INTERNATIONAL EMDRIA ASSOCIATION™

EMDRIA NEWSLETTER

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In This Issue

President's Column: On Scholars and Drunks

Steve Lazrove, MD

Within the past two months, I have been asked twice by EMDR proponents to intercede with large healthcare organizations in controversies related to the implementation of EMDR. In both cases, the ethics of using EMDR was challenged based an the impression that Dr. Shapiro controls all training in EMDR through the EMDR institute.

What is the best response to questions such as these and in general, how should one answer critics of EMDR?

Critics of EMDR fall into two camps. The first includes those sincere individuals who have genuine, legitimate questions about EMDR's scientific basis or application. These people are looking for information. It is reasonable to ask how and whether a counter-intuitive method such as EMDR works. Such inquirers should be considered "fellow travelers on the path of Knowledge," for they force us to be rigorous in our thinking and practice, and to make sure that EMDR is consistent with the larger body of scientific knowledge. Questions related to EMDR's active ingredient are an incentive to examine and refine the model. The challenge to prove that EMDR is clinically effective ultimately provides the best justification for using it.

There is another set of critics, however, who cannot be considered "fellow travelers" in any sense of the term. These individuals may employ the language of the scientific method to increase their authority, but in reality, they use science in the same way that a drunk uses a light post: more for support than illumination. The presentation of half-truths, emphasis on invalid data, failure to attend to issues of treatment fidelity, and literature reviews which omit published data that support EMDR's efficacy do not aid and abet the scientific process. They do, though, create a body of literature which can be referenced and create in the public mind the impression that EMDR is ineffective. Such dissembling promotes antagonism and polarization so that what should have been a scientific issue, has become a political one.

When the question of monopoly over training was broached, I was able to state unequivocally that training in EMDR is not exclusionary, that training standards were developed by EMDRIA, that individual training programs are evaluated by EMDRIA, and that anyone teaching EMDR may apply to have their curriculum evaluated and approved by EMDRIA. I noted that the document, "EMDRIA Standards of Training in EMDR," is available via the EMDR web site (www.emdria.org), and that the web site also includes a list of EMDRIA-approved training programs, of which the program offered by the EMDR Institute, Inc. is one. The publication of objective standards developed by a membership organization is the best way to provide convincing evidence that training is not restrictive.

The existence of EMDRIA enhances the authority of EMDR because EMDR must grow beyond the personal imprimatur of its creator. This reality is clearer to no one

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FROM THE EDITOR

Lois Allen-Byrd, Ph.D.

In this issue of the *Newsletter*, you will find a ballot to vote for positions on EMDRIA's Board of Directors. Please fill it out and return it as soon as possible. It is important that members have a voice in how their organization is run and this is one way to accomplish that goal.

Among the articles included in this issue is a very touching letter from Gary Fulcher in Australia who was severely burned a few months ago, and is now in the process of recovery. I know I speak for all EMDRIA members in wishing Gary continued success in his healing process, and that our thoughts are with him.

There are two other articles from Australia. One is from Mark Grant regarding the use of EMDR with a Shaman, and the other from Jennifer Braithwaite on research and debate about EMDR.

Also included are articles on a variety of topics ranging from membership benefits; to a book review on trauma research methodology; to perspectives on the use of the "safe place"; to a meditation/relaxation exercise; to a description of EMDR, EMDRIA, and HAP; to information on the EMDR Register.

Last, but clearly not least, there is an announcement for the July 11 -13, 1997 EMDR Conference in San Francisco, California. Plan to attend and register early. As indicated by the programs you should have already received, there are a number of exciting topics being presented, and it is a wonderful way to network and meet new clinicians with similar interests.

Regarding the deadline for the next *Newsletter*, as with last year, the next issue will be dedicated to the conference. Those articles should be received by July 20th. Articles for the following issue should be submitted by no later than September 15, 1997.

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than to Francine Shapiro. It was Dr. Shapiro, herself, who stimulated initial interest in the development of an independent association, and she has supported it ever since. The body of work that EMDRIA has produced during the past 12 months, of which the "Training Standards" and the web site are two elements, is representative of the type of publicization (as opposed to privatization) which must occur for EMDR to evolve.

Which brings us by a commodious vicus of recirculation (cf. Finnegans Wake), back to the question of how to deal with the second type of critic of EMDR. Providing information to correct errors is a successful strategy only when the recipient's mind is sufficiently open for data to enter. A logical argument stemming from a personal bias is vacuous and irrefutable because the argument is not predicated upon a testable hypothesis. The statement, "I do not think EMDR works," cannot be disproved; yet, in my opinion, what often passes as an objective review of EMDR is a presentation of biased information so as to make this unprovable assumption appear to be a logical conclusion.

Up to now we have ignored the critics, or have tried to answer the substantive issues objectively, believing that eventually the worth of EMDR will be established and that the jabbering will stop. That has not yet occurred, nor is it likely to occur on its own in the near future. In the meantime, EMDR is being hurt in a variety of ways, For example, research is not being funded, and compensation is being denied by third party payers, to name but two. The time has come to be more proactive.

I am appointing a Blue Ribbon Panel to determine whether any professionals have disseminated misinformation about EMDR maliciously or knowingly. I also have asked the Panel to recommend action based on its findings as such behavior clearly would be in violation of the ethical guidelines of some professional associations. I am looking forward to receiving this report and will make it available to the Association once it has been completed.

This is the end of my last column as President of EMDRIA. Mark Twain wrote to Winston Churchill, "Tis noble to do good, but it is nobler to teach good, and less trouble." No kidding. This past year has been hard work, but it has gone by quickly. I am proud of all that we have done, though I wish we had done more. I leave with relief that the office will pass into the able hands of Curt Rouanzion, Ph.D. Curt has worked on EMDRIA since before it even had its name; his commitment has been unwavering. I also want to single out Dave Wilson, Ph.D., who has served as Chair of the Board; his unflagging support has been invaluable. To everyone who has contributed to the birth and growth of the Association, my sincere thanks.

It has been an honor to serve. ■

EMDRIA Chair's Column

Dave Wilson, Ph.D.

When I wrote my first column as Chair of the Board of Directors for EMDRIA last year, I had only assumed this role a few months earlier when Ron Doctor had to step down because of serious health problems. Honored to be selected by my colleagues for this position, I focused on creating the infrastructure necessary to make EMDRIA fully functional. Over the past year, I have worked closely with President Steve Lazrove and at Steve's request, continued to put out the agenda and support materials and chair the Board and Executive Council meetings, while Steve focused on creating the EMDRIA program. I have found this work richly satisfying, mainly because of the quality of the company I have been keeping in providing the organizational support that underlies EMDR. This will be the last "Chair's Column" as I have successfully worked myself out of a job. In that context, there are a number of people I want to acknowledge.

First, Ron Doctor for his work in guiding us through the process of incorporating EMDRIA as a nonprofit educational organization, and providing the leadership, money, and structure that allowed EMDRIA to get started. Ron went so far as to loan EMDRIA start-up money and secure our first line of credit with his own credit card. How many of us would have gone that far? Unfortunately, Ron had to step down as Chair last year because of a potentially life-threatening health challenge. Fortunately, Ron's surgery was completely successful and he has recovered well. Understandably, in confronting his own mortality, he has reassessed the priorities in his life and chose to leave the Board to pursue other commitments. Nonetheless, Ron Doctor got EMDRIA off the ground.

Second, I want to acknowledge Jocelyne Shiromoto for holding EMDRIA on course when Ron was out of commission and the rest of us were not up to speed. Perhaps no one other than Ron, Jocelyne, and I really know the extent to which she guided EMDRIA through a difficult transitional period. If it were not for Jocelyne's work during that time, I do not know where EMDRIA would be today, or even if EMDRIA would be. For this work, Jocelyne really deserves our gratitude.

Next, I want to acknowledge Steve Lazrove for the outstanding work he has done as EMDRIA's first president. Steve has certainly been "presidential," always calling for lower taxes (dues) and increased services. Under Steve's leadership, EMDRIA has established a basic program of services highlighted under "Member Benefits" appearing elsewhere in this *Newsletter*. It has become clear to me that Steve will never "rest satisfied" with what he has contributed, but even a cursory review of what he has put in place over the past year will give you an idea of the tremendous amount of work he has done on behalf of EMDR and EMDRIA. If "work is love made visible," we are talking about a really loving human being here.

Also, I want to acknowledge the exceptional work of some of our committee chairs, Rod Nurse and Curt Rouanzion (Co-chairs Professional Standards and Training), Mark Dworkin (Chair, Health Services), and Carol York (Conference Chair). Other board members, committee chairs, and members have also worked hard and contributed to the organization, but these people have really been stalwarts--effective, efficient, accountable. I have truly appreciated these qualities in my present role.

Finally, I acknowledge Francine Shapiro for creating EMDR, for holding the vision of what EMDR can offer to the world, and for empowering EMDRIA in this work. Francine "turned it over" to EMDRIA. Not once over the past year has Francine intruded into, or meddled with, the work of EMDRIA. To appreciate the extent of this empowerment, consider handing over your first born child to the care of a committee of twelve. Francine is the source of the vision that moves EMDRIA in providing the organizational assistance that supports EMDR. For sharing her vision with us and empowering all of us in our work, thank you.

So I sign off as Chair. It has been a good run and great fun. I look forward to seeing you all at the Convention. ■

EMDRIA, EMDR, HAP... What's All the Alphabet Soup About

Curtis C. Rouanzion, Ph.D.

Since the establishment of EMDRIA, I, and most of EMDRIA's Board members have been asked many times about what EMDRIA is and if or how it is different from the EMDR Institute. So here it goes...

The EMDR Institute is a private, for-profit training institution run by the originator and developer of EMDR, Dr. Francine Shapiro. It is the organization through which most of those trained in EMDR have received their training. The Humanitarian Assistance Program (HAP) is a nonprofit, charitable organization developed by the Institute to provide training and support to therapists and victims of trauma.

The Eye Movement Desensitization and Reprocessing International Association (EMDRIA) is registered as a 501 C (3) organization by the IRS. This means that it is consid-

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ered a non-profit, charitable, educational, and scientific organization by the IRS. EMDRIA is an independent organization with no affiliation to the EMDR Institute.

Several years ago, many EMDR clinicians (including Dr. Shapiro) believed that the time would come when EMDR would outgrow any one training institute. In order to thrive, there had to be an independent organization where diversity of thought and differences of opinion could be openly addressed and debated. The primary goal was the advancement of EMDR as an effective treatment of trauma and trauma-based disorders. The history of psychology is full of stories about the creation of a therapeutic innovation and its later demise due to splinter groups, in-fighting, and quests for lone legitimacy. EMDRIA was established as an organization to promote EMDR in the hopes of avoiding the repetition of psychological history.

EMDRIA has established training guidelines and criteria for EMDR in both educational (graduate schools) and independent organizations. The EMDR Institute is one of many who have applied, met the criteria, and have been EMDRIA-Approved to train in EMDR. (For a more complete list, please check our web site: http://www.emdria.org)

EMDRIA is now responsible for the yearly conference on EMDR. Its programs and workshops will continue to reflect the diversity and openness to divergent opinions. It will also emphasize the verification of strong opinion by publishable, solid, scientific research. To this end, EMDRIA has funded on-going research. EMDRIA also supports and funds charitable work (e.g., HAP or any other charitable organization that promotes the humanitarian use of EMDR or EMDR training).

Over the past couple of years, I have heard some therapists state that EMDRIA is just a "rubber stamp" for the EMDR Institute. It is another attempt to appear as though there is an independent organization, but in reality, it is the EMDR Institute "calling the shots." All I can say is--that belief is simply not true. EMDRIA is independent and must be so because of our IRS tax-exempt status. EMDRIA must act independently of any for-profit organization or it will jeopardize our tax-exempt status. Our mission statement promotes the advancement of EMDR, not a particular EMDR training.

EMDR and EMDRIA both owe a profound debt of gratitude to Dr. Francine Shapiro and the EMDR Institute. Through Dr. Shapiro, EMDR was born. Through the Institute, EMDR continues to develop. Now through EMDRIA, EMDR has an independent forum for its continued growth and development. Dr. Shapiro was forward thinking enough to realize the potential for growth of EMDR and the potential for problems. For this reason, she called me nearly four years ago and asked me to develop a task force and look into the development of such an independent organization as EMDRIA. As any good parent knows, there comes a point when the "baby" must make its own way and grow up away from home. Dr. Shapiro has courageously and continually supported the independence of EMDRIA, even when our decisions or opinions have not been the same as hers. If Freud could have maintained such an attitude, who knows what might have happened.

EMDRIA is an independent organization and will stay that way. I encourage all therapists trained in EMDR to join EMDRIA. Allow your opinions to be heard and be open to hearing the opinions of others. For this reason, EMDRIA is your organization.

I would like to close with a statement made famous during the Protestant Reformation: "In essentials, unity. In nonessentials, liberty. In all things, charity." ■

Message to My Many EMDR Friends and Supporters

Gary Fulcher, Ph.D.; Sydney, Australia

I am writing this personal column to the many, many EMDR folk who have shown interest and support in my health and progress since my accident. There are too many to thank individually, so I thought I would use this *Newsletter* to provide an account of what happened, my current status, and my heartfelt thanks to the many who have assisted in my healing.

On 12 December, 1996, I suffered a hypoglycemic episode while driving home from work. I pulled over two streets from home and in my low sugar confused state, tried to begin driving again. My glucose-starved brain was not up to the task, however, and all I could manage was to rev the engine without engaging the gears. Surprisingly, a fire started under my car which quickly produced intense heat which allowed the fire to enter the car through the gear stick cover. The heat in the car became so intense that the windscreen shattered, the ceiling melted, and the external roof paint exploded off the car surface.

My glucose-starved state prevented me from being able to continue my actions well enough to undo my seat belt to escape. I was able to focus enough to tell a good Samaritan who tried to save me to get away as I thought the car might explode and injure him. The brave man used his garden hose to spray my upper body through the car window which probably saved my life and definitely

reduced my facial scarring. He stayed close to the car despite warnings from me and his neighbors. His wife phoned the emergency services. Wendy, my wife, and I have nominated him for a bravery award.

As the shock released glucose and adrenaline into my system, I tried to undo my seat belt, but my fingers were so badly burned by then that they could not carry out the task. I therefore remained trapped in the fire until the Fire Brigade arrived and an asbestos-covered fireman was able to reach in and release me. It is amazing how the brain works--I remember hitting the back of my head on the road as he heaved me out of the car. Despite being on fire from head to toe, I clearly remember thinking as my head hit the asphalt, "Oh shit, that hurt!" The ambulance arrived shortly after and I was taken to a local hospital for stabilisation and then transferred to Concord Hospital's specialist Burns Unit. The irony of this location was that I had been Director of the Department of Psychology at Concord for 10 years and had worked in the Burns Unit for about 5 years!

I suffered burns to almost 60% of my body, mostly of full thickness (50% is considered to be the point at which patients are at strong risk of perishing). My left side was burned worse than my right. Both legs were burned right around with nerve damage in the left leg which has affected sensation, balance, and walking ability. The left knee and shin were burned to the bone and there were grave fears for that leg. However, healing has occurred naturally and I am getting stronger daily and walking reasonably well.

Both arms were burned right around and the fingers were burned so completely that I lost most of all of my fingers. This has left me with a severe and difficult disability. I am learning to do amazing things with my few remaining stumps, however, and may be assisted even more with prostheses in the future. My shoulders, some of my neck, and parts of my back were burned. My scalp was badly burned by molted vinyl dripping from the car ceiling and I became bald overnight. The left side of my face, forehead, and nose were partially burned and therefore, scarred.

My eyelids retracted and needed to be replaced by grafting. My throat was burned, affected by toxic gases, and scarred by intubation tubes resulting in the loss of my voice. It is hoped that laser surgery will bring my voice back.

I was Intensive Care for three weeks before being able to move into the Burns Unit. I had eight operations of skin grafting with donor sites from my stomach and buttocks. At the time of this writing, I have been in the hospital for four months and have about one month to go before discharge. I will need more surgery and lots of rehabilitation over the next few years. I will need to wear pressure garments (including a head mask) for about two years. So, I have been, and will be, doing it pretty rough for some time.

I have, however, been provided with marvelous support from Wendy, my family, and my close friends. I have also been overwhelmed by the support I have received from my other friends and colleagues. The EMDR group is an example of this support. I have received so many cards, letters, and messages to help and support my healing that I feel blessed. The amount of love and energy that has come my way has been wonderful and has definitely helped me in my healing process. I feel greatly undeserving of the level of input, but want to thank everyone of you who gave of yourself to help me in my needy time. I really appreciate every card, every word, every prayer, every flow of energy that you have sent. I have surprised the Burns Unit with my attitude and the speed of my recovery, and I am sure that part of my progress is due to the support I have received.

I hope to continue to work in the field of trauma and to meet you all at some future EMDR activity. I designed and had made a hook to allow me to open drawers, doors, and the like, and to grasp things I previously could not grasp. One of my favourite bands has been Dr. Hook and I guess there is every chance that I may end up with that as my nickname (more irony)! Oh well, I can think of much worse to be called. Thank you again for all you have done for me and I hope to meet up with you soon.

Gary

Editors Note: Gary Fulcher's address is PO Box 252, Mortdale, NSW 2223

MEDITATION/RELAXATION EXERCISE

Chad Glang, Ph.D; Colorado

For twenty years, I have been guiding most of my clients through a particular meditation/relaxation exercise. It seems widely applicable, and to be well received by most people. Recently, I have used eye movements to enhance the effect. For several clients, it has served as a positive introduction to EMDR, and an effective way to establish a very safe place, often with a spiritual feel to it.

This meditation was developed by Assagioli (1973) as part of the therapeutic approach he calls psychosynthesis. What follows is an adaptation of Assagioli's "Exercise in Identification." The client closes her eyes, assumes a relaxed posture, and listens to these words (which I record for her later use):

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Begin by simply observing your physical experience. Let your awareness be curious and neutral, and float around your body, noticing what is true for you now, physically. Observe without judgment, simply noticing what is. For example, you might observe temperature: where do you feel warm, where cool? How does the temperature on the soles of your feet compare with that of your forehead? Or the palms of your hands with the backs of your hands? You might notice your breathing, the rising and falling of your chest with each breath, or the passing of air through your nostrils. Perhaps you'll notice that the incoming air is slightly cooler, the outgoing air warmer. Notice if there are parts of your body which are more tense or relaxed than others. Without labeling a particular sensation good or bad, simply notice what is.

As you do so, reflect on all the different experiences your body provides you with. Your body is a vehicle for getting around, a set of tools for accomplishing things. At a given moment, your body may be rested or tired, hungry or full, in good health or poor health, in good shape or poor shape. You know that whatever you are experiencing physically, it is temporary. It will pass, be replaced by another experience, and you'll remain the same person. And so you might silently try the words, "I have a body, but I am not by body."

Now turn your awareness to your thoughts. In the same neutral curious way, observe your thoughts. Probably, like most people, you have a more or less constant stream of thoughts going through your mind. You might imagine that your thoughts actually form a stream, and it's as if you can stand on the bank and watch them go by. Observe your thoughts. Without labeling a thought good and pursuing it, without labeling a thought bad and rejecting it, just watch them as they move through your mind. Notice how a thought comes into your mind for a time, then moves on, and is replaced by another. Watch curiously, neutrally.

As you do so, reflect on all the mental experiences your mind provides you with. Your mind is a wonderfully complex instrument which allows you to recall the past, plan for the future, get to know people and situations, acquire knowledge, and solve problems. You may have thoughts about small unimportant details in your life, or far-ranging issues of great significance... and everything in between. Once again, you know that whatever mental experience you are having, it is always temporary, it will pass, be replaced by a new experience, and you'll remain the same person. So you might silently try the words, "I have a mind, but I am not my mind."

Now turn your awareness to your emotions. Look inside in the same neutral, curious way, and notice what feeling or mix of feelings is present for you. Without labeling a feeling good or bad, just see what is true for you emotionally right now As you do so, reflect on all the different emotional experiences you have. Like your thoughts, your emotions can change moment to moment. You may feel bored, anxious, relieved, jealous, delighted, confused, angry, loving, joyful. So many different emotions which add color and texture to your life. Once again, you know that whatever you are experiencing emotionally, it is always temporary; it will pass, be replaced by a new experience, and you'll remain the same person. So you might try the words, "I have emotions, but I am not my emotions."

Take a moment to reflect on all you have done to this point. You've observed, and in the act of observing, gained some perspective on these three realms of your experience: the physical, mental, and emotional. Now let yourself settle down a little more deeply into that part of you that does the observing. I would suggest that this is a place of constancy and safety...deep inside...beneath, as it were, all the comings and goings physically, mentally, and emotionally. Let yourself rest in this deep, centered part of yourself.

Now, in this last part, I'd like you to remain in the same curious, observing mode. There is nothing to do, just watch. Please imagine a blank white screen, like a movie screen. In a moment, it will be time for an image to form on the screen. It may be anything at all: a person, an object, a scene of some kind. Anything is fine. Now allow a picture to form that represents this deep part of yourself, this place of constancy and safety.

I'm going to be silent now, and when the picture forms, I'd like you to remain with your eyes closed and describe it to me.

After the client describes the picture, gives it a title (word, phrase, or sentence), tells me what he or she is feeling emotionally and physically, he or she opens his or her eyes for some eye movements (EM). (I use a light bar, which we have already positioned, so there is a seamless transition from the meditation to EM.)

Case Examples

Jed, thirty-six, had been unable to establish himself in a career or a committed relationship. He had struggled with intermittent depression for years as he drifted from one job to another. Now, in a new and promising relationship, he was considering parenthood. However, as he urgently put it, "I've got to get a grasp on my life first."

Jed's image was of himself in a mountain meadow surrounded by trees. He was able to smell the trees, hear birds, and feel the late afternoon sun on his skin. The title of his picture was "Serenity--I belong." Through several

sets of EM, Jed's face shifted from calm to smiling to laughter. He reported several details of the scene and ultimately said, "You know, I'm not so concerned with 'getting a grasp'... I'm actually feeling like I'm the one who's in the grasp, being held by something bigger." This safe place, and new sense of perspective, provided a good foundation for subsequent EMDR work on the fears which had kept him from making commitments in his life.

Marie, 51, was burned out on her work as a middle school teacher because of some particularly boisterous students who had her at her wits' end. Though she had been named "teacher of the year" during the prior year, and was currently handling some tough situations well, she was depressing herself with the negative cognition, "I'm a bad teacher." A dark cloud hung over her as we began the meditation.

Her image was of a giant sunflower, with herself in the center. The title was "Peace," and her feelings were warmth, calm, and safety. With a few sets of EM, Marie smiled broadly and giggled, "I haven't felt this good in I don't know how long! I'm going to leave work at work and go home and have a great evening with my family."

The following week, we proceeded with our planned double session, using a target of her "classroom from hell." The SUDs had moved from 9 to 5 in the intervening week, and the work was abreaction-free.

For most clients, this meditation seems to evoke a personal image of peace, depth, and power. In addition to being an introductory target for EMDR, the image is a gift from the client's deeper self which may be drawn upon or visualized whenever desired. The meditation itself is easily done by oneself, with or without the tape. I suggest that clients use the meditation and/or the image as preventive tools, or whenever they feel a need to regain their center.

Reference

Assagioll, R. (1973). *The act of will.* New York: Viking Press. ■

Book Review

David Baldwin, Ph.D.; Oregon

Trauma Research Methodology, edited by Eve B. Carlson, Ph.D. (1996), is a fine introductory textbook for clinicians who want to conduct research on the effectiveness of EMDR (or other clinical methods) for treating symptoms of Posttraumatic Stress Disorder (PTSD). This would also be an excellent choice as a text for a college course on trauma research.

The book covers essential aspects spanning much of the research endeavor, including initial literature searches and writing for publication. Its twelve chapters, contributed by eighteen experienced trauma researchers, are all easy to read and consistently offer practical advice that clinicians or researchers will find immediately helpful in designing and conducting trauma studies. The focus throughout is specifically on pragmatic aspects of trauma research since relevant information concerning other topics in clinical research, e.g., single case studies, qualitative research, and process vs. outcome designs, are more readily available through standard sources. This is not the only reference you will need to carry out trauma studies, but it offers valuable guidance.

The opening chapter, by Fred Lerner, introduces several bibliographic resources including the PILOTS ("Published International Literature On Traumatic Stress") online data base, and gives tips on developing and modifying a literature search. Eight chapters at the heart of this book cover a wide range of issues relating to research methods and design, instruments, and data analysis. Fran Norris discusses fundamental technical issues in designing trauma studies. Susan Solomon and Terence Keane (and colleagues) summarize eight available self-report psychometric scales and seven structured interviews, as well as discuss selection of appropriate PTSD measures, while Danny Kaloupek and Douglas Bremmer's chapter focuses on the use of psychophysiological measures. John Fairbank et al. discuss important sampling issues in epidemiological studies, and Elizabeth Smith's chapter explores practical considerations in carrying out trauma research in the field. Frank Putnam's chapter considers special methods for studying trauma in children, and Judith Armstrong discusses emotional and ethical issues in trauma research generally. Beth Stamm and Stephen Bierber's chapter on data analysis clearly describes how the specific questions of interest to the investigator relate to selection of discrete vs. continuous variables and determine choice of appropriate statistic methods.

The book's final three chapters focus on presenting results and obtaining research funding. Eve Carlson writes about submitting and presenting conference papers. Bonnie Green (former editor of the *Journal of Traumatic Stress)* covers writing and submitting manuscripts for publication. Malcolm Gordon's final chapter focuses on writing grant proposals and selecting a funding source.

Trauma Research Methodology ($18.95) is published in paperback by Sid Press of Lutherville MD. (410) 825-8888 or sidran@access.digex.net. ■

EMDR IN THE AMAZON RAINFOREST

Mark Grant; Noraville NSW

I recently travelled to the South American Rainforest whilst on vacation as I had heard reports that some native peoples use eye movements in healing rituals (e.g., Australian Aboriginals and some South American Indians). As the author of EMDR self-use tapes, I am interested in other applications of REM type stimuli. I was curious to find out first hand whether native people utilize eye movements and how. I was also interested in investigating native approaches to pain and healing because of my work with chronic pain sufferers.

The first thing I noticed about the native people of South America was their vitality and enthusiasm. I thought that in general, their eyes moved quite a bit, even when they were not attending specifically to visual tasks. They seemed to be very alert and aware, and in-tune with what was going on around them. I got the impression that dissociation was less common amongst the people of the rainforest, as well as the other native people I encountered in South America.

One day in October 1996, I met with a Shaman (or Witchdoctor) in the Amazon rainforest, about 75kms downstream from Iquitos, one of the largest settlements on the Amazon. The Shaman and I talked for some time (a local guide interpreted for me) about natural medicines. He explained that if a person gets sick, he might first give this individual a preparation of an hallucinogenic drug ('Iawaska') which, when coupled with his guidance, enables the sick person to 'see' what is wrong with him or her. (Incidentally, incorrectly prepared Iawaska can make one extremely sick.) Based on what the person sees and tells the witchdoctor, the appropriate herbs and medicines are then given. The witchdoctor will also pray over the sick person and he may spend days ministering over him or her.

Coming from a western culture where medicine is the province of trained specialists and patients are encouraged to be passive recipients, the Shaman's account of bush-medicine struck me on several levels: 1) the degree of patient involvement, e.g., the level of involvement in diagnosing him or herself; 2) the combination of drug therapy with spirituality; 3) the absence of separation of mind and body; and 4) the level of support provided to the sick person by the witchdoctor. These are the basic elements of native medicine as it is practised in this area. These are also characteristic features of folk-medicine anywhere which are increasingly recognised as necessary elements of any healing relationship.

In response to my question as to whether he ever incorporated eye movements in healing procedures, the Shaman replied in the negative. This was disappointing, but not surprising as my survey of native medicine was admittedly narrow. However, as an after-thought, I wondered how a native person would respond to EMDR.

I learned the Shaman was suffering from chest pain during the interview. (Chest infections are common in the jungle because of the dampness.) I decided to try EMDR on his chest pain. Toward the end of our talk, I asked the Shaman if he would like to see some "white man's magic." He said yes.

I instructed him to notice the pain in his chest and watch my finger as I moved it back and forth in front of his eyes in the usual way. He was quite a good subject and had no problem concentrating and tracking my finger. After one set he immediately reported feeling some relief in his chest. After a second set he reported more pain relief and a feeling of tranquillity, and appeared bemused. Because of the constraints of time and using the interpreter, I did not follow through with installation of antidote imagery etc. Unfortunately, I also neglected to take a SUDs rating, but his subjective report and his expression indicated there had been a substantial improvement in his chest pain. The relief in his face was clearly visible.

I asked the Shaman what he thought of "white man's magic." He laughingly replied, "you win!"

This brief intervention demonstrated to me that in whatever way EMDR works, it must be accessing an innate mechanism that is present in all people.

Perhaps native persons are good candidates for EMDR. In this instance, the Shaman had good concentration, an absence of secondary gain issues, and an absence of dissociative phenomena and unresolved trauma. EMDR therapy could thus present a viable alternative or adjunct to traditional and/or western medicine, the latter being expensive and difficult to access in remote areas.

I would be interested to hear if anyone else has used EMDR with native people and with what results. In closing, dear politically-correct reader, please note that the Shaman's response to EMDR was not meant or taken as a negation of his medicine.

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CLINICAL NOTES

Steve Lazrove, MD

During EMDR trainings, trainers make clear that EMDR is not a "cookie-cutter," in the sense of being a rote technique. It is expected that with practice, clinicians will personalize the method according to their own needs and experiences. However, it can be difficult at times to determine whether one is adapting EMDR to meet one's needs, or is unwittingly violating basic principles. The following is the first in series of articles illustrating how senior EMDR clinicians have personalized EMDR. I hope that "peering into each others' consulting rooms" will offer new insights and ideas that will enhance our practice of EMDR. It is important to be clear that the positions elaborated below represent personal opinions and approaches to treatment and are not official EMDRIA policy.

The Safe Place

The safe place is a relatively new addition to the EMDR protocol. Its routine use was initiated by Sandra Wilson, Ph.D., and Bob Tinker, Ph.D., first in their research study of PTSD, and then in working with victims of the Oklahoma City bombing. Initially used because those clinical situations did not allow a comprehensive clinical assessment prior to beginning EMDR, the safe place subsequently was incorporated into the standard EMDR protocol. Clinicians are taught not to use eye movements to install the safe place during Level I EMDR Institute training, but the use of eye movements is introduced as an option during Level 11 Institute training. Here is how some experienced therapists use, and do not use, the safe place.

Sheila Bender, Ph.D.
Department of Psychiatry
New Jersey Medical School

The Thought. In the second phase of treatment in EMDR, the therapist asks the client to develop a helpful image that can be used as a resting place during prolonged reprocessing, or as a way of reducing disturbance at the end of an incomplete session. The safe place, as it is called, also provides a self-care method for responding to disturbing material that may emerge between sessions.

Although none would argue the merits of a safe place, there is controversy around the issue of whether or not the installation of the safe place should include eye movements. The proponents argue that eye movements enhance the experience and make the safe place more accessible during the actual EMDR session. In addition, the arguments continue, if the patient is unable to tolerate the eye movements in such a benign experience, the therapist needs to consider further safety measures before proceeding with the trauma work.

There are two issues that need to be addressed with this thinking. The first concerns the theoretical issue of what is one doing by using eye movements in combination with the safe place; the second involves the practical reasons for establishing safe place--safety.

Theoretical Issues. The safe place is a hypnotic technique. If eye movements are used with the technique, is one doing hypnosis or EMDR? Reports that subjects are able to spontaneously go to their safe place during EMDR, or that the experience of the safe place is enhanced by the addition of eye movements, may simply mean the subject is going into or is in trance at that point.

Practical Concern. If the safe place is not effective enough without eye movements, is it more relevant for those whose potential for abreaction is greatest? In other words, for the person at high risk for abreaction, is it not more critical to ensure that no potential for abreacting be created as early as the development of the safe place? Although small in number, it would seem the critical few.

Conclusion. The safe place should be just that--SAFE. If while installing it, you trip the wire attached to all that came before, you have left your patient unsafe. If a good experience of a safe place can be obtained without eye movements, why muddy the waters? The experience can be heightened after the clutter is cleared. The safe place with bilateral stimulation may represent an overlap of phenomena and/or a separate phenomenon. It needs further exploration.

Steven Lazrove, MD
Department of Psychiatry
Yale University School of Medicine
President, EMDRIA

I routinely ask the client to envision a safe place prior to the first EMDR session, and then I install the safe place with eye movements. My experience has been that roughly a quarter of patients spontaneously go to their safe place during EMDR, and that using eye movements enhances the feeling of safety appreciably. This increased sense of safety makes the safe place more accessible during the actual EMDR session. Arguing in reverse, if the client is unable to tolerate eye movements while envisioning a "safe place," what is going to happen when traumatic material is brought up? In that light, doing eye movements when creating the safe place is a useful barometer that allows the therapist to gauge whether a client is adequately prepared to tolerate EMDR. If the safe place cannot be created using eye movements, I would want to be sure that some other grounding technique is in place before proceeding with the trauma work. I believe this argument is the most common and compelling one supporting the use of eye movements to install the safe place.

My instructions are, "Think of a place where you would feel safe. It can be real, or it can be imaginary. It can be a

place you've been or a place to which you'd like to go. Tell me when you have it in mind." Once the client has envisioned his or her safe place, I start the eye movements (having previously checked for distance and speed). During a single set of eye movements lasting 30 to 45 seconds, I say, "Notice what it is like to be in this place. Look around. What do you see? Listen. What do you hear? What you feel? And just notice what it's like to feel safe." I do a few more sets, then I stop without saying, "Blank it out," or "Let it go." I ask how the person feels. If I get positive feedback, I say, "That is your safe place. You can go there anytime during the session you need to feel safe." If the client does not feel safe, or the response is equivocal, then I ask, "What would make it more safe?" Usually the answer is something like, "Locking the door," or "Having my friend with me." I say, "Imagine that," and do another set of eye movements. Again I ask how the client feels. If he or she does not feel safe at this point, I consider another grounding technique, and reevaluate whether this person is ready to do EMDR.

Andrew Leeds, Ph.D.
Private Practice
EMDR Institute Trainer

From my first exposures to guided imagery in the 1970s, my purpose in using imagery has been a blend of assessment and treatment, and my approach has always balanced structure and spontaneous interaction with the client's images. I consider the use of a "safe place" imagery exercise as a standard step in EMDR protocols to be quite useful with a high percentage of traumatized patients, and it is a standard element in my preparation of clients for the reprocessing of traumatic memories. I generally follow the eight step safe place exercise as described in Francine Shapiro's basic text on EMDR (Shapiro, 1995, pp. 122-123). As an authorized Senior Trainer with the EMDR Institute, I teach the entire eight step exercise in Level 1 training programs in the Client Preparation phase whenever time permits. As a clinician, I have found that taking the time in session to teach clients the use of the safe place exercise to regulate their level of arousal pays large dividends. The clients with whom I do this complete exercise spontaneously report using and benefiting from the safe place exercise many times during the week.

When I teach the safe place exercise, I always add two or three sets of eye movements (SEM) to introduce the eye movements (EM) with a neutral or positive association, and to determine the stability of the client's selected safe place. If adding EM to the safe place enhances the client's feelings of safety and calm, I interpret that as further evidence, in addition to other clinical signs of ego strength and emotional containment, that it is appropriate to proceed to reprocessing. If clients do not respond to the use of inner imagery with feelings of safety and calm, another approach must be found to help them have appropriate self-control methods for emotional and physiological regulation. If before or when we add EM, clients report changes in the image of the safe place that include disturbing or frightening elements such as monsters, ghosts, dark or foreboding images, I generally interpret that as evidence that the patient does not yet have sufficient positive emotional resources to proceed to reprocessing. I then modify the treatment plan to focus on further assessing and developing these resources.

I would urge clinical attention to two specific issues in the safe place exercise. First, clients (not therapists) must select their own safe place image. Second, the selected safe place must represent a present (adult) safe place, not the memory of the childhood closet where the client hid when distressed or frightened. Childhood images of a safe place are often intrinsically associated with the relative danger, powerlessness, and limited choices available to children. In particular, it seems that for clients who survived repetitive traumas or chronic neglect in childhood and who may suffering from ego state disorders, the childhood images of safety remain bound to the child ego state. The safe place should instead represent current adult, positive emotional resources of safety, strength, and choice.

Curtis C. Rouanzion, Ph.D.
President-elect of EMDRIA

I have found the "safe place" metaphor to be a very useful technique in therapy. It provides a centering and grounding experience for patients who have intense emotional reactions in therapy, particularly when I use EMDR.

A small percentage of my patients may enter therapy with a previous background or experience with hypnosis, imagery, or meditation and have used similar safe place techniques. As a result, I have them image their safe place and install it with a short sequence (10 to 15) of eye movements (EM).

The majority of my patients often have no such previous experience or they are highly dissociative. With these clients, I take time to educate them about the safe place technique, give them a homework assignment of generating the parameters of a safe place, and making an audio tape (in session) utilizing the parameters they have generated. I choose to make such a relaxation, safe place audiotape so my voice is associated with their relaxation and centering. I have found this helpful after intense abreactive experiences.

A "typical" relaxation safe place tape usually consists of five parts: 1) controlled deep breathing to help trigger the body's own relaxation response; 2) guided imagery (such as a relaxing light) which moves from head to toe through the different body parts. (This allows the patient to focus on his or her body and, along with the deep, slow breathing, allow his or her body to relax; 3) a deepening maneuver

such as counting down from 10 to 1 with each count allowing the patient to relax more and more; 4) the development of the safe place. It is here that I use the patient's own parameters in the construction the safe place (it could be a room, fortress, forest, or whatever the patient views as safe). I have the patients experience their safe place with all their senses--"See the colors that surround you... notice the sounds in the air ... the smells and fragrances around you ... notice the texture of things around you .... the roughness or smoothness of the things around you...At this point, I allow 1 to 2 minutes of silence to be recorded on the audiotape; and 5) Re-entry. Here I begin to bring the patient back to the "here and now, this time, this place...carrying a piece of this relaxation with you" and bring the patient out by counting backwards from 10 to 1.

With a few patients, even a relaxation tape is too threatening. In these cases, I use a modified Jacobson relaxing approach using the alternating tensing and releasing of tension of particular muscle groups (along with controlled breathing) to develop the contrast of tension and relaxation. This is a more concrete, pragmatic way to develop the contrast of tension and relaxation, as well as a way to develop a safe place without triggering unintended splitting of awareness on the part of the patient.

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The "Safe Place" exercise is often difficult or impossible for many, perhaps the vast majority, of the multiply traumatized war veterans with PTSD with whom we work. What we have found is that their anxiety has generalized to the extent that there is no place, real or imaginary, where they feel safe. Nonetheless, we advocate attempting the exercises as it provides insight as to the extent of this generalization. If the client cannot do the safe place exercises, then the need for alternative forms of tension reduction becomes even greater. In particular, techniques not requiring imagery and which are quick to learn with strong physical components appear very useful, such as Progressive Relaxation Training.

On the other hand, our work with recent trauma survivors and their therapists has served to underline the usefulness of the exercise. Particularly when the trauma was a single one, it is often fairly easy for an individual to identify a discrete safe place, either real or imaginary. This approach has the advantage of requiring virtually no training on the part of the client and is, therefore, particularly useful when working in circumstances where repeated contact with the client may not be possible, such as during a mass disaster or critical incident.

David Wilson, Ph.D.
Chair, EMDRIA Board
Private Practice

I think teaching patients the use of a safe place or some other grounding procedure is a sound practice. However, in my own work, I rarely use the imagery of a "safe place." I typically teach relaxation methods and guided imagery, both for the intrinsic value of the processes and as a means for identifying individuals who have a poor tolerance for low arousal states. I also frequently use the eye movements themselves as a relaxation process, mainly to test response to the eye movements, and as a self-management skill and self-soothing process. With select patients, I encourage home practice with self-directed eye movements. This may be unorthodox, but: 1) people seem to find it useful, 2) it does not appear to do any harm, and 3) many patients are probably going to experiment with self-directed eye movements anyway. I have found that self-directed eye movements are particularly useful in connection with insomnia. (Remember grandma's home remedy, "Count the sheep...") I keep the directions simple, "Just count each time you come back to the left." I strive always to teach some form of a meditative stance; that is, the cultivation of an "observational attitude" towards one's experience.

In summary, I use relaxation and grounding procedures, employ the eye movements themselves as a relaxation process, and encourage some patients in self-directed home practice.

Ricky Greenwald, Psy.D.
Chair, EMDRIA Special Interest Group on
Children and Adolescents

I see the safe place as a variant of the cognitive interweave in that both are ways that the client accesses inner resources on a non-spontaneous basis. In contrast with the standard protocol, with these interventions, the therapist selects the type of resource, as well as the timing of access. Of course, the safe place is more holistic than a typical cognitive interweave because imagery and sensation are involved in addition to cognition. This holism may be one reason that this type of installation has such impact.

The safe place is but one possibility among the many available holistic interweaves and, in my opinion, is not always the best choice. Rather than the therapist deciding what type of resource would be most helpful, why not ask the client? This can be done, with children or adults, as follows: "If this memory were a bad dream, and you had to go back into that dream, what would you need to be safe?" Depending on the client's response, a variety of holistic installation options are available. (For details, see Greenwald, 1993a, 1993b). ■

Stray Thoughts
The Search For Integration

Francine Shapiro, Ph.D.

Since EMDR is an integrated mode of psychotherapy, there are incorporated principles, protocols, and procedures that are compatible with all the major modalities. It is important to remember that this integration was developed over time in order to strengthen EMDR treatment effects. That development is on-going and every trained clinician has the ability to assist in making the procedures and protocols more robust. The only caveat is to make sure that the treatment effects derived from any alteration or change of existing practices leads to treatment effects that are at least as good, or better than those currently achieved. The best way to determine that is through standardized and behavioral measures that document robust and stable effects over time.

In previous books and articles I have tried to give the reasons for the present elements and procedures so that we all have an understanding of the rationale for the standard practices. This can allow us to customize the treatment to best fit the needs of each individual client. In the textbook (Shapiro, 1995) I also tried to show how different modalities are integrated in EMDR and how various procedural elements came to be used. This textbook establishes the standards of practice of EMDR, but it was not written in order to stifle further exploration and evolution of the method. To assist in the theoretical and procedural development, I would ask that each clinician honor his or her own background and strengths. In a book to be published in the latter half of next year, experts of various modalities will be answering the following questions. I ask all of you to think about those questions and share your procedural developments and suggestions in future *Newsletters* and conference presentations:

What elements of EMDR are representations of traditional thought? How does EMDR allow individuals practicing various modalities to "use what they know?" How does EMDR complement or extend the outcomes of previous work? What suggestions do you have for strengthening the EMDR protocols: e.g., by exploring new avenues that might be successful as predicted by the principles inherent in traditional models, or incorporating aspects of the various modalities that are not presently included? How can EMDR be used as a resource to investigate open questions or interesting areas in their modality of origin?

For instance, I believe that models such as simple deconditioning or exposure/habituation are inadequate to exploit the full EMDR applications. There are clear differences between simple desensitization and total reprocessing which led to the formulation of the three-pronged protocol. A desensitization model could not predict the ability of using EMDR to learn new skills and behaviors. On the other hand, the incorporation and integration of basic behavioral learning principles was necessary to develop a focused treatment. In clinical practice, every model describes the boundaries of application, and the one that can best honor and incorporate the widest range of positive treatment effects would be my first choice. How do you view EMDR? How do you describe its effects to colleagues trained in various modalities?

One idea that has continued to intrigue me over the past year is how the wealth of knowledge in the psychodynamic tradition that conceptualizes object relations can be better incorporated into the EMDR treatment protocols. Specifically, what transference experiences can best be used to incorporate positive templates that will allow a client with a severe trauma background to learn to bond, to trust, to maintain object constancy? What learning did not take place during the client's childhood? What developmental windows need to be reopened and what is the specific nature of the learning that needs to take place? What client/clinician interactions can best be structured to that purpose? Once the positive experiences have been achieved, when and how can they best be elicited to serve as a template for future actions? How can they be used as a springboard to real-world, positive relationships? I hope that psychodynamic therapists will begin to take these questions seriously. While an intuitive, skilled therapist may be accomplishing these goals over time, a more rigorous understanding of the needed steps would assist in speeding the treatment. Further, a clearer understanding of the process, and ways to incorporate the needed elements will ensure that a more thorough, comprehensive treatment is available to a greater number of clients.

Also intriguing is how various modalities can be integrated theoretically. A case in point is the narrative/constructivist modality which has received a great deal of attention in recent years. The following is an excerpt from a forthcoming article (Shapiro, in press) which explores EMDR from a constructivist vantage point. It struck me that in modern terms, perhaps Frankl could be viewed as a seminal constructivist. In addition to his important and I believe indisputable point regarding the need for greater meaning and purpose in life; in EMDR terms, I feel he described another truly important treatment goal:

In his seminal work, *Man's Search for Meaning* (1959/1984), a pivotal thought expressed by Victor Frankl is that one is free to choose one's attitude to any event. That ability to construct meaning and interpret reality in a

flexible manner may truly be one of the best ways to help define the mental health of any individual. However, when an individual is locked into a particular interpretation of reality, the source of the problem may be found in an interaction of the present situation with previously stored experiences that have a direct physiological effect. That is, preconstructed and rigid shema appear to be manifestations of unprocessed information in which negative affect dominates (see Shapiro, 1995). In essence, the individual reacts dysfunctionally to current situations because of automatic, physiologically-based responses defined by past events. The primary goal of Eye Movement Desensitization and Reprocessing (EMDR) therapy is to release the individual from the dysfunctional ties of the past, so that adaptive responses can be made in the present.

The application of EMDR to critical incidents and post-traumatic stress disorder (PTSD) is predicated on the conceptual framework that the victim may be unable to appropriately interpret and interact socially because, on a primary perceptual level, "the past is present" (see Levin, Shapiro, & Weakland, 1996)...

...The third phase of EMDR treatment is Assessment, during which the clinician identifies the components of the target. Once a particular event is identified, the client selects the image that best represents it. Then he or she chooses a negative cognition that expresses a dysfunctional, maladaptive, self-assessment related to his or her participation in the event. Negative cognitions are considered verbalizations of the disturbing affect and include statements such as "I am useless," "I am worthless," "I am unlovable/ dirty/bad," etc. The client then identifies a positive cognition that will be used as a replacement for the negative cognition during the installation phase of processing (Phase Five). When possible, this cognition should incorporate an internal locus of control, such as "I am worthwhile/ lovable/ a good person/in control" or "I can succeed." Then the client assesses the validity of the positive cognition using the 1-to-7 Validity of Cognition (VOC) scale (Shapiro, 1989), where 1 signifies "completely false" and 7 signifies "completely true." Typically, the client does not assess the positive cognition to be true at more than a "4" level of validity. Although the he or she may understand intellectually that the statement is true, the negative affect predominating the stored information relegates the statement to a merely cognitive construct. The goal of the EMDR therapy is to make the statement affectively valid. However, it is important to remember that the cognition is viewed as a manifestation of therapeutic effect, not the cause of change. In narrative constructivist terms, however, the use of the cognitions might be considered the identification and succinct verbalization of the beginning and desired "story." Once the information-processing system is activated, however, the client spontaneously creates a narrative which leads to the desired perspective. In fact, in most instances, the client surpasses the initially designated desired construction as the information evolves to an even more self-enhancing form. Therefore, the client is not confined to the limitations of previous perceptions, nor to the perceptions or subjective constructions of the clinician...

...The existence of the somatic responses in the previously dysfunctional stored traumata is proposed as the primary reason for the non-adaptive feedback loop which keeps the victim yoked to self-limiting constructs and cognitions. Specifically, when a previously stored memory is associatively stimulated by a present situation, the person experiences the somatic responses which are part of the insufficiently processed information. Consequently, when an affective state such as fear is triggered, there is a current perception of danger, whether or not the situation "objectively" warrants it. The triggering of internal response not only influences the current construction, but reinforces the earlier response, since the cognitive state (e.g., perception of danger), in turn, elicits the autonomic response which become associatively paired with the presenting stimuli. Until the earlier events are sufficiently processed and no longer elicit distressing affect on a sensory level, they will impede present functioning on a cognitive and behavioral level.

Breaking the Chains

As I have mentioned in previous *Newsletters*, one of the most exciting possibilities of recent years is the potential to use EMDR to break the cycle of violence. The following is a section from the new book (Shapiro & Forrest, 1997) to illustrate that point:

EMDR may also show us that one way of stopping tragedy is to target the trauma that underlies potential violence before it breaks to the surface. Of course, perpetrators must be held responsible for their actions, but it seems eminently better to fix the problem than merely to fix blame. Such a stance was taken by Reverend David Price, an EMDR therapist at Bowden Institution, Canada's largest federal prison. He has reported that the majority of the prison's population are sex offenders and that the most difficult are the pedophiles, who are often thought to be untreatable. When a small number of pedophiles was to be released in ninety to one hundred days into the community without supervision, he decided to try EMDR with three of these men. They had been active participants in sex offender programming during this as well as previous incarcerations. Each of them had a history of sex offending and a pattern of repeating their crimes, on average, three to six weeks

after being released. Reverend Price chose to work with these particular men because all three had taken responsibility for their crimes and had a spiritual relationship to a "higher power." It was important for the EMDR work that all had identified their "crime cycle," a process that involves mapping the events that trigger the heightened emotions and the thoughts and behaviors that progressively build and culminate in the criminal behavior.

One of the three, Sam, processed the traumatic memories associated with his nine triggers. As Reverend Price put it, "A major breakthrough occurred in Session 4. Sam recollected a repressed memory of rage. His sister, eight years his senior, would threaten and actually destroy his favorite toys if he did not perform sexual acts with her. Only nine years old, Sam had buried his rage, shame, and confusion over his sister's behavior for years. Sam participated in fourteen EMDR sessions over a two-month period and, like the other subjects, was followed after his release. Sam reported that his old thought patterns were gone and that even though he was harshly treated by his peers, he felt a sense of strength, peace, and control.

"I have maintained a biweekly telephone follow-up with Sam," Reverend Price reports. "He has experienced rejection, abandonment, shaming, as well as ridicule and denial of employment. In his untreated past, any one of these events would have caused him to isolate and progress to his offending cycle. To his delight, none of these emotional and behavioral patterns has emerged. Instead, Sam has established a positive support group, utilizing self-management skills he has learned. He keeps working at finding employment and made voluntary connections with the police. He is even working with the police to help set up prevention programs for parents and children. He reports no rage at society or self-loathing. He is gradually developing an appropriate relationship with an adult of his own age. He has been in free society for nine months, crime-free. The other two men report similar results."

A large scale study is now being planned to further investigate the use of EMDR with this population. Any of you who have had similar cases or experiences please contact MaryAnn Gutoff at the EMDR HAP office. We are collecting a data base of those who are working with perpetrators in order to share details, protocols, and resources. We are also trying to obtain funding to inaugurate inner city pilot projects to work with victims of violence. If you have any interest, or resources please contact:

EMDR HAP
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The dissemination of EMDR has always been a grass roots effort. There are now approximately 22,000 clinicians trained and over one million clients who have been treated. However, the level of suffering worldwide still demands our dedication and commitment. It has been 10 years since EMDR's inception, but the work has just begun.

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A Brief Report on Integrating Focusing Oriented Psychotherapy and EMDR

Mary Armstrong, MSW, CSW

This presentation was given at the 9th International Focusing Conference held near Pforzheim in Germany. Focusing Oriented psychotherapists were introduced to the role EMDR could play as part of their experiential therapy. Participants were urge to become trained in EMDR as it provides a powerful "jump start" to the work we do with trauma and phobias through Focusing.

Compatibility was stressed. EMDR, like Focusing Oriented Psychotherapy, is client-centered. The process of working with EMDR does not contaminate the client's process, views the client as having the solutions, and respects the client's right to be a full partner in the therapy.

VanderKolk's work on trauma was presented to give further understanding of why it is important for the therapist to integrate EMDR into Focusing Oriented Psychotherapy. Case examples of survivors of childhood trauma illustrated the integration of Shapiro's EMDR with Gendlin's Focusing Oriented Psychotherapy. ■

INTERNATIONAL UPDATE

Francine Shapiro, Ph.D.

After a recent inquirer suggested that EMDR was akin to Mesmerism and asked if I saw the parallels, I responded with the following:

"As it was related to me by someone who had studied it, the actual history of Mesmer's "banishment" made for an interesting story. The committee that was supposed to include Franklin wouldn't come into the house to investigate what he was doing because the weather in Paris was too stifling at the time. So they stood at the open door and looked inside for a few minutes and then went off and made their report. Franklin was laid up with the gout in the country and didn't even make it into town that day. Certainly I see some parallels there."

Unfortunately, a high level of misinformation abounds regarding EMDR which continues to be recycled. The following is a quotation from book published in 1996 entitled *Crazy Therapies* by M.T. Singer and J. Lalich. They were making the point that EMDR is being offered as a panacea:

"According to Shapiro's book and related literature, EMDR could be used for pain control, grief, delusions, ritual abuse, phobias, generalized anxiety, paranoid schizophrenia, learning disabilities, eating disorders, substance abuse, pathological jealousy, rage, guilt, multiple personality disorder, cancer, AIDS, somatic disorders, couples therapy, and for children as young as two" (p. 187).

I have no idea what "literature" they are talking about, but they have given voice to a prevalent belief that EMDR is being used as a "stand alone technique" for a variety of disorders. Unfortunately, those "standing in the doorway" are not aware that EMDR is integrated into the traditional therapies that apply to any given specialty population. It is important that clinicians, especially those writing on email discussion lists and those making presentations, set the record straight. EMDR can augment the treatment of complaints that are based on disturbing life experiences. It is not a magic bullet. It must be integrated within a comprehensive treatment plan. For instance, where systematic desensitization or flooding were previously used, EMDR can be substituted instead. However, it should only be used by a clinician who is experienced with the target population. For instance, integrating the use of EMDR into the treatment of a client with substance abuse demands the integration of standard treatments, stabilizations, support systems, and all the wisdom that a specialist in substance abuse has to muster.

Some of the prevalent misconceptions seem to be based upon recycled misinformation, and flawed analyses of the controlled literature (e.g., Lohr et al., 1996 and Tolin et al., 1996). In the last *EMDRIA Newsletter* I gave extensive examples of such errors. However, due to the usual publications delays, my published article (Shapiro, 1996) did not appear in print until at least eight months after the initial reviews. Errors have a tendency to propagate, and now there are at least two new literature reviews that reference the flawed reviews. Adding to the misinformation regarding the method is the publication of research that does not follow acceptable standards. The most recent example is a study of the treatment of phobias published in *the Journal of Anxiety Disorders* (Bates et al., 1996). A researcher who had received no training in EMDR appointed himself "knowledgeable" enough to train someone else and do a fidelity check. None of the EMDR phobia protocols were used in the study. Nevertheless, the null results were attributed to EMDR and it was declared to be useless for phobias.

Many clinicians whose experiences of EMDR are confined to experiences in private practice and networking with other EMDR therapists, are not aware of the need to actively disseminate accurate information regarding the method. There is a tremendous amount of resistance that needs to be overcome. When research such as the one I just described is published, it increases the difficulty of getting managed care companies to reimburse for the method. The people best suited to do clinical work appropriately are clinicians. I hope that those of you with clinical practices will consider documenting your cases, and networking at the conference or on the EMDR email group with those that can help you publish your cases. At this point, not one of the published phobia studies has used the EMDR protocols as described in the trainings and in my textbook which was published over two years ago. Single cases and case series on any of the protocols aside from PTSD are publishable--and needed in the literature. There are simple self-report questionnaires and behavioral measures that can be used to define treatment effects. How do you define them in your office?

Unless practicing clinicians become more vocal and engaged in meaningful tests of therapeutic methods, clients will ultimately suffer because they will be denied the treatments that can help them. Please become actively involved in the publication, presentation, and dissemination of accurate information. As EMDR gets closer to full acceptance, the attacks from certain quarters are becoming more defuse, virulent, and unfounded. If you need accurate information or research review publications, call the EMDR Institute office. If you need help with insurance companies, call the EMDRIA office. If you need help to organize a publishable case series for phobias, or any of the

other protocols, please make your need known. At the EMDR annual conference, Allen Rubin, Ph.D., is presenting on "The fundamentals of single-case evaluation for use by EMDR practitioners." Please attend. We all need your help. Let EMDRIA know how you can best be supported in getting the correct information out where it can do the most good.

On the brighter side, I have been asked to participate in the APA Psychotherapy Videotape Series II which focuses on psychotherapies for specific disorders and populations. EMDR for PTSD will be the content of a simulated client/clinician interchange. The tape is expected to be released some time in the fall. In addition, while I have had to curtail my travelling schedule because of health reasons, the following presentations are scheduled for 1997:

- Harvard Trauma Conference--Invited plenary
- 14th International Congress of Hypnosis--Invited address
- American Psychological Association--Invited workshop and address
- Torture and Trauma Survivors 5th Anniversary Conference (Stockholm)--Keynote address
- 9th International Conference --National Institute for the Clinical Application of Behavior Medicine -- Keynote

I will also be conducting a number of university seminars in Columbia in coordination with the non-profit organization "Forjar." We are investigating whether EMDR can be incorporated into a variety of social programs to assist in stopping the cycle of violence. Dan Merlis and Deany Laliotis also gave an excellent and well-received presentation at the Family Therapy Networker Conference. Wendy Freitag made presentations on a number of TV and radio talk shows in Milwaukee. Numerous people then called for referrals. Please make sure that your contribution becomes known. Many of your local organizations are in need of informative speakers. This helps disseminate word about EMDR, and your availability as a clinician.

I hope to see you at the EMDRIA annual conference in San Francisco. The program looks wonderful and past participants have described it as a high spot of their professional year. There will also be an awards banquet with proceeds going to the EMDR Humanitarian Assistance Programs. Last year we all left feeling energized and inspired.

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EMDR Research and Debate

Jennifer Braithwaite, Consulting Psychologist; Sydney, Australia

In recent months there have been two articles published in the Australian psychology media concerning EMDR—one by David Kavanagh appearing in *The APS Bulletin* (August, 1996) entitled "EMDR - Pseudoscientific Fad or Unique and Significant Advance?" and the other by Grant Deville in *Psychotherapy in Australia* (1996) entitled "EMDR and PTSD, The Score at Half Time." Both articles included a review of research on EMDR. Both concluded on the basis of the research that EMDR remains unproved as an advance on current techniques. However, editors vanderKolk, McFarlane, and Weisaeth (1996) in a book on Traumatic Stress include a more positive review of EMDR research and also point out some advantages of using EMDR.

They say, and I quote:

> In recent years several unusual and novel techniques have been proposed to assist in the integration of traumatic memories, including EMDR...After an initial flurry of single-case reports and open studies, a number of systematic studies of EMDR have been conducted in recent years. Positive results have been found in at least four controlled studies (Shapiro, 1989; Wilson, Covi, Foster, & Silver, 1993; Wilson, Tinker, & Becker, in press; Vaughan, Weise, Gold, & Turner, 1994), equivocal results in two studies (Boudewyns, Stwertka, Hyer, Albrecht, & Speer, 1993; Pitman et al., 1996a), and negative outcomes in two studies (Jensen, 1994; Sanderson & Carpenter, 1992).

The equivocal and negative studies were conducted on very chronic populations; such patients have also proven resistant to pharmacological (e.g., vanderKolk et al., 1994) and cognitive-behavioral (Pitman et al., 1996b) interventions. In the EMDR studies with positive treatment outcomes, beneficial effects have particularly been demonstrated in the frequency and intensity of intrusive recollections, such as nightmares and flashbacks (e.g., Vaughan et al., 1994; Shapiro, 1995; Wilson et al., in press).

In a recent open treatment outcome comparison of novel techniques at Florida State University's Psychosocial Stress Research Program (Figley & Carbonell, 1995), EMDR was but one of several novel techniques that showed promise in helping people reduce the frequency and intensity of intrusive traumatic recollections. What is interesting about all these techniques is the patients are not required to spell out the entirety of their traumatic experiences in words in order to achieve a reduction in their PTSD scores...

The originators of these methods claim that the principal active ingredient in these new therapies involves enabling patients to experience their memories in a way that distances them from their original experiences. By doing so, the clients can view the experience from at least one additional vantage point, and as a result can change their current perspective and begin to make peace with the past (Figley, 1996).

The rationales provided for these treatments at this point tend to be largely untested post hoc hypotheses constructed to justify the methods. Figley (personal communication, 1996) argues that there are particular benefits because these novel treatments provide patients with a treatment setting where they have more control over the pace and process of treatment and do not have to verbalise the totality of their pain (pp. 548-549).

In the weekly round of treatment sessions where clients struggle to deal with the anguish of traumatic stress, EMDR continues to provide both my clients and me with an intervention which almost always manages to both surprise and empower us. It also seems, at times, quite remote from the dry science of academia. Yet, research and debate are essential if we are to move towards a better understanding and treatment of traumatic stress. EMDR is an innovative treatment technique and for better or for worse, it too must be subject to scrutiny by both clinicians and researchers. Robust outcome studies, as well as research on the physiological processes involved in EMDR, are essential in order to get a clear picture of what is happening. Until then, we can only continue to use EMDR with care along with our good clinical skills and last, but not least, a measure of gratefulness.

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THE EMDRIA REGISTER

Curtis C. Rouanzion, Ph.D.
President-Elect of EMDRIA

EMDRIA is ready to begin publishing a REGISTER of EMDR-trained clinicians. The Register is different from our Membership Directory which will include all members (Life, Charter, Full, and Associate) who have met the criteria for membership in EMDRIA. The Register's requirements for inclusion are different. Members and Non-members of EMDRIA will be listed as long as they meet the criteria. The following outlines the purpose of the Register and the criteria for listing.

The purpose of the EMDRIA REGISTER is to benefit the general public by providing a convenient place to locate a centralized list of EMDR therapists who voluntarily applied and met the criteria for listing in the Register where these criteria are recognized as promoting the integrity of EMDR. In furtherance of this purpose, the EMDRIA Register will be made available to the general public through widespread publication. For example, if feasible, the EMDRIA REGISTER will be made available on the Internet.

Therapists listed in the Register recognize and accept that EMDR is a method of psychotherapy. Consequently, treatment with EMDR should be undertaken only by individuals licensed or certified to practice psychotherapy and who have completed formal training in the clinical use of EMDR. Therapists listed in the Register agree to use EMDR according to whatever independent organization's Standards of Practice govern the performance of psychotherapy in their respective disciplines, e.g., American Psychological Association, American Psychiatric Association, National Association of Social Workers, American Association for Marriage and Family Therapy, etc.).

CRITERIA FOR LISTING

Therapists listed in the Register must meet the following criteria:

1. A current license or certification as a mental health professional allowing for the independent practice of his/her mental health profession.
2. Successful completion of an EMDRIA-Approved training program in the practice of EMDR administered by an independent organization.
3. An affidavit declaring that the therapist has conducted at least 50 EMDR sessions with at least 25 clients and has participated in peer and/or other supervision with at least 10 cases of their own or others.
4. Completing a total of 12 hours of EMDRIA-Approved continuing education units in EMDR, administered by EMDRIA or other EMDRIA-Approved Organizations every two years. NOTE: This requirement will not be in effect until 1999; only 6 hours CE will be required for listing in 1998, 12 hours in 1999 and thereafter. (EMDRIA will offer approved CE units at the Annual Conference and other EMDRIA-Approved courses will be accepted.)

EMDRIA does not engage in testing and certification of EMDR therapists nor does EMDRIA provide any referral service or ethics review. EMDRIA does not make guarantees of any kind regarding the competence and proficiency in EMDR of therapists listed in the EMDRIA REGISTER. The EMDRIA REGISTER merely indicates that each listed therapist sought to be listed and voluntarily provided evidence of meeting the criteria for inclusion in the Register.

APPLICATION FOR LISTING IN THE EMDRIA REGISTER

Listing in the EMDRIA REGISTER is available to anyone who meets the criteria for listing which includes:

1. A photocopy of your license or certification as a mental health professional (psychologist, psychiatrist, LCSW, MFCC, or equivalent) and proof of successful completion of an EMDRIA-Approved training course administered by an independent organization.

And

2. An affidavit declaring that the therapist has conducted at least 50 EMDR sessions with at least 25 clients and has participated in peer and/or other supervision with at least 10 cases of their own or others.
3. Complete at least 6 units of EMDRIA-Approved continuing education units in EMDR, administered by EMDRIA or other EMDRIA-Approved Organizations, by 1998; 12 hours by 1999; and 12 hours thereafter for two years. (EMDRIA will offer approved CE units at the Annual Conference and other EMDRIA-Approved courses will be accepted.)

The EMDRIA Board of Directors reserves the right to amend or modify eligibility criteria affecting current of future members in the EMDRIA REGISTER.

FEES FOR LISTING

Fees for listing in the EMDRIA REGISTER are as follows:

1. FREE for Charter and Life Members of EMDRIA
2. FREE for International Members
3. FREE for current full members of EMDRIA prior to the end of the July 1997 Conference. The cost will then be $50 thereafter.
4. $75 for non-members of EMDRIA who elect to submit a concurrent application for full membership in EMDRIA.
5. $100 for non-members of EMDRIA who meet the criteria.

EMDRIA projects an Annual Renewal Fee of $10 for members of EMDRIA and $25 for non-members.

PROCEDURES FOR REMOVAL FROM LISTING IN THE EMDRIA REGISTER

EMDRIA reserves the right to remove any therapist from listing when it has been determined by an independent ethics board or licensing/certification agency that a listed therapist no longer meets licensing/certification requirements, has engaged in professional misconduct, or has committed a serious crime.

The Membership Directory lists individuals who have minimal training in EMDR and are involved in ongoing interests about EMDR. The Register will list independently licensed/certified mental health professionals who have utilized EMDR in their clinical practice, have pursued ongoing supervision/consultation, and continue to use it in the highest ethical and professional manner. It is the Register that the public may use to find an EMDR-trained therapist in their area. EMDRIA plans on making the Register available on the Internet, as well as in hard-bound copies for therapists.

I encourage all of you who meet the criteria to consider applying for inclusion in EMDRIA's REGISTER as soon as possible. Take advantage of the low cost now.

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Degree Highest degree (M.A., Ph.D., M.D., etc.) _____

Institution where received: _____ (Date)

License/ Certification License or Certification to practice independently _____ (Mental Health Profession)

_____ (ID Number)

State or Country Issued: _____ (State) _____ (Country)

Please send a copy of your license/certification ☐ (Check Box)

EMDRIA Approved Training Please send a copy of your certificate of completion (certificate must list total hours and be signed by Instructor) ☐ (Check Box)

Other EMDR Training (e.g., Teacher/Trainer/Facilitator for EMDRIA-Approved EMDR Instruction) _____

_____

_____

Continued on back

Other Board Certifications

(e.g., ABPP, AAMFT Approved Supervisor, ACSW, etc.) _____

_____

_____

_____

List Specialties

(e.g., PTSD, DD, Sexual Abuse, etc.) _____

_____

_____

_____

Affidavit

I declare that I have conducted at least 50 EMDR sessions with at least 25 clients and have participated in peer and/or other supervision/consultation with at least 10 cases of my own or others.

_____ _____

Signature Date

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EMDRIA Newsletter Submission Information

The following are guidelines/policies for submitting articles to the *EMDRIA Newsletter*

- **ALL ARTICLES MUST BE IN APA STYLE AND FORMAT.**

- **ALL ARTICLES MUST BE SUBMITTED ON A DISK WITH A HARD COPY INCLUDED. THE DISK MUST BE COMPATIBLE WITH IBM AND MICROSOFT WORD.**

- As author, it is your responsibility to ensure that all aspects of your paper are correct and in accordance with APA style, e.g., spelling and punctuation are correct; quotations are accurate and include the page numbers, author, and year; the paper is well organized; the list of references is complete and in proper order; the paper is proofread with all corrections, revisions, changes, and being made before submission to the *Newsletter.*

- Refer to the *Publication Manual of the American Psychological Association, 4th Edition,* for specifics.

- Submit only the final draft--once the article is received, revisions to it will not be accepted unless the editor has requested them or you have a prior, agreed upon arrangement with the editor.

- All articles are subject to editorial revision.

- The editor cannot guarantee when, or if, any article will be published.

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