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EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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Stray Thoughts

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One of the most upsetting professional experiences I have so far encountered occurred in November 1995. One of the participants at the Level II training in New York handed me a letter from a relative of hers. She had suggested that her sister get EMDR treatment and counseled her to call the EMDR Institute office for a referral. The following are excerpts from the letter:

"For seventeen years I have not been able to have a good night's sleep and have been in varying stages of mood and depression. All these years I have been seeking professional help with no success. Six months ago I called Dr. Shapiro and she referred me to Dr. _____ in _____. I sought his professional help for over ten hours. During this time he told me that my depression was at a very high level and that I have had more than twenty different traumas in my life."

She had called the EMDR Institute office for a referral, and was given the names of three trained clinicians to call. As luck would have it, Dr.____ was the first one she spoke to.

"We worked together on all my problems and he instructed me in the method of tapping under my eyes and on top of my hands for which I have been doing with no luck. The first few weeks I felt a little better but then I went back to square one with having nightmares and being extremely depressed."

Dr. _____ treated her by standing at her side and having her do about ten eye movements. He then told her to tap under her eyes, and on assorted places on her body. He led her to believe that this was EMDR.

"Dr. _____ told me this technique of EMDR will work for some patients, the results will show after three sessions and if not it means that it is not possible to use on me."

He had asked for $1000 in advance, and when her three sessions were up—told her EMDR couldn't work for her and there was nothing more he could do. But if she just continued the tapping (under her eyes and the side of her hands) she would be fine.

"After a period of one month of not seeing him I was feeling very miserable and sad, I called him to get advice. He then told me the only thing he can suggest is for me to keep doing the tapping under my eyes and hands."

To treat a client in this way is clearly reprehensible. What is also problematic is to call something EMDR, when it is not. EMDR should not be misrepresented to clients. When EMDR is being substantially modified from the standards established in the trainings and research, clients should be told they are being offered an experimental variation that has no research validation. It should also be made clear that the method is not being used according to suggested clinical practice—or that another method is being used instead. When I called this

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client to investigate, she told me that she had become suicidal and the clinician told her just to continue tapping. She said that one of the things that caused her despair was the belief that EMDR hadn't helped her. She had trusted her sister-in-law and the clinician told her he was using it—but it obviously didn't work for her!

This experience has lead me to rethink our policy of referring clients to clinicians under the blanket assumption that they know what they are doing. Since the entire field of psychology seems moving to a competency based model, partially inspired by managed care panels, I believe we should do so as well. I have described a suggested framework for it in the International Update column of this Newsletter.

* * *

The attention placed on EMDR by the media has caused a number of "eye movement techniques" to proliferate around the world. Misinformation is also causing a great deal of confusion in the field causing other approaches to be mistakenly equated with EMDR (see Steven Silver in this Newsletter). For purposes of clarity, it is important to reiterate that EMDR is not a simple anxiety-reducing technique. It is a method that should be used by trained clinicians with prepared clients. According to clinicians that have been trained in different approaches, what appears to make EMDR different is the rapid accessing and processing of memory networks in a way that leads to not only a desensitization, but the emergence of insights, cognitive restructuring, and recognitions of patterns. The generalization of treatment effects and its consequent results with multiply traumatized clients is also being reported as unique. Since the EMDR model suggests a specific approach to pathology, it includes the installation of templates for appropriate future action. In order to implement EMDR most comprehensively for the clients overall improvement, it is suggested that all its strengths be utilized.

* * *

At the point the Wilson, Becker & Tinker study was accepted by the Journal of Consulting and Clinical Psychology, I calculated the number of subjects subjected to evaluation in other PTSD studies. Here is the breakup of subjects studied in all the non-EMDR controlled studies combined.

Desensitization — 40
Flooding — 46
Psychodynamic — 29
Hypnotherapy — 29
Cognitive — 9

In contrast, the effect of EMDR has been evaluated on more than 400 subjects in controlled studies. I'd say one important goal for the field would be to increase the number of controlled clinical outcome studies of PTSD in general. It should be mentioned that an added advantage of the Wilson, Becker & Tinker study is that it included a mixed sample of subjects. Approximately half (47%) had a PTSD diagnosis, while the other half had some PTSD criteria. That allowed a comparison of effects for a range of clients that is useful to the practicing clinician. In addition, the 37 subjects that did have a PTSD diagnosis, made it the second or third largest subject pool in all the extant, published PTSD studies. Hopefully, the scientific rigor used in its evaluation will become a hallmark for future studies.

* * *

A very exciting study has been completed in Colorado Springs by M. Scheck, J. Scheffer and C. Gillete. The following is a paraphrase of the abstract: The subjects were high-risk females presenting in a community agency (e.g., prostitutes, pregnant teens, drug addicts, etc.). It has been found that providing mental health services to this group is often hindered by their unstable lifestyles, however psychological dysfunction is a major issue. Sixty females, between 16 and 25 years old, approximately two-thirds who had PTSD, were randomly assigned to EMDR and an active reflective listening (ARL) control. Pre-post effect sizes for the EMDR group averaged 1.47 compared to the 0.64 effect size in the ARL group. Measures used included the Beck Depression scale, State Anxiety, Tennessee Self-Concept, Penn PTSD, and IES. Since over 90% of the subjects reported childhood abuse, these statistically and clinically significant findings, after only two sessions, provide added incentive for trying to locate funding for pilot projects in the inner cities. Another study, by Purna Datta, Ph.D. also found clinically significant results in a study of adolescent males who were institutionalized for sexual offenses. The report indicated that three sessions of EMDR resulted in less disturbance, greater sense of cognitive control, and that after treatment, the subject felt greater empathy towards the victim. This is also very encouraging to the global vision that EMDR can be used to help stop the cycle of violence and abuse worldwide. Pilot projects that target inner city "prevention", and high-risk populations can be sponsored under the EMDR Humanitarian Assistance Programs (see International Update) if we can find funding. Anyone that knows any possible individual donors or corporate sponsors for any of the outreach programs, please let us know.

* * *

At the Evolution of Psychotherapy Conference this year I had the pleasure of meeting Arnold Lazarus, Ph.D. He has been one of the pioneers in the field promoting the concept of integration. I was most impressed with his BASIC I.D. model which is highly compatible with EMDR. I also thought very highly of his Multimodal Life History Inventory. It would appear to be a tremendous boon to the practicing clinician. The complete inventory (by Arnold & Clifford Lazarus) may be obtained from Research Press, 2612 North Mattis Avenue, Champaign, IL 61821.

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THE MULTIMODAL ORIENTATION

Arnold A. Lazarus, Ph.D., ABPP

When I took the Level 1 EMDR training, I was impressed by the fact that it dovetails very nicely with the multimodal outlook and tends to cover the same essential modalities. In Las Vegas, while we were at the Evolution of Psychotherapy Conference, Dr. Francine Shapiro and I chatted about numerous ideas, including the way in which people familiar with EMDR could profit from employing multimodal assessment methods. Dr. Shapiro perused the Multimodal Life History Questionnaire (Lazarus & Lazarus, 1991), for instance, and felt that it could be a useful addendum in the hands of well-trained EMDR therapists and invited me to write this very brief outline of the multimodal therapy rationale.

At base, we are biological organisms (neurophysiological/biochemical entities) who *behave* (act and react), *emote* (experience affective responses), *sense* (respond to tactile, olfactory, gustatory, visual and auditory stimuli), *imagine* (conjure up sights, sounds and other events in our mind's eye), *think* (entertain beliefs, opinions, values and attitudes), and *interact* with one another (enjoy, tolerate, or suffer various interpersonal relationships). By referring to these seven discrete, but interaction dimensions or modalities as **B**ehavior, **A**ffect, **S**ensation, **I**magery, **C**ognition, **I**nterpersonal, **D**rugs/Biologicals, the convenient acronym **BASIC I.D.** emerges from the first letter of each one.

Many psychotherapeutic approaches are trimodal, addressing affect, cognition and behavior—ABC. The multimodal approach provides clinicians with a comprehensive template. By separating sensations from emotions, distinguishing between images and cognitions, emphasizing both intra-individual and interpersonal behaviors, and underscoring the biological substrate, the multimodal orientation is most far-reaching. By assessing a client's BASIC I.D., one endeavors to "leave no stone unturned."

The elements of a thorough assessment involve the following range of questions:

B: What is this individual doing that is getting in the way of his or her happiness or personal fulfillment (self-defeating actions, maladaptive behaviors)? What does the client need to increase and decrease? What should he/she stop doing and start doing?

A: What emotions (affective reactions) are predominant? Are we dealing with anger, anxiety, depression, combinations thereof, and to what extent (e.g., irritation versus rage, sadness versus profound melancholy)? What appears to generate these negative affects—certain cognitions, images, interpersonal conflicts? How does the person respond (behave) when feeling a certain way? It is important to look for interactive processes—what impact do various behaviors have on the person's affect and vice versa? How does this influence each of the other modalities?

S: Are there specific sensory complaints (e.g., tension, chronic pain, tremors)? What feelings, thoughts, and behaviors are connected to these negative sensations? What positive sensations (e.g., visual, auditory, tactile, olfactory, and gustatory delights) does the person report? This includes the individual as a sensual and sexual being. When called for, the enhancement or cultivation of erotic pleasure is a viable therapeutic goal.

I: What fantasies and images are predominant? What is the person's "self-image"? Are there specific success or failure images? Are there negative or intrusive images (e.g., flashbacks to unhappy or traumatic experiences)? And how are these images connected to ongoing cognitions, behaviors, affective reactions, etc.?

C: Can we determine the individual's main attitudes, values, beliefs, and opinions? What are this person's predominant shoulds, oughts, and musts? Are there any definite dysfunctional beliefs or irrational ideas? Can we detect any untoward automatic thoughts that undermine his or her functioning?

I: Interpersonally, who are the significant others in this individual's life? What does he or she want, desire, expect, and receive from them, and what does he or she, in turn, give to and do for them? What relationships give him or her particular pleasures and pains?

D: Is this person biologically healthy and health conscious? Does he or she have any medical complaints or concerns? What relevant details pertain to diet, weight, sleep, exercise, alcohol, and drug use?

EMDR Network Newsletter Submission Information

The Newsletter is now under "new management." This means, among other things, that articles and disks will henceforth be submitted to:

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Remaining the same are the requirements for APA style and format, and that the editor cannot guarantee when, or if, an article will be published. Additionally, all articles are subject to editorial revisions.

The foregoing are some of the main issues that multimodal clinicians traverse while assessing the client's BASIC I.D. A more comprehensive problem identification sequence is derived from asking most clients to complete the Multimodal Life History Inventory. This 15-page questionnaire facilitates treatment when conscientiously filled in by clients as a homework assignment, usually after the initial session. Seriously disturbed (i.e., deluded, deeply depressed, highly agitated) clients will obviously not be expected to comply, but most psychiatric outpatients who are reasonably literate will find the exercise useful for speeding up routine history taking and readily provide the therapist with a BASIC I.D. analysis.

It should be understood that the multimodal approach is not one that insists on treating everyone across the entire BASIC I.D. Some problems respond better to focused interventions. However, when progress falters or when no treatment gains are evident, we recommend a BASIC I.D. assessment as a means of shedding light on otherwise concealed issues that may be amenable to change.

If anyone is interested in obtaining much more detailed information on the subject, may I recommend my book *The Practice of Multimodal Therapy* (Lazarus, 1989) and two chapters in edited books (Lazarus, 1992, 1995).

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The "Active Ingredient" Project and EMDR- Perspective of a Participant

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As one of the two EMDR clinicians involved in the "Active Ingredient" project (Roger Solomon being the other), I have found myself receiving a number of questions about the other therapies investigated and how they might relate to EMDR. In the EMDR Level I trainings I have conducted, it has become clear that some clinicians have heard a variety of stories of what took place at Florida State University (under the direction of Charles Figley, Ph.D.), where the project was conducted, which has led to some unfortunate misunderstandings.

First, I think it important to say that EMDR and the other methods investigated--Thought Field Therapy (TFT), Trauma Incident Resolution (TIR), and NLP's Visual Kinesthetic Dissociation--all were selected on the basis of reports from clinicians in the field; none was intended to be the "gold standard" by which the others were evaluated. The attempt, as explained to me repeatedly, was not to conduct a comparative "horse race," but rather to see what these four approaches might have in common.

Subjects selected were not individuals having a diagnosis of PTSD; they were volunteers who had various levels of anxiety. For example, one of my subjects was suffering from a severe blood phobia. Another was concerned about terminating a family grocery store which was taking up too much of her time, and was anxious about telling her mother-in-law of her decision. Another was a "walk-in" mental health counselor who happened to be visiting FSU, heard the presentation by Roger and myself, and volunteered for the study to work on some childhood memories. Yet another was a woman who was anxious about returning to the work force after being unemployed for some time.

Thus, this was NOT a study of treatment of PTSD. Unfortunately, many have characterized the study as being a comparison of PTSD treatments.

Since the client groups for each treatment were not the same, it becomes extremely difficult to compare results. For example, in the case of the person with the blood phobia noted above, a single session with one follow-up session for reevaluation was sufficient for complete resolution with EMDR. How do we compare that with the woman returning to the work force who got a job the day after treatment? Both were successful, but about all they had in common were the broad variables of anxiety and sex of the subject.

Indeed, I elected not to use EMDR with the woman with the family business as it was not needed; she stated she knew what she had to do after simply getting a chance to talk about it. Another subject, a woman who had been raped, asked for a female therapist. I assisted her in being referred. After the study was completed, the number of subjects seen were reported. I was subsequently told that the EMDR team was denigrated by some for "selecting" our subjects as opposed to using EMDR with everyone we were assigned. I regarded my conduct as ethical and appropriate and, had I known it would have been used to cast EMDR in a negative light, I would have done the same.

We tried, as far as was possible, to follow the full EMDR protocol. The intention, after all, was to identify an ingredient common to all the proce-

dures, so clearly time was not meant to be a factor. For a couple of subjects this meant I spent a session ensuring there was adequate informed consent, a sufficient client history was developed, and specifying the target to be addressed. For others, after identifying and reprocessing the original presenting complaints, the client requested, or I suggested, targeting additional areas of disturbance. The use of the allocated three sessions was simply an opportunity to cover as much clinical ground with EMDR as possible. Later, I was told that time spent in treatment was a variable being tracked and presented. However, that was not told to either Roger or me before we began and as above, it would have made no difference.

Thus, the study was not a comparative study of treatments for PTSD. The design would have had to have been radically different for such. All that can be said is that all four treatments produced some positive outcomes with a wide variety of subjects. The results themselves cannot be compared because clinical goals varied. For instance, although EMDR resulted in lower SUD ratings than the other therapies, we did not stop using EMDR when it achieved those results. What EMDR supplies is an accelerated processing with a restructuring of a person's cognitive framework rather than just the desensitization which you might otherwise achieve with the other approaches.

The need for integration of methods is clear. Depending on the approach, it might be highly useful in terms of developing the therapeutic relationship, providing the client with tools useful for closure or between sessions, developing ego strength, or in dealing with secondary gain (and loss) issues. For example, I make use of a great deal of my early training in Rogerian Client Centered Therapy in developing the relationship, clarifying the target, and building self-esteem and ego strength. Does this accomplish therapeutic gains? Of course it does. It also, in an integrated approach, helps prepare the client for EMDR.

Another aspect of integration, however, comes into play when the other treatment is viewed as another approach specifically for the kind of problem for which EMDR is being considered, such as PTSD. There is now more controlled group research demonstrating the efficacy of EMDR than all other nonpharmaceutical treatments combined. It is very clear that EMDR is fast becoming regarded as the treatment of first choice. Thus, if there is a reason for not using EMDR, then I might use another treatment. In other words, there may be nothing to integrate if EMDR is effective.

On the other hand, I use hypnosis, depending on the client, along with EMDR in the treatment of PTSD in a number of ways. Hypnosis and self-hypnosis can be effective stress reduction techniques to use during the closure phase or between sessions. The ability of hypnosis to implant suggestions can often be useful in helping to develop ego strength. For clients with severe chronic pain, the anesthetic techniques of hypnosis might be useful for pain control so they can participate in EMDR without distraction.

What were my own views of the other therapies investigated in the Active Ingredient project? I think the project was important not because it said anything new about EMDR — the body of research on that is large and growing. Nor did it tell us much about how EMDR and the other treatments compared with each other — that will require a different protocol. The value of the project is that it put several therapies out in view. Unlike EMDR, the other three therapies have virtually no research and the exposure they received in Florida will help to encourage that. As that is accomplished, we shall learn more about what works with our clients and, in the long run, that may well be the most important outcome of the Active Ingredient project.

EMDR WITH COUPLES

Art Anton, Ph.D.
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It is generally held that EMDR is not to be used with couples, and I agree that it is not appropriate to do so when the primary items being dealt with are such issues as power, intimacy, trust, communication, conflict, or control of impulses and emotions. However, I discovered recently that EMDR can be used successfully and effectively with couples in at least one particular type of circumstance. The circumstance I have in mind is that in which a couple faces an external threat or severe loss that creates a crisis atmosphere to which each member of the couple is reacting with considerable anxiety and extreme distress. However, rather than allowing their relationship to degenerate into mutual blaming and fault-finding, the members of the couple maintain their bonding to each other, continue to support each other, and constitute a unified front in regard to the threat or loss.

Recently I had occasion to treat two couples fitting the description given above. The first couple consisted of a health care provider--(not a mental health professional, I might add), who had been accused (falsely, I believe) by a female patient of having touched her improperly during an examination--and his wife, who assists him in his office. The husband was strongly proclaiming his innocence of the charge, and his wife was steadfastly supporting his contention. Both of them were angry at the accuser and outraged at the accusations, but they were also experiencing acute and severe anxiety such that the husband was having chest pains and the wife was suffering from an irritable bowel syndrome. Consequently, they both needed to be seen on an urgent basis. I found that their anxiety was being fueled by extremely negative thoughts--his having to do with damage to his reputation, the loss of his practice, and of a

part-time teaching job, and hers with the loss of their financial base and of their home. While their anxiety-producing thoughts were not identical, they "hooked" those of the other. I listed all of their thoughts and since they were sitting side-by-side on the couch in my office, instructed them both to follow my finger movements with their eyes after having first read the first thought on the list (which happened to be the wife's) and elicited the SUDs level for each. After the SUDs level for both the husband and wife was reduced to zero, I followed the same procedure in regard to all of their other thoughts. After two sessions, both members of the couple reported that their anxiety levels had dropped considerably, that their physical symptoms had been substantially alleviated, and that they were both determined and optimistic in regard to the pending legal action against the husband.

The second couple, also needing to be seen urgently, was reeling from the impact of a totally unexpected, particularly hideous, and nearly fatal suicide attempt of a son. Their quest was for assistance in maintaining their unity and their ability to support each other in the face of this devastating family tragedy. They were both experiencing severe anxiety, shock, grief, and, in the case of the husband, some anger. As was the case with the first couple, their emotional reactions were being fueled by their own thoughts and while the husband's were not identical with the wife's, his were "hooking" hers, and vice versa. I used the same procedure as that which I described above in regard to the first couple, and after two sessions, they had both processed a great deal of the trauma, had achieved good emotional control, and were supporting each other very well.

The foregoing demonstrates that it is possible to obtain good therapeutic results from treating both members of a couple simultaneously. At the same time, I consider the circumstances in which this can be done to be circumscribed or limited, and would discourage the use of the procedure described above in more typical or usual cases of couples' counseling.

Case Study
Jimmye D. Angell, Ph.D.
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The client is an intelligent, attractive, 46-year-old married woman with an abusive background (as well as multiple dysfunctions in her blended family). Using EMDR, as well as other approaches, we have worked through many issues of co-dependency, anger, self-worth, boundaries, and assertiveness. Although she was feeling better, something was still amiss. We decided to do an EMDR session on the death of her 2-1/2-year-old son which occurred 21 years ago. On June 29, 1995 (which was the client's birthday, as well as her son's), we processed the middle-of-the-night unexpected death. She awakened in 1974 terrified and knowing that something was wrong. She was frozen in our session, just as she was that night (eg., she was frozen in the doorway, her body cold and clammy, her upper chest heavy, sad, and feeling as if a vise was on her forehead). Her body became hot as she was able to move from the doorway and she told me, "I have been frozen in that doorway for 21 years, afraid to go forward or back, and now, I'm thawing." We processed the rest of that night's events: telling her husband, not being allowed to feel anything because of taking valium, and being separated from her son's body. Cognitions changed from, "I'm helpless; I should have been there," to "I did the best I could with the lack of knowledge; it's okay for me to be spontaneous and emotionally close." The client felt her body temperature return to normal and she experienced relief from the tension of always expecting the worst, day by day, in all aspects of her life. She had been afraid of everything, including attachment, for fear of loss. She felt good, even her eyebrows relaxed downward.

Her new calm has held now for 5 weeks, and pervasive systemic shifts in her life have been noticeable. She has no unrealistic fear, no guilt regarding her son, no more questioning of herself, has a slower pace, and has increased awareness of her surroundings. "I was at a fast pace to get through 'whatever,' before disaster struck." She has been spending more time and money on herself. Since her changes, people around her also have changed. Her husband has become more responsive, helpful, and attentive; he has listened to her at last. For the first time, she feels like an adult; as if she has "grown into her skin." She is letting love in, connecting with friends, feeling no need to impress people, is more spontaneous, and her self-talk is more positive. Overwhelmed by these changes, she now wants to experience everything instead of avoiding life.

She says her heart was encased in a locked metal box. Now, her oversized heart is softer and the box is gone. "I can cry now in the present moment, and I can empathize." No longer operating out of a need for approval, she now wants to give to others out of a sense of fullness.

"I am at peace, the fear is gone, and I stay calm in stressful situations. I feel 'cured,' 'healed,' 'light,' and no longer am I dreading the day when I get up in the morning."

EMDR AND MEDICAL CONDITIONS
Graciela Rodriguez, MD; Pablo Solvey, MD; Raquel Solvey, MD; Susana Tagliavini, Lic. Psic.
Argentine EMDR Foundation

We have successfully treated some clients with somatic complaints, and would like to share our experiences with you. The following very briefly

describe cases for which we used EMDR successfully.

A 76-year-old man, referred by an ear, nose, and throat specialist, had for 7 years been annoyed by a very troublesome tinnitus. He also had a concurrent insomnia, which was not caused by the tinnitus (when he slept he was not disturbed by it at all). The symptoms had worsened when his wife asked for a divorce, some 2 years ago. The SUDs on the sensation was 8, the negative cognition was, "I can't stand it anymore," and the positive cognition was, "I can live with it," with a VoC of 2. We worked for three sessions, with the sensation as the target. The SUDs went to 2, and the VoC up to 7. He stated he continued having the tinnitus, but that it did not trouble him anymore. ("I hear it, but I don't listen to it. It's there all right, in the background, but I kind of forget about it.") With a follow-up of 6 months, he is still fine, and his insomnia has diminished markedly.

A 7-year-old girl had a severe allergy on her right hand: it was red and swollen, it was wet, it burned and hurt. We targeted those sensations, which had a SUDs of 10, and she remembered different scenes with her mother and her newborn sister. The negative cognition that then appeared was, "My mother doesn't need me anymore." After three sessions, the allergy gradually improved, until it practically disappeared. She is 90% better at a 6-month follow-up.

An 11-year-old girl had a chronic allergy caused by low lgE, a low immunity disorder. Her whole body had itched and bled in places since she was 6. We worked for 12 sessions with hypnosis and EMDR, alternately, with no results. Her family insisted that she have only "positive thoughts," to which she paid lip service by repeating positive affirmations day and night. It then occurred to us that she did not really believe them, so we targeted on the cognition, "I'll never get any better." After three sessions with this negative cognition, her allergy became 75% better. However, it was practically impossible for her to imagine herself totally free of the disease. We had her symbolize her illness, her being healthy, and different in-between states with different colored papers. These papers ranged in color from brown to yellow, and were in different sizes. While she watched the papers, from left to right and from brown to yellow, we did EMDR (actually finger snapping). We asked her what color best represented her allergy and what color represented herself free of the illness. (Both size and color represented the degree of illness.) We also included some brown papers in the middle of the yellow ones, to prepare her for relapses of the allergy, and she could accept them as temporary. During several sessions, she got stuck with one of the colored papers, saying she could not imagine getting any better than she currently was (that is, about 75% better). However, targeting on that little paper, she remembered some nightmares that made her very anxious, in which she saw herself with no skin and bleeding all over. She was actually afraid of losing all her skin, and that was by no means impossible. After we processed this, she was able to get past the little paper further on, to almost the limit of "health" (the yellowest and smallest paper), and in a few days, her skin cleared another 15%. The treatment continues at the present time, and she is 90% improved.

A 21-year-old medical student had fibrositis, a common disorder characterized by chronic fatigue, muscular aches, and non-restorative sleep. The disorder includes "trigger points" in different muscles, which ache, and sufferers may sleep for a normal period of time, but always awaken feeling tired, or non-restored. They actually have an increased amount of alpha frequency activity in their slow-wave sleep EEG recordings—that is, an "alpha delta" type sleep pattern—and do not reach delta levels. Two sessions of EMDR allowed her to calm her muscle aches and achieve restorative sleep. As we could not find any negative cognitions, we simply targeted on the feeling of awakening tired. No memories appeared, just kinesthetic sensations. When the first session was over, she said, "I feel as if I had a brain massage." The disorder returned 8 months later, however, so we had two EMDR sessions, and they were once again successful. This was 4 months ago and it is holding (we are keeping a close watch on her).

A 50-year-old woman with Tourette Syndrome had a blinking tic and a coughing and hiccuping tic for years. Lately, the coughing-hiccuping tic had worsened to the point that she swallowed lots of air, apparently causing her three neumothoraxes in the last 5 years. She also had a severe speech impairment because of her coughing-hiccuping tic. We targeted on this tic, and she remembered three traumatic events with her sons. The tic got much better, but did not disappear, so we targeted on the negative cognition, "I have to tic this way and no other," and "This is the only tic that feels just right." The positive cognition with a VoC of 2 was, "I could tic some other way," and "Other tics—perhaps at the feet or toes—could feel just as right." We worked on it with EMDR for three sessions, and it went down to her toes—which no one sees, of course. At a 7-month follow-up, the tic is still at her toes. In times of stress, she returns to the coughing-hiccuping tic, but only temporarily. The blinking has not changed.

Three children, ages 8, 9, and 14, with moderately severe ADHD, who were medicated with 10 mg of Imipramine, experienced improved grades and concentration. We then started working with EMDR. With an average of four sessions, the hyperactivity reduced some more, and attention increased—including grades at school, which improved. We targeted the impulsive acting and its consequences, and the need to move targeting to future images of being calm and quiet; the latter for which we used vertical saccades. We then included working on the cognitions that had developed over the years such as, "I'm lazy," "I'm no good," "It's my fault," etc. We soon suspended medication, and they maintained their progress. The treatment continues at the present time, with no medication.

A 46-year-old woman had asthma

when she was 4 years old which lasted for 2 years. She had asthma again at 30, during a marriage crisis, and this time it lasted one year. She sought treatment because her asthma had returned about a month prior, again during a marriage crisis. We targeted on the memories of the asthma attacks (SUDs = 10), on the marriage crisis (SUDs = 10), and on her fear of divorce (SUDs = 10). The negative cognition on all scenes, including the childhood ones, was, "I'm no good," and the positive cognition was, "I'm lovable," and "I deserve to be listened to." The SUDs went down to 1, and the VoC up to 7. After four sessions, she stopped having asthma attacks, and at a follow-up of 8 months, she continues free of the disease, and goes about without the inhalator.

A 52-year-old man with PTSD consulted us after the death of three very close friends, each of whom died in the space of 2 years of a lymphoma. He also complained of a chronic migraine, which he had been having for at least 10 years and which struck twice a week, with a peculiar periodicity: it happened every Saturday and Wednesday. It always started with a luminous aura and prodrome on his right eye, the pain lasting for about 24 hours, and usually no treatment was effective. As we could only work for two sessions, just before summer holidays, we targeted on the PTSD intruding scenes (the ones of the death of his friends, with a SUDs of 8), until the SUDs reduced to 0. When we returned 2 months later and resumed our sessions, his migraines were 90% better. However, a very stressful incident happened in his family: his wife was diagnosed with advanced breast cancer. It was then that the migraines returned, but at a 50% level of intensity and frequency. We then targeted on the luminous aura and the particular sensation on his right eye. The SUDs was 8, and no cognition was available. After two sessions, the luminous aura sensation had vanished and he could not bring it back. The SUDs went down to 1. When he returned the following week, the migraine had disappeared and to this date (3 months later), he is free of it.

Two months ago, a 40-year-old man had developed a very severe symptom: he had attacks of vocal chord closure during which his glottis also closed, and he choked severely, with practically no air passage. He was hospitalized several times, and an anesthesiologist had to use a tracheal tube to allow him to breathe. He was warned that he could die of these attacks. The only solution they had to offer was shots of clostridium botulinum (botulism) toxin in his larynx and on his vocal chords to numb the chords and the glottis, and diminish the nervous conductibility. This would work for about 7 or 8 months, and had to be repeated periodically. It would also cause a severe impairment on his speech. He was referred for EMDR as a last-chance treatment, even if it was a long shot, in the hope of avoiding the clostridium botulinum toxin.

The SUDs on the attacks was 10, and we were pretty fearful of targeting on the symptom, since there was always the danger of producing an attack. Still, as there was no other way, we prepared, just in case, some adrenaline and Decadron shots as a stand-by. When we started with the eye movements, he said how happy he was that his little daughter had recovered from leukemia; she was considered cured. Two months ago—just prior to the attacks—she had finished her last session of chemotherapy and he was celebrating with his wife. He then remembered that he paid a last visit to the cancer specialist who said everything was okay, and told them to return next year for a routine check-up. The doctor was very optimistic, and so were they. He then remembered something he had forgotten: They had seen in the waiting room another girl, whom they knew also had leukemia and was considered cured for some two years now. She was there with her parents who were very distressed because she had had a relapse. When he remembered this, he stated choking, so we kept moving our fingers like mad. (I do not know who was more scared of the two.) We had him move his eyes on and on, until the attack—which never got to a dangerous point—passed. Fortunately, he did not need the shots. We then had two more sessions, targeting on the fear that his daughter could have a relapse. This was three months ago. We keep in touch by telephone and he is doing fine. He has had no more attacks to the present time—and with no botulism toxin.

ALL EMDR TRAINED CLINICIANS
FROM THE EDITOR
Lois Allen-Byrd, Ph.D.

I hope that all of you had a wonderful holiday season and will enjoy a peaceful and prosperous new year. The EMDR Network is taking off in a new direction and it is hoped that it will produce wonderful benefits for both the organization and its members.

I am writing this brief Editorial as a reminder about two issues that have recently been brought to my attention. The first is regarding how clinicians describe their EMDR training. I have become aware, while perusing listings of professionals (e.g., MFCCs, social workers, psychologists), that some people, including interns, are identifying themselves as being certified in EMDR.

REMEMBER:
THERE IS NO CERTIFICATION IN EMDR.

Thus, to list yourself as such is untrue and misleading, particularly to others who are not familiar with the implications of certification vs. no certification. I am sure that these listings indicate a misunderstanding by some EMDR clinicians. However, please remember that when you update existing listings or submit new information about your training, you do not state that you are certified in EMDR.

Second, now that Dr. Shapiro's book is published, there may be professionals (as well as non-professionals) who read it, and then begin to use EMDR without receiving any formalized training. The ethics of the profession demand that we, as professionals, avail ourselves of as much training as we can in order to be deemed competent when using a particular method or technique. Therefore, to solely read a book when more comprehensive training is available does a disservice to our profession, our clients, and, in this case, EMDR.

In essence, this Editorial is really a brief reminder that all of us must work to maintain the integrity of EMDR. We all are aware of the criticisms that EMDR and Dr. Shapiro have received and endured over the years, even to the present. When you consider the wonderful gift she has given to us and our clients, I think it is important for to do what we can to reduce the risk of engaging in behaviors, even if inadvertently, that may be questioned or considered unethical.

International Update

Francine Shapiro, Ph.D
Mental Research Institute
Palo Alto, CA

The EMDR Humanitarian Assistance Programs (EMDR HAP) successfully completed another training program in the Balkans. Drs. Steven Silver, Gerald Puk, Susan Rogers, and Geoffry White were flown over by Catholic Relief Services and gave two trainings in Sarajevo to mental health professionals, many of whom were themselves traumatized by the war.

The training team landed the day NATO troops arrived. During much of the training, there was sporadic gunfire in the background. Words cannot express our appreciation for their efforts. As stated by Geoffrey White when he accepted the EMDR Humanitarian Service award at last year's conference for his efforts to bring EMDR to the Balkans, "All it takes for evil to exist is for good people to do nothing." Only through a united effort can good truly prevail.

In that spirit, EMDR HAP is now seeking funds to finance training programs that have been requested in Rwanda, Belgrade, Northern Ireland, Bucherest, Navajo Reservations, and Columbia. The request from Columbia has come from an organization called Forjar which treats abandoned children who have been diagnosed with AIDS or cancer. We now have many requests, but little financing. In order to aid in the humanitarian effort, I asked for a vote at the last conference, and received an overwhelming mandate to turn the EMDR Network into a service organization. Since the EMDR International Association (EMDRIA) will now take on all the professional functions (Newsletter, directory, regional meetings, study groups, conferences) previously organized by the Network, we can turn our efforts in this new direction.

In trying to conceptualize the relationships between these various organizations, as well as their separate functions, I came up with the following chart:

EMDR Institute	EMDR Network	EMDR HAP	EMDRIA
trainings	membership	pro bono programs	professional service
alumni support	preferred providers	donations	training standards

Obviously, before things are finalized, I would like your input on my ideas and any suggestions you might have about how to expedite the process most judiciously. Here is my thinking so far: The EMDR Institute will continue offering trainings to mental health professionals. However, it will be only one of many sources, since the training restrictions were removed, and the training agreements have been cancelled. However, in order to allow some hope of quality control in the mental health field, EMDRIA (as a separately incorporated professional entity) will serve as the professional support organization for clinicians trained by any organization that meets its requirements.

Obviously, clinicians should have the opportunity to attend local trainings, but they should have some organization that can steer them to trainers that meet acceptable professional requirements. Clients should also have access to an organization that can refer to trained clinicians who have completed the appropriate courses, university sponsored, and otherwise. Membership in EMDRIA will be limited to clinicians meeting those standards. EMDRIA will provide professional support services including a newsletter (soon to become journal), general directory, regional meetings and study groups, conferences, and provide outreach to managed care companies, professional groups, and the public. EMDRIA is a fete accompli—independent of the Institute. The only connection between the two will be the co-sponsoring of the 1996 EMDR Conference in Denver. Future conferences will be handled completely by EMDRIA. Many of you have already joined, and elections will be held shortly. Their first Newsletter will be sent this April. This is the last Newsletter of this kind that you will receive from the EMDR Network.

The part that I am still conceptualizing, and would like your input on, is the relationship of the EMDR Network and EMDR HAP. Since EMDR HAP is a non-profit, public benefit corporation, it is presently soliciting donations, through a fund-raiser, to fulfill the requests for services. For instance, the request to train clinicians to work with children in Rwanda will take approximately $5,000 to fulfill. All services are being offered pro bono. Trainers and facilitators are donating their efforts, but travel to Africa and housing alone cost $5,000. Likewise, in order to respond to a disaster, such as the effort to provide services to Oklahoma City, approximately $50,000 in travel, lodging, and professional support is required. Although the programs are obviously needed, and we have been profusely

thanked for previous services, it turns out that corporate donors will generally not contribute unless there is a steady source of income. In other words, we must find a guaranteed financial support base.

In order to do this, the mandate delivered at the conference to turn the EMDR Network into a service organization is perfect. The EMDR Network, which will be made up of alumni of the EMDR Institute, is a non-profit professional, membership, organization. All donations made to it by mental health professionals are tax-deductible. We will offer membership at a sliding scale with dues that will allow the guaranteed financial base the corporate donors look for. The dues will go exclusively to finance HAP, and grants for specialized research projects (e.g., inner city prevention programs). A yearly *Newsletter* will report to the membership on how the monies have been spent. In addition, because of the problem I mentioned in the "Stray Thoughts" column, we will allow members of the Network to take a proficiency exam to established a preferred providers list. That way, those of us who truly care about providing humanitarian services worldwide, and support the concept of quality care, will have the opportunity to join forces. The EMDR Institute will then only refer clients who inquire about services to clinicians who are listed on the preferred providers list. The goal is for you to feel safe if you refer a family member or friend.

The range of understanding and competency is so vast we need to start making descriminations. We have hundreds of requests for referrals every month, and it will become even more frequent when two books for lay people are published next year. For those who choose not to participate in a competency evaluation, EMDRIA will be providing referrals and a directory of its members who need only to have completed the required courses. I think participation in both organizations is vital, but choices are certainly available. However, EMDRIA will be the equivalent of an APA. It will continue to open up the doors for EMDR's expansion throughout the professional and lay community. It will make sure that standards are recognized worldwide so that EMDR is not lost amid the myriad of "eye movement therapies" that are proliferating. Therefore, I would expect anyone interested in EMDR HAP to want to support EMDRIA's mandate as well.

Facilitators are currently working on the examination for the preferred providers list. For those who do not pass, a course is being designed out of which, the clinician will have to test. We are committed to keeping the costs as low as possible. Facilitators will have to be paid for their time, meeting space, travel, etc. will have to be covered—but the goal is to establish a resource base of which we can all be proud. It will exist not only to serve clients who request aid, but to place clinicians on the humanitarian assistance provider rolls for disaster response.

Many of you have heard me say repeatedly that I learned long ago that I could not please everyone. This structure is clearly not for those who ask only, "What's in it for me." It is really for people who have the kind of awareness that I have seen so often in our trainings. People whose hearts are open. People who care about humanity. People who support others and deserve to be supported.

Years ago, I was told that the author Robert Heinlein lived nearby. Many of you may remember him for his novel, Stranger in a Strange Land. It was a book that inspired many of us in the 1960s. At any rate, the story goes that a young man came to see him saying, "I want to thank you so much. What can I do to repay what you've done for me? What can I do to repay you for all you've given to me?" Heinlein looked at him gently and said, " No, No. You're not getting it. You don't pay back. You pay forward."

That is what I would like the EMDR Network and EMDR HAP to be about. Anyone that wants to play on that level is more than welcome. So, if any of you have other ideas or constructive comments about the plan, please do not be shy. Write to me. We are all in this together.

* * *

While I gave invited EMDR presentations at a number of major conferences in 1995, including at the 1st Pan-Pacific Brief Psychotherapy Conference, the American Academy of Psychotherapists, and the Anxiety Disorders Association of America convention, the highlight came in December. As an invited speaker at the Evolution of Psychotherapy Conference, EMDR was represented as a "state of the art" therapy. Six thousand people attended the conference and approximately two thousand of them attended my presentation on EMDR. The whole experience was gratifying to say the least.

In 1996, the following invited presentations are already scheduled:

Jan. 12-15	New Traumatology Conference Clearwater Beach, FL
Feb. 23-24	The Menninger Clinic Topeka, Kansas
Feb 29- Mar 4	Trauma, Loss and Dissociation Washington, D.C.
March 21-23	Family Therapy Networker Washington, D.C.
March 25-28	American Society of Clinical Hypnosis Orlando, FL
March 29-30	Active Ingredient Project Tallahassee, FL
April 26-28	Society for Exploration of Psychotherapy Integration (submitted symposium) San Francisco, CA
Aug. 9-13	American Psychological Association Toronto, Canada
Nov. 22	Mount Sinai Hospital Psychiatry Academic Day Toronto, Canada
Dec. 11-15	Ericksonian Brief Therapy Conference San Francisco, CA

I think it is fair to say that judging from the wide range of invited keynotes, and the plenary sessions, EMDR has become generally accepted as an important advance in psychotherapy. Now, to conclude its acceptance in the field, it is only a matter of time until the already completed research makes its way into publication. The American Psychological Association's Task force on the Evaluation and Dissemination of Empirically Validated Meth-

ods, has chosen not to include EMDR in this year's listing because the studies supporting it, that meet their other guidelines, have not yet been accepted for publication. To-date, there are a total of thirteen completed PTSD studies. One shows negative results, (Jensen, 1991). Two show mixed results (Boudewyns, 1990; Pitman, 1993). The others show positive results, with the most recent ones supporting that 84-90% of participants no longer meet PTSD criteria after only three sessions. No other controlled research shows equivalent results in so few sessions. No other method has this much controlled research supporting it.

We have included a research overview of twelve of the PTSD studies with this Network packet. An additional two studies are: 1) a comparison of EMDR to standard Kaiser Care by Stephen Marcus and Priscilla Marquis for PTSD clients and 2) a study of women at risk (prostitutes, drug addicts, etc.) comparing EMDR and standard active reflective listening by Maggie Scheck, Judith Schaeffer, Ph.D., and Craig Gillette, Ph.D. Both studies, along with an update on the Wilson, Becker, & Tinker data and the Carlson, Chemtob, et al. comparative research on combat veterans will be presented at the 1996 EMDR Conference. The Wilson, Becker, & Tinker study appeared as a special feature in the Journal of Consulting and Clinical Psychology in December 1995. A copy of the article is included in this packet. Of course, this has not stopped the refrain I am sure all of you have heard, "it's too good to be true" and "there's no research." That is why it is vital for responsible clinicians to continue making presentations on EMDR at professional conferences. It is also necessary that more controlled research be done. Extraordinary claims, demand extraordinary proofs. Old paradigms die hard.

One study that we are looking forward to is being conducted by Bessel van der Kolk, M.D., at Harvard comparing EMDR to prozac, using brain scans. The study should begin in February and continue to the end of the year. Steven Lazrove, M.D., at Yale is consulting on the project. Dr. Lazrove is also conducting his own studies of EMDR compared to hypnosis for single trauma victims—many of whom are members of MADD. In consequence of his preliminary research with this group, MADD is supporting the dissemination and use of EMDR throughout its own network. It is quite wonderful to see the healing effects spreading so rapidly.

The 1996 EMDR International Conference will be held June 28-30 in Denver. The headliners are Bessel van der Kolk, M.D., Catherine Fine, Ph.D., Steven Gilligan, Ph.D., and Jeffrey Mitchell, Ph.D. All are trained and using EMDR in their research or clinical practice. In addition, I have been asked to give a keynote address. According to the coordinator, Carol York, LMSW — it is "an interdisciplinary conference designed for all those trained, working, studying, and involve with EMDR. There will be emphasis on enhancing skills and knowledge, as well as networking among clinical professionals and researchers. We are most proud to highlight the interest, the work, and continued efforts of EMDR professionals involved in worldwide humanitarian activities." There will be presentations on using EMDR with family systems, complicated bereavement, various issues with children, somatic disorders, anxiety, sports, etc. Each annual conference has increased in content, attendance, and substance, with last year's participants giving it an overall rating of over a 4.6 out of 5. We look forward this year to an even greater, heart-warming success.

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EMDR AND MENIERE'S DISEASE

Ann Martin, M.S.
Oregon

On March 6, 1995, a female client, age 26, came in presenting extreme stress about performance anxiety in anticipation of her music final in voice. (She was a music major with a vocal emphasis at the state college where I am a counselor.) The client's complaint was that she could not hear many of the notes on the piano to sing due to the ringing and white noise in her ears.

She began noticing hearing problems in high school when she was 15 years old, and was diagnosed with Meniere's disease (Stedman, 1990) in 1990 at age 20 by her medical doctor. The client reported that her right ear was at 50-60% hearing capacity and her left ear at 10% capacity. Her medical doctor had told her that her hearing would not improve beyond this 10%.

After preparing the client and assessing the baseline information, we had two sessions using Eye Movement Desensitization and Reprocessing (EMDR), targeting her hearing problem. Up to this time, she had been following her diet for Meniere's, avoiding salts, fats, caffeine, and some sugars. After the first session with EMDR for her hearing problems, her Subjective Units of Disturbance (SUDs) Scale (Wolpe, 1991) numbers went from 8 to 5/6, and the Validity of Cognition (VoC) Scale (Shapiro, 1995) numbers from 1 to 5/6. The client took her performance final between the first and second counseling sessions. (In the second session, the client reported there was no ringing in her ears.) To her surprise all went well. She could hear the piano notes and her performance received an above average grade. We then focused on the white noise in the left ear. She gave this a SUDs of 4 at the onset. When we finished, the SUDs was 0, indicating that the white noise had been reduced significantly. In both sessions I suggested the client use an image that each ear was a speaker and she was a miniature person who could go in and turn the knobs on the tuner down for volume on each ear.

Conclusion

As of January 1996, the client reports continued absence of ringing in the ears, and only faint white noise remains (which has not interfered with her musical abilities). In the past, the client experienced dizzy spells and vomiting frequently during hot weather, but since treatment, has only experienced this twice—in August and in September. There has not been any vertigo since those two incidents. Since last March, she has regularly enjoyed some of the foods she was previously avoiding with Meniere's disease. Eating these foods has not caused ringing in her ears to date. All in all, the client reports being extremely satisfied with the results of EMDR and her ability now to hear notes clearly and sing them. Her sense of competence and confidence musically has been increased and enhanced as well.

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Addiction Research Project

Arnold J. Popky, M.A.
Haight Ashbury Free Clinic

Silke Voglemann-Sine, Ph.D., and Larry Sine, Ph.D., are developing a research design for addictions to be presented at the 1996 EMDR International Conference in Denver this June. The research project will cover a broad range of substance addictions as nicotine, marijuana, cocaine, crack, heroin, alcohol, methamphetamine, and prescription drugs. Dysfunctional addictive behaviors such as overeating, bulemia, and anorexia; sex; shoplifting; and work will also be included. The research project will be built around and based on, "The Integrative EMDR Addiction Treatment Model."

Accompanying their research design will be a presentation describing the addiction model and a preview of a one day training on the model, with videos demonstrating the components with different clients. The one day training is planned for late 1996, and will be made available to EMDR trained therapists only who are interested in participating in the research project.

The purpose of the conference presentation is to identify those government, educational, and private organizations, as well as individuals across the country, interested in working with the addictive populations. It is hoped that these individuals and organizations will be willing to try new and innovative lasting solutions for those suffering with this growing problem.

There will be a discussion on the organization and coordination of the various independent efforts involved in this research task.

EMDR Mail List on the Internet

An EMDR mail-list on the Internet is scheduled for March-April. This list will be restricted to EMDR trained therapists and by subscription only. The purpose of the list is to promote closer communications among the EMDR family and for sharing individual experiences. Those interested please email ***ajpopky@emdr.org***. Enter mail list in the subject area and "subscribe" <yourname> in the body. I will contact you with the details when the list is on line.

Good–bye
Lois Allen-Byrd, Ph.D.
Editor, EMDR Newsletter

As most of you know by now, this is the last issue of the Newsletter as produced by the EMDR Network. I have had the pleasure of being the editor of the Newsletter for some time now, and have enjoyed the challenges that seem to have been inherent in the task.

While it is wonderful to consider moving ahead to what hopefully will a stronger organization, it is important to take a moment and reflect on what has passed. We have watched the organization rapidly grow over the years, and have seen innovations in both the method and its applications since its inception. It has been a remarkable journey and one that has not yet reached its final destination. Many people have helped EMDR reach this point (with most of the effort and guidance being Dr. Shapiro's), and many of them have been mentioned in previous Newsletters. As with most organizations, there are those who do very important work--work without the glory, but work that helped hold things together--and I would like to take a moment to thank them and let them know I speak for all of us in expressing this gratitude.

Beginning with the EMDR Network staff, thanks for your untiring efforts in getting the Newsletter out, organizing the material that would accompany it, and handling questions, comments, and complaints--all while being responsible for your daily tasks-thanks Robbie, Stacy, Ravia, Anne, Lyn, Peggy, Karen, and Michael.

To those of you who subscribed to the Newsletter and/or submitted articles, thank you for your continued interest in, and support of, EMDR.

Last, but definitely not least -- tremendous gratitude to A. J. Popky, MA, publisher, and Sharon Lucas, data entry, for your outstanding efforts in ensuring that the Newsletter was the best it could be. Without either one of these dedicated individuals, the sometimes painful struggle to get the Newsletter finished would have been unbearable. Thanks to both of you for your hard work and support.

Announcing...

The 1996 International EMDR Conference

"Research and Clinical Applications"

June 28/29/30, 1996
Denver, CO

The Westin Hotel
Tabor Center Denver

Sponsored by
EMDRIA
and the
EMDR Institute, Inc.

Mark Your Calendar!!

EMDR HELP WANTED
THE NOTICES IN THIS COLUMN WILL NOT AUTOMATICALLY BE CONTINUED IN THE NEXT NEWSLETTER. SHOULD YOU WISH TO RESUBMIT YOUR NOTICE FOR CONSIDERATION, PLEASE SEND IT TO:

EMDRIA, THE ADMINISTRATOR
3900 E. CAMELBACK RD. SUITE 300
PHOENIX, AZ 85018

EMDR
Research/Training Institute

The EMDR Research/Training Center at MRI is looking for individuals who want to take part in research projects on victims of natural disasters. Please call *Cliff Levin, Ph.D. (415) 326-6465.*

Going to be in Beijing?

I recently met with a group of psychotherapists there who want very much to meet with experienced Western therapists for the purpose of learning new approaches and discussion of cultural differences. These therapists meet monthly for mutual support and organizing creative projects, such as hot-lines for single parents, HIV-counseling, etc. There is very little training for psychotherapy in China, and what there is seems dated. (The feeling they gave me when I twice met with them is reminiscent of the excitement and lust for learning inherent in the burgeoning field of psychotherapy in the 70s in the Bay Area.) Please contact me if you are planning a visit and can spare extra time and I will put you in touch with them. Also, books on psychotherapy and articles on family therapy are requested (in particular, "Coping with Family Transitions and Research Methods Used"). Contact: *Sheryll Thomson, MFCC, 1641 Hopkins St., Berkeley, CA 94707; (510) 525-8081 (Office/Voice Mail).*

Fluent in a 2nd Language?

Any EMDR trained therapists fluent in a second language, please contact the EMDR office at *(408) 372-3900.*

Spiritual Insights

If you have clients who have reported experiencing spiritual openings or insights during or after EMDR sessions and would like to share these vignettes, please write up these cases and send them to: *Laurel Parnel, Ph.D. 22 Von Ct, Fairfax, CA 94930. (415) 454-2084*

Managed Care

In speaking to managed care organizations, hospitals, and reluctant-to-believe colleagues, it would be helpful to be able to offer names of recognized institutions which endorse the use of EMDR. I would like to compile lists of treatment facilities, large employers, and insurance companies/managed care organizations that do support its use. These lists could be distributed via network mailings. Please send contributions (including a name/phone/address for verification) to: *Chad Glang, Ph.D., 1027 N. Weber, Colorado Springs, CO 80903.*

Published?

If you are an EMDR trained clinician and have had any books published, please contact *the EMDR office at (408) 372-3900.*

RET/EMDR

Practitioners interested or experienced in RET/EMDR, please contact: *Dennis Coates, 216 Avenue P South, Saskatoon, Saskatchewan S7M 2W2 (306) 665-2788 or (306) 242-6847*

Research Subjects Needed

Research subjects needed for PTSD outcome study, using EMDR and another proven treatment for PTSD. Potential subjects must be Kaiser Permanente Health Plan members able to receive treatment in the South Bay Area. They must meet DSM-III-R criteria for PTSD, be stable on medication, not suicidal, have no litigation pending, no drug or alcohol abuse or dependence, no Multiple Personality Disorder or Dissociative Disorder, no psychosis, and must have had symptoms for greater than one month. Since this is a randomized study, subjects may not be assigned to the EMDR condition and therefore, it is important that they are not referred with the intention of receiving EMDR. Benefits to participation are that the individuals will receive careful evaluation, treatment implementation and follow-up, and will add to our knowledge of treatment for PTSD. Once again, it is important to remember that we cannot accept subjects into the study who expect EMDR because they may be randomized to an alternative therapy. All patient referrals must be willing to receive either treatment. For questions and referrals, please call *Linda Kolstad at (408) 236-6763.*

Babies

I am still collecting stories and ideas about using EMDR with babies. Someone told me an interesting story about working with a traumatized 5-month-old which I will submit for the next Newsletter—along with others? Please call or write: *Sheryll Thomson, MFCC, 1641 Hopkins St., Berkeley, CA 94707; (510) 525-8081 (Office/Voice Mail).*

CALIFORNIA EMDR STUDY GROUPS

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CENTURY CITY/SANTA MONICA
Robert Goldblatt (310) 917-2277
Coordinating a new group 90067, 90401 zip area for West L.A.

CERRITOS/CENTRAL CITIES
Pauline Hume (213) 869-0055
Pat Sonnenburg (310) 924-7307
Coordinating a new group. Open

CUPERTINO
Gerry Bauer (408) 973-1001
Meets 2nd Wed. 2:00 - 3:00 pm. Case consultation. Open

EAST BAY
Edith Ankersmit (510) 526-5297
Meets 3rd Fri. 7:30pm. Case discussion only. Group is closed to new members, willing to coordinate new E. Bay group.

EAST BAY/ALBANY
Sandra Dibble-Hope (510)843-1396x48
Meets 1st Mon. 8 - 9:30pm, 1035 San Pablo Ave., Ste. 8.

EAST BAY/OAKLAND
Hank Ormond (510) 832-2525
Meets one Friday a month. Call for time & day. Open

FRESNO
Darrell Dunkel (209) 435-7849
Meets 1st Fri. at Fresno VAMC. Primarily case discussions.

Nancy Stark, MFCC (209) 292-1700
Jams Sheppard, MFCC
Meets every other Friday. Call for information.

FULLERTON
Curtis Rouanzoin (714) 680-0663
Jocelyne Shiromoto
Meets 2nd Tuesday from 9:30 - 11:30 AM.

HUNTINGTON BEACH
Jocelyne Shiromoto (714) 965-1550

IRVINE
Charles Wilkerson (714) 543-8251
Meets 2nd Thursday of month. Primarily case discussion. Open. Call for directions.

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

LOS GATOS/SARATOGA/CAMPBELL
Jean Bitter-Moore (408) 354-4048
Meets the 3rd Thurs. 12:00-1:30pm at Mission Oaks Hospital, Conference Room 1, Los Gatos. Open

MANHATTAN/REDONDO BEACH
Randall Jost (213) 539-3682
Coordinating a new group.

MARIN COUNTY
Gilda Meyers (415) 472-2765
1 Friday per month. 10am - 11:30am. Call.

MONTEREY
Jean Paul Beaudoin, Ph.D. (408) 648-0845
Evelyne Zulueta, MFCC (408) 373-1572
Coordinating a new group. Open

NAPA
Marguerite McCorkle (707) 226-5056

NEVADA CITY/GRASS VALLEY
Judith Jones (916) 477-2857
Call for time. Open

PALMDALE/LANCASTER
Elizabeth White (805) 272-8880
Coordinating a new group. Open

PALO ALTO
Ferol Larsen (415) 326-6896
1st Wed. 10am MRI conference room. Case discussion.

REDDING
Dave Wilson (916) 223-2777
Meets monthly at the Frisbee Mansion on East Street. Discussions, case presentations, videos, role playing.

RIVERSIDE/SAN BERNARDINO
Byron Perkins (909) 732-2142
Meets 3rd Friday of every month, 9:30am - 11:00am.

SACRAMENTO
Bea Favre (916) 972-9408
Connie Sears (916) 483-6059
Meets third Friday of every month 1:00 - 3:00pm.
At 2740 Fulton Ave., Sacramento, CA 95821

SAN DIEGO
Arthur T. Horvath, Ph.D. (619) 445-0042
Call about meeting times and places.

Mary Anderson (619) 434-4422
Meets 2nd Friday of every month from 9:00 - 10:30am. Primarily case discussion. Call regarding availability.

Elizabeth Snyker (619) 942-6347
Meets 3rd Wednesday of every month, 9:00am - 10:30am.
191 Calle Magdelena St., Ste. 230, Encenitas, 92024.

SAN FRANCISCO
Sylvia Mills (415) 221-3030
Meets Friday, call for next date. Potluck dinner and case discussion. New members welcome.

Stan Yantis (415) 241-5601
Meets 1st Wed. 8 - 10pm., 180 Beaumont St. Please call to confirm. Case discussion and group process. Open.

SAN LUIS OBISPO
Marilyn Rice, Ph.D. (805) 438-3850

SAN MATEO/BURLINGAME/REDWOOD CITY
Pat Grabinsky (415) 692-4658
Florence Radin (415) 593-7175
Coordinating a new group. Contact Florence.

SANTA CRUZ AREA
Linda Neider, MA, ATR, MFCC (408) 475-2849
Meets monthly on a Fri. Call for time. Case discussion.

SARATOGA/W. SAN JOSE
Dwight Goodwin (408) 241-0198
Meets alternate Fridays, 9:30am - 11:30am.

SOLANO/ NAPA COUNTY
Micah Altman (707) 747-9178
Willing to coordinate new group. Call if interested.

SONOMA COUNTY
Kay Caldwell (707) 525-0911
Meets in Santa Rosa at Kay's office the 4th Tues. 12:30 - 2:00pm. Case discussion, videos and "troubleshooting." Open

TORRANCE
James Pratty (800) 767-7264
Coordinating a new group. Open

WEST LOS ANGELES
Geoffry White (310) 202-7445
David Ready (310) 479-6368
Coordinating a new group. Open

WOODLAND HILLS/NORTHRIDGE/WESTWOOD
Ron Doctor (818) 342-6370
Ginger Gilson (818) 342-6370
Seeking new members. Contact Ginger.

If you are interested in coordinating a new study group in your region, please notify the EMDR office at:
PO Box 51010, Pacific Grove, CA 93950-6010 (408) 372-3900 Fax (408) 647-9881