EMDRIA NEWSLETTER

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In This Issue

A Message from the President: Maintaining Perspective

Curtis C. Rouanzoin, Ph.D.

EMDRIA is an infant organization, just entering toddlerhood. We are but two-and-one-half years old—it only *feels* much longer.

As I look back on my decision to help develop an independent organization like EMDRIA, the thought sometimes occurs to me that I was nuts. Never in my wildest dreams did I anticipate the work, effort, and volunteer hours the endeavor would require—and I have little doubt the other Board Members and Committee Members would echo these sentiments. The Board is saddled with the responsibility of developing policy, monitoring IRS requirements, and being responsive to the membership. At the same time, the Board Members have their own lives. They suffer illness, endure the personal crises, and navigate the day-to-day challenges we all face.

As President, I am in the position of hearing everything anyone finds disagreeable about EMDRIA. We are criticized for things we do and for things we do not do—sometimes for things people simply *think* we have done. On good days, I take it all in stride and do my best to inform whoever offers an opinion. On bad days, I want to quit, run to the hills, and say "please let someone else do this thankless job!" On bad days, I regret the moment I agreed to help in the development of this organization. On bad days, I could care less whether anyone ever asks me about EMDRIA again.

In reality, it takes very little to remind me why I do what I do. When a patient resolves years of trauma in a few sessions and goes on living a quality life, I remember. When a child is eased of his or her nightmares . . . when an abused patient no longer carries the burden of blame for his abuse . . .when a traumatized worker can return to her job . . . I remember.

I recently traveled to Colombia, South America with Francine Shapiro and Linda Vanderlaan. While there, I remembered why I choose to endure the frustrations and headaches. EMDR changes peoples' lives. EMDR can break the cycle of violence pervasive in so many countries today.

In Colombia, I was reminded how blessed my life is, how my "headaches" are nothing when compared to the suffering of others—and how others endure it with much more grace than I am able to manage. The Colombian people see EMDR as a way to help begin a peacemaking process. The people know that, as long as the pain remains, the violence will continue. And they know that EMDR offers hope to end the pain.

When I feel tired and frustrated with the infrastructure of organizational development, I remember the face of that child in Colombia and know I can do anything. Then I know that I can put up with anything. I remember why I do what I do. EMDR truly does offer hope to end the pain.

EMDRIA is needed now more than ever. Despite its youth, it will survive and prosper into a vibrant adult organization. When it does, I will take a deep breath and remember. ⇔

From the Editor: Choices

Brad Wasserman, LCSW-C

On our cover, Curt Rouanzoin provides his perspective on the first years of an organization still finding its way as it enters toddlerhood. And, on page four, Carol York ponders the efforts and events that have shaped EMDRIA over the past year. For those who have been involved from the beginning, it is perhaps now easier to understand that an organization, even one with a conviction derived from the most worthy of missions, must endure and overcome the same kind of developmental challenges that loom for the newborn baby as it unevenly matures.

At EMDRIA, we believe this publication must be an essential part of that growth. This newsletter must be an agent of change as well as a fundamental component of the organization that parallels and reflects the changes of the organization itself. Although this is but the sixth issue of The EMDRIA Newsletter, this publication has been true to form, as the editorial and publication process has already navigated numerous transitions as it learns to walk before it can run.

Despite the shifts and changes that have been a part of The Newsletter thus far, we believe those who contribute to its production are learning and growing as EMDRIA learns and grows. We know The Newsletter can and will be an integral, purposeful reflection of the quality of our organization. We know it will be a conduit through which our leadership and members more easily connect with each other and with the mission of the organization. And we are confident that it will be a forum that empowers our members to make their unique contributions to that mission.

Because of the depth and importance of our vision and the quality and conviction of the people behind it, we have no doubt that EMDRIA will thrive and mature into productive adulthood.

So each of us has a choice. We can watch from a distance. Or we can take action and offer a voice that contributes to this organization's momentum.

EMDRIA knows which choice we want you to make.

We want you with us.⇔

Events and Deadlines

The deadline for inclusion in *The EMDR Register* is February 28, 1998, with the deadline for free registration set for December 31, 1997.

Contributions to the next *EMDRIA Newsletter* are due on February 15, 1998. Articles for the following issue should be received by April 15, 1998. Please refer to the Submission Information on page 19 for details.

From the International Scene

Marilyn Luber, Ph.D.
Marluber@aol.com

As I thought about writing this column and what to include, I realized that the most profound resources we have are the members of our EMDR community. With this in mind, I decided to devote a part of this column to introducing one or more members of our EMDR world in each newsletter. I will, of course, continue to include news from our international membership and the International Committee.

Member Profile

Two years ago, in September, 1995, I met Alan Cohen at a Level I training in London. Originally British subjects, Alan and his wife, Katya, immigrated to Israel in the early 80's. He received his first degree in General Psychology from Manchester and his second degree in Applied Psychology from the University of Aston in Birmingham.

I noted his wry sense of humor when we first met, but it was not until I visited Israel in June, 1996 that I got to know and appreciate Alan and the important work he has been doing with Mooli Lahad and his colleagues at the Community Stress Prevention Centre in Kiryat Shmona. The Center was founded in 1981 in the north of Israel after a number of attacks on border settlements. From that time, it has served all of the people of Israel's northern border towns, villages and kibbutzim, no matter their religion or ethnic background. The stated aims of the CSPC are, according to Alan, "to prepare the civilian population to cope with crisis and disaster, to train local authorities to cope with the situation and handle it effectively, before, during, and after these incidents, and to train professionals in emergency intervention techniques." The CSPC's work is known throughout Israel and has been adopted by cities, local municipalities, government offices and countries outside of Israel. Their first project was successful—a model for the development of a psycho-educational program to handle the effects of attacks or threats of attacks through the schools.

Alan and his colleagues have been in the forefront of the provision of services to the Kiryat Shmona area. He is among the first to enter a site

after a bomb, missile, or terrorist attack. When I asked how he handled his own trauma, he answered, "I have a great tolerance for trauma. I tell myself the statistics for who is hit. And, in truth, it's a rare occurrence!"

Both Alan and Mooli were among the first trained in February, 1989 when Francine Shapiro did her first training in Israel. Since then, EMD and later EMDR became an important part of their treatment protocols when dealing with trauma. Alan used EMDR when he intervened with the emergency teams after the terrible helicopter crash in the small suburb of Shear Yeshoof in which 73 Israeli soldiers lost their lives. The social work staff who were on site were so impressed that they decided to take the training in EMDR themselves and sent about ten people to Alan to deal with the horror of the crash. Recently, he was called in to work with the 9th grade girls who were attending a school outing when a Jordanian gunman killed seven of their friends. He reported that "EMDR brought about a significant transformation in most cases in two to three sessions in seven out of 10 of those treated."

Since 1989, the CSPC has received referrals for people of all ages who are suffering from all types of traumatic incidents. Ultimately, Alan wrote, "Our hope is that in the future we will be able to use EMDR to enhance creativity and nurture potential rather than put right the damage done by one person to another."

From Around the World

- **Australia**: Word from Mark Grant is that the Australian Association had its second meeting in October and is in the process of becoming legally incorporated. Mark himself has published a web page about chronic pain and will include information about EMDR on it that can be accessed at http://www.ozemail.com.au/~markgra.
- **Belgium**: EMDR-Belgium has had their third network-reunion in October, 1997 including 15 participants.They are in the process of designing a research project comparing EMDR with a behavioral therapy technique.
- **Canada**: The Canadian constituency of EMDR therapists numbering in excess of 150 members has submitted a constitution to become incorporated as EMDR Association of Canada (EMDRAC). They are hoping to join together with facilitators in the Seattle area to have a regional conference that will mingle western Canadian EMDR-trained clinicians with those from the Northwestern United States.
- **Europe**: Richard Mitchell has been talking to members of his group on the telephone, abandoning e-mail for voice-to-voice contact! The European group is in the process of coordinating training across Europe to help reduce costs, avoid overlap, and "promote cooperation and sharing." The international flavor of EMDR trainings in Europe was thought "to add a very special quality that was worth preserving."
- **Germany**: Arne Hofmann reports that EMDR has become part of a national training schedule for trauma-therapists. Through the Trauma Institute in Cologne run by Professor Fischer a prospective, early intervention trial is underway to help high-risk crime victims. The crime victims are treated with a new integrated psychodynamic method vs. EMDR. Crime victims come from the police in Cologne shortly after the incident. A trauma conference is planned for March 5-7, 1998 and will be sponsored by a State Ministry. Bessel van der Kolk and J.P. Reemtsma will be speakers at the conference. Dr. van der Kolk needs no introduction. Dr. Reemtsma is a famous industrialist and researcher who was held hostage himself and will speak about the concept of "justice" in dealing with crimes and victims.
- **Holland:** Ad de Jongh reports that two TV documentaries about EMDR have helped to introduce EMDR to the Dutch people. He presented *Treatment of a patient with panic disorder and dental phobia with EMDR: A videoclip.* XXVII Congress of European Association for Behavioural and Cognitive Therapies, Venice, 24-27 September, 1997. He was also invited to present at two large PTSD symposiums next year in The Netherlands and notes that "EMDR is being recognized as a major treatment mode more and more."
- **Israel:** EMDR-IS has been established as a non-profit association and is open to all Level 1-trained professionals. The first EMDR panel occurred at the annual Israel Psychological Association conference in Tel Aviv. Dr. Gary Quinn has been giving lectures about EMDR around the country and successfully treated several of the survivors of the last bombing in Jerusalem. Udi Oren in Tel Aviv, Elan Shapiro in Haifa, Gary Quinn in Jerusalem and Frances Yoeli are holding network support groups for trained EMDR practitioners.
- **South Africa**: We are pleased to introduce and welcome a new member of our committee, Reyhana Seedat-Ravat from South Africa. Reyhana brings much vitality and enthusiasm to whatever she undertakes and we look forward to her being an active and integral part of the International Committee.
- **Ukraine**: Alexander Bondarenko has almost finished translating *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures.*
- **United Kingdom/Ireland**: David Blore is going to Moscow in April, 1998 to lecture to the Moscow Centre of Psychology and Psychotherapy on the use of EMDR amongst traumatized miners. Remember that his electronic European magazine can be found at:

(http://www.geocities.com/HotSprings/Spa/1999).

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REFLECTIONS...

Carol York, MSSW, LMSW-ACP

The year has come to an end. It is the usual time for reflections and resolutions for the new year. What are reflections? Are they nothing more than the processing of memories which help us come to some resolutions? I believe we are all familiar with this process.

As I reflect on EMDRIA's past year, I think not only about the Association within the past year, but find my mind sifting through so many events and moments. I think of the many people who have come together and worked hard to form the Association. I remember the intense emotions felt by everyone through the Association's inception, and of course, I remember my own. As is inevitable when people come together, we all have had various opinions and tend to believe that our way is the best way.

There have been mistakes, but there have also been successes. One of the most outstanding accomplishments was through the direction of the Association's first President, Steven Lazrove, M.D., who recognized that the Association needed its own office instead of contracting out the Administrative work. Steve knew the Association was not going to make it in its current state of operation. It was dying a slow death and EMDRIA's purpose was too important to let that happen. Thus, the office was established in Austin, Texas on January 1, 1997. When Steve asked me to become the Administrator, I asked for time to think about it.

So I began to reflect on my relationship with the Association, reflections that led me to think about my involvement with EMDR. I remember when I first met Francine Shapiro and how I was taken with EMDR and Dr. Shapiro's brilliance. I had attended other trainings and been impressed with the knowledge of the presenters, but somehow this was different. Her enthusiasm and genuine desire to help others were impressive and, by the training's end, I felt compelled to enthusiastically offer to do what I could to help with EMDR.

As I have come to know Dr. Shapiro and the other EMDR professionals throughout the years, the mission has been steady and unfaltering—to get EMDR out to the world. When I think about what has been accomplished in the last ten years, I am astonished. I believe the mission is well on its way, but we cannot rest. In presenting EMDR to the world, we are charged with the responsibilities for developing EMDR and maintaining its integrity. We owe this to ourselves as professionals, to our clients and potential clients, and to the world.

My reflecting must come to a close for the moment. The picture is clear. The mission remains the same. Our work is not done. I would ask each and every one of us to take a moment to reflect on our experiences with EMDR.

I am very clear about my commitment to our mission and that is why I said "yes" to Steve. People are hurting. EMDR has a mission. EMDRIA has a mission and a responsibility to the world. Please come join us. We need your help!⇔

EMDR AND PERSONALITY DISORDERS

Herbert Fensterheim, Ph.D., ABPP

[Thanks to William Zangwill for his helpful comments on an earlier draft of this paper.]

There is some tendency in psychotherapy to suggest that the treatments for Axis I disorders and Axis II disorders should be based on different concepts. Millon (1988), for example, argues that the behavioral approaches are appropriate for the Axis I disorders but that an integrated approach is indicated for those that fall within Axis II. It is worth considering that different EMDR protocols and methods may be required for these different conditions.

Much of the EMDR work has centered on high intensity emotional reactions to a specific or a set of specific traumatic events. When dealing with many of the Axis II diagnoses, the Personality Disorders, a very different picture may be involved. Instead of specific traumas, there may be a number of different and subtle patterns of events, none of which elicits strong emotional reactions in the present. The feelings evoked may also be subtle and low level but very difficult to modify. Sometimes, for example, obsessive thoughts may get more or less "sticky" without any change in feeling being reported. Defenses may also be extremely subtle and complex. Overlaying all this may be a series of Axis I symptoms stemming from or being maintained by the personality disorder.

Based on clinical observations during the EMDR treatment of a number of patients with Personality Disorders, some suggestions as to helpful modifications may be advanced. These are extremely preliminary and tentative and are presented for the purpose of calling attention to this area.

1. The therapeutic relation is far more important in working with patients with Personality Disorders than it is in the treatment of trauma victims. Hence, the introduction of EMDR should not be hurried; sufficient time should be allowed for the therapeutic relation to be firmly established.
2. Before introducing EMDR, the therapist should have a working formulation of the major problems. This may be in whatever terms the therapist feels most comfortable in using and it must lead to some organized treatment approach, a systematic way of selecting treatment targets. However, the therapist must be flexible and ready to change the formulation as new material emerges from the EMDR elicited associations. Fensterheim (1996) provides a case illustration of such flexibility.
3. Try to limit the patient's report of occurrences and associations strictly to the time of actual eye movements. With many people with Personality Disorders, other associations, memories, or thoughts are usually part of the defensive structure and (especially with a bright, creative patient) may throw treatment off track. The decision to do this requires good clinical judgment and a solid knowledge of the patient because many times such associations are indeed quite helpful. However, with Axis II patients, this alternative should always be kept in mind.
4. With some patients with Personality Disorders, the emphasis has to be on increasing the believability of the constructive thought rather than reducing the disruptive effect of the disturbing thought. While working with the disturbing thought, many such patients tend to loop and it seems that nothing will be able to break that looping; or they may freely associate but bring about no change in feelings, sensations or thoughts. However, the installation of the constructive thought can bring about meaningful change and emphasis may have to shift to those thoughts. (Indeed, there have been several patients which, for a number of sessions, I used only the constructive thought.)
5. In many instances, the reduction of the SUD level of the disturbed thought is only temporary. At a later time, disturbed feelings to the target scene and thought may reemerge although sometimes the disturbed feeling is different (e.g., guilt replacing anger). What seems to be happening is that, as the power of the disturbance is reduced, defenses can control it. As further work continues and there is lesser need for the defenses, the disturbed feelings can once again emerge. (With one patient, this happened five times over a two-month period.)
6. In several instances, the formulation of the case indicated that certain scenes and thoughts were crucial. Yet the scene and disturbed thought elicited minimal or no disturbance and the constructive thought felt completely believable. Constant repetition of EMDR for several sessions did eventually yield substantial change; in some instances feelings eventually emerged while in others change took place in life situations without any change of feeling during the eye movement procedure.
7. The ego of some patients may be weak that working on underlying problems must be approached with great care. This is especially true of patients with a comorbidity of ADD, but is far from limited to that group. In these cases, the initial EMDR sessions might be devoted to strengthening coping behaviors or perhaps some non-EMDR ego-strengthening treatments may be undertaken.
8. Because we are not dealing with high intensity disturbances, relaxation and even body scan at the end of a session may be undesirable. These procedures may bring on a feeling of closure when such closure is therapeutically contraindicated. Again, because of the possibility of extremely disturbing reactions between sessions, good clinical judgment and a solid knowledge of the patient is necessary.
9. Group therapy may be a very helpful adjunct to the EMDR treatment of Personality Disorders. These patients tend to be quite complex, with many aspects to their pathology, and, although discernible progress may be seen all along, overall progress is slow and treatment may be lengthy. The group reinforces the changes that occur, provides for the sharing of a common experience, and appears to deepen and to facilitate the EMDR treatment itself.

Again, I note that these are very preliminary suggestions, based on clinical experience, and presented here to begin discussion of this important area. The major point that I see as emerging is that with these complicated Personality Disorders clinical acumen must dominate and the Lazarus principle of "It Depends" sets a major theme of treatment, custom tailoring the treatment to the specific patient and the specific clinical situation.⇔

REFERENCES

Fensterheim, H. (1996). Eye movement desensitization and reprocessing with complex personality pathology: An integrative therapy. Journal of Psychotherapy Integration. 6:27– 38.

Millon, T. (1988). Personologic psychotherapy: Ten commandments for a posteclectic approach to integrative treatment. Psychotherapy 25: 209 – 219.

Book Review: *Transforming Trauma, EMDR*

David Grand, R.C.S.W.,
Bellmore, New York

Transforming Trauma, EMDR, by Laurel Parnell, Ph.D. (1997), is the first major book written on the subject of EMDR by someone other than Francine Shapiro, EMDR's originator. Parnell takes full advantage of this opportunity by giving voice to her deeply personal experiences as an EMDR trainee, client, therapist, and teacher. She presents a comprehensive picture which brings the EMDR process alive for clinicians in and out of the EMDR world, as well as those interested from the general public.

Interspersed with a multitude of relevant case examples, Transforming Trauma includes a number of cases contributed by the clients themselves. Most poignant is the personal account Parnell gives of her own transformation process, which ironically began in the client role in the practicum of her Level One EMDR Training. She weaves her EMDR metamorphosis from the recollection of an early defining childhood traumatic memory leading to the development of distorted self perceptions. Parnell follows her path through marital separation until eventually finding inner and outer emotional and spiritual harmony.

Transforming Trauma is sensitively and thoughtfully written, well organized and comprehensive. Parnell provides the reader with a thorough chronicle on the background, theory, and practice of EMDR as she covers all the essential points. This includes the unusual commonality of experience shared by EMDR therapists around the world, as well as the clients' process of complete resolution, healing, and release from their formerly insurmountable suffering. However, despite the open, honest, and accurate account presented here, the readers skepticism will never be dispelled by anything less than a direct, personal experience with EMDR.

Although the book is technically sound, I take issue with some of its observations. In reflecting on the technique's limitations, Parnell notes that OCD (Obsessive Compulsive Disorder) and severe Personality Disorders do not respond well to EMDR. Integrated approaches incorporating ego strengthening and resource installation interweaves and appropriate use of medication have met with success with the application of longer term EMDR with these clients. She also states that EMDR bypasses the defenses, but it would be more technically correct to observe that processing tends to activate higher level defenses which accordingly lessens the clients reliance on more primitive forms of self protection.

Parnell enters a risky area when discussing clients who have reported either past life regressions or psychic experiences during EMDR. Working with these examples of "New Age" phenomena is often considered taboo in serious clinical circles, however, she demonstrates sensitivity and wisdom by refraining from passing judgment on these clients and their experiences. Parnell demonstrates how a therapist can respect a client without having to validate their specific belief system. She also emphasizes the unique spiritual uplift shared by both client and therapist joining together in the profound awe of healing and transformation. This theme threads throughout Transforming Trauma, infusing it with the author's personal and therapeutic inspiration and joy. ⇔

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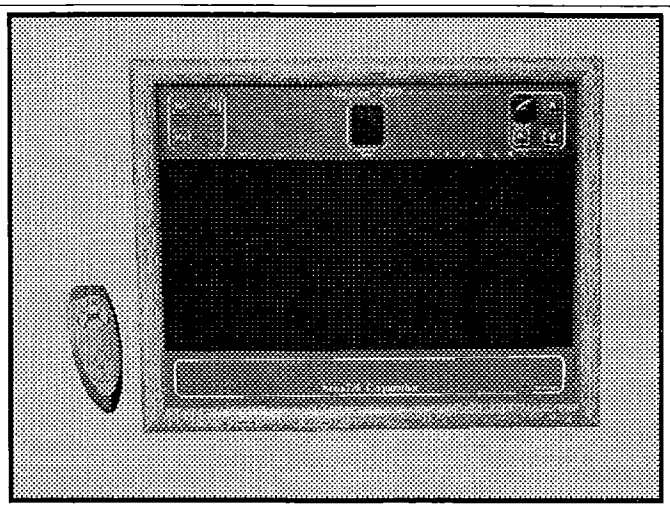

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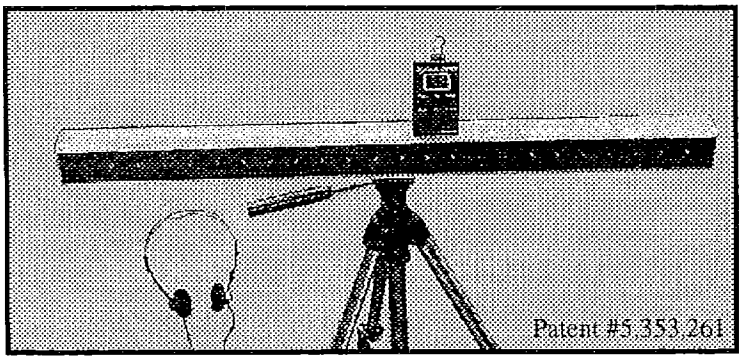

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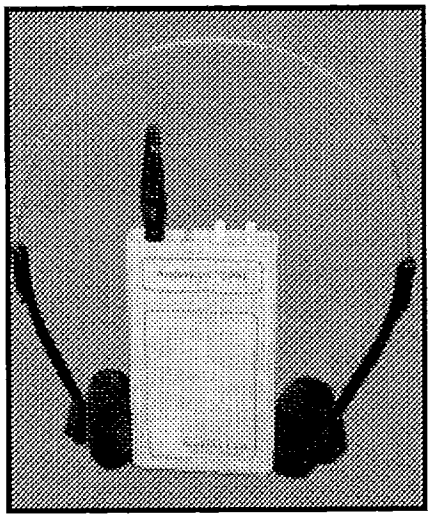

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EMDR and a Critical Incident of Trauma

Terry Becker-Fritz, MS, RN, CS

EMDR came into my life as part of my professional need to work with children and teenagers who had been exposed to the most horrible traumas. Traditional play therapy and talking therapy were not working and I watched children develop into unhappy, lonely, angry, and depressed adolescents who acted out everywhere.

I took the Level I training in Chicago under Francine Shapiro over a weekend. Although I attended with some level of disbelief, I was immediately impressed with the potential of what I could do with children in my practice. I left that training weekend excited and ready to try it.

An Unexpected Event

Our family left for vacation to the Outer Banks of North Carolina the next Friday—little did I know that my first use of EMDR would be my 6-year-old daughter!

Kadie was playing on the beach with two friends running in out of the waves. My friend supervised the children, as I relaxed on the porch. I was startled from my dozing when my daughter came running towards me screaming "I want my Mommy" again and again in the high-pitched terror that no parent wants to hear. My friend ran after her and said that a wave had "knocked Kadie down and, before she could get up, another took her tumbling into the ocean."

Although a lifeguard, my friend was unable to reach Kadie and rescue her. A man jogging on the beach saw what happened and ran full force into the surf, grabbing Kadie and rescuing her from drowning. She did not need resuscitation, but was terrorized beyond control.

When Kadie reached me, she was hysterical and clearly hyperventilating, unable to stop her screaming. At the same time, I was aware that there were layers of sand in her hair, mouth, nose—everywhere except her eyes, which were in immediate danger if I did not get rid of the sand. So I scooped her up, placed my hand over her eyes, and carried Kadie to the shower to wash away the sand that threatened her eyesight.

Unknowingly, I had recreated the position she had been in just moments before under the water, and Kadie went totally out of control—fighting, kicking, screaming and crying. Talking to her, singing to her, and wrapping my arms around her had no effect. Although I was operating out of love and concern, I had retraumatized her.

By the time I was finished getting the sand out of her hair and off of her body, Kadie was limp and whimpering like a beaten animal. No amount of cuddling or holding relieved the terror. My daughter continued to hide in my arms and to whimper and cry. The look of fear on her face and in her eyes was so intense that I knew something had to be done or my child would begin to live her life without the freedom and happiness she had always enjoyed.

Worth a Try

Because EMDR was so fresh in my mind, I decided to try it. My expectations were limited—I only hoped it might help in this moment. I remembered what Dr. Shapiro had said about children sometimes having a better response to sound than to the movement of fingers across the midline. So I spoke to Kadie, "Look at my hand with your eyes when you hear me snap my fingers" as I began to snap my fingers, alternating with each hand. Kadie was able to look sideways at each hand while facing me, even as she was crying silently and whimpering. I asked her to "think about the ocean and what happened to you."

Following a set of 30 finger snaps, with Kadie moving her eyes back and forth, the most unbelievable magic happened. My terrorized daughter's face suddenly relaxed, she took a breath, and straightened her shoulders. Kadie looked me in the eyes and said "I'm better, are we all done yet?" I was so amazed! I said, "No, let's do this again."

This time I told her to "think about the ocean and how it made you feel" while doing the finger snapping. She followed with her eyes and told me, "The ocean was mean. I got knocked over, and then it tipped me upside down. I couldn't stand, and I couldn't breathe. It was mean and it made me angry and scared. I couldn't see anything and I was upside down."

I then asked her, "What did you learn?" Kadie sat moving her eyes to the snapping for about three seconds, before saying, "I went out too deep. I won't play so close next time." By this time, her respiration was even, she was smiling, and the horrible terror in her eyes was gone.

Kadie then asked, "Can I go back out and play in the ocean?" We went over her plan to stay near the ocean's edge, and my lovely daughter returned to the beach to play without any fear of the water.

As the event unfolded, my husband had been watching helplessly from across the room. He referred

(Continued on page 10)

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(Continued from page 8)
to the EMDR as "voodoo," while my friend simply sat with us, shaking her head and saying, "Unbelievable! This stuff really works!"

Timely Intervention

In the ocean, Kadie had experienced a critical incident of terror—no other traumatic memories had fed into this incident. I began EMDR within 20 minutes of the trauma and, although the EMDR only lasted two or three minutes, a remarkable shift occurred, just as Dr. Shapiro had described. Needless to say, I was sold on EMDR!

To this day, Kadie has the memory of the near drowning, but has no negative emotions attached to it. I have heard her tell her physician about it as if it occurred to someone else, providing details without emotion.

After the trauma and its reprocessing, Kadie returned to the ocean immediately and had a wonderful week there. She has returned many times since and the sounds of waves, the sight of the ocean, and the feel of the surf—any of which might trigger memories—do not affect her. And Kadie has never shown any fear of the swimming pool in our yard.

If we can intervene with children immediately after a trauma has occurred, what a gift EMDR can be. I often wonder how we can compel the Departments of Human Services, the people who work with abused and neglected children around the country, to make EMDR a required treatment at the time a child is placed into foster care. Think of the potential to turn around the damage that children might otherwise carry with them throughout their lives!

I can't thank Francine enough for the unbelievable gift she has given to the world. But mostly, for the gift she has given to my daughter Kadie!⇔

Identifying Hidden Blocking Beliefs

Jim Knipe, Ph.D.
Private Practice, Colorado Springs

Sometimes, EMDR processing can be blocked by a belief or "point of view" that the client has about the problem that is the focus of treatment. The situation can be difficult if the blocking belief is hidden to both client and therapist. Often the belief is just outside the client's awareness, or is not linked up in the client's mind with the problem to be solved.

When EMDR therapy is "stuck" for no apparent reason, I have found it useful to ask the client to take a few minutes to fill out the following questionnaire, which is basically a request for a VOC on a number of commonly observed blocking beliefs. The questionnaire is not scored, but instead serves as a stimulus for discussion. Usually, a stuck client will have one or more ratings of "5" or above, and this will point to the obstacle to processing, and the solution. Many clients will understand and resolve their block just in filling out the questionnaire.

It is not unusual, though, for EMDR to remain blocked even after the belief has been identified, and even after the therapist has gently attempted to point out the ways the belief is illogical or self-defeating. In these instances, it can often be useful to find an alternative belief that is antithetical to the problem cognition. For example, a client wishing to quit smoking indicated a "7" on "I will never get over this problem," and went on to explain, "I can quit for a while, but I always have the urges. I shouldn't want to smoke, so when I feel that urge, I feel extremely self-critical, and I break down and have a cigarette." He was able to see that it was the smoking itself, not the urges, per se, that was problematic, but he still was angry at himself for his "lack of control." I asked him to hold in mind a situation that was a powerful trigger for his smoking urge, and repeat to himself, "I completely accept myself, even though I have this urge to smoke," while we did a SEM. With each repetition, he reported that the words felt "truer." He was then able to use the Popky method to eliminate his smoking urge to his most powerful triggers. In subsequent weeks, he stopped smoking, and said that he had frequently repeated the phrase of self-acceptance whenever he felt the urge, and this strengthened his resolve.

For other clients, a more appropriate phrase might be, "I accept myself, even if I never get over this problem (i.e. even if I never quit smoking)." It seems a little counter-intuitive, but for many clients this type of affirmation facilitates working directly on the identified problem (i.e., quitting smoking). The affirmation separates the problem itself from the shame or helplessness at having the problem.

On the facing page, a list of possible blocking beliefs is presented as a start, and I'm sure there are many others. It is important that the client name the problem (preferably, using one to five words) before filling out the rest of the questionnaire.

IDENTIFYING BLOCKING BELIEFS WORKSHEET

Problem I Want to Solve _____

	Feels Completely True ——> ——>Feels Completely Untrue						
	1	2	3	4	5	6	7
I'm embarrassed that I have this problem.							
I will never get over this problem.							
I'm not sure I want to get over this problem.							
If I solve this problem, I will feel deprived.							
I don't have the strength or the will power to solve this problem							
If I really talk about this problem, something bad will happen.							
This is a problem that can only be solved by someone else.							
If I ever solve this problem, I will lose a part of who I really am.							
I don't want to think about this problem any more.							
I should solve this problem, but I don't always do what I should.							
I like people who have this problem better than people who don't.							
It could be dangerous for me to get over this problem.							
When I try to think about this problem, I can't keep my mind on it.							
I say I want to solve this problem, but I never do.							
It could be bad for someone else for me to get over this problem.							
If I get over this problem, I can never go back to having it again.							
I don't deserve to get over this problem.							
This problem is bigger than I am.							
If I got over this problem, it would go against my values.							
Someone in my life hates this problem.							
There are some good things about having this problem.							
Frankly, I don't have a problem.							
I've had this problem so long, I could never completely solve it							
I have to wait to solve this problem.							
If I solve this problem, I could lose a lot.							
If I solve this problem, it will be mainly for someone else.							

REFERENCE

Popky, A.J., Smoking Protocol, EMDR Annual Conference, Sunnyvale, Ca., 1994.

THE ENIGMA OF EMDR

David E. Dillon, Ed.D

[*The author is an associate professor at Trinity International University in Deerfield, Illinois.* *This article originally appeared in Christian Counseling Today, vol. 5, no. 1, pp. 40-43,* *copyright 1997, and is used by permission.*]

Eye Movement Desensitization and Reprocessing took me by surprise in the fall of 1994, when a person we'll call Ann told me how she had recovered from PTSD symptoms in one two-hour session. While in a foreign country, she had seen several violent acts that she could not forget. For two years after returning to the States, Ann had tried to escape flashbacks and frightening dreams.

Then someone told her about a therapist who practiced a new therapy that might help her free herself from the crippling effects of the trauma. Ann took her advice by seeing this therapist for one two-hour interview that liberated her from the PTSD symptoms.

Obviously, I was incredulous but could not easily discount her experience. Ann went on to explain how the nonhypnotic therapy proceeded. Apparently her visual memory of the traumas was so strong the therapist had to use alternating left-right sounds instead of eye movements to process the memories. Through most of the two hours, Ann remembered and abreacted until the memories had no further power to torment her. She left the session completely free from the symptoms of PTSD.

My first reaction was to not take her very seriously, even to think that Ann's experience was an aberration explainable by the high motivation and faith she had in this therapist. In short, I "blew it off" until I learned that Ann was a very reliable person and an excellent student. I could not take her experience lightly. So when I learned the first EMDR training session was to be offered in January of 1995 in Chicago, I registered, hoping I would either be convinced or dismiss the matter completely.

What is EMDR?

What is this EMDR that changed Ann so dramatically? EMDR uses right brain/left brain stimulation (visually, tactically, and/or audibly) while counselees focus on a distressing memory, with the result of desensitizing the memory until it has little or no effect on them. It's unfortunate that eye movement became a part of the name, since sound and touch will also facilitate desensitization and reprocessing.

Francine Shapiro serendipitously discovered the effect of eye movement when she would walk in a park while at the same time thinking about troublesome issues. Her emotional pain decreased, a phenomenon that puzzled her so much that she began to investigate why this happened. Shapiro hypothesized that the increased eye movements, occurring naturally in a scenic setting, had something to do with the reduction in emotional pain associated with her issues.

Armed with this clue, she experimented with eye movement in therapy, discovering that her clients needed some guidance to get their eyes to move during the therapy session. Shapiro started using her hand to help guide their eyes while they focused on painful memories. Similar to her experience in the park, they began to recover.

Shapiro designed a study with a treatment and control group, but when she learned that the treatment group was getting better and the control group was not, she treated both groups out of concern for their pain. Compassion has guided Shapiro's decisions about the dissemination of information and training of EMDR therapists.

Like Freud, Shapiro has chosen to control how and when the EMDR protocols will be given. Though she set up her own institute rather that turning her findings over to the academy for research, Shapiro has consistently welcomed research findings. But because of the personal nature of therapy, psychological research is difficult at best, if not impossible. There are several reasons why this is particularly true of EMDR research.

Why Research Is Difficult

First, EMDR is not a therapy system but a method or procedure that fits with many existing therapy models. Effects of treatment (as in any system of therapy) are dependent on many factors. Among these is the therapeutic relationship. EMDR works best with an empathic relationship. Current methods of research require strict control of extraneous variables that might confound the results of the study. This restraint, unfortunately, removes rapport which is a key ingredient for success with EMDR (and most other methods and models). Katy Butler raises the same question: "How do you dissect something as seamless and subtle and multi-faceted as good therapy without killing it, like a bug on a pin?"[2]

Spontaneity is a second reason for the difficulty of experimentally examining EMDR. Putting therapist and counselee under experimental scrutiny creates a "be spontaneous" paradox that hinders accurate findings.[3] In short, people are not able to respond spontaneously on command, because if they could, it would no longer be spontaneous, and if they don't, they are not obeying the command. Experimental controls create a paradoxical " no win" situation that reduces the therapeutic efficiency.

A third reason involves the credentials of the researcher and the unfortunate gap between research and clinical practice. Researchers learn and practice EMDR protocols in order to test the method fairly. Typically researchers are not clinicians, and even if they are, practicing a method like EMDR without adequate training and experience is clinically unethical and/or academically useless. Clinical experience with EMDR convinces people of its efficacy. But is this replicable in the lab? At the University of Florida

in 1993, Charles Figley and Joyce Carbonell attempted to discover the effectiveness of EMDR along with three other avant-garde approaches to PTSD (and less severe emotional disorders).[4] They designed a different experimental approach that involved bringing successful practitioners to the University for a week-long inquiry by observation of actual therapy, measurement of before-and-after indices of symptoms, and discussion of possible commonalities among the methods.

As expected, tight research protocols were absent or violated by sincere attempts on the part of the clinicians to actually help their subjects. Each method, however, brought some relief to the subjects chosen by Figley and Carbonell. But any commonality among the methods remained elusive.

Jay Efran, a Temple University psychology professor, comments: "They [the academic establishment] are holding EMDR (and other methods) to an unfair standard, and requiring more in the way of proof than is normally required, simply because the method does not make sense to them."[5] (Brackets are mine.) Mary Sykes Wylie quotes one psychology professor who impugns much academic research because the method under study is turned over to "inexperienced students" who get frustrated with the manual, do their own ad hoc therapy, and "write it up as if the manual did the trick."[6]

Good research controls confounding variables by removing them from the study (e.g., limiting the subjects to one gender, intelligence level, and/or educational level) or by statistically controlling their influence. But statisticians know that when a population is divided into two groups, there are members of each group who are most unlike each other (these people are the ones used for comparison on a dependent variable), but the closer people come to the mean or average, the less the distinction. The largest number of people in both groups are the approximately two-thirds within one standard deviation above and below the mean. The closer to the mean, the more people are alike. The fact that EMDR is used by thousands of therapists who report successful results suggests there is little possibility that one or even a few factors are influencing the outcome of EMDR results. For example, if these therapists were of one theoretical persuasion, personality, or sex, we could then say that similarity is consistently influencing the outcome of EMDR therapy.

Another reason to disqualify EMDR as an effective method is to question the veracity of the reported successes. At best, this says EMDR therapists are naive and at worst, charlatans. Such deductions pale when we consider the sheer number of therapists who are claiming enthusiastically that EMDR works. Wylie comments: "These reports, heard over and over, sound like stories of conversion and salvation—first I was lost, then I was found—that have been too easy for skeptics to dismiss as so much pseudo-religious hot air. Clearly something "real" is happening—to simply react out of hand the experiences of hundreds of thousands of clients and therapists because empirical trials are lacking seems perverse."[7]

We may disagree with Wylie, but the fact remains: Anyone who sincerely learns and practices EMDR knows that it works. Thousands of clinicians are claiming the success of EMDR, as well as numerous people who have been helped. The good news is that solid research is beginning to appear in journals. Wilson, Becker, and Tinker report significant decreases in anxiety and increased positive cognition regarding stressful experiences of 80 participants.[8] The study employed an independent assessor and several EMDR therapists who were strictly monitored. Above average statistical procedures were employed to assure accurate results.

Personal Experience

My own experience also supports the efficacy of EMDR. I have used EMDR in a single session to relieve symptoms resulting from witnessing an auto accident where several children were injured to one case that lasted 10 months, involving childhood emotional and physical abuse. Before learning EMDR, I would not have had the same success with such cases, other than to work through the memories and encourage the sufferer to know where the pain is coming from and then focusing on the present and future. But now, cases like these are resolved, and the client happily terminates, reporting no need for further help.

Another case involved a woman who for all of her adult life had a lingering dissatisfaction with life. She was constantly looking for "something" to satisfy a deep longing within. We decided to try EMDR and, in one double session, we discovered memories connected to her understanding of sex and her sexuality. We worked through her memory of how she had learned about heterosexuality, how disgusted she had felt, and her conclusion as a child that she was not like the neighbor kids who told her about sex and who appeared happy about what they knew.

We also worked through a teenage memory of learning that she had been sexually abused as an infant. These and other unprocessed memories had led her to conclude that she was bad. When we faced this cognition with EMDR, she worked through not only the shame and guilt, but also the false conclusion about her own sexuality. At the end of that EMDR session, she reported that a great weight had been lifted and those memories were now faded and unimportant.

Success like this is a regular experience for me. But none of this comes without considerable emotional pain. EMDR is not effortless emotionally for the counselee or the therapist. We must be willing to experience their pain as it is desensitized. Yet EMDR therapists continue to practice it because it works—people get better—and EMDR counselees return for subsequent sessions—even though the last one was painful—because they find permanent relief from distressing memories and their influence on their lives.

Since learning EMDR, I have terminated more satisfied counselees than in the same period before EMDR. Counselees spontaneously and enthusiastically report how

(Continued on page 16)

BioLateral Tapes: An Effective Alternative to Eye Movements

Produced by David Grand, RCSW
EMDR Facilitator

What Are BioLateral Tapes?

BioLateral audiotapes can replace eye movements as the sole source of stimulation. The tapes' ability to integrate EMDR bilateral stimulation with music and sound healing is opening new vistas of treatment, healing, relaxation, and meditation. Through the use of BioLateral, clients often report that they experience deeper meaning, increased insight, and improved ability to synthesize material. And therapists have found that BioLateral tapes are the least costly of all alternative EMDR technologies and can be easily used by clients during as well as between sessions.

More than eight hundred BioLateral tapes have been sold and are being used around the United States, Canada, Europe, South America, and Australia. After more than two years of use, feedback regarding the efficacy of BioLateral tapes continues to reflect excitement and enthusiasm.

How Were BioLateral Tapes Developed?

BioLateral tapes were created in a production studio by myself and musician friend, Evan Seinfeld, the lead singer of the rock group Biohazard. Instead of making a tape limited to tones that alternated between the left and right speakers, we decided to incorporate music-like sound. We recorded and experimentally mixed six separate tracks using the healing sounds of ocean waves, a Tibetan bell, an Indian drum, and a synthesizer, utilizing computer technology to encompass frequencies across the sound spectrum. After production, we found that the free-form nature of the production process infused the tapes with human, creative, and spontaneous qualities.

The first tests of BioLateral were performed with friends and family, who uniformly reported they experienced a powerful relaxation effect with both soothing and deep, yet non-agitating, processing. I began using BioLateral with clients in session using a stereo "walkman," providing appropriate clients with a BioLateral tape for home use between sessions. All of my clients who tried the tapes preferred BioLateral to the audio machine, which they sometimes found annoying or agitating.

The success of the original tape led to requests for new ones. We accordingly returned to the studio and recorded BioLateral 2, Going To Wave Lengths, which combines ocean sounds with a bilateral brush tone and BioLateral 3, Round the Lake, which fully integrates the bilateral stimulation into music that sounds both Gaelic and Eastern. Responses to all of the tapes continued to be enthusiastic.

How Are the Tapes Used?

It is easy to personally evaluate the effectiveness of BioLateral-simply sit in a quiet place and think of something that is bothering you at that moment. Work up your own protocol with a SUDS and follow your associations. Then, observe the nature of your processing and occasionally return to target and retake the SUDS. In session, work up or use an existing target and protocol. Then have clients listen to the tape, again using stereo headphones (no eye movement is necessary). Inform clients that all they have to do is to observe the flow of their processing, although they have the option of keeping their eyes open or closed. You may stop them periodically to check "where they are" or have them stop when they have reached a period of quiescence or have something they want to verbally process.

How Will My Client's Benefit from BioLateral Tapes?

BioLateral tapes take advantage of the client's ability to process through auditory stimulation. Because they provide a different, low-cost means of effecting bilateral stimulation, the tapes provide a number of distinct advantages:

- The left/right aural tones produce the same bilateral stimulation as the eye scanning, eliminating the need for eye movement.
- Client eye strain, as well as therapist arm and shoulder stress, are eliminated.

- The passive stimulation of Bio*Lateral* tapes tends to reduce client distraction that can result from other methods.
- Clients can choose to process with their eyes closed, allowing for more imagery and deeper processing.
- The tapes allow each set to continue as long as you or the client chooses. Therapists have reported that educated clients are often better able to determine the length of a set as they are witnessing the processing "from the inside."
- With Bio*Lateral* tapes, sets can last for many minutes and may contain hundreds, and sometimes thousands, of repetitions.
- Clients can listen to Bio*Lateral* throughout the session, even when dialoguing with the therapist, often helping clients to experience deeper meaning, greater insight, and synthesis of material.
- Bio*Lateral* can even be played during a non-EMDR session for deepening the process and enhancing insights.
- A number of therapists have reported that, in many cases, Bio*Lateral* has helped dissociative clients process with less agitation.
- Bio*Lateral* can be used in between sessions to reduce client agitation, generalized anxiety and panic attacks, insomnia, and to understand and control cravings and compulsive behaviors.
- The low cost of Bio*Lateral* makes it far more affordable than the existing audio stimulation machine and allows therapists to cost-effectively support clients both in and out of session.

THREE BIO*LATERAL* TAPES CURRENTLY AVAILABLE

Bio*Lateral* 1—Original Recipe

These are recorded and experimentally mixed six separate tracks using the healing sounds of ocean waves, a Tibetan bell, and an Indian drum as well as Evan Seinfeld on the synthesizer. The tape also utilizes used computer technology that helped to cover frequencies across the sound spectrum. The free-form production process infused Original Recipe with a human, creative, and spontaneous essence.

Bio*Lateral* 2—Going To Wave Lengths

Going to Wave Lengths combines ocean sounds with a bilateral brush tone. This tape is especially helpful for processing with clients who are easily distracted and is particularly effective for reducing insomnia and agitation in between sessions.

Bio*Lateral* 3—Round the Lake

This tape fully integrates the bilateral stimulation into music which sounds both Gaelic and Eastern. It includes a background harp with bass guitar tone and Evan Seinfeld live in studio on guitar.

TO ORDER BIO*LATERAL* TAPES OR RECIEVE PRICING OR OTHER INFORMATION:

David Grand, the producer of the Bio*Lateral* tapes is anxious to hear from you and to provide answers to your questions. Please feel free to contact him at:

2415 Jerusalem Avenue, Suite 105, Bellmore, NY 11710

Telephone: (516) 785-0460

Fax: (516) 799-7625

E-mail: DGrand1952@aol.com

(ENIGMA, Continued from page 13)
much better they feel and think. Before EMDR, people I had treated might, after several years, tell me how much I had helped them, or I would learn indirectly from another person that a previous counselee appreciated the therapy he or she had with me. EMDR has revolutionized my counseling practice.

Biblical & Theological Considerations

What happens when anyone heals whether physically or psychologically? Consistent with a theistic view (as contrasted with a deistic one), I believe God's influence in the world is both constant and ubiquitous, resulting in his common grace working both for believers and nonbelievers alike. He provides for physical and psychological healing for all human beings, even when the psychological and medical interventions are given by those who do not believe in him. It is easier to see how medical interventions free the body from the sway of evil in the various forms of disease. Psychological procedures free the human mind and heart from distressing attitudes, thoughts, beliefs, memories, and experiences. Generally when medical and psychological practitioners help another human being, they are making a way for God's common grace to heal the sufferer. EMDR, like the surgeon's scalpel or the dentist's drill, opens and removes the problem, allowing counselees to heal on their own.

What general biblical principles are applicable to the EMDR method? Paul expected believers to progress toward Christlikeness as part of their sanctification process (Rom. 8:28-30). Believers are to change both cognitively (Rom 12:2, Eph. 4:17-24) and behaviorally (Eph. 4:25-5:15). Most people may not have painful memories to hinder their spiritual and psychological development. But what about those who are plagued by distressing childhood and/or adult experiences?

David Seamands addresses painful memories by practicing what he calls the healing of damaged emotions. In a careful fashion, Seamands enters into the counselee's past, primarily assisting the counselee into prayers of confession and petition for God's help with the painful memory. This kind of intervention allows counselees to view themselves, others, and the world differently. Cognitive change accompanies the healing of the memory.

EMDR as used by an unbelieving therapist functions in a similar way without the religious practices of prayer and confession. I include prayer as part of the EMDR protocol, and I have repeatedly found my Christian counselees turning toward the Lord Jesus or discovering He is right there with them in the painful moment.

Obviously EMDR, like many other modern psychological interventions, is not found in the Bible. Yet, there is biblical warrant for forgetting and that is what EMDR helps people to do. In Philippians 3:13, Paul illustrates the importance of future focus by emphasizing his forgetting those things that were behind him. We cannot fully look to the future while we cling to the past. But forgetting what is behind is not always easy or possible. What then?

Paul could brag about his birth, education, and religious practices. But he also fiercely persecuted the church. He sanctioned and witnessed the death of Stephen. Paul's pedigree and heinous acts were indelibly etched on his mind. Yet he recommends in Philippians that his readers forget, just as he has forgotten the past. How? Forgetting is usually a natural process. Memories are processed by talking about them, reviewing their meaning, and emoting their pain. Paul may have forgotten his past in this natural way, or he may have had the help of the Lord either on the Damascus road or during the three years of special training the Lord gave him after his conversion.

Either way, Paul forgot the past and focused on the future. Can we do the same thing? Usually we do. But there are experiences so hard to forget that we are not able to let go of them and focus on the present and future. People need help in these cases, and EMDR has proven itself effective.

Some have said, "The proof of the pudding is in the eating." The same is true for EMDR. If you're still looking for proof, first look within. Are there memories that still seem vivid and laden with emotion? Do they interfere with your progress as a Christian? Like the "proof of the pudding," tasting EMDR for yourself is the best way to determine its effectiveness and veracity.⇔

ENDNOTES

1. F. Shapiro, Eye Movement Desensitization and Reprocessing (New York: Guilford, 1995), p. 39.

2. K. Butler, "Too Good To Be True?" Family Therapy Networker 6 (1993): 25.

3. D. Dillon, Short Term Counseling (Waco, TX: Word, 1992), p. 180ff.

4. M. Wylie, "Going for the Cure," Family Therapy Networker 4 (1996).

5. Ibid., p. 31.

6. Ibid., p. 32.

7. Ibid., p. 37.

8. S. Wilson, L. Becker, and R. Tinker, "Eye Movement Desensitization and Reprocessing (EMDR) Treatment for Psychologically Traumatized Individuals," Journal of Consulting and Clinical Psychology 63 (1995): 928-37.

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New Addition to EMDR Institute Discussion List: Two-Week Specialty Topic Discussions Led by Institute Staff

Andrew Leeds, Ph.D., EMDR Discussion List Moderator

In the 19 months since its founding in May 1996, discussion threads on the EMDR list have mostly arisen at random in response to inquiries from list subscribers. Occasionally, I have prompted discussion in certain areas. Last August, I had an idea to supplement and strengthen the general discussions and case inquiries with a series of parallel threads on a specialty topic led by a guest presenter.

I extended an invitation to a number of EMDR Institute staff members who have presented on specialty topics at Level II trainings or at the annual conference. I asked these EMDR clinicians to volunteer to take a two-week active role in leading a discussion on the EMDR discussion list on a specialty topic in their area of expertise. I am delighted that several have agreed to support this experiment with two weeks of focused discussion on a topic of special interest.

General postings and case inquiries on the full range of topics covered in the list policy guidelines will always be welcomed. I will continue to moderate the general discussion and enforce list policies. Guest presenters will introduce their topics and invite discussion on their specialty topic.

If you know a specialty presenter from the conference or a Level I or Level II training you'd like to see on the discussion list as a guest presenter, please contact them or let me know and I'll do what I can to encourage them to participate.

I look forward to seeing you online.⇔

Schedule for Two-Week Specialty Topics

Start Date of Two-week Discussion	Name of Guest Consultant	Discussion Topic
December 15, 1997	to be announced	———
January 1, 1998, Rescheduled	Carol York, MSSW	Applications of EMDR with Eating Disorders
January 15, 1998	Silke Vogelmann-Sine, Ph.D., CSAC, NCACI	Chemical Dependency Protocol
February 1, 1998	Ad de Jongh, Ph.D	Specific phobias
February 15, 1998	to be announced	———
March 1, 1998	to be announced	———

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2500 E. Nutwood Ave,Ste. 212
Fullerton, CA 92831
Work: (714) 680-0663
Fax: (714) 680-0570
ccrounzun@aol.com

PRESIDENT-ELECT
Dan Merlis, MSW
7257-C Hanover Pkwy.
Greenbelt, MD 20708
Work: (301) 982-9259
Fax: (301) 982-9259
DanMerlis@aol.com

SECRETARY
Peggy V. Moore, M.S.W.
2741 Indian School Road N.E.
Albuquerque, NM 87106
Work: (505) 255-8682
Fax: (505) 255-7890
pvmoore@unm.edu

SECRETARY-ELECT
Wendy Freitag, Ph.D.
333 Bishop's Way #125
Brookfield, WI 53005
Work: (414) 797-0315
Fax: (414) 797-0358
WF1705@aol.com

TREASURER
Elaine Alvarez, M.S.W.
33 Treaty Road
Drexel Hill, PA 19026
Work: (610) 543-1588
Fax: (610) 543-1738
Currently no e-mail

TREASURER-ELECT
Marguerite McCorkle, Ph.D.
295 Franklin Street
Napa, CA 94559
Work: (707) 257-8842
Fax: (707) 226-5056
Currently no e-mail

DIRECTORS

DIRECTOR
David L. Wilson, Ph.D.
616 Azalea Avenue
Redding, CA 96002
Work: (916) 223-2777
Fax: (916) 223-0977
dwilson@awwwsome.com

DIRECTOR
Jocelyne Shiromoto, M.S.W.
2500 E. Nutwood Ave., Ste 212
Fullerton, CA 92831
Voice Mail: (714) 764-3419
Fax: (714) 528-9676
shiroflex@aol.com

DIRECTOR
Marilyn Luber, Ph.D.
255 S. 17th St., Ste. 804
Philadelphia, PA 19103
Work: (215) 545-8296
Fax: (215) 545-7245
marluber@aol.com

DIRECTOR
Sandra Paulsen, Ph.D.
3765 Highland Rd
Lafayette, CA 94549
Work: (510) 299-6886
Fax: (510) 299-6887
Pcresources@compuserve.com

DIRECTOR
Landry Wildwind, LCSW
109 Bayside Ct
Richmond, CA 94804
Work: (510) 236-2126
Fax: (510) 233-2616

DIRECTOR
Cliff Straehley, M.D.
11630 Fair Oaks Blvd. #203
Fair Oaks, CA 95628
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Currently no e-mail

COMMITTEES

AWARDS
Dan Merlis, M.S.W.
(See Officers List)

CONFERENCE
Carol York, M.S.S.W.
EMDRIA
P.O. Box 140824
Austin, TX 78714-0824
Tel: (512) 302-9943
Fax: (512) 451-0329
cvyork@aol.com

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MEMBERSHIP
Darlene Wade, M.S.W.
1188 Bishop Street #3205
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San Francisco, CA 94104
Work: (415) 931-3156
Fax: (415) 433-2674
samrolf@aol.com

RESEARCH CO-CHAIR
Lee Becker, Ph.D.
Department of Psychology
University of Colorado
1420 Austin Bluff Parkway
Colorado Springs, CO
80933-7150
Work: (719) 262-3227
Fax: (719) 262-3140
lbecker@mail.uccs.edu

RESEARCH CO-CHAIR
Susan Rogers, Ph.D.
Psychology Service
116B VA Medical Center
Coatesville, PA 19320
Work: (610) 384-7711 x 4016
Fax: (610) 383-0207
rogers.susan@forum.va.gov

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Curt Rouanzoin, Ph.D.
(See Officers List)

EMDRIA Office
P.O. Box 140824
Austin, TX 78714-0824
Tel: (512) 302-9943
Fax: (512) 451-0329
E-mail: EMDRIA@aol.com
Web Page: www.emdria.org

EMDRIA *Newsletter* Submission Information

We welcome and encourage your contributions to the Newsletter. Please note the following guidelines and policies when making submissions:

- All articles must be submitted in APA style and format.
- Articles, columns, and other non-advertisement submissions must be provided in electronic format. They may be submitted on 3½-inch diskette or, ideally, via e-mail. WordPerfect 6.1 for Windows or Microsoft WORD 7.0 or earlier versions are the preferred formats, although a standard text format (i.e., ASCII or Rich Text) may be used. The electronic format of each contribution should be specified in the accompanying e-mail or on the diskette.
- In general, advertisements should be submitted in camera-ready format. Exceptions may be provided for text-only formatting. Various requirements and restrictions apply to advertising for legal and other reasons, so please contact the Editor before preparing your advertisement for submission. Also, please note that, due the Association's legal status, the *Newsletter* cannot publish pricing information.
- It is the author's responsibility to ensure that all aspects of submitted articles are correct and in accordance with APA style including: correct spelling and punctuation; accurate quotations that include page numbers, author, and year; and a complete list of references in proper order. (Please refer to the *Publication Manual of the American Psychological Association, 4th Edition*, for specifics.)
- Contributions should be well-organized and proofread. (It is requested that you make every attempt to complete the final draft before submitting your contribution. It may be difficult to incorporate revisions after the editorial process has begun.)
- Please note that all contributions are subject to editorial revision by the Publications Committee and the Editor.
- The Publications Committee and the Editor cannot guarantee when or if any contribution will be published.

Please submit articles and other contributions to the Editor:

Brad Wasserman, LCSW-C
superVisions Consulting Services
11306 Coral Gables Drive
N. Potomac, MD 20878
Telephone: 301-340-6501
Fax: 301-340-2130
E-mail: superVisns@aol.com

Deadline for Next Newsletter

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Eye Movement Desensitization and Reprocessing International Association
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Suite 360
Austin, TX 78731

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