The
EMDRIA Newsletter

Vol. 7, Issue 2 Quarterly Publication June 2002

From the President: Byron Perkins, Psy.D.

Membership: The Voice of EMDRIA

EMDRIA is a professional membership organization. As a result, the views and participation of the membership are central to its functioning. The membership is the heart and soul of EMDRIA. This article is about its voice.

A number of avenues are available for members who would like to become more involved. The EMDRIA Newsletter is one vehicle which is open for member participation. As many of you are probably aware, considerable confusion has evolved in recent years around EMDR research and practice. The Newsletter and Special Issues provide an opportunity for the voice of EMDRIA to be heard. Topics can include, but are not limited to, news, clinical practice or innovation, theory, and research.

Such participation could benefit the membership as a whole as well as the clientele they serve. Just one example is research reviews designed to help members educate clients and colleagues regarding EMDR. Participation in these types of activities must not be left to a few. Given the size of EMDRIA, there is room for everyone to take a role where they feel comfortable. The greater the participation, the stronger and more clear the voice of EMDRIA.

Another opportunity for the voice of EMDRIA is when a committee is considering making policy recommendations to the Board of Directors, and first seeks the opinions of the membership. A recent example of this was when the Standards and Training Committee was considering potential changes in policy regarding EMDRIA Credits, Certification, Approved Consultants, and Approved Instructors. During the process of its deliberations, the committee submitted the possible changes to the most affected portions of the membership and asked for their feedback.

Many of you submitted responses and engaged in an exchange, which I regard as vital to the health of EMDRIA. You are to be congratulated for your thoughtful efforts and willingness to engage in the process. As a result, the voice of EMDRIA was again heard, an initial deadline for completion of the projects was eliminated, and a dialogue between the committee and membership was begun. The committee is considering the various proposals in light of both membership feedback, as well as the welfare of consumers. As the Standards and Training and the Board of Directors continue their work, additional communications will occur to encourage a continuing dialogue. Your participation is vital in this process and will help provide clarity to the voice of EMDRIA in these important areas.

Direct committee participation is another vital role for members. The majority of Association business occurs in committee settings, and there is a perennial need for those who are willing to contribute to the work of EMDRIA in this format. The diversity of committees also offers a flexibility which could match many different interests. For example, if your interest or skill is in writing, you might want to inquire about involvement in the Publications Committee. Besides contributing to the ongoing functions of EMDRIA, committee involvement also offers the opportunity to help shape policy recommendations made by the various committees to the Board of Directors.

Additional information about the committees of EMDRIA can be obtained through the website or by contacting the central office. If the membership is the heart and soul of EMDRIA, then committees are the muscles through which it can do its work.

A fifth avenue for member involvement is through elected positions as Directors and Officers of the Association. EMDRIA is always looking for qualified, committed members who are willing to serve in these capacities. Inquiries made to the central office will then be considered by the Nominations and Elections Committee for the 2003 election.

There are probably many other ways in which members can contribute to EMDRIA and to EMDR in general. If there are needs or problems that you see, please feel free to contact us. Creative suggestions are always carefully considered. Commitment to excellence and a willingness to be involved are EMDRIA cornerstones. The clarity and strength of the voice of EMDRIA depends upon the committed participation of good people seeking the good ends of EMDR, the mental health professions, and the Association.

Good people make the difference.

Highlights

Inside

The EMDRIA Newsletter
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Newsletter deadlines for 2002 are as follows:

January 20th for the March Issue
April 20th for the June Issue
July 20th for the September Issue
October 20th for the December Issue.

Deadlines are *strictly* adhered to. Please contact the Managing Editor for article or advertising submission guidelines.

Jennifer Turner, Managing Editor
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by contacting the Administrative Office

From the Desk of the Executive Director

Carol York, MSSW, LMSW-ACP
Executive Director
Task Force Chair

The EMDRIA Board has assigned a task force to help develop "General Philosophy and Guidelines" in order that the general purposes and specific purposes of the organization can be delineated and maintained according to our bylaws.

The Bylaws of the EMDR International Association state that "General Purposes" of EMDRIA are "to promote, foster, and preserve that which is legal and beneficial to establish, maintain, and promote the highest standard of excellence and integrity in EMDR practice and for the membership of the mental health profession and to the community which shall be served by the mental health profession. The "Specific Purposes" of EMDRIA are to "promote and foster professional standards commonly accepted within the mental health community; to induce and practice integrity in business relationships; to acquire, preserve, and disseminate useful information for those in the mental health profession; to cooperate and coordinate with professional entities and associations for mutual benefit; and to pursue that which is considered of best interest both to the mental health profession and to members which rely upon it for professional services."

EMDRIA is dedicated to the development and professionalism of EMDR. Although EMDRIA as an organization has only been around for a little over six years, EMDR as a model of therapy has been around 10+ years. In establishing ourselves as a profession, we must attend to both the privileges and the responsibilities of a profession. We are asking society and other professionals to accept our designation as a group of trained professionals who possess specialized clinical and research knowledge. In order to gain this status and maintain it, professional organizations must develop and adhere to guidelines that help establish and guide the profession and the professionals who practice within the profession.

It is our hope that by establishing "General Philosophy and Guidelines" in addition to our existing policies and procedures, EMDRIA will help strengthen EMDR as a profession.

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EMDRIA Standards and Training Committee: An Invitation for Member Involvement

In March of this year, the EMDRIA Standard and Training Committee (STC) sent to EMDRIA Members Certified in EMDR, EMDRIA Approved Instructors, Consultants and EMDRIA Credit Providers proposed revised criteria specific to their level of credentialing. The purpose of this mailing was to solicit member feedback on these proposed criteria. The STC was overzealous in our plan to have the new criteria ready for final distribution at the 2002 Conference in June. In hindsight, it is clear that the Committee did not initially offer members the necessary time for the thoughtful feedback we were requesting on these important proposals. It also appears we did not give you any rationale or background on the issues that led to the changes we were proposing. Based on your feedback, we have slowed the process and would like to share with you on why we proposed the changes we did. We apologize for our initial failure to involve membership sufficiently in the development of these changes in criteria. We intend to take steps to correct these oversights through a regular column in the EMDRIA Newsletter, through e-broadcasts making use of new capabilities of the EMDRIA website and through programs at the Annual Conference. Most importantly, we are reading your feedback and listening. This column represents a step in this process. We sincerely hope this information provides you with the "why" or rationale for the proposed changes, and clarifies "what" changes are being proposed and for "whom." We invite those of you who have not already provided feedback on these proposals to do so in the weeks ahead.

The RATIONALE for the Proposed Changes:

During the last four years, the EMDRIA office staff consistently received applications for EMDRIA Credits, Certification, Approved Consultant, and Approved Instructor that were late, incomplete, or revealed gaps in existing written policy (e.g., policy for handling variances requested by individual members). Carol York, Executive Director, and Curt Rouanzoin, STC Chair, requested that the Committee: 1) review the existing written policies; 2) address the lack of clarity and oversights; and 3) review the underlying standards in light of changes in EMDR and the field since 1998, when the existing policies and criteria were developed and published.

Carol York emphasized the legal exposure faced by EMDRIA when written criteria fail to address specific circumstances and decisions are made in the absence of explicit written policies. Hence, the proposed criteria and policies were intended to set specified policy, as a means of protecting EMDRIA and its members.

There have been significant advancements in the practice of and research in EMDR since 1998, when the existing standards were developed and published. For example, Maxfield & Hyer (2002) clearly demonstrated what many EMDR clinicians already knew. Completing basic training in EMDR alone is insufficient to achieve positive treatment outcomes. Their meta-analysis of EMDR treatment outcomes studies shows that treatment effect sizes are directly and strongly correlated to treatment fidelity.

Secondly, the initial requirement of consultation by an Approved Consultant revealed that the majority of consultees pursuing Certification did not fully understand or use the standard PTSD protocol as taught in the basic training. Furthermore, those Approved Consultants who decided independently to require videotapes of actual EMDR treatment sessions (such as are used in research studies) found significant gaps between consultees' verbal reports of what occurred and what actually occurred in the EMDR session. More importantly, the most highly experienced Approved Consultants found that verbal reports alone during consultation have been insufficient to correct treatment fidelity, even in clinicians who have had years of regular consultation. If EMDRIA's Certification and Approved Consultant programs are to achieve recognition in the professional and lay communities they must be based on the same empirically tested procedures and evidence as EMDR itself. Failing to move towards direct behavioral observation as the standard for EMDRIA Certification in EMDR would leave these credentials vulnerable to the criticism that they have no demonstrated empirical foundation. Also many Approved Consultants already implement the requirement for a behavioral sample from their consultees. Their feedback to the STC was in favor of this new requirement, as it supports them in requiring direct observational evidence of a minimal level of competence in EMDR demonstrated by consultees.

Examples of Problems or Dilemmas Designed to be Addressed by the Proposed Criteria

1. What happens to an applicant for Certification who has obtained all 20 of their required hours from a Consultant-in-Training (CIT) when the CIT abandons their own application or does not obtain a letter of recommendation from their Approved Consultant? The STC felt it necessary to propose criteria that would protect applicants for Certification in these situations.

2. Applications and renewals for all levels of credentialing, as well as requests for EMDRIA Credits, have been late, unpaid, incomplete or request variances from the established policy. The lack of written and published policies to address these issues has left both EMDRIA and our members unprotected in these circumstances. Without published policies, EMDRIA cannot require members to conform to something they did not know existed. As well, it is not fiscally sound for the organization or a good use of staff and Committee time to continuously change procedures, applications, or the necessary documentation.

Cont. from pg. 3

3. What constitutes continuing education in EMDR? Should the location of the presentation determine the appropriateness for granting EMDRIA Credits? For example is a theoretically based, trauma-related, non-EMDR workshop appropriate for continuing education in EMDR when it advances the EMDR clinician's knowledge of trauma and therefore, their practice of EMDR? And what happens when this workshop is given at the EMDRIA Conference, where EMDRIA Credits are granted, yet EMDRIA Credits are not granted when the exact same workshop is given elsewhere? These are some of the questions the STC wrestle with on an ongoing basis. It is EMDRIA's charge to maintain and promote standards of excellence in training and practice, and at the same time, meet the needs of the membership.

Specific Proposed Changes:

In the responses we received so far, many members either express their distress, provided detailed feedback to clarify language or praise these proposals. Before explicitly specifying the proposed changes, we need to clarify some points of obvious confusion. There was a great deal of concern about some policies that haven't actually changed or about others that do not even exist. For example, as indicated on the application forms for Certification or Approved Consultant, a notarized statement has always been required attesting to the identity of the clinician who asserts they have conducted the required number of EMDR sessions. The inclusion of this requirement among the listed criteria led to complaints about legalistic language, rigid policies and lack of trust. Yet, this is not a change in existing policy and remains necessary to assure the applicant has the requisite experience. Other members were concerned that they would be required to take a written examination every two years to renew status as Certified or as an Approved Consultant. A written examination has never been required and was not proposed as an EMDRIA requirement.

Proposed Criteria for the EMDRIA Credit Program:

EMDRIA Credits (EC) are required for becoming an EMDRIA Approved Instructor, Approved Consultant and becoming Certified in EMDR. EC's are also required for renewal of all these levels of credentialing by EMDRIA. EC's are offered at the annual EMDRIA Conference, at specialty presentations, and at some Regional Meetings.

EC's must meet the requirements of post-graduate level credits. The EC application includes: an abstract of the presentation, a list of learning objectives, a timetable/schedule of the material to be covered, an examination, a vita of the presenter, and the promotional materials. These materials are necessary for the STC to decide whether the presenter is qualified and the proposed presentation warrants the requested number of credits. The Committee must also verify that the promotional materials meet the legal requirements for disability information, refund policies, and such. Following the presentation, the EC Provider must submit a list of attendees, attendance sheets, evaluations and examinations to the EMDRIA office to substantiate that a member did in fact receive the credits and when.

One of the main reasons for the proposed revision to the EC Program is the wide variety of presentations requesting EC's. A major concern in determining the appropriateness for EC is the amount of EMDR clinical application that actually appears within a presentation. We believe that the significance of learning about theoretical issues related to EMDR is quite different from learning actual clinical applications of EMDR. Since we believe that both are important, we wanted to ensure that EC requirements reflect the need for both. The same is true for the Research Categories. Additionally, publicizing the Level of Evidence Category for the presentation provides our members the opportunity to make informed choices about how they spend their time and money.

Proposed Criteria for Becoming Certified in EMDR:

The central question is "What does it mean to achieve the designation of EMDRIA Certified in EMDR." The most significant proposed change for new applicants for Certification would be demonstrating a minimum level of competence in applying the standard EMDR protocol through a live practicum or videotape. The requirement could be met in a variety of ways and settings. Live or videotaped observation of actual clinical work with a client would provide the strongest evidence. However, it can be challenging to provide, due to client reluctance to be videotaped and the cost of access to needed equipment. Videotaping does permit those in remote areas to demonstrate their competence as part of telephone consultation. Practicum work during group consultation can also provide direct evidence of competence and supports learning in the group setting.

Proposed Criteria for Becoming an Approved Consultant:

Two primary changes were proposed for those applying to become an Approved Consultant. First is the requirement to achieve Certification before applying to offer consultation. Second is the requirement not to offer consultation until after an application to serve as a Consultant-in-Training has been filed and approved by the EMDRIA office. This requirement is intended to assure that consultees are able to get full credit for any hours of consultation they obtain from Consultants-in-Training.

Proposed Criteria for Renewal of Certification:

The only proposed change that would affect renewal of those presently Certified in EMDR would be if the EC Program were revised. In that case, 6 of the now required 12 hours would need to be in programs that meet the proposed Clinical category of EC's. This is to assure that those Certified in EMDR spend at least one day every two years learning about EMDR procedures for which there is some evidence of clinical effectiveness.

Proposed Criteria for Renewal of Approved Consultants:

If the revised EC Program were implemented, those renewing as Approved Consultants would be required to have 18 rather than the present 12 hours of EC's every two years. This reflects the higher standards expected of Approved Consultants to address not only changing clinical issues, but evolving standards in consultation as well. Thus, Approved Consultants would also be required to have 3 hours of EC's in Consultation every 2 years, as part of the 18 hours. This is intended to support minimum standards for understanding the ethical and legal issues related to consultation. It will also support the development of basic competence and inter-rater reliability for evaluating and giving feedback to consultees about their clinical use of EMDR. The development of future educational programs would be encouraged specifically for Approved Consultants at the annual Conference and in local regions that include the use of clinical vignettes and training videos to address these issues.

Proposed Criteria for Becoming an Approved Instructor:

In looking at the existing criteria for Approved Instructors, it was immediately apparent that there was insufficient specificity of requirements as to teaching experience, course details, and qualifications of teaching assistants. The lack of clearly defined criteria for Approved Instructors, as well as a mechanism for evaluation of Approved Instructors prior to their actually teaching the course, made the approval process far too subjective. We recognized that we needed to find a way to evaluate people's teaching experience in general and their teaching of EMDR in particular. We wanted to ensure a high quality of instruction, as well as making the playing field more equal. The clearer the standards, the more able an unknown person with a high level of excellence is to get approved as an EMDRIA Approved Instructor.

We also recognized that the receipt of handouts and videos in advance allowed us to evaluate potential applicants and programs, as well as support and encourage creativity in the Instructors.

A universal concern in teaching EMDR has been the insufficiency of practicum experience. EMDR Institute facilitators have mentioned this concern for years. As well, the research data noted above demonstrates the importance of treatment fidelity and supports the need for increased supervised clinical practicum during training. The more competent clinicians are as they leave training, the more likely they are to do EMDR and to do it well. This is also likely to increase the probability that they will make EMDR an important part of their clinical practice.

The addition of having supervised practice in assessing and enhancing affect tolerance and anxiety management prior to the first EMDR practicum experience was thought to provide safety for all participants. It also ensures that our graduates were able to adequately prepare their clients for EMDR in as safe a context as possible.

Membership Involvement:

The need for change is clear. The proposed criteria were designed to fill the needs mentioned above. However, the ways in which these changes take place are open to discussion and feedback. Equally true is that the work of developing written policies and criteria is time consuming and demanding. Your involvement in this process is welcomed and needed. Your specific, thoughtful written feedback helps greatly.

What is most critical to the future of EMDR practice is that the different levels of credentialing, such as Approved Consultant or Certification in EMDR, need to have a consistent meaning about the quality and fidelity of our clinicians. It seems incumbent on all of us to ensure that this standard of excellence is achieved and maintained. The STC invites anyone with an interest in this ongoing process to consider joining the Committee. Please contact the EMDRIA Office if you are interested.

The STC sincerely hopes that the information provided here has helped to explain our rationale, clarify points of confusion, shore up your trust in us as YOUR organization, and demonstrate our commitment to working for and with you, now and in the future.

Respectfully,
The EMDRIA Standards and Training Committee

Curt Rouanzoin, Ph.D. - Chair
Mark Dworkin, MSW
Celia Grand, LCSW, BCD
Sandra Kaplan, MSW, CSW
Daniel T. Merlis, MSW
Bennet Wolper, MSW
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Ginger Gilson, MA, MFT
Andrew M. Leeds, Ph.D.
Jari Preston, M.Ed.
Carol York, MSSW, LMSW-ACP

Maxfield, L., & Hyer, L. (2002). The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. *Journal of Clinical Psychology, 58*(1), 23-41.

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Consultation/Supervision

EMDR group and individual consultation for clinicians in Maryland, D.C., and Northern Virginia by Deany Laliotis, LCSW-C and Dan Merlis, LCSW-C. Call 301-718-9700 or email dlaliotis@aol.com

Educational Workshops

Deany Laliotis and Dan Merlis sponsor advanced practice EMDR and other specialty workshops in the mid-Atlantic area. Join our mailing list for notice on workshops and other events we sponsor in the mid-Atlantic area. Call 301-718-9700 x5 or email your name, address, phone and email info to danmerlis@aol.com. Please encourage other non-EMDRIA colleagues to contact us so that we can grow an EMDR community in this region.

OVERCOMING PAIN with EMDR by Mark Grant. 3 1/2 hour workshop VIDEO presentation; $85.00. Contact Linda Vanderlaan 909-279-7099

EMDRIA Credit Schedule

as of May 15, 2002

Dates Location No. of EMDRIA Credits	Provider Name Title of Program	Presenter	Contact	Phone No.	Provider # Program #
6/1-2/02 Long Island, NY 13 Credits	Andrew Leeds, Ph.D. **Strenghthening the Self - Part 2: Clinical Application and Practicum**	Andrew Leeds, Ph.D.	Andrew Leeds	707-579-9457	99019 99019-22
6/3/02 Poughkeepsie, NY 1.5 Credits	Mid Hudson Valley EMDRIA Regional Meeting **EMDR and Creativity**	Christine Ranck, CSW, Ph.D.	John Nash, Ph.D.	845-471-8354	RC99009 RC99009-07
6/8-9/02 Toronto, ON CANADA 14 Credits	Roy Kiessling, LISW **Integrating Resource Installation Strategies Into Your EMDR Practice**	Roy Kiessling, LISW	Roy Kiessling	513-324-3637	00015 00015-17
7/12-13/02 San Antonio, TX 12 Credits	Shirley Jean Schmidt, MA, LPC **Developmental Needs Meeting Strategy for EMDR**	Shirley Jean Schmidt, MA, LPC	Shirley Jean Schmidt	210-561-9200	00013 00013-06
8/24-25/02 Raleigh, NC 14 Credits	Roy Kiessling, LISW **Integrating Resource Installation Strategies Into Your EMDR Practice**	Roy Kiessling, LISW	Roy Kiessling	513-324-3637	00015 00015-18
9/27-29/02 Toronto, ON CANADA 16 Credits	Maureen Kitchur, MSW, RSW **The Strategic Development Model for EMDR**	Maureen Kitchur, MSW, RSW	Maureen Kitchur	403-270-0652	99015 99015-08
10/11-12/02 Cincinnati, OH 13.5 Credits	Cincinnati Trauma Connection **Critical Incident Stress Intervention for EMDR Therapists Part-I**	Roger Solomon, Ph.D.	Barbara Hensley	513-961-2400	99024 99024-05
10/19-20/02 New York, NY 13.5 Credits	Advanced Therapeutic Skills Seminars **Deepening EMDR Treatment Effects Across the Diagnostic Spectrum**	Carol Forgash, CSW	Beverly Wright	631-423-6809	01005 01005-05
11/23/02 Cincinnati, OH 6.5 Credits	Cincinnati Trauma Connection **Using Eating Disorders with EMDR**	Eileen Freedland, MSW	Barbara Hensley	513-961-2400	99024 99024-06
12/6-7/02 Bellevue, WA 13 Credits	First Friday Forum **Restructuring the Self - Part II**	Carol York, MSSW, LMSW-ACP	Jari Preston	206-527-8696	01001 01001-03
1/18-19/03 Cincinnati, OH 13.5 Credits	Cincinnati Trauma Connection **Critical Incident Stress Intervention for EMDR Therapists-Part II**	Roger Solomon, Ph.D.	Barbara Hensley	513-961-2400	99024 99024-07

Yes! Sign me up!

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A Tool for Working with Dissociative Clients

Jim Knipe, Ph.D.
Colorado School of Professional Psychology

For those clients who are suffering from Complex PTSD, especially those whose condition originates in childhood abuse or neglect, dissociation is likely to be part of the presenting clinical picture. To the extent that dissociation is occurring, the healing power of EMDR may be blocked, and more importantly, the use of the standard EMDR protocol may put the client at risk for a non-therapeutic dissociative abreaction.

For the past three years, with clients who have dissociative vulnerability, I have been using a procedure which allows assessment, moment to moment, in the session, of the client's degree of awareness of present orientation and safety. Put another way, this is a process measure of the degree to which the client is dissociating, or beginning to dissociate in the session. In many ways, this assessment procedure gives both client and therapist a greater degree of control over trauma-focused EMDR work. This method is used as an addition to self-soothing procedures, appropriate metaphors, and the development and installation of "safe place" and other positive resources.

The Back-of-the-Head Scale (BHS) is introduced during the Preparation Phase, but then is used during the Desensitization Phase, whenever the client is perceived as possibly edging closer to a non-therapeutic dissociative abreaction. Prior to any trauma work, the therapist says:

"Think of a line that goes all the way from here (therapist holds up one index finger about 15 inches in front of the Person's face*), running right from my finger to the back of your head. Let this point on the line* (therapist moves index finger*) mean that you are completely aware of being present here with me in this room, that you can easily listen to what I am saying and that you are not at all distracted by any other thoughts. Let the other point on the line, at the back of your head* (therapist points to the back of their own head*) mean that you are so distracted by disturbing thoughts, feelings or memory pictures that you feel like you are somewhere else—your eyes may be open, but your thoughts and your awareness are completely focused on another time, or place or experience. At this very moment, show with your finger where you are on this line."*

The therapist should check to make sure the client gets this idea. Most clients who have dissociative experience will quickly recognize this procedure as a way of measuring and expressing a familiar aspect of their mental life. The assumption is that the more the person points toward the "most present" end point of the line, the safer it is to do trauma work with EM. As a rough rule of thumb, I have assumed that it is necessary for the person to point to a position at least four inches in front of their face, in order for trauma-focused work to proceed. The use of the BHS throughout a therapy session can be very useful in insuring that the client is staying "present" while reprocessing disturbing memories.

During trauma work, the BHS can be used in connection with a procedure of constantly installing present orientation and safety (CIPOS). Through this procedure, the client is able to maintain duel attention much more easily, and processing of traumatic memory material can proceed in a manner that feels more "in control." This CIPOS interweave procedure is as follows.

Prior to asking the client to access the troubling memory, the therapist asks a series of simple questions relating to the actual reality of the therapist's office, with each client answer followed by a short set of eye movements to strengthen the client's sense of present orientation. . For example,

Therapist: "I am going to ask some 'simple-minded' questions. Just say whatever is true. Where are we right now?

Client: "We're in your office."

Therapist: "Think of that," followed by about 6-9 EM.

Other examples of these orienting questions would be: "Can you hear the cars outside?" "How many clocks do I have in this room?" "As you look around the room right now, what catches your eye? ", "Can you find the flaw in this rug? ", etc. Thus, with the "simple questions," the therapist is directly guiding the client to an awareness of these present stimuli, and the feelings of safety associated with the therapist's office.

A particularly effective method of creating a focus on the immediate present reality is to ask the client to catch and toss an object (pillow, wad of tissue) back and forth. This task probably attenuates the client's orienting response. Many clients will report, after a short game of "catch" that they are no longer dissociated, and that they are now experientially present. This shift towards safety can then be installed as a positive resource with EM. Lipke (1995) and Stickgold (2002) have previously proposed that the therapeutic effects observed with EMDR may be due in large part to stimulation of the orienting response, which in turn has the neurological effects of weakening episodic traumatic memories and enhancing useful semantic associational connections. Whatever the neurological explanation, this procedure seems to have the reliable effect of helping a dissociating client "come back in the room."

When the resource of present safety is being installed, I generally use EM as the mode of Alternating Bilateral Stimulation (i.e. not hand taps or alternating tones). With the client's eyes open, it is easier for the therapist to see changes in the client's experience, and keep the procedure in a safe zone.

Through the use of the Back of the Head Scale (BHS) the therapist is able to assess the effectiveness of these CIPOS interventions. In this way, it can be insured that the client is remaining sufficiently grounded in the present, so that reprocessing of the trauma can occur. There is a saying, "don't jump into water if you don't know how deep it is." If a client wades into an old memory, without one foot on solid ground, it is likely to be re-traumatizing, not therapeutic. The BHS is a way of making sure the client remains safely in "shallow water," while processing traumatic material. The accompanying graph illustrates how this method may be safely used.

When present orientation is sufficiently established, the client is asked if they are willing to go into their memory image for a very brief period of time (e.g. two to ten seconds), with the therapist keeping track of the time. This is essentially a carefully controlled dissociative process – giving in to the "pull" of the dissociation, but in a planful way, with the explicit prior agreement to come back at the end of the period of seconds. When the 2-10 seconds is up, the therapist instructs the client, using soothing but repetitive and emphatic words, to "come back into the room now, just open your eyes, find your way back here now, that's right, just open your eyes, etc.," until the client's eyes open and they are looking out into the room again.

At this point, the therapist gives encouragement ("Good,"or, "That's right.") and then resumes the CIPOS interventions, with statements like, "Where are you right now in actual fact?" with the answers followed by additional short sets of eye movements. The CIPOS interventions are continued until the client is able to report, using the BHS, that they are once again oriented towards the present reality of the therapist's office. At this point, the client may "go back into" the memory material for another period of seconds, with the therapist keeping track of the time. In every case, the duration of the controlled "going in" to the memory must be kept sufficiently short so that the client will be able to open the eyes and come back relatively easily. Note that at this stage of the CIPOS procedure, EM are not paired with traumatic material, only with an awareness of present safety.

As this process continues, with repeated brief experiencing of the memory, alternating with installation of present orientation and safety, the client develops an increased sense of control, as well as greater confidence that they will be able to "stay present" while confronting the disturbing memory. This slowly opens the door to the safe use of the standard EMDR protocol, i.e. of directly pairing EM (or other ABS) with traumatic material.

An underlying assumption of this method is that the therapist is alert to any positive shift in the client's experience of the traumatic memory, and is constantly strengthening these shifts as resources, through EM. For example, a client might say, "I see now how alone I was as a child." These words express a very sad fact of the client's life, but this realization may nevertheless be a positive step in coming to an adult understanding of the childhood events. Therefore, the therapist might then ask, "Is it helpful to you to see that now?" If the client says, "Yes," the therapist can assume the new information is experienced as a positive resource, and install it with an additional set of EM.

The client's answers to the "simple" orienting questions may reflect the reality of the therapist's office, but may also express information regarding the trauma itself. For example:

Therapist: "What is good about being here right now, in this office?"

Client: "You aren't hurting me."

Such an answer is clearly more about the trauma than about the therapist's office, and when these types of answers are paired with EM, desensitization of traumatic material occurs, but in a way which can feel softer and safer to the client.

The BHS can be used not just to assess clients' current orientation but also to provide additional positive resources during the processing. These resources may be installed as they emerge, with the resulting effect of further enhancing the client's sense of empowerment in resolving the disturbing memory. A client might say, at one point in time, that she is still "way back in the head." At another point, a few minutes later, after a set of CIPOS interventions, the client might report that on the BHS he is now about six inches in front of her nose. The question, "What's different now?" would focus the client's awareness on something positive she had just accomplished, and whatever response is made to this question may be regarded as a resource, which then became even stronger and more positive with a short set of eye movements.

The BHS can also be useful with clients who present in therapy with depressed affect and an emotionally detached interpersonal style. Oftentimes, the depression partially originates in social anxiety and difficulty in engaging in satisfying interpersonal interaction. The BHS gives therapist and client a "language" to discuss the issue of being comfortably engaged with others. In addition, long-term goals of therapy, and within-session Positive Cognitions can be defined in the context of the BHS: e.g. "Would you like it if you could easily be 'out here' on the line, and easily enjoy talking with other people?"

To date, I have used this procedure with approximately 15-20 clients. It appears to have been helpful on all but one occasion. The exception was a situation with a client with a DID diagnosis, on a day of particularly high stress. In this instance, the EM paired with an awareness of present surroundings increased the client's disturbance, and so the procedure was immediately discontinued, and other methods of self-calming and self-control were utilized. With this same client, on other less stressful days, the procedure has been very helpful. This illustrates a principle worth repeating: that with this client population, neither this nor any other procedure is an adequate substitute for appropriate training, experience, and accurate atunement to the client. But, with this important caveat, the BHS seems to be a useful tool in the treatment of individuals with dissociative conditions.

Lipke, Howard (1995) Manual for the teaching of Shapiro's EMDR in the treatment of combat related PTSD. Pacific Grove, CA: EMDR Institute.
Stickgold, Robert (2002) EMDR: A putative neurobiological mechanism of action. Journal of Clinical Psychology, Vol. 58(1), 61-75.

EMDRIA Committee Reports

Research Committee

Chair: Nancy Smyth, Ph.D., CSW

Committee Activity Update: Planned Conference Activities

In addition to our usual consultation activities, we've been working on organizing research-related activities for the annual conference. Among other offerings this year's conference will feature the following opportunities for those interested in research:

* Poster Session: Posters are excellent ways to summarize research or single case studies, and to present a conceptual model or assessment package. At most professional conferences poster sessions are the primary vehicle for the presentation of new research, case study applications, literature review summaries and new assessment instruments. We've been receiving some very interesting abstracts—it sounds like it will be an excellent poster session! This year, the poster session will be featured at the Saturday night closing reception, which is where we will give out the award for best poster.
* Workshop: So You're Thinking About Doing Some Research: What's the Next Step? This workshop will cover how to begin doing research. Topics covered will include: how to make a contribution to EMDR research, how to test a new intervention you've developed, sources of brief assessment instruments for use in clinical practice research, resources to assist you in exploring the research process. (Friday afternoon).
* Researcher Networking Meeting: This is an open meeting to: 1) facilitate networking among EMDR Researchers; and 2) generate ideas on how EMDRIA might best be able to support the needs of the EMDR research community. All EMDR researchers and those interested in doing EMDR research in the future (e.g., students, clinicians, aspiring to do research, academics training future EMDR researchers) are encouraged to attend. (Saturday morning).
* Roundtable Discussion: Setting Guidelines for EMDR Research. Research on EMDR has reached the stage where it is now important to have recommended directions and strategies for research on specific applications of EMDR. This session will be a working discussion of research committee members, and any other interested participants on this topic. The goal of this session is to develop draft guidelines for EMDR research on PTSD, phobias, complex trauma, and components analyses/dismantling studies. Join us to help influence the direction of future EMDR research. (Friday afternoon).
* Plenary Session: Physiological Data Confirms that EMDR is a Unique Reprocessing Therapy: A Synergistic Theoretical Approach to the Nature of Both EMDR and PTSD: Malcolm MacCulloch, MD, F.R.C.Psych. This plenary features the exciting work of Dr. Malcolm MacCulloch, a researcher from the United Kingdom, who has been investigating the role of eye movements in EMDR. (Sunday morning).

EMDRIA Pre-licensed Clinician Support Sub-Committee

Chair: Linda Vanderlaan, Ph.D
Co-Chair: Nicole Nestor, MFT

Are you Pre-licensed?
Need someone to consult with?

We want you to know we are here to support you. During this past year the Membership Committee has developed a list of therapists who are willing to provide low-fee consultation and EMDR training for all those who are pre-licensed. Take some time to check out the information provided on the new web site at www.EMDRIA.org. See how we are helping those not yet licensed. Look for us under "Member Services", and click on the highlighted "Pre-licensed clinician support sub-committee" in the text.

Feel free to let us know how else we can help. We are here to help fill the gap!

Electronic Communications

Chair: Rosalie Thomas, RN, Ph.D.

Website News

The EMDRIA Electronic Communications Committee (ECC) hopes you've all had a chance to check out the new EMDRIA website at www.emdria.org. There you can find recent announcements, information about upcoming events, regularly updated EMDRIA Credit offerings, member benefits, current information about Committee activities, access to all past years' EMDRIA Newsletters and Special Editions and much more! We hope you like the progress so far.

EMDRIA Members should log on to the 'Members Only' section and review your individual listing in the Member Directory. Please call or email the office if you haven't received your user name and password. Many email notices were returned as "undeliverable," so be sure to check your currently listed email address and update it as necessary. Please note that you can make your listing "visible" to other members, or you can make yourself "invisible" on this list. That will allow you to remove your name from time to time if you want to limit access.

We are still adding information to the site and are looking for ways to increase its usefulness to EMDRIA Members. Please send any ideas or comments to the ECC at www.emdria.org. You can use the "Contact Us" button to compose and forward your email. We look forward to hearing from you.

Publications

Chair: Dan Merlis, MSW

We have received many positive responses from EMDRIA members concerning the last special clinical issue on 'resourcing' in EMDR practice and wish again to thank the authors, editors, and reviewers who made this possible. We are currently collecting submissions for the next special clinical issue which will be a general issue. We will publish this issue once we have adequate edited material. Please consider submitting an article, case report, research study, even a brief clinical anecdote. Or consider a brief letter to the editor regarding a clinical observation, question, or comment for others to consider.

The Publications Committee has been working over the past several months to improve the infrastructure related to the publication of quarterly and special clinical editions of the *EMDRIA Newsletter.* You will notice that in the quarterly *Newsletter*, we are introducing two new features. First, a "Letters to the Editor" section which we hope will encourage feedback from members on issues of concern to them including responses to clinical articles published in the quarterly and special clinical issues. Second, we are offering a classified advertising section to better serve member needs for timely information on upcoming trainings and workshops, EMDR-related services, and EMDR-related products. We hope that you will also post job possibilities for EMDR clinicians and office space available for EMDR clinicians. More services....more debate....more innovative ideas...the Committee seeks to serve your needs and to engage you in sharing your ideas and practice experiences with each other. Dan Merlis, Chair of Publications, has persuaded Jim Gach, past-Treasurer and current board member to serve as Co-Chair of Publications Committee. Good things will come of this!

Inquiring Minds: Questions for the Research Committee

How can practitioners contribute to EMDR Research?

Many EMDR practitioners inquire about how they might contribute to the research on EMDR. Some basic guidelines on doing research are presented here—they have been adapted from an EMDR Institute Listserv post by Louise Maxfield. The purpose of research is to test the effectiveness of a specific protocol. To do this, we have to be able to say that the results would not have been achieved without the treatment; i.e., that the person would not have improved as a result of time or attention. There are 2 simple designs that can be used by practitioners to collect such data. These are single case designs and waitlist designs. A third design is treatment comparison, which tests whether EMDR is more effective than another therapy. This other therapy might be CBT, standard care, or modifications of EMDR, etc. The following are simple descriptions of these designs. Please note that these can often be more complex.

In a single case design, measures are administered on several occasions prior to the start of treatment to establish a baseline. This evaluates the severity of symptoms over time without treatment. Then, when treatment starts, the measures are administered on a regular basis. The same thing is done after the end of treatment to measure maintenance of treatment effects. What you end up with is a graph with 3 sections, Pre, During, and Post treatment. Each section of the graph has a line with several data points measuring symptom severity. For example:

	Pre			During				Post			
Scores	78	80	76	54	49	35	42	26	20	23	22	18
Week:	1	2	3	4	5	6	7	8	9	10	11	12

Just collecting the data during and post treatment is not considered scientifically compelling, because it is possible that the person may have had a similar improvement without treatment. The pre-score baseline demonstrates that this is probably not the case. Published studies generally show a series of clients with the same disorder, using the same measures. The simplest single case designs (pre, during and post) are called A-B-C designs (A for baseline, B for intervention phase, C for follow-up). These designs are easy to implement, but aren't as rigorous as more complex single case designs which can establish an intervention's effectiveness more convincingly.

Many practitioners may choose to collect "During" and "Post" data in their own practice to document the effectiveness of the therapy they provide. This is also very useful, but has a different goal. Therapists can use this type of information to help them to identify any patterns of response among their own client group, the advantages of changing or modifying the protocol, etc.

The second type of design that could be used is the waitlist design. This involves randomly assigning clients to either receive treatment, or wait for treatment. All clients requesting treatment complete measures at Time 1; half get treatment right away, half wait for treatment. For example:

Time-1	Time-2	Time-3	Time-4	Time-5
1 Test	EMDR	Test	Test	
2 Test	waitlist	Test	EMDR	Test

This is a more rigorous design than the A-B-C single-case design. The total time depends on the length of treatment, and the time for follow-up tests. For example, there could be 8 weeks between Time 1 and Time 2, to accommodate 8 treatment sessions; then another 2 months, until Time 3, for follow-up measures for the treatment group. In other words, the waitlist group might wait 4 months for treatment. In some designs, the waitlist starts treatment after Time 2. Such studies usually require at least 10 persons per condition, ideally 20. The third type of design compares EMDR to another treatment. This could be standard care provided in the agency, relaxation, or another treatment known to be effective, and in which the therapist is trained and competent. This is a more rigorous design than the waitlist design. Although some studies are published with about 10 persons per condition, having 20 or more per condition gives more statistical power to analyze differences in outcome.

For example,

Time-1	Time-2	Time-3	Time-4
1 Test	treatment	Test	Test
2 Test	EMDR	Test	Test

Where Research Is Needed

A large body of research already exists demonstrating EMDR's efficacy in the treatment of PTSD for civilian, non-complex trauma. However, this research uses (almost exclusively) eye movements and not tones, tapping or tactile stimulation. So we need research evaluating the effectiveness of these alternate stimuli. Research is very much needed to evaluate EMDR treatment of phobias and panic disorders. We still lack empirical evidence for EMDR's efficacy with these disorders. Related questions include if EMDR is enhanced by the addition of in-vivo exposure; and, if EMDR is primarily effective for phobias with traumatic onset versus those with no traumatic onset. Research is needed for all the specialized protocols, e.g., the Kitchur model, the addiction protocols, Resource Installation, EMDR with ego-state, Imaginal nurturing, etc. In addition, research is needed for all applications of EMDR to other disorders (e.g., eating disorders, somatoform disorders, etc.).

Research is also needed to assess the role of eye movements in EMDR (and other dual attention stimuli). Randomized controlled studies would require a large sample, which would be difficult for the individual practitioner. Case series designs could be done, measuring first the baseline, then response to EMDR-with-EMs, then response to EMDR-without-EMs, then post measures. These treatment conditions would be provided in the opposite order to half the clients. The treatment series could also be repeated.

Treatment Fidelity

Because research involves testing a specific protocol, therapists do not have the freedom to move outside the box. Therapists are required to maintain fidelity to the protocol, even if they feel that the client might benefit from adding an additional approach. This can be difficult for those of us who are creative in our treatment application; however, the standardized protocol has generally been found to be effective. If the protocol is modified during the research, it is not possible to determine how effective the treatment is. In an analysis of methodological factors, Louise Maxfield and Lee Hyer found that EMDR studies that had good treatment fidelity were the studies that tended to achieve larger effects. Fidelity is assessed by having tapes of your sessions viewed by an assessor who uses a fidelity checklist to measure your adherence to the protocol. Ideally, the assessor should not know the purpose of outcomes of your study.

Where Can I Get Help on Doing Research?

Conducting research on EMDR can be a great way to expand your skills, as well as add to what we know about EMDR. If you think you'd like to conduct a study, remember that you can obtain free research consultation from the research committee, and that there is a research support listserv that is sponsored by the EMDRIA research committee. You can obtain information on both of these services by checking the EMDRIA web page, or by contacting Nancy J. Smyth, committee chair at 716-645-3381 x232 or njsmyth@buffalo.edu

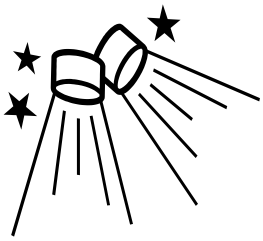
Do You Have a Research Related Question?

Each issue of the newsletter will feature a question related to EMDR research. If you have a question that you would like to have featured, either e-mail it to the chair,

Nancy Smyth, Ph.D., at njsmyth@buffalo.edu

or send it to EMDRIA's Research Committee, P.O. Box 141925, Austin, Texas 78714-1925.

When you send your question, please let us know if it's okay to publish your name & affiliation (if you don't specify, we'll leave it anonymous).



IN THE SPOTLIGHT: Jim Knipe, Ph.D.

By Marilyn Luber, Ph.D.

Who is this man, Jim Knipe, who lives in the mountains of Colorado?

Here is what his friends and colleagues say:

"I remember the first impression of him when I went up to the bus which took us to the lecture hall in Istanbul. I was the only one who didn't know him from the Israeli delegation and as I passed by, quite inhibited in the beginning, he introduced himself offering me to sit beside him. Since then I was sorry to realize that the way from the hotel to the lecture hall is too near because the conversation was always exciting and too short. I don't know him too well but he "gives a taste of more" (that's a Hebrew idiom)".
-Brurit Laub, Israel

"To me he has just been a very nice, warm-hearted handsome man. Around him is always an aura of authentic calmness and humour."
-Lene Jacobsen, Denmark

"Jim is great…all around a talented, sensitive, humanitarian and stable guy".
-Robbie Dunton, USA

"Jim helped me with my recent presentation in Toronto. What I would say throughout all of this is that he has been supportive, generous, highly creative, a fun and highly informed individual to tour Turkey with, and an excellent clinician based on the videotapes of his works I have seen. Everyone has a shadow side. Perhaps Jim has made friends with that part of him because his generosity and friendship with me even in stressful situations is the part that keeps showing up. I have told him that he is like a brother to me and I deeply care for him".
Elizabeth Snyker, USA

I had seen Jim at various EMDR functions and we have talked briefly here and there, but it was not until a fall afternoon at the EMDRIA 2000 Toronto Conference that I felt that I got to know him. What a rich, warm, and enjoyable afternoon that turned out to be.

Jim makes an impressive appearance with his white hair and sparkling eyes. He is a soft-spoken man who has lived all of his life in the western United States. He loves the mountains, folk songs, and his Gibson J50 guitar, and, living a life that is thoughtful and purposeful.

The core of who he is resonates with the teachings of Viktor Frankl. His belief is that it is his conscience that directs him to life's meaning as a kind of moral sense organ. Conscience is like a sense organ in that it allows each of us to perceive where the meaning in life can be found. Service seems to be the organizing principle through which Jim experiences his world. In this way, he follows in the footsteps of his father, who died in Okinawa 12 days after setting up a hospital subsequent to the WWII invasion. Jim believes that the times when we can make a difference are "rare and brief", and he thinks that it is important to take those opportunities when they arise. He believes in the continuity and connectedness in life and feels a genetic and spiritual connection with his ancestors, his family, and extended family.

In keeping with this credo, Jim chose a life as a mental health care worker. He completed his B.A. in 1966 in Psychology from Lawrence University in Wisconsin. He went on to receive his M.A. in Developmental Psychology (1968) and Ph.D. in Clinical Psychology (1972), both from the University of Illinois at Urbana-Champaign. He is guided by the wish to work with and assist in the healing process of those suffering the most. He told me that the accomplishment of which he is most proud is the 24-hour Crisis and Day Treatment Center that he implemented for people who are Chronically Mentally Ill. After 23 years, it is still going strong, and he is a Consultant to the program.

He is fascinated by the difficulties that clients with DID or Axis 2 diagnoses bring to his office and how they learned to protect themselves from the trauma that befell them. He wrote a chapter in Philip Manfield's text, *Extending EMDR*, that he called "*It was a golden time: Healing narcissistic vulnerability*" and he continues to actively think about these problems on his own and in conjunction with his colleagues. Recently, he has written a chapter for a book edited by Carol Forgash on the use of EMDR with Ego State Disorders and on EMDR and the treatment of Dissociative Disorders for this issue of the EMDRIA Newsletter.

And, he loves to teach. In January 2001, as an adjunct faculty member at the Colorado School of Professional Psychology in Colorado Springs, he began teaching a new curriculum. The theme of the course was the effects and treatment of psychological trauma with the use of EMDR as the major treatment component. It is an equivalent of an EMDR Institute Level 1 course. The Level 2 equivalent course began in January 2002. The Level 1 included the added benefit of giving students a thorough grasp of psychological trauma. This is a new course and is part of the developing "Trauma Specialization" curriculum at the school. He is teaching in conjunction with another EMDR trainer, good friend and colleague, John Hartung.

How did he get so interested in Turkey? That's easy! It started back in the sixties when he and his wife got to know an exchange student who came from Turkey. Over the past 30 years, their Turkish friends came to visit the United States several times. His first trip to Turkey occurred in 1992. In 1996, he went back to visit his friends and thought it would be interesting to connect with mental health professionals while he was there. When he was in Istanbul, he went to visit a Domestic Violence Clinic and met colleagues there where he told them about EMDR. At that time, he met Emre Konuk, a quiet, yet dynamic man, who, for many years, has been President of the Turkish Psychological Association, Istanbul Branch. It is Emre who did all the groundwork to sponsor the first Turkish EMDR training.

On August 17, 1999, terrible earthquakes occurred in Turkey. Within less than a minute, 10,000 people died. By the end of this natural disaster, 15-20,000 additional people had died. Emre immediately e-mailed Jim and within a short period of time, with the assistance of Francine Shapiro and EMDR-HAP, an emergency EMDR training was planned.

The question was "What will it take for these therapists to be overnight experts in EMDR?" With Udi Oren, Gary Quinn and Elan Shapiro and the whole Israeli team, they established the prototype for a new way of training participants in disaster areas that maintained the integrity of the original seminars. At first, Jim and Philip Manfield worked with survivors who had been in the earthquake zones and taped these EMDR sessions. They then had excellent videos to show the method to the Turkish therapists. The training included an emphasis on how to fashion a safe place and three additional clinical practices for the training. Then, the

facilitators followed the newly trained therapists to the tent cities and supervised their work. They also made sure that the participants had healed their own trauma from the earthquake.

Jim began to choke up when he recounted a moment that he often thinks about. During the post-training supervision of trainees in the tent city clinics, there was one therapist who was very apprehensive about using EMDR with a very traumatized little girl. After their very successful session, both the girl and the therapist emerged with faces showing confidence and relief. It is the picture of these two faces of confidence and relief that still lives in Jim's mind and is symbolic of his work and the healing that has occurred through the use of EMDR in Turkey.

Emre –picking up on the importance of support and peer supervision- met with the newly trained therapists 3 hours a week. He made videos of the facilitators working and used them as important elements of his supervision. By June, each of the therapists who had learned EMDR was using it, and had worked with an average of 50 clients each. He noted that 8000 EMDR sessions took place in that first 11 months in Turkey; that is a lot of healing! There have been three introductory trainings (159 Turkish therapists) and one advanced training (66 Turkish therapists). The clinics run by the Turkish Psychological Association, Istanbul Branch, are still in operation in the earthquake zones. In January 2001, there was a second advanced EMDR, HAP-sponsored training which was very well-attended. Plans to have an additional beginning training sponsored by HAP in September,2001 were put aside following a severe economic downturn in Turkey during the past year. (Jim noted that the Turkish currency lost 55% of its value overnight, which added to the traumatization of the Turkish people). In spite of this setback, there continues to be an active EMDR therapist community in Turkey, involved in both practice and research. EMDR Turkey is now a member of EMDR Europe, with a flag on The EMDR Practitioner electronic magazine website.

In December, 2000, Jim was part of the initial assessment team that went to Indonesia. This team was under the direction of Michael Keller from the United States and included Elaine Alvarez of the United States and Reyhana Seedat-Ravat of South Africa. In August/September 2001, Jim coordinated the HAP introductory trainings in Gaza and Ramallah. Jim reports that Roy Kiessling did "an outstanding job as the trainer" and Judith Daniel, Joany Spierings and Peggy Moore did an excellent job under very stressful circumstances. Jim noted the following about the training: "While we were there, we repeatedly witnessed the violence and anger that is part of the suffering in this part of the world. It was very discouraging to see the tragic and intractable nature of this conflict. In spite of this, though, we deeply appreciated the commitment of the Palestinian therapists to learn as much as they could about trauma therapy in general and EMDR in particular. We tried in these trainings to focus on the use of EMDR with grief issues and with children. Active e-mail contact between these therapists and the HAP team has continued, and we hope to resume this program as soon as conditions of peace and safety return to the area".

Jim states, *"I feel strongly about EMDR. I feel strongly about the work we do as therapists. It is a sacred responsibility. There are many ways for us to do something. There is a lot at stake and sometimes more than you realize. It is important to be mindful of the importance of what we are doing and the energy that comes from it. What I felt was a mutual energizing process*." With this in mind, Jim is the Regional Coordinator for the Pikes Peak region for the EMDR International Association. Prior to that, he was one of the coordinators for informal monthly meetings that occurred between 1992 and 1995 on EMDR. He has served in his professional organizations as Board Member, Chairman, and President. In 2000, he was asked to become a Board Member for EMDR-HAP. He has participated in many of the EMDR outcome studies of Sandra Wilson, Lee Becker and Robert Tinker.

Jim's life partner and wife, Nancy, brought her own expertise to the women in the tent cities through their good friend Atilla Ozsuz. Atilla was the Director of one of the tent cities. Working through the Foundation for the Support of Women's Work, she was helpful in assisting Turkish women to sell their textile products. After coming back several times, Nancy and her Turkish colleagues became friends. They have been selling the textiles in the United States and will continue to do so.

Because of the intensity of the Turkish project and his work with HAP as a Board Member, most of Jim's other interests have been placed on the back burner. However, when he is home on the weekends, he and Nancy continue their tradition of going to their home in the mountains where they read, walk, socialize and let their lives settle. Here is a place where they retire from the hustle and bustle of the working world and relax with each other and their dogs: Sally and Ben, and their 18-year-old cat, Nemo. Ben is short for "Ben Buyuk", which is Turkish for "I am big." (His name is also his positive cognition!). Their two children, Anne and Paul, have moved off into the world on their own adventures. Anne is a librarian in Grand Junction, Colorado, and Paul was married last month to Archana Singh, and they live in San Francisco.

Let us end as we began with reflections of Jim's friends and colleagues:

"Jim Knipe has been an advocate of EMDR since October 1992, when he, John Hartung and I all took the first Level 1 training in Denver. I remember on the ride back to Colorado Springs, his disbelief and amazement at the effectiveness of this new treatment, and his saying to us, "You know this will change our lives! I wonder how it will?" In ways we have never guessed, our lives have been enriched and given purpose others only dream about."
-Sandra Wilson, USA

"Since late 1974 I have jogged, bicycled, traveled, argued, learned, roamed and laughed with Jim Knipe, and have worked out of an office 5 meters from his. As the joke goes, in spite of all of our time together, we still consider ourselves best friends....Whether I am learning from him, or taking advantage of an opportunity to try some new "stuff" out with him, the time with Jim is so consistently a blessing. That he is also capable of the most gloriously, hilariously, absurd humor does not diminish the pleasure of being in his company."
-John Hartung, USA

"From a personal point of view thinking about Jim when I was in Turkey in the autumn of 1999, I now have this vision of him as a kindly Samaritan who spread a sense of calm across the whole proceedings. My theory is that it's the white beard almost like a trainee Santa Claus. He also struck me as someone with a great sense of humility, always willing to listen to others sympathetically and great at giving the team encouragement and leadership. One small memory that I feel I must write down relates to when we were given a special ashtray designed and realised by (I think) Emre Konuk's wife. I happened to see the expression on Jim's face. It was as thought he'd been presented with the (British) Crown Jewels, he was so grateful for the present and surprised, and yet here was a man who'd really earned a special token – it was one of the warmest moments I can recall."
-David Blore, United Kingdom

(Revised and updated from an article that appeared in The EMDR Practitioner in 2000).

Announcing…

Is your Certification or Approved Consultant status about to expire?

You may want to check the expiration date on your Certificate to find out. Don't forget that you must complete 12 hours of EMDRIA Credits during your two year Certification period. When it is time for you to renew, you will need to submit copies of your certificates for EMDRIA Credits. If you are unsure of your expiration date, please feel free to call or email our office. We will send out renewal notices approximately 90 days prior to your expiration date.

Interested in Advertising in the EMDRIA NEWSLETTER ?

Contact Gayla Turner at the EMDRIA Administrative Office for details.

2002 ADVERTISING/ARTICLE SUBMISSION DEADLINES:
January 20th for the March Issue
April 20th for the June Issue
July 20th for the September Issue
October 20th for the December Issue

Ads must be professional in nature and pertain to EMDR. All ads must be submitted on camera ready copy or by PageMaker file. We reserve the right to decline the use of an ad for any reason. EMDRIA does not provide graphic design services.

EMDRIA Office Announces New Staff E-mail Addresses!

With the launch of the new EMDRIA Website, we're maximizing the use of the EMDRIA identity and domain name. Our new staff e-mail addresses are:

Carol York, MSSW, LMSW-ACP, Executive Director
info@emdria.org

Gayla Turner, Associate Director/Conference Coordinator
GTurner@emdria.org

Terri Curtis, Asst. Conference Coordinator
TCurtis@emdria.org

Sheila Kulczyk, Accounts Processor
SKulczyk@emdria.org

Sarah Tolino, Certification & EMDRIA Credit Coordinator
STolino@emdria.org

Marilyn Luber, Ph.D.

Argentina

Pablo Solvey writes in from Buenos Aires that David Grand gave a workshop on "The Natural Flow of EMDR" in March 2002. Among the 100 colleagues who attended were therapists from Chile and Uruguay. David gave a conference for the public and was also interviewed by a local radio station. He notes that "These activities were of great importance for contributing to the local development of EMDR".

Australia

Mark Grant tells us that EMDRAA will be getting a website by the time we go to press. It will include the usual information about EMDR, the history of EMDR in Australia and a referral list. The address will be www.emdraa.com.

Belgium

Ludwig Cornil writes in with much pride about the first advanced training that will be held on Belgian soil. He and his team feel that this is an important move in meeting the goal of their organization: "to see a quality application of EMDR in Belgium". In Belgium, participants must demonstrate knowledge of the protocol before receiving advanced training so that the learning process is not slowed. Supervision after the advanced training will allow the supervisees to demonstrate their competence and earn the certificate of EMDR-Practitioner. Ludwig and his colleagues hope to create a network of well-trained therapists as they believe that there are a large group of traumatized people who suffer in silence. They must sensitize both doctors and lay people to trauma and its consequences. He says, "The more people understand about this, the more people will be reached and will be able to lay down the unnecessary burden PTSD is".

Burma

Libby Call has just returned from her 9th trip to the Thai-Burma border with Peggy Bacon. She writes the following; "Over the past three years we have been collaborating with Dr. Cynthia Maung, founder of the Mae Tao Clinic, to develop a mental health program for the Burmese refugees and migrant workers living in makeshift villages along the border. Efforts thus far have focused on building a solid and trusting relationship with Dr. Cynthia and the clinic staff, doing an in-depth needs assessment and training staff medics to assess and begin to treat depression, PTSD, psychosis, suicidality, substance abuse and domestic violence. There is now a core group of reproductive health medics who are beginning to have the skills to do basic assessment and intervention. On this latest trip, we introduced drawings and the butterfly hug for Safe Place and Resource Installation to these senior medics who are often as traumatized as the people they treat. They loved the experience and began at once discussing clients who might benefit from it. Our next visit is scheduled in July. We plan to continue to develop a conceptual foundation for introducing trauma work using EMDR".

Ecuador

Esly Carvalho notes that in March, 2002, he presented a workshop on "EMDR, Metaphors and Pictures" in Quito. The presentation includes powerful drawings that illustrate the difference before and after using EMDR. He presented this workshop at the 3rd Latin American Congress of Psychotherapy.

Also, in Quito, from April 16-18, 2002. John Hartung taught an introductory level of EMDR to 21 therapists involved in sexual abuse recovery as well as family violence; this was through the Ecuadorian municipal government. The advanced level is projected for November 2002.

John Hartung noted that the "trainees were overheard to talk about how comforting it would be if only they could somehow get their salaries up to $200 a month. These trainees would never have been able to attend an EMDR seminar had Esly not been able to interest the Ecuadorian government and private groups in sponsoring the project, which will continue with Part 2 in November."

El Salvador

John Hartung writes that "The 6-phase El Salvador project was completed in March with the final training conducted by Ligia and myself. We graduated about 20 marvelously skilled psychologists. Thanks again to Reginaldo, Nacho, Luci, Ligia, Maria Elena, Barbara, Susana and Elizabeth. We also pre-selected five of the graduates as red badge candidates. Ligia has become the "sort of Central American coordinator".

France

David Servan-Schrieber reports, in March 2002, he recently completed "a very successful" beginning training in Paris. This marks the first time the training was given entirely in French with French facilitators. There is a plan for a June 2002 training in Aix-en-Provence. He notes that he as become "Charge de Cours" (Clinical Instructor) with the Faculte de Medecin de L'University de Lyon "with the charge to teach EMDR in the training module on cognitive therapies. This is an important step in the integration of EMDR to the official curriculum in psychiatry and psychology in France".

Germany

Marilyn Luber reports that 13 supervisors from Austria, Germany and Switzerland finished the Supervisory Training that she taught in March 2002. The therapists who were part of the supervisory group include: Dagmar Hofsass Bock, Esther Ebner, Theresia Falkner, Roswitha J. Keller, Astrid Klein, Gaby Kluwe-Schleberger, Gerd Kuznik, Elfrun Magloire, Karl Plueddemann, Jacqueline Schmid, Marion Seidlel, Guenter H. Seidler, and Dirk Wehrsig,

Guatemala

John Hartung writes in that he and Ligia Barascout de Piedra Santa did trainings in Guatemala in March. He notes that "At one training, we had students from Puerto Rico and Costa Rica, so I can now say that we have formal sponsors in those two countries". The two newest sponsors are Ruben Arroyo in Puerto Rico, and Gabriela Segura Fonseca from Costa Rica who is affiliated with the University of Costa Rica. A student from Venezuela attended also.

Israel

Alan Cohen writes in that he has been very busy post 9/11. Due to the work that he does through the Stress Prevention Center in Northern Israel, he was in the US at that time to talk to Emergency professionals in New Jersey and also talk to professionals in Hartford, CT. Alan and his team continue to work with the victim's of the bombings in Israel. He reports that Gary Quinn, in Jerusalem, set up an emergency clinic to treat the victims of these attacks. Gary and Alan made a joint presentation at a Conference for Religious Mental Health Professionals (Nefesh) on EMDR. He notes that there are now trainings for smaller groups of psychologists. He ends with "As you can see - a hive of EMDR activity".

Gary Quinn -who lives in Jerusalem and has had a long history of working with victims of terrorism- has been consumed with dealing with the current violence that is occurring. He notes that he has begun to work at an Acute Care Center that operates like an ER. The Center is next to the ambulance stop and he is able to treat people immediately. Mainly, he is doing debriefing but also uses EMDR for Resource Installation where he reminds people that they are safe from the event. Although he says, "In Israel "You are safe now" always get the response, "No, I am not, another terrorist attack is going to happen". He reported that "After a bus was blown up and terrorists were on both sides of the road shooting and throwing hand grenades, the bus driver saved more than 50 people -besides rescue workers- by continuing to drive despite having no tires and very little engine left and drove for more than 15 minutes on a twisty windy mountain road to get people to safety. 10 people were killed in the attack besides scores being wounded. I went up by a bullet proof van to treat the victims of that terrorist attack". He is in the process of organizing a training for a group of therapists living on the West Bank (Yehuda and Shomron). He would go in by bullet-proof van. He is hoping to organize a training for a group. He says that living in Jerusalem is to confront the constant threat of terrorism to his person and that of his children and wife. On a lighter note, he and his Israeli team will be conducting a training in April 2002.

Friends of mine from Israel (non-therapists who have known about EMDR from the first training in Israel) recently wrote**,** "In a weekly supplement for a major newspaper here (Maariv), appeared a 3 1/2 page article about EMDR, with pictures of Dr. Ehud Oren, as well as Drs. Brom & Gliksman, explaining the importance of eye pupils movements and more, we were so proud"

Japan

Masaya Ichii from Okinawa reports that there are now presentations on EMDR in Japanese conferences. In September 2001, at the annual conference of Japanese Clinical Psychology, a symposium on EMDR was held with the title, "New psychotherapy to process traumatic memory. Masaya - with 3 other EMDR-trained therapists (Hinako Tanaka, Mii Ohkawara, Tatsuyuki Arimura). In October, Masaya presented "What does EMDR suggest for Behavior Therapy?" for the symposium, "New developments in Behavior Therapy Techniques" at the Annual Conference of the Japanese Association of Behavior Therapy. Also, Hiroaki Kumano presented "Efficacy and limitation of EMDR for Panic Disorders and Masaya presented a two-hour workshop "Possibilities of EMDR" at the same conference. In November 2001, at the Annual Conference of Japanese Counseling Science, there were three presentations on EMDR: two research and one case presentation. The research found that horizontal eye movements decrease the negative emotion but the vertical did not; they used both self-report and brain topography. Unfortunately, the presenters were not trained clinicians and Masaya suggested that they come to the next Japanese training. He was pleased that the Japanese version of the APA video "EMDR for Trauma" is out. Now the Japanese can watch Francine do the actual procedure with Japanese subtitles! The only problem is that the mistranslated "Blank it out" and said "It's all right" instead.
Other than this, it is very good tool for the Japanese clinician to learn EMDR.

In March 2002, the Japanese Society of Traumatic Stress Studies was founded. Some of the Japanese EMDR facilitators are members of the Board of Directors. At the conference, EMDR was seen as a promising treatment method and many think of it as an important treatment tool that trauma therapists need to learn. Beginning and advanced level trainings will occur in Tokyo in August. Recently, there have been inquiries about EMDR from therapists in Korea and Hong Kong.

The Netherlands

Ad de Jongh is proud to announce that about one or two groups of about 35 clinical psychologists or psychiatrists are being trained in a 3 ½ day format which is about 400-500 therapists per year.

There have been several articles about EMDR in scientific journals and there are many newspaper articles. Ad adds, " I think EMDR is the most rapidly growing treatment method in our country". In March 2002, Ad presented on "The Application of EMDR to the treatment of Dental Phobias" at the Annual Conference of International Association of Dental Research (IADR) in San Diego.

Joany Spierings notes that the EMDR team in the Netherlands is in the process of formalizing the requirements for supervision. In the Netherlands, before completing the second level of the EMDR training, participants need to demonstrate a standardized set of skills based on the basic protocol. They are in the process of developing a similar standardized set of skills for the advanced applications of EMDR. Joany generously invited EMDR consultants who would like a free copy of one or both sets to e-mail her at joanyspr@knoware.nl .

New Zealand

Barbara Anderson has been living in Wellington, New Zealand over the past year and has been spreading the word about EMDR. She is volunteering at a Children's Grief Agency and has given several introductory presentations on EMDR for the local professional community. As a result, they are eager to be trained.

Sweden

Anne Martinelli-Vestin reports that EMDR-Sweden had their annual workshop in March 2002.

United States

California

HAP

Jeanette Paroly writes in that presenters for the EMDR Vacation Retreats, sponsored by the EMDR Institute, from this July through January 2003, are donating their honorariums to EMDR-HAP. You can find out more about this at www.emdr.org

Michigan

Don and K. L. Welch are looking forward to the publishing of their article later this year in "Clinical Psychology and Psychotherapy" with the title, "Eye Movement Desensitization and Reprocessing: A Treatment Efficacy Model.

New York

Uri Bergmann writes in that he and David Grand are invited to the EMDREA Conference in Frankfurt at the end of May to present their experiences with 9/11 survivors. Uri will present civilian survivor effects and David will discuss the aftermath and treatment for the firemen, police and their families that he has seen. Uri continues to deepen his work on the Neurobiology of Trauma in EMDR; this work was presented at ISSD in December 2001 and will be presented at this year's EMDRIA conference in June 2002. Uri also notes that David has been working to bring EMDR-HAP to members of the Fire Department of New York.

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David Grand reports, "I have led a team of EMDR therapists into the firehouse that lost the most firefighters on 9/11 (Hazmat 1) where we directly treated 15 firefighters. This is the first of many such forays we are planning. I have also instituted a monthly program where I go into the Fire Lieutenants Training program in Fort Totten, Queens, and do small group EMDR (using bilateral sound CDs). So far we have treated 80 firefighters with very positive results reported. Finally, I have just completed my fourth year teaching EMDR acting techniques at the New Actors Workshop, Mike Nichol's acting school".

Oregon

David Baldwin notes that the ninth "issue" of the Trauma Pages Update list has been published on-line. The announcement was sent to over 2200 e-mail subscribers. If you are not a subscriber, you can visit the site at www.trauma-pages.com

Pennsylvania

Donald Nathanson reports that at the Silvan S. Tomkins Institute Clinical Conference on Therapeutic Impasse and Unexplored Affect, Richard P. Kluft was awarded the 5th Michael Franz Basch Memorial Award. The award is presented each year "to a scholar or clinician whose work has furthered our understanding of the link between affective development and psychotherapy". The title of this year's lecture was "Four Consultations: From Quagmires to Collaborations" and featured references to his work with EMDR. At the same conference, Joseph Izzo, presented a Master Class with the title, "Franchising the Disenfranchised"; Joe focused on his work with EMDR with disenfranchised populations such as Gay, Lesbian, Bisexual and Transgendered persons with HIV/AIDS.

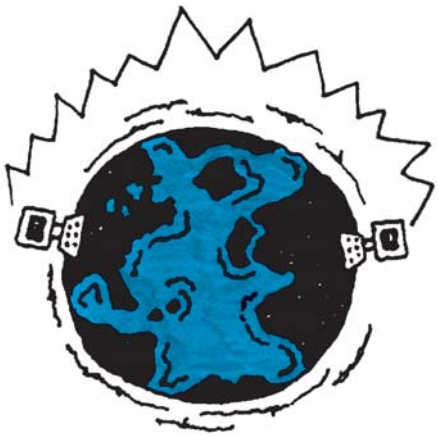
Susan Rogers, Ph.D. continues her work in researching the effects of EMDR. Recently her attention has turned to the possible application of EMDR to pain management. A successful pilot study has led to a formal research proposal that is being studied. "Within the EMDR community," Susan notes, "we are hearing more and more of clinicians using EMDR for their clients with chronic pain. Within the Department of Veterans Affairs, pain is regarded as the 'Fifth Vital Sign.' Given the high proportion of veterans with chronic conditions, particularly for those wounded in combat, it was a natural extension of our work with war-related PTSD."

Dr. Rogers and Steve Silver, Ph.D. also contributed to the January edition of the Journal of Clinical Psychology that examined EMDR, with an article entitled, "Is EMDR exposure therapy? A review of trauma protocols (JCP, 58, p 43-60)."One of the old claims is that EMDR is nothing more than another exposure therapy and any treatment effects it produces is simply because of the exposure elements in it. However, it is pretty clear from the body of research on exposure, that EMDR violates the conditions needed for effective treatment through exposure," Dr. Rogers says," Unfortunately, this body of research tends to be overlooked," Dr. Silver adds, "and so we see a continued confusion about what makes EMDR work."

Virginia

Denise Horton reports that she, as the chair, Kristine Hall, and Laura Lee Skauge presented a panel on "EMDR and the Treatment of Child Sexual Assault and Abuse" at the annual statewide training conference of VAASA (Virginians Aligned Against Sexual Assault), on March 13-14, 2002, in Charlottesville, VA. She notes that "Although the conference coordinators were initially concerned about the "controversial nature" of EMDR, the panel was well-attended and allowed a wide audience of school and agency administrators and staff to be exposed to important EMDR information".

www.EMDRIA.org



Gayla Turner,
Conference Coordinator
Associate Director

By the time you read this article, the Conference will be days away or it may have already come and gone. Either way, if you plan on attending or you did attend, we hope it is or was a wonderful experience for you.

We have already begun with the planning for the 2003 EMDRIA Conference. It is to be held in Montreal, Canada. The dates are October 2nd through the 5th. You should receive the Call for Papers sometime between June and August of this year. So, if you are interested in presenting next year in Montreal, please be sure to complete the Call for Papers and get it turned in by the deadline date designated. It will also be available on our website as soon as it goes out in the mail.

For those of you who have never attended one of our Conferences before, the following are some attendee comments from previous Conferences. We hope that you decide to join us in San Diego and/or Montreal!

"The best organized workshops I have attended in over 15 years!"

"I have attended conferences for several years from the west coast to Louisiana, and have found this experience at the very top of my list."

"Excellent Plenary speakers – many choices of speakers and subjects."

"This was a "Top Notch" conference. (I go to a lot of them too!) Every single workshop was superb. I loved the opportunity to be in one workshop all day, and the quality of each presenter was the best."

"As my first EMDR Conference, I am very impressed with the excellent quality of the presentations."

Coming Soon!

Call for Papers

for

2003 EMDR International Association Conference

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CANADA

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