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Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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STRAY THOUGHTS

Francine Shapiro, Ph.D.
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The report of the bombing in Oklahoma City was extremely painful for many of us. As I watched TV, I was struck again by the level of pain we put each other through, and the level of suffering some of us endure. It also made me think of the obligation we have as mental health professionals to the world at large.

The Accelerated Information Processing model that I use as a clinical heuristic for EMDR application, explicitly states that present dysfunction (excluding those of organic/chemical origins) are based on earlier life experiences. As I have stated in the trainings, this is not a great revelation because unless we think that pathology is caused by an alien virus visitation, clearly inappropriate reactions in the present are based on previous experiences that are being triggered. For example, the alleged perpetrator in the Oklahoma bombing is apparently a Gulf War veteran. His hometown neighbors said that when he returned from the war, he seemed to be a different person. They say that the person he became seemed to have no relation to the little boy they had known. It seems clear that had he been successfully treated for his war experiences and level of rage and pain, this tragic bombing might never have occurred. Some people may become caught up in the "militia rhetoric," but I think as a profession, we need to direct our attention to the psychological drivers underlying the hate.

For years, clinicians have reported explosive dysfunctional reactions in veterans that were continuing to disrupt their present relationships. The spouses and children of suffering combat veterans were often victimized by the rage. It has also been reported that more combat veterans have committed suicide than died in Vietnam. Now we are witnessing first-hand one of the experiences many of them went through. We are forced to hopelessly watch the effects of a military act on innocent civilians. Some of us are heartbroken at the sight of the mangled and bloody bodies—just as many of the veterans I have treated have suffered over the past years. As a profession, we need to mobilize not only to relieve the suffering of the present victims, but to relieve the suffering of those that may be capable of committing such acts of violence and continuing the cycle of inhumanity.

I was appalled to hear that during a speech at the last International Society for Traumatic Stress Studies conference, clinicians were told that there is nothing we can do for veterans after so many years. Clinicians were told to just "close them up and prepare them to live with it." As EMDR clinicians, we know that this is not true—and it is incumbent on all of us as therapists, and as citizens of the

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world to say, "No, this will not stand." Even if we believed that there was nothing presently available, our attention should be directed at how we can work to change the present system to learn more, to develop more, and to make healing more possible.

Over ten thousand clinicians have been trained in EMDR worldwide. If each person devoted only 48 hours of the year to working for change, we could make a difference. We need to help others see the need to band together as a profession in order to integrate services and allow the wisdom of our profession to inform our organizations. For instance, we know that secondary gains prevent substantial treatment effects in combat veterans (as well as others). Therefore, we have to become vocal to change the structure of VA benefits so that compensation checks are not denied the veteran if the symptoms remit. We have to inspire the VA to inaugurate halfway houses to teach veterans the requisite skills necessary so they can feel less fear and have greater ability to reenter the world. There are reports in the literature of World War II and Korean War veterans becoming nonsymptomatic when properly treated. Time is not the significant factor, but making the situation conducive to healing is.

We need to become vocal within our professional organizations. We need to help inaugurate standing committees that set training, research, and publication standards in order to test new methods, develop already efficacious procedures, and having validated them, make them more readily known to the field. Experienced, seasoned, practicing clinicians who have been validated as competent in the various methods should have a leading role in the committees. They should not be run exclusively by academicians and researchers simply because they have the time or the organizational position. The practicing clinician is the one in the trenches and we need to get our priorities straight. If we are going to help our clients, and in doing so have a positive impact on humanity as a whole, we need to make sure we have delineated and clarified our standards regarding training, research, informed consent, and client practice. The official who said, "Just close them up, nothing can help" should not be the one to be heard. The practicing clinicians that know there are ways to help should be the ones to lead the way. However we must do it judiciously, and with all the rigor necessary to get the point across. We must be vocal during professional meetings, conferences, and in newsletters and journals. We must do what we can to bring forward a new standard of practice, research, and training. We must do it because, as a profession, we have taken on for ourselves the role of guardian for the world's psyche—and we can no longer afford to be cavalier or nonchalant about slipshod or uninformed work.

Geoffrey White, Ph.D., took the time to find organizations willing to set up an EMDR training in Croatia. It was not easy, but he saw the need. Gerry Puk, Ph.D., and Steven Silver, Ph.D., donated their time to train the clinicians in Zagreb. It was not easy, but they were determined to go. During the training, they heard guns in the distance, because fighting had erupted. Three psychiatrists from Sarajevo managed to get to the training by a circuitous route and arrived at 5 AM on the day of the training. One of the psychiatrists seemed very skeptical, but participated as a client in the practicum. Steve noticed that she seemed stuck in the material she had targeted and coached the person in the therapist role. The block opened, and she leaned back and smiled. Shortly afterwards she asked if Steve and Gerry would come to Sarajevo to do another training and they agreed. Later that day, in speaking about it, they told the host, "We'll go wherever we're asked. We'd even go to Serbia." Even though the Serbs were the mortal enemy, the host said, "Good, you should go there. This fighting won't stop until we all get past the pain." Can we all take that message to heart? The world's suffering will not stop until individual people get past the pain.

This is our goal: thousands of therapists throughout the world helping people to open to a greater sense of community and interconnectedness. Thousands of therapists setting the kinds of standards that make clients safe and our profession strong enough to fulfill its mandate. Thousands of therapists vocal enough and loud enough that elective deafness and cognitive dissonance and misguided ideology in our presently divided profession do not stand a chance. And isn't this goal possible if every clinician devoted just 48 hours a year to being an advocate for change? Isn't it possible if you are just willing to stand up and try?

HEAVEN'S BARBECUE

Emily Brodeur, LCSW
Nashville, TN

The client is a 27-year-old woman known to me from her first psychiatric hospitalization 2 1/2 years ago, during which she was diagnosed with Major Depression with psychotic features. She also had dissociative symptoms including well-defined "parts," though she did not experience time loss. She had tried about 20 different psychoactive medications prior to her first EMDR session, and had also received outpatient electroconvulsive therapy (ECT) 18 months earlier. During ECT, she maintained a straight-A average in her course work to obtain a second degree in nursing.

Although she experienced a brief remission of symptoms during the course of ECT, shortly thereafter, she found herself unable to eat or drive, was experiencing severe anxiety and shaking, and ". . . felt like a weird thing was telling me to kill myself." She was laid off from her job as volunteer coordinator at a social services agency, went on disability, and in a virtually catatonic state, returned to

live with her parents for 6 months. She felt that her "brain was across the room," she had trouble with spatial relationships, and she half believed there had been a nuclear holocaust and she was the last person left alive. She also felt a compulsion to kill both of her parents and/or herself, but the fact that she was unable to get out of bed helped to control this urge.

Upon her return to Nashville, she went back into therapy with her original outpatient therapist, with whom I work in tandem. The following is an account of her third EMDR session, during which time she was unable to trust in any decision-making ability. She described her depression as ". . . holding me down and choking me" and she related this to a dream in which she had crashed her car into a "rib joint" where other people were able to eat and enjoy food, while she was ". . . not able to swallow even the things that would fill a hunger." This was the negative cognition, and the positive cognition was, "I can take care of myself without hurting myself."

She immediately had an image of ". . . a bratty kid screaming and breaking things." She associated this with her childhood history of running around the house so frantically that she would be unable to stop unless she hurled herself into the furniture. In the first few passes, "the kid" was raging and stomping, breaking glass, cutting and clawing herself, and screaming incomprehensible gibberish.

I instructed her to ask the child what she wanted and what she had to say, and in her first attempt she yelled, "What the fuck is wrong?" and did not get much of a response. When she was able to try a calmer, less insulting approach, a dialogue ensued. The child let her know that, "I have to keep running because when I stop, it all comes crashing in. She's crying and says she's so tired, but I can't sleep because of the nightmares. Even crying sucks and there's no way out. It seems endless." The two sat down and joined each other in an attitude of total despair.

In the previous session, the client had found herself on a sunny path "....where all the pure souls are before they were injured." I suggested that she take the child with her "on the path," and suddenly she began to laugh. She saw them eating barbecue sandwiches, surrounded by light and congenial friends. Her awareness was, "We all have to toil and struggle, but there's always a place for our best selves, where our difficulties are celebrated as parts of living."

A few days later, she saw the physician who had hospitalized her and had administered her ECT. She felt "disgusted and violated" at being told, "She had chronic depression and there was nothing that could be done about it." The depression lifted, and she made other plans to obtain her Synthroid and Sinequan. There has been continued optimism and a marked improvement in her ability to set limits with others.

The client now has a degree in fine arts, leads a support group for teenagers, and makes original jewelry.

EMDR Network Newsletter Submission Information

EMDR has generated a tremendous amount of enthusiasm among practitioners and all of us are anxious to read about the latest developments in, and/or experiences with, this exciting method. Because of this enthusiasm and desire to acquire more knowledge, I believe that it is important to produce a publication that provides a forum for articles that are more formal (e.g., research, protocols, etc.), as well as for those that are less formal (e.g., case studies, innovative ideas, etc.).

To this end, the following represent the guidelines for submissions to the Newsletter: Send articles to Lois Allen-Byrd, Ph.D., Editor, EMDR Newsletter, 555 Middlefield Road, Palo Alto, CA, 94301. Please include home and business telephone numbers, professional degree, location of practice (city and state only), professional affiliation (if applicable—university, if a lecturer or teacher, and/or institute, if an associate). Example: John Smith, Ph.D., John Doe University, Johnson, WA. If possible, please submit articles on a diskette, IBM format.

ARTICLES SHOULD BE DOUBLE SPACED WITH WIDE MARGINS. APA STANDARD AND STYLE–BOTH TEXT AND REFERENCES MUST BE IN ACCORDANCE WITH APA STANDARDS. ALL SUBMISSIONS ARE SUBJECT TO EDITORIAL REVISIONS.

Proofreading of material is required before submission. Authors submitting a manuscript do so with the understanding that, if it is selected for publication, copyright of the article is assigned to the Newsletter.

Because the Newsletter depends on you, the members of the network, I welcome any suggestions or comments that you may have. If there are any questions regarding the above, I can be reached at (415) 326-6465.

A THERAPEUTIC AND SPIRITUAL TRANSFORMATION

Judith Donovon, LICSW
Charlottesville, VA

I work in an office where we do assessments and referrals, as well as mental health and substance abuse treatment. Client A was referred to me from our EAP colleague as a possible candidate for EMDR. She arrived for our intake session as scheduled, presenting quite anxiously and childlike, both verbally and in her body posture. She spoke in a soft,

wispy voice, and her small frame folded over itself as she sat in her chair so that she seemed even smaller. As her story unfolded, she was embarrassed to be weeping and it became apparent she had been emotionally stuck at age four, although she was reportedly a happily married woman and mother of two children, ages three and five. She had been working part-time outside of the home and her job was ending that week, for which she was "mostly relieved."

The presenting problem was an obsession with death. She had been increasingly depressed for the past few months, and it had recently escalated into constant fear and obsession around her own death, the death of someone close to her, and refusal to attend a wake or funeral, to the extent that it was starting to create tension in her family. Other symptoms included difficulty making decisions, irritability, spontaneous crying, low energy, and low self-esteem with a critical ego, plus some self-medication with wine that was concerning her.

The referral was made as she had a clear picture in her mind of her father's death. When she was four years old (remember, her children's ages are three and five), she had been playing with her sister on the beach over the Fourth of July weekend. (The client came in for treatment in July.) Suddenly, "Everyone was running around screaming and crying." Someone told her that her father had died. Later she discovered that he had had a heart attack.

She was never allowed to talk of him again; in fact, it was a long time before she understood words like "funeral" and "death." After her father's death, she experienced many years of trauma, including being made to sleep with her mother before her mother's remarriage eight months later, moves to other states, losses due to older siblings refusing to live at home, and sexual molestation. Her mother, who married her brother-in-law (thus making cousins "sisters") stated that this was a new family now. (Her mother still refuses to talk of client's biological father.)

During our first meeting, a history was taken and EMDR was reviewed briefly. The client was given a book about death to read to herself and her children. The second session consisted of a more in-depth exploration of EMDR. We ended with the client experiencing a relaxation exercise with healing around the self-protection role that fear and tension had played in her life. I recommended that she continue relaxation daily. Her stated treatment goal was to be able to talk about death without crying. She had already noted some improvement after reading and rereading the book four to five times and a decision to return to church.

The client returned for the EMDR session anxious about the process, fearful she would cry, but determined to do something to end her suffering. Her negative cognitions were, "I am confused, afraid, and angry about death and life. I am angry at God." Her positive cognitions were, "I accept death as a normal part of life that I do not have to fear. I can survive even an unexpected death." Her SUDs level was 10 and her VoC was 3 or lower, as she sometimes felt she would rather die than suffer any longer. She had intense physical sensations (such as tightening) in her stomach.

As she progressed through the EMDR session, she abreacted extensively. At first she would cut off her crying and needed much encouragement. Soon she was wailing, shaking, and sobbing, much as a small child would. When her SUDs level would not go below a 3, she expressed her fear that if she let go of her pain, she would forget her father. She let out some long repressed anger by punching a pillow and really allowing her angry feelings to be expressed, including anger at her mother, God, and her father. A dysfunctional belief system had been to repress anger and be a nice girl. We went with her fears, embarrassment, and tightness in her stomach.

As her SUDs level went to 0, she stated, "It just feels like a bubble came up from my throat and went out my mouth. I feel so relaxed." The abreactions then started again as we went through the positive cognition. Then her cognitions started shifting spontaneously. "I do not have to be a Marine and take care of everyone." "I can miss my father and not be overwhelmed." "I am at peace."

The client was advised to call me in two days (or before if necessary) to journal, and to continue relaxation exercises. She was also informed of the possibility of bodily or emotional reactions occurring, even the possibility of significant dreams as she adjusted to the healing she had experienced. When the client had not called within the agreed upon time, I contacted her. She stated that she had been busy and was feeling fine.

When she returned one week later, she held her body straighter, appeared taller, and her voice had dropped several octaves. She confidently stated, "I am more solid, feeling powerful, more in control of myself rather than trying to control others. I can breathe better. I am able to laugh out loud. I am sleeping better. I am not afraid of the dark. I have moved beyond my mother. I feel free. It does not kill me to remember my father."

We discussed two dreams that were quite significant in their symbolism to a tremendous healing and new life direction. Then she asked, "Something else happened this morning that was not a dream. Do you want to hear about it?" "Of course." She then related: "As I was lying in bed this morning, I suddenly reached my hand up towards the sky. A hand reached down and held my hand. As I opened my eyes and looked up at the ceiling, I could still see the hand and feel it holding mine."

I asked whose hand it was. She answered, "My father's, of course. I am finally connected to my father! I no longer need to come in for therapy."

We discussed her husband's reaction to her transformation and the possibility that he could feel threatened and/or confused about the transformational changes of her new outlook on life. She felt confident that she could talk with him and was enthusiastic about leaving. She again stated that she did not want to return for treatment and asked, "Could I hug you for helping me so much?"

SLOW DOWN

Virginia Novak, MSW
Tucson, AZ

In attempting to make EMDR more comfortable for myself and my clients, I have come across an approach which seems to be extremely helpful—SLOW DOWN.

After attending an EMDR training, I was very excited about the possibilities, not only for my clients, but also for myself. After 8 months of using the method successfully with my clients, I was finally able to use it for my own issues. However, my mind never seemed to be able to get the hang of it. I just kept derailing or ending up at dead ends.

Rather than give up, I began experimenting on my own with a variety of eye movement patterns and speeds. Eventually, I tried slowing the movements down, not just a little, but quite a bit. Finally, my mind was able to stay on a topic, deal with the attached emotions, and process out experiences.

When I tried applying this approach with my clients, I had a number of exciting results. The clients I would have expected to have difficulty focusing often were able to do so when the pace was slowed. Also, clients rarely reported having many of emotions, memories, or issues come up between sessions. Even clients who had extensive histories of abuse and neglect were able to focus on relatively minor issues (e.g., relationship problems) without their entire history being raised.

By a slow movement, I mean as slow as 30 seconds for one finger sweep or a total of 5 minutes for a set of 10 movements. Yes, these are REALLY SLOW movements, and most clients do not need it quite this slow before they are able to report concentrating. However, for at least one client with an extensive abuse history, this speed was necessary before she was able to address her feelings of anger when in an intimate relationship.

I find these results particularly interesting since I had noticed that EMDR can sometimes seem to override the mind's defense mechanisms, and that the "blocking" or topic skipping that was happening for some clients appeared to be the mind's last ditch effort to remain in control. It seems as if slowing down the pace can help the mind keep its defense mechanisms in place while still dealing with the target material.

I am very interested in knowing if other clinicians experience similar results with this approach.

EMDR
Network Newsletter
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EMDR FOR THOUGHT DISORDERED CLIENTS

Juliana Garza, CMHC
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I have found that EMDR is a useful therapy in the treatment of persons with a major mental illness. The people with whom I have been working have been diagnosed with Paranoid Schizophrenia, Personality Disorder NOS, Bipolar Mixed, Schizoaffective Disorder, Borderline Personality Disorder, Panic Disorder, Agoraphobia, and Dysthymic Disorder. All of these people have been physically and/or sexually abused. Although we can treat thought and mood disorders with medication, the emotional memories of the trauma remain and can exacerbate the illness.

I have been working with these clients for a number of years and know them quite well. As our agency uses the Client's Strength and Assessment Model, I have already helped the clients to identify their strengths. Because the onset of mental illness is itself traumatic and devastating to a person's self-esteem, I have found it important to establish a Position of Power (Popky, 1994) before attempting to process the trauma.

To start the procedure, I ask clients to identify a successful event or accomplishment. I help them to identify an event that is real and significant to them, although it may seem insignificant to anyone else. With one client, it was the birth of her child; with another, it was her first paycheck; a third client identified a basketball game where she made the winning basket. I then ask them to remember that feeling of success, that experience of "YES," or "I did it." I ask the client to visualize the event and use the eye movements to install the experience of success. I can see from their expressions that they are reexperiencing or getting in touch with their feelings of success. I then use Popky's protocol for Creating a Position of Power to create a Successful State. I anchor it into their physiology with a touch on their hand. When they feel insecure, they can recall that feeling of success by touching the spot on their hand where we anchored the successful state. I then continue with the standard EMDR protocol. To demonstrate how this

has been useful, I will review one case out of the five with whom I have been working using EMDR.

Maria (name has been changed for confidentiality) is a 31-year-old, divorced, Mexican female, who has been in treatment with this agency since 1987. Maria has had three psychiatric hospitalizations occurring in 1980, 1984, and 1989. Her diagnosis is Paranoid Schizophrenia. Maria has been on psychiatric medication since 1981 and has been maintained on Prolixin Decanoate for the past several years. This summer, her medication was changed to Risparadol, 3 mg twice a day, because of concerns about the potential long-term effects of Prolixin. She says that the Risparadol is more effective than the Prolixin and that she feels more alert and has feelings. Maria stated that when she has been "sick" in the past, she becomes very paranoid and hallucinates. She also displays a lot of bizarre behaviors such as wearing clothes that are four sizes too small, thinking that a stranger is really her ex-husband in another body, and being sexually promiscuous.

Maria has been stable for the past three years; stable enough, in fact, to complete a year of college prep courses offered by our local community college. She was beginning regular college courses and was afraid that she could not make it because of insecure feelings that began when she had to return to school after her first psychotic episode at the age of 16. She related to me that she had been experiencing nightmares and fear that her father was going to come and hurt her.

In August 1994, we began the procedure by installing the Position of Power. She remembered when she made the winning basket in high school before the onset of her mental illness. When she became fully aware of the memory, I could see the change in her body. She sat up in her chair, her eyes widened, she smiled, and she looked "proud." She also reported that she could feel that experience of success. She also was able to disclose to me her memory of physical and sexual abuse, which she has never had the courage to talk about before. She reports that the nightmares have ceased and that she is no longer experiencing the fear that her father is going to beat her up again. I am using EMDR to work on these traumas and others that are beginning to surface.

I think that I was able to use EMDR because Maria was stable and her fears were based on reality. The feelings of fear that she described were different from the paranoia that she experienced before Risparadol treatment. She knows she has a mental illness and wants to make changes in her life. I have not used EMDR with clients who both have thought disorders and are in denial of their mental illness or who are not being treated with medication. I would be interested in hearing from other therapists who are using EMDR with thought disordered clients.

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International Update

Francine Shapiro, Ph.D.
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The EMDR training in Croatia took place in Zagreb in March and 40 clinicians attended. The work of Geoffrey White, Ph.D., in arranging it, and the dedication of Steven Silver, Ph.D., and Gerald Puk, Ph.D., in donating their time to teach cannot be overemphasized. As a result of the reports by three Sarajevo psychiatrists that attended (traveling at risk of their lives), we have been requested by Catholic Relief Services in Bosnia to put on another training in Sarajevo during the summer. The same teaching team, and a number of other clinicians, have already volunteered to go.

The Oklahoma City bombing took its toll with 167 people dead and thousands who are emotionally devastated. After a call from a representative of the FBI that requested EMDR clinicians to help in the relief effort, Judy Albert, MFCC, left for Oklahoma City to start setting up facilities and contacts for therapy. Virginia Denman, LCSW, an EMDR clinician and resident of Oklahoma City, has been a wonderful host and networking resource, along with EMDR facilitator Karin Kleiner, MFCC, who, as a past resident of Oklahoma, flew in to assist the effort. So far, two offices, appointment staffs, telephones, and an apartment have been donated for the use of EMDR clinicians. Judy has already met with 6 EMDR clinicians who are residents of Oklahoma and provided them with some additional training and refreshers. She used the recent trauma protocol and tapes of the Hurricane Andrew interventions she did during that disaster response. Steven Lazrove, MD, is coordinating a possible interface between the EMDR project and other organizations, such as Operation Healing directed by Charles Figley, Ph.D., and CISD directed by Jeff Mitchell, Ph.D. Level II trained EMDR clinicians (critical incident experience may be useful) are requested to help in a relief effort. The plan is to have cohorts of EMDR clinicians rotate in every week. Sandra Wilson, Ph.D., and Lee Becker, Ph.D., will simultaneously be coordinating research to document the effects of EMDR treatment. The primary goal, however, is to help relieve the suffering. Judy Albert and Sandra Wilson are attempting to organize on-site financial backing for travel and lodging. If you are able to donate time, please send the questionnaire included in this Network packet to:

Judy Albert, MFCC
17610 Beach Blvd. #38
Huntington Beach, CA 92647
or fax it to: 714-846-0646 (ring once, hang up and then fax)

For those of you who would like to help, and would like critical incident training, if you are planning to attend the annual EMDR conference, you can learn from experts Jeffrey Mitchell, Ph.D., and Roger Solomon, Ph.D., who will be giving an all day workshop on the topic.

In order to be better prepared for the next crisis, we would like to have an EMDR Disaster Response team already organized. The EMDR Network, which is a non-profit organization, will collect tax-deductible donations earmarked specifically for that purpose. The donations will be used to provide travel expenses for the first-line team of providers that in the past has had to pay their own way. If you are unable to donate your time to the project, please consider making a financial donation. It will be used exclusively for clinical work to provide clinical relief for disaster victims. Please send donations to the Pacific Grove office at the address listed on this Newsletter.

The EMDR annual conference will also see the inauguration of the EMDR International Association. The association will function as a professional organization and help to set EMDR training and practice standards for other organizations that will be conducting EMDR trainings now that the textbook has been published. The plan is for it to take on many, if not all, of the EMDR Network functions as of 1996. The EMDR Network would then become the equivalent of an alumni association for the EMDR Institute and a service organization. Donations would be solicited to fund the disaster relief project; the assistance programs, such as the free trainings in Croatia; scholarships and research grants. Alternatives will be discussed at the annual EMDR conference and a vote will be taken at that time. Please think about it in the meanwhile and feel free to send me any suggestions.

There have been a number of articles in professional newsletters throughout the country that are continuing the myth that there is no EMDR research. At this point, there are ten completed controlled studies, making EMDR by far the most widely studied method in the treatment of trauma. Please consider writing your own articles and referencing the studies reviewed in the EMDR publications and research list included in this packet and in my textbook. Managed care companies throughout the country are apt to be swayed by the misguided rhetoric and ignorance. Please help the professional and public community be more aware of the actual situation. In addition, let us continue to encourage well-designed research by well-trained science-practitioners.

The best news in the EMDR research world is that the controlled study of 80 trauma victims implemented by Sandra Wilson, Ph.D., Lee Becker, Ph.D., and Bob Tinker, Ph.D., has been accepted for publication in the Journal of Consulting and Clinical Psychology. The journal is the most respected research journal in the country and only accepts 10% of the manuscripts submitted. Drs. Wilson, Becker, and Tinker did a magnificent job in writing up their results. They, and the Colorado clinicians who donated their time to do the therapy, have done a great service to EMDR. Once the article is published, it should be impossible for any reasonable professional to question the existence of well-designed research validating EMDR effects.

I have also been informed that another well-designed, randomized, controlled, comparative study has been completed by principal investigators Jac Carlson, Ph.D., and Claude Chemtob, Ph.D., in Honolulu. EMDR has been reported to show substantial superiority to the controls. We are looking forward to its presentation, hopefully at the annual conference.

The EMDR Network will be sending out selected articles this year along with a list of published material and abstracts of those articles that appear in professional journals. In addition to sending copies of EMDR articles to the office, please send them to David Baldwin, Ph.D., PO Box 11148, Eugene, Oregon 97440. Dr. Baldwin has agreed to supplement the author's abstract with information that would be particularly relevant to the EMDR clinician. We will continue to send out some of the articles, but as you saw from last year's financial report, we need to cut back on the amount of paper being duplicated and sent or raise the dues. Many of you suggested this solution and I thank you for taking the time to do so.

Once again, we would like to be able to extend the assistance programs by financing free EMDR trainings in third world and/or war torn countries and by sending clinicians to help in disaster areas. Please consider making a donation to the Network, or offering your time as an on-site clinician. An interview with Geoffrey White (who set up the Croatian EMDR training) quoted him as saying, "As a father, I was very disturbed by media coverage of the brutality of war, repeatedly depicting how snipers around Sarajevo, for example, would deliberately kill children in the arms of their mothers as a way of demoralizing the civilian population. I read about the rape camps where young girls (my daughter's age) were deliberately impregnated as a part of the policy of 'ethnic cleansing.' When my children are old enough to read about the former Yugoslavia, I want to have something to say when they look at me and ask, "Dad, what did you do to help?" There's no limit to what we can do if we all take a hand.

FROM THE EDITOR

The editor cannot guarantee when, or if, a submission to the Newsletter will be published.

A CASE OF SPONTANEOUS EMDR IN A CHILD

Gary W. Lea, Psy.D.
Kelowna, BC, Canada

Clinicians trained in Eye Movement Desensitization and Reprocessing (EMDR) are well aware of the oft cited report of Dr. Shapiro's discovery of Eye Movement Desensitization. The following is a brief account of an 8-year-old male sexual abuse victim who spontaneously discovered eye movement desensitization.

In August 1994, I began providing counseling services to the boy's parents who were in a blended family. The teenage daughter (the father's offspring from a previous marriage), herself a sexual abuse victim, was discovered sexually assaulting her half-brother. This discovery put significant strain on the spousal relationship and was a threat to the mother's day care. For a period of time, I provided services only to the parents, while the daughter was placed in foster care and the son received psychotherapy from a child care counselor. The parents mentioned to me that their son had been having nightmares and fears, but that he had spontaneously learned to reduce his anxiety by rapid eye movements. Surprised to hear of this, I asked to interview the boy in January, 1995. When I met with him, he presented as a bright youngster who readily talked about the molestation and his fear that "she [his half-sister] could come and get me." When I asked him how he had been coping with this, he told me that while lying prone in his bed, he would move his eyes from one side to the other of his window in a lateral, then a horizontal, and finally, a diagonal fashion. Sometimes he would move his eyes in a "star" fashion. He found that when he did this, his anxiety abated and he was able to sleep, although he found it necessary to repeat the procedure most nights. I am now working with him in a structured fashion and assume that he will enjoy permanent benefit from EMDR in short order.

CHANGING COGNITIONS

Bea Scarlata, MA, LPC
Brentwood, TN

Linda (not her real name) is a 40-year-old professional woman whose avocation is healing and who is proficient in several of the touch therapies. She has a Dissociative Disorder with well-defined "parts," but she has not experienced time loss. She is not on medication and although she is often depressed, she is able to function fairly well most of the time. As a child, she was emotionally and sexually abused by her father for approximately ten years. He is bedridden now, but she is still subject to his verbal abuse when she visits him once a week. He has never acknowledged his abuse, nor has she confronted him about it (although she has told her mother). She said she will not feel totally safe until he is dead. We have had ten sessions together. EMDR was used in most of our sessions during which she processed specific incidents of abuse that were very traumatic for her. She believes that she has many dissociated infant and child parts—each of whom hold a memory of one of the abusive incidents she experienced.

During our last session, Linda wanted to work on her reluctance to accept payment for her work as an energy healer, even though she knows that her work is excellent. I asked if she had ever been reluctant to receive payment before and she said yes. Her preliminary negative cognition was, "It is the duty of the child to give, the child cannot expect to receive," which evolved to, "It's safer to give than receive, it's not safe to receive," with an image of being forced to receive oral sex at the age of three, feeling frightened, suffocated, and helpless. The chosen negative cognition was, "I am not safe; I am going to die."

After several sets of saccades, Linda said, "Receiving can be deadly." After several more she said, "When you're good to Daddy you can live, but sometimes it's not worth it." This brought up a great deal of sadness for her, as she visualized many dead child parts inside.

I used her father's first name (rather than calling him "Daddy" or "Father") to ask if he had ever given her anything she wanted. Linda said that he gave her a camera one Christmas, but that most of his gifts to her involved something she did not want (which was also true of his gifts to her mother). He favored her brother and she was taught that because females are inferior, they are supposed to serve males.

Linda's next negative cognition was, "I will never get what I ask for, I am not worth giving to." This brought up a lot of anger, which she was never allowed to express. She saw her inner child parts angry and upset and concluded that, "It's bad to be angry, so they deserved what they got."

During a cognitive interweave, I said, "The fight or flight syndrome is a normal response to danger, an automatic built-in mechanism by the Creator that helps assure the survival of the human race. Anger is an appropriate response to fear of suffocation and death, and no one deserves to be raped—especially not an innocent child. Children deserve to be protected, nurtured, and loved unconditionally by their parents." (Linda has a daughter, so she knows firsthand that this statement is true.)

She said that the children inside were listening to my cognitive interweave and beginning to feel better. I continued and said that the perpetrator was no longer a danger to them or to anyone, that they were safe now. Our goal that day was to honor their efforts on Linda's behalf to contain the abuse she sustained during her childhood, to enable her to go to school, play with friends, and continue living an otherwise normal life—during the times when she was not being put-down, humiliated, and/or raped. I told the children to design a perfect playroom for themselves, a playroom that was 100% safe—a large, sunny,

beautiful, bright, colorful room with all their favorite toys, their favorite playmates, pets and music, and everything they had ever requested and been denied.

They seemed to respond positively and Linda's face softened. During my next interweave, I told them to let go of any thoughts or feelings they had about being bad or inferior. They were very, very good, and exceptionally gifted; in truth, they were perfect. They were beautiful, bright, innocent, brave, creative, self-sacrificing little children who had saved Linda's life many times, often at the expense of their own lives.

As the set ended, Linda told me that the children inside liked what I said and when I was speaking, they all gathered around a huge blanket that was spread on the ground and curled up at the edges like a bowl. Then they pulled out "gunky," black stuff from their heart-space and threw it on the blanket. As the blanket became full, this stuff looked like thick, black oil. Linda said she thought the angels would come and gather up the blanket and carry it off to be purified, but as she watched, the oil began to recede to the bottom and be replaced on top by a clear fluid resembling water. The children reached into the water and picked up a small piece of coal with a very large diamond on it. Then they gave the brilliant diamond with its black mounting to Linda, and told her to use it to stimulate her empathy and understanding of others, especially those who come to her for healing. This was a very vivid image and one that clearly pleased Linda.

The interweave with the closing saccades focused on safety and the right occupation. Linda is safe now. Her father is old and sick and can no longer hurt her. Because all of her child parts feel safe enough to bless her healing work (as symbolized by their special gift), and they are willing to help stimulate her understanding and empathy for her clients, it is only right for her to appreciate how worthwhile her work is, and how worthwhile she is. While the path of service may be the highest spiritual path there is, it is sometimes a very expensive one. As Linda continues to seek further training in this field, she will need to be able to pay for that training. Just as she expects to pay for services rendered to her, her clients expect to pay for services she renders to them. A fair exchange will help ensure that her healing work will not only continue, but progress and improve.

After installing a sense of safety and self-efficacy, Linda said that she had always been terrified of tapping into her anger for fear that it would overwhelm her. She was very relieved and pleased by the way she had processed it. She felt empowered—clearer, more energized, happier, and more in control of her emotions after the session. She was even able to imagine feeling comfortable while receiving payment for her services in the future. (To be continued.)

THE CASE OF A SEXUALLY ABUSED WOMAN RE-ENTERING HER BODY AFTER A COGNITIVE INTERWEAVE

Laurel Parnell, Ph.D.
California Institute of Integral Studies
San Rafael, CA

I was working with a woman who had been repeatedly molested by her teenage brother when she was very young. As we reached the end of the session, she was aware that as a child, she left her body so he could not hurt her. Although she believed that it was not safe to be in her body, she did feel safe and secure outside of her body looking down on things. I suggested to her that, "It wasn't safe to be in your body then, but it is now." She agreed, and we did another set of eye movements. At the end of that set she exclaimed, "I can feel myself in my body for the first time! I never knew I wasn't in my body before." She kept saying how strange it felt to be in her body. She was so surprised! It was like she had been living hovering outside of her body since she was a child without being aware of it, and suddenly had popped back into it.

The next week she came in and reported that she felt physically very different. She realized how cut off from her body she had been all of her life to the extent that she typically went all day without going to the bathroom or eating. She reported feeling more solid, centered, and present with a new assertiveness. This feeling of being in her body stayed with her over several months continuing until she left treatment.

EMDR AND THE "ADD" CONNECTION

Landry Wildwind, LCSW
Albany & Santa Rosa, CA

You or your clients may be coping with Attention Deficit Disorder (ADD, termed Attention Deficit Hyperactivity Disorder in the DSM IV). For reasons I will explain below, it is more likely if you use EMDR that you will encounter this condition.

The symptoms we usually associate with ADD are hyperactivity and defiant or destructive acting out, especially in young boys and a few girls. For many years, such children were prescribed Ritalin, a stimulant that helped them function and focus. It was believed that ADD goes away with adolescence.

Now we know that ADD never goes away; it only becomes less problematic in certain situations and more

problematic in others. ADD in adults, especially without hyperactivity, in women; and in conscientious, anxiety-driven people; looks very different, and mimics many other problems. Possible cues in the lives of people with ADD are:

Chronic anxiety. This can rise to panic or feeling overwhelmed.

Impatience. The person has trouble completing informational reading, finishes sentences for other people, becomes angry at waiting, etc. He or she often leaves relationships or jobs or changes plans.

Piles of unfinished projects, mail, papers. Keeping track of detail may elicit anxiety and/or frequent errors. There may be anger at demands for more organization.

Low self-esteem. No matter how much the person has realistically accomplished, there is a haunting fear that, due to some error or neglected detail, everything could come crashing down. Or there may be overdependence on others to give positive feedback. The person may be highly self-critical and demonstrate an inability to sort negative feedback. He or she may experience the imposter syndrome.

Body pain. By age 30 to 50 years of age, there are chronic aches from constantly using fear as a stimulant for focus. Jaw grinding during sleep, musculoskeletal, digestive, and immune system diseases such as chronic fatigue may be experienced. There is also often hypersensitivity to hot and cold, noise, odors, messes, clothes or other textures, as well as low pain tolerance.

Disorganization and procrastination in handling time, work, paper, money, and decisions. For example, the client is usually late to sessions, even when seeming sincerely eager to be there. There is difficulty with making and following through with plans of all kinds.

Emotional lability, with a low tolerance for processing negative emotions. Irritability, boredom, impatience and confusion, depression and anxiety, exhaustion and self-doubt are typical; with frequent shifts in affect and content. During EMDR, the client may begin with vivid content and intense emotions, but there is tangential or distracted processing, and less completion. Problems persist even when EMDR goes well.

Addiction. This is typical and covers drugs and alcohol as well as food, work, sex, or destructive relationships. The client is impulsive, even with high motivation and insight, and resistant to treatment.

Hyperfocus. With the right stimulus, often emotional or visual intensity, it is possible to become so focused that distractions disappear. This is so soothing to the person that such activities are compelling. For example, even though reading for information is difficult, reading fiction can become a compulsive activity, especially before sleep. For some, there is a constant quest for stimulation and intense action. Periods of transition or unplanned leisure often lead to restlessness, poor use of time, even depression.

Social phobia or avoidance. These individuals are typically disorganized and anxious in groups, and shy when meeting new people. They are impulsive or reactive and make unguarded comments that get them in trouble in social situations. Often issues develop with authorities about following procedures. There is discomfort or insecurity when around organized or highly successful people. For this reason and others, including a need to feel understood, people often choose to marry someone with ADD—even when neither partner is aware of the precence of ADD. (Raising ADD children is especially difficult for ADD parents.)

Accident proneness, restless sleep, and problems with impulse control, risk-taking, boundary protection, conflict, relationships, parenting, and performance are all common in adults with ADD. Family histories often include other family members who have ADD as it is inhetited. There are also reports of allergies, depression, addiction, and learning disabilities.

Creativity, quickness, empathy, visualization, intuitive thinking, and high IQ also characterize these very interesting people. They are drawn to emotional intensity and expression. They are often writers or artists who feel that something is preventing them from living up to their potential.

As you can see, these symptoms can appear with many other conditions, including fear of success, depression, PTSD, anxiety disorders, personality disorders, and dissociation. When the therapist checks the history, there usually are a number of traumas and family dysfunctions to explain them; however, these symptoms return or do not clear when EMDR is done.

Hallowell and Ratey in the 1994 book, Driven to Distraction, point out that this genetic disorder could not be diagnosed with much assurance until a test was developed using an MRI to map the brain and demonstrate the difference between normal glucose uptake (brain area activity) in the frontal lobes and ADD-type uptake patterns showing far less activity in those regions. For those clients who need a definitive diagnosis, find and refer to a specialized ADD clinic for the test.

Just how common is ADD? Should you screen everyone? Hallowell (1994) proposes a possible reason why there are so many more people with ADD in the United States. In Europe and elsewhere, of the people in a given area or ethnic or economic group who were experiencing negative conditions, those with ADD were far more likely to emigrate. In fact, it is possible that it is so common in Americans that it has affected the development of our national character—creative, now-oriented, fast-paced, and impa-

tient with tradition and long-term goals.

Following this reasoning, consider these questions:

1. Of those in the United States, who is likely to move to California? The Bay Area?

2. Of those in the Bay Area, who is likely to choose therapy as a profession (emotional focus, little distraction, creative and empathic, autonomous)? Of those, who would be most likely to be attracted to EMDR? (It is quick, intuitive, visual, intense, new creative . . .)

3. Of clients in therapy, who is likely to be attracted to doing EMDR? Who is likely to have PTSD, be suffering from phobias or anxiety, or not be improving in other therapy?

Obviously, we are in a unique position as EMDR therapists. We are likely to be or know peers who have ADD; we are also very likely to attract clients with ADD. Once we understand if we have it, we are far more likely to be able to spot the symptoms and ask the questions needed. Given the impatient and self-critical nature of such clients, it is vital that we check for ADD early on in the treatment process to maximize our clients' chances of success.

Knowing about it is extremely helpful, even if the client refuses medication. There are now support groups available that are more appropriate than most recovery groups for this population. Medication can be very effective; look for doctors willing to prescribe Ritalin, Cylert, and Dexadrine, as they are usually more effective than antidepressants for ADD. Biofeedback can be helpful for those seeking non-chemical intervention.

For clinicians, understanding the special therapy needs created by ADD can improve both the relationship with your client and the results of your efforts. You can help coach your client in planning and decision making, and provide education on the way ADD is interacting with other problems. You can also support your client in delegating difficult tasks.

With a rethink of the messages from parents and others throughout life, many negative cognitions can now be reprocessed more completly. It is also clearer why some, such as, "I can't count on myself, something's wrong with me" never did move. The identity needs to be "decominated" to eliminate shame about the history of inadequate functioning. Problem solving and effective tolerance skills can then be gradually increased as the motivation to avoid disappears.

Once these clients are adequately diagnosed and treated, they become more reliable, more relaxed, and much more rewarding.

References

Hallowell, E. & Ratey, J. (1994) Driven to distraction. NY: Random House.

REGIONAL NETWORK COORDINATORS - USA
National Coordinator: Norva Accornero, MSW (408) 356-1414

Arizona	Jonathan Brooks, Ph.D.	(602) 493-3110
	Pat Penn, Ph.D.	(602) 770-7407
Arkansas	Stephanie Zack, LCSW	(501) 442-9997
California (Northern)	Norva Accornero, MSW	(408) 356-1414
(Southern)	Curtis Rouanzoin, Ph.D.	(714) 680-0663
	Ron Doctor, Ph.D.	(818) 885-2827
Colorado	Laura Knutson, LPC	(303) 620-7198
	Jana Marzano, MA	(303) 220-1151
Connecticut	SteveLazrove,MD	(203 787-0227
	David Russell, Ph.D.	(203) 231-9191
DC	Deany Laliotis, LPC	(301) 982-9259
	Dan Merlis, LCSW-C	(301) 982-9259
Georgia	Pat Hammett, Ph.D.	(404) 633-4796
Hawaii	Silke Vogelmann-Sine, Ph.D.	(808) 531-1232
Idaho	Dean Funabiki, Ph.D.	(509) 334-0677
Illinois	Howard Lipke, Ph.D.	(708) 537-7243
Maryland	Gene Schwartz, LCSW-C	(410) 889-8338
	Mike Brenner, MD	(410) 771-4438
Massachusetts	Lorie Bollinger, MA	(508) 456-8623
Missouri	Marcia Whisman, LCSW	(314) 644-1241
New York	William Zangwill, Ph.D.	(212) 663-2989
	Gerald Puk, Ph.D.	(914) 635-1300
New Mexico	Peggy Moore, LSW	(505) 255-8682
Ohio	Kay Werk, LISW	(614) 274-7000x349
Oregon	Ann Kafoury, LPC	(503) 291-9343
Pennsylvania	Georgia Sloane, MS	(215) 667-6490
Texas	Carol York, MSW	(512) 343-9550
Utah	Dan Sternberg, Ph.D.	(801) 364-2779
Washington	Steve Riggins, MA	(206) 328-5626

FROM THE EDITOR

Below is some correspondence between clinician Michael E. Holtby, LCSW, BCD, and Douglas E. Mould, Ph.D., who is with a managed care organization. Mr. Holtby thought this would be of interest to EMDR practitioners and I agree. Dr. Mould has clearly stated his company's policy regarding abreactive work and, although it may not represent the views of other managed care organizations, I suspect any differences are probably minimal.

September 5, 1995

Dear Dr. Allen-Byrd:

I thought you and the Network membership would be interested in the response I am getting from managed health care groups to my use of EMDR. The enclosed letter from PMHM is in response to my description of a specialization with EMDR/hypnosis, detailing my training and experience. I am also sending you the letter I am writing in reply. I am aware this specialization is proving a liability with not just PMHM, but other groups as well, i.e., MCC. PMHM was just courteous enough to express their concerns, whereas with the others, I hear of things more indirectly. I would be interested in what others are doing about this.

Sincerely,
Michael E. Holtby, LCSW, BCD

August 29, 1994

Dear Mr. Holtby:

I am in receipt of your application to be a preferred provider with us. Let me be forthright in my concern. We have found that therapists who use abreaction as the cornerstone of their therapy with PTSD and/or dissociative disorders have a high rate of undesirable results, often with multiple suicide attempts, hospitalizations, and false memories on the part of their clients. Thus, we will not knowingly provide coverage for such treatment, and neither do we include in our panel therapists who rely on abreaction for treatment of PTSD or dissociative disorders. Parenthetically, I believe we have seen only the tip of the iceberg vis-a-vis litigation and false memory syndrome. Thus, please clarify for us whether or not abreaction is your treatment of choice for such clients.

Sincerely,
Douglas E. Mould, Ph.D.
Preferred Mental Health Management, Inc.

September 5, 1994

Dear Dr. Mould:

I greatly appreciate your letter, as you could have easily rejected my application to be a part of your panel with no explanation. I appreciate the opportunity to respond, as I too am concerned with the adverse consequences of abreactive therapy. The last thing I want is a lawsuit, or a client's hospitalization or suicide precipitated by my own interventions. For this reason, I am extremely cautious with any use of EMDR or hypnosis. Yes, I do get abreactions with these modalities. However, it is not before a thorough assessment has been done, as well as some relationship established with the client. In the ten years I have been using these methods, there has not been a single instance of adverse reactions. My rate of inpatient hospitalization is about one every two years, and in the last two instances, it has been for drug and alcohol abuse. I do have clients sign an informed consent form for EMDR. Although EMDR can be abreactive, it has never in my experience led to problems. In fact, EMDR is gaining a reputation as faster and more effective than other approaches to PTSD (i.e., Joseph Wolpe).

If this does not assuage your concerns I would be happy to not use these methods with PMHM cases. I hope that you will, however, use me for my primary specialization areas of homosexual clients and HIV/AIDS concerns. These cases are much more typically unrelated to PTSD or dissociative disorders

Again, thank you for your consideration.

Sincerely,
Michael E. Holtby, LCSW, BCD

September 16, 1994

Dear Dr. Allen-Byrd:

Just a follow-up on the letter I shared with you from the managed health care group, PMHM, that had reservations about using providers who do abreactive therapy. My letter in response to them (which I also sent to you) was sufficient to allay their reservations and I was admitted onto their panel.

Sincerely,
Michael E. Holtby, LCSW, BCD

NOTE!

LEVEL I SCHEDULE CHANGES

At the request of past participants to have more practica time, the EMDR Level I training has been expanded three hours to include one evening session.

Day 1:	**6:30PM - 9:30PM evening session**
Day 2:	**9:00AM - 5:30PM**
Day 3:	**9:00AM - 5:30PM**

Oklahoma City

ONE MORE SECOND

Rebecca Goldman, 7th Grade
Daughter of
member Robert Goldman

Everything so peaceful, everything calm
No indication of fear, no one thing doing wrong.
A Normal setting, a normal day
Then we all got down to pray .

An explosion of sadness, innocence and fright
Not a pretty world, not a pretty sight.
What a second does, no one understood
Not until today, no one ever would.

The burst, the blood, the screaming, the cries
Now it's time, we need to rise.
Pulling victims out, having not a clue
Not a memory retraced, not knowing what to do.

Needing a hospital as quick as they can
One more second could be the end.
Where's my loved ones, where's my friends?
Alive or dead, all hearts bend.

Looking and searching in every direction
Not leaving till we find perfection.
Only one question lies
Why me? Why Oklahoma?
Answer won't you please.

Strangers stopping by, to pull another out
Terror and horror, running all about.
When all hopes are gone, when faith has steered away
We gather together and distinguish this today.

So many deserve praise, so many deserve more
But the thanks they receive is much counted for.
What we'd do without them, how could we survive?
How we would struggle, how we would strive._

We cannot say enough, we cannot say any less,
Hopefully it works out to be the very best!
We give our hopes, to all our hurt and changed friends
We are here let our hearts and souls mend.

"EMDR Helping Hands" Oklahoma Clty Disaster

Judy Albert, MFCC
Huntington Beach, CA

EMDR Helping Hands has been launched in Oklahoma City. The Hospice of Central Oklahoma and the FBI expressed interest in having EMDR and CISD (Critical Incident Stress Debriefing) trained and experienced therapists work with their staff who were first on the scene after the senseless bombing of the Oklahoma City Federal Building on April 19, 1995. In faith that the funds would bo forthcoming to cover expenses, Judy L. Albert, Clinical Coordinator, and Chair of the EMDR Association Disaster Response Committee, arrived in Oklahoma City on May 5th. Dr. Sandra Wilson, Research Coordinator, followed on May 9th to assess the feasability of a research study.

After Judy conducted an assessment of the community need and positive receptivity to EMDR, Dr. Francine Shapiro and Robbie Dunton made a special written appeal to facilitators interested in donating their expertise, time, and financial support to help the victims of the bombing. They were requested to answer a detailed questionnaire used to aid in the selection of the most qualified and experienced volunteers. The response has been marvelous with thirty national trainers and facilitators offering to help in the healing effort. Tentatively we are planning to have at least two EMDR therapists in Oklahoma City for the next 3 months or longer. We already have in place two office locations, in both north and south sections of town. Many doors are opening as we network and educate commu-

nity and mental health professionals about EMDR. The first six EMDR sessions have had excellent results with concluding comments such as, "I got me back." "These are tears of joy which I have not felt in over 10 years." "I'm whole again." "This crap just drained out of me."

THE CHALLENGE!

EMDR Helping Hands challenges every EMDR trained clinidan to DONATE ONE SESSION FEE to aid in healing the friendly, open, and needy community of Oklahoma City. Please send immediately; tax-deductible donations to help defray the costs to:

EMDR Network-OKC
PO Box 51098
Pacific Grove, CA 93950

Obtain EMDR Oklahoma City Volunteers Questionnaire if you have Level 1 & 11 training and can donate a minimum of 1 week. Write:

Judy L. Albert, MFCC
17610 Beach Blvd #38
Huntington Beach, CA 92647

Sandra A. Wilson, Ph.D.
Coordinator for EMDR
Oklahoma Helping Hands Project.

The response of EMDR facilitators to the request for volunteers for the Oklahoman tragedy has been heartwarming. As of May 15th, we have approximately 30 volunteers. The intent is to remain in Oklahoma City until the end of August for a total of 15 weeks, requiring 2 therapists minimum per week (30) to provide an estimated 500 EMDR treatment sessions.

At the request of Virginia Denman, LCSW, an Oklahoma EMDR therapist, Judy Albert was on the scene May 5th and began coordinating agencies, providing treatment, and meeting with the local EMDR therapists. The local EMDR therapists have been incredible in their support of this effort; to date they have provided two free offices for our use, a free one-bedroom apartment for therapist housing, free transportation, and important community networking. They have also offered a southern hospitality that makes a stranger feel like family. I arrived May 9th, to continue the efforts and work that Judy Albert had begun. Karen Kleiner arrived May 11th, and as of May 16th, 20 clients have received EMDR treatment.

The need continues to grow daily as the community and clients become familiar with the positive treatment effects. Lee Becker and Bob Tinker spent two days here to help determine the most accurate way to assess treatment effectiveness. Steve Lazrove and Stephanie Zack will arrive the weekend of May 20th. Several other therapists have also been scheduled. If you have an interest in volunteering, please fax your information sheet to Judy Albert. This grassroots effort is EMDR at its finest. We are so grateful that we have a treatment to offer to a community in pain that makes A DIFFERENCE .

Please donate one EMDR treatment session for someone in Oklahoma City. If each EMDR therapist would send to the EMDR Network office the cost of one EMDR session of treatment (your cost) we could have enough funds within our own network to fund our own project instead of the continuous begging that has become necessary. Some cost has already been deferred with donated office space etc. PLEASE SUPPORT OUR EMDR RELIEF PROJECT.

Karin Kleiner, M.A., MFCC
Oakland, CA

Although I have not lived there in twenty years, Oklahoma City is still my home. I grew up there, my family and my roots are there. I have been back several times a year while I have lived in California. On the day of the bombing, I felt like I had been kicked in the stomach. My home had been violated.

Now I am here in Oklahoma City with the EMDR trauma team. I see the familiar faces with their usual friendliness and southern ease. Very near the surface, there is a sorrow so heavy that I feel it everywhere. No one has been left untouched. It is in the voices of my friends and on the faces of the people I have contacted. I hear their stories—so many funerals, so much pain, so many tears, so much anger and disbelief, so many distraught children, so much fear, and so many memorials—flowers, pictures, and ribbons to commemorate the dead.

From those I have treated with EMDR the horrors emerge. A baby dropped by a male nurse/Red Cross volunteer as he is running out of the building (when the first rescuers had to evacuate fearing another bomb) had been found. The baby, probably dead, covered with blood and slick, is impossible to hold with the nurse's thick, bloody gloves. He feels responsible for the baby's death. The baby haunts him. He sees the baby, feels the baby's cold hand, and sees the baby's blue shirt with the "OshKosh" emblem every waking moment and in his nightmares. He has lost fifteen pounds, cannot be with people, cannot concentrate, and lost his job four days ago. His story is but one of many, his pain and horror unique to him, but also felt to some degree by all.

The work is hard and very rewarding. The people are warm and welcoming; naturally skeptical of EMDR, but very receptive. I am grateful to be here.

EMDR HELP WANTED

"Help Wanted" is designed to assist you in a variety of ways. If you are looking for a position, have positions available, have an interest in research collaboration, want information of specific populations or problems, etc., submit them to the Newsletter and include your name, address, telephone, and fax numbers.

EMDR Research/Training Institute

The EMDR Research/Training Center at MRI is looking for individuals who want to take part in two research projects; (1) Victims of natural disasters and (2) Smoking cessation. Any therapists who have clients interested in participating, please call *Cliff Levin, Ph.D. (415) 326-6465.*

Babies

Anyone using EMDR and/or other body-mind therapies with babies, please communicate with me. I am willing to facilitate a round robin exchange of letters from all over the world and I am also interested in an EMDR perinatology study group in the East Bay. Contact: *Sheryll Thomson, 1641 Hopkin St., Berkeley, CA 94707, (510) 525-8031.*

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 Parnell, Ph.D. 22 Von Ct, Fairfax, CA 94930. (415) 454-2084*

Published?

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

Fluent in a 2nd Language?

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

Success with Schizophrenics?

Anyone having success treating schizophrenia using EMDR. Please contact: *Carol A. Anderson, 4781 E. Gettysburg Rd., Fresno, CA 93726, (209) 445 8522*

Addictions

I would like to hear from Level II trained clinicians that have experience using the addiction protocol with clients. I am summarizing results for the 1995 EMDR Conference this June 95 in Santa Monica, Calif. Please write, call, or fax: *A. J. Popky, M.A., 17461 Pleasant View Ave., Monte Sereno, CA 95030 408-395-8541, or fax 408-395-0846*

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.*

1995
International EMDR Conference
June 23-25, 1995
Santa Monica, California

CALIFORNIA EMDR STUDY GROUPS

Norva Accornero, LCSW California Network Coordinator (408) 354-4048

CENTURY CITY/SANTA MONICA

Robert Goldblatt (213) 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 a new E. Bay group.

EAST BAY/ALBANY

Sandra Dibble-Hope (510) 843-1396 x48
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. Primary case discussions.

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

FULLERTON

Curtis Rouanzoin (714) 680-0663
Jocelyne Shiromoto (714) 965-1550
Meets 2nd Tuesday from 9:30 - 11:30 AM.

HUNTINGTON BEACH

Jocelyne Shiromoto (714) 965-1550
Open. Call for time.

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 10a.m.-11:30a.m. Call for information.

MONTEREY

Robbie Dunton (408) 372-3900
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 Wednesday 10am in 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, troubleshooting.

RIVERSIDE/SAN BERNARDINO

Byron Perkins (909) 737-2142
Meets 3rd Friday of every month, 9:30am - 11:00am.

SACRAMENTO

Bea Favre, Psy.D. (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

Jim Fox, MFCC (619) 260-0414
Meets second Friday of Each Month, 9:30am - 11:00am.

Arthur T. Horvath, Ph.D. (619) 455-0042
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
Meets fourth Sunday of each month. Call for details.

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 every month on a Friday (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