Landry Wildwind, LCSW
Albany, CA

We know that having a positive cognition in mind is crucial to effective EMDR. Sometimes the patient produces an excellent positive cognition with little help. However, more often, even when asked how she/he would rather think or feel about it, the patient is still unable to produce an appropriate positive self-statement. Instead, the desired cognition may refer to the actions of others, or contain a negative, or an unrealistic component. These factors limit the usefulness of the statement since an unrealistic cognition will not 'stick' for a variety of reasons; e.g., the person knows better, negatives are very tricky at the unconscious level, the work can never control the behavior of others, etc. When difficulty arises in producing a positive cognition, it is sometimes helpful to offer alternatives to the patient. However, many of us are uncomfortable about "putting words in people's mouths," which leaves us in the position of struggling to help the client obtain a positive cognition.

I was asked to create the following list of examples of positive cognitions for EMDR training purposes.

PRELIMINARY CONCEPT	POSITIVE COGNITION
It wasn't my fault	I did the best I could
I never want that to happen again	It's over
I don't want to keep thinking about it	I'm free to go on with my life
I did something wrong	I learned from my it/my mistake
I couldn't get her love	She had a problem giving love
It's a terrible memory	It's just a memory
I wish it never happened	I survived
I should have (run, screamed, etc.)	I did what I could
It will never happen again	I'm safe now
I couldn't protect myself	I'm strong now
He never loved me	I love myself
I couldn't help it	I can help myself now
I don't want to stay trapped	I'm free
I never told the secret	I can choose to tell
I want to trust more	I can decide when to trust
I don't need them anymore	I can rely on myself
NEGATIVE COGNITIONS	
It was my fault	I did the best I could
I didn't do everything I could have	I did the best I could with what I knew at the time
I was helpless/I'm overwhelmed	It's over
I should have done something	I am worthy
I have no control	I have control
It was shameful	It's over/I am worthy

It has been effective to show the list to patients who are struggling with a positive cognition. Many patients select one or more cognitions, since having two or more seems helpful to them; others understand the idea more completely from the examples and are able to develop their own positive statements.

[International Update continued]

I have always enjoyed contemplating the "ripple effect." That just as a stone dropped in a lake causes movement far beyond the ability of the eye to see, likewise do our actions. And now I feel that we are entering into history as a movement in psychology that can aid in healing a vast amount of suffering on the planet. It just takes people willing to work towards it, to make their hands do the work of their heart. So my gratitude goes out to all of you dedicated clinicians and researchers, SIG- leaders, Network leaders, and facilitators. And in this time of transition and "quantum leap," allow me to give my special thanks to the dedicated support team that holds it all in place: Lois Allen-Byrd, Robbie Dunton, Cliff Levin, and A.J. Popky. And for the initial framework—to Pat Ryley—who contributed more than she will ever take credit for. Thanks to all of you—while we may spill more than a drop on occasion—the intention remains clear.