INTERNATIONAL EMDRIA ASSOCIATION™

EMDRIA NEWSLETTER

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Deadline for Next Newsletter

April 15, 1997

President's Column: What is New?

Steve Lazrove, MD

In the last column of the *Newsletter*, "What is EMDRIA?" I promised to use this venue to keep you appraised of the evolution of the Association. This is risky business in a way because discussing/reviewing ideas and nascent policies exposes missteps and guffaws in addition to blinding brilliance. Ahem. The advantage, though, is that such candor allows members to see how their input affects the growth of the Association which hopefully encourages active participation. (The hidden agenda!) To this end, I have chosen three topics in which EMDRIA policy was modified in response to feedback.

The Grand Scheme

When EMDRIA was formed, the idea was that the Association would serve the needs of individual EMDR clinicians worldwide. In other words, the same set of rules, dues, etc. would apply to therapists everywhere as EMDRIA endeavored to be all things to all people. At the 1996 Conference, non-US members objected to this policy strenuously. They pointed out that it was unlikely that the needs of US members, with their relatively greater wealth and concerns about managed care, would address the needs of European clinicians, for example, and would be even less likely to reflect the needs of therapists in non-Western regions, say South America and Asia. Further, they correctly pointed out that a policy of centralized control had practical limitations. For example, the EMDRIA Board of Directors is not sufficiently familiar with local conditions and the system of health care delivery in each individual country to make informed decisions about regional issues, such as what constitutes appropriate credentials for EMDR training eligibility. It became clear that an EMDRIA policy of we-tell-you-what-you-want makes little sense. Further, this top-down structure jarred with the fact that EMDR's rapid growth has been fueled by clinician enthusiasm. EMDRIA's policies must honor EMDR as a grassroots movement worldwide and centralized control does not foster this model. I am pleased to report that EMDRIA has changed its orientation and is now moving to a chapter-type structure which will integrate and respect the national organizations that already exist, and encourage and support the development of new regional chapters outside the US.

Money

As with any other organization, EMDRIA required money to function. Startup costs were considerable, and no one knew how many members would join EMDRIA initially. The first year dues structure came out of discussions held during the 1995 pre-Conference facilitator meeting. A core group of EMDR clinicians generously agreed to contribute more than what would be customary dues to get the origination started. Charter members paid $200.00 for the privilege of being a charger member, while the rest anted up $150.00. The reality is that not everyone can afford to be this generous, nor is everyone so inclined. Discussion on the EMDR forum on the Internet this fall made it obvious that many interested clinicians were not joining because the cost of membership was too high. The goal of EMDRIA is for all active EMDR clinicians and researchers to become members of the Association.

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FROM THE EDITOR
LOIS ALLEN-BYRD, PH.D.

In this issue of the Newsletter, you will find contributions from two clinicians from the Ukraine. I am delighted that we are able to exchange information with professionals from other countries as it adds to our own knowledge base in the U.S.

Also included in this issue are some important guidelines to consider when treating adults who were, or possibly were, abused as children. Dr. Christine Courtois has graciously allowed us to publish her paper which cogently and clearly summarizes the views/consensus of experts in the field of trauma treatment regarding ethical and competent practice.

Once again the Newsletter is publishing a "Client Safety Checklist" which was designed by Dr. Virginia Lewis. This checklist appeared early in the lifetime of EMDR and I have had a number of requests to have it made available again.

You will also find a "Call for Nominations," as well as information about the 1997 EMDR conference. Please participate in the nomination process as the Board of Directors is in place to represent and serve you the members.

A few years ago I asked members of the EMDR Network to provide me with suggestions regarding what they would like to see included in the Newsletter, e.g., topics, columns, etc. I again make this request--as editor, I am always interested in hearing and incorporating new ideas. Please send your suggestions to: Lois Allen-Byrd, Ph.D., 555 Middlefield Road, Palo Alto, CA 94301.

Lazrove, continued from p.1

Accordingly, the Board has set membership dues for 1997 as follows:

General Member	$75.00
Renew Membership	$35.00
Student (nonvoting)	$50.00

This dues structure is lower than the fees charged by most professional organizations and should not exclude anyone seriously interested in joining EMDRIA. Non-US chapters will set their own fees and will contribute $20.00 per member to EMDRIA.

EMDRIA Register

Preserving the integrity of EMDR is the mission of our Association. Recently, it came to our attention that a 1-day training program in EMDR was being offered to non-licensed therapists. Active intervention by EMDRIA led to public clarification that the program was an "overview of EMDR" and not formal training. This incident stresses the need for vigilance on the part of the Association in making sure that the quality of EMDR training is not diluted and that ersatz EMDR therapists do not give EMDR a bad name by generating poor outcomes.

The issue of quality is tricky because our tax status, a 501(C) (3) nonprofit corporation, prohibits us from certifying individuals in EMDR. So, what do we do? How can EMDRIA help the pubic determine who among self-proclaimed EMDR-practitioners truly is qualified in the method?

While we are not allowed to certify individuals in EMDR, we are empowered to set standards for training programs in EMDR. Thus, the EMDR Institute, Inc., a for-profit corporation, has presented its syllabus to the EMDRIA Professional Standards Committee for evaluation and its training was approved on a vote by the Board of Directors. This means that everyone who has a received a "Certificate of Completion" from the EMDR Institute, Inc. (Level II training) is a graduate of an EMDRIA-approved training program. Several university-based training programs also have been approved by the Association, and other proposals are under evaluation. At the risk of redundancy, though, let me stress that EMDRIA does not evaluate the competency of individual graduates; that is up to the training programs.

Given that the public good will be served by maintaining a list of clinicians qualified to practice EMDR, EMDRIA intends to develop and maintain a Register of EMDR therapists who meet standards set by EMDRIA. This Register will be distinct from the Membership Directory. Final requirements for enrollment in the EMDRIA Register have yet to be determined, but likely elements will include state licensure, completion of an EMDRIA-approved training program, continuing education in EMDR, and adherence to EMDRIA standards of practice. Passing a formal proficiency examination will be required once such programs are approved by EMDRIA. The publication of such a Register is likely to be useful to individuals seeking EMDR referrals, program administrators, and healthcare providers looking for quality assurance. EMDRIA itself will not maintain a preferred provider list, nor will it make actual referrals.

Of the topics I have discussed, clearly the development of a Register is the least far along and no doubt the final form will differ from the rudiments I have presented here. Yet, consistent with my original premise, I think it is worthwhile to show the work in progress. Looking ahead to tasks yet undone is daunting, but seeing how far we have come since I raised the issue of certification in the last *Newsletter* is reassuring. To quote that old saw, "Obstacles are what you see when you take your eye off the goal."

Let me end with a plea for members of EMDRIA to encourage fellow EMDR-practitioners who are not members to join. It is terribly important that our professional association be able to speak with authority. We can do this only by having the numbers to back up our claim that we are the professional association representing EMDR therapists. ■

GUIDELINES FOR THE TREATMENT OF ADULTS ABUSED OR POSSIBLY ABUSED AS CHILDREN

(WITH ATTENTION TO ISSUES OF DELAYED/RECOVERED MEMORY)

Christine A. Courtois, Ph.D.; Washington D.C.

These guidelines provide practicing clinicians with information regarding psychotherapy with adults who: 1) disclose an abuse history (physical, sexual, emotional) at the beginning of therapy; 2) do not disclose abuse despite having knowledge and memory about such events in their past; 3) report new (delayed or recovered) memories of abuse during the course of therapy; and/or 4) suspect past abuse, but have no clear memories of having been abused. The most common clinical scenario involves an individual who has retained memory for past abuse, but recalls additional events or details during therapy. The less common scenario is for an individual to have totally absent any memory of abuse and to later develop highly detailed memory. Practitioners should expect a range of memory presentations and must work to neither suggest nor suppress abuse-related issues that arise in the course of therapy.

Treatment of abuse-related psychological effects follows the established principles of practice for generic psychotherapy; yet, specialized knowledge and skills are required to address the complex issues that often are involved. These guidelines outline general principles for post-trauma treatment of abuse along with cautions and recommendations for working with delayed/recovered memories when they emerge during the course of treatment. This document is not intended to be overly prescriptive nor does it constitute a formal standard of care; rather, it summarizes the present consensus among experts in post-abuse and post-trauma treatment regarding ethical and competent practice and takes into consideration critiques and suggestions offered by memory researchers. Furthermore, these guidelines can be modified as needed for different mental health disciplines, theoretical orientations, and cultural considerations. They are expected to evolve as additional clinical information and research data become available on a number of topics pertinent to this treatment (e.g., post-traumatic response, the psychobiology of trauma, memory for traumatic versus non-traumatic events, dissociation, etc.). For this reason, practitioners are advised to keep abreast of developing and newly published research and literature relevant to this treatment and this population.

I. GENERAL TREATMENT ISSUES

1. Practice within the established code of ethics and practice standards. First and foremost, the practitioner is advised to abide by the ethical code and standards of practice for his/her discipline. As of yet, no formal practice standards have been adopted for post-trauma treatment (in general or for post-abuse and delayed/recovered memory issues). Professional organizations are only currently devising principles, recommendations, and statements as precursors to the development of standards of practice; consequently, clinicians must exercise caution and sensitivity when working with these issues. Interim guidelines and policy statements are now available from the following professional organizations: American Medical Association, American Psychiatric Association Board of Trustees, American Psychological Association (Working Group on the Investigation of Memories of Childhood Abuse and Board of Directors), American Psychological Association Division 17 (Counseling Psychology) Section on Women, American Professional Society on the Abuse of Children (guidelines under development), American Society of Clinical Hypnosis, Australian Psychological Association, British Psychological Society Working Party on Recovered Memory, Canadian Psychiatric Association, and The International Society for the Study of Dissociation. Most can be ordered through the respective association's public affairs or publications departments.

2. Develop specialized knowledge and competence. The practitioner who works with abuse-related cases has responsibility for developing specialized knowledge in issues of abuse, trauma, memory, and post-trauma treatment, as well as developing competence in this treatment. In all likelihood, these issues were not addressed during the practitioner's formal clinical training since they have been largely absent from mental health curricula; therefore, they must be learned through supplemental focused training, continuing education, and professional reading and through ongoing participation in consultation, supervision, and peer study/support groups. An additional training issue pertains to students or novice therapists who, due to their apprentice status, may not have either the knowledge or skills to work effectively with the complexities and high-risk situations inherent in many of these cases.

Trainer/supervisors must closely monitor the trainee's ability to understand and manage the dynamics of these

cases and, wherever possible, assign cases that are commensurate with the trainee's knowledge and developmental progression as a therapist.

3. Maintain an awareness of transference, countertransference, and self-care issues. The therapist should strive to maintain an awareness of transference, countertransference, vicarious traumatization, and burn-out issues that characterize these cases. Self-monitoring, self-analysis, and supervision/consultation assist in therapeutically managing rather than inappropriately reacting to or enacting patient issues. The practitioner should, whenever possible, maintain a varied caseload, avoiding one that is overly taxing and/or one comprised only of abuse and trauma cases. Furthermore, the practitioner does well to avoid becoming isolated in work with these patients and should engage in adequate self-care, including a variety of social outlets. It is crucial that the therapist also monitor the status of his/her mental health, seeking additional support and personal therapy during times of intense stress or crisis. When a therapist has a personal history similar to the patient's, over- or underidentification may be problematic and additional consultation may be necessary to maintain a therapeutic role and perspective.

4. Provide information about treatment and establish a therapeutic contract. The practitioner should consider using some sort of "Rights and Responsibility Statement" at the initial meeting to provide the prospective patient with information about the practitioner's therapeutic orientation and practice, and the mutual rights and responsibilities of patient and therapist. Such a document is tailored to the needs and practice preferences of the individual clinician and includes discussion of numerous issues such as assessment and diagnosis; consent to treatment, goal-setting, and treatment planning; scheduling; fees and payment; insurance issues; limits of confidentiality and reporting requirements; therapist availability and absences; cancellation and therapy termination policies; adjunctive evaluations and treatment; collateral assessments; the use of contracts for specific issues; safety issues; the use of hospitalization and medication and how determined, etc. A signed Informed Consent Statement can be used in conjunction with this general orientation statement and more specific forms prepared when any specialized technique (e.g., hypnosis, EMDR) is introduced and under consideration.

Preliminary information about how the practitioner works with abuse and trauma and delayed/recovered memory issues can also be included, and can be supplemented with more specific materials as needed. For example, the American Psychiatric Association Statement on Delayed Memory, a concise but comprehensive overview of these issues, can be amended. This introductory material provides the basis of a mutual understanding of the practitioner's approach that is addressed in more depth and detail during the course of treatment, as discussed below.

5. Begin with a comprehensive assessment including questions about past abuse/trauma and use psychological testing and ancillary assessments as warranted. The practitioner begins treatment with a comprehensive psychosocial and personality assessment. Questions about experiencing or witnessing problematic family and childhood events (such as family violence of any sort, intra-or extrafamilial sexual contact, serious childhood medical conditions, significant family crises) should be included among other questions in the initial history-taking. These provide a baseline of information and further indicate to the potential patient the legitimacy and importance of these events and the practitioner's openness to discussing them. At the outset of treatment, some individuals with a positive history of abuse and trauma will spontaneously disclose, others will make a direct disclosure only upon direct inquiry, others will deliberately not disclose even with direct inquiry, and others will not know such information. Non-disclosure or a "disguised presentation" of a positive history is not uncommon and may be part of the individual's post-traumatic (avoidance/dissociative) response. For this reason, assessment should be considered an ongoing experience throughout the course of treatment to be returned to as warranted by the emergence of any new memories, issues, and symptoms. The therapist must recognize however that a significant number of individuals who seek therapy do not disclose because they have a negative abuse/trauma history and thus have nothing to disclose. In this circumstance, the therapist should make no assumptions regarding the meaning of a lack of disclosure and, in particular, should not assume that the individual is consciously or unconsciously concealing an abuse history.

Psychological testing should be considered as part of the assessment. Generic screening and assessment instruments (e.g., the MMPI, MCMI, Beck Depression Scale, SCL-90) can be used to provide general assessment and diagnostic information (including co-morbid conditions). In the case of known or strongly suspected abuse/trauma in the patient's background, trauma-specific instruments (e.g., Dissociative Experiences Scale, Impact of Events Scale, Structured Clinical Interview for Dissociation, Traumatic Antecedents Questionnaire, The Trauma Symptom Inventory) can provide information on trauma-related symptoms not covered systematically in the more generic instruments.

As part of the comprehensive assessment, records should be requested for any previous psychological (and at times, medical) treatment so that issues of assessment, diagnosis, and course of treatment can be reviewed. Additionally, the practitioner should consider the utility of second opinion, formal consultation, and ancillary assessments (e.g., psychiatric and/or medical examinations and treatment) as needed. This applies to a variety of issues, but may be especially important in cases of variable/spotty or delayed/recovered memory to rule out other explanations for memory loss (e.g., organic conditions, alcoholism, or other disorders that affect memory). It is helpful if the practitioner develops a network of professionals who are comfortable working with, and consulting on, the wide array of conditions and complications that arise in these types of cases.

6. Develop a diagnostic formulation over time and after considering a range of information. A preliminary diagnosis is made after careful consideration of the individual and his/her presenting information, symptoms, and level of functioning. Individuals who have been abused often have a variety of co-morbid conditions and thus meet criteria for a number of diagnoses, including possibly Post-traumatic Stress Disorder. Optimally, multiple diagnoses should be listed hierarchically according to their urgency and their order in the treatment process (with the understanding that treatment of one issue often--but not always--has a simultaneous effect on others and/or allows for the emergence of previously unavailable material once the original concern is successfully treated. Obviously, treatment strategies will vary according to the patient's individual diagnostic picture and general psychological condition.

When past abuse/trauma is in question, a diagnosis of PTSD is generally not made because Criterion A (i.e., witnessing, experiencing or being confronted with a traumatic event), necessary for making the diagnosis, is not definitively met; however, when the symptom picture is post-traumatic without the patient's conscious knowledge of a specific trauma history, the diagnosis might be held in abeyance or given provisionally. A post-trauma and post-abuse treatment model (see item 7 for a description) is adopted when PTSD is formally or provisionally diagnosed. For patients who suspect abuse yet do not have post-traumatic symptoms, a more generic treatment strategy is followed.

7. Follow the consensus model of sequenced treatment for trauma. The practitioner is advised to establish a treatment plan that conforms with the consensus model of post-trauma treatment that is sequenced and organized initially around patient stabilization/functioning and that addresses traumatic content as necessary. The treatment is individualized and titrated according to the patient's status, needs, and available resources; is systematic rather than laissez-faire; and organized in progressive stages and tasks. The trauma is addressed planfully rather than haphazardly after the patient has developed the skills and defenses necessary to address both traumatic content and affect.

Following pre-therapy assessment, three stages of treatment are generally outlined in this model: 1) directed towards personal safety, stabilization, and functioning, the resolution of immediate problems and crises, the improvement of current personal and interpersonal functioning, the teaching of coping and self-soothing skills, and the development of the therapeutic alliance; 2) addressed to the traumatic content and emotions, titrated to the individual's capacities; and 3) directed towards issues remaining after the trauma resolution stage. As noted in item 6, when no trauma history is known or determined from available information, a more generic model of treatment is recommended. This three-stage model with its initial emphasis on present-day issues and functioning resembles more generic treatment. Thus, its adoption provides for an adequate course of treatment for a patient with questions about a trauma history, whether or not such a history is later determined.

II. ISSUES PERTAINING TO MEMORY

8. Ascertain personal and professional assumptions and biases and work for a stance of supportive neutrality. The practitioner must monitor personal and professional assumptions and biases and avoid leading questions, specific suggestions, premature closure of exploration, and/or the ready acceptance of the individual's recollections as historical truth. The practitioner should also assess his/her ability to tolerate and support a patient's uncertainty about the past. An open and non-authoritarian perspective is especially important with individuals who are excessively dependent or suggestible or with those who have a high capacity for hypnotizability. It is advisable to adopt a neutral therapeutic stance to the possibility of abuse, to ask open rather than closed or suggestive questions, and to encourage exploration and the cross-referencing of information without drawing premature conclusions. According to Judith Herman, M.D., therapists must be technically neutral, but be morally cognizant of the prevalence and possibility of abuse. Neutral and open-ended do not mean therapist denial of abuse as a serious and common occurrence. The individual must come to a understanding of and comfort with his/her personal history. This, of necessity, may include living with uncertainty, a circumstance that may be highly distressing, requiring support and empathy (and at times, empathic confrontation) on the part of the therapist.

9. Watch assumptions about incomplete and spotty childhood memory. The practitioner should not assume that an individual who cannot remember much from childhood is repressing or denying childhood abuse. Normal memory for childhood is spotty, childhood (infantile) amnesia generally ends between the ages of 2 1/2 to 3 1/2, and older children remember more detail and with greater accuracy than younger children. The therapist should make note of an individual's report of circumscribed time periods in childhood and/or adolescence with totally absent memory (especially if observed and corroborated by others and if other signs and symptoms indicative of a possible abuse history are available, e.g., medical records, outside validation or corroboration, the client obviously dissociates). Even so, periods of complete amnesia in childhood or adulthood are not, in and of themselves, enough of a basis on which to make an exclusive determination of childhood sexual abuse in the absence or other information.

10. Do not automatically assume abuse from a set of symptoms. No one symptom or set of symptoms (either initially or long-term) is pathognomonic of childhood sexual abuse so the practitioner should not automatically and conclusively assume an abuse history due to particular symptoms, especially when no memory of abuse is available. The therapist nevertheless needs to be alert to the emergence of signs and symptoms commonly associated with a trauma history that are not immediately consciously available to the patient. In such a circumstance, the therapist needs to encourage exploration of the possibility of abuse or other trauma because denial and other dynamics may make personal acceptance difficult, if not impossible, without outside support. A return to more formalized assessment might also be considered at this point.

11. Be open to the possibility of other childhood trauma besides abuse. The practitioner should be open to the possibility that other childhood events and trauma (e.g., parental separation and divorce, family violence, significant deaths and illnesses, medical conditions requiring invasive techniques and physical immobility, accidents, and natural disasters) might account for a patient's [post-traumatic] symptoms. Sexual abuse should not be assumed or suggested as the only possibility. Most psychological disorders develop from and are influenced by a number of events (as well as other factors such as the child's resilience, family functioning, sources of outside support, etc.).

12. Keep adequately detailed records. The practitioner should keep records in sufficient detail to document communications with the patient and should further insure that they are neutral in tone and fact-based. Any erroneous expectations and misinformation held by the patient should be charted along with documentation of the provision of more accurate information. (The therapist can document giving the patient information about the delayed memory dispute, human memory processes and the issue of accuracy and memory, trauma and memory, the patient's responsibility for making a determination about his/her own experience, the maintenance of a stance of therapeutic neutrality, and various techniques and their efficacy and substantiation). Chart notes should document memories and events as "reported by" the patient rather than as historical reality and specifically document any attempts by the patient to get the therapist to "confirm" an abuse history based on recovered memories alone, especially when corroboration is missing. During sessions when the patient is struggling with issues of unclear memory or reporting recovered/delayed memories, the therapist might consider audiotaping, videotaping, and/or taking process notes.

13. Do not use hypnosis for memory retrieval per se. Hypnosis is one of the most controversial techniques in the delayed/repressed memory controversy. Research is quite conclusive at this point that memories that emerge as a result of hypnosis can be compelling, yet inaccurate, and that the veridicality of these memories should not be assumed. Hypnosis (or any similar technique) therefore should not be used to uncover, discover, or re-work delayed memories of abuse; rather, its use should be restricted to such therapeutic tasks as ego strengthening, coping, self-soothing, temporizing, and pacing, etc. Moreover, hypnosis should not be used if a patient is involved in any type of legal proceeding or has any likelihood of taking any legal action in the future (whether related to past abuse or not). The use of hypnosis may result in the inadmissibility of material in a court case. Similar to any other specialized technique, hypnosis should be used only if the therapist has been trained in its use and with the informed consent of the patient.

14. Ascertain the individual's understandings and expectations about memory, therapy, and any sources of influence and social compliance issues. Correct misinformation so that if at the outset or during the course of treatment, an individual suspects a non-remembered history of abuse and has unrealistic expectations of therapy and/or misinformation about abuse, trauma, and memory, the practitioner should inquire about these matters. In particular, possible sources of influence, social compliance, or misinformation should be determined (these might include exposure through reading and viewing biased or overzeal-

ous material, participation in abuse-focused self-help and therapy groups, and participation in previous therapy--especially if unconventional, of the sort that provided or supported erroneous information or a certain perspective regarding abuse and memory issues, and/or emphasized the use of hypnosis for memory retrieval). The practitioner must correct specific misinformation and guide the individual to a broadened understanding of the malleability and reconstructive nature of memory, the currently unanswered questions about memory for trauma, and the ways memory issues will be addressed in therapy. Concerning the latter, the practitioner educates the individual about the sequenced treatment strategy (as described above in item 7) that is holistic rather than solely focused on abuse and memory retrieval.

Although the clinician is open to the exploration of a patient's suspicions of abuse, it should be based on open-ended questioning and free narrative to lessen the possibility of suggestion. A scientific attitude involving the careful weighing of evidence over time and the avoidance of "jumping to conclusions" and premature closure is encouraged. It is crucially important that the practitioner not "fill in," "confirm," or "disconfirm" reported suspicions of a non-remembered abuse history, but rather help the patient explore the content and its possible meaning while guarding against suggestion, pro or con. Individuals with positive histories of abuse and trauma often struggle with differentiating what is real and what is not, experience strongly ambivalent emotions, and require a supportive context in which to consider various perspectives. Similarly, individuals with suspicions, but no memories, and those with incomplete and reinstated memories must have the latitude to explore without constraint. Although the clinician maintains as much neutrality as possible, at times there is a need to educate or challenge the patient on material that is clearly improbable, seems delusional, and/or in which the patient is overinvested. As noted in item 10, a return to more formalized assessment might be in order.

15. Recommend self-help books and groups when familiar with their content and perspective. The practitioner should be cautious in recommending self-help books and do so only when he/she is familiar with their content. In the case of suspected abuse with no clear memory, a generic book on the effects of a painful childhood is initially preferable to a book on signs and symptoms of sexual abuse, or a book on repressed memories that offers suggestive methods for retrieving absent memory. A related issue involves referrals to self-help or therapy groups. The patient with absent autobiographical memory for abuse is best referred to a heterogeneous group for general mental health concerns rather than a homogeneous abuse-focused one. A difficult circumstance arises when a patient with suspicions of abuse and a sketchy memory has read books, viewed media presentations, or participated in groups that have suggestive content or push a certain perspective. The clinician must re-educate the patient and correct skewed content.

16. Support a patient's search for corroboration after adequate exploration and preparation in therapy. Some patients decide they want to seek outside sources of information regarding possible childhood abuse (e.g., medical and school records, witnesses, other victims, etc). The clinician can support a search as a means of gaining potential material to be assessed and weighed in the course of therapy. It is advisable, however, that the patient first explore the ramifications of such a search with the therapist and take action only after having achieved a relative degree of life and symptom stability and after adequate preparation. The patient should consider the range of possible consequences of a search, from positive to negative, and the relative probability of each. Possible responses should also be anticipated and prepared for--finding or not finding evidence and corroborative can be very unsettling. Optimally, a support system is in place to assist the patient with the results and emotional consequences of a search.

17. Do not recommend family cut-offs on the basis of recovered memory. The practitioner should also be cautious in suggesting that patients limit or cut off contact with their families, especially when recovered memories form the basis for their abuse suspicions or beliefs; however, in cases of a positive abuse history and reports of ongoing abuse or other clear and present danger, the practitioner is responsible for helping the patient assess the cost/danger in continuing contact (and may further have a duty to report). The therapist must keep the client's safety paramount while helping him/her to recognize ongoing danger and learn assertive and self-protective strategies with unsafe or abusive others.

18. Contract for no unplanned/impulsive disclosures, confrontations, or legal initiatives. The practitioner should have a collaborative agreement with the patient that unplanned/impulsive disclosures, confrontations, or legal initiatives not be undertaken without extensive discussion in therapy. These actions are quite risky even when the patient has clear memory and some corroboration; when abuse is suspected or believed on the basis of recovered memory without corroboration, they are even more risky (for both patient and therapist). The cost benefits of these actions are best considered when the patient's symptoms and life circumstances are stabilized and, in the case of

known abuse, after the bulk of trauma resolution work has been completed. They should only be undertaken following a period of careful planning including deliberation about possible consequences, including family estrangement, threats and violence, legal initiatives, etc. Consideration should also be given to whether they should be done within or outside of the therapy. In either event, thorough preparation is recommended.

19. Do not encourage or suggest a lawsuit. It is not the practitioner's role to encourage or suggest a lawsuit. If the patient chooses to investigate this option, the therapist should encourage the gathering of comprehensive information on which to base decision-making. Litigation is enormously stressful and requires an extensive time commitment, as well as the allocation of significant personal and financial resources. The patient/ plaintiff must meet a standard of proof that is not found in a clinical setting. Also, since the advent of the memory controversy, plaintiffs seeking damages for past abuse have been challenged on the basis of false memory production, a challenge that has made the process even more difficult. Should a patient opt to initiate a lawsuit, the practitioner must keep the treatment and legal action separate and insist that the patient get a separate psychological expert; otherwise, the practitioner becomes engaged in a dual role relationship with the patient and therapy becomes derailed.

These practice guidelines are evolving, adapted in part from suggestions by Carolyn C. Battle, Ph.D., David Calof, Stephen Lindsay, Ph.D., Nancy Perry, Ph.D., Michael Yapko, Ph.D., and others and in the aftermath of the NATO Advanced Study Institute on Recollections of Trauma, France, June, 1996.

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EMDR Client Safety Checklist

Directions: Before using EMDR with a client, read the following questions and answer as honestly as possible.

CLINICIAN	NO	YES
1. Do I have sufficient training and experience to treat this particular problem?	☐	☐
2. Do I know how to work through abreactions?	☐	☐
3. Do I know how to activate reprocessing and avoid retraumatization?	☐	☐
4. Do I know the standard EMDR protocol?	☐	☐
5. Do I know how to "read" the "complex network" of physiological cues?	☐	☐
6. Do I understand the "language" of hand movements (direction, close/distant location, speed, length of sets?	☐	☐
7. Have I provided informed consent to my client, i.e., discussed potential risks/benefits?	☐	☐
8. Do I know how to effectively debrief a client at the end of a session?	☐	☐
9. Do I know what to do if session time has ended and the client has not completed resolution?	☐	☐
10. Do I know when ***not*** to use EMDR?	☐	☐
CLIENT		
1. Is the client sufficiently prepared?	☐	☐
2. Is the client non-suicidal?	☐	☐
3. Does the client have sufficient ego strength?	☐	☐
4. Are the client's treatment needs compatible with EMDR?	☐	☐
5. Can the client tell you to stop the EMDR procedure at any point if necessary?	☐	☐
6. Are the client's problems within the therapist's area of competence?	☐	☐
7. Does the client have good rapport with the therapist?	☐	☐
8. Is the client free of medical problems that could impact upon client safety (e.g., eye problems, organic impairment, seizure disorders, pregnancy, chemical toxicity, etc.)?	☐	☐
9. Does the client have a stable life environment?	☐	☐
10. Does the client have an available support system?	☐	☐

If you answered NO to any of the above questions, **DO NOT USE EMDR** until you have consulted with an experienced EMDR therapist and/or have found a sufficient answer in the EMDR literature.

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INTERNATIONAL UPDATE

Francine Shapiro, Ph.D.

I regret to inform you of some unfortunate news. One of EMDR's senior trainers, Gary Fulcher, was in a serious car mishap on December 12th. The car burst into flames and he sustained severe burns over 40% of his body. He has been in severe pain, is undergoing multiple skin grafts, and a long healing process is anticipated. Those who know Gary know him to be a wonderful, giving person who has been instrumental in establishing EMDR in Australia, Japan, and South Africa. Please send any cards to Gary Fulcher, P O 252 Mortdale, NSW 2223 Australia.

On a happier note, I recently completed a book for laypeople entitled EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma which will be published by Basic Books (Harper Collins) in February 1997. I co-authored it with Margot Forrest, who used her journalist's skills to bring the longer cases to life, making it both informative and engaging for the general public. Although the stories show EMDR application to a variety of complaints, one of my goals was to normalize pathology--to allow people to better understand themselves and those around them. The reviews by people such as Bessel van der Kolk, M.D. (Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society); Ned Hallowell, M.D. (Driven to Distraction); Herbert Fensterheim, Ph.D. (Don't Say Yes When You Want to Say No); and Philip G. Zimbardo, Ph.D. (Psychology and Life), indicate that it is both educational and enjoyable reading. I placed it within the context of theoretical and research literature to position it solidly within mainstream psychology.

I wrote it to allow the lay reader to see what EMDR therapy could do--and how it should be done well. The first two chapters give an overview of the history, research, and information processing model. The rest of the chapters show EMDR applications in detail--along with stories illustrating how life experiences negatively impact us, how lives are changed, what happens in the therapy room, and the aftermath. It should serve as a good explanation for potential clients, as well as a detailed introduction for interested clinicians. I have also been told by EMDR clinicians who have read it that it serves as a useful casebook of clinical applications since it shows diverse approaches, case formulation, choice points, etc. in detail. The final chapter deals with global EMDR interventions and future research questions. These include the possible applications to prevention programs. For instance, three pedophiles, given EMDR treatment by Reverend David Price of Alberta, Canada, were slated to be released into the community. Although they had previously habitually reoffended within three-to-six weeks of release, extensive follow-up over the past nine months finds them no longer being triggered into offending behaviors. In fact, one of them is working with the police to coordinate prevention and detection programs for parents and children. Results such as these beg for extensive research investigation.

The book will be available in local bookstores the beginning of March. If you, along with your present and past clients, begin requesting/ordering it at the bookstores, it can mobilize the situation by increasing the advance sales and make the bookstores and publisher more prone to give it sufficient visibility. Thanks to its title, this, in turn, will guarantee that more new people find out about the availability of EMDR therapy. I know many clients have asked for ways to explain EMDR to encourage loved ones and colleagues to come into therapy. This book was written to fill that need.

Most of you have heard of Philip Zimbardo, Ph.D. In a addition to his many accomplishments, his mock prison study has been required reading in psychology programs--and hence part of the psychologists' common lore. Dr. Zimbardo's introductory psychology textbook, Psychology and Life, is now in its fourteenth edition. He has included EMDR as a new treatment for PTSD--thereby solidly entering it into mainstream psychology. The hope has always been that EMDR would be taught as part of a university curriculum. With the advent of EMDRIA, and the standards of training set for university courses, we can hope to see EMDR normalized as part of standard psychology programs. Those of you who are qualified and have university affiliations are encouraged to contact the EMDRIA committee for the standards and assistance in incorporating courses.

The EMDR Humanitarian Assistance Programs (HAP) recently completed a very exciting pro bono training in Northern Ireland. Spearheaded by Programs Chair, David Grand, we trained both Catholic and Protestant clinicians, as well as 10 clinicians from Dunblane, Scotland--the site of the schoolchildren shooting. Although there was a great deal of media attention and political posturing after the tragedy in Scotland, it appears that little in the way of real help was supplied. EMDR is now being used by the local clinicians and a recent letter to me speaks of the excellent results. I want to thank all of those of you who have supported the trainings financially with your donations to HAP. The training team, consisted of Steven Silver, David Grand, Elaine Alvarez, and Barbara Korzun. Additional trainings are planned for 1997.

EMDRIA made its presence known at the managed care conference in San Francisco this year. The study by Marcus, Marquis, and Sakai, which was funded by Kaiser, showed EMDR to be clinically superior to Kaiser Care and

in only half of the sessions. The cost savings are enormous ($2.8 million per year) and many managed care companies have become interested. If you have connections with managed care companies, please contact Mark Dworkin, CSW, the chair of the EMDRIA Health Care committee so that the proper materials can be sent out.

The proficiency examinations are now being finalized at the request of a number of managed care companies. While the companies want to include EMDR as a standard treatment, they want to make sure that clinicians have been adequately screened. Therefore, a proficiency exam will be inaugurated shortly after the first of the year. The written exam will consist of multiple choice questions based on the textbook and training, as well as open-ended questions based on clinical vignettes. The goal is to qualify people for a preferred providers list offered to managed care companies and to be used as referrals by the EMDR Institute. The proficiency exam will also be one of the optional credentials listed in the EMDRIA Registry.

As I mentioned in one of last year's Newsletter articles, a number of negative experiences have led me to rethink the past policy of referring to clinicians only on the basis of workshop attendance. The goal of the preferred providers list is to have a group of clinicians to whom any of us would feel confident in referring. It means that managed care companies can be better assured that cases will not blow up in their faces because the person slept through the training. It also means that we will have a network of trained clinicians with whom we can be confidently connected. This is particularly important for the coming year since the laypeople's book offers a referral source. I want to make sure that we are ready with screened clinicians because I am expecting a large influx of clients wanting referrals. As I said previously, I do not want them going down a "dark hole."

We are very sensitive to the present state of clinical work and the financial straits that many of you are under. We will keep the costs for the proficiency exam as low as possible. The cost will cover the venue for test-taking, administrative expenses (e.g., mailings, etc.), and the facilitator time for test administration and grading. Obviously, those of you who do not want to become qualified for the referral list do not need to take the exam. I hope, however, that most of you will choose to do so in order to set a standard of EMDR administration of which we can all be proud. There are a number of trainings and videos now available on assorted "eye-movement techniques." There is a high likelihood that people can get hurt and it is imperative to make sure that the public is adequately protected. Most recently, a member of a state board of medical examiners approached one of the EMDR Institute trainers saying they were considering making it illegal for any but licensed mental health professionals to use EMDR. They had fielded a number of ethical complaints and found that they stemmed primarily from those clinicians who had not been trained. If we set appropriate standards, the rest of the field may follow.

The following articles and presentations are new additions to the EMDR literature. As noted in a "Science News Update" by the American Association for the Advancement of Science, EMDR "comes of age...Recent independent studies have found it up to 90% successful."

Allen, J. G. & Lewis, L. (1996). A conceptual framework for treating traumatic memories and its application to EMDR. Bulletin of the Menninger Clinic, 60, 238-263.

Boudewyns, P.A. & Hyer, L.A. (in press). Eye movement desensitization and reprocessing (EMDR) as treatment for post-traumatic stress disorder (PTSD). Clinical Psychology and Psychiatry.

Carlson, J.G., Chemtob, C.M., Rusnak, K., & Hedlund, N.L. (1996). Eye movement desensitization and reprocessing treatment for combat PTSD. Psychotherapy, 33, 104-113.

Carlson, J.G., Chemtob, C.M., Rusnak, K., Hedlund, N.L., & Muraoka, M.Y. (in press). Eye movement desensitization and reprocessing for combat-related posttraumatic stress disorder. Journal of Traumatic Stress.

Chemtob, C.M. (1996, Nov). Eye movement desensitization and reprocessing (EMDR) treatment for children with treatment resistant disaster related distress. Paper presented at the International Society for Traumatic Stress Studies. San Francisco, CA.

Datta, P.C. & Wallace, J. (1996, November). Enhancement of victim empathy along with reduction of anxiety and increase of positive cognition of sex offenders after treatment with EMDR. Paper presented at the EMDR Special Interest Group at the Annual Convention of the Association for the Advancement of Behavior Therapy, New York.

Fensterheim, H. (in press). Eye movement desensitization and reprocessing with complex personality pathology: An integrative therapy. Journal of Psychotherapy Integration.

Foster, S. & Lendl, J. (in press). Four case studies of a new tool for executive coaching and restoring employee performance after setbacks. Consulting Psychology Journal.

Foster, S. & Lendl, J. (1996, August). Eye movement desensitization and reprocessing: Applications to competition preparation for athletes. Paper presented to the 104th Annual Convention of the American Psychological Association, Toronto, Canada.

Grainger, R.D., Levin, C., Allen-Byrd, L. , Doctor, R.M., & Lee, H. (in press). An empirical evaluation of eye movement desensitization and reprocessing (EMDR) with survivors of a natural catastrophe. Journal of Traumatic Stress.

Henry, S.L. (in press). Pathological gambling: Etiological considerations and treatment efficacy of eye movement desensitization/reprocessing. Journal of Gambling Studies.

Hyer, L. (1995). Use of EMDR in a "dementing" PTSD survivor. Clinical Gerontologist, 16, 70-73.

Lazrove, S., Kite, L., Triffleman, E., McGlashan, T., & Rounsaville, B. (1995, Nov.). The use of EMDR as treatment for chronic PTSD-encouraging results of an open trial. Paper presented a the 11th annual meeting of the International Society for Traumatic Stress Studies, Boston, MA.

Marcus, S. , Marquis, P., & Sakai, C. (1996, August). Eye movement desensitization and reprocessing: A clinical outcome study for post-traumatic stress disorder. Paper presented at the American Psychological Association annual convention, Toronto, Canada.

Pitman, R.K., Orr, S.P., Altman, B., Longpre, R.E., Poire, R.E, & Macklin, M.L. (in press). Emotional processing during eye-movement desensitization and reprocessing therapy of Vietnam veterans with chronic post-traumatic stress disorder. Contemporary Psychiatry.

Puffer, M.K., Greenwald, R., & Elrod, D.E. (1996). A controlled study of eye movement desensitization and reprocessing (EMDR) with traumatized children and adolescents. Presented at the International Society for Traumatic Stress Studies. San Francisco, CA.

Rothbaum, B.O. (in press). A controlled study of eye movement desensitization and reprocessing for posttraumatic stress disordered sexual assault victims. Bulletin of the Menninger Clinic.

Rothbaum, B.O. (1995, Nov.). A controlled study of EMDR for PTSD. Paper presented at the 29th Annual Convention of the Association for the Advancement of Behavior Therapy, Washington, DC.

Scheck, M.M., Schaeffer, J.A., & Gillette, C.S. (in press). Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. Journal of Traumatic Stress.

Shapiro, F. (1996). Eye movement desensitization and reprocessing (EMDR): Evaluation of controlled PTSD research. Journal of Behavior Therapy and Experimental Psychiatry, 27, 209-218.

Shapiro, F. (1996). Errors of context and review of eye movement desensitization and reprocessing research. Journal of Behavior Therapy and Experimental Psychiatry, 27, 313-317.

Shapiro, F. (1996). EMDR: Adaptive information processing. Independent Practice, 16, 142-146

Wilson, D., Silver, S.M, Covi, W., & Foster, S. (1996). Eye movement desensitization and reprocessing: Effectiveness and autonomic correlates. Journal of Behavior Therapy and Experimental Psychiatry, 27 , 219-229.

Wilson, S.A., Becker, L.A., & Tinker, R.H. (in press). 15-month follow-up of eye movement desensitization and reprocessing (EMDR) treatment for psychological trauma. Journal of Consulting and Clinical Psychology.

THANK YOU FROM THE FORJAR FOUNDATION IN BOGATA, COLUMBIA

Karen Correa, Director
Linda Vanderlaan, Ph.D.

We at Forjar, especially our children with cancer, are overwhelmed by the tremendous outpouring of support we have received from the representatives and therapists of the EMDR Institute, EMDRIA, and EMDR-HAP (Humanitarian Assistance Program). Beginning with the Level I training given by Francine, John Hartung, Pablo Solvay, and Graciela Rodriguez in April 1996. Following the Denver EMDRIA Conference, we received a monetary donation from the Board of Directors of both EMDRIA and HAP. This money was used in August to provide 10 of the Level I trained therapists with a week of supervision, consultation, and the specialty training of protocols that could be used with our children who have life-threatening illnesses. More importantly, the donation allowed us to bring a boy dying from cancer and living only on beef broth to Forjar where he will live and receive medical and EMDR treatment indefinitely. Since August, we have set up a Godparent program where an EMDR therapist provides once per week treatment to a Forjar child. Francine has graciously agreed to come back to Forjar in February 1997 when we will be offering our second Level I and First Level II trainings.

Our deepest appreciation goes to all of you who have offered you ideas, time, and support to Forjar's efforts in Columbia. Thank you to the Boards of Directors of EMDRIA and HAP for your generous donations. A special thank you to goes to Francine who has given her love to our children. A special thank you also goes to Dr. Curt Rouanzoin who played a major role in bringing EMDR and Forjar together.

Love Trauma Psychotherapy Using EMDR: Analysis of Three Cases

Professor Alexander F. Bondarenko; Kiev, Ukraine

Most psychologists and psychotherapists practicing in the former Soviet Union (FSU) can be divided into two groups: the problem-oriented ones (who prefer to work in one of the counseling or psychotherapy fields, e.g., family psychotherapy, PTSD psychotherapy, etc.) and those who are technically oriented, i.e., prefer to work strictly with a definite psychotherapeutic paradigm (behavioral, existential, etc.).

As for me, I belong to the first group. The area of my professional interests is psychotherapy of emotional trauma as a whole, and specifically "love trauma psychotherapy" as its particular aspect (victims of neurotic love, adultery, sudden rupture of love affair, etc.). As for psychotechniques or psychotherapeutic paradigms, I prefer (as do many of my colleagues in the FSU) in each specific case to proceed from that psychotherapeutic approach (or combination of those) which, from my professional point of view, might become the most efficient for my client. The specific using of these or other psychotherapeutic techniques depends on a number of factors: the client's personal typology, the depth of trauma, and the kind of psychotherapeutic task (situational psychotherapy, deep personal therapy, family therapy, etc.). This approach might be named "eclectic" or, more exactly, "synclectic." After taking the Level I and Level II EMDR trainings in Amsterdam, I tried this method in my work with clients who came to me for counseling and therapy on love matters.

Case I

Miss E., a 21-year-old student, was referred to me by a neuropathologist. In February 1995 the fast train "Moscow-Kiev" met with a railway accident. My client's fiance was in the last carriage which suffered the most damage--it was thrown off the train, overturned, and fell down an embankment. The young man and some other passengers perished. After the funeral, Miss E. suffered from intense psychological distress. She had tried medication therapy with no success and in May 1995, her mother brought her to see me based on the referral from the neuropathologist. Preliminary computer diagnostics (short version of MMPI) and projective tests (Lusher, House, Tree, Man) detected high levels of anxiety, frustration, and feelings of estrangement from others, as well as intense feelings of lack of safety and other parameters directly indicating the high traumatic level of the event for my client.

The sudden and untimely death of the beloved man with whom all of her life plans were connected made her grief reaction very hard and resulted in the hypertrophic feeling of self-blame and infantile (defensive) striving to avoid accepting the loss. Another difficulty of the case was the client's active unwillingness to participate in psychotherapy. She said, "It would be dishonest from my side to avoid the grieving for the dear man." It was because of this belief that my initial professional position was to offer my assistance in an acceptable form--as a help in her grieving, not against it.

After some preliminary meetings wherein I was performing diagnostics and establishing psychotherapeutic contact, I offered to start teaching her relaxation techniques. For this purpose, I involved some traditional methods for autogenic training and guided imagery. Since Miss E. was able to achieve a state of relaxation in my presence, I suggested that she try EMDR (as assigned in the full protocol "International Version"). We started with the most distressful moment which was the telephone message about the tragedy. Her SUDs was 10 and the tears flowed as she followed the instructions. The most disturbing episodes besides the aforementioned one were: the sight of the coffin standing on the table of her fiance's apartment, being at the cemetery, and an after-burial feeling of emptiness and senselessness of life.

The first EMDR session was accompanied by stormy abreactions and lasted for about two hours after which the client reported some calming. Before the second session she said that in her dream, she had seen her lost fiance as if from a distance. He was going away, but his attitude to her was full of friendship and understanding. After five sessions, she reported acceptance of the loss and was reconciling to the situation. Further supporting psychotherapy over the two following months provided the adequate model of grieving and emotional separating from the trauma.

Case II

A 24-year-old-wife of a businessman asked for counseling in July 1996. The reason for her trauma was her husband's sudden adultery. The peculiarity of the situation was that he was unfaithful not with another woman but, so to speak, with another country. Being in the USA with the purpose of studying for one year in one of the universities, he faxed her a message saying that he was not coming back; he decided to stay in the USA. It happened unexpectedly--within two months of his departure and without any preliminary warning. He and my client had been married for 8 months and the blow was completely unexpected for her. All of his previous letters and fax messages were full of tender and love words.

During our first meeting, my client could hardly speak and cried a lot. As soon as I was able to establish the psy-

chotherapeutic contact and start the dialogue, I offered to initiate trauma reprocessing from the moment when that ill-fated fax was received. Her SUDs was 10 and after a few sets of eye movements, her abreaction took the form of heavy sobbing. The session ended with the first really noticeable relaxation. The next three sessions were devoted to reprocessing some episodes of her private life with her husband. During treatment, she reported the intensification of her dreams. She also had been keeping a log of her feelings. After the fourth session, she felt the "ground under my feet" for the first time. Further deep personal therapy allowed my client to move away emotionally from her husband's betrayal and to prepare herself psychologically for a divorce. Once more she was taken through the EMDR procedure shortly before the divorce. The main efforts were aimed at the desensitization of the upcoming event.

Case III

Mrs. M., 36-years-old, came to therapy for the following reasons: her husband, the participant of the Chernobyl nuclear accident consequences mitigation, suffered from absolute impotence. Considering her sense of duty and devotion to her husband and family (they had two children), she did not want a divorce and more than that, she kept faith with her husband. However, in 1996 in Hungary with her younger child on summer holidays, she "quite unexpectedly," for herself, entered into a three week sexual relationship with a young man. It stopped because of her returning home. Having returned to Kiev, Mrs. M. (once again "unexpectedly") realized that she was not able psychologically to continue her former life in the family. The situation became more dramatic because her husband's alcoholism, resulting from his impotence, had aggravated.

From a situation such as this, the client entered into depression, characterized by strong intra-punitive self-blame and hallucinations, and synthesis; it seemed that her young lover made love to her which worsened her intra-punitive reactions. After one such moment when she clearly became aware of his presence close to her, she felt a heat over her body and then had an intensive orgasm.

Having consulted with both a psychiatrist and a neuropathologist, who confirmed the diagnosis of Reactive Psychosis, our psychotherapy was initiated.

We began with relaxation training during which the necessary psychotherpeutic rapport was established. (She was also taking Amitriptyline HLC in combination with small doses of tranquilizers). We then began EMDR and started with the most traumatic event--hallucinative emotion of sexual relations ending with orgasm.

It should be noted that the intensity of my client's abreactions was the longest--lasting for more than two hours--and strongest I have ever seen in my professional life. She had shivers, then a strong inclination to urinate and intensive evacuation, and vomiting. However, after the first EMDR session, she reported that she had slept long and tight.

During the following EMDR session we reprocessed in sequence the most significant traumatic episodes of her family and private life of recent months and years. The last, and eighth, session of EMDR was devoted to installation of the positive-neutral attitude to her husband. After completion of these EMDR sessions, which took about three weeks, we agreed upon several more sessions of supporting therapy. At the end of treatment, the emotional balance of the client was completely rehabilitated and she had found the power to make her husband undertake treatment for alcoholism.

Discussion

I suppose that in the above mentioned cases, the role of EMDR was primarily one of catalyzing the emotional working out of traumatic feelings. In comparison with other psychotherapeutic techniques which could perform a similar function (e.g., NLP, holotropic breathwork, etc.), EMDR seemed to be more acceptable and advantageous because:

1. It is rather ecological and contains minimum difficult or unpleasant manipulations for a client.

2. It addresses directly the subconscious "self" of a client, particularly the emotional working out while dreaming (about which the client is informed beforehand using the suggesting effect).

3. It has a noticeable influence on a client and therefore increases his or her trust in the efficacy of psychotherapy.

4. It is extremely evident because of the preliminary involvement of the client into some scientific myth (while the introducing instruction is communicated) and it solves the problem of probable client dependence on the therapist making it possible to establish a relationship of real therapeutic partnership.

I realize that psychophysiological mechanisms of EMDR are beyond the limits of this discussion and perhaps in the course of time, I will have a chance to share my ideas and results of special research dedicated to this problem. In the meanwhile, I would like to express my deep gratitude to Dr. Francine Shapiro and her devoted colleagues, whose energy and enthusiasm contributed so much to dissemination of EMDR in the FSU. Dr. Roger Solomon and Robbie Dunton are at the top of this list.

I can be contacted at the following: Prof. Al Bondarenko; P O Box 434; Kiev-150, 252150, Ukraine; Telephone/Fax: 380-44-227-2301. ■

EMDR: Functions Providing the Dynamics of Transformation

Igor G. Timoshchuk;
Simferopol, Crimea, Ukraine

In psychotherapy, the solving of a client's problem is usually connected with the transformation of his or her personal features or some aspects of his or her experience. These could be changes in his or her systems of values, personal meanings and rules, habitual behavioral patterns, etc. These changes derive from the complex of deep transformations involving the whole system of psychics. The system analysis of the multilevel hierarchical structure formed by connections between the conscious and unconscious, allows us to detect both the changing mechanisms and main functions providing the transformation, e.g., to solve a problem.

Different psychotherapeutic approaches and theories give different interpretations as to the nature and character of changes happening at sessions. The main criteria of changes should be chosen to avoid contradictory explanations or obscurities. These criteria would become the points to describe the trajectory of the transformation process. One of these criteria is the client's ability to perceive the environment and him or herself in a new way. Though we can judge these changes mainly by the client's words, there exist also a number of indirect signs. e.g., nonverbal reactions, emotional manifestations, etc.

For instance, when using NLP, a therapist clears up unconscious contents related to one or another concept of experience. Working with transactional analysis, the therapist adds moments of cognition to the client's communicative position and ego state. In Gestalt therapy, the cognition of self "here and now" provides both the integration of non-amplified psychic contents and structurization of conscious behavior, as well as supplements the latter with the direction, aim, and sense of unnecessary unconscious material being eliminated. Any technique of the above mentioned approaches includes mechanisms to promote the conscious contents level increasing, by which problems might be resolved.

Mechanisms of psychotherapeutic assistance using EMDR offered in 1987 by the American psychologist, Dr. Francine Shapiro, are discussed hereafter. In the former Soviet Union, EMDR training is conducted in the Counseling Center of Professor Al Bondarenko at Kiev Linguistic University.

The first stage of work in EMDR is a cognitive choice of the most traumatic emotion in order to fix attention on the most distressful mnemonic image which may be visual, kinesthetic, audible, or a complex impression. A therapist initiates his or her client to focus on the emotional trauma visual image which starts to symbolize the trauma itself. The client can see a picture that not only corresponds to the recent distressful impact, but also embodies all of its conscious and unconscious aspects. Analyzing the specific "pictures" sequence of their apparition and changing, the therapist is able to follow the integral transformation system of unconscious material. These processes are likely going on between the conscious and unconscious, and the therapist is able to interfere. The results of this interference could be described in the form of functions relevant to the integral EMDR method. The first function (the explicating one) detects, fixes, and introduces into the client's consciousness the material which was not cognitive before, but became so as a result of using EMDR (observation of visual images alternation). This function stimulates a number of images to "break through" the locked consciousness which has been fixed on a traumatic event.

The function of desensitization or reprocessing deals with negative post-images. The working out and wiping off of the negative images and intense and proprioceptive sensations rehabilitates the normal work of the client's psychics. The client's consciousness was overloaded with negative impressions and feelings and thus, he or she has been using all of his or her power not on perception and processing of the new information which enters permanently through his or her sense organs, but on the erection of a psychological defensive wall against all of the new information (because it might become as distressful for him or her as the initial traumatic emotion). The saccadic eye movements in EMDR initiate "the burnout" of energy supplied by the defensive mechanisms and projections so that it cannot further cause frustration, rigid, or compulsive behavior, etc.

Case I

Natasha, a student of 22, complained that feelings of anxiety and loneliness appeared after a quarrel with her beloved man. The anxiety was very strong, turning into real despair, and she could hardly express her state with words. The day before the consultation, Natasha felt a headache and powerlessness. During our conversation, it turned out that the entire previous week she suffered from "squeezing in the chest and in the head." In the course of

the first three sets of eye movements (SEM), the feeling of squeezing shifted to her shoulders and back. She was asked about other feelings besides squeezing and she remembered an episode of the recent conflict. While quarreling, her friend abruptly pushed her away just at the moment when she wanted reconciliation. Immediately afer, she felt a pain in the chest and in the spine. Further, she remembered being ill and staying in bed for six months in her childhood. It was at that time that her father left the family. The client called to mind the episode of her father leaving: he turned his back upon her without looking at her or saying good-bye. Then Natasha reflected the feelings she experienced--abandonment; helplessness; diffidence accompanied by pain and spasms in the chest, head, and back .

After the second SEM, Natasha was able to identify the pain experienced in her childhood with the feeling of heaviness and pressure in her spine she had after the quarrel with her friend. The third SEM gave the first positive result--the pain shifted to the arms. At that moment, she remembered the last episode of their conflict, she wanted to strike the man but restrained her temper and burst into tears. Further, Natasha reflected all of her feelings very quickly and was able to connect her impressions, which were aroused by the quarrel with her friend, with the feeling of offense at her father in childhood, as well as to comprehend the essence of her attitude towards the young men with whom she was close in her life.

About 15 SEM were made during the hour. The sensation of spasms, pain, and heaviness shifted alternately out of her head to her neck, then to the shoulders, spine, and legs. The last stage was working out the feeling of diffidence and helplessness which were associated for Natasha with the impossibility to walk (move, stand on her feet). Her main problem, as it appeared, was her fear to be alone which had worsened after the quarrel. Working on resolving this fear became the last point of therapy. It was suggested to Natasha that she imagine herself skating because while skating, a person must be in control of his or her body, be mobile, and free. She started with dancing with a partner, then imagined herself performing a beautiful solo dance. Her mental success and positive emotions were consolidated by two SEM.

Case II

This case concerned a woman of 28 who was afraid of spiders, cockroaches, and other unpleasant small creatures. An appearance of any of these excited the panic terror and sensation of tightness, constraint, and squeezing. After the first three SEM, her unconscious "delivered" an episode of her childhood when an enormous spider climbed on her arm and she could not get rid of it because she immediately was in shock.

The first 20 minutes of work gave no positive result. The visual image of spiders moved about, increased in proportions, then decreased, but the sensation of "something vile, sticky, dreadful" did not vanish. After 25 to 30 minutes, the first results appeared. The client remembered another episode from childhood--being on an excursion and seeing a frog at which time one of her schoolmates called her a toad. She felt deep mortification and anger mixed with fear and disgust. At that moment, she was not able to express her emotions. She forgot the episode, but each time she saw spiders, toads, lizards, caterpillars, etc., she felt as though she had entered that situation of her childhood again. The emotional background got complicated by the fact that she was not satisfied with her appearance and figure and felt herself ponderous, stocky, and clumsy.

Answering my questions about her emotions at the moment, she responded with connotative semantics in the area of discomfort: "not comfortable, nasty, unpleasant"--which were a result of my client's unconscious identification with the emotions experienced in childhood. During the next 20 minutes, the EMDR work was going on and resulted in some clearing up of the negative post-image. The visual "picture" first increased then decreased, but did not vanish. I used horizontal and vertical movements, then there was a moment when I needed to use circular movements. In the end, the negative post-image decreased vanished.

The work in the kinesthetic modality was simultaneous with the visual image changing. Negative sensations of my client caused by the image of her body disappeared. There was a moment when her feelings became so intense that she identified herself with the vile spider, then the peak of kinesthetic sensations passed.

As is clear, the EMDR method is very effective not only in establishing the connections between the conscious and unconscious of a client, but it also initiates the more intensive exchange of information between these two parts of psychics. The EMDR method provides the stable therapeutic effect in quite different cases including those where the neurotic problem is extremely complicated and manifests systematically in a person's behavior and activities. It might be supposed that functions providing the dynamics of transformation in the EMDR procedure are connected with semiotic transformations of information in different modalities of human perception. ■

EYE MOVEMENT DESENSITIZATION AND REPROCESSING INTERNATIONAL ASSOCIATION

Serving as President of EMDRIA this past year has been interesting indeed. The task of developing a professional association of EMDR practitioners has been very exciting and deeply satisfying. The horrors of dealing with administration woes, the IRS, and lawyers have taught me personal lessons in patience and persistence. Yet, overall, I have to say that I am pleased with what we have accomplished and believe that EMDRIA is well on its way to becoming a powerful force within our profession.

In addition to the advantages of joining EMDRIA outlined in the Membership Application, you may also be interested in hearing about some of EMDRIA's other activities. For example, Dr. Bessel van der Kolk is using brain imaging (SPECT scans) to investigate changes in brain function as a result of EMDR. If Dr. van der Kolk can demonstrate objective changes in brain function as a result of EMDR, then acceptance will be raised to another level. However, traditional funding sources are in no hurry to sponsor research into EMDR, and this research is being done only because EMDRIA supports it. In a completely different vein, the EMDRIA Health Care Committee is working exhaustively with managed care companies to help us obtain recognition and remuneration for EMDR sessions. One major health care provider already recommended EMDR as first-line treatment for PTSD, and we are working to develop guidelines for its implementation. We also are in contact with other HMOs who are interested in including EMDR as a compensable service.

That being said, I am please to inform you that the EMDRIA Board of Directors has reduced the fee for membership renewal to $35.00 for 1997. This one time reduction in dues acknowledges your generous, and essential, financial support during EMDRIA's start-up. It also recognizes the difficulty we have had providing all the services we promised as quickly as we had hoped. In essence, we are saying both "Thank you, " and, and "Won't you please continue your support for the coming year as we finish putting our house in order?"

A strong professional association is the best protection for the integrity of EMDR. I very much hope that you renew you membership in EMDRIA for 1997.

Best regards,

Steven Lazrove, MD
President, EMDRIA

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STRAY THOUGHTS

Francine Shapiro, Ph.D.

There is an obvious need for dispassionate reviews of all methods in psychotherapy. Unfortunately, misinformation often has colored the atmosphere surrounding the appraisal of EMDR. I will use part of this column to try and give a summation of a number of the errors, and the actual historical facts. In doing so, let me again emphasize that there is a vital need for the appropriate evaluation of all methods. While EMDR's protocols for PTSD have been substantiated by over a dozen controlled studies, there is a vital need for more research to evaluate the EMDR protocols applied to the other pathologies. In addition, while there is abundant anecdotal evidence of the success of EMDR as it is currently being used in the Balkans and in the original intervention in Oklahoma City, a more rigorous evaluation is in order. We hope to be able to make research of the treatment effects, and their applicability to crises and disaster situations, one of the functions of ongoing EMDR Humanitarian Assistance Programs. Only through additional evaluation can we best learn how to use our time and resources.

STUDIES OF CHILDREN

EMDRIA currently has a scientific committee, and I urge all responsible researchers to take part in its evolution and growth. I was also very pleased to hear Ricky Greenwald mention at the conference that he is helping to coordinate a panel of individuals who are willing to provide services specifically available for people interested in doing EMDR research with children. It is a scandal that there are currently no published controlled studies on treatment outcomes with children suffering PTSD--with any psychotherapy method. It is an important area that needs attention. We congratulate Marion Puffer for her dissertation--a pilot study of EMDR with young children. In addition, congratulations go to Margaret Scheck, Judith Schaeffer, and Craig Gillette for their comparison of EMDR to active listening with adolescent girls evidencing high-risk behavior and to Claude Chemtob for his study of treatment resistant children still suffering from the effects of Hurricane Iniki. These three studies will make an admirable contribution to the PTSD literature. However, clearly there is much more work that needs to be done. The negative aftereffects of unhealed trauma include self- and societally-destructive behaviors. The results of these studies will help serve to guide us in the formulation of prevention programs for traumatized youths.

EVALUATIVE ERRORS OF CONTEXT

In regards to contemporary evaluation of EMDR, one error that appears prevalent in some "Letters to the Editor" is the belief that EMDR was offered prematurely as a replacement for other, well-proven methods of treatment. However, at the time EMDR was introduced in a peer-reviewed controlled study (Shapiro, 1989a) as a method for treating posttraumatic stress disorder (PTSD), only one other controlled clinical outcome study of this disorder had been published (Peniston, 1986). The Peniston (1986) study compared 45 sessions of relaxation and biofeedback-assisted desensitization to a non-treatment control, and reported significant differences in muscle tension and in unstandardized measures of nightmares and anxiety.

In 1989, along with the Shapiro study, three other controlled PTSD studies were published (Brom, Kleber, & Defares, 1989; Cooper & Clum, 1989; Keane, Fairbank, Caddell, & Zimering, 1989). The Brom, Kleber, and Defares study (1989) compared the results of psychodynamic therapy, hypnotherapy, and desensitization based on the mean of 16 sessions. There were equivalent, (small to moderately significant) clinical treatment effects with all three approaches on various measures in approximately 60% of the subjects. The Cooper and Clum (1989) study compared flooding to standard VA care and reported small clinical effects in 6 to14 sessions, with a 50% drop-out rate. The Keane, Fairbank, Caddell, and Zimering (1989) study compared flooding to a wait-list control and reported small clinical effects after 14 to16 sessions. In contrast, the EMDR study (Shapiro, 1989a) reported very substantial treatment effects after only one session.

The dissemination of the results of the controlled study on EMDR into the behavioral literature (Shapiro, 1989b) was done with the intention of inviting researchers to evaluate its purported benefits. This was deemed particularly important since the observed EMDR treatment effects with the 22 subjects studied by Shapiro (1989a) were in such dramatic contrast to those obtained for the eight desensitization subjects in the Peniston (1986) study, and for the 18 flooding subjects examined in the combined Cooper and Clum (1989) and Keane, Fairbank, Caddell, and Zimering (1989) studies. Although the reductions of PTSD symptomatology in Shapiro's subjects had been verified in all but four cases (where no significant observer was available) by the primary therapist or a family member, this study was marred by the lack of standardized psychometrics and the fact that the researcher and therapist were the same.

Despite the constraints of the Shapiro (1989a) study, the data appeared promising to a number of practicing thera-

pists. Since no other therapy for PTSD appeared as effective, and none had been experimentally verified as an adequate treatment, it was decided that EMDR would be taught to interested clinicians as an "experimental method" (requiring that informed consent be obtained from clients) until such time as independent confirmatory studies had been conducted. After the completion of five training workshops in the method (two for researchers, one for the International Society of Traumatic Stress Studies, and two for private practitioners), it was learned that laypeople, tutored by past EMDR workshop participants, had begun to employ various versions of the procedure and some of their clients reported harmful effects. Therefore, until recently, training restrictions were enforced to protect the experimental status of this method (see Shapiro, 1995b). While the subject of much debate, the existence of these restrictions has serendipitously provided a unique opportunity to evaluate the level of training evinced by researchers of the method. It should also be noted, that contrary to an apparently widely held misconception, a recent independent review indicated that no method for the treatment of PTSD has yet been accorded the status of well-established efficacy (see Chambless, et al., 1996; Shapiro, in press).

EMDR RESEARCH EVALUATION

The extensive research literature on the efficacy of EMDR indicates that contrary to earlier concerns (Acierno, Hersen, Van Hasselt, Tremont, & Meuser, 1994), the previous restrictions on EMDR training did not inhibit independent evaluation of this method. More than 140 subjects have been examined in both single- and multiple-case studies and in the overwhelming majority of these cases, positive treatment effects were obtained (see Shapiro, 1995a). In approximately one-third of the successful cases, treatment effects were assessed by standardized outcome measures, while for the remaining two-thirds, subjective reports and behavioral measures were used. In addition, eleven additional controlled studies of EMDR have been completed and reviewed (see Shapiro, 1996a). Two of these have reported mixed results (Boudewyns, Stwertka, Hyer, Albrecht, & Speer, 1993; Pitman, Orr, Altman, Longpre, Poire, & Lasko, 1993, 1995) and one found negative results (Jensen, 1994). Four of these studies demonstrated the superiority of EMDR over one or more alternative treatments (Boudewyns, Hyer, Peralme, Touze, & Kiel., 1995; Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1995; Levin, Grainger, Allen-Byrd, & Fulcher, 1994; Vaughan, Armstrong, Gold, O'Connor, Jenneke, & Tarrier, 1994), and two found EMDR to be superior to wait-list controls (Rothbaum, 1995; S. Wilson, Becker, & Tinker, 1995a). In addition, the substantial alleviation of PTSD symptomatology has been reported in two controlled component analyses (Renfrey & Spates, 1994; D.Wilson, Silver, Covi, & Foster, 1996), as well as in case studies (see Shapiro, 1995a, 1996a). While it is useful to note the extensive amount of EMDR research compared to other methods used in the treatment of PTSD (i.e., only three non-EMDR controlled clinical outcome studies have been published since 1989; see Shapiro, 1995a, 1996; Solomon, Gerrity & Muff, 1992), the attention placed upon EMDR has also highlighted some problematic areas of evaluation (Greenwald, 1996). Since the publication of my most recent review (Shapiro, 1996a), the three children studies mentioned above, and a comparative study funded by Kaiser (Marcus, Marquis, & Sakai, 1996), have been presented at national conferences. Therefore, the number of positive controlled EMDR studies now reaches fifteen.

While dispassionate reviews of the literature are vital, it is unfortunate that one recent review (Lohr et al., 1995) has served to add to the confusion rather than to clarify the situation. The review contains a large number of errors throughout the citations of the literature, as well as the evaluations. Since the number of problems is too great to ennumerate in this article (for a more comprehensive review see Shapiro, 1996b), I will merely give an example of some of the errors inherent in the analysis of only one of the studies covered. In the space below, I will give the statement by Lohr et al. (1995) followed by the actual data found in the article by Silver et al. (1995):

Lohr: The dependent variable was an unstandardized measure of general symptomatology (p. 294).

Silver: Test-Retest Reliability for the scales averaged .86, with a range of .77 to .95. Content validity was seen as met and some scales had construct validity through correlation with MMPI research scales (p. 338).

Lohr: EMDR showed significantly more improvement than milieu-only group on three out of eight scales (p. 294).

Silver: EMDR showed significantly more improvement in five of eight scales (Anxiety, Isolation, Intrusive Thoughts, Nightmares, and Relationship Problems) (pp. 339-340).

Lohr: EMDR appeared to produce results superior to relaxation on two of eight scales and superior to biofeedback on five of eight scales (p. 294).

Silver: EMDR did better than relaxation on seven of eight scales. EMDR did better than biofeedback on eight out of eight scales (pp. 339-340).

Lohr: No PTSD verification, co-morbid psychiatric disorders not ruled out (pp. 294-295).

Silver: Three separate assessments for PTSD were made, co-morbid psychiatric disorders ruled out (information freely available from principal investigator).

Lohr: Raw scores were subjected to multiple (40) t-tests between groups (p. 295).

Silver: Total comparisons were 24 not 40 resulting in half the probability of error intimated (p. 339-340).

Lohr: The use of raw change scores increases the likelihood [of] measurement artifact because of extreme values (p. 295).

Silver: If the artifact had occurred, a change in scores would be expected between two test points "Evaluation" and two months later, "Entry." There was no change (p. 338).

The errors contained in the article by Lohr et al.'s evaluation of the EMDR literature persist throughout the entire investigation. It is to be hoped that future reviewers will take the time to read the original articles in question and evaluate them within the context of the other PTSD research as well as the constraints of the populations studied. There is clearly a need for dispassionate and competent literature reviews of the EMDR research.

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The Supportive Use of EMDR in Working with Patients with Dissociative Identity Disorder

Robert Schwarz, PsyD.

The question had bothered me throughout the EMDR Level II training. When working with a client with Dissociative Identity Disorder (DID), how does the therapist know when an EMDR protocol will lead a client through a trauma to relative safety vs. precipitate an overwhelming abreaction because of all of the traumas linked up in the associative chain? I am clear that it is more important to help a client maintain safety and functioning rather than work on memories per se. However, it is also important to help a client deal with the traumatic incidents in his or her life, particularly ones that seem to be involved in significant cognitive distortions.

It was in this frame that I have begun to experiment with what I am calling the supportive use of EMDR in working with DID clients. I am presenting this information as a work in progress with absolutely no claim on whether this would work better than other approaches. I do think that the use of EMDR explicitly as a supportive technique with DID has not been previously described. I hope that this paper will stimulate some dialogue.

Essentially, the procedure is rather simple. I only use cognitive interweave protocols with these patients when the patient is in a partial flashback or is evidencing significant stuckness or distortion in his or her cognition, or significant fear and anxiety associated with significant cognitive distortions. The cognitive distortions generally include a component of self-blame (usually strongly conditioned by his or her abuser). Other distortions have included confusion about time (the client feels as if he or she is in the past where the abuse occurred, the alter is confused about what year it is, etc.), issues around the motivations of alter personalities (e.g., an alter believing that she is exactly like her abusing father), etc. I am working only with the alter that is present in executive control.

I have used this technique with clients who have been in treatment some time and there is a positive relationship. Since the client is in the middle of some crisis I

will say something like, "I am going to tell you something and then I would like you to watch my finger and tell me what happens." For example, one DID client had an alter who thought she was an exact duplicate of her sadistic father. This alter was internally abusing other parts while she was hearing and reliving the voice of her father telling her she was just like him as he was raping her. She was dissociating and completely under the sway of her father's voice. She was asked to consider the following: "He said you were just like him, but did you like it when he raped you?" About 12 to 15 sets of eye movements (SEM) were used and the client's affect changed from one of vengeful/anger to fear and pain. I asked, "What are you aware of?"

Client: "It hurts."

Therapist: "That's right, it hurt back then." (12 SEM)

Client (confused): "But, I liked it, I wanted it."

Therapist: "Did you think that or did he tell you that?" (12 to 15 SEM)

Client (becomes more childlike): "He told me that over and over."

Therapist: "Just because he says it over and over does not mean it is true." (12 SEM)

Client (protesting, but very confused): "But I am him."

Therapist: "You are a separate person from him." (12 to 15 SEM)

Client (becoming upset): "I hated it. Why did he do this?"

Therapist: "It really hurts, but it happened it a long time ago and it was not your fault." (15 SEM)

Client (calming down, breathing is more regular): "So, who am I if I am not him?"

This ended the sequence using EMDR and we shifted back into "regular" psychotherapy. The decision to end the sequence had partially to do with the amount of time left in the session, as well as with the quasi-guidelines that I use which include:

1) Conservativeness with respect to how much material to cover in a given amount of time so as not to overwhelm the person;

2) Using the EMDR interweave protocol to ameliorate the cognitive distortion. Once the distortion has been successfully challenged, it is a good time to end the protocol; and

3) Ending with clients feeling relatively calm and safe and having some closure. In the example used, the client was out of the cognitive distortion and was open to being asked questions. She had calmed down considerably and a point of closure had been reached.

There is absolutely no intent to go into the trauma further. In fact, the goal is to help reinforce the client's ego functioning by keeping the client associated to the here and now while remaining aware of the traumatic memory. Another way of thinking about this is that EMDR is used to punctuate and emphasize positive change (trusting that there will be other times to move into the trauma). For instance, a basic healing part of a DID client was dealing with the fact that she needed to begin to accept her counterpart on the dark side of her system. She asked me how it was possible that I accepted the fact that there was evil in the world and that even though there were parts of her that had bought into this evil, that I did not believe this was their true nature. I replied by asking her what she would think if there was someone just like her who asked her the same question, would she think that the person was evil. She had an "Aha" experience and said that if the woman asked the question, that meant that she was not evil. It was at this point that we did a brief EMDR installation to reinforce this idea and to link up to as many parts of her system as possible considering it was the end of the session.

So far the results have been that the client quickly stops abreacting and becomes grounded in the here and now and calms down. The client (or at least the alter who is out) remembers what happens, but is not living the experience. In addition, there are some in-roads made into the client's cognitive distortions. It should be noted that the cognitive distortions may show up again in another alter or in some form in the same alter. The idea is to chip away at the hold the distortion has over the client.

The reasoning behind this type of intervention is rather straight forward. With some DID patients, it is not the lack of access to traumatic material that is the problem. They have no difficulty moving along the "associative track" rather, they have huge problems with cognitive distortions and tremendous difficulty with

affect tolerance so that whenever they do step into traumatic material, they are re-traumatized.

The use of a supportive cognitive interweave helps to strengthen the DID clients' ability to think more clearly and with less distortions so they can better tolerate aversive affect. The vast majority of trauma victims have relatively intact ego functioning which helps to keep the traumatic material separate and guards against its full intrusion into consciousness. EMDR provides a rapid and structured way to access and process the material without overwhelming the person's ego functioning. Severely dissociative clients who have early childhood histories of severe abuse often have substantially impaired ego functioning with special problems in the area of affect tolerance. There is considerable risk that activation of traumatic memories simply overwhelms the ability of these individuals to cope, often precipitating downward spirals.

In addition, in some number of these clients, there are special injunctions not to tell and not to remember that cause substantial trouble if these have not been "deactivated" before the client remembers or tells. Attempts to process these memories with or without EMDR could quickly lead to a decompensation.

The results of my early uses of this have all been that the client calms down in the presence of traumatic material. Most of the DID patients I have encountered have had far too many experiences of moving into trauma and far too few experiences of being able to calm down in the presence of traumatic material. Using EMDR in this manner seems to provide just this type of experience. Hopefully, this helps to build the expectation that one can go through increasingly difficult material and still come out on the other end in a relatively calm manner.

To summarize, the supportive use of cognitive interweave techniques for DID clients focuses only on the cognitive distortions of the client without any attempt to go further into traumatic material. The goal is to help support the client's ability to tolerate aversive affect as well as to mitigate the cognitive distortions that impair his or her thinking and amplify negative emotion. The approach is centered on the principles that working with DID clients slower and safer is better. ■

Music and the Brain in EMDR Therapy: Is Music, Itself, EMDR?

Sheryll Stuart Thomson, MFCC

This paper brings together my experiences with music in EMDR therapy and the experiences of myself and others with music and the brain. I describe some of the components and forms of music--e.g., imagined music, humming, singing, dance-like movements in EMDR, eliciting from the client the words of a song, re-storying the negative cognitions from a deeply-embedded song, and rhythm and chanting--and how, together with EMDR, they can evoke open, integrative states which are more amenable to deep change than either is alone. I believe that since music has some of the same basic attributes as EMDR, music by itself may be included with EMDR techniques, e.g., eye movements, clicking, tapping, etc.

Before learning EMDR, I sometimes asked a client to "allow any song to come to mind." The song's words often revealed a more basic state or different truth for the client from what he or she was able to express by speaking. I had also used rhythm and chanting (to the rhythm of clapping or rhythm instruments) to help embed new positive cognitions as they arose. I later learned the following about how music can affect the brain which further developed my use of music or "musicality" (in the way I move my hand) combined with EMDR.

Some disorders, such as stuttering, Tourette's, or Parkinson's disease, can be completely absent when the person is listening to music or singing a song (Sacks, 1990). According to Sacks, a man who had severe and violent tics with Tourette's syndrome, "could play the guitar and sing, and when he did this he came together completely, was freed of his explosive tics and impulses, restored to himself. As soon as the music ended he would disintegrate again" (1994b, p. 15). A Tourettic brain surgeon in British Columbia is utterly without tics during the "smooth orchestrated flow of movement" of practiced surgery, although frantic ticcing occurs during both his pre-operative scrubbing and immediately after the surgery (Reiner,1995; Sacks, 1995, p. 95-98). About stuttering and music Sacks says, "...every sort of stutter, it has been known from antiquity, can be helped by music and musically cadenced forms of speech, as in recitation. [Author's emphasis.] Thus the severest stutterers are able to sing without stuttering, and usually to intone, orate, or recite as well..." (Sacks, 1994b, p. 3-4).

After learning these facts, I wondered if there was a connection between the brain surgeon's practiced, "one-thing-leading-to-another movements" (non-musical, though

reminiscent of recitation) which completely calmed his ticcing, and the ways music can calm some other people with brain disorders. I began to wonder if I might introduce "music," or a music-like experience, into the EMDR session solely by the way my hand and arm moved and the way clients' eyes moved as they followed. It seemed to me this "musical," or dance-like movement, could access the "musical parts of the brain" (Blakesley, 1995) and evoke in the client a deeper, more integrative experience in relation to the problematic node than what the client would experience with "basic" EMDR.

INVITING "MUSICALITY" INTO EMDR THROUGH DANCE-LIKE MOVEMENTS OF THE HAND/ARM

After using horizontal eye movements with one client, a 46-year-old brilliant woman who has a style of being cynical or wary, I shifted to drawing figure-eight movements in the air, but in a "musical" or dance-like way, and she noticeably relaxed. Another client, with OCD styles, also relaxed significantly into deeper work when I used dance-like arm movements and asked her to follow with her eyes. Since then, I have used this approach (moving at angles as well as horizontally) with good effect in many sessions and with other clients. I find myself drawn to using these movements particularly with clients who are overly controlled and wary, and it may be that it makes the most pronounced shifts with them.

It is important that the movements the therapist uses have a true dance feel to them. When the therapist can experience a sense of relaxed, lyrical pleasure in her or his arm movements, the client may experience more of the musicality. A client may laugh initially, as the new kinds of movements on the part of the therapist may seem funny or strange. For exmple, one worried client smiled all during the new, flowing style of eye movements, announcing, "Maybe it doesn't all have to be doom and gloom." It would be important not to call attention to the therapist in this, or seem to ridicule the client's mood, but to keep the focus on the hand in relationship with the eye movements. Indeed, any eye movements in EMDR which follow the therapist's hand can be seen as a dance between the therapist and client, and all the responsiveness and attention one shows when dancing with a partner on a dance floor are recommended here.

CHANTING AND DANCE-LIKE MOVEMENTS

The cognitions of another woman, age 35, spontaneously evolved into chanting and more basic levels of belief while experiencing the "musical" arm/hand movements. Her mother had committed suicide when she was 18, and she was recovering from her own suicidal crisis triggered by the behavior of a sociopathic lover. She began one session with a childhood memory of a teacher angrily drawing "a big red 'F'" on her paper when she evidenced confusion about what the teacher was trying to tell her. Her negative cognition was, "I'm bad." In the middle of a series of EMDR sets, when I began to move my hand/arm in a dance-like way (using figure-eights on two diagonals), she suddenly shifted significantly in the clarity of her reports and the depth of her content. She next reported, in a chant-like way, "It's better to be alone/ You're safer alone." (Before this, she had reported on early memories; now more of the negative beliefs underlying those memories were emerging.) After more dance-like arm/hand movements she reported the discovery, again in a way which had a chant-like quality, "It's O.K. to need people/ If they're good people." She added, spontaneously, "I hear myself repeating this like a chant." Remarkably, clients have only couched their cognitions in chanting when I used the dance-like movements. (Soon after this work she met a reliable man with whom she has developed the first deep and trusting relationship of her life and is likely to marry.)

RHYTHM IS BASIC TO THE MIND AND TO EMDR

Chanting is rhythm--repetition and its implied predictability. Since EMDR includes rhythmical clicking and tapping, as well as rhythmical eye movements, possibly the rhythmical qualities inherent in EMDR approaches are basic to their effectiveness. Rhythm is apparently a deep-seated function of the mind, according to Pribram (1982, p. 21) and we know that shamans in primitive cultures use one-tone rhythmical drumming to evoke more accessible states of mind.

ELICITING A SONG CAN REVEAL USEFUL INFORMATION

I have sometimes, spontaneously, asked a client to think of a song, to focus on the first song that comes to mind, and the words of the particular song may suggest useful meanings and directions. For example, with a woman who was unsure she could believe the positive changes she was beginning to experience in therapy, I invited a song toward the end of a session. This elicited the lyrics, "I am a beautiful woman," which she sang, and we installed immediately, using eye movements. This seemed to embed the positive changes she had made and to relax her anxiety about changing. When I have asked clients to "allow a song to come to mind," they have almost uniformly thought of a song with words relevant to the subject on which they had been working.

IMAGINED MUSIC

If a client is not able to come up with a song when invited, the therapist can ask for just "music" during thera-

py and this can simply be thought/imagined, effectively stimulating the music areas in the brain (Blakesley, 1995). When a client declines to sing a song, but is willing to "listen" to it internally, I have asked the him or her to tap (hand on one knee) in rhythm to the song heard, while moving the eyes, so that I can visually match my arm movements to the internal rhythm of the music and not disrupt it. A bright young woman who had been diagnosed with OCD and was taking Prozac, could, after some trouble, "hear" music, but no words of a song came to her. She was not willing to hum the music she heard aloud, but she did imagine it internally while tapping the rhythm and moving her eyes and which seemed to calm her and move her to a deeper area of work beyond what she had been able to manage previously.

A NEGATIVE COGNITION EMBEDDED IN A REMEMBERED SONG

Again, a song figured powerfully in the therapy of a man who had been abandoned in many ways by his mother even before her death when he was 14. He experienced anxiety during the session, and had a debilitating and sharp shoulder pain which he finally connected to his anxiety about not being able to reach his lover by phone in another city the night before the pain began. After using eye movements to focus on the discomfort in his stomach and then in his neck, he reported tightness in his throat. (A constriction in the throat suggests to me a conflict about the need to express something.) I asked him to allow a song to come to mind and he immediately laughed ironically about a song he had heard on an airport loudspeaker when he was saying goodby to his lover not long before, a wrenching experience for both of them. The irony was that this was the same song he had heard on the radio 30 years ago in his mother's room immediately after he was told she had died. The lyrics included, "Don't they know it's the end of the world.....Why does my heart go on beating?" I asked him if he would sing the song, which he did, and later he said he had felt like crying while he was singing. Indeed, the anguished look on his face as he sang was the closest he had been to weeping in front of me in seven years of three substantial terms of therapy. Afterwards he said the excruciating shoulder pain, which had lasted unabated for five days before this, had lessened substantially--at least temporarily.

RE-STORYING THE SONG'S NEGATIVE LYRICS COUPLED WITH ITS BEAUTIFUL MUSIC IS LIKE EMDR

Another session with this man was held on the eve of his going to meet his lover in the other city and to move into a new house part-time with her, a step requiring a great leap of faith for him. His shoulder was again in constant pain and he spoke about not trusting the people he usually trusts, including his lover and me. He began to talk about his fears of dying, and that he felt he would even welcome it. It became obvious he was a man who could not believe his good luck, and that his paradigms about what he could expect in the world were indeed dying. The song he had mentioned two sessions before came up, the words of which seemed to have hypnotized him at his mother's death at age 14, and which have stayed with him to age 47. Indeed, he said, every time he encountered the song, "I would stop and fall into a trance." I suggested we could change the words to that song, which were no longer affirming, and keep the music. In introducing this idea, I told him that a song's words can stay with us, and affect us powerfully, partly because the music they are sung to is so affecting (he had mentioned several times how beautiful he thought the music was). Together we changed the negative words of the song which had so entranced him so that, "Why does my heart go on beating," became, "It's wild the way my heart is beating/ Good thing I'm no longer shy," and, "Don't they know it's the start of the world/ It started when you told me, Hi." Instead of, "I can't understand...," we made it, "I now understand, yes, I now understand, why life goes on the way it does." After this process, which was fun, connective, and obviously creative, this man reported, "I feel lighter," and--in marked contrast to the attitude of general distrust with which he began the session--he said shyly, "I felt pretty good about you a couple of times there." With much encouragement by me he went off more lightly to be in love which, for him, had been and still was a bit, "like going to war." The next morning, synchronistically, as I was writing this, the client called me from the airport specifically to tell me: "Changing the words of that song really helped. I feel really changed, still lighter. I still have some fears; they go in and out, but the pain in my arm is much less and I slept well last night for the first time in a long time. I just wanted you to know. Thank you."

During the reworking of the song we did not use eye movements; if there had been time, any of the new, positive words could have been embedded using eye movements, even while singing the song. For him, singing the new, positive words coupled with the beauty of the music, which had heretofore been connected with a negative experience, had operated, it seems to me, in a similarly productive way therapeutically as does holding a negative cognition together in focus with a positive cognition during EMDR.

MUSIC IN MUSCLES AND HEALING

Music can be deeply embedded neurologically in relationship to muscles and healing which was suggested by the significant reduction, literally overnight, of the previ-

ous male client's experience of re-storying his song. Sacks demonstrates this dramatically in his description of his own re-learning to walk, with the help of music, after surgery for torn nerves and tendons in one leg. Sacks heard no music in the hospital and was under great distress, feeling himself to be 'unmusicked' and feeling the need for music.

> With the leg immobilized, and effectively paralyzed, I lost all sense of its existence--I seemed to lose, indeed, the idea of moving it, and could no longer evoke even an image of walking (such imagery is always accompanied by minute muscular movements, the movements that normally go with the action, and if these movements are unavailable the inner imagery is undermined).

Finally, a friend brought him a tape recorder and one tape, the Mendelssohn Violin Concerto. He says,

> Playing this repeatedly gave me great pleasure, and a general sense of being alive and well. There was, however, no specificity in the feeling: I could not translate it directly to the leg, the limb which so needed to be 'remusicked.' Neitzsche writes, 'One listens to music with one's muscles,' but I could not respond to music fully, the leg would not keep time...until its muscles (and their nerve supply) were sufficiently recovered.

This took fifteen days, "the longest fifteen days" of his life.

> On the fifteenth day, I was stood up to walk, but I could not, had no idea how to, until music came to my aid--made me do it: this coincided with the sudden playing of the Violin Concerto, fortissimo, in my mind. Suddenly, without thinking, I found myself walking, easily, unselfconsciously, joyfully, with the music. It was as if I suddenly remembered how to walk, indeed, not 'as if'--I remembered how to walk. All of a sudden I remembered walking's natural, unconscious rhythm and melody; it came to me suddenly, like remembering a once-familiar but long forgotten tune, and it came hand in hand with the Mendelssohn rhythm and tune" (Sacks, 1994a, p. 9-10).

POSSIBLY MUSIC ITSELF IS EMDR

My simple working model of how EMDR works has long included the concept that any activity that both rhythmically and alternatingly evokes both sides of the brain, e.g., clicking, eye movements, hand-tapping, or tones, "relaxes" the corpus callosum to the degree that new, stronger connections can be made between the two sides of the brain, creating the availability of more beneficial information. This is not based on an in-depth study of brain physiology, but is a schema based on my many experiences using several cross-lateral movement techniques and EMDR approaches, all of which employ the two sides of the body (and therefore, the brain), sequentially and rhythmically. Peter Levine, Ph.D., a Reichian trauma therapist, has used crawling "properly," using opposing arm and leg at the same time, moving the body as a whole, panther-like. These cat-like, primitive, or whole-body movements are reminiscent of the "musical" arm-hand eye movements described above. This can be used with people who are feeling fragmented or unfocused, and who may not have had enough of a chance, as babies, to crawl. (P. Levine, personal communication, 1987.) I have heard of, and used to good effect, a technique which employs humming by the client while cross-lateral movements are performed standing, right hand touching left knee, alternating sides, approximately 10 to 30 times. This technique has resulted in experiences of calmness and centering in many clients. It may be that singing, an activity which combines both words and music, is itself an integrative experience due to the fact that some language centers seem to be located exclusively in the left hemispheric regions while music is in the right (Blakesley, 1995), therefore evoking connections across the corpus callosum.

Pribram (1982) emphasizes the deep-seated function of song in the brain. He reports that "the vocalizations of non-human primates consist almost entirely of changes in pitch and duration..." and in light of that, Leonard Bernstein has suggested that "the first communicative uses of sounds were sung" (Pribram, p. 24-25).

In addition, Calvin and Ojemann (1994) report that in general, "Music depends on both sides of the brain...It's been suggested that as you gain profiency in music, it is organized increasingly like a language, dependent on your left brain. But not on exactly the same areas as spoken language" (p. 72-73). The same authors report that listening to a Mozart sonata before taking an IQ test resulted in temporary increases of 8 to 9% in normal subjects (p. 278). It is as if the music, which stimulates areas in both sides of the brain, had evoked the brain as a whole, allowing the subjects access to a greater amount of their own knowledge and abilities.

THE EYES ARE CONNECTED WITH THE JAW

In further thinking about singing, or any vocal expression in connection with EMDR, it is also interesting to speculate on the implications of a recent new discovery of a muscle which connects the eyes with the lower jaw on each side (Leary, 1996). Since learning this, I have imagined that during eye movements, the jaw is being gently, if

subtly, agitated or massaged--indeed, some clients' jaws do move perceptibly from side to side--and that this movement naturally loosens up and processes stuck or silenced expressions which had previously been held back by muscles in the jaw. Singing, itself, would also massage the jaw muscles (and the eyes).

MUSIC NORMALIZES MENTAL DISABILITIES AND SHEDS LIGHT ON NORMAL-RANGE THERAPY

In discovering how songs affect the brain, it is also useful to know that songs have aided autistic, retarded, and brain-injured people in learning and in performing tasks. One can then understand more fully how, in EMDR with "normal-range people," music and chanting may help embed a positive cognition. Indeed, even with "normal-range people," one never knows where there might be a glitch in learning ability, and looking at how music may be the key to the extremes of disability may show us the way for some clients who are not seen to be disabled, but for whom other therapies fail.

Thus, in some aphasic people, language can be regained if words are first embedded in music, as music and song is usually not lost in aphasia, according to Sacks (1994). With patients who had frontal lobe damage and lost the ability to carry out a complex chain of actions, such as how to dress, "music can be very useful as a mnemonic, or a narrative--in effect a series of commands or promptings in the form of rhyme or song, as in the childhood rhyme, 'one, two, buckle my shoe'" and the same has been true with severely retarded people (Sacks, 1994b, p. 17).

An autistic savant whom Sacks knows cannot express emotions unless in the context of music, when his stilted postures, averted gaze, and tics, "all vanish, and he seems, for the duration of the song or dance, entirely normal. It seems, when he is singing, that he may be able to access a whole range of emotions and states of mind which are, for the most part, unreachable by him" (Sacks, 1994b, p. 29).

In the book, Awakenings, Sacks describes how music dramatically affected temporary healing with post-encephalitic brain-damaged patients.

> When we were able to make EEG studies on these patients, such arousals could effect a real physiological transformation. Many of these patients had exceedingly slow EEGs, dominated by slow waves in the 1-4 hz. (delta) range; if we could find music that worked, their EEGs would change, normalize, in the same moment as their clinical states. We observed this when patients listened to music, or sang or played it--or even imagined it. Music is not a luxury but a necessity to such patients, and can (if it works, and for awhile) provide what their brain can no longer supply (1994b, p. 4-5).

CAUTIONS IN USING MUSIC WITH BRAIN-INJURED PATIENTS

Sacks goes on to add several cautions about the use of music with brain-damaged patients: "...I say, 'If it works', because, quite frequently, with such patients, music does not work." And it may even drive some patients further into their disorders (Sacks, 1994b, p. 14). "There is no generic music," Sacks emphasizes, "which will work, like light or photic stimulation, with every patient" (p. 6). The late author, May Sarton, said, after a debilitiating stroke, that she could not listen to music for years afterwards, it would have been too painful. I am guessing music would have allowed too many connections to be made at once, overwhelming a vulnerable brain intent on healing (Sarton, 1992, p. 10).

For many people, music seems to be one of the most healing of activities and one of the last and most basic of abilities and knowledges to be lost when a person's brain has been damaged. There are some reports which even seem to indicate that the duration of coma can be lessened by music (Sacks, 1994b, p. 25-26) Additionally, "In Alzheimer's (as in the amnesias), musical memory is relatively preserved, not only for recognizing music, but for performing it (if this had been possible before)" (Sacks, 1994b, p. 23). Sacks suggests, "Even when dementias are far advanced, a quality and dignity of life can be nourished or restored; and nothing is more important here, in addition to everything else, than the provision of music as therapy" (p. 22). The implications are obvious, perhaps, for treating the last stages of life in AIDS patients and others, for: ... it is the inner life of music which can still make contact with their inner lives, with them; which can awaken the hidden, seemingly extinguished soul; and evoke a wholly personal response of memory, associations, feelings, images, a return of thought and sensibility, an answering identity (p. 23).

CONCLUSIONS

Music (alone or with EMDR), in some form and with some people, seems to encourage more effective connections to the self than would using EMDR in the traditional ways, thus, perhaps, leading to profound resolutions. Because music can be an integrative experience for the brain, as is EMDR, together, the two present potent opportunities for enhanced learning and change.

During EMDR, an affirming or comforting song or piece of music elicited from the client can be held in consciousness in tandem with a negative belief or image, an uncomfortable sensation, and/or distressing memory to create a broader and deeper experience of wholeness and resolution. Moving the therapist's arm in a fluid, dance-like way,

thereby encouraging the same fluidity in clients eye movements, may invite musicality into the process of EMDR. These may be particularly useful for some people for whom basic EMDR seems not to be workiÙng. Re-storying with a client the words of a lingering song which has negative effects can disempower the old messages toward a positive outcome. Asking for songs and using them as EMDR focusing points, and listening for the chant-like qualities in clients' positive reports and affirming them with EMDR, may accelerate the work. Indeed, the very rhythmicity of the eye movements (or tapping, clicking, etc.) may be among the ways in which EMDR effects profound change. If EMDR's efficacy is based in activities that evoke both sides of the brain, sequentially and rhythmically, music, which also evokes both sides of the brain and employs rhythm, may itself be considered EMDR.

Author's note: This article is meant to offer information which will be helpful in therapy and to stimulate therapists' interest and creativity in the use of music and aspects of music in therapy and research. I would enjoy hearing from any readers with information you have on using music in EMDR therapy and, specifically, how you may find thoughts and information in this article helpful in your work. Sheryll Thomson, 1641 Hopkins Street, Berkeley, CA 94709, 510-845-3345.

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When is 0 not Equal to 0?

Steve Lazrove, MD

EMDR protocols rely heavily on the SUDs and VoC as both process and outcome measures. It is my impression that these scales are much less global in assessing the patient's mental state than generally assumed and that clinicians need to be aware of the limitations of these ratings. The following clinical example illustrates my point.

A 56-year-old man underwent EMDR for PTSD secondary to a head-on motor vehicle accident in which he almost died. A highly intelligent individual, he wrote a several-page account of his crash in anticipation of his first EMDR session which was conducted one year after the accident. The standard EMDR trauma treatment pro-

tocol was used and the patient was able to process the event sequentially as it occurred in real time. At this point, recalling the original incident produced no distress and the scene did not change with another set of eye movements. The patient reported that the SUDs was 0, not disturbing at all. It was "completely over." However, something about his presentation left me unconvinced that no disturbing material remained. So I pushed him gently, asking, "If you had to say something was still disturbing, what would it be?" He initially continued to deny that anything disturbing remained, but after some thought, he offered, "Oh, I don't know, maybe just that when I think of the crash, I can still hear the BOOM!" yelling, "BOOM!" in a voice loud enough to raise me out of my chair. He then processed the sounds of the crash to a SUDs of 0 announcing that he felt much better. When challenged again, he once more denied that anything still bothered him, but ultimately identified a tightness in his chest. The somatic sensation served as the lead to processing the kinesthetic sense of the accident. He held his crushed chest and reflexively stamped on an imaginary car brake with his right foot as he processed the accident from yet another perspective. Again the SUDs decreased to 0 and he reported feeling much better. I challenged him once more, and again after initially insisting that all material really was processed by that point, he came up with a vivid image of the hood ornament of the vehicle that hit him. He resumed processing the sights of the accident and again reached a SUDs of 0. No further material related to the accident emerged, although associations to other life traumas arose during subsequent sessions.

The point I want to make is simple. In EMDR parlance, when a person has processed information to the end of a channel, she or he has a pervasive sense of accomplishment and resolution. In this state, the person may not be able to tell whether or not additional unprocessed material remains when he or she returns to target. I do not believe that this phenomenon has anything to do with "resistance" or "defense" against emerging material. It is just that the sense of relief and accomplishment overshadows any residual ill feelings. It is the therapist's responsibility to maintain the therapeutic focus and not join in the celebration. In this case, the patient was very cognitively oriented so once the cognitive chain of associations was processed, it seemed as though all of the work had been completed, though clearly it had not been.

By asking the question, "If you had to say something that still bothered you, what would it be?" the therapist takes responsibility for continuing the search for residual distress. Because the patient feels fine, directly asking what else is troublesome may invalidate the sense of accomplishment over what has been done so far. The challenge is to consolidate achievements while moving to the next channel. The spirit in which the question is posed is casual and friendly, something like, "Well, we both know that everything is probably done and it isn't likely that we'll find anything else to work on, but won't you please humor me and just see whether there isn't anything else left?" If the patient really has cleaned out a channel, he or she initially should insist that nothing is wrong. This is because the SUDs is 0--there is no disturbance. Yet, following a moment or two of silent self-reflection, the patient may discover something else. Often the significance is minimized when first mentioned because the distress is such a small point on the mental landscape. Often, however, this dot turns out to be the tip of the iceberg. A typical response could be something such as, "Oh, I don't know, I know now that it really is over, yet in my heart I know that it really was my fault." This statement becomes the next target, the therapist begins the next set of saccades right away. Questioning about residual distress is continued until no new material is uncovered. At this point, the therapist asks, "If something about what happened were to bother you some time in the future, what would it be?" and the process is repeated. A similar approach is used when obtaining the VoC.

When I first observed this phenomenon, I was perplexed. How could my patients really think that the SUDs was 0 and yet still come up with such powerful negative statements? Was I not explaining the method correctly? Were they holding out on me for some reason? The answer is that the SUDs is a measure of the immediate mental state only. It does not address other mental configurations. In essence it says, "I am fine this instant." This is why it is so important to conduct a reassessment (Stage 8) following a successful EMDR session. New material comes up between sessions as life provides triggers that stimulate unprocessed material. The line of questioning suggested here accomplishes something similar. To answer hypothetical questions, the patient must shift the arrangement of mental constructs, and in so doing, may uncover unprocessed material. This imprecise metaphoric explanation is a useful heuristic, but clearly is not a scientific explanation.

Therapists need to be aware that unprocessed lacunae of disturbance may exist even when the SUDs is 0. Challenging the patient to find residual distress by direct questioning may speed treatment by increasing the amount of material processed within a single session. ■

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