EMDRIA

December 2016 The Information Resource for EMDR Therapists Vol 21 Issue 4

Making Strides

The Path to Reaching 2017's Goals

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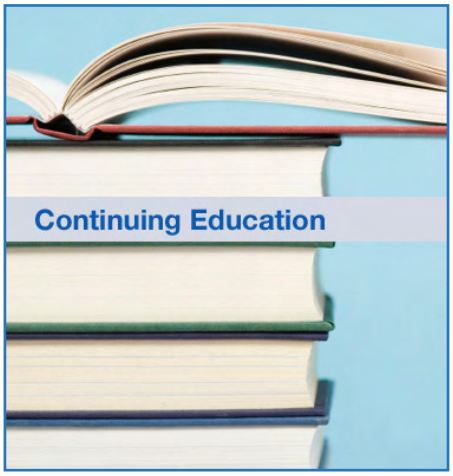

Articles & Information

A word from the President...

DaLene Forester-Thacker, Ph.D., LMFT
EMDRIA President

My dear friends and colleagues, this is my last newsletter article as President. I want to thank all of you for supporting this organization that has meant so much to me personally. My family taught me that if you believe in something, get involved. I could not have predicted the first time I volunteered with EMDRIA that someday I would have the opportunity to serve as President. It has truly been an honor to serve our EMDRIA community in this way.

It is exciting to see the direction EMDRIA is headed with increased membership, the new branding that continues to be unveiled, the newly energized Regional Coordinator program, the live streaming opportunities, stepped-up advocacy and so many other EMDRIA supported projects.

We started 2016 with the goals to 1) grow membership with an emphasis on diversity; 2) be recognized as an indispensable resource for member networking, professional development, education and integration of research into practice; 3) be recognized by consumers, professional and general populations as an expert for issues related to trauma and other adverse life experiences; and 4) be recognized for advancing interventions, fostering alliances and developing professional standards for paraprofessionals and first aid responders who are treating trauma and other adverse life experiences. I believe we have made great strides in these goals in 2016 and are well on our path for 2017.

I hope many of you took the opportunity to respond to the EMDRIA "call to action" to address the APA (American Psychological Association). The APA inaccurately drafted guidelines on the treatment of adult PTSD claiming EMDR therapy as inferior to CBT despite overwhelming evidence to the contrary. EMDR therapy was downgraded from a "moderate" recommendation to a "weak" recommendation while designating CBT as "strong." The recommendation was based on an incorrect representation of EMDR therapy as well as inaccurately representing research that supports EMDR therapy. It is critical that when these types of factually inaccurate recommendations are put forth, the EMDRIA Community reacts quickly and with a torrent of evidence. Thank you to those who brought this to EMDRIA's attention and to all who responded, the EMDRIA Community owes you a debt of gratitude.

I have had many conversations lately about how, we as clinicians and citizens, can have meaningful impact in our communities, our country and our world. I would like to remind us all, EMDR therapy is needed more now than ever. For this reason, I want to remind you that the EMDR Research Foundation needs your support. The EMDR Research Foundation is a separate "sister" entity from EMDRIA and holds non-profit status allowing you to make tax-deductible donations directly to the EMDR Research Foundation (www.emdrresearchfoundation.org). If every member of EMDRIA became a member of the "Visionary Alliance" and donated the equitant of one session a month (or even a half a session each month), EMDR therapy research would be funded on a level like no other psychotherapy. Remember the words of Francine…research, research, research! Please consider a donation to the EMDR Research Foundation (www.emdrresearchfoundation.org) to support our efforts in making EMDR therapy a household name. Please, be the change you want to see.

I am so grateful for the opportunity to publicly thank those of the EMDRIA Board who will be stepping off the Board this year and to Mark Doherty as he prepares for retirement. Thank you, Carrie Ann Carr, Ira Dressner, Dean Dickerson and Brenda Rohren. Your service has been greatly appreciated and I know you will all stay supportively involved with the EMDRIA Community. Thank you, Mark, I know you won't be leaving EMDRIA until we have a new Executive Director in place and for that we are all grateful as well.

It has been my great pleasure to work with the dedicated EMDRIA Board, staff, various EMDRIA committee members, the international EMDR community and the EMDRIA membership. I look forward to supporting Evelyn Wright in her term as the EMDRIA President.

Thank you for the honor of allowing me to serve. ❖

Announcements

Board of Director Election Nominations

The EMDRIA Board of Directors are soliciting Director nominations for the Spring 2017 Election. The elected Directors will serve a four-year term starting in January of 2018. In order to be qualified for the Directorship, you must be a Full or Associate Member of EMDRIA, and it is suggested that you have served on an EMDRIA committee for at least one year and/or demonstrated equivalent services for other EMDR or similar organizations, and demonstrate a clear and unambiguous commitment to and identification with EMDRIA. If you are interested in serving on the Board, please email Gayla Turner at gturner@emdria.org to request an application packet. Completed applications are due by February 15, 2017.

Seeking Names of Approved Consultants who Provide Long-Distance Consultation

The EMDRIA Office often receives phone calls and emails from clinicians hoping to become EMDRIA Certified in EMDR but that live in remote areas without an Approved Consultant within driving distance. We are building a list of Approved Consultants who offer consultation via phone or web-based medium (Skype, etc.) to better respond to these inquiries. If you or an Approved Consultant you know provide distance consultation, please email info@emdria.org with the consultant's full name, communication medium (ie: phone, Skype, etc.) and any additional information that the consultant wishes to provide.

Do you know of any Residential & Inpatient Treatment Centers that utilize EMDR?

The EMDRIA Administrative Staff needs your input! We've received multiple calls from the public requesting information about Residential and Inpatient Treatment Centers that utilize EMDR in their programs. We've compiled the names and locations of a few we've found but are hoping to have a more comprehensive list for the public and our members to reference. If you know of any Residential or Inpatient Treatment Centers that utilize EMDR, please email the NAME and WEBSITE to info@emdria.org.

EMDRIA on Social Media

EMDRIA's Social Media presence allow the public and members an insider's view of day-to-day operations, office announcements and important news in the EMDR Community that you may often miss from a Newsletter or email. Tweet us, follow us on Instagram or share the latest news article on EMDR therapy by liking our public Facebook page! For questions regarding EMDRIA's Social Media venues, email Sarah Frazier, our Administrative Coordinator, at sfrazier@emdria.org.

Coming Soon: EMDRIA's YouTube Channel

Keep an eye out for more information on EMDRIA's YouTube Channel. From interviews to public service announcements on EMDR therapy, this will be a source of informative material for EMDR therapists and clients. Do you have a video that could benefit others on EMDR therapy? Send an email to Bergen Villegas, our Membership Services Coordinator, at bvillegas@emdria.org.

Executive Director's Message

Mark G. Doherty, CAE
EMDRIA Executive Director

After a number of years working for EMDRIA, this message will most likely be my last as I move into retirement. It's been my privilege to serve as your Executive Director. We've grown our community to more than 7,000 members. We're making significant headway with the Veterans Health Administration where recommendations for the implementation of EMDR therapy within the VHA system are being drafted at this time and an important requirement is that EMDR training for qualified VHA providers be an EMDRIA Approved Training. The recommendation includes a statement that the VHA Office of Mental Health leadership champion efforts to train clinicians in EMDR to provide access throughout the VA to ensure the best available care for our nation's veterans. VHA is also encouraging clinicians to maintain EMDR proficiency and become EMDRIA Certified Therapists and EMDRIA Approved Consultants. By the way, the number of EMDRIA Certified Therapists and Approved Consultants is at an all-time high.

When I started at EMDRIA, I saw a real challenge in making EMDR therapy better known. My challenge soon became my mission. My focus was initially on the warriors of my generation, Vietnam. But soon I grasped the enormity of the problem with so many of our young warriors returning from Iraq and Afghanistan. Then I began thinking about the first responders whom I know from first-hand experience are exposed to actual and vicarious trauma on a daily basis. Then there are those who suffer adverse life experiences and traumatic occurrences due to accidents, crimes, where they live, and the list goes on. Rolf Carriere further opened my eyes when he gave his plenary talk at the 2014 EMDRIA Conference in Denver that discussed the man-made and natural disasters happening throughout the world. There is so much global trauma, making the need for EMDR therapy so great. Rolf called EMDR therapy penicillin for trauma. I totally agree with him.

My time at EMDRIA has been the most personally rewarding of my 33-year career in working with associations. I'm not a therapist; I'm an engineer by training. The other associations I've run are math, science, computer based professional societies where what is important is that my algorithms or computer programs run faster than someone else's; my mathematical solution is more elegant and shorter than yours. They're more about things and stuff. At EMDRIA, we are working with members who help people. That was a huge change for me and one that I found to be the capstone of my professional life.

I've been fortunate to meet many of you at Conferences and through your volunteer efforts. I'm amazed how dedicated you are to EMDR therapy, wanting it better known, and treating your clients using EMDR. Your dedication to EMDRIA also stands out. Many members of professional societies join to get ahead in their careers. EMDRIA members are here for the betterment of their community of EMDR therapists so they can better serve clients. Again, a very big professional difference from my past, but one that makes EMDRIA members who they are.

Being at EMDRIA has given me the opportunity to see EMDR from a global perspective. Working with our colleagues from around the world who share a common vision of helping people through EMDR therapy is something special. It's not an us and them thing, rather it's how do we collaborate to improve EMDR and make it more accessible to people.

We have challenges ahead. How we reach underserved populations in inner cities and rural communities remain. How we keep costs down and expand the reach of EMDR trainings need to be addressed so the number of EMDR trained clinicians can grow even faster. Getting EMDR therapy integrated into academic curricula and textbooks so those students going through university programs to become therapists learn about and are even trained in EMDR is important. We must continue our efforts with the VHA and DoD to assure that veterans and military personnel have access to EMDR therapy. Upholding our standards of practice and encouraging more research in EMDR is a never ending battle that we must continue to fend off groups like the APA that wish to downgrade EMDR's relevance.

I plan to stay on until my successor is selected and to transition to her/him in an orderly manner. EMDRIA has become an important part of my life in a way no other association has. I want to keep the momentum we have going and the great dedicated staff who work behind the scenes engaged in EMDRIA's future successes. Five years ago, I would never have thought I'd be working for an organization like EMDRIA and trying to make EMDR therapy a household name. I thank the EMDRIA Board of Directors for giving me the opportunity to become part of the EMDRIA family and to see if an engineer's skills can be put to use on behalf of a group of dedicated therapists.

As always, I welcome your thoughts and comments. Feel free to contact me at 512.451.5200 or mdoherty@emdria.org. The staff and I are here to be of service to you, our members.❖

Conference Corner

Planning for the 2017 EMDRIA Conference is already well underway. The theme for the 2017 EMDRIA Conference is: **EMDR Therapy: New Frontiers**. The Conference will be held August 24-27, in Bellevue, WA (just outside of Seattle) at the Hyatt Regency Bellevue.

2017 EMDRIA Conference Call for Presentations

Thank you to those who submitted their proposal for the 2017 EMDRIA Conference. The deadline for submissions was Monday, January 9th. Those whose proposals were accepted will be contacted in the months to come.

2016 EMDRIA Conference Certificates

Conference certificates of completion are available for download from the EMDRIA website. Click on the Conference tab, then choose 2016 Conference Certificates to get to the download page. You'll log in by entering your First Name and Last Name (as they appeared on your Conference badge). Click the "Submit" button and you will be able to print your certificate.

Conference Audio Recordings

Audio recordings from this year's Conference are available through Convention Media. A link can be found on our website. Under the Conference tab, choose Audio Recordings, then click on 2016 Audio Recordings. You will have several options for purchasing Conference recordings synchronized with handouts – you can purchase a complete set of audio recordings or you can purchase individual sessions. There are a small number of sessions that were not recorded at the speaker's request. Audio recordings from past EMDRIA Conferences can also be purchased.❖

Hyatt Regency Bellevue

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This highly-reviewed Webinar can be virtually-attended from the comfort of your own computer, and will automatically flex to your timezone on the day and time most convenient for you. This unique distance-learning format is an opportunity to join other EMDR therapists from around the world. You can read the reviews and learn more at bilateralinnovations.com.

Register Online Today

February 15-19

"I founded Bilateral Innovations with you in mind, striving to provide high-quality EMDR Consultation, Education, and Resources" - Mark Odland

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Mark Odland - MA, LMFT, MDIV

BILATERAL INNOVATIONS

TRAUMA RECOVERY/HAP UPDATE

***BY CAROL R. MARTIN** - EXECUTIVE DIRECTOR, TRAUMA RECOVERY/HAP*

TRAUMA RECOVERY is not a part of EMDRIA; this article is published as a service to EMDRIA members.

Trauma Recovery HAP Faculty Academy - Faithful yet Innovative.

Is it possible to be innovative and faithful to your founding principles at the same time? We think it is.

Trainings at our Faculty Academy have been the only trainings in the nation completely faithful to EMDR therapy as developed and approved by Francine Shapiro, Ph.D., the original developer of EMDR therapy. In fact, until this year, all trainer trainings were conducted by Dr. Shapiro personally. Yet to fulfill our mission to increase the capacity for effective treatment of psychological trauma in under-served communities, we need to be innovative in delivery of our training without sacrificing rigor.

All of Trauma Recovery HAP's trainers are experienced facilitators. Invited to be trainers after a 360-degree evaluation over several years, all trainers must complete exacting Level 1 and Level 2 trainings. Morning information sessions at each level are followed by afternoon practicums. Here, facilitators-in-training can observe highly experienced facilitators or receive live supervision while practicing EMDR methods.

Facilitators-in-training are assigned a mentor to guide their development as a practitioner. During multiple training events over the course of an intensive training schedule, skill development is individually evaluated. After meeting stringent standards for both Level 1 and Level 2 trainings, trainees must complete another twenty hours of consultations. Only then can a therapist become EMDR Accredited.

For the first time in more than twenty-years, the 2016 trainer trainings were not conducted personally by Francine Shapiro. This a milestone for us for two reasons: it demonstrates that we now have enough experience and talent to conduct the trainings as approved by Dr. Shapiro, and it also increases our ability to conduct multiple ongoing trainings.

Trauma Recovery HAP Centers of Excellence: An innovative approach to expanding capacity.

Of particular note is our latest initiative to create Centers of Excellence at key nonprofits around the country. Our first Center will be with the Women's Consortium in Hamden, CT. Ongoing collaboration with the Women's Consortium, and other nonprofits in the future, will guarantee continued EMDR professional training in places where the need is most acute.

A Center of Excellence is a community agency recognized and selected by Trauma Recovery HAP, to provide a regular and consistent Basic Training Program in EMDR therapy, as well as specialty trainings to fit local community needs. Much like the Trauma Recovery HAP mission itself, these agencies are dedicated to working with underserved populations, and demonstrate a passion for the advancement of EMDR therapy in their region.

The selected agencies will serve as a "beacon of training" for their region and will sponsor trainings, held throughout the year, at the agency site. Working in collaboration with the Trauma Recovery HAP office, an annual training schedule will be established. Importantly, specialty trainings can be implemented in coordination with the Trauma Recovery HAP office, that address the unique needs of the clients that the agency serves.

We anticipate that Centers of Excellence will have one or more EMDR therapy trained clinicians working within the agency who will promote new trainings in conjunction with the agency administrative staff. The Trauma Recovery HAP Clinical Director, Program and Community Development Director, and other key staff will play an active part in supporting the training events.

The Centers of Excellence, working closely with Trauma Recovery HAP, will provide comprehensive and ongoing training, designed to help clinicians work with underserved populations. This could include individuals with complex trauma, low-income clients, victims of community disasters, first responders and others who could benefit from timely EMDR therapy services, specifically the Recent Event Protocol where appropriate.

This program has been designed to make EMDR therapy available to community residents being served by agencies, to be timely in response to their needs and to reduce suffering, especially in treating clients with recent trauma.

As we look ahead at the work of 2017, we continue to be inspired by our volunteer faculty. Our trainers are passionate, driven for the success of EMDR therapy and the need for more EMDR trained clinicians.

In the last year, we've offered many trainings. We wish to congratulate this group of EMDRIA members for their successful completion of Level 1 and Level 2 training this year: Bernadette Talia of El Cajon, CA, Cheryl Kenn of New Haven, CT, Claire Mauer of Maitland, FL, Debra Silveria of Huntington Beach, CA, Judy Cabeceiras of Collinsville, CT, Leslie Brown of Highland, UT, Merrill Powers of Auburn, CA, Alexis Polles of Purvis, MS, Denise Gelinas of Northampton, MA, Ted Olejnik of Easthampton, MA, and Jullie Miller of Tucson, AZ.

Looking ahead, we are excited by the opportunities before us as we to continue to expand high-level, EMDR capacity through new and traditional means. ❖

NOET Corner

NOET, the Network of EMDR Trainers, continues to invite EMDR trainers, as well as trainers-in-training to join this group of independent EMDR teachers. The purpose of the organization is to share information and support each other as we strive to find better and more effective ways of training others in the psychotherapy and the procedures of EMDR. In this issue, we hear from Mary Froning (Maryfroning@compuserve.com) of the Child Trauma Institute (www.childtrauma.com) and her concerns regarding proper preparation for EMDR therapy.

Preparing Trainees to Prepare Clients for EMDR Therapy

"Recently I had the experience of working with a consultee who reported that a couple of her clients had been emotionally overwhelmed during processing, and each of these clients then become wary of continuing with EMDR therapy. Upon questioning, it turns out she was not using all I had taught her about helping clients manage their affect during trauma processing. Since the issue of emotional preparedness is one of the sometimes controversial aspects of EMDR therapy, I thought it might be helpful to review how our training model handles this in a way that we find works.

Based on years of experience, we at The Trauma Institute and Child Trauma Institute have found that trainees are not necessarily trauma-informed therapists when they come to us to learn EMDR therapy. We believe we need to help them incorporate a trauma view into their current work and provide them with confidence in decision-making about when and how to process trauma-related material. Thus, for the entire first week-end of the Basic course we focus on what needs to happen for clients to be ready, willing and able to do EMDR therapy. We focus on Phases 1 (History Taking) and 2 (Preparation) of the 8-phase model. This ensures that the trainees have a common foundation before we teach the desensitization and reprocessing phases of the treatment method. During that first week-end, we emphasize a personal training approach—that is, guiding the client in taking step-by-step actions leading to mastery. We want to encourage trainees to use EMDR therapy with most of their clients, partly by expanding the definition of trauma to include loss and repetitive small t traumas. We help trainees with strategies to help the client take responsibility for their own treatment (motivation), understand the derivation of their current issues (case formulation), and develop a shared stepwise plan on how therapy will proceed (treatment plan).

Our approach may differ from that of other training providers in a few ways. For instance, after a first session of general history taking (for me, including a genogram of their family of origin) and rapport building, we do a Trauma/Loss History (without a specific number of items) during the second session with a client. Having the therapist present and using a list approach enables the client to talk briefly about each memory without dropping into the emotion associated with the memories. We then get a SUDS for each item by quickly going through the list. We follow that with deep breathing and a list of best things from the client's history. I encourage trainees to teach their clients Safe Place and Container in that same session to ensure that their clients leave believing that emotional memories can safely be both brought out and put away. This builds in belief that they can face their pasts and remain stable. From there many clients will need to develop increased affect tolerance. We teach trainees to help those clients build fences for safety in their environment. In addition we teach many tried and true techniques to help strengthen the client one step at a time to be able to manage their emotions until they are ready to process their trauma memories. Later we incorporate the dual focus approach and other titrating as the processing proceeds.

We encourage our trainees to take a "just enough" risk taking approach to the work, so that clients remain motivated and safe, but also not unnecessarily deprived of the wonderful healing powers of EMDR therapy. We hope that keeping this balance would be the goal of all good EMDR therapists."

The next issue of NOET Corner explores another Preparation Phase concern, screening for dissociation. For questions about NOET or submissions to the NOET Corner, please contact: Andrew Seubert: seuberta@mac.com. ❖

EMDR RESEARCH FOUNDATION

BY WENDY J. FREITAG, PH.D. *- PRESIDENT, EMDR RESEARCH FOUNDATION*

The EMDR Research Foundation is not a part of EMDRIA; this article is published as a service to EMDRIA members.

Nurturing Research, Inspiring Hope

As 2016 comes to a close, so does a ***Decade of Making a Difference*** for the EMDR Research Foundation. First I want to say, on behalf of the Board, we are grateful to all of you who have supported EMDR therapy research over the last 10 years. Research helps us speak with confidence about what we do and why as well as informs and guides our clinical decisions. Research really does matter and perhaps now more than ever before. We need you and everyone else who cares about EMDR therapy!

Perhaps you are aware that the panel in charge of drafting the Clinical Guidelines for PTSD Treatment by the American Psychological Association has downgraded their recommendation of EMDR therapy to "weak" support. At the same time, the panel strongly recommends CBT, CPT, CT and EXP for adult patients with PTSD. Furthermore, the draft states, "Based on the new trials…there was insufficient evidence to determine whether the recommendations for eye movement desensitization and reprocessing therapy… would change." The unfortunate take-away is that high quality research trials are lacking to support EMDR's previous ranking of "strong" support. The stark reality is that these APA Clinical Guidelines for PTSD Treatment can have far reaching effects on every EMDR therapy clinician's practice. It is too late to provide comment to the APA panel, but it is NOT too late to support the mission of the EMDR Research Foundation and high quality research. As you consider your year-end charitable giving or your commitment to worthy causes in 2017, put your clinical practice first, ensuring the future of EMDR therapy by supporting research!!

We need your help--plain and simple! There is an extremely important sector of potential donors that the EMDR Research Foundation has been unable to tap—and that would be—clients who have benefited from EMDR therapy. For obvious reasons, there are ethical constraints on clinicians talking with their clients about supporting EMDR therapy research. However, there is a way you can help out. We have two beautifully crafted waiting room posters, in two sizes, available at: https://onedrive.live.com/?authkey=%21ACUt7kBsjkt2SD4&id=B101DF58257D569%213326&cid=0B101DF58257D569. At the EMDRIA Conference in August the posters received rave reviews by attendees. Another way to passively support EMDR therapy research is through the Amazon Smile program by choosing the EMDR Research Foundation as the charitable organization you support. This costs you nothing, excepting signing into your Amazon Smile account before placing your order. Please visit http://emdrresearchfoundation.org/get-involved/amazon-smile-program, where you can find out more information to set up your account. Please consider hanging one of the posters in your waiting room, signing up for Amazon Smile, as well as sharing these important public service announcements with your colleagues, study groups, EMDRIA regional network and/or at EMDRIA Credit workshop you sponsor or attend. Your efforts will help us continue to support EMDR therapy research like the following three studies.

We are pleased to announce the three new recipients of an award from the Foundation. A $25,000 Research Award was given to **Marleen Rijkeboer, Marcel van den Hout, Erick ten Broeke** of Utrecht University, Netherlands for their project, entitled, EMDR as an Innovative Strategy in the Treatment of OCD. The aim of this research is to critically examine the effect of EMDR added to Exposure and Response Prevention (ERP) on treatment acceptability and outcome in patients with OCD. The evidence of the effect of EMDR for OCD is scant, although on theoretical grounds and clinical impressions it is hypothesized that EMDR will effectively reduce the impact of fear imagery in OCD, thereby lowering distress. Hence, it is expected that patients will be more prepared to engage in, and less inclined to drop-out, leading to an increase of the overall OCD treatment effect.

A $5000 Dissertation Award was granted to **Yvette Eriksen** at Charles Sturt University, Australia for her dissertation, Ecological Evaluation, Acceptability and Effectiveness of the Standard Eye Movement Desensitisation and Reprocessing (EMDR) Protocol for Post-traumatic Symptoms with an Aboriginal Australian Community: A Collaborative Mixed Methods Enquiry. There is no research to date evaluating the cultural sensitivity, acceptability or effectiveness of EMDR with Indigenous Australian peoples. This research aims to provide valuable, culturally appropriate evaluation of EMDR to inform future trauma-focused interventions for Indigenous Australian peoples.

A $1000 consultation award has been given to **Amanda Roberts Ph.D., MA & Larry Shrier, MA** for their proposed research project, The EMDR Group Traumatic Event Protocol with an Oncology Population. The ultimate goal of this project is to show that the G-TEP protocol is highly effective and safe for use with cancer patients and significantly reduces post-traumatic symptoms, anxiety and depression.

The Foundation's Board of Directors is grateful we are able to offer funding to these deserving projects and look forward to their results. As a reminder for future funding, we have two yearly cycles with submission deadlines of February 1 and July 1. For the Research Grants, the award will be up to $25000 and the Dissertation Award is up to $5000. The Foundation also offers Consultation and Dissemination Travel Awards, which are available year round. Please see our website for more information about the grants and awards we offer.

In my last article I shared with you some of the challenges the EMDR Research Foundation faces. Today I wrote about the stark reality facing EMDR therapy, as a recommended treatment approach for PTSD. I want to close out the Decade of Making a Difference with a few brief quotes from our Visionary Alliance Charter members dating back to 2011.

"I see my monetary contribution here as a natural extension of the community of relationships I have with my colleagues in the EMDR world, my clients who benefit from what EMDR allows them to experience and restore in their own lives, and my own therapists who first shared their expertise in EMDR with me. The advances in EMDR are dependent on the courage and ambition of all of us to validate the known process and explore for new ones." - Storey C. Smith MA, MSW, New Mexico Veterans Administration Healthcare System

"I have witnessed the life-changing gift of EMDR in my client's lives over the past 13 years. I want to support EMDR research monetarily, so EMDR can continue to help people to heal all over the world." - Betsy Prince, L.C.S.W., EMDRIA Consultant, HAP Facilitator, Regional Coordinator from NJ

"I decided to commit to the monthly donation program to support EMDR Research for three main reasons: 1) I believe that EMDR provides extraordinary opportunities for healing and restored well-being, so much so that I rarely refer to a therapist who is not trained and experienced in EMDR; 2) I have become aware of how critical good research data is in getting the word out about this phenomenal therapeutic methodology in a way that is credible; and 3) It has literally changed my life and the lives of many of my clients in numerous ways." - Linda K Laffey, MFT; Certified EMDR Therapist, California

"*As a non-researcher, I consider it a privilege to be able to impact the future of EMDR by offering a recurring monetary contribution to the EMDR Research Foundation.*"- Irene Giessl, Ed.D, EMDRIA Approved Consultant, Ohio

"EMDR is the most effective therapy I have ever used; my hope is that the EMDR Community will join forces in supporting the research that is desperately needed. It is only through research that EMDR can be "proven" effective for all of the conditions it is effective with. I feel honored and a privileged to assist in the healing that clients experience with EMDR. Hopefully, one day, EMDR will be fully recognized as the remarkable therapy it is." - Roxann A. Hassett, LPC, NCC, EMDR-HAP Facilitator, South Carolina

These are reminders of why we do what we do. I hope they offer you some hope and inspiration as you consider your role in nurturing EMDR therapy research now and in the future. Lastly, I extend my warmest wishes to everyone for a very Peaceful, Safe and Prosperous 2017. ❖

In the Spotlight: Sombat Tapanya

BY MARILYN LUBER, PH.D.

Sombat Tapanya grew up in a loving home, where people appreciated learning. His father, Sriwang, was an elementary school teacher and lived in a small province in the North of Thailand. He was known in his community and probably met his mother, Sutin, as he rode around the area by bicycle. Sombat did not know because his family did not talk about that sort of thing. What he did learn was that the warmth and affection of his family upbringing would prove to be a resource throughout the rest of his life.

During his childhood, Sombat's family did not have electricity and running water. Instead they used a hand pump to draw water from underground. His family's home was a large wooden house on stilts with many open spaced areas for living. He noted that life was "peaceful, warm and secure" with many cousins and the families of aunts and uncles.

Sombat learned to appreciate learning by example as he observed his father reading and studying as he moved up in his career. While his cousins could have as many toys as they wanted, his choices were books. Although his parents were affectionate and caring, they wanted him to have a good education. He was sent to a famous Catholic school in Chiang Mai about 70 kms from their village in third grade and had to live in a dormitory. He was a shy, introspective young boy, the youngest and smallest in every class. During the course of his studies through high school, he was lonely, often bullied, and the recipient of harsh discipline from the priests. Despite the difficulties, he continues to connect with his old school friends through their alumnae group, and over 100 are still in touch. Also, he became sensitized to the troubles of children in difficult situations and this may have motivated him to be attracted to his current type of work.

When it came time to choose his major in college, psychology seemed a natural choice. He studied at Chiang Mai University as it was the only university in Thailand that offered a B.Sc. in psychology with a clinical track. At the time, psychologists were responsible only for psychological assessment of patients. He worked at Somdet Chaopraya Psychiatric Hospital in Bangkok until he received a scholarship to do his M.S. in Special Education at the Southern Connecticut State University from the World Federation for Mental Health. His horizons broadened there when he learned about another master's program in Counseling Education with a specialization in Gestalt Therapy. He returned from Thailand two years later, completing his second Masters in 1981.

When he returned to Thailand, he married and had two sons within three years. He was uncomfortable bringing them up in the crowded city of Bangkok, so he returned to Chiang Mai, in its University's Medical School, staying there until he retired in 2011.

From 1990-1996, he received a scholarship from the Canadian government called the "Canadian International Development Agency (CIDA)", and went to the University of New Brunswick to do his Ph.D. He focused on Health Psychology and did his dissertation on the adherence to medical regimens among Type 2 diabetic patients.

When Sombat returned to Thailand, although his main job was to teach psychology to medical students, his interest grew in the area of child abuse and domestic violence. It was a natural segue into working in the area of child protection and later the field of trauma. He remembered discovering the work of George Albee (Vermont University) in "Primary Prevention," during his undergraduate work and liked the idea of finding ways of preventing psychological problems and promoting mental health.

Sombat's wish was granted in the forms of Ute Sodermann and Peter Bumke, two German sociologists who had been working in Asia and South America for over 20 years, who came to visit him in Thailand because of his expertise in child abuse. They concluded that the Thai mental health community was capable of helping or rescuing abused women and children, but they needed to know what to do to help them to heal. During this time, the tsunami of 2004 struck Asia and everyone focused on the disaster. The Prime Minister refused to support the German plan so they moved the project to Indonesia instead. Sombat was introduced to EMDR therapy by Gary Quinn (Israel) as a group of Israeli EMDR practitioners came in response to the crisis. He learned more about EMDR when he went to Germany and became involved with the Mekong Project.

Sombat was in the U.S. for his Counseling Masters when he first heard of EMDR therapy and he remembers how it was ridiculed. At his first training, he found it difficult because the EMDR Standard Protocol was not natural to his language. Later, he and his colleagues had to find ways to refine it to reflect Thai thinking. They were concerned about modifying too much and now the EMDR Thailand Association will be in charge of standardizing their practice based on EMDR Asia standards. They are looking forward to formal EMDR training in Thailand 2017. At the moment, they are focused on stabilization and psychoeducation concerning trauma and have trained 30-40 clinicians. They are also reaching out to the younger generation.

In 2006, Ute and Peter created the Mekong Project in Indonesia, Cambodia and Myanmar. Their goals were to treat traumatized victims suffering from traumatic experiences and offer free trauma treatment and training to health care providers to teach them to work closely with patients by empathizing with their problem, identifying those who have been exposed to violence and other types of psychological distress. They are concluding the second phase now and will start the third phase of the project in mid-2017. Sombat's work through this project has been eye opening. He has been struck by the prevalence of traumatized people in these projects and how the experience of being treated badly and humiliated is correlated to the use of violence later in life and how it sets the stage for domestic violence and intergenerational transmission of violence.

Sombat is also passionate about preventing trauma from happening. In the spirit of Vincent Felitti's Adverse Childhood Experience Study who found that one of the common causes of trauma is interpersonal violence, he has been working over the past decade with Save the Children International and the Thai Ministry of Education to eliminate physical punishment in schools and families. They are using Joan Durrant's (University of Manitoba) work on "Positive Discipline." He has trained 1000s of teachers and parents throughout Thailand on this subject and has worked in Laos and the Solomon Islands as well. He has used some of the principles of Aikido, a martial art in which he is a master, to become allies with parents and teachers instead of pointing fingers at them. He noted that there is a worldwide movement (at least 50 countries) that has called for the eliminating of corporal punishment; it is strong and growing. Durrant studied 18,000 substantiated cases of child abuse in 2003. 77% were found to be the result of parents' attempting to correct the child's behavior and it escalated to abuse. He is hoping that by educating parents, they can prevent a great deal of trauma.

It follows that Sombat's research interest is in the area of violence prevention in children and adolescents. He has conducted research projects on positive discipline and bullying prevention through a grant from the Thai Health Promotion Foundations. Also, he is on a research team with Duke University on the effects of parenting behavior on children's adjustment across cultures and with Temple University on adolescents' decision-making. He is part of Joan Durrant's team at the University of Manitoba researching the effect of positive discipline on families trapped in the cycle of violence. Another research project is on youth resilience with Dalhousie University in Canada.

Sombat is a speaker who presents on topics ranging from stress management, communication and interpersonal relationship skills, assertive behavior, counseling skills, AIDS counseling, Gestalt Therapy, personal growth, conflict resolution and mediation, violence prevention, sexual abuse, harassment and assault prevention and traditional Thai massage. He has written over 11 articles in English and 10 in Thai on subjects ranging from community psychology, Thai massage, psychologists, psychology in Thailand, physical discipline and children's adjustment, progressive relaxation, burnout in AIDS workers and bullying prevention.

Another important part of Sombat's life is the practice of Aikido. This is a Japanese martial art that is non-violent and non-competitive. In many ways, it integrates what is close to his heart in that it promotes a spirit of loving protection and is conducive to physical and mental health. He has trained in Aikido for almost 40 years and is still training. He holds a fourth degree black belt. During his years at university, he founded the CMU Aikido Club and now, after his retirement, he has created an Aikido Training Center on part of his property called, "Renshinkan" (the place to cultivate the mind). Here is a way that Sombat brings together families –both children and adults- to involve them in various activities. The Center sponsors about 30 children. He recently established a charitable foundation called "Peace Culture Foundation" to engage in community projects and research to strengthen family and community and to cultivate peace in Thai society.

Message to the EMDR Therapy Community:

Although treatment of trauma-related problems is necessary and worthy of praise, I think we cannot just continue to treat people affected without trying to do something to prevent it from happening in the first place. We will have to help society to be more informed about trauma and how it affects all aspects of our lives, and support adults in their care of children so that we will not continue to transmit our trauma through generations.

Sombat has two sons and one granddaughter, aged 4. His current partner shares his interests and is a theater artist, actor and director who is finishing her Ph.D. in Peace Building at Payap Univeristy, Chiang Mai. He is a welcomed member of our community. ❖

Self Compassion as a Resource in Healing Traumatized Children

Self Compassion is the ability to be compassionate to oneself. There are three main components of self compassion; self-kindness, mindful awareness and common humanity.

As EMDR therapists we are trained to understand how the mind and body function together. The Adaptive Information Processing model identifies our bodies' ability to assimilate new experiences into already existing memory networks. Yet, we also learn that certain conditions and experiences disrupt the function of the AIP system. People with complex trauma histories often have impaired attachment and according to Porges Polyvagal Theory, an even greater difficulty accessing their care circuitry.

My experience in working with clients to process traumas is that the capacity to have self-compassion is a quality that activates the care circuitry, repairs attachment wounds and thus, greatly facilitates the engagement of the AIP system. Self Compassion promotes the dynamic balancing of the sympathetic and parasympathetic nervous system.

So how does this process translate into working with clients and for the purposes of this article, working with children in particular…. It is my experience that the positive core belief (Roy Keissling's model) is the window into Self Compassion. During the target setup we might ask kids to tell us what they think about themselves when they remember their problem or yucky experience. This is the core negative belief or NC. Their negative, and often times chronic self-criticism, stimulates their threat system, having a detrimental impact on a child's ability to feel positive emotions. We then ask the child to tell us what they would like to think about themselves instead. It is important to give them a menu of good beliefs to choose from as a first step in stimulating their self-compassionate self. A child might be able to identify a positive belief (or PC), but they might tell us that they can only believe this in their head, that they don't really feel it in their gut or that it is not really true. This correlates with a low VOC.

The next step is to introduce self compassion. In Buddhist Psychology there is the belief that we all have a self compassionate part. It is powerful to accept this premise and to tell kids that they actually already have this part inside themselves and that sometimes that part gets harder to feel and hear because the bad thoughts get big and loud. I tell them that we are going to rediscover that part. I let them know that Self compassion doesn't stop bad things from happening, but it can help soothe them if bad things happen. Here is a simple way to describe self compassion:

Once you have established a target set up, create three round circles of different colors, made of material that the child can step on. Place them on the floor and have the child step on the Problem Circle to target the Negative Core Belief.

- Self Kindness Circle - Positive Core Belief: Draw soothing/comforting/happy things you can say to yourself/do for yourself while you are having this problem/bad memory.
- Mindful Awareness Circle: Create a picture of you watching the bad thoughts/feelings just going by.
- Common Humanity Circle: It can even be a picture of the world– Tell or read a story of other people who had hard things happen.

Once you have established the foundation of self compassion in a child there are many ways to use it in the preparation treatment phase. I encourage all of you to use this in your work with children and to post comments and questions on the Child SIG listserv about the application of this practice.

There is an expanding body of literature and research in the field of Self Compassion if people are interested in reading more about this.

Contact: Nancy Simons, LMHC, Publications Chair, Child and Adolescent Special Interest Group at Nancysimons60@gmail.com. ❖

Child and Adolescent Special Interest Group Update

We would like to notify the at-large community of the all the good work taking place in the EMDR community of clinicians working with children and adolescents:

- We had over 45 participants attend the Child SIG meeting at the national EMDRIA Conference in Minneapolis, MN this past August, our biggest gathering to date.
- On October 14, 2016 the Child SIG hosted a three hour webinar with Ana Gomez. 150 participated in this fabulous training.
- In collaboration with EMDRIA we are working on developing the framework for a Child and Adolescent Specialty track at the EMDRIA Conference. We are encouraging all EMDR therapists to talk with us about submitting a proposal for this purpose. We also encourage any members who would like to learn how to put together a training to be in touch with us as well.
- There are new additions to the Bibliography so please take a look online.
- Gael Thompson, our Executive Chair, and Karen Sullivan, our Membership Chair, have co-authored a chapter on EMDR with Children in Directive Play Therapy, edited by Leggett and Bowell and published by Springer, congratulations Gael and Karen and thanks for this fabulous contribution. ❖

RECENT ARTICLES ON EMDR

BY ANDREW LEEDS, PH.D.

This regular column appears in each quarterly issue of the EMDRIA Newsletter and the EMDR Europe Newsletter. It lists citations, abstracts, and preprint/reprint information—when available—on all EMDR therapy related journal articles. The listings include peer reviewed research reports and case studies directly related to EMDR therapy—whether favorable or not—including original studies, review articles and meta-analyses accepted for publication or that have appeared in the previous six months in scholarly journals. Authors and others aware of articles accepted for publication are invited to submit pre-press or reprint information. Listings in this column will exclude: published comments and most letters to the editor, non-peer reviewed articles, non-English articles unless the abstract is in English, dissertations, and conference presentations, as well as books, book chapters, tapes, CDs, and videos. Please send submissions and corrections to: aleeds@theLeeds.net.

Note: a comprehensive database of all EMDR therapy references from journal articles, dissertations, book chapters, and conference presentations is available in The Francine Shapiro Library hosted by the EMDR International Association at: http://emdria.omeka.net/.

Previous columns from 2005 to the present are available on the EMDRIA web site at: http://www.emdria.org/?page=43.

Amano, T., & Toichi, M. (2016). Possible neural mechanisms of psychotherapy for trauma-related symptoms: Cerebral responses to the neuropsychological treatment of post-traumatic stress disorder model individuals. *Scientific Reports*, 6, 34610. doi:10.1038/srep34610

Full text: http://www.nature.com/articles/srep34610.

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ABSTRACT

Psychotherapy is often effective for treating psychogenic disorders, but the changes that occur in the brain during such treatments remain unknown. To investigate this, we monitored cerebral activity throughout an entire session using a psychotherapeutic technique in healthy subjects. Since post-traumatic stress disorder (PTSD) is a typical psychogenic psychiatric disorder, we used PTSD-model volunteers who had experienced a moderately traumatic event. The technique used as psychotherapy was eye movement desensitisation and reprocessing (EMDR), a standard method for treating PTSD. The oxygenated haemoglobin concentration ([oxy-Hb]), a sensitive index of brain activation, measured using multi-channel near-infrared spectroscopy, revealed changes in [oxy-Hb] in the superior temporal sulcus (STS) and orbitofrontal cortex (OFC). During a vital therapeutic stage, a significant reduction in the activation by forced eye movements was observed in the right STS, and a trend toward a reduction in the left OFC. The hyperactivation of the right STS on the recall of unpleasant memories, and its normalisation by eye movements, seem to reflect an important neural mechanism of the psychotherapy. These findings suggest that psychotherapy for traumatic symptoms involves brain regions related to memory representation and emotion, and possibly those that link memory and emotion, such as the amygdala.

Amano, T., & Toichi, M. (2016). The role of alternating bilateral stimulation in establishing positive cognition in EMDR therapy: A multi-channel near-infrared spectroscopy study. *PLoS ONE*, 11(10), e0162735. doi:10.1371/journal.pone.0162735

Full text: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0162735.

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ABSTRACT

Eye movement desensitisation and reprocessing (EMDR) is a standard method for treating post-traumatic stress disorder. EMDR treatment consists of desensitisation and resource development and installation (RDI) stages. Both protocols provide a positive alternating bilateral stimulation (BLS). The effect of desensitisation with BLS has been elucidated. However, a role for BLS in RDI remains unknown. Therefore, it is important to measure feelings as subjective data and physiological indicators as objective data to clarify the role of BLS in RDI. RDI was administered to 15 healthy volunteer subjects who experienced pleasant memories. Their oxygenated haemoglobin concentration ([oxy-Hb]), a sensitive index of brain activity, was measured from the prefrontal cortex (PFC) to the temporal cortex using multi-channel near-infrared spectroscopy during recall of a pleasant memory with or without BLS. The BLS used was alternating bilateral tactile stimulation with a vibration machine. The psychological evaluation suggested that RDI was successful. The results showed that, compared with non-BLS conditions, accessibility was increased and subjects were more relaxed under BLS conditions. A significant increase in [oxy-Hb] was detected in the right superior temporal sulcus (STS), and a decrease in the wide bilateral areas of the PFC was observed in response to BLS. The significant BLS-induced activation observed in the right STS, which is closely related to memory representation, suggests that BLS may help the recall of more representative pleasant memories. Furthermore, the significant reduction in the PFC, which is related to emotion regulation,

suggests that BLS induces relaxation and comfortable feelings. These results indicate an important neural mechanism of RDI that emotional processing occurred rather than higher cognitive processing during this stage. Considering the neuroscientific evidence to date, BLS in RDI may enhance comfortable feelings about pleasant memories. Based on the current findings, the use of BLS in RDI may be warranted in some clinical situations.

Bhagwagar, H. (2016). EMDR in the treatment of panic disorder with agoraphobia: A case description. *Journal of EMDR Practice and Research*, 10(4). doi:10.1891/1933-3196.10.4.256.

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ABSTRACT

The results of preliminary research investigating the application of eye movement desensitization and reprocessing (EMDR) treatment in panic disorder and panic disorder with agoraphobia suggests that reprocessing of past traumas produces significant reduction of anxiety and consequently, remission from panic attacks and avoidance behavior. This article describes the case study of a 30-year-old working professional where EMDR treatment, used to target early childhood traumas, led to reduction in symptoms of panic disorder with agoraphobia. Panic attacks diminished after 17 sessions of EMDR treatment, which followed Leeds's treatment model. Treatment gains were maintained 5 years after termination. The study shows the value of solid preparation work, and of addressing the current triggers and recent events, before targeting historical traumas. EMDR worked as a first-line treatment to resolving the roots of the panic at-tacks, suggesting that the resolution of traumatic childhood memories can make a significant difference to current symptoms of panic disorder with agoraphobia.

Chiorino, V., Roveraro, S., Caterina Cattaneo, M., Salerno, R., Macchi, E. A., Bertolucci, G. G., . . . Fernandez, I. (2016). A model of clinical intervention in the maternity ward: The breastfeeding and bonding EMDR protocol. *Journal of EMDR Practice and Research*, 10(4). doi:10.1891/1933-3196.10.4.275.

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ABSTRACT

Breastfeeding is one of the main manifestations of the bond that a mother builds with her newborn baby. Literature on psychological support for mothers in the early stages of breastfeeding is limited and interventions often do not pinpoint the actual roots of the difficulties. Breastfeeding difficulties may cause emotional distress to women and this can impact significantly on bonding and the perinatal period may turn into a state of crisis. Therefore, it is essential for the clinical psychologist to intervene selectively and in a prompt, effective way, especially when working in a maternity ward. This article suggests a model of intervention: the Breastfeeding and Bonding EMDR Protocol. This protocol, created ad hoc for breastfeeding, combines the work with eye movement desensitization and reprocessing (EMDR) on recent events, the standard protocol and the installation of resources. The hospital case study presented here thoroughly illustrates the various stages of the protocol and the peculiarity and functionality of EMDR regarding breastfeeding and bonding issues in the immediate postpartum period. Prevention is the paramount subject of the model of clinical intervention on breastfeeding hereafter presented.

Courtney, D. M. (2016). EMDR to treat children and adolescents: Clinicians' experiences using the EMDR journey game. *Journal of EMDR Practice and Research*, 10(4). doi:10.1891/1933-3196.10.4.245.

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ABSTRACT

Childhood trauma is a pervasive social issue with profound consequences. Eye movement desensitization and reprocessing (EMDR) therapy is an effective treatment for children. Challenges can arise when using EMDR with children, such as difficulty engaging children and developmental fit of the protocol. Child experts have developed creative tools to address these challenges. The EMDR Journey Game is one such tool that integrates creative modalities with EMDR. This study explored the relationship between use of the game and clinician's perceived client engagement and clinician confidence. This study employed an observational, cross-sectional design, surveying (online) 69 EMDR-trained clinicians, half of whom had used the game and half of whom had not. Results show clinicians were motivated to use the EMDR Journey Game to engage children in EMDR and to increase their confidence. Findings also suggest the game was perceived to enhance children's engagement with EMDR; clinicians' experience (years and frequency of use) with EMDR impacts their confidence using EMDR with adolescents and adults, but not with children. Results support the efforts of child experts to develop appropriate, creative tools to adapt EMDR for children. Further exploration of clinician confidence using EMDR with children is necessary.

Dorsey, S., McLaughlin, K. A., Kerns, S. E. U., Harrison, J. P., Lambert, H. K., Briggs, E. C., . . . Amaya-Jackson, L. (2016). Evidence base update for psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology*, 1-28. doi:10.1080/15374416.2016.1220309.

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ABSTRACT

Child and adolescent trauma exposure is prevalent, with trauma exposure-related symptoms, including posttraumatic stress, depressive, and anxiety symptoms often causing substantial impairment. This article updates the evidence base on psychosocial treatments for child and adolescent trauma exposure completed for this journal by Silverman et al. (2008). For this review, we focus on 37 studies conducted during the seven years since the last review. Treatments are grouped by overall treatment family (e.g., cognitive behavioral therapy), treatment modality (e.g., individual vs. group), and treatment participants (e.g., child only vs. child and parent). All studies were evaluated for methodological rigor according to Journal of Clinical Child & Adolescent Psychology evidence-based treatment evaluation criteria (Southam-Gerow & Prinstein, 2014), with cumulative designations for level of support for each treatment family. Individual CBT with parent involvement, individual CBT, and group CBT were deemed well-established; group CBT with parent involvement and eye movement desensitization and reprocessing (EMDR) were deemed probably efficacious; individual integrated therapy for complex trauma and group mind-body skills were deemed possibly efficacious; individual client-centered play therapy, individual mind-body skills, and individual psychoanalysis were deemed experimental; and group creative expressive + CBT was deemed questionable efficacy. Advances in the evidence base, with comparisons to the state of the science at the time of the Silverman et al. (2008) review, are discussed. Finally, we present dissemination and implementation challenges and areas for future research.

Gillies, D., Maiocchi, L., Bhandari, A. P., Taylor, F., Gray, C., & O'Brien, L. (2016). Psychological therapies for children and adolescents exposed to trauma. Cochrane Database of Systematic Reviews (Online), 10, CD012371. doi:10.1002/14651858.CD012371

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ABSTRACT

Background: Children and adolescents who have experienced trauma are at high risk of developing post-traumatic stress disorder (PTSD) and other negative emotional, behavioural and mental health costs. A wide range of psychological treatments

are used to prevent negative outcomes associated with trauma in children and adolescents.

Objectives: To assess the effects of psychological therapies in preventing PTSD and associated negative emotional, behavioural and mental health outcomes in children and adolescents who have undergone a traumatic event.

Search Methods: We searched the Cochrane Common Mental Disorders Group's Specialised Register to 29 May 2015. This register contains reports of relevant randomised controlled trials from The Cochrane Library (all years), EMBASE (1974 to date), MEDLINE (1950 to date) and PsycINFO (1967 to date). We also checked reference lists of relevant studies and reviews. We did not restrict the searches by date, language or publication status.

Selection Criteria: All randomised controlled trials of psychological therapies compared with a control such as treatment as usual, waiting list or no treatment, pharmacological therapy or other treatments in children or adolescents who had undergone a traumatic event.

Data Collection and Analysis: Two members of the review group independently extracted data. We calculated odds ratios for binary outcomes and standardised mean differences for continuous outcomes using a random-effects model. We analysed data as short-term (up to and including one month after therapy), medium-term (one month to one year after therapy) and long-term (one year or longer).

Main Results: Investigators included 6201 participants in the 51 included trials. Twenty studies included only children, two included only preschool children and ten only adolescents; all others included both children and adolescents. Participants were exposed to sexual abuse in 12 trials, to war or community violence in ten, to physical trauma and natural disaster in six each and to interpersonal violence in three; participants had suffered a life-threatening illness and had been physically abused or maltreated in one trial each. Participants in remaining trials were exposed to a range of traumas. Most trials compared a psychological therapy with a control such as treatment as usual, wait list or no treatment. Seventeen trials used cognitive-behavioural therapy (CBT); four used family therapy; three required debriefing; two trials each used eye movement desensitisation and reprocessing (EMDR), narrative therapy, psychoeducation and supportive therapy; and one trial each provided exposure and CBT plus narrative therapy. Eight trials compared CBT with supportive therapy, two compared CBT with EMDR and one trial each compared CBT with psychodynamic therapy, exposure plus supportive therapy with supportive therapy alone and narrative therapy plus CBT versus CBT alone. Four trials compared individual delivery of psychological therapy to a group model of the same therapy, and one compared CBT for children versus CBT for both mothers and children. The likelihood of being diagnosed with PTSD in children and adolescents who received a psychological therapy was significantly reduced compared to those who received no treatment, treatment as usual or were on a waiting list for up to a month following treatment (odds ratio (OR) 0.51, 95% confidence interval (CI) 0.34 to 0.77; number needed to treat for an additional beneficial outcome (NNTB) 6.25, 95% CI 3.70 to 16.67; five studies; 874 participants). However the overall quality of evidence for the diagnosis of PTSD was rated as very low. PTSD symptoms were also significantly reduced for a month after therapy (standardised mean difference (SMD) -0.42, 95% CI -0.61 to -0.24; 15 studies; 2051 participants) and the quality of evidence was rated as low. These effects of psychological therapies were not apparent over the longer term. CBT was found to be no more or less effective than EMDR and supportive therapy in reducing diagnosis

of PTSD in the short term (OR 0.74, 95% CI 0.29 to 1.91; 2 studies; 160 participants), however this was considered very low quality evidence. For reduction of PTSD symptoms in the short term, there was a small effect favouring CBT over EMDR, play therapy and supportive therapies (SMD -0.24, 95% CI -0.42 to -0.05; 7 studies; 466 participants). The quality of evidence for this outcome was rated as moderate. We did not identify any studies that compared pharmacological therapies with psychological therapies.

Author's Conclusions: The meta-analyses in this review provide some evidence for the effectiveness of psychological therapies in prevention of PTSD and reduction of symptoms in children and adolescents exposed to trauma for up to a month. However, our confidence in these findings is limited by the quality of the included studies and by substantial heterogeneity between studies. Much more evidence is needed to demonstrate the relative effectiveness of different psychological therapies for children exposed to trauma, particularly over the longer term. High-quality studies should be conducted to compare these therapies.

Hegarty, K., Tarzia, L., Hooker, L., & Taft, A. (2016). Interventions to support recovery after domestic and sexual violence in primary care. *International Review of Psychiatry* (Abingdon, England), 28(5), 519-532. doi:10.1080/09540261.2016.1210103.

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ABSTRACT

Experiences of domestic and sexual violence are common in patients attending primary care. Most often they are not identified due to barriers to asking by health practitioners and disclosure by patients. Women are more likely than men to experience such violence and present with mental and physical health symptoms to health practitioners. If identified through screening or case finding as experiencing violence they need to be supported to recover from these traumas. This paper draws on systematic reviews published in 2013-2015 and a further literature search undertaken to identify recent intervention studies relevant to recovery from domestic and sexual violence in primary care. There is limited evidence as to what interventions in primary care assist with recovery from domestic violence; however, they can be categorized into the following areas: first line response and referral, psychological treatments, safety planning and advocacy, including through home visitation and peer support programmes, and parenting and mother-child interventions. Sexual violence interventions usually include trauma informed care and models to support recovery. The most promising results have been from nurse home visiting advocacy programmes, mother-child psychotherapeutic interventions, and specific psychological treatments (Cognitive Behaviour Therapy, Trauma informed Cognitive Behaviour Therapy and, for sexual assault, Exposure and Eye Movement Desensitization and Reprocessing Interventions). Holistic healing models have not been formally tested by randomized controlled trials, but show some promise. Further research into what supports women and their children on their trajectory of recovery from domestic and sexual violence is urgently needed.

Hernandez, D. F., Waits, W., Calvio, L., & Byrne, M. (2016). Practice comparisons between accelerated resolution therapy, eye movement desensitization and reprocessing and cognitive processing therapy with case examples. *Nurse Education Today*, 47, 74-80. doi:10.1016/j.nedt.2016.05.010.

ABSTRACT

Recent outcomes for Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) therapy indicate that as many as 60-72% of patients retain their PTSD diagnosis after treatment with CPT or PE. One emerging therapy with the potential to augment existing trauma focused therapies is Accelerated Resolution Therapy (ART). ART is currently being used along with evidence based approaches at Fort Belvoir Community Hospital and by report has been both positive for clients as well as less taxing on professionals trained in ART. The following is an in-practice theoretical comparison of CPT, EMDR and ART with case examples from Fort Belvoir Community Hospital. While all three approaches share common elements and interventions, ART distinguishes itself through emphasis on the rescripting of traumatic events and the brevity of the intervention. While these case reports are not part of a formal study, they suggest that ART has the potential to augment and enhance the current delivery methods of mental health care in military environments.

Onderdonk, S. W., & van den Hout, M. A. (2016). Comparisons of eye movements and matched changing visual input. *Journal of Behavior Therapy and Experimental Psychiatry*, 53, 34-40. doi:10.1016/j.jbtep.2015.10.010.

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ABSTRACT

Background and Objectives: During EMDR trauma therapy, performing EM taxes WM, and simultaneously recalled memories become less vivid. It has been proposed that this WM occupation results from CVI which occurs during EM. This study sought to compare the effects of EM on memory to a task presenting identical visual stimulus to stationary eyes..

Methods: In Study 1, participants recorded RT while performing two tasks: EM, and a task with visually identical images displayed on screen. In Study 2, these same tasks were performed while simultaneously recalling negative emotional memories.

Results: Study 1 found RT was slowest in the EM condition, while RT in the CVI condition was still slower than in the control condition. Study 2 found decreases in memory vividness and emotionality after EM, while after CVI there was a small decrease

in negativity which was not greater than in the control..

Limitations: Neither study included EM with no visual input; conclusions cannot be made about the effect of motor movement on WM taxation or recall. As neither study was conducted with trauma patients, it is unknown if the observed effects would be comparable in the population for which EMDR is intended.

Conclusions: Performing EM taxes more WM resources and has greater impact on both memory vividness and emotionality than matched CVI. This demonstrates that the effects observed in EMDR treatment are the result of more than occupying WM systems with visual stimuli alone.

Rimini, D., Molinari, F., Liboni, W., Balbo, M., Darò, R., Viotti, E., & Fernandez, I. (2016). Effect of ocular movements during eye movement desensitization and reprocessing (EMDR) therapy: A near-infrared spectroscopy study. *PLoS ONE*, 11(10), e0164379. doi:10.1371/journal.pone.0164379.

Full text: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0164379.

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ABSTRACT

Introduction: Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapeutic treatment resolving emotional distress caused by traumatic events. With EMDR, information processing is facilitated by eye movements (EM) during the recall of a traumatic memory (RECALL). The aim of this study is to investigate the effects of ocular movements of EMDR on the hemodynamics of the prefrontal cortex (PFC).

Material and Methods: Two groups were recruited: a trial group (wEM) received a complete EMDR treatment, whereas a control group (woEM) received a therapy without EM. PFC hemodynamics was monitored by near-infrared spectroscopy during RECALL and during focusing on the worst image of the trauma (pre-RECALL). The parameters of oxy- (oxy-Hb), and deoxy-hemoglobin (deoxy-Hb) were acquired and analyzed in time domain, by calculating the slope within pre-RECALL and RECALL periods, and in the frequency domain, by calculating the mean power of oxy-Hb and deoxy-Hb in the very-low frequency (VLF, 20-40 mHz) and low frequency (LF, 40-140 mHz) bandwidths. We compared pre-RECALL with RECALL periods within subjects, and pre-RECALL and RECALL parameters of wEM with the corresponding of woEM.

Results: An effect of group on mean slope of oxy-Hb and deoxy-Hb in pre-RECALL and oxy-Hb in RECALL periods was observed. wEM showed a lower percentage of positive angular coefficients during pre-RECALL with respect to RECALL, on the opposite of woEM. In the frequency domain, wEM had significant difference in oxy-Hb and deoxy-Hb LF of left hemisphere, whereas woEM showed no difference.

Discussion and Conclusion: We observed the effect of EM on PFC oxygenation during EMDR, since wEM subjects showed a mean increase of oxy-Hb during RECALL and a decrease during pre-RECALL, as opposed to woEM. Frequency analysis evidenced a reduction of activity of sympathetic nervous system in wEM group during pre-RECALL. Our outcomes revealed a different hemodynamics induced by eye movements in wEM with respect to woEM group.

Sack, M., Zehl, S., Otti, A., Lahmann, C., Henningsen, P., Kruse, J., & Stingl, M. (2016). A comparison of dual attention, eye movements, and exposure only during eye movement desensitization and reprocessing for posttraumatic stress disorder: Results from a randomized clinical trial. *Psychotherapy and Psychosomatics*, 85(6), 357-365. doi:10.1159/000447671.

Prof. Dr. med. Martin Sack. Department of Psychosomatic Medicine and Psychotherapy, University Hospital Rechts der Isar, Technische Universität München, Munich, Germany. E-Mail m.sack@tum.de.

ABSTRACT

Background: Currently, there is controversy on the possible benefits of dual-attention tasks during eye movement desensitization and reprocessing (EMDR) for patients with posttraumatic stress disorder (PTSD).

Methods: A total of 139 consecutive patients (including 85 females) suffering from PTSD were allocated randomly among 3 different treatment conditions: exposure with eyes moving while fixating on the therapist's moving hand (EM), exposure with eyes fixating on the therapist's nonmoving hand (EF), and exposure without explicit visual focus of attention as control condition (EC). Except for the variation in stimulation, treatment strictly followed the standard EMDR manual. Symptom changes from pre- to posttreatment were measured with the Clinician-Administered PTSD Scale (CAPS) by an investigator blinded to treatment allocation.

Results: In total, 116 patients completed the treatment, with an average of 4.6 sessions applied. Intention-to-treat analysis revealed a significant improvement in PTSD symptoms with a high overall effect size (Cohen's d = 1.96, 95% CI: 1.67-2.24) and a high remission rate of PTSD diagnosis (79.8%). In comparison to the control condition, EM and EF were associated with significantly larger pre-post symptom decrease (ΔCAPS: EM = 35.8, EF = 40.5, EC = 31.0) and significantly larger effect sizes (EM: d = 2.06, 95% CI: 1.55-2.57, EF: d = 2.58, 95% CI: 2.01-3.11, EC: d = 1.44, 95% CI: 0.97-1.91). No significant differences in symptom decrease and effect size were found between EM and EF.

Conclusions: Exposure in combination with an explicit external focus of attention leads to larger PTSD symptom reduction than exposure alone. Eye movements have no advantage compared to visually fixating on a nonmoving hand.

Staring, A. B. P., van den Berg, D. P. G., Cath, D. C., Schoorl, M., Engelhard, I. M., & Korrelboom, C. W. (2016). Self-esteem treatment in anxiety: A randomized controlled crossover trial of eye movement desensitization and reprocessing (EMDR) versus competitive memory training (COMET) in patients with anxiety disorders. *Behaviour Research and Therapy*, 82, 11-20. doi:10.1016/j.brat.2016.04.002.

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ABSTRACT

Background and Purpose: Little is known about treating low self-esteem in anxiety disorders. This study evaluated two treatments targeting different mechanisms: (1) Eye Movement Desensitization and Reprocessing (EMDR), which aims to desensitize negative memory representations that are proposed to maintain low self-esteem; and (2) Competitive Memory Training (COMET), which aims to activate positive representations for enhancing self-esteem.

Methods: A Randomized Controlled Trial (RCT) was used with a crossover design. Group 1 received six sessions EMDR first and then six sessions COMET; group 2 vice versa. Assessments were made at baseline (T0), end of first treatment (T1), and end of second treatment (T2). Main outcome was self-esteem. We included 47 patients and performed Linear Mixed Models.

Results: COMET showed more improvements in self-esteem than EMDR: effect-sizes 1.25 versus 0.46 post-treatment. Unexpectedly, when EMDR was given first, subsequent effects of COMET were significantly reduced in comparison to COMET as the first intervention. For EMDR, sequence made no difference. Reductions in anxiety and depression were mediated by better self-esteem.

Conclusions: COMET was associated with significantly greater improvements in self-esteem than EMDR in patients with anxiety disorders. EMDR treatment reduced the effectiveness of subsequent COMET. Improved self-esteem mediated reductions in anxiety and depression symptoms.

Steinert, C., Bumke, P. J., Hollekamp, R. L., Larisch, A., Leichsenring, F., Mattheß, H., . . . Kruse, J. (2016). Resource activation for treating post-traumatic stress disorder, co-morbid symptoms and impaired functioning: A randomized controlled trial in Cambodia. *Psychological Medicine*, 1-12. doi:10.1017/S0033291716002592.

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ABSTRACT

Background: Mental health morbidity in post-conflict settings is high. Nevertheless, randomized controlled trials of psychotherapy on site are rare. Our aim was to integrate rigorous research procedures into a humanitarian programme and test the efficacy of resource activation (ROTATE) in treating post-traumatic stress disorder (PTSD), co-morbid symptoms and impaired functioning in Cambodia.

Method: A total of 86 out-patients with PTSD were randomly assigned to five sessions of ROTATE (n = 53) or a 5-week waiting-list control (WLC) condition (n = 33). Treatment was provided by six Cambodian psychologists who had received extensive training in ROTATE. Masked assessments were made before and after therapy.

Results: PTSD remission rates according to the DSM-IV algorithm of the Harvard Trauma Questionnaire were 95.9% in ROTATE and 24.1% in the WLC condition. Thus, patients receiving ROTATE had a significantly higher likelihood of PTSD remission (odds ratio 0.012, 95% confidence interval 0.002-0.071, $p < 0.00001$). Additionally, levels of anxiety, depression and impaired functioning were significantly reduced compared with the WLC condition ($p < 0.00001$, between-group effect sizes d = 2.41, 2.26 and 2.54, respectively). No harms were reported.

Conclusions: ROTATE was efficacious in treating Cambodian patients with high symptom levels of PTSD, emotional distress and impaired functioning. ROTATE is a brief, culturally adaptable intervention focusing on stabilization and strengthening resources rather than trauma confrontation. It can be taught to local professionals and paraprofessionals and enhance access to mental health care for patients in need.

Tarquinio, C., Rotonda, C., Houllé, W. A., Montel, S., Rydberg, J. A., Minary, L., . . . Alla, F. (2016). Early psychological preventive intervention for workplace violence: A randomized controlled explorative and comparative study between EMDR-recent event and critical incident stress debriefing. *Issues in Mental Health Nursing*, 1-13. doi:10.1080/01612840.2016.1224282.

ABSTRACT

This randomized controlled trial study aims to investigate the efficacy of an early psychological intervention called EMDR-RE compared to Critical Incident Stress Debriefing on 60 victims of workplace violence, which were divided into three groups: 'EMDR-RE' (n = 19), 'CISD' (n = 23), and 'delayed EMDR-RE' (n = 18). EMDR-RE and CISD took place 48 hours after the event, whilst third intervention was delayed by an additional 48 hours. Results showed that after 3 months PCLS and SUDS scores were significantly lower with EMDR-RE and delayed EMDR-RE compared to CISD. After 48 hours and 3 months, none of the EMDR-RE-treated victims showed PTSD symptoms.

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van den Berg, D. P., van der Vleugel, B. M., de Bont, P. A., Thijssen, G., de Roos, C., de Kleine, R., . . . van der Gaag, M. (2016). Exposing therapists to trauma-focused treatment in psychosis: Effects on credibility, expected burden, and harm expectancies. *European Journal of Psychotraumatology*, 7, 31712.

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ABSTRACT

Background: Despite robust empirical support for the efficacy of trauma-focused treatments, the dissemination proves difficult, especially in relation to patients with comorbid psychosis. Many therapists endorse negative beliefs about the credibility, burden, and harm of such treatment.

Objective: This feasibility study explores the impact of specialized training on therapists' beliefs about trauma-focused treatment within a randomized controlled trial.

Method: Therapist-rated (n=16) credibility, expected burden, and harm expectancies of trauma-focused treatment were assessed at baseline, post-theoretical training, post-technical training, post-supervised practical training, and at 2-year follow-up. Credibility and burden beliefs of therapists concerning the treatment of every specific patient in the trial were also assessed.

Results: Over time, therapist-rated credibility of trauma-focused treatment showed a significant increase, whereas therapists' expected burden and harm expectancies decreased significantly. In treating posttraumatic stress disorder (PTSD) in patients with psychotic disorders (n=79), pre-treatment symptom severity was not associated with therapist-rated credibility or expected burden of that specific treatment. Treatment outcome had no influence on patient-specific credibility or burden expectancies of therapists.

Conclusions: These findings support the notion that specialized training, including practical training with supervision, has long-term positive effects on therapists' credibility, burden, and harm beliefs concerning trauma-focused treatment.

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van Minnen, A., van der Vleugel, B., van den Berg, D., de Bont, P., de Roos, C., van der Gaag, M., & de Jongh, A. (2016). Effectiveness of trauma-focused treatment for patients with psychosis with and without the dissociative subtype of post-traumatic stress disorder. The British Journal of Psychiatry : *The Journal of Mental Science*. doi:10.1192/bjp.bp.116.185579.

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ABSTRACT

This study presents secondary analyses of a recently published trial in which post-traumatic stress disorder (PTSD) patients with psychosis (n = 108) underwent 8 sessions of trauma-focused treatment, either prolonged exposure (PE) or eye movement desensitisation and reprocessing (EMDR) therapy. 24.1% fulfilled the criteria for the dissociative subtype, a newly introduced PTSD subtype in DSM-5. Treatment outcome was compared for patients with and without the dissociative subtype of PTSD. Patients with the dissociative subtype of PTSD showed large reductions in clinician-administered PTSD scale (CAPS) score, comparable with patients without the dissociative subtype of PTSD. It is concluded that even in a population with severe mental illness, patients with the dissociative subtype of PTSD do benefit from trauma-focused treatments without a pre-phase of emotion regulation skill training and should not be excluded from these treatments.

Wise, A., & Marich, J. (2016). The perceived effects of standard and addiction-specific EMDR therapy protocols. *Journal of EMDR Practice and Research*, 10(4), 231-244. doi:10.1891/1933-3196.10.4.231.

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ABSTRACT

Existing literature on co-occurring posttraumatic stress disorder (PTSD) and addictive disorders suggests improved outcomes when both diagnoses are treated concurrently. Eye movement desensitization and reprocessing (EMDR) using the 8-phase protocol and standard 11-step targeting sequence has been investigated within integrated treatment models. However, use of newer EMDR addiction-specific protocols (e.g., desensitization of triggers and urge reprocessing [DeTUR], feeling-state addiction protocol [FSAP], craving extinguished [CravEx]) in treatment has been studied less extensively. A qualitative, phenomeno-logical design was employed to investigate the lived experience of 9 participants with co-occurring PTSD and addictive disorders. These participants experienced both standard protocols/targeting sequences and the addiction-specific protocols as part of their treatment. Creswell's system for interpreting meaning units in qualitative data, based largely on the work of Moustakas, was used to analyze the data gleaned from semistandardized interviews. All participants reported positive outcomes from the combined EMDR approaches; 4 major themes emerged. Participants recognized their trauma and addictions as related. As a result of this insight, their thoughts and addictive behaviors changed. All recognized remission of symptoms of both disorders; EMDR therapy was reported to be effective whether the traumatic symptoms were treated before or after the addictive symptoms. All indicated that integrated treatments (including other supportive services) were optimum for their ongoing recovery. The relationship with the therapist was integral to the overall success of treatment. ❖

ALGERIA

Mohamed Chakali reports: "In Algeria, the Algerie EMDR Association was created in January 2016. In November, we did an EMDR Basic Training with Karsten Bohm, a German colleague. In March, we will have the 5th Part 1 training which will be provided by Martine Ircane from France and will be the first organized by Algerie EMDR. We currently have nearly a hundred EMDR practitioners trained or undergoing training."

BRAZIL

Esly Carvalho reports: "I have a new book coming out in English: a casebook called *"Deal with your Past,"* and available on Amazon. In January 2017, I will be teaching *"Creative EMDR Protocols"* in Minneapolis.

FRANCE

Delphine Pécoul reports: "The National Cancer Control League has agreed to fund the first randomized controlled trial in France to evaluate the efficacy of EMDR (Eye Movement Desensitization Reprocessing) in the reduction of anxiety-depressive disorders in patients with breast cancer. Professor Tarquinio is the principal investigator and this project is being carried out in collaboration with the Research Center of the Pierre Janet Center, which is a partner of our French Institute of EMDR."

MADAGASCAR

Anne Dewailly reports: "In 2015, HAP France organized a training in psychotraumatology for 35 participants and then a Part 1 training for 22 doctors who had degrees in mental health and two psychiatrists. In 2016, they received 10 hours of supervision. In November 2016, trainer Martine Iracane and facilitator Annis Gasse came back to Madagascar for Part 2. One very sad piece of news - Josette Tardy who was a member of HAP France the head of the this project in Madagascar, died in June 2016 after a long illness. Josette had made an invaluable contribution to the Madagascar project as well as other projects in the past. She will be greatly missed by all of us."

Martine Ircane reports: "During the Part 2 in Antananarivo, Madagascar, the trainees created the EMDR Madagascar Association. The president is Vololona Razafindrasolo, a charming woman psychiatrist."

NEPAL

Anne Dewailly reports: "An EMDR project in Nepal was started in 2016. It is a collaboration with the NGO Action Against Hunger (ACF) and the French Institute of EMDR (IFE) for the training which took place in Paris in October, thanks to Delphine Pecoul (IFE president), Martine Iracane (EMDR Trainer) and Monica Miravet (EMDR consultant who will provide the supervision for this group). In November, a training in Psychotraumatology took place for clinical social workers and social workers of ACF and other Nepalese NGO. In December, an EMDR Part 1 training took place to train ACF psychologists and other Nepalese psychologists working in the NGO sector. EMDR Trainer Eva Zimmerman (Switzerland) agreed to give this training with Thomas Renz (EMDR facilitator). This project is organized by the HAP France coordinators, Fanny Guidot and Cathy Bonnet and the ACF supporters are Cecile Bizouerne and Anne Pla Filorizzo/ Francesca Corna for Asia."

Eva Zimmermann reports: "I am in Nepal and just finished a Part1 EMDR training yesterday. There were 14 Nepalese, 4 Bangladeshi, 1 Indian and 4 French colleagues from the NGO "Action Contre La Faim" (ACF) who sponsored this training for HAP France. We will go back in 2017 for Part 2."

NORWAY

Janne Ekeberg Amundsen reports: "We have a new president in Norway, Mette P.Uthus."

SPAIN

Benedikt Amann reports: "We have included the first five bipolar patients with histories of trauma in our randomized controlled trial (RCT) versus supportive therapy, using our Bipolar EMDR Protocol. In another RCT, initiated by Aries Nieves, we found very positive results in favor of EMDR versus waiting list in subjects with chronic non-malignant pain disorders. I am currently reorganizing a psychiatric inpatient unit in Barcelona and my aim for 2017 is to incorporate an EMDR therapist."

SRI LANKA

Janet Nethsinge reports: "This year we had two EMDR training programs: Parts I and 2, both conducted by Sushma Mehrotra and Parul Tank from India. We had 20 participants for Part 1 and 5 participants for Part 2. We also conducted 2 training programs in the North of Sri Lanka (where the war was raging until 2009) to equip 25 psychosocial workers with more skills to work with people affected by war. Our aim was to prepare them to be trained in EMDR therapy at a later stage."

SWITZERLAND

Olivier Piedfort reports: "I will be starting a new scientific journal, *The European Journal on Trauma and Dissociation*. It will appear in English and French and will be the official journal of the ESTD and the new AFTD (Association Francophone of Trauma and Dissociation) and of course articles on EMDR therapy will be welcome ."

TAIWAN

Yi An Lu reports: "We have a newsletter that includes the purpose of Taiwan EMDRIA (TEMDRIA), the introduction of EMDR Basic training provided by Sigmund Burzynski and feedback from trainees and clients. We also hold free lectures to people in community committed to public psychoeducation. On the other hand, our trainees have their own reading and discussion groups. The newsletter also introduced the books we translated into Mandarin and some articles and theses written by our trainees.

We have finished our most recent training and there are 10 trainees who finished EMDR Basic Training in September 2016. We thank Peili Wu for her many years of service to TEMDRIA and the Board. The Council had this year's first General Assembly a new election for board members., Hu Ahenrong is the new chairman. Together, we are committed to continuing to expand EMDR in Taiwan, even in Asia!"

UGANDA

Rosemary Masters reports: "For the past eight years, New York City's Trauma Studies Center (a division of the Institute for Contemporary Psychotherapy), in cooperation with the Uganda Counselling Association, has sponsored a project of bringing advanced training in the theory and treatment of psychological trauma to Ugandan mental health professionals. Between 2011 and 2016 this project has focused specifically on sending American EMDR specialists to Uganda to train Ugandan psychotherapists in the use of EMDR. As a result of the work, over 50 Ugandan mental health counselors have been trained in EMDR. From the start, our long-term goal has been the transfer of responsibility for EMDR training and supervision to Ugandan professionals. In so doing, we aim to eliminate dependence on Americans for specialized trauma training. In fulfillment of our long-term goal, last week the Trauma Studies Center hosted two distinguished Ugandan clinicians, Lois Ochieng and Dismas Bweigye. Together with two American EMDR therapists, who had previously assisted with EMDR training in Uganda, Lois and Dismas had the opportunity to observe William Zangwill's approach to teaching EMDR therapy. In addition, our guests were able to sit in on the Trauma Studies Center's trauma theory course as well as a senior clinician consultation group. They had the opportunity to visit the 9/11 memorial, a drug and alcohol treatment center and a federally funded research program that serves Iraq war veterans at New York Presbyterian Hospital. To give our guests a break from the focus on trauma, we found time for them to visit the Frick museum, the Metropolitan Museum and to attend both an Episcopal Sunday service and a Rosh Hashanah service. Fulfilling their essential task, Lois and Dismas sat down for many hours with members of the Trauma Studies Center faculty and began to map out the process by which responsibility for EMDR training would pass from the ICP's Trauma Studies Center to the Ugandan EMDR Association (which is in the process of being formed). A timeline finishing by May 2018 was established.

EMDRIA can feel proud of the role its members are playing in this exciting and very worthwhile project. We are very grateful to William Zangwill's generosity of time, attention and energy for his mentorship.

UNITED STATES

Arizona

Carolyn Settle reports: "Robbie Adler-Tapia and I have recently published a second edition of their book and treatment manual now named, *EMDR and the Art of Psychotherapy with Children: Infants to Adolescence*, Springer Publishing 2017. The revised edition has been expanded to address infants, toddlers and preschoolers and preteens and teens. It addresses the current issues that children and teens face today and includes information on how to pace EMDR therapy in Intensive Outpatient Programs and Residential Treatment Centers. There is a Table titled Phases, Ages and Stages that provides a quick way for clinicians to identify what phase of EMDR to modify based on the age and developmental stage of the child. It also includes a blocking belief questionnaire specifically for children and teens and the language that they use."

EMDR HAP/Trauma Recovery

Hope Payson reports: "Something wonderful that is happening in Connecticut. Three agencies have been working closely together making a huge impact in increasing the availability of EMDR therapy to persons with histories of mental illness and addiction and building EMDR capacity statewide. They are: The Department of Mental Health and Addiction Services (DMHAS), The Connecticut Women's Consortium (CWC), and Trauma Recovery EMDR HAP. DMHAS is an agency with the primary mandate to serve adults (over 18 years of age) with psychiatric or substance use disorders, or both, who lack the financial means to obtain such services on their own. CWC is an organization that works collaboratively with nonprofits, state departments, and providers to promote trauma-informed, gender-responsive training to increase understanding, empowerment, and safety for those struggling with behavioral health issues such as

mental illness, addiction, and poverty. This organization has regularly been sponsoring and promoting Trauma Recovery HAP trainings, in addition to encouraging advanced training to build capacity throughout the State services system. Trauma Recovery EMDR HAP, is an organization that most of us know, which works to increase the capacity for effective treatment of psychological trauma in underserved communities anywhere in the world. They have organized and staffed all of the EMDR Basic Trainings at the CWC with volunteer training teams. In the past four years, they have accomplished the following: 70 DMHAS employees trained in EMDR therapy; 16 EMDR training weekends sponsored by the CWC and staffed by Trauma Recovery HAP; 7 DMHAS employees are now EMDRIA Certified; 6 EMDR peer consultation groups are regularly being run within DMHAS to support new trainees; 4 DMHAS clinicians are now EMDRIA Approved Consultants and are supporting the new trainees and promoting EMDR within the agency; 7 EMDR advanced specialty trainings are being offered at the CWC at no charge to DMHAS employees; 6 EMDR Basic Training weekends are currently scheduled with CWC and Trauma Recovery HAP in 2016. This means 100's of people with chronic mental health issues are now benefiting from the collaborative efforts of these three agencies, their staff and Trauma Recovery HAP volunteers.

Massachusetts

Jim Helling and Stephanie Baird report: "A thoughtful and respectful dialogue about community inclusion highlighted the annual Western Mass EMDRIA Fall Meeting October 25, 2016 in Northampton, MA. Nearly 40 therapists attended and received copies of the new EMDRIA Board Statement Regarding Diversity and Cultural Competence and previewed the recently released public service announcement introducing the new EMDRIA branding, logo, and message. Local therapist, EMDRIA Board member, EMDR trainer, consultant and author Mark Nickerson talked about his newest book Cultural Competence and Healing Culturally Based Trauma with EMDR Therapy. Mark described the journey of investigation and innovation that led to this collaborative project and to his expansion of the AIP Model to include focus on social information processing. He gave some background on research in social psychology that has supported his development of EMDR Therapy interventions in cases of traumatization or adversity involving stigma, oppression, disruptions of social attachment, negative appraisals of self and others based on socio-cultural identities, and the fundamental human need to belong. Following a brief exercise on personal identity experiences and negative beliefs, the evening turned to a heartfelt and self-reflective community dialogue about culture, identity, difference and inclusion. Personal sharing of experiences and perspectives led to collective brainstorming about obstacles to and strategies for making our regional EMDR community more connected with and inclusive of communities and clinicians of color, particularly in the Hamden County area. Key themes of the dialogue identified for follow-up work included the high cost of EMDR Basic Training; the need for collaborative relationships of mutual interest with communities and clinicians of color among whom EMDR Therapy is less well established; the need for additional individual and community opportunities to work through issues of stigma, privilege, implicit bias, oppression and maladaptive social information processing that create or sustain barriers to meaningful engagement across lines of difference; and the need for additional professional development to become more familiar with and fluent in the language of social psychology and social information processing. Jason-Rose Langston, Steering Committee member, EMDR presenter and consultant, is heading up a subcommittee of the newly reconstituted non-profit Western Mass EMDRIA Board of Directors charged with strategic planning and action on issues of culture, diversity and inclusion. Lastly, our Spring Conference is set for April 8, 2017 at UMass Amherst and will feature Hope Payson, as the keynote, presenting "Recovery Community: Helping Complex Trauma Survivors Find Their Way Home."

David Sherwood reports: "I retired from my private practice in Poughkeepsie, NY in 2013 and have moved to Plymouth, MA. I still keep involved in EMDR through being a HAP facilitator, an Approved Consultant, and a member of the EMDRIA Research Foundation Board."

New York

Carol Forgash reports: "I presented the first EMDR Masters Workshop, "Healing the Heart of Complex Trauma with EMDR and Ego State therapy," in Little Rock, AR in October sponsored by Gary Scarborough. On October 21, The Long Island EMDR Regional Network sponsored a presentation at the Hofstra University Club, on "Surviving Suicidal Loss; Clinical Interventions for Traumatic Grief Integrating EMDR and Somatic Therapies." Rebecca Waikley's presentation was well attended and very informative. On Veteran's Day, Channel 12 News' Mary Mucci featured a segment on her Long Island Naturally Program about EMDR, PTSD, veterans and our Long Island TRN. Fran Donavan graciously volunteered to film the spot with one of her patients. Kudos to Fran on a terrific job! Thank you to Mary Mucci who is a big proponent of EMDR therapy. The Long Island Trauma Recovery Network had a holiday brunch on December 3, 2016 hosted by Margery David. The brunch was open to members and Level 2 EMDR clinicians interested in finding out more about our TRN. We discussed our 2017 goals including: bringing a GTEP to Long Island, recruitment, and developing a clear-cut procedures for our TRN's disaster response. Cathy Menzies has developed a Facebook page for the Long Island Trauma Recovery Network. All current activities, news articles, etc. are listed. It's a wonderful way to build our EMDR community on Long island."

ZIMBABWE

Anne Dewailly reports: "In May 2016, HAP France organized an EMDR Children Part 1 training in Zimbabwe with Michel Silvestre. The participants also received a day of training on dealing with domestic violence. The next step is for all the participants of the Basic EMDR training to pass their final supervision in order to become EMDR practitioners. HAP France is also hoping that a Zimbabwean EMDR association can be established in due course. I am still overseeing this project." ❖

EMDRIA 2015 Financial Review

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INDEPENDENT ACCOUNTANTS' REVIEW REPORT

To the Board of Directors
EMDR International Association

We have reviewed the accompanying financial statements of the EMDR International Association (a nonprofit organization), which comprise the statements of financial position as of December 31, 2015 and 2014, and the related statements of activities and cash flows for the year then ended, and the related notes to the financial statements. A review includes primarily applying analytical procedures to management's financial data and making inquiries of management. A review is substantially less in scope than an audit, the objective of which is the expression of an opinion regarding the financial statements as a whole. Accordingly, we do not express such an opinion.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement whether due to fraud or error.

Accountants' Responsibility

Our responsibility is to conduct the review engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. Those standards require us to perform procedures to obtain limited assurance as a basis for reporting whether we are aware of any material modifications that should be made to the financial statements for them to be in accordance with accounting principles generally accepted in the United States of America. We believe that the results of our procedures provide a reasonable basis for our conclusion.

Accountants' Conclusion

Based on our review, we are not aware of any material modifications that should be made to the accompanying financial statements in order for them to be in accordance with accounting principles generally accepted in the United States of America.

DRAFT #2

Austin, Texas
March 14, 2016

EMDRIA 2015 Financial Review

EMDR INTERNATIONAL ASSOCIATION
(Nonprofit Corporation)

STATEMENTS OF FINANCIAL POSITION

As of December 31, 2015 and 2014

	2015	2014
Assets		
Current Assets		
Cash and cash equivalents	$ 475,272	$ 398,767
Investments - certificates of deposit	205,679	203,406
Accounts receivable	5,565	5,355
Prepaid expenses	25,132	29,852
Total Current Assets	711,648	637,380
Fixed Assets		
Furniture and equipment	58,146	40,496
Accumulated depreciation	(43,521)	(40,496)
Net Fixed Assets	14,625	-
Total Assets	$ 726,273	$ 637,380
Liabilities and Net Assets		
Current Liabilities		
Accounts payable	$ 6,790	$ 1,650
Accrued vacation	21,282	20,608
Deferred revenue	381,735	278,398
Accrued expenses	246	246
Total Current Liabilities	410,053	300,902
Total Liabilities	410,053	300,902
Unrestricted Net Assets	316,220	336,478
Total Liabilities and Net Assets	$ 726,273	$ 637,380

EMDRIA 2015 Financial Review

EMDR INTERNATIONAL ASSOCIATION
(Nonprofit Corporation)

STATEMENTS OF ACTIVITIES

For the Years Ended December 31, 2015 and 2014

	2015	2014
Unrestricted Net Assets:		
Revenue		
Membership dues	$ 705,642	$ 662,725
Conference fees	452,178	490,184
Education and training fees	275,387	222,700
Interest income	2,536	2,025
Publications	57,828	65,298
Total Revenue	1,493,571	1,442,932
Expenses		
Program services	1,221,357	1,064,113
General and administrative	292,472	271,153
Total Expenses	1,513,829	1,335,266
Change in unrestricted net assets	(20,258)	107,666
Net assets, beginning of year	336,478	228,812
Net assets, end of year	$ 316,220	$ 336,478

EMDRIA Credit Programs

To view the full list of EMDRIA Approved Distance Learning Workshops,
please visit www.emdria.org and click on Calendar of Events box on the homepage.

PROGRAM # / EMDRIA CREDITS / TITLE	PROVIDER NAME / PRESENTERS	CONTACT	PHONE	DATES / LOCATION
14006-13 24 Credits *Integrating Somatic Psychotherapy with EMDR Therapy*	Craig Penner, MFT Craig Penner, MFT	Craig Penner	805.866.7794	February 2-5, 2017 Austin, TX
13016-11 7 Credits *Treating Early Attachment Wounding: Somatic Interventions to Enhance EMDR Effectiveness*	Lana Epstein, LICSW Lana Epstein, LICSW	Lana Epstein	781.862.0574	February 3, 2017 Los Angeles, CA
06003-70 20 Credits *The Art of EMDR*	Kathleen Martin, LCSW Roger Solomon, Ph.D. & Kathleen Martin, LCSW	Kathleen Martin	585.473.2119	February 6-10, 2017 Costa Rica
13016-12 7 Credits *Treating Early Attachment Wounding: Somatic Interventions to Enhance EMDR Effectiveness*	Lana Epstein, LICSW Lana Epstein, LICSW	Lana Epstein	781.862.0574	February 10, 2017 Berkeley, CA
13004-12 7 Credits *Healing the Whole Self: Treating Dissociation in Harmony with EMDR Therapy*	Dragonfly International Therapy LLP Sarah Jenkins, MC, LPC	Sarah Jenkins	480.370.7630	February 17, 2017 Tucson, AZ
00002-10 12 Credits *Easy Ego State Interventions with EMDR*	Robin Shapiro, MSW, LICSW Robin Shapiro, MSW, LICSW	Robin Shapiro	206.799.5933	Feb. 17-19, 2017 Rome, Italy
15005-04 12 Credits *EMDR & Children: Utilizing Play Therapy Techniques*	Roxanne Grobbel, JD, LCSW Roxanne Grobbel, JD, LCSW	Roxanne Grobbel	561.756.3477	Feb. 23-24, 2017 Boynton Beach, FL
10006-20 13 Credits *"I Can't Do It!" Clearing Roadblocks to Optimal Functioning After Trauma: Integrating EMDR & Life Performance Tools*	Laurie Tetreault, MA, LMFT Jennifer Lendl, Ph.D.	Laurie Tetreault	928.771.9422	Feb. 24-25, 2017 Phoenix, AZ
01007-32 12 Credits *EMDR Integrative Attachment Trauma Protocol for Children*	Debra Wesselmann, MS, LIMHP Debra Wesselmann, MS, LIMHP	Debra Wesselmann	402.981.6130	Feb. 24 - Mar. 4, 2017 Live Webinar
16008-01 12 Credits *The Body in EMDR Therapy: Essential Skills*	Eno Center PLLC Catherine Lidov, LCSW	Catherine Lidov	909.680.3024	March 3-4, 2017 Durham, NC
09008-09 14 Credits *EMDR Toolbox: AIP Model for Treating Adults with Complex PTSD & Dissociative Personality Structure*	Jim Knipe, Ph.D. Jim Knipe, Ph.D.	Carol Miles	985.893.1248	March 3-4, 2017 New Orleans, LA
06003-71 20 Credits *The Art of EMDR*	Kathleen Martin, LCSW Roger Solomon, Ph.D. & Kathleen Martin, LCSW	Kathleen Martin	585.473.2119	March 10-13, 2017 Niagra-on-the-Lake, Ontario, Canada
03010-15 12 Credits *EMDR Boot Camp*	Dressner Counseling Services Inc Ira Dressner, Ph.D.	Ira Dressner	626.523.9987	March 11-12, 2017 Phoenix, AZ
14007-05 13 Credits *DeTUR for Addictions & Dysfunctional Behaviors*	Jordan Shafer, MS, LPC Arnold J. Popky, Ph.D.	Jordan Shafer	972.342.2448	March 11-12, 2017 Los Gatos, CA

EMDRIA Credit Programs

PROGRAM # / EMDRIA CREDITS / TITLE	PROVIDER NAME / PRESENTERS	CONTACT	PHONE	DATES / LOCATION
03002-42 12 Credits *EMDR Therapy Tools for Attachment Trauma*	Maiberger Institute Barb Maiberger, MA, LPC & Arielle Schwartz, Ph.D.	Barb Maiberger	303.834.0515	March 18-19, 2017 Boulder, CO
01007-33 19 Credits *Integrative Attachment Trauma Protocol (ATP) for Children*	Debra Wesselmann, MS, LIMHP Debra Wesselmann, MS, LIMHP	Debra Wesselmann	402.981.6130	April 6-8, 2017 Hamilton, NJ
14019-06 12 Credits *The Dynamic Trio: EMDR, Positive Psychology and Coaching*	Ann-Marie McKelvey Ann-Marie McKelvey, MA, LPCC	Ann-Marie McKelvey	505.989.3374	Apr. 11 - May 30, 2017 Live Conf. Calls
GP1508-09 12 Credits *Dissociation of the Personality & the EMDR Treatment of Chronic Traumatization*	Mark Nickerson, LICSW Onno van der Hart, Ph.D. & Denise J. Gelinas, Ph.D.	Mark Nickerson	413.256.0550	April 21-23, 2017 Natick, MA
GP1507-03 13 Credits *Advanced Issues in Working with Complex Dissociative Disorders: Chronic Shame, Resistance & Traumatic Memory*	Jill Strunk, Ed.D, LP Kathy Steele, CS, APRN	Jill Strunk	952.936.7547	April 22-23, 2017 Minnetonka, MN
03002-43 12 Credits *EMDR Therapy Tools for Addiction*	Maiberger Institute Barb Maiberger, MA, LPC & John Gray, MA, LPC	Barb Maiberger	303.834.0515	April 29-30, 2017 Boulder, CO
14006-14 24 Credits *Integrating Somatic Psychotherapy with EMDR Therapy*	Craig Penner, MFT Craig Penner, MFT	Craig Penner	805.866.7794	May 19-22, 2017 Byfield, MA
14007-06 14 Credits *EMDR Treatment of Chronically Traumatized Clients*	Jordan Shafer, MS, LPC Roger Solomon, Ph.D.	Jordan Shafer	972.342.2448	May 19-20, 2017 Allen, TX
13008-12 30 Credits *EMDR as a Transpersonal Therapy: A Cross Cultural Perspective Where East Meets West*	Irene Siegel, Ph.D., LCSW Irene Siegel, Ph.D., LCSW	Irene Siegel	631.547.5433	May 22-27, 2017 Hilo, HI
06003-73 20 Credits *Mastering EMDR Therapy: A Practicum for Personal & Professional Development*	Kathleen Martin, LCSW Kathleen Martin, LCSW	Sarah Jenkins	480.370.7630	June 1-4, 2017 Paradise Valley, AZ
09008-10 14 Credits *EMDR Toolbox: AIP Model for Treating Adults with Complex PTSD & Dissociative Personality Structure*	Jim Knipe, Ph.D. Jim Knipe, Ph.D.	Kimber Olson	907.903.7880	June 16-17, 2017 Anchorage, AK
14019-07 12 Credits *The Dynamic Trio: EMDR, Positive Psychology and Coaching*	Ann-Marie McKelvey Ann-Marie McKelvey, MA, LPCC	Ann-Marie McKelvey	505.989.3374	July 11 - Aug. 29, 2017 Live Conf. Calls
13008-13 30 Credits *EMDR as a Transpersonal Therapy: A Cross Cultural Perspective Where East Meets West*	Irene Siegel, Ph.D., LCSW Irene Siegel, Ph.D., LCSW	Irene Siegel	631.547.5433	July 31 - Aug. 4, 2017 Garrison, NY
00000 Various Credits *Annual EMDRIA Conference*	2017 EMDRIA Conference Various Presenters	EMDRIA	512.451.5200	August 24-27, 2017 Bellevue, WA

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Welcome to EMDRIA! We are so pleased that you have chosen to join us as a member of EMDRIA! For those of you who are now Full Members, we hope that you will consider continuing your EMDR education by meeting the additional requirements to become a Certified EMDR Therapist. For more information on Certification, please visit www.emdria.org or email Susanna Kaufman at skaufmanemdria.org today!

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