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Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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STRAY THOUGHTS
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Frozen Childhood

Clinical observations of **EMDR** treatment sessions indicate that therapeutic results are often achieved through the progressive emergence of an adult perspective, particularly when the client was previously locked into the emotional responses of a childhood-based trauma. Clearly, most childhood experiences are infused with a sense of powerlessness, lack of choice, lack of control, and inadequacy. Even the best of childhoods have moments when the parents attempt to leave for the evening and the child feels abandoned, powerless, and uncared for. Indeed, an entire generation of children was raised by a book that dictated feeding hours and parents were encouraged to avoid reinforcing the child's crying for food at other times. Consequently, thousands of children were left crying in the dark for food. Regardless of the fact that language was not yet encoded, arguably, this situation set up certain emotional nodes regarding "Self," "Suffering," and "Others." The **EMDR** model posits that the wide variety of childhood experiences are neurological touchstones for many dysfunctions.

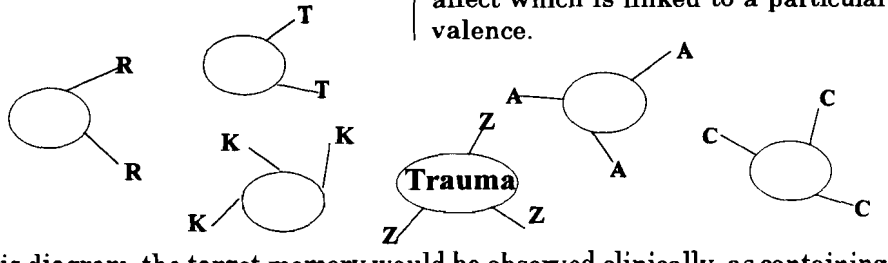
The language of the client often reveals these expressions of the childhood state: powerlessness, lack of choice, fear, inadequacy, etc. The fifty year-old client who speaks long-distance to her mother and starts reacting with fear, frustration and anxiety, is not reacting to a 75 year-old invalid on the telephone in present time. Rather, the emotions of childhood are stimulated by the sparking of the neural network associated with mother. Earlier touchstone memories that include intense feelings of fear and lack of safety are being triggered. Essentially the client cannot emerge into a state of calm in reaction to the mother until the earlier memories are metabolized and take their place in the past.

By catalyzing the information processing system through **EMDR**, it appears as though the guilt and fear of the child perspective are able to be progressively transmuted to the adult perspective of appropriate responsibility, safety, and the ability to make choices. What was perfectly true because of physical, "real-world" parameters in childhood, or during a rape or combat tour (e.g., lack of control), is no longer valid as an adult in the present moment.

The parallel of childhood experience to the experience of the trauma victim deserves to be underscored. In both there are the feelings of self-blame and inadequacy, plus feelings of lack of control, safety, or choices. Adequate information reprocessing allows the material to progress to client recognition of appropriate present parameters on an emotional, as well as a cognitive level. Allowing clients to evolve progressively to a state of self-forgiveness, safety, and a sense of control in present time appears to be the hallmark of a vast number of **EMDR** sessions.

BIO-ELECTRICAL VALENCE

Since it appears that the adult perspective is able to emerge progressively, it may be useful to metaphorically envision the progressive linkage of neural networks through a shift in synaptic or receptor valence. While we are again exploring a <u>hypothetical</u> model, the idea that information is at least partially organized through affect is not new. The diagram below indicates the extrapolation that neural networks are organized in part by affect which is linked to a particular valence.



In this diagram, the target memory would be observed clinically, as containing the affect of intense self-blame and the associated cognition of "I'm detestable

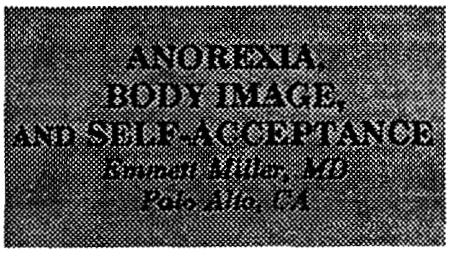
and worthless." The information stored regarding this memory is encapsulated in a neural network with a high valence. While "Z" valence could be hypothesized as containing information with the most self-destructive affect and self-assessment, "A" valence would be the most adaptive and appropriate assessment (e.g., "I am a lovable, worthy, life-enhancing being.") "Z" through "A" would constitute the valences of the receptors of the variety of information plateaus and levels of adaptive information stored separately in respective neural networks. Consequently, the high valence target network is unable to link into more adaptive information stored in other networks with a lower valence (e.g., various levels of counter-examples, compliments, self-help book information, etc.).

Possibly, when the processing system is catalyzed by **EMDR**, the valence of the receptors is shifted downward, so they are progressively able to link to the other networks and incorporate the more adaptive information (e.g., "T" valence—"I'm not always to blame." "K" valence—"I did well that time"). This is evident by the progressive discharge of the negative affect, and the evolving of the more adaptive cognitions and positive memories which emerge.

The clinical implications of the affect/valence hypothesis can be observed in a variety of areas. For instance, molestation victims often report horrific nightmares in which they are being dismembered by monsters. If we suppose that it is the earlier molestation memories that are attempting to be processed in REM sleep, then being "dismembered by monsters" is the cognitive parallel to the high level of affect locked in the earlier memories. In other words, a child would experience great terror at an adult entering the room and pulling her legs open; however, as an adult, that level of terror would not be generated by another adult, but rather by an uncontrollable monster. The symbolism is the "cognitive rationalization" of the affect state during the period of processing.

Consequently, when **EMDR** is used to target the dream image, a high level of terror is induced ("Z" valence). As a sufficient amount of the information has been processed, the affect shifts downward. The lowered valence allows the appropriate cognitive connections to be made through the linkage of alternative neural networks. With this shift in affect, the symbolic representation (i.e., cognitive distortion) can be removed, and the client perceives the real-life players. For instance, the abuse victim who reported being chased by a monster through a cave, after a number of SEM (sets of eye movements) exclaimed, "That's my stepfather (who molested me) chasing me through my childhood home." Other symbolic representations are often found to be the cognitive rationalization of the affect state and physical sensations (e.g., earlier memories of satanic abuse may often resolve to recognition of abuse by an uncle). The interpretations may be due to the activation of the congruent cognitive network of parallel valence.

Another possible extrapolation of the affect/valence hypothesis is the escalation of self-abuse behavior observed in many clients (e.g., increased severe cutting, engaging in riskier sex encounters). It is possible that the affect of the core memories, with the conjoint valence, connects with certain behaviors that are consistent with that client's subjective level of pain. As the behaviors become desensitized through repeated exposures, the valence of the core memories stimulates other behaviors that had been higher on the disturbance hierarchy (i.e., just as SUDs levels drop throughout the hierarchy during reciprocal inhibition), but are now merely parallel to that level of affect. Therefore, what appears to be a level of escalation from an external observer is behavior generated internally from the same level of affect. Ultimately, the goal of **EMDR** is to target the dysfunction, whether through the initial memories, dream symbolism, or present reactions in order to reprocess the material to an adaptive resolution. At that point, the affect and cognitions are appropriate to an empowered adult perspective in present time.



From the ages of 6 to 13, Melody, who was a gymnast, practiced 6 to 8 hours per day and was thin, lean, and wiry. She cut back on her athletics to focus on schoolwork, but by her senior year in high school had begun a dietary regimen to try to regain her 13 year-old body. This was a goal that seemed healthy in her mind, had been promoted as healthy by her exercise-addicted family, and was the image she saw paid homage to in the media.

Having little more than a couple of glasses of orange juice per day on many days, her weight went down to her goal of 100 and beyond to the dangerous 80 to 90 pound range. Her menstrual periods stopped and she felt nervous and frightened all of the time. After several years she decided, with the help of a nutritional therapist, that "it was not worth it" and after a couple of months on a health diet, had reached a more reasonable weight of 120 pounds. She felt good, but when she mounted her scale and saw the number 120, she was overcome with panic. Images of herself blowing up into a butterball (as she had become subsequent to a rather sedentary, several month study trip to South America a number of years ago) flooded her mind.

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When I saw her, she was in great conflict. Everyone she respected gave her positive feedback on her looks, including her boyfriend; however, inside she felt "fat" and could not stop thinking with disgust about the soft roundness of her breasts, hips, and thighs. As a result, the fear grew greater each time she placed a fork of health food into her mouth. She felt despair each time she found herself longing for her anorexic body.

Working with the **EMDR** method, it was determined that her SUDS level was 7 or 8 when she thought about her body. The statement, "My body should be weighing 100 pounds or less," was given a VoC of 3 out of 7, and the statement, "My body's just fine the way it is," was given a VoC of 4.

Rapport was easy to establish with this sincere, intelligent, attractive young woman in her early 20s, and **EMDR** was initiated. After the first set, her SUDS level went down to 5, after the second it was down to 3, and after the third, it had essentially reached 0 and a look of amazement appeared on her face. After one more set, the VoC of, "My body is fine just the way it is" was given a rating of 7.

At this point (after 10 minutes of the **EMDR** procedure), it was clear that she had a very positive inner image of herself which was rich with sensory details and I switched to a Selective Awareness mode, inducing a deep state of relaxation directly from her receptive state of bewildered amazement. Her body image was intensified through imagery and she was encouraged to visualize and experience herself in this body while carrying out her normal activities at work and with friends. An audio cassette was made of this experience for her to use for practice.

At the end of the session, she described how at the beginning, the image of a healthy body seemed far away (she pointed across the room) and felt frightening. With each successive set, she found the image moved closer to her and when the SUDS reached 0, she became one with it.

INTERNATIONAL UPDATE

Francine Shapiro, Ph.D.
Mental Research Institute
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The International Society for Traumatic Stress Studies (ISTSS) 1992 Annual Conference hosted five **EMDR** presentations. In addition to the three panels I mentioned in the last Newsletter, two independent submissions were accepted: **Sandra Paulsen, Ph.D.**, Pacific Institute of Behavioral Medicine, HI, gave a report on cross-cultural effects of **EMDR**, and **Pat Boudewyns, Ph.D.**, VA Medical Center (VAMC) Augusta, GA, reported on the results of a study on chronic in-patient veterans. In addition, **Howard Lipke, Ph.D.**, VAMC North Chicago, presented the results of his study on one-session desensitization effects and the correlations to perpetrator involvement in the veteran population. He was part of a panel on PTSD. The results of his study will be published in the next Newsletter.

Dr. Lipke has also sent out a survey to all **EMDR** practitioners trained prior to February, 1992. This work is being done under the auspices of the Veterans Administration. If you have not yet sent back your survey, please do so. The results will be invaluable as a means to obtain an independent and adequate assessment of **EMDR** effects and possible contraindications.

In the last Newsletter I erred by stating that the funding for extensive **EMDR** research at the VAMC in Augusta, GA, was NIMH funded. In fact, it is VA funded. To date, we have trained VAMC staffs in Pennsylvania, Illinois, Arizona, Massachusetts, North Carolina, and Georgia, and have attracted individual VA personnel from all over the country.

The presentation at the International Society for Traumatic Stress Studies

by the panel of four VAMC PTSD unit directors, whose staff are using **EMDR** as a treatment of choice will, I believe, encourage many others in the VA system to be trained. At this point, many veterans who have failed to find relief within previous program offerings are being successfully treated with **EMDR**. **Steven Silver, Ph.D.**, Director of the inpatient PTSD unit in Coatesville, PA, has been working with veterans since 1972 and received the prestigious 1992 national **VA Service Director's Award in Mental Health and Behavioral Science.** He stated, as a member of the ISTSS panel, that denying **EMDR** treatment, at this point, is "verging on unethical" considering the clinical reports, and the suicide rate of the veteran population.

What also clearly emerged from the ISTSS Conference was the need for controlled research. While clinical reports abound, and by all means should continue, they are not taken seriously by many academics and a significant portion of the mental health population. The controlled studies are going to be vital to give **EMDR** the credibility it needs to enter the university systems. So far the only controlled study on a pathological population has been the Boudewyn study at the Augusta, GA VAMC. As previously noted, while self-report measures from client and therapist showed positive results, there were not significant changes in physiological measures and standard psychometrics. The interpretations for the lack of changes include problems engendered by the use of a taped combat scene to assess response. While the effects of an **EMDR** session are a change in cognitive perspective regarding the memory, the tape recording provided the initial interpretation, and the physiological measures of the subject's responses to it could not distinguish between fear and anger. Additionally, the psychometrics were not geared to check responses to single event reprocessing in multi-event veterans. While the treatment results were positive enough to gain further funding, other studies on a variety of populations are necessary. The chronic in-patient veteran population is the hardest to show consistent treatment results due to a variety of secondary gain and compensation factors. If any of you are in practice with clinicians who do not use **EMDR**, particularly in agencies or centers, we could certainly use your help in formulating and implementing some clinical studies under controlled conditions. Please contact us if this is at all feasible.

As you may know from a previous mailing, the Association for the Advancement of Behavior Therapy (AABT) 1992 Conference will have no official **EMDR** presentations, as politics seems to have prevailed over science. There will be six hours of Special Interest Group presentations which will include: *Research Results on PTSD and Sleep Disorders*, **Neal Daniels, Ph.D.**, Director, PTSD Program, VAMC, Philadelphia, PA; *Research Results on Agoraphobia and Panic Disorders*, **Alan Goldstein, Ph.D.**, Director, Agoraphobia and Anxiety Treatment Center, Dept. of Psychiatry, Temple University, Philadelphia, PA; *Psychometric Treatment Outcomes of a Complex Case*, **Ronald Kleinknecht, Ph.D.**, Chair, Psychology Dept., Western Washington University, Bellingham, WA; *Survey Results of 1,200 EMDR Trained Clinicians*, **Howard Lipke, Ph.D.**, Director, Stress Disorders Treatment Unit, VAMC, North Chicago, IL; and a clinical roundtable by me on "**EMDR** -Integrative Treatment Effects." I have come to view **EMDR** as offering an Integrative Information Processing model; therefore, it may prove that **EMDR** cannot comfortably reside at AABT. I think that would be an error, but politics and antiquated (in my mind) definitions may prevail. It will be a subject of conversation at the November AABT Conference and I will report on the discussions in the next Newsletter.

Many of you have done presentations at regional and local APA meetings. **James Marshall, MA**, and **John Patterson, Ph.D.**, presented on **EMDR** at the Second Annual International Christian Counseling Congress in Atlanta, GA. These personal efforts continue to be a major source of credibility for **EMDR**. Please let us know if there is anything we can do to help you in disseminating information in the appropriate circles. In addition, **Sandra Paulsen, Ph.D.**, has written a description of **EMDR** which will be included in the next edition of the Encyclopedia of Psychology, edited by **Raymond Corsini, Ph.D.**

EMDR seems to be sparking considerable interest in many circles, as I have presented Grand Rounds at Duke University and University of San Francisco at Langley Porter. A number of psychiatrists at Duke University suggested additional information regarding information processing in support of the **EMDR** model. We hope to have the transcript for the next Newsletter.

Worldwide, we now have trained over 3,000 clinicians dispersed through Canada, England, France, Germany, Israel, Australia, El Salvador, Costa Rica, as well as throughout the United States. While some people are attempting to do research without training, with obvious results, most are showing a proper respect for the scientific process. There will, of course, be a number of conflicting reports in the coming years. The reader's first question regarding research might be "Have you been trained?" We already have one report of a study proporting to test **EMDR**, where the researchers "simplified the procedure" from my early article and based their research on observed effects of only a drop in 2 SUDs after seven restricted sets of eye movements. Since they never had an adequate baseline, they considered this an **EMDR** effect. Obviously, while the research is severely wanting, it will be cited once published. We will send it to you at that time. The reason I am mentioning

this study is that I used to believe, as you might, that this kind of research would be unthinkable. I have learned differently, and it is unfortunately uncontrollable. The problem, of course, is that faulty results will inappropriately sway clinicians into withholding **EMDR** from clients.

On the upside, we trained over 400 clinicians during the workshops in Australia, and many of them are planning to do research studies. We will be returning for another round of trainings in January and should have some news of research at that time.

I want to express my gratitude to all the clinicians who worked toward an **EMDR** response to the disasters in Hawaii and Florida. We had tried to put on an **EMDR** training in Florida, but received only four responses from Miami, probably due to the fact that clinicians were more concerned with getting a roof over their own heads at that time. On the basis of that response, and the flu I had been living with since July, I very reluctantly cancelled the workshop. We refunded the money to the Miami participants and invited them as guests to any of the other trainings. We will be keeping an eye on Florida to judge when the time might be ripe to offer another workshop. In the meanwhile, many thanks go to **Ruth Grainger, Ph.D.**, and **Sheryll Thomson, MFCC**, for coordinating relief efforts.

In the coming months I will be working with a number of facilitators, who have used **EMDR** for two years, in order to train them as trainers. They will then be available to give smaller trainings in different parts of the country. In addition, I will be working on an **EMDR** text, hopefully to be published in 1994. Once some more of the replication studies are published, the text will be available for those of you who want to supervise others in learning **EMDR**. The text will not be a substitute for training and the need for a supervised practicum, but it will assist in the process.

The next Newsletter will be due out in January. So let me wish you a joyous Holiday season.

BEHAVIORAL VALIDATION OF EMDR: TWO PTSD CASES

Robert T. Flint, Ph.D.
Oakland, CA

Clinicians trained in Eye Movement Desensitization and Reprocessing (**EMDR**) often describe approaching the method with great skepticism that transforms into enthusiasm and a desire to proselytize. This enthusiasm is often mixed with the lament that more behavioral validation studies have not been performed. This note records two cases in which people suffering from chronic Posttraumatic Stress Disorder (PTSD) symptoms demonstrated striking behavioral changes after a single brief **EMDR** treatment.

Case A

Mr. A had been a police officer for only three months in 1971 when he was assigned to undercover duty. As he was given minimal training and had no practical experience, he was soon detected by the criminals against whom he was working.

His first clue that his "cover had been blown" came while sitting in his car. A masked man held a gun to his head and said, "You're a cop and I'm going to kill you." The masked man then pulled the trigger, but the gun misfired. He pulled the trigger again. The gun misfired again. The officer scrambled out of his car with his own gun drawn, but it also malfunctioned. The criminal escaped.

Mr. A sought psychotherapy nearly 20 years later. A cognitive-behavioral approach was used to address his severe anxiety problems which included nightmares, avoidance of the site of the attack, counterphobic behavior that had earned him two medals for valor, and panic attacks. He was taught relaxation techniques and self-hypnosis and engaged in many hours of talk therapy, guided imagery, and desensitization. A psychiatrist assisted his treatment with prescriptions for antidepressant and antianxiety medications and he was also placed on leave from his responsibilities as a police officer.

When he returned to a limited duty position, Mr. A found that he was unable to resume patrol duties as his anxiety symptoms rendered him dysfunctional whenever he encountered the slightest confrontation. He soon found that even tiffs among his subordinates in his light duty assignment caused him severe psychological and physical distress. He ultimately was awarded a disability retirement. He reported thereafter that he continued to be anxious and apprehensive in confrontational situations, but was more comfortable because of his ability to walk away from them. Being relieved of a police officer's responsibility for intervention apparently helped, but did not eliminate, his symptoms. However, he remained unable to talk about the 1971 incident without becoming extremely distressed. When the site of the event was mentioned, his face would immediately contort uncontrollably and tears would flow. He handled this problem by avoiding as much as possible returning to the community where the incident occurred and by totally avoiding the part of town where he was attacked.

After finding a new job, Mr. A terminated treatment. The therapeutic point of diminishing returns had been reached as he no longer complained of nightmares, physical distress, and the many other complaints with which he initially had presented.

Mr. A was asked to return for a therapeutic session after this author was trained in the **EMDR** procedure. Mr.

A was taken through a standard EMDR procedure in which he was asked to envision the incident, to identify and focus on any physical discomfort that he experienced, to hold in consciousness the emotions that he was currently experiencing, and to repeat silently to himself the negative cognition. His face contorted and tears flowed as he followed the instructions. His Subjective Units of Discomfort Scale (SUDs) rating was 10. After only a few sets of eye movements, his face relaxed, the tears stopped, and his breathing, initially fast and shallow, smoothed. The eye movements were stopped and he was allowed to relax. He reported that the image was less clear than it had been at first and that he no longer felt so frightened. He was again instructed to focus on the image, his emotions, and his physical sensations. After a few more sets of eye movements he reported feeling well, both physically and psychologically. He was able to describe the attempt on his life unemotionally and expressed both joy and amazement that reciting the event no longer was distressing.

Mr. A returned to the office in about one month to work on some other matters. He quickly demonstrated that he could talk about the attempt on his life without being upset and said that he had told many people about it since the last session. He reported that the attack was now "just a memory."

Case B

Mr. B, like Mr. A, was a police officer. He developed strong symptoms of PTSD after shooting and killing an armed suspect from a distance of 75 feet.

Mr. B was seen with his wife in treatment for over one year. Treatment included a 30-day in-service alcohol rehabilitation program. Extensive psychotherapy, utilizing the various procedures outlined in the previous case, resulted in his being able to return to permanent limited duty. Unlike Officer A, he took no psychoactive medication after he returned to duty. He maintained his sobriety and completely changed his lifestyle. He expressed great pleasure in his formerly neglected family and in his newfound artistic skills.

One symptom remained "untouchable" however. He always developed uncontrollable tremors at the 25-yard marker on the firing range during his regularly scheduled firing practice. He inevitably experienced flashbacks immediately after firing his gun and nightmares the night after he qualified. He finally learned to handle the problem by resigning himself to being distressed after shooting and began to regularly schedule "mental health days" the day after he fired.

He, like Mr. A, was offered further treatment subsequent to this author's training in EMDR. He was told to focus on the shooting incident, as well as his subjective reactions to it. A standard EMDR procedure was initiated. Although his initial SUDs rating was 10, in less than one hour he reported that he was not experiencing any anxiety when he remembered the event and that he was looking forward to going to the firing range. Three days later, he fired 75 rounds from the 25-yard marker. Whereas he had missed the target altogether from that distance during the previous five years, all but three of his bullets hit the target. Moreover, most of his shots were clustered in the center of the ring. He experienced no anxiety and fired daily for a few days thereafter with ever-improving results.

Discussion

These two cases are noteworthy for the following features: 1) Both clients initially presented with long-standing symptoms of Post-traumatic Stress Disorder; 2) Both cooperated with treatment and benefited to a great degree; 3) Although both ceased to exhibit many of the symptoms with which they presented, each had to devise techniques for coping with certain intractable symptoms; 4) With both, care was taken by the clinician to state no explicit expectations of their experiences; 5) Each reported an immediate diminution of subjective feelings of anxiety, followed by a report of the extinction of the anxiety response when confronted with the stimuli that had previously been overwhelming; and 6) Each demonstrated behaviors they had been incapable of performing prior to the EMDR treatment.

The first individual was able to talk comfortably about the life-threatening experience that he had undergone over two decades earlier, and the second was able to fire accurately from a distance of 75 feet.

Further individual EMDR work is scheduled for previously treated police officers who have residual PTSD symptoms caused by a shooting incident. Large scale, controlled research with police officers who are troubled by post-shooting symptoms is being developed.

NETWORK DIRECTORY

We would like to inaugurate a Network Directory for 1993. We get numerous calls from colleagues asking for other EMDR clinicians for family, friends, or transient clients. To assist matters, a 1993 renewal form is provided on page 23 and in the Network flier. These forms request name, business address, telephone, specialty area, level of training, and whether you are open to take referrals. We will list clinicians according to state and local area. This directory will be available to Network members, agencies, and insurance providers, etc.

It has been suggested that a listing be available of EMDR practititoners able to give case consultations. Any suggestions for alternative uses are welcome.

In order to cover the cost of the directory, newsletter, tapes, and articles, dues for 1993 will be $50. However, members will receive discounts on **EMDR** Conferences and specialty trainings. With sufficient membership, we can hire project personnel, including one to deliberately educate insurance providers regarding **EMDR**, and laison with appropriate media to disseminate information in a judicious manner. Regional coordinators will set nominal fees for the cost of local meetings. The quarterly California meetings will be an additional $20. Fees will vary according to region. Please contact your regional coordinator for price, dates, and location [see page 3].

1993 EMDR ANNUAL CONFERENCE MARCH 19-21, 1993

Francine Shapiro, Ph.D.

Scheduled for the next few months is a formalizing of the ***EMDR Conference Schedule***. As you know, we have changed the dates to ***March 19-21, 1993***, at the Sunnyvale Hilton near San Jose. There will be three days of workshops and presentations that will be of the highest calibre on a variety of **EMDR** topics. Headliners include: **Alan Goldstein, Ph.D.**, the Director of the Agoraphobia and Anxiety Treatment Center, Dept. of Psychiatry, Temple University, who will present on the use of **EMDR** with Agoraphobia and Panic Disorder; **Nancy Baker, Ph.D.**, Psychologist, LA County Sheriff's Department, who will present on the use of **EMDR** with victims of Sexual Harassment, and interaction with previous sexual abuse history; and **Emmett Miller, MD**, who will show how to use hypnosis to augment the **EMDR** treatment session.

The evaluations of last year's Conference were superb, and will be the standard for 1993 as well. If you have any proposals of topics, or research, please send them to me immediately.

DIFFICULT CASES

Andrew M. Leeds, Ph.D.
Petaluma, CA

The Case of the Self-Defeating, Telephone Sex Addict:

An **EMDR** clinician, who prefers to remain anonymous, describes a case in which there has been only limited progress in three years of therapy. The therapist has used **EMDR** several times with little apparent effect.

Case Summary by Anonymous

"Charlie" is a 41 year-old married white male who presented for treatment about three years ago for a sexual compulsion. His compulsion focuses on making secretive telephone calls to phone sex services and massage parlors, becoming sexually aroused, and often masturbating. When his wife finally learned of his problem, she demanded that he seek professional help. When he presented for therapy, his monthly phone sex bill was more than $500.

"Charlie" works in his wife's home-based business as her employee. He had been dismissed from his last position for inappropriate behavior towards a female employee. "Charlie" is well educated and had worked in a professional capacity in another state. In addition to his phone sex problem, there is considerable conflict between "Charlie" and his wife over his productivity at work. He also makes occasional mistakes that cost the business money or lost time. These mistakes could each be considered inadvertent were it not for their frequency and severity.

"Charlie's" wife is a survivor of childhood sexual molestation. She is dramatic in her emotional life, frequently expressing in highly charged ways her disappointment, anger, and sense of abandonment about his lack of support. There has been an undercurrent of instability in their marriage the entire time "Charlie" has been in therapy. I offered them couple counseling for several months early in "Charlie's" therapy, but this did not help much. Each of them continued to feel easily criticized, rejected, and inadequate. I finally referred the wife to another therapist for her survivor issues.

At my request, "Charlie" has become active in a 12 step program for sexual addiction. His sexual acting out has decreased with periods of abstinence lasting weeks or months, but he does have frequent relapses. "Charlie's" wife has asked, and "Charlie" has agreed, to disclose to her any further phone sex episodes. However, most of his relapses begin with periods when he keeps his behavior hidden from her or from me.

"Charlie's" depression has worsened in recent months, perhaps in response to his wife telling him to find a job outside the home business. I sent him to a psychiatrist for medication evaluation and he is now taking Anafrinil and Prozac. Since starting on the medication, his episodes of uncontrolled crying and his suicidal ideation have both decreased. On the other hand, a recent loss at work has cost the business over $20,000. It is not certain whether "Charlie" was directly responsible for the loss. However, both he and his wife blame "Charlie." Recently, she has been making comments about ending the marriage and having "Charlie" move out.

I have used **EMDR** in four or five sessions to decrease "Charlie's" urges to act out sexually and strengthen his sense of self-worth. These sessions have focused on memories of his step-father's random and unpredictable outbursts of anger and criticism. ("Charlie" has no memories of his step-father's loving acceptance.) During **EMDR** sessions, "Charlie" had

changes in the target picture and shifts to the target memory and no abreaction or expression of emotion. There have been no significant shifts in behavior, feeling, or memories following **EMDR** sessions. "Charlie" does keep a log after **EMDR** sessions.

"Charlie's" mood stabilized after beginning the medication and he has asked to resume **EMDR** sessions. After our most recent **EMDR** session, I pointed out to ""Charlie"' that he seemed to be "floating" above his feelings during the **EMDR** work. He said his previous therapists had always told him that he was out of touch with his emotions, especially anger, and he asked what he could do to get more in touch with his feelings.

"Charlie" has frequently reported losing control of himself emotionally. He has crying episodes and sometimes he hits the wall with his fist or his head when he gets angry. I had not thought of him as being out of touch with his feelings. I am confused about how to move forward with Charlie. He always comes in for his sessions and he has asked to continue with **EMDR** in spite of the limited success we have had with it to date. I would appreciate any guidance you can give me.

Case Commentary and Suggestions

This is an extremely challenging case. Anonymous has been providing a positive frame for the therapeutic work. Anonymous involved "Charlie" in a support system through the 12 step group and has made a good beginning with **EMDR** by identifying touchstone memories for "Charlie's" low self-esteem and self-defeating behavior. Anonymous has "Charlie" keeping a log.

"Charlie" presents some borderline features (e.g., the "mistakes" at work, poor impulse control, and a lack of differentiation in his feelings). Part of the confusion comes from considering "Charlie's" impulsive acting out of emotion (phone sex calls, head banging, and uncontrolled weeping) to be equivalent to an ability to contain and express emotion. They are not the same. Anonymous may find more progress will come from helping "Charlie" develop a greater ability to contain, differentiate, and express emotion. "Charlie's" inability to abreact or to express emotion during **EMDR** sessions reflects a defense that can itself be the focus of further **EMDR** sessions.

"Charlie's" defensive belief is that it is not safe for him to feel and express his feelings. Have "Charlie" identify the touchstone memories for this belief and process them. Work on resolving this defense may help "Charlie" to work through the challenge of learning to differentiate and contain his feelings. Because of the borderline elements, this work is likely to proceed slowly. The current crisis and instability in the marriage may also slow this work down. You have made a strong therapeutic alliance with "Charlie." He trusts you.

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The fact that he asks for further **EMDR** sessions suggests that he has some sense that it is helping him. Write again in a few months and let us know what progress you have made.

Have you experienced atypical responses to **EMDR**, lack of progress, even outright therapeutic failures? Submit your challenging clinical problem to **Difficult Cases**. Your proposed solutions are welcome, but are not necessary. Additional solutions submitted regarding these cases are welcome, especially if you have successfully treated a similar patient. Send submissions, **which may be anonymous**, to Andrew Leeds, Ph.D., **EMDR Network,** P. O. Box 51010, Pacific Grove, California, 93950. If you have any ideas or suggestions to deal with "Charlie's" case, please submit comments.

EMDR: INNOVATIVE USES

Ron Martinez, Ph.D., Co-editor
Burlingame, CA

*This section will appear in each Newsletter and will present innovative uses/variations of the **EMDR** that have been discovered by clinicians trained in the method. I would very much appreciate it if any of you who have found new variations on how to use **EMDR** would write these up and send them to me at the address below, so that I can include them in future Newsletters. Though your write-ups can be informal, I would appreciate you including the specific steps of the technique; the number of people on which it has been successful; any specific outcomes that you have consistently noticed; and any further comments. Please include your name, address, and phone number, so that I can reach you with any questions. Thank you.*

First of all, let me open up by offering my apologies to **Carrie Greenberg, LCSW,** of Santa Rosa. In the last "Innovative Uses" column, Carrie was the person who sent in the article on using the combination of **EMDR** and hypnosis while working with a Vietnam vet. The effects were quite powerful and Carrie deserves full marks for combining these two modalities. Unfortunately, due to the omission of a paragraph, it appeared that this was a technique that I (Ron Martinez) had developed and used and I want to take this opportunity right off the bat to thank Carrie for her contribution and her patience during the time in which she was not given proper credit.

Edith Ankersmit, LCSW, of Berkeley, has sent in a write-up on several cases in which she combined **EMDR** with various bioenergetics techniques. Edith is a certified bioenergetics analyst who has not used this modality for several years. However, she found some cases in which it seemed to work hand in hand with **EMDR** in a very productive way. The most noticeable case was of Clara, a 27 year-old woman who had a problem of staying in bed in the morning in what seemed to Edith to be an angry depression. Clara refused to get up and go to work. As she is self-employed, this caused a great many problems for her. When Edith began the **EMDR** process, Clara promptly connected with her transfer from public school to catholic school when she was in fifth grade. It was a difficult transition and she felt she was rejected by all of the "cool" kids at the new school. They threatened and humiliated her, and she felt she had very little power to respond. At that time, Clara developed a hatred of getting out of bed and going to school and would often pretend to be sick. Edith and Clara formulated a positive cognition together of, "It's in the past. I can get up now and nobody is going to beat me up and say mean things." The highest VoC they were able to attain on this was 4. Later, during the **EMDR** process, Edith asked Clara what she would like to say to those girls who were mean to her. Clara stated that she would like to beat them up. Edith then had Clara go through a bioenergetics technique in which she used a "boffer" while standing in a well grounded position and imagining that she was hitting those girls and also telling them what she thought of them in the process. When she completed the exercise, Clara told Edith that she felt she had her pride back and that now she no longer felt rejected by these girls. Moreover, she no longer felt an interest or need in wanting their acceptance. They tried the original cognition again at this point and the VoC was 7. Clara then added another cognition on her own, "I'm a very strong person. I have no problem now telling people how I feel. I've learned from the past." This too installed easily and powerfully.

Upon telephone follow-up, Edith learned that Clara's improvement initially was slow, but then gradually she reached a point in which she was able to get up from bed and go to work regularly.

Finally, **A.J. Popky, CHT**, sent me an extensive protocol on how he is using **EMDR** in combination with hypnosis and other clinical concepts in working with smoking cessation. The protocol is too lengthy to go into here, but both A.J. and I would be very interested in hearing the kinds of results that other people would obtain in using this process. For a copy of the protocol, please contact A.J. Popky, CHT, at 17461 Pleasant View, Monte Sereno, CA, 95030.

ERRATUM AND CLARIFICATION

Robert H. Kitchen, MA
Hayward, CA

In my article, "Relapse Therapy" in the **EMDR** Newsletter (Vol. 1, No. 2), I made reference to a study done by Cynthia Downing, Ph.D.—"Surrender to Powerlessness and Its Re-

NATIONAL NETWORK MEETINGS

Jean Bitter-Moore Ph.D. California Network Coordinator (408)354-4043

1993 EMDR Network Schedule
Saturday, March 20th - at the EMDR Conference, 12:00-2:30pm
[If you are not attending the Conference, but wish to attend the Network Meeting, contact EMDR office (408) 372-3900 or fax (408) 647-9881.]
Saturday, June 26th
Saturday, September 18th
Saturday, November 13th
9:30am to 4:00pm

The Network meetings are held at the Sunnyvale Hilton, 1250 Lakeside Drive, Sunnyvale, California (408) 738-4888.

SCHEDULE *for Jun, Sept., and Nov.*

9:30-10:00am Registration & coffee

10:00-11:30am Special Interest Groups (SIG) meet to share new information.

11:30-1:00pm Lunch [We suggest a second SIG meeting during lunch.]

1:00-4:00pm General meeting. Presentations by SIGs and Francine.

The quarterly Network meetings have been a success as a forum for sharing new applications of **EMDR**, learning about the latest research results, and observing talented colleagues demonstrate innovative twists with **EMDR**.

lationship to Relapse in Recovering Alcoholics" (1991), which was part of her doctoral dissertation for the Saybrook Institute in San Francisco. I incorrectly reported that "Cynthia Downing, Ph.D. determined in late 1990 that 97% of chronic relapse clients had experienced a life-threatening experience wherein they perceived their imminent death and could do nothing to prevent it." **The figure 97.5% was incorrect and should have read 41 out of 50 chronic relapsers.**

She reported that 41 out of 50 chronic relapsers had a history of such a life-threatening experience as opposed to 30 out of 50 of the non-relapse prone. Dr. Downing's study included 50 relapsers and 50 nonrelapsers. While this is a significant difference, the frequency of a life-threatening experience was not nearly as large as I had reported. While the error was inadvertent, the responsibility for it is completely mine. I regret any confusion or misunderstanding that my error caused readers of the article.

Dr. Downing found self-reports of physical and sexual abuse histories at roughly similar rates among relapsers and nonrelapsers. On the other hand, not seeking therapy (as contrasted with prior substance abuse treatment) differentiated chronic relapsers (41 out of 50) from nonrelapsers (31 out of 50). Substance choice also differentiated relapsers who tended to use alcohol and drugs (43 out of 50) from nonrelapsers who used only alcohol (41 out of 50).

While nonrelapsers also frequently have a history of a life-threatening experience, more of chronic relapsers will show this history. Empirically, I have found that looking for a history of a life-threatening experience, and addressing it with the **EMDR** method, has enabled me to better serve my clients as a relapse prevention specialist.

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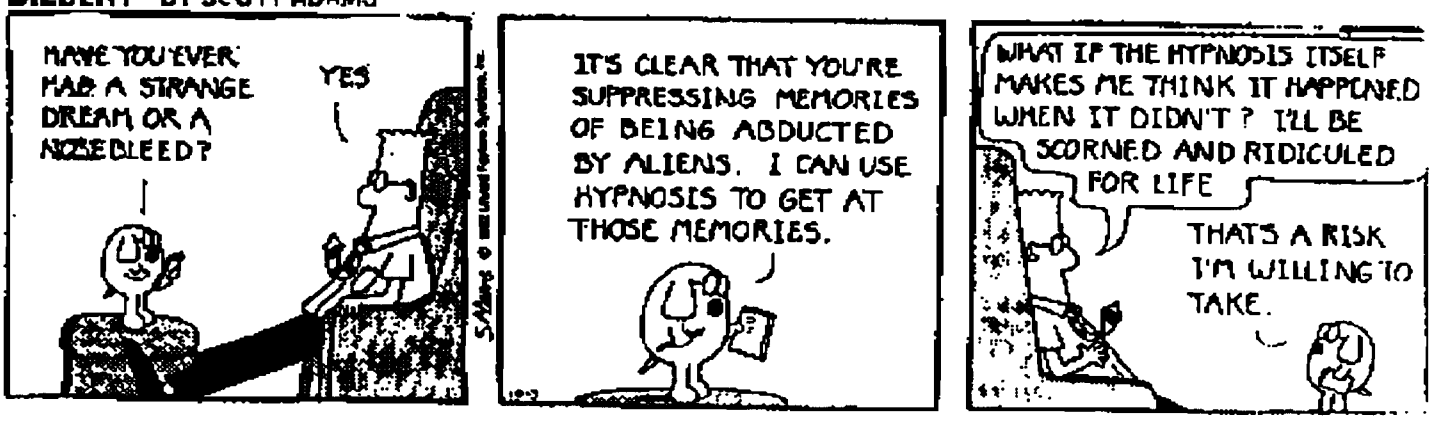
In addition to the obvious referent, the following cartoon struck me as a good description of those clinicians who push to use EMDR without training—FS



SUBJECTIVE UNIT OF MOTIVATION

Linda A. Nader, MA, ATR
Santa Cruz, CA

During the course of clinical work, there are times when the VoC and SUDs scale do not provide the information needed in order to set the focus for clinical and **EMDR** work and/or to determine the probability of change in the client. The Subjective Unit Motivation (SUM) has been useful for ferreting out this therapeutic material.

The SUM is measured in percentages of 0 to 100% in order to distinguish it from the other two scales. The client is instructed to determine how motivated he/she is to follow through on a desired outcome that is presented in the session and to rate this on a scale of 0 to 100%. High percentages can be an indicator of a desired behavior (e.g., getting a job) or an undesired behavior (e.g., committing suicide). The same is true for low percentages. Once the percentage is established, the clinician can query the client as to what is needed to increase or decrease the percentage in the desired direction. This material can then be the focus for **EMDR** or other appropriate therapeutic procedures.

Possible uses of the SUM are: predicting suicide, determining substance abuse abstinence or relapse, changes in relationship issues, determining the success of overcoming performance anxiety, and improving one's health.

Case Examples: (Details have been changed to protect clients' confidentiality.)

In the first case, the client was involved in a career change and had become immobile in the process; a consequence of which was friction in his primary relationship. Memories regarding this issue had been previously resolved (the VoC was 6.5 and the SUDs was 1). When the client was asked how motivated he was to take the next career step, he rated his SUM at 60%. The client was surprised that his SUM was not higher. He realized then that he had a greater "desire" for change than "motivation" for change. Once the resistance around the motivation was worked through with **EMDR**, the SUM increased to 95% and the client followed through with the necessary behavior change.

In the second case, the SUM was used during the assessment phase of therapy. The client rated the following therapy goals and SUM values: attend CODA meetings (SUM 45%), improve self-esteem (SUM 55%), maintain healthy relationship (SUM 75%), complete graduate school (SUM 80%), and get a job (SUM 80%). When asked why the SUM for 12-Step meetings was so low, the client replied, "I would have to admit that I have a problem." The SUM enabled the client to set priorities and the focus for the therapeutic work. The client has started working as of this writing.

At this time, I only use the SUM sporadically. I offer this information on the SUM in the hope that it may be useful to other clinicians and I would appreciate any feedback.

"SAM" FOSTER TO CREATE EMDR RESEARCH DATABASE

Sandra Foster, Ph.D.
Mountain View, California

As Coordinator of the California Network, I have thoroughly enjoyed the opportunity to meet many of you who have attended our quarterly meetings in Sunnyvale. It has been a pleasure to interact with such talented people as the Special Interest Group (SIG) members who share their findings and new applications during the afternoon presentations. After two years, I feel quite ready to "pass the baton" and am pleased to announce that **Jean Bitter-Moore, Ph.D.** (recently married—CONGRATULATIONS!) will be the new California Network Coordinator. Jean will be responsible for conducting the quarterly gatherings and helping Network members join existing study groups or start new ones. I know she will do an excellent job.

After establishing the PEAK Performance Special Interest Group in December, 1990, and leading this group with **Jennifer Lendl, Ph.D.**, I am happy to announce a new SIG leader, **Barbara Erickson, RN, MS**, of Sacramento. Barbara brings her experience in working with business people and other clients to her role as facilitator. She will lead the Peak Performance SIG at Network meetings beginning November 14. **Bill Covi, Ph.D.**, also of Sacramento, will assist her.

This "retirement" allows me more time to complete a project that I proposed to Francine in late August—organizing the research on **EMDR** into a database that interested persons can easily access. To that end, I am contacting those professionals who have published, or are in the process of conducting, **EMDR** research in order to collect summaries of results and copies of protocols and measures. I expect that the database will be on-line by mid-January, 1993.

The database will be organized by population served and diagnosis, as well as the researcher's name and affiliations. People with research ideas can obtain addresses and phone numbers of the investigators doing related research by calling (408) 372-3900. Please submit requests in writing specifying the research you are planning and the "key words" in which you are interested. We can then access our database and provide information about how to contact the investigators.

For those graduate students plan-

ning dissertations using **EMDR**, a Pacific Graduate School student, **Priscilla Marquis, MA**, has graciously agreed to assist other doctoral candidates with advice on her literature review. She can be reached in the evenings at home in San Francisco (415) 285-4065.

For researchers with proposals in the planning stages, I can answer specific questions about research design and measures. The best way to enlist my time is to mail a copy of your research proposal or questions to me at 1503 Grant Road, Suite 160, Mountain View, CA, 94040. You can also fax proposals or questions to me by dialing (415) 365-8689.

I am very excited about taking on this project and hope to have the database in place by January. A second function of my new role will be to summarize recent research findings for this Newsletter. In this issue, I feature the results of research conducted by **Roger Solomon, Ph.D.**, who has been investigating critical incident stress interventions employing **EMDR**.

PROTOCOL FOR DESENSITIZATION OF RECENT TRAUMATIC EVENTS

Roger M. Solomon, Ph.D.
Washington State Patrol
Seattle, WA

I. Initial assessment of impact of event.

Go through the incident with the client "frame by frame," with the client describing what took place moment by moment. It is important that the client not only describe the events that occurred, but also the perceptions, thoughts, and feelings he or she experienced. Be sure to ask about the aftermath of the event. Investigations, reactions of friends and significant others, treatment at a hospital, etc., can be very stressful.

Significant sensory impressions (e.g., sights, sounds, sensations, tastes, and smells) and their meanings to the client should be noted as potential "nodes" for reprocessing. It is also important to take note of moments of vulnerability and/or lack of control—the essence of the traumatic experience. Coming face to face with mortality ("I thought I was going to die"), perceptions of helplessness and powerlessness ("there was nothing I could do"), or witnessing tragedy, especially when one can closely identify with the event ("that could have been my child..."), are moments that will need reprocessing.

II. Desensitization of the event.

There are several ways to reprocess the traumatic experience with **EMDR**.

A. The therapist can take the client through the experience in chronological order, reprocessing each traumatic and emotionally meaningful moment.

B. Start with most intrusive sensory experience. As an alternative to proceeding chronologically through the incident, the therapist can reprocess the event according to the client's organization of the experience. Start with the client's most vivid image, or whatever images come to mind, and ask the client to focus on the one that is most distressing. This image is often the best starting place because it may be difficult to focus on another part of the incident without the intrusion of the most distressing image. If the "worst" moment is too upsetting to think of, it may be helpful to start with a less stressful image.

Quite often upon reprocessing the most distressing image, other moments or images of trauma automatically manifest. They may be in chronological order, in order of distress to the client, or in a seemingly random order that is meaningful to the client. If no other images or moments come up spontaneously, ask the client to think of the incident and pay attention to images, feelings, sensations, or thoughts that arise and reprocess them.

I have found using the client's most intrusive image as the starting point to be more effective than going by chronological order, although empirical research is needed to determine which method is most effective.

III. Reprocess from beginning to end.

After all traumatic images and moments have been reprocessed, have the client go through the entire experience in his or her mind, from beginning to end, with his or her eyes closed. The stopping point should be when the client felt SAFE after the incident was over.

Instruct the client to stop if anything becomes upsetting. It is common during this step that stressful feelings, thoughts, or sensations will emerge that were previously suppressed or blocked. Be sure to separately reprocess any new material that comes up, as well as any other moments that still cause arousal. Repeat, going through the entire incident with the client doing the eye movements until it can be completed without discomfort.

IV. Installation of positive cognition and integration.

The last step is for the entire incident to be replayed with the eye movements and the positive cognition in mind.

When the client has replayed the

entire incident with a low SUDS level, I have found it ecological to ask the client how he or she is thinking about the incident now that it feels better. The answer to this question often yields new positive cognitions that were not thought of, or even conceived of, prior to reprocessing. For example, many clients may not have been aware that they were assuming some responsibility for an event beyond their control. After reprocessing, they suddenly realize it was not their fault and THEY DID ALL THEY REALISTICALLY COULD AT THE TIME. Only after a new vantage point is achieved, can some people realize where they were stuck.

V. Intrusions of past traumatic memories.

While reprocessing a recent traumatic event, a past traumatic event may intrude. Should this occur, it may be best to stay with the past event and follow the client's organization of his or her experience rather than holding off until the current experience is desensitized.

VI. Legal cautions.

If there is going to be a legal investigation, it may be prudent to put off doing **EMDR** until after legal statements have been made. **EMDR** often causes gory, traumatic, visual pictures to lose detail and become more distant. These details may be important to an investigation or court case. If there is a chance the case is going to court, it may be best to put off **EMDR** until the case is legally resolved. If the court case is not scheduled until some distant time in the future, and it is determined that **EMDR** should be conducted to ease suffering, be sure to document the client's sensory impressions should they be needed for future reference.

VA HONORS STEVEN SILVER, PH.D.

The Veterans Administrations has awarded Steven Silver, Ph.D., the 1992 VA Service Director's Award in Mental Health and Behavioral Science. Dr. Silver is Director of the inpatient PTSD unit in Coatsville, PA. He served in Vietnam as a Marine Corps officer and has been working with other veterans since 1972.

BOOK REVIEW

Ronald Kaufman, MS
Pepperdine University

THE WET MIND: THE NEW COGNITIVE NEUROSCIENCE

by Stephan M. Kosslyn and Olivier Koenig
Free Press, New York 1992

This book integrates the most recent advances in the relationship between cognitive processes and their underlying brain functions. The authors communicate their purpose in an engaging style calculated to follow in the footsteps of ***Cognitive Psychology*** (Neisser, 1967), ***Languages of the Brain*** (Pribram, 1971), and ***Godel, Escher and Bach: An Eternal Golden Braid*** (Hofstader, 1980). The authors do not, however, retread basic information processing theory. Rather, they celebrate the emerging discipline of cognitive neuroscience and introduce outsiders through example, case study, research, and analog to its distinctive tools—computer modeling and brain scanning.

The authors challenge us to see their sweeping vision of the brain-mind interlock. Make no mistake, however. In their survey of this new field, Kosslyn and Koenig come to proselytize, not educate. Polemics are kept to a minimum and the processes for the majority of sensory modalities and for various levels of mode integration are patently absent. To **EMDR** practitioners, these omissions are especially disappointing since so much of what is processed in the course of **EMDR** resides outside visual channels.

While Kosslyn and Olivier may paint their picture with overly broad strokes and in bright, tacky colors, it is easy for the reader to forgive them their excesses—not because the authors are so enthused about their subject matter, but because they present us with a masterpiece to rival Van Gogh's ***Sunflowers***. The book promises to become a classic which should ignite the collective imagination of a generation of scientific readers and confront the rest of us for our phlegmatic conceptualizations of mind.

The contents of the book may be divided into three parts. The first part, which seeks to credential cognitive neuroscience, offers a brief history of its antecedents, a general definition of the problem area, unique characteristics of the approach, and insight into its assumptive principles. The middle portion outlines the constituent subsystems for brain processes responsible for progressive grades of mental activities beginning with visual perception, moving to visual cognition, then language processes, and on into movement and memory. The end chapter, entitled *"Gray Matters,"* looks to the future of cognitive neuroscience by pointing to topics of interesting speculation and extreme controversy.

While this user friendly volume is full of information, insight, and innuendo, it is *"Visual Cognition,"* (Chapter 4) which may be of most interest to **EMDR** practitioners. Each paragraph of the text, however, is pregnant with potential, and complete hierarchies of alternate hypotheses to explain our clinical observations of **EMDR** phenomenon

suggest themselves on every page. The following is one example of the many eye-catchers in this book: Imagine what you would see when you first enter your living room. Most people make eye movements when imagining the furniture. This makes sense if the location information is stored in a motoric form, and the movement is performed as part of accessing the stored information. Now try imaging your living room again. And then again. Do you move your eyes as much on the third time as you did on the first? By the third time you should have recorded the information into a categorical form...these representations rely on categorical spatial relationships (which are not necessarily verbal) and do not involve motor commands. Thus, one need not move one's eyes when retrieving this sort of information (p. 142).

While it would be sophomoric to suggest that we already have too many arcane tomes on brain-behavior research, I genuinely enjoyed reading this companionable work. Yet, when I put it down, I felt like I had aquired more from it than an ego massage. If the growing body of neuropsychological literature seems too daunting to attack, or if you have walked away from your growing pile of journal articles and textbooks on the subject feeling like Orpheus emerging from Hell, perhaps Doctors Kosslyn and Olivier have written something you might be interested in as well.

NEWS BULLETIN

At the last Network meeting in San Jose, CA, participants voted unanimously to allocate a Norman Cousins Scholarship of $1000 to research costs for Hurricane Andrew's victims. Francine will personaly match this, giving a total of $2000. A project advisor familar with research protocol design is being sought.

OBSERVATIONS ON USING EMDR WITH PATIENTS WITH A HISTORY OF SADISTIC AND RITUAL ABUSE

Walter Young, MD
National Center for Treatment of Dissociative Disorders
Denver, CO

When working with patients with a history of sadistic and ritual abuse, judgment needs to be made as to his or her readiness to continue when alters present for **EMDR**. For example, in preparing one patient for **EMDR**, a child alter presented. Feeling that this was her starting point, she began to realize she was not yet prepared and felt too much was coming at her. In another patient, a "non-feeling" satanic alter presented. I assumed the starting point was of a state that did not feel and that the processing would lead this state to the pain of the others (which it did). Another woman recalled concentrating on "Satan's" robe when raped, seeing it was not ironed, but wrinkled, and asked herself how a demon could present with a wrinkled robe. She was on the way to becoming more realistic.

When working with this population, one needs to be cautious about a number of factors. First, in dealing with ritual abuse, we want to be cautious that our enthusiasm for **EMDR** does not detract from our awareness that patients with severe and chronic abuse are going to have a great many traumatic episodes that are linked with many nodal points; some of which are equally painful to the one at which the patient starts. They also may not understand that they are to return to the original memory to see whether it has decreased in power. In my personal experience, where the patient may end up is still somewhat unpredictable. He or she might end up in a very painful place because of the frequent nodal points of trauma and association links between trauma. For example, one patient said, "The original memory has no more power over me." However, there were continuing memories that did have power over her that needed to be worked through before she could feel as though she had mastered the experiences she was describing.

Secondly, as therapists, we need to recognize that it is not necessarily our job to know for certain that what is being reported to us represents an historically accurate event. It has been very easy for therapists caught up in reports of this kind of abuse to want to feel the material is somehow true and actual as it is being described when, in fact, it may be subject to a variety of distortions that therapists may not have been trained to think of or recognize.

I have seen issues surface of malingering, contagion or the absorption of someone else's memory where the origin of the memory had dissipated and the patient re-experiences it unconsciously as his or her own, where loose fears and ideas attach themselves to actual events so that the new "memory" is a combination of both real and unreal events, as well as other kinds of distortions. Fantasy and contagion that are dealt with in periods of trauma require more scientific inquiry than currently exists. Are they re-dissociated? The use of hypnosis itself is a potential source of contamination which may make it possible to create traumatic memory even as we are alleviating the same memories we create. Before we automatically decide with what it is we are dealing, these are subjects that need more complete study.

Fortunately, our patients will be presenting these experiences in ways that are similar to actual memory and they will often follow the rules, and therefore the shifts in cognitive sets one sees with dissociative storage. With this degree of trauma, one will need to see to what extent sig-

nificant cognitive distortions remain concerning the way the clients think about these issues once the issues have come to surface and are "known." It is often true that memory not only needs to be "known," but it needs to be thought in an adult, well perceived, and integrated fashion through the mind of an adult.

In the long run, we are bringing some patients through a long series of difficult material, whether we use **EMDR** or any other therapy. There may be certain patients who are suffering experiences we do not yet know how to recognize as artificial from those that are real, and the patient may struggle inordinately when it is not necessary. This information will be available more clearly to us as research and investigation bring us more accurate evidence.

Presently, the average therapist needs to take a very cautious, nonjudgmental, and open minded stance when dealing with memories of ritual abuse. One should not automatically assume everything that is heard has occurred in the way one hears it. Further, one needs to be aware that a variety of distortions which could be introduced or attained may come into play. This is something a patient may do in finding his/her own truth.

However, we need to begin to develop clinical and research profiles to separate out those individuals who have experienced chronic traumatization, show more history of trauma, or who are highly suggestible and compare them to others reporting amnesia for real documented abuse. This way, at least, some comparative testing can be used as data to determine whether what we are hearing represents some aspect of an actual set of events or the production of distorted or inaccurate events that may need to be worked through even more to uncover the more realistic issues that are their underpinnings. This whole area is potentially wide open for study and one of great interest if we can do it carefully and thoughtfully. We must highlight caution in our approach to patients.

Treatment issues surround not just remembering and resolving specific events in a patient's life, but also in working with a patient as a whole individual, constructing a life that he or she would like to choose for himself or herself and finding the proper perspective to place on multiple trauma in individuals who feel disempowered and have very little self-esteem.

Finally, we need to be aware that in this particular field we are applying a new method of **EMDR** that was designed for briefer and less difficult times of post-traumatic stress disorders. Therefore, potential complications need to be thought out in a straight forward manner and discussed openly rather than simply making claims of massive success without reporting difficulties that may simultaneously occur if information comes out too quickly or prematurely without the ability to contain it between sessions.

DO YOU HEAR FLORIDA CALLING?

NOW IS THE TIME TO RESPOND!

Judy L. Albert, MA
Huntington Beach, CA

I attended the Network meeting in Sunnyvale and I was deeply moved into action when I received the compelling request from Florida **EMDR** therapist **Ruth Knowles Grainger, Ph.D.**, asking me to join a Volunteer Disaster Response Team of **EMDR** trained therapists to work with Hurricane Andrew and/or Iniki survivors.

I will join Dr. Grainger in Miami November 29 thru December 6 along with at least one other therapist. Many more **EMDR** trained therapists are needed to work in the three locations welcoming our skills, including the worst hit city of Homestead. Teams of 2 therapists at a time would be of great assistance in the next few months.

When Ruth's first attempts to get airlines to donate tickets failed, I did not stop. I successfully wrote a letter to the Chief Executive Officer/ Administrator at College Hospital (Psychiatric), Cerritos, CA, where I have hospital privileges. I requested the hospital sponsor me by buying a round trip ticket to Miami and cover the cost of a one week rental car. Generously, the hospital chose to provide the ticket. I would like to encourage all **EMDR** trained therapists who might be considering donating a week in Florida or Hawaii to ask in your own community for sponsorship to assist you with transportation. If they deny you a ticket, ask them to make a tax deductible charitable financial donation to Therapy Research Institute, Inc., 8585 Sunset Drive, Ste. 65, Miami, FL 33143.

The teams coordination in California is competently being handled by **Sheryll Thomson, MFCC**, (510) 465-2542 if you are interested in joining in this very needy and worthy research project.

Item #2:

Judy Albert, MA, asks: Does your arm, elbow, shoulder get tired after using **EMDR?** Sometimes mine does even after using both arms. I had to search for an arm relief alternative since I will be going to Miami, FL, to work on the **EMDR** Disaster Response Team treating Hurricane Andrew survivors. My success came when I found an Emphasis "Pocket Pointer" which is extendable to 25" in length and retracts to the size of less than a small ink pen and has a clip on it to attach to a pocket. They are used in lectures as pointers for presentations. Some even have a

light on the end. I purchased my metal pointer at a large stationary store for $4.98. My body and clients have responded very favorably.

HURRICANE ANDREW DISASTER RESPONSE TEAM

Ruth Knowles Granger, Ph.D.
Miami, FL

On November 1, 1992, a three-person disaster response team of **EMDR** trained therapists, consisting of **Nancy Walker, MFCC**, from Sunnyvale, CA, and **Bill Reid, LSW**, and **Bill Owens, LISW**, from Columbus, OH, paid their way to Miami for the privilege of working with disaster survivors and utilizing **EMDR**. The team was oriented to the disaster area, including a self-guided tour, during which time the team saw four clients. The Team worked 5 days in three locations (Homestead, Cutler Ridge, and Sunset area), and 30 clients were seen that 11th week after Hurricane Andrew. Clients ranged in age from 3 - 87 and included police officers, nurses, administrators, managers, real estate salesmen, attorneys, nursing faculty, and volunteer relief workers. Those treated were from the US, Columbia, Cuba, Guyana, Nicaragua, Panama, Peru, and Puerto Rico. The procedure was often conducted in English and through a translator in Spanish.

The original purpose of the Team working in Miami was to provide **EMDR** treatment to Hurricane Andrew survivors. After the first day, however, we decided we would be able to conduct preliminary disaster field research. The project was designed and forms printed that night. Each client listed his/her symptoms since the hurricane, filled out an Impact of Events Scale (IES), and reported SUDS levels prior to and following the **EMDR** treatment. No control groups were used for this field research. Due to the difficulties inherent in a disaster, SUDS levels and IES were obtained from only a portion of those treated. (Also, there were Spanish-speaking individuals with whom **EMDR** was conducted with an interpreter and they did not fill out the English scale.) Pre- and post- SUDS levels were obtained on 16 clients, the pre-SUDS averaging 8.0, and a post-SUDS averaging 2.2.

22 clients filled out the Impact of Events Scale, with an intrusive subscale mean of 23 and an avoidance subscale mean of 21 with the total mean of 44 (out of a possible 75).

Six clients returned phone calls to participate in the one week follow-up, reporting SUDS levels which averaged 2.3 and IES totals of 31 (Intrusive mean 13 and Avoidance mean of 18). The newer rating method of 0,1,3,5 was utilized.

The average number of hours spent by the **EMDR** team was 1.5 hours per session. 14 out of the 30 seen had lost their homes (nearly 50 %). The major symptoms complained of were: irritability/anger/frustration (16), sleep difficulties (9), depression (8), anxiety (5), eating difficulties (4), nightmares (4), crying (3), and physical complaints such as palpitations, nausea, high blood pressure, headache, and asthma. Other reports included feelings of guilt, pity, disorientation, hopelessness, helplessness, fear, and worry.

Clients wrote comments regarding their treatment: "The experience I have had with this therapy is truly amazing. It's like being able to look at yourself, from within, but also from without. My feelings and emotions came through, without really knowing that I felt so strongly about some of these things. I really like the feeling of peace I have at this moment. Thanks."

"I have reduced my negative feelings and thoughts substantially, and am now more hopeful about the future."

"Excellent therapy provided by an excellent therapist. Through (this) procedure, I've been able to feel a calm that I haven't felt in months."

And on one week follow-up, comments included: "It worked. If you want a recommendation from me, just call."

"Calm ... the most striking thing was calm. My problem is still there, but I can handle it."

A three-year old child who screamed every time the wind blew, refused to have the door open or to play outside, was treated with **EMDR**. The next day the mother reported he left the door open and was happily playing outside in the wind.

We are greatly encouraged by the response of the clients we were able to see.

Teams of **EMDR** trained therapists will be arriving in South Florida November 29, and will be here through December 17, and will once again be providing **EMDR** treatment to Hurricane Andrew survivors, without cost to the individual. **Sheryll Thomson, MFCC**, continues to coordinate efforts from California. Please call her at (510) 462-542 to volunteer for the team. We have several slots still open.

Research indicates the most difficult time psychologically is the 3-6 month period following the disaster (Christmas falls right at 4 months). We are concerned about imminent depression and increase in the suicide rate during that period. Hopefully, the Team's arrival in early December will mitigate that.

The need for **EMDR** in South Florida will continue for months, possibly years. If the estimated 75-80% of disaster survivors resolve their difficulties naturally, and without psy-

chological assistance, in 16-21 months, that still leaves several hundred thousand individuals who eventually will need treatment in South Florida. At this early time after the disaster, almost everyone is having symptoms of post-hurricane stress to some degree, and could benefit from **EMDR**. The Team felt like there is a "window of opportunity" when survivors are vulnerable after the disaster, making **EMDR** even more effective. We anticipate this psychological window to last for the next several months, and would be grateful to have as many survivors treated as possible, hopefully preventing PTSD.

Please consider volunteering to spend a week in Florida. The Disaster Response Team needs funds for airline tickets, rental cars, food, lodging, copying, posters, research requirements, stamps, secretarial support to schedule appointments, supplies, etc. If you can not volunteer in Florida, please make a contribution for the Team, payable to: Therapy Research Institute, Inc. Donations are tax deductible according to the Internal Revenue Code.

VA NETWORK

An **EMDR** mail group exists on the VA electronic bulletin board. You need access to FORUM to get to the mail group—this is obtained at your local station. This is open only to VA individuals who have completed **EMDR** training. For enrollment, send copy of training certificate with access name and address to:

JOAN BARRON MN, RN, C.S. (118)
V.A. Medical Center
4100 West Third Street
Dayton, Ohio 45428
(513) 268 - 6411 ext 2678
FTS Phone # 950 - 2678

BOOK REVIEW

(Reprinted from Journal of Traumatic Stress, Vol. 5, No. 3, 1992)

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

GIVE SORROW WORDS: WORKING WITH A DYING CHILD

By Dorothy Judd

London: Free Association Books, 1990. 217 pages. $45

Not an Endorsement

This book is the well-written account of a loving Kleinian therapist's work with a dying 7 1/2 year old-boy. The author opens with a very articulate and informed discussion of the concepts of death and dying, with particular emphasis on children's attitudes toward death. Her presentation is richly textured with psychodynamic impressions, interspersed with literary allusions and metaphors.

These opening chapters lay the groundwork for the heart of the book, a day-by-day journal of the therapist's work with Robert who is suffering from leukemia. Robert's family has opted for an experimental treatment which affords his only, though slim, possibility of survival. The author attempts to place this treatment "within the context of new developments in hospice and hospital care" and concludes the book with a plea for informed consent regarding medical treatment-i.e., a clear understanding of the compromise to quality of life that experimental procedures may entail. Ironically, the author's understanding and enlightened approach to alternative medical, group, and hospice care does not seem to be mirrored in her own psychological treatment of the dying child. This is highlighted in her day-by-day journal, the reading of which represented the most painful experience of this reviewer's professional career.

The book reveals a therapist with "training in psychoanalytic psychotherapy," attempting to "share and explore the aspects of the child which previously were not accessible to his conscious mind" (p. 61). As such, "the transference and its interpretation becomes one of the main tools in bringing about change" (p. 6). While the author readily notes limitations that the hospital setting places on this form of therapy (e.g., the inability to keep the session time constant, and the need to focus on the child's response to the illness), she fails to alter the traditional analytic stance by the introduction of other approaches during her own treatment sessions. Consequently, during the two and a half months of treatment, primary interventions of this therapist are limited to a form of interpretive play therapy, e.g., "you're like the baby (doll), lying down a lot and having to be looked after" (p. 87) and pointed observations.

Particularly illustrative of the author's therapeutic approach is her deduction that Robert's picking at his nose is a form of masturbatory play and an attempt at mastery and control because of his illness and hospital confinement. On the basis of this interpretation she "talk(s) to him about how busy he is with his nose, and how important it must be to be the one who decides now about poking in, when doctors and nurses have to poke in a lot these days, in different ways" (p. 106). Similarly, she observes of the gurgling intravenous tube, "The drip is deciding to feed you. Even your tummy isn't deciding when it's hungry .... It's being automatically fed every few moments" (p. 106). At no time does the author introduce any pain control or self-mastery techniques, guided visualizations, hypnotic fantasies, cognitive restructuring, or relaxation techniques. Instead, as readers, we are forced through the

disheartening experience of watching the day-by-day disintegration of a child in pain, picking his lip and nose to shreds-while the therapist, albeit sorrowfully, observes that analytic writers have concluded that "nose-picking appears to be more of a masturbation equivalent" than face-fingering (p. 130).

After the boy's death, the mother reconciles her feelings and states to the author, "You were there for Robert, and he valued you. That's the important thing" (p. 145). However, an equally pertinent view might be found in a question the author herself posed as she observed nurses popping their heads into the room while she was treating the boy: "Some seem puzzled about who I am and what I'm doing here" (p. 100). The question transcends any particular perspective on debatable issues such as the manner in which a person should face death, or the long-term effects of rapid psychological change. Perhaps, the question can more fruitfully serve clinicians to focus attention on their boundaries and limitations, how they interface with the unique needs of the client and situation, and the degree of informed consent of the client regarding alternative approaches.

It appears to this reviewer to be an ethical mandate that the client and situation dictate the form of the therapeutic practice. As extrapolated from this text, we as clinicians must remember that theoretical approaches, other than those we favor, may be sincerely held by honorable and competent people, and ultimately that the client must be offered choices. Just as informed consent is ethically mandated medically and in research, no
less should it be mandated clinically. For this, the present volume, though inadvertently, provides an eloquent plea.

THE HEART OF EMDR

Clifford Lazrus, Ph.D.
National Network Coordinator
Mental Research Institute
Palo Alto, CA

Sometimes the **EMDR** work can bring unexpected delights. I was working with a client whom I had been seeing for close to a year for general anxiety and procrastination. We were in the middle of a session, involved with constructing a cognitive weave regarding a projected behavior. The positive cognition was, "Taking even a small step is good for me." Following the set of eye movements, the client in his customary "deadpan" fashion said five (VoC = 5). I asked the client to repeat the sentence to himself again and proceeded with another set of eye movements. This time he responded, in the same deadpan fashion, five and one-eighth. He saw the puzzlement on my face as I began to comment about what fine gradations of truth he was able to evaluate. Without cracking even the hint of a smile, he looked directly at me and said, "Taking even a small step is good for me."

Another client I dealt with was referred for the loss of a finger in an industrial accident by a psychiatrist who was not able to help this client psychologically adjust to the loss. The **EMDR** method seemed to deal with this issue completely in one session, although the chain of association led to some other life events and stressors for which we spent quite a few sessions. Yet, how do we know that an event so traumatic as losing part of ourselves is really dealt with in a complete fashion? A couple of weeks after we worked on the loss of the finger, the client came in with a big smile on his face as he settled down in his chair. Typically, I would surreptitiously examine the stub of his finger at the beginning of each session to make a layperson's evaluation about how it was healing (e.g., checking for any sign of inflammation or infection). This time, my glance downward was rewarded by one of the most unusual sights I have ever seen. The client had fabricated a small leather cap that perfectly fit over the finger stump and had inserted into the top of the cap a small brass hook (yes, he had become the Captain Hook of the industrial accident crowd). As my sense of immediate shock dissipated, we both broke into laughter and shared a moment which I will always hold as precious.

The efficacy of the **EMDR** procedure may certainly be approximated by reduced SUDS and increased VoC levels. However, a smile or a funny line can also signify the subtle shifts we see with clients and can certainly touch my heart.

We would like to include similar case stories in future Newsletters. Please consider sending in your favorite "heart warmer." There is more to professional support than sharing the "pain"! Let's also share the joy. Francine

Best Wishes for a
Safe, Healthy, and Festive
Holiday Season
Francine and the EMDR staff

EMDR HELP WANTED

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

Informed Consent

While we had hoped to distribute a sample informed consent form with this packet, EPIC has recommended that it be reviewed by an attorney to assess any redflags not obvious to lay people. We will attempt to send the form with the next packet. It is necessary to keep in mind, however, that regardless of a single attorney's response, each clinician should have it reassessed, since each state will have different legal criteria.

EPIC (EMDR Professional Issues Committee)

The **EMDR** Professional Issues Committee (EPIC) is recruiting new members that have either experience or interest in professional and ethical issues. We meet on the third Wednesday of each month from 10:00 A.M. to 11:00 A.M. in Palo Alto. Contact one of the following:

Lois Allen-Byrd, Ph.D.(415) 326-6465
Virginia Lewis, Ph.D.(415) 326-8752
M. McCorkle, Ph.D. (415) 322-4884

Fighting Predjuce

I am asking for ideas or collaboration in developing interventions for modification of prejudice. During my work in the Mississippi Delta at a community mental health center, it has often seemed that individual patterns of intense prejudice could be viewed as schema driven clusters of intense negative affect, irrational thinking, and behavior which result in both avoidance of cue exposure and maintenance/support of core cognitions. Many victims have also experienced related traumas or long series of "mini traumas." **EMDR** could be part of a schema-focused, cognitive-behavioral intervention. Contact: *Richard Sayner, Ph.D., Life Help, P.O. Box 1505, Greenwood, MS, 38930.*

EMDR In Employee Assistance Program (EAP)

EAP professionals who are using **EMDR** are invited to network with other EAP professionals to explore selection criteria, contraindications, evaluation, and research possibilities. Contact: *Robert J. Peters, LCSW, CEAP, Mgr, Employee Assistance Program, Rocky Mountain Adventist Healthcare, 2465 S. Downing Street, Ste. 200 A, Denver, CO 80210, (303) 778-5272, FAX (303) 778-5769*

Surveys

Howard Lipke, Ph.D., Director of the Stress Disorder Treatment Unit of the N.Chicago, VAMC, sent out surveys to all **EMDR** clinicians trained before Feb., 1992. Please return the survey to him before January. It will be invaluable for an independent assessment of **EMDR** treatment effects and pitfalls. Results will be published in 1993.

Clients With Head Injuries

Clinicians who are using **EMDR** with this population are invited to network with other clinicians to explore indications, contraindications, evaluation, and research possibilities. For more information. Contact:
Robert J. Peters, LCSW, CEAP
1720 S. Bellaire Street, Ste. 805
Denver, Colorado 80222
(303) 790-5762

Disaster Research Tools

Ruth Grainger requests copies of disaster research tools. If you would like to consult on a longitudinal disaster study to determine the efficacy of **EMDR** as a post-disaster treatment, contact: *Ruth Grainger, Ph.D., Therapy Research Institute, Inc., 8585 Sunset Drive, Ste. 65, Miami, FL 33143 (305) 595-3399 eve.*

Volunters for Rape Research

Priscilla Marquis, MS, and **Andrew Leeds, Ph.D.**, are planning an **EMDR** research project using rape victims as subjects. This project intends to answer criticisms of Francine's original 1989a study. They are looking for interested Level II trained therapists who live in the Bay Area or who are willing to travel to the Bay Area for a research training. The time commitment will involve a one day research protocol training and approximately an additional ten hour commitment. Clinicians who participate must be willing to videotape their sessions for research purposes and have access to videotape equipment. Therapists will participate on a voluntary basis. Priscilla and Andrew hope to recruit 15 clinicians. The project should begin in December, 1992, and last approximately three months. Contact: *Priscilla Marquis, MS at (415) 285¬4065.*

EMDR Bulletin Board

We are still considering an **EMDR** computer Bulletin Board where questions can be posted regarding problems encountered in clinical practice where other clinicians could reply with solutions and ideas from their personal experiences. Ideas, data, and information exchange on Special Interest Groups or client related topics would be available 24 hours a day, 7 days a week for Network subscribers. Contact:
A. J. Popky, CHT, (408) 395-8541, fax: (408) 395-0846

MONITORING THERAPEUTIC CHANGE VIA DREAM CONTENT

William Larsen, MFCC
Grass Valley, CA

Many of my clients are combat veterans who have been experiencing their various PTSD symptomatology for 20 years or longer. Because of the extremely subjective nature of their experiences, and the fact that gains in reprocessing do not necessarily transfer into immediate behavioral changes, I have sought ways to document my clients' progress as treatment continues.

Among the most common symptoms reported by my clients are sleep disturbance and nightmares. Soon after beginning to use **EMDR**, it became apparent to me that both the frequency and content of these nighttime SUDS were being affected. In general, I am noticing an immediate short-term increase in sleep disturbance/nightmares when **EMDR** is first utilized, followed by a gradual tapering off of both frequency and intensity as sessions progress. More interesting, however, are dramatic changes in the content of remembered nightmares,

The first time I noticed this was with a 100% disabled vet who was suffering combat oriented nightmares 2-3 times a week. The most common of these involved his being chased by Viet Cong soldiers through the jungle. On the night following his first **EMDR** session, he had a dream that he was chasing several Viet Cong who ran up a ridge and disappeared over the crest. This was the first time that he had dreamed of himself in a power position regarding Vietnam. He has since reported a dramatic decrease in the rate and intensity of his nightmare terror experiences.

Other changes reported by my clients include an initial sharpening of images in cases where the perceived threat is unknown, and a gradual fading of emotional intensity as the images are re-experienced after several sessions. Long-standing recurrent dreams seem to undergo revision with treatment, and this revisioning almost always pertains to an increase in the vet's ability to negotiate the imaged threats in the dream sequence

The gain in image clarity has proven extremely helpful for "fancy footwork" intervention to identity and remediate issues related to the individual gestalt of a particular vet (e.g., earlier traumas, his relationship with authority, etc.). I have also noticed an improved ability to dream and/or remember dreams among my clients with whom I use **EMDR**. (I see this as basically an increased access to their repressed imagery as reprocessing continues.)

These observations are obviously anecdotal and preliminary. I would be most interested in hearing from other clinicians who utilize dreaming in their work with **EMDR**. William Larsen, MFCC, PO Box 1061, Grass Valley, CA 94945, (916) 265-5950.

CALIFORNIA EMDR STUDY GROUPS

Jean Bitter-Moore, Ph.D. California Network Coordinator (408) 35404048

[Listed Geographically North to South]

REDDING

Dave Wilson (916) 223-2777
Meets once monthly at the Frisbee Mansion on East Street in Redding. Discussions, case presentations, videos, role playing, and "troubleshooting." Open to new members.

SACRAMENTO

Barbara Erickson (916) 737-1789
Coordinating new group. Meets on 2nd Fri. 1-3pm

SONOMA COUNTY

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

MARIN COUNTY

Steve Bodian (415) 454-6149
Coordinating a new group. Open

EAST BAY

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

EAST BAY/ALBANY

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

EAST BAY/OAKLAND

Hank Ormand (510) 530-1875
Meets in Lake Merritt area on Fri. 10-11:30am. Open.

SAN FRANCISCO

Sylvia Mills (415) 221-3030
Case discussion and group process. Open to new members.

Stan Yantis, MD (415) 241-5601
Open to new members.

SAN MATEO/BURLINGAME/REDWOOD CITY

Ron Martinez (415) 692-4658
Meets 2nd Mon. 7:00-8.30 pm. Forum to further the understanding and use of EMDR. Case consultation and practice sessions available. Open

Pat Grapinsky (415) 692-4658
Florence Radin (415) 593-7175
Coordinating a new group. Contact Florence.

PALO ALTO

Ferol Larsen (415) 326-6896
Meets 1st Wed. 10:00am in MRI conference room. Case discussion. Limited to 10 participants.

LOS ALTOS/PALO ALTO

John Marquis (415) 965-2422
Dewey Lipe (415) 852-2855
Meets ad hoc at Pacific Graduate School of Psychology in Palo Alto. Primarily case discussion. Open.

CUPERTINO

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

LOS GATOS/SARATOGA/CAMPBELL

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

SARATOGA/W. SAN JOSE

Dwight Goodwin (408) 241-0198
Meets Fri. 10am-12:30. Open

SANTA CRUZ

Linda Neider (408) 475-2849
Meets every month on a Fri. 7:00pm. Primarily case discussion. Open.

FRESNO

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

PALMDALE/LANCASTER

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

WOODLAND HILLS/NORTHRIDGE/WESTWOOD

Ron Doctor/Ginger Gilsen (818) 907-7506
Seeking new members. Contact Ginger

CENTURY CITY/SANTA MONICA

Robert Goldblatt (213) 917-2277
Coordinating a new group in the 90067, 90401 zip area for West L.A.

WEST LOS ANGELES

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

DOWNEY

Pauline Hume (213) 869-0055
Coordinating a new group. Open

MANHATTAN/REDONDO BEACH

Randall Jost (213) 539-3682
Coordinating a new group. Open

TORRANCE

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

ORANGE COUNTY/HUNTINGTON BEACH

Jocelyne Shiromoto (714) 680-0663
Meets 2nd Tue. from 9:30 - 11:00 AM. Open (714) 764-3419

SAN DIEGO

Marcee Sherrill (619) 233-0460
Times and dates to be arranged.

EMDR Newsletter Staff

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EMDR Coordinator:	Robbie Dunton, MA

1993
Newsletter Publication Dates
Deadline for Submissions
Jan. 2, 1993 for Jan. 20, 1993
Mar. 15, 1993 for Apr. 20, 1993
Jul. 15, 1993 for Aug. 20, 1993
Oct. 15, 1993 for Nov. 20, 1993

SUBMISSION INFORMATION

Submit all articles to ***EMDR*** **Network** *Newsletter, P. O. Box 51010, Pacific Grove, CA 93950-6010, (408) 372-3900. [Address articles for "Innovative Ideas" to Ron Martinez, Ph.D., and "Difficult Cases" to Andrew Leeds, Ph.D.] If possible, articles need to be submitted on an IBM formatted diskette, Apple hi-density diskette or typewritten. The deadline for the next Newsletter will be January 2, 1993.*

1993 Network Registration Form

(Print following information as you want it to appear in directory.) _____$50 ____$70 (Includes CA Meetings)

Last name:_____First name:_____
Professional Degree:_____City where practicing:_____State:_____Zip:_____
[Mailing address and residence phone number will not appear in directory.]
Mailing Address:_____City:_____State:____Zip:_____
Phone (Bus):_____(Res)_____
Professional Licensing:_____Willing to take referrals:_____yes____no
Specialty Areas:_____
Membership: _____ISTSS_____AABT_____APA_____Other:_____
Academic Affiliation:_____Research Interests:_____
SIGs or special interest areas:_____
EMDR Level: [ ] Level I - Year trained:_____ [ ] Level II - Year:_____ [ ] Facilitator
Comments:_____

Cost for participating in the Nat'l Network is $50 for 1993 [$70 includes Nat'l Network meetings in Calif. Bay Area.] Nat'l membership entitles you to receive copies of the EMDR Newsletters, journal articles, directory, selected audiotapes and discounts on the EMDR Conference and specialty trainings.

Check payable to: **EMDR Network* P. O. Box 51010* Pacific Grove* CA 93950-6010* (415) 328-5821**

Newsletter

Training Registration Form

PLEASE PRINT NAME THE WAY YOU WANT IT TO APPEAR ON THE CERTIFICATE

Name:_____Phone (Bus): _____
Address:_____Phone (Res): _____
City: _____State: _____Zip: _____Prof. Lic. #:_____
COST: $285.00 [$315 postmarked 15 to 30 days before seminar date, $345 less than 14 days before seminar, CEU $10].
Make check payable to: **EMDR**, P.O. Box 51010, Pacific Grove, CA 93950-6010, (408) 372-3900, fax (408) 647-9881
Please circle: **LEVEL I:** Location:_____Date:_____
LEVEL II Location:_____Date:_____
If LEVEL II: Your date of Level I Basic Training:_____Specialty:_____
Additional requests for topics in training:_____
[For Office use Only: Amt_____Ck_____Confrm_____]

Newsletter

1993 LEVEL I BASIC TRAININGS

Presented by Francine Shapiro, Ph.D.

Date	Location	Local Sponsor	Phone
Jan. 21/22 Thurs./Fri.	Perth, Australia Parmelia Hilton	Graham Taylor, MA Chris Lee, MSC	(01161) 9310 3254 (01161) 9389 2100
Jan. 29/30 Fri./Sat.	Sydney, Australia The Ritz-Carlton	Robbie Corbet, B.S.C., Dip.Psych. Gary Fulcher, M.Psych.	(01161) 2389 4021 (01161) 2736 6550
Feb. 3/4 Wed./Thurs.	Wellington, NZ Park Royal	Robbie Dunton, MA Coordinator, **EMDR**	(408) 372-3900
Feb. 19/20 Fri./Sat.	San Jose, CA Sunnyvale Hilton	Robbie Dunton, MA Coordinator, **EMDR**	(408) 372-3900
Feb. 27/28 Sat./Sun.	Dallas, TX Holiday Inn DFW Airport N.	Deborah Corley, MA Dir., Diamond Mt. Center/Dallas	(214) 350-1431
Apr. 3/4 Sat./Sun.	Washington, DC Omni Shoreham	Sherrie Vavrichek, LCSW Connie Olsen, LCSW Myron Brenner, MD Manuel Morales, Ph.D.	(301) 593-4040 (301) 217-0098 (410) 771-4438 (410) 266-0070
Apr. 17/18 Sat./Sun.	Denver, CO Sheraton Denver Tech. Center	Andrew Sweet, Psy.D. Behavior Therapist Inst. of CO	(303) 759-3720
May 1/2 Sat./Sun.	Chicago, IL Holiday Inn Crowne Plaza Northbrook, IL	Howard Lipke, Ph.D. Dir., Stress Disorder Treatment Ctr. N. Chicago VAMC	(708) 688-1900x4673
May 14/15 Fri./Sat.	San Jose, CA Sunnyvale Hilton	Robbie Dunton, MA Coordinator, **EMDR**	(408) 372-3900
May 22/23 Sat./Sun.	Honolulu, HI Pacific Beach Hotel	Sandra Paulsen, Ph.D. Pacific Inst. of Behavioral Med.	(808) 523-2990
June 18/19 Fri./Sat.	New York, NY Loews NY Hotel (51st. & Lexington)	William Zangwill, Ph.D. Gerald Puk, Ph.D.	(212) 663-2989 (914) 635-1300
June 27/28 Sun./Mon.	Portland, OR Sheraton Portland Airport	Jean Sutton, LCSW	(503) 452-9625

1993 LEVEL II TRAININGS

Presented by Francine Shapiro, Ph.D.

Apr. 23/24, 1993 Fri/Sat	San Jose, CA Sunnyvale Hilton
June 12/13, 1993 Sat/Sun	Denver, CO Sheraton Denver Tech. Center
July 10/11, 1993 Sat/Sun	Chicago, IL Holiday Inn Crowne Plaza

- **History-taking and specified questioning for focused identification of problem areas**
- **Closing down "incomplete" sessions**
- **Axis II applications**
- **Integration of EMDR with cognitive therapy**
- **Dissociative & other major disorders**
- **Abreactive responses and alternative strategies**
- **Working with difficult/resistant clients**
- **Integrating "self-control" techniques**
- **Treatment of Process Phobias**

Contact: Robbie Dunton, MA
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