INTERNATIONAL EMDRIA™ ASSOCIATION

EMDRIA™ NEWSLETTER

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Message From The President: Remembering the Gift

Curtis C. Rouanzoin, Ph.D.

As I write this column, I am excited about the International Conference that will be held in Baltimore on July 10th through 12th. The Conference will have something for everyone, including terrific keynote speakers and workshops for nearly all clinical interests. I hope to see you there.

The past several months have brought the ongoing importance of EMDR to my consciousness again. At times, I take for granted the powerful gift EMDR is to all of us who work with traumatized people. I take for granted dramatic and rapid changes . . . the termination of long-held symptoms . . . the ease with which some chronic patients end their suffering.

Over the past several months, those of us in the United States have seen numerous shootings in our public schools, survivors of violent crimes and catastrophes, and the horrible effects of trauma on everyday people. As I watch these news reports, I find myself saying, "I can help them." For years, I watched these reports and shook my head, feeling how unfortunate it was that the victims suffered so horribly. I knew I could help to some extent, but deep inside I did not believe I could be *truly* helpful. Supportive—yes. Empathetic—yes. Even help with problem solving—yes. But deep inside, I relied on the hope of change within the patient to end his or her suffering (almost in spite of my efforts).

With EMDR, I now view such news stories and I know I can help. I know *we* can help. Not just by putting a band-aid on trauma, but by ending the ongoing repetition of traumatic stress for good.

I recently saw a patient who was horribly abused for years. As a mature mother and wife, she had gone through many years of excellent traditional treatment. She was referred by her primary therapist in the hope of ending the ongoing nightmares and irrational fears about the abuses of long ago. After an extensive intake, we targeted some of the most disturbing memories. In two months, her flashbacks ended, her nightmares stopped, and she finally realized that she could no longer be hurt by her abusers. Cognitively and intellectually, she had known this for years. For her, the difference was in the fact that, after EMDR, she felt and totally believed it was over. She left treatment with a sense of peace and security that I could have only hoped for prior to EMDR.

We have a gift to offer our patients. I hope all of you will not "take for granted" the power of this method as I found myself doing. In the eyes of our patients, it is not just another treatment modality. It is a life saver.

May you practice it in peace.

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From the International Scene

Marilyn Luber, Ph.D.
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We are quickly moving toward the middle of July and the EMDR International Association Conference: EMDR~Treatment & Transformation. This year, Baltimore is hosting this convocation of EMDR aficionados and I hope that all of you plan to attend. Graciela Rodriguez is leading a program on the differences, surprises, and joys of teaching and using EMDR in different cultural settings. We hope you will be there and bring your own observations and experiences. If you cannot attend, please write to me at the above e-mail address so I can include them.

I am delighted to introduce our readers to Mark Grant from Sydney, Australia. Mark has been using EMDR from early on and is an active member of the EMDR Association of Australia (EMDRAA). In his current capacity as Chairman of the committee that governs EMDRAA, he has helped to coordinate the legal incorporation of the EMDR Association of Australia. He has referred to this experience as "a process with more 'blockages' than a resistant EMDR client!" The headquarters of EMDRAA is based in Sydney but Mark reports that he foresees the administration moving around the country as the committee faces re-election every two years. He hopes that EMDRAA will serve the needs of Australian therapists and extends an invitation to other EMDR associations in the Pacific region to call on EMDRAA to provide advice and support. EMDRAA produces a quarterly newsletter called *Saccades* that is currently guided by the leadership of Jennifer Braithwaite (one of the original founders of EMDRAA). She writes about Mark in the September, 1997 edition of *Saccades*: "My first and very pleasurable task as the new Editor of *Saccades* is to thank Mark Grant for his hardworking and able efforts in launching our newsletter. Mark is dedicated to developing and strengthening the Association. The role he played as Editor and his new role as Chairman demonstrates his commitment to these ends and we as members reap the benefits. Thank you, Mark."

When Mark is not tending to EMDRAA business, he can be found in Sydney where he maintains a private practice. He is known for his interest and contribution to the use of EMDR in the treatment of pain management and has developed methods of incorporating EMDR into the psychological management of pain. He presented on this subject at the EMDR International Association Conference in San Francisco in 1997 and has written a manual for chronic pain that is currently being submitted for publication. He is also interested in the interface between pain and culture. The concept of Emotional Intelligence and the possible correlation between EQ and susceptibility to EMDR is another area of fascination for Mark. He is the author of two self-help tapes that incorporate bilateral stimulation and were inspired by its use in EMDR.

In addition to his involvement in politics, publishing, and psychotherapy, Mark is a clinician who has mastered the intricacies of the Internet and he has produced a website called "Mark Grant's Chronic Pain Pages." His website includes articles about the psychological treatment of chronic pain (including the use of EMDR), medication, links to other pain sites, scans of pain patients, information about support groups, self-help resources (including EMDR tapes), and information about EMDR trainings. You can find this website at:

http://www.ozemail.com.au/~markgra

One of six siblings, Mark notes that his first 20 years were spent in New Zealand and the last 20 have been dedicated to Australia. He sees himself coming from "a transplanted English culture, with a bit of pioneer spirit thrown in." He studied psychology at the University of Sydney and graduated with a Master of Arts, majoring in Psychology in 1989. While at the University, he participated in a research project investigating the role of attitudes and beliefs in peoples' reactions to information about AIDS.

Mark not only works hard, he plays hard and admits to a love of nature and the ocean. He enjoys exploring the Australian coastline and recently went snorkeling on the Great Barrier Reef where, after floating above the many different-shaped and multi-colored corals and viewing the colored fish, he had this to say: "I felt a powerful awareness of the tremendous variety of life on our planet, and the preciousness of that." He relaxes with Yoga and enjoys non-fiction books concerning the universe, sci-fi movies, and spicy foreign food.

We look forward to Mark's continuing involvement with the evolving world of EMDR.

News from Around the World

- **Europe:** There will be a convocation of European EMDR International Association members in Holland at the end of May to explore the pooling of the resources of European members. The spirit of cooperation exhibited by the European members has been a wonderful process dating back to beginning friendships that occurred during the first EMDR trainings in Amsterdam in the early 90's and continuing into the present. Congratulations, EMDR-Europe.

- **France:** Francois Bonnel is happy to report that red badges are being trained in France.
- **Germany:** Gottfried Fischer, Monika Becker-Fischer and Arne Hofmann hosted a very successful Congress on Trauma in Cologne during March, 1998 featuring Bessel van der Kolk as the keynote speaker. Five hundred German clinicians attended and many others had to be turned away because of the lack of space! Four days later in Gottingen, Ulrich Sacchsse hosted an afternoon symposium on trauma and had 300 attendees! The concept of trauma is one that is coming of age in Germany. Our German colleagues are doing their best to ensure that their colleagues are well-trained in identifying, understanding and treating trauma in their patients. Christof T. Eschenroder edited the first book published in German, *Eine neue Methode zur Berarbeitung traumatischer Erinnerungen, a* text that includes work by American, Dutch, and German authors.
- **Israel:** EMDR-IS, under the expert tutelage of Elan Shapiro, Udi Oren, and Gary Quinn, just sponsored Level I and II seminars in Bet Berl at Levinson College. These three EMDRIA™ members have been working hard to introduce the benefits of EMDR to Israeli therapists and the Israeli communities. Many women's groups , as well as members of the organization AMCHA, dedicated to working with survivors of the Holocaust and their children, attended these two trainings.
- **Latin America:** John Hartung reports that he presented at the Psychology and Peace Conference in Guatemala.
- **United Kingdom/Ireland:** David Blore is back from a HAP-funded trip to Moscow to present a workshop on his "Underground Trauma Protocol"—an updated version of his Level II specialty presentation, "Tips from the Pits"—subsequent to two major mining disasters in Siberia and the Ukraine. As a result, there is a formal request for a Level I training in Moscow, and he was asked to lecture at Moscow State University in May, 1999.
- **United States:** Donna D'Aloia reports that she has just developed a protocol for treating post herpectic pain (shingles) and has had "great results," including helping people to eliminate their need for pain medication.

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EMDRIA™ WORLD WIDE LINK (WWL)

Jocelyne Shiromoto, LCSW

We are well on our way in helping those interested in becoming EMDRIA™ WWL Regional Meetings Coordinators to set up shop. We ask for your continuing support and patience as we begin this new sub-organizational task and smooth out some of the rough edges along the way.

EMDRIA™ WWL Regional Coordinators

The first step is to provide you with Regional Coordinator(s) for your area. We recently sent Regional Coordinator Applications to all of the past 1997 and current EMDRIA™ members. If you did not receive one and are interested in applying, you can request an application by contacting our administrative office or obtain one from our EMDRIA™ Website at www.emdria.org. Again, we want to invite those who currently have active meetings to apply in order to be under the auspices of EMDRIA™.

Thus far, we have had quite a few responses from those interested in becoming Regional Coordinators. When an application is made, a WWL committee consultant will contact the applicant(s) to further help with the initial setting up process, consult, and give on-going support as needed. If there is more than one applicant in the same area, they will be given each other's name and asked to develop an area team. While team coordination offers opportunities to contribute as well as to share the workload, there may be problems with developing such a team in certain areas. If this is the case, a WWL consultant and/or an EMDRIA™ Administrative Office staff will help in developing other alternative plans.

By the next *EMDRIA™ Newsletter*, we hope to begin listing EMDRIA™ WWL Regional Coordinators. After Regional Coordinator(s) are identified in your area, please contact those individual(s) to express your interest in attending meetings. Coordinators will mail meeting information to EMDRIA™ members in their area and attempts also will be made to contact non-members who have completed EMDRIA™-approved training in EMDR.

First Annual Regional Coordinators Meeting

For those coming on board as Regional Coordinators, we will be holding our first annual Regional Coordinators Meeting at the 1998 EMDRIA™ International Association Conference on Saturday, July 11th from 12:00 noon to 1:30 p.m. (You're welcome to bring your lunch to the meeting room.) If you cannot attend the conference, we will notify you of the discussions and results of the meeting.

EMDRIA™ Continuing Education Experience in EMDR (CEE)

In the last *Newsletter*, we reported that CEEs will be needed to apply and/or reapply for the *EMDRIA™ Register*. There will be many opportunities to earn CEEs especially at the WWL Regional Meetings and our EMDRIA™ Annual Conference. If you have further questions regarding CEEs or the *Register*, please call our administrative office.

Changes with the EMDRIA™ Speakers Bureau

The list of EMDRIA™-approved speakers has been shifted to the Standards and Training Committee, chaired by Curt Rouanzoin, to ensure quality in continuing education. In the next *Newsletter*, there will be more information concerning this change and transition. Meanwhile, we ask for your indulgence.

EMDRIA™ Library

We are still working on this endeavor and will keep you posted as progress develops.

Newsletter and Website Listings of "Not for Fee" Study Groups

We need your help! If you are an EMDRIA™ member and have an active study group (or want to begin one), and you want your study group to be listed in the *EMDRIA™ Newsletter* (see pages 6 and 7) and on the EMDRIA™ Website, please submit the information directly to Liz Snyker (see listing below).

If you have any further questions, please notify our administrative office or any of the WWL Committee members below. See you at the Conference!

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* *Study Groups are not an affiliation of EMDRIA™ nor does EMDRIA™ bear any responsibility for Study Group activities.* ⇔

POST YOUR EMDR STUDY GROUP IN THE NEXT *EMDRIA™ NEWSLETTER*!

If you have an existing Study Group—or will be starting a Study Group—and want it posted in the next *EMDRIA™ Newsletter*, please submit it to the EMDRIA™ administration office by August 15, 1998. When submitting your Study Group, please provide the following information (by completing and sending this form or providing the information in another format.)

My Name: _____

Study Group Date: _____ Day: _____ Time: _____

(If Study Group start date is not yet known, please state "time open.")

City: _____ State/Province: _____

Phone: _____ Fax: _____ Email: _____

(Please see page 6 of this issue for current postings to the Study Group Listing.)

STUDY GROUP LISTING

The following list is provided to give EMDR-trained clinicians an opportunity to join a Study Group in their area. These are "no fee" discussion meetings. If you would like to join a Study Group, please contact the group leader in your area.

If you would like to start an EMDR Study Group, please contact the following EMDRIA™-approved training entity. (Other training entities will be listed in future editions of the *Newsletter*.):

EMDR Institute, P.O. Box 51010, Pacific Grove, CA 93950-6010
Tele: (408) 372-3900
Fax: (408) 647-9881
E-mail: Inst@emdr.com

Please Note: Although the Study Groups are listed in this EMDRIA™ Newsletter, these groups are not an affiliation of EMDRIA,™ nor does EMDRIA™ warrant or otherwise assume responsibility for content of meetings nor competency of group leaders.

UNITED STATES

Alaska

City: Anchorage, AK
Name: Larry Holman
Tele: 907-272-7002
Fax: 907-272-2851
E-mail: lholman@alaska.net

California

Southern California
(Santa Barbara to San Diego)
Advanced EMDR Clinician Study Group
Name: Jocelyne Shiromoto
Tele: 714-764-3419
E-mail: shiroflex@aol.com
Every two months. Location will rotate

City: Corona, CA
(Riverside, San Bernadino)
Name: Linda Vanderlaan
Tele: 909-279-7099
Fax: 909-279-4837
E-mail: Lvanderlan@aol.com
1st Friday each month, 9:30 to 11:00 a.m.

City: Fullerton, CA
Name: Curt Rouanzoin
Tele: 714-680-0663
Fax: 714-680-0570
E-mail: CCRounzun@aol.com
2nd Tuesday of each month,
9:30 a.m. to 11:00 a.m.

City: Irvine, CA
Name: Lois Bregman
Tele: 714-262-3266
Fax: 714-262-3299
4th Friday of each month,
9:30 a.m. to 11:00 a.m.

City: San Diego, CA
Name: Liz Snyker & Carol Seidenwurm
Tele: 760-942-6347 & 760-944-7273
E-mail: esnyker@bigfoot.com
1st Saturday of each month,
9:00 a.m. to 10:30 a.m..

Colorado

City: Boulder, CO
Name: Keith Andresen
Tele: 303-443-5682
Fax: 303-443-5682
E-mail: kandre1041@aol.com

City: Denver, CO
Name: Laura Knutson
Tele: 303-753-8850
Fax: 303-753-4650
E-mail: lauknutson@aol.com

Connecticut

City: Hartford, CT
Name: David Russell
Tele: 860-233-7887
Every other month, 2nd Saturday,
10:00 a.m. to 12:00 p.m.

Delaware

City: Wilmington, DE
Name: Frankie Klaff
Tele: 410-392-6086
E-mail: klaf54944@dpnet.net
3rd Friday of each month,
12:00 p.m. to 1:30 p.m.

Florida

City: Orlando, FL
Name: Carl Nickeson
Tele: 407-898-8544
Fax: 407-898-9384
3rd Tuesday of each month,
8:30 a.m. to 10:00 a.m.

City: Pompano Beach, FL
Name: Brenda Starr
Tele: 954-974-8329
Fax: 954-629-4779
E-mail: bastarr@loveable.com
Every 4 to 6 weeks on Friday,
12p.m. to 1:30 p.m.

Hawaii

City: Honolulu, HI
Name: Silke Vogelmann-Sine &
Larry Sine
Tele: 808-531-1232
Fax: 808-523-9275
E-mail: silke@silke.com &
sine@sineposta.com

Name: Darlene Wade & Terry Wade
Tele: 808-545-7706
Fax: 808-545-5020
E-mail: wadeandwade@compuserve.com

Illinois

City: Chicago, IL
Name: Howard Lipke
Tele: 847-537-7423
E-mail: HLipke@aol.com

Kansas

City: Overland Pass, KS
(Greater Kansas City area)
Name: Lawrence Nieters
Tele: 913-469-6069
E-mail: lnieters@juno.com
2nd Thursday of each month,
8:30 a.m. to 10:00 a.m.

Michigan

City: Bloomfield Hills, MI
Name: Eileen Freedland
Tele: 248-647-0050
Fax: 248-683-7010

Minnesota

City: St. Paul, MN
Name: Chris Baldwin
Tele: 612-825-4407
Fax: 612-825-0768
E-mail: baldwoo2@maroorto.tc.umn.edu

Montana

City: Missoula, MT
Name: Nancy Errebo
Tele: 406-721-4918
E-mail: nerrbo@montana.com
1st Monday of each month,
11:15a.m. to 1:00 p.m.

New Jersey

Name: Barbara Korzun
Tele: 609-895-1070
Fax: 215-862-9370
E-mail: bkorzun@dplus.net
1st Friday of each month,
9:30 a.m. to 11:30 a.m.

New Mexico

Name: Peggy Moore
Tele: 505-255-8682 ext. 145
Fax: 505-255-7890
E-mail: pvmoore@unm.edu

New York

City: Fayetteville, Syracuse, NY
Name: Maudie Ritchie
Tele: 315-251-0909
Fax: 315-637-2643
E-mail: msritchie@aol.com
1st Monday of each month
12:00 p.m. to 1:30 p.m.

City: Southampton, NY
Name: Marcia Schwartz
Tele: 516-287-3758
Once a month on Saturday,
11:30 a.m.-1:30 p.m.

City: New York City, NY
Name: William Zangwill
Tele: 212-663-2989
Fax: 212-663-2989
E-mail: WZANGWILL@aol.com
Meets quarterly.

Oregon

City: Bend, OR (Central Oregon)
Name: Karen Forte
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Once per month on Tuesdays,
12:15p.m. to 2:00 p.m.

Pennsylvania

City: Bloomsburg, PA
Name: Dorothy Ashman
Tele: 717-387-1832
Fax: 717-387-5103
E-mail: kent@csrlink.net
Once per month on Fridays,
9:00 a.m. to 10:00 a.m.

Texas

City: Fort Worth, TX
Name: Janet Ragsdale
Tele: 817-336-7925
Fax: 817-336-7925

City: Hurst, TX
Name: William Gumm
Tele: 817-589-1419
Fax: 817-589-7918

City: San Antonio, TX
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4th Tuesday of each month,
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Fax 804-282-3038
E-mail: jspiro@atlas.vcu.edu

Washington

City: Spokane, WA
Name: Marty Jones
Tele: 509-685-1436
E-mail: martyj@plixx.com
1st Monday of each month
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11:00 a.m. to 1:00 p.m.

City: Olympia, WA
Name: Diana Cushing
Tele: 360-786-5009

Wisconsin

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OUTSIDE THE UNITED STATES

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City: Vancouver, B.C.
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1st Monday of each month,
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Israel

City: Raanana
Name: Udi Oren
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E-mail: udioren@inter.net.il
2nd or 3rd Friday of each month,
9:30 a.m. to 12:30 p.m.

City: Tivon (Haifa and Northern Region)
Name: Elan Shapiro, Yair Emanuel, and Esti Bar-Sadeh
Tele: +(0)4-983 2760
Fax: + (0)4-953 0048
E-mail: elan@mofet.macam98.ac.il
1st Wednesday of each month,
8:00 to 10:00 p.m.

NOTE: To maintain a current Study Group list, PLEASE notify the EMDRIA™ Administrative Office with up-to-date information about your group.

BioLateral Sound Recordings: An Effective Alternative to Eye Movements

Invented and Produced by
David Grand, RCSW, EMDR Facilitator

What Are BioLateral Sound Recordings?

BioLateral Sound Recordings (or BioLateral for short) are tapes and CDs which can replace eye movements in EMDR stimulation. Their ability to integrate bilateral and psycho-acoustic stimulation is opening new vistas of treatment, healing, relaxation, and meditation. BioLateral offers one of the least costly of all alternative EMDR technologies and can be easily used by clients during, as well as in between, sessions. Through the use of BioLateral, clients frequently report experiencing deeper meaning, increased insight, and improved ability to synthesize material.

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

How Were BioLateral Tapes Developed?

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

The first tests of BioLateral were performed with friends and family, who uniformly reported they experienced a powerful relaxation effect with both soothing and deep, yet non-agitating, processing. I began using BioLateral with clients in session using a stereo "walkman," providing clients with a BioLateral tape for home use between sessions.

The success of the original tape led to requests for new ones. We accordingly returned to the studio and recorded BioLateral 2–*Going To Wave Lengths*, which combines ocean sounds with a bilateral brush tone and BioLateral 3–*Round the Lake*, which fully integrates the bilateral stimulation into music that sounds both Gaelic and Eastern, and BioLateral 4–*A Simple Progression*, a basic bilateral chorded eight-step progression. Responses to all of the tapes continued to be enthusiastic.

I have also just released a CD, *The Best of* BioLateral, which contains tracks of all four BioLateral melodies, digitally remastered for the highest sound quality possible.

How Is BioLateral Used?

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

How Will My Client's Benefit from BioLateral?

BioLateral tapes and CDs take advantage of the client's ability to process through auditory stimulation and provide an effective, low-cost means of effecting bilateral stimulation, including the following advantages:

- The left/right aural tones produce the same bilateral stimulation as the eye scanning, eliminating the need for eye movement.
- Client eye strain, as well as therapist arm and shoulder stress, are eliminated.
- The passive stimulation of BioLateral tapes tends to reduce client distraction that can result from other methods.
- Clients can choose to process with their eyes closed, allowing for more imagery and deeper processing.
- The tapes and CDs allow each set to continue as long as you or the client chooses. Therapists have reported that educated clients are often better able to determine the length of a set as they are witnessing the processing "from the inside."

Internal Conference Room Ego-State Therapy and the Resolution of Double Binds: Preparing Clients for EMDR Trauma Processing

Shirley Jean Schmidt, MA, LPC

Since its inception, EMDR has grown to work with an ever-increasing variety of therapeutic methods in the mental health community, and ego-state therapy is no exception. Ego-state therapy has roots in hypnoanalytic therapy and the treatment of dissociative disorders (DD). Even without hypnosis, and with non-DD clients, ego-state therapy can be an important companion to EMDR therapy. It has great diagnostic value, can aid in screening and preparing EMDR candidates, and can help unblock stuck processing during EMDR. This article focuses specifically on one ego-strengthening method that can be very useful to EMDR therapists when preparing clients for trauma processing.

I recently realized the power of ego-state therapy while working with a client with many chronic illnesses and too little ego strength for processing her significant childhood trauma. Our initial sessions focused on learning about and addressing her paralyzing double binds, and on strengthening inner resources. I was surprised to learn that, after a short time, she experienced a dramatic reduction in symptoms. Her story is summarized at the end of this article.

There are many whose concepts have led the way to understanding consciousness as "parts" or ego-states. Ellenberger (1970) noted that St. Augustine in his "Confessions" pondered whether personality was a unity, and that "Divided personality" was known by the end of the eighteenth century. Janet (1907, 1925) described this phenomenon in his work with dissociative disordered patients. John Watkins was greatly influenced by the concepts of psychic energy and ego-states of Paul Federn (1952) and his disciple Edoardo Weiss (1960) and began his formulation of ego-states theory in the early 1970's. During that time, Roberto Assogioli (1973, 1965/1975) published his ideas about the multiplicity of the mind as subpersonalities. In addition to these subpersonalities, Jung (1963, 1968, 1969) and Assogioli talked about the Self or Center that is different from the parts. Schwartz (1995) elaborated on these concepts and applied his family systems training to conceiving and working with a person as a system of parts and a Self. Learning from his clients, Schwartz focused on the relationships among the parts and the Self and defined the Internal Family Systems (IFS) therapy. From the work of Watkins and Schwartz, the parts concepts can be applied far beyond the treatment of dissociation, to a broad spectrum of other psychogenic disorders, as well as normal problems of adjustment (Watkins, 1997).

Parts models assume an individual is a conglomeration of different ego-states (a.k.a. parts, or inner selves). It may be helpful to think of ego-states as specialized neural networks that hold specific packages of information related to behavior, affect, sensations, and knowledge of our life experiences (Braum, 1988). For example, a corporate executive may have one neural network for behaving in the boardroom, another for interacting with his/her spouse, and yet another for playing with his/her small children.

All is well when ego-states communicate, cooperate, and appreciate each other. However, problems may occur for the individual who grows up in a dysfunctional family or chaotic household, leading to diametrically opposing neural networks for storing different traumatic experiences. As an example, one neural network may hold evidence that it is dangerous to be passive, while another may hold evidence it is dangerous to be assertive. When this traumatized person is grown and has to decide whether it is better (safer) to approach a particular problem by being passive or assertive, these parts may go to war with each other. This double bind may not resolve easily, because there is "good evidence" from personal experience, to support each opposing view.

Fraser (1991) wrote about the internal conference room as an important tool for communicating with alters in his treatment of dissociative disorders. In brief, the internal conference room is a guided imagery technique which involves asking the client to imagine a safe meeting place such as a conference room, and invite all ego-states (parts) to enter the room and take a seat at a conference table for the purpose of personal growth. Fraser found this approach helped gain access to the inner ego system of his dissociative identity disorder clients. Many clinicians have found this true for non-DD clients too.

The conference table approach offers a great climate for working through the double bind, a type of internal conflict between parts holding diametrically opposing views. For example: one part may believe that safety comes from being in relationships, while another believes safety comes from being alone; one part may believe that safety comes from being sick, while another believes safety comes from being healthy. In my opinion, it is best to learn about and resolve these conflicts as much as possible, before processing trauma, for two reasons: (1) addressing these conflicts increases ego strength, and (2) EMDR may be ineffective when opposing ego states are working at cross purposes. Ego-state therapy helps the inner ego system pull together as a team to work towards the same goals.

Below is a simplified example of using ego-state therapy to address a double bind. Client, Betty, wrestles with confusion about how to react to her abusive husband. Part of her favors being assertive and standing up for herself, even leaving the marriage if necessary. This part gets angry at the

husband and believes self-protection comes from pushing back aggressors. Another part of her favors being passive, giving in to the abuser's demands and soothing him when he is upset. This part feels sorry for the husband and believes self-protection comes from "caving in." To work through this dilemma it may be helpful to take Betty through a series of steps:

1. Starting to Connect the Parts

Say to Betty, "Close your eyes and imagine these two parts of you (passive part and assertive part) sitting across a table from each other, and describe what you see." Do not be surprised to hear of images of great conflict, like two monsters fighting, or a little girl crying and an angry woman yelling, and so forth. Sometimes conflict is not evident from the images and it is necessary to ask, "Would you describe their relationship as more 'friendly' or more 'hostile'?" If the double bind is significant the answer will likely be "hostile."

2. Acknowledging Common Interests/Goals

"What goals do you suppose both of you (parts) have in common?" If an answer is not forthcoming say, "I'll bet you're both interested in helping Betty feel safer. The only problem is you don't agree on how to do it. Does that sound right?" Expect agreement.

3. Acknowledging Survival Intentions

"Betty, would it be okay if I talked with the 'passive' part?" (Do so only with permission.) "I would like you (passive part) to know how much I appreciate your being here now, and that I understand and honor the hard work you have been doing for so long to protect Betty. When I consider your history it makes perfect sense to me that you believe safety comes from giving in to abusers. I suspect you would not be here if you did not believe there was a real need for your services now. Does this sound right to you?" Expect agreement.

4. Hinting that the Desired Safety May Be Possible through Other Means

"Do you (passive part) ever find there are disadvantages to protecting Betty this way? For example, does it require a lot of energy?" Parts will typically name one or more disadvantages. Follow up with, "If it were possible to ensure the same level of protection and safety you get from being passive, without the disadvantages, would you be interested?" Expect a "yes" answer.

5. Checking for Uncomfortable Body Sensations

"Betty, what do you notice in your body now?" If this part is open to new possibilities for safety, the body will likely release tension; if this part is fearful, the body will suddenly feel uncomfortable. If discomfort comes up, talk to the discomfort, as if it were a part, and say, "Thank you very much for expressing your feelings. There must be a very good reason for feeling this way, will you help me understand it?" Depending on the answer, you may go back to Step 3 and honor the intention of the fear in promoting survival.

6. Acknowledging Survival Intentions of the Next Relevant Part

Once the "passive" part is open to new possibilities, ask for permission to talk with the "assertive" part, and attend to the same questions from Steps 3 to 5, honoring the belief that safety comes from standing up to abusers.

7. Can Parts Agree to Work as a Team? / Assessing EMDR Readiness

Once all relevant parts and body sensations have been heard, validated, honored, and respected, ask Betty about how the picture of the two parts at the table has changed. Expect the parts to appear less threatening to each other. Ask, "If it were possible for you (addressing both parts) to get more safety by working together, as a team, would you be interested?" It might be helpful to add, "If this other part had an important contribution to make to your safety and well being, would you be interested?" This is a very important moment in client screening and preparation. If the idea is frightening, Betty is not yet a good trauma processing candidate. However, if the notion of a team approach eels hopeful and if it releases tension in the body, Betty is fast becoming a good EMDR candidate.

8. Strengthening the Team / Assessing EMDR Readiness

"What might be required to make it safe enough for you (two parts) to begin working together?" The answer to this question may lead to other necessary resource installations, cognitive interweaves, and/or psycho-educational interventions. This may also be a good time to help the parts respectfully exchange views—point and counterpoint—to gain a deeper appreciation of each other's intentions to protect. The willingness of parts to work cooperatively may or may not be easy to accomplish, depending on the nature of the trauma history and the level of dissociative defenses. This step could take minutes, sessions, or months.

9. Installing the Team Spirit and Associated Positive Cognition

Finally, when Betty reports that all relevant parts are feeling friendly towards each other, willing to learn from each other and work together, and the body feels relaxed and hopeful, strengthen this bond by installing it with bilateral stimulation. If it feels true to the client, use a PC like, "We

(Continued on page 12)

(Ego-State Therapy - Continued from page 11)
can learn to work together as a team for Betty's safety and well being," using the clients own words. Strengthen the PC with bilateral stimulation.

10. Testing Ego Strength / Assessing EMDR Readiness

If this is Betty's first time with bilateral stimulation begin with a short set and check if it is helping or not. A client's initial response to bilateral stimulation may be an important indicator of ego-strength. If she reports little to no change with the bilateral stimulation, one may need to go slowly—using minimal bilateral stimulation in the beginning and only to strengthen positives, where appropriate. If the PC strengthens a lot, more insights arise, and client returns to the next session with reports of positive change in her life, it may be appropriate to do future ego-state processing with continuous bilateral stimulation. As with EMDR trauma processing, the bilateral stimulation seems to help the opposing neural networks exchange information more readily as if these neuro-segments are connecting to form a continuous neuro-path. This seems to lead to a more rapid integration of adaptive information between ego states.

The steps outlined above are rather directive and as such may be counter to the working style of some therapists. In my experience these steps are highly validating and reassuring to clients who, generally, have never before considered that there may be "benefits" to their reactive parts and shadow sides. The dialogue proposed provides a model clients can use for approaching their inner conflicts. Over time, they internalize these dialogues and learn to validate, honor, and respect the survival intention of their dissenting parts. While this example describes working with two parts in conflict, sometimes several parts are relevant to a double bind. The same steps can be used with two or more parts.

Working with parts and the relationships among parts is more than merely following a suggested protocol. John and Helen Watkins offer extensive workshops on the fundamentals of ego-state therapy and Dick Schwartz offers a two-year training program at the Family Institute, Northwestern University. The use of this protocol may uncover previously undiagnosed DD. Clinicians who are not trained in treating DD should not attempt to do so with proper supervision.

Case study

My experience working with a 54-year-old female I'll call Georgia illustrates the value of this approach. Last fall I began working with Georgia, who was living with her abusive husband of 34 years. She presented with several chronic health problems, including fibromyalgia, osteoarthritis, endolymphatic hydrops, borderline hypercalcimia, hyperparathyroidism, heat intolerance, sleep disorder, and Crohn's disease. Over a 20-year period she has had all but one-fourth of her bowel surgically removed. She used a walker and often wore a headband with ice cubes because if her brain became too warm she would suffer temporary neurological distortions. Her energy level was chronically low and she was in constant pain.

Georgia had been in psychotherapy on and off for 25 years. When she came to me, she was afraid to work on her childhood traumas directly, which included chronic sexual abuse, because she feared she would become flooded and overwhelmed, as she had in past therapy. She agreed to work with me when I told her we would do nothing but ego strengthening until she felt ready to address the trauma, which she believed to be the root of her many problems. I even postponed taking her history because she said it would be too stressful.

This was the first time she had experienced ego-state therapy. She reported many ego states, and two were much like the passive and assertive parts of Betty, but with a twist. There was also an ego state that believed she had to stay married to her abusive husband to maintain her medical insurance. Because her chronic illnesses (and her husband) had kept her out of the work force, she feared she would have to stay married to keep the medical coverage she needed. Fortunately, she had several wonderful, loving resource ego states, and a remarkable capacity to quickly get in touch with an unconditional higher power loving kindness. The focus of our work has been three fold: (1) addressing multiple double binds (with the steps listed above, often with bilateral tactile stimulation), (2) connecting the loving resources (internal and higher power) with ego states that needed love and understanding (strengthened with bilateral tactile stimulation), and (3) learning how to have a more loving relationship with her chronically ill body.

Just a few weeks after resolving many of her paralyzing double binds, Betty began to report significant improvement in her health, her outlook on life, and her self-esteem, and she continues to improve on all fronts. She has since filed for divorce, something she has wanted to do for more than 20 years. Six months later, we are just beginning to process childhood traumas with EMDR. She is handling the requisite emotional disturbances very well and connects quickly to her inner resources as needed. She describes her own progress by saying:

> "Since I began (ego-state) therapy in November '97, there have been several significant changes in my physical, mental, and emotional well-being. For several years, I had been almost homebound at times. I have endolymphatic hydrops which resulted in problems with my balance to the extent that I had been using a walker when I went out to do almost anything. I haven't used my walker since January 1. I still experience brief periods of feeling "tilty," but I am able to compensate by using techniques I have learned as a side benefit of the therapy we have been doing. Because of the fibromyalgia, I experienced a great deal of pain at times. When the weather was beginning to change, not only would the

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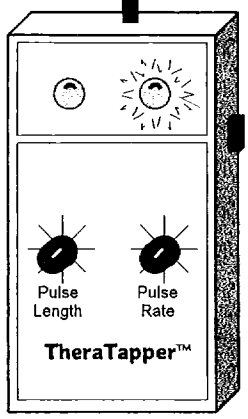

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"I find that 90% of my clients prefer the TheraTapper to EMs. I was initially surprised to find, that in addition to the increased ease and comfort for the client, most reported increased effectiveness in processing with the TheraTapper, and that feedback has continued over the 6 months I've used the device. I find the TheraTapper to be invaluable in my EMDR practice." **Rick Levinson, MSSW**

"Before I bought my TheraTapper I found EMDR with my highly cognitive clients was often ineffective and disappointing. When I started using the TheraTapper I was absolutely amazed. It somehow allowed these clients to break through their over-intellectualizing, allowing safe passage to the painful issues that most needed attention." **Regina Cansler, MA, LMFT**

"I work with kids a lot. I tell them the TheraTapper is a "gizmo." They think of it as a fun electronic device, and take to it quickly. It is much easier for kids to hold the gizmo than to sustain EMs." **John Palmer, LMSW**

"The TheraTapper is an excellent addition to the growing field of EMDR technology. It is the only one which provides bilateral tactile stimulation. It is non-intrusive and highly effective and has my endorsement. It works!" **David Grand, RCSW EMDR Facilitator**

"I like the TheraTapper, it is nice and soothing. It is not abrupt or startling at all for the client. It also gives me a lot of space from the client if they cannot tolerate the closeness EMs require. It saves my arm, can be an additional stimulation other than the eyes, and is generally easy to use and handy." **Susan Thompson, LSCSW**

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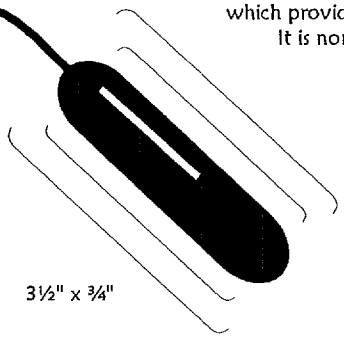
"I first used my TheraTapper with 4 patients who had been reluctant or unable to respond to EMs or any kind of physical touch – such was the severity of their trauma. The TheraTapper performed its task well. All 4 showed improvement and relief over several sessions. I'm happy with this tool." **Irene R. Mazer, PhD**

"I enjoy the TheraTapper very much in my practice, it is much more convenient than EMs in that I don't have to start and stop - can continue processing as long as is needed, doesn't seem to break the flow. It is relaxing and seems less threatening to clients than EMs. I have seen a lot of progress in many of my clients while using the TheraTapper." **Stephanie Ecke, LPC, LCDC**

"A tool that is kept in the front of a toolbox is simply one that works. Many times I find that the TheraTapper reaches places that eye or ear stimulation do not. That's why I keep my TheraTapper right in the front of my toolbox." **Lawrence Nieters, PhD**



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pain level increase, but I would also have greater difficulty concentrating and processing information, along with difficulty with word retrieval. I now am much less sensitive to changes in the weather and no longer anticipate having problems when the weather changes. I seldom have problems with word retrieval now and have made a correlation between sleep deprivation and the "mental fog" I often experienced in the past several years. My sleep patterns have improved, and except in periods of unresolved and unusual stress, I am sleeping longer at night with fewer times of waking up.

Overall, I am much less sensitive to changes in my environment. I had been using a frozen headband on my head to keep me cool, in order to deal with an over-sensitivity to heat. I even had a special vest used by firemen to handle periods of extreme heat. So far this year, even with temperatures in the 90's, I have not used any of these products. I am still sensitive to heat, but I am able to calm down that hyper-reaction most of the time. I recently noticed I have recovered my ability to sweat, which had been gone for 10 years.

The fatigue that I experienced most of the time for many years has lessened and it is my anticipation that I will gradually be able to return to work. I no longer view myself as a chronically ill person but as someone with physical difficulties that are manageable. I have been able to decrease the medication I take for pain management to a very low dose, at times even discontinuing it entirely. I am on more or less the same level of antidepressant. I also still take medication every night to help me sleep but anticipate being able to reduce and hopefully discontinue that medication within the next six months. I still have an ileostomy and short gut syndrome due to Crohn's disease, and I still have osteoarthritis, fibromyalgia, etc.

There are some things that I will continue to deal with every day that I cannot change, but how I deal with them has changed. The therapy we have been doing has changed my life. My outlook has improved to the point that I now am caught off-guard if I revert to my old habits of feeling like there is no hope and my life is over. I feel hopeful, excited about the possibilities of my present and future, in control of my own life, and able to handle whatever comes. I've never felt more alive and centered."

Special thanks to James A. Kowal, M.A. and Andrew Leeds, Ph.D. for reviewing my drafts and providing valuable feedback and encouragement.

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THE EMDRIA™ REGISTER

EMDRIA™ is publishing a *Register* of EMDR-trained clinicians. The *Register* is different from our *Membership Directory*. The *Register* differs in that it will independently list licensed/certified mental health professionals who have utilized EMDR in their clinical practice, have pursued ongoing supervision/consultation, and continue to use it in the highest ethical and professional manner. Members and non-members of EMDRIA™ will be listed as long as they meet the criteria.

Purpose of the *EMDRIA™ Register*

The purpose of the *EMDRIA™ Register* is to benefit the general public by providing a convenient, centralized list of EMDR therapists who voluntarily applied and met the criteria for listing in the *Register*, where such criteria are recognized as promoting the integrity of EMDR. To support this purpose, the *EMDRIA™ Register* will be made available to the general public. The public may utilize the *Register* to find an EMDR-trained therapist in their area, and EMDRIA™ plans to publish the *Register* on the Internet as well as in hard bound copy for therapists.

Criteria for Listing

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

Therapists listed in the *Register* must meet the following criteria:

1. A current license or certification as a mental health professional allowing for the practice of his/her mental health profession.
2. Successful completion of an EMDRIA™-approved training program in the practice of EMDR administered by an independent organization.
3. An affidavit declaring that the therapist has conducted at least 50 EMDR sessions with at least 25 clients and has participated in peer and/or other supervision of at least 10 of their own or others' cases.
4. Completion of a total of 12 hours of EMDRIA™-approved continuing education experience (CEE) in EMDR, administered by EMDRIA™ or other EMDRIA™-approved organizations every two years. NOTE: This requirement will not be in effect until 1999; only 6 hours of CEEs will be required for listing in 1998, 6 hours in 1999 totaling 12 hours by December 31, 1999. The requirement will then be 12 hours at the end of two years, renewing every two years thereafter. (EMDRIA™ will offer approved CEEs at the Annual Conference and other EMDRIA™-approved courses will be accepted.)

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

Application for Listing in the *EMDRIA™ Register:*

For listing, please submit the following:

1. Completed *Register* Application.
2. An affidavit declaring that the applicant has conducted at least 50 EMDR sessions with at least 25 clients and has participated in peer and/or other supervision of at least 10 of the applicant's or others' cases.

3. A photocopy of the applicant's license or certification as a mental health professional (psychologist, psychiatrist, LCSW, MFCC, or equivalent) and proof of successful completion of an EMDRIA™-approved training course administered by an independent organization.
4. Documentation of at least 6 hours of EMDRIA™-approved continuing education experience (CEEs) in EMDR, administered by EMDRIA™ or other EMDRIA™-approved organizations, by December 31, 1998; 6 hours by December 31, 1999; 12 hours every two years thereafter. (EMDRIA™ will offer approved CEEs at the Annual Conference and other EMDRIA™-approved courses will be accepted.)

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

Renewal for Listing in the EMDRIA™ Register

1. A photocopy of applicants current license or certification as a mental health professional (Psychologist, Psychiatrist, LCSW, MFCC, or equivalent)
2. Documentation of at least 6 hours of EMDRIA™ approved continuing education experience (CEE) in EMDR, administrated by EMDRIA™ or other EMDRIA™ approved organizations completed by December 31, 1998. (List of EMDRIA™ approved CEE providers is available in the Administrative office and on the website)

Fees for Listing

Fees for being listed in the *EMDRIA™ Register* are as follows:

New Applicants:

$50 for applicants who are current Members of EMDRIA™ and who meet the criteria.

$100 for applicants who are not current Members of EMDRIA™ and who meet the criteria.

Renewing Applicants:

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

The *EMDRIA™ Register* is designed to provide a benefit to both the general public and EMDR therapists by providing a convenient, centralized list of EMDR practitioners. To achieve this goal and to be included in the next printing of the *Register*, all mental health professionals who meet the criteria are encouraged to apply or renew for inclusion as soon as possible.

The 1998 *Register* will be issued in the Spring of 1999.

THE EMDRIA™ REGISTER APPLICATION

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OFFICE ADDRESS_____ STE._____

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TEL_____ FAX_____ E-MAIL_____

ADDITIONAL OFFICE ADDRESS_____

CITY_____ STATE_____ ZIP_____ COUNTRY_____

TEL_____ FAX_____

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

Institution where received:_____ DATE_____

LICENSE/CERTIFICATION: License or Certification to practice.

Mental Health Profession_____ ID Number_____

State or Country issued:_____
STATE OR COUNTRY

Please send a copy of your license/certification ❑ (Check box)

EMDRIA™ APPROVED TRAINING: Please send a copy of your certificate of completion for EMDRIA™ approved training (I.E. Level I AND Level II from the EMDR Institute or other EMDRIA™ approved Institutes, -or- have completed a minimum of 18 didactic and 13 supervised hours in an academic institution, etc) (certificate must list total hours and be signed by Instructor)

❑ (Check box)

OTHER EMDR TRAINING: (e.g., Teacher/Trainer/Facilitator for EMDRIA™-approved EMDR Instruction) **(Limit 2)**

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THE EMDRIA™ REGISTER APPLICATION continued

OTHER BOARD CERTIFICATIONS: (e.g., ABPP, AAMFT Approved Supervisor, ACSW, etc.)**(Limit 2)**

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_____

LIST SPECIALTIES: (e.g., PTSD, DD, Sexual Abuse, etc.) **(Limit 4)**

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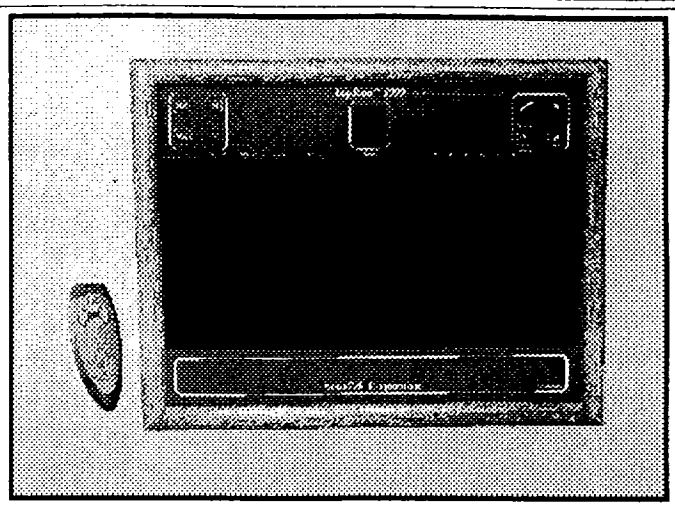

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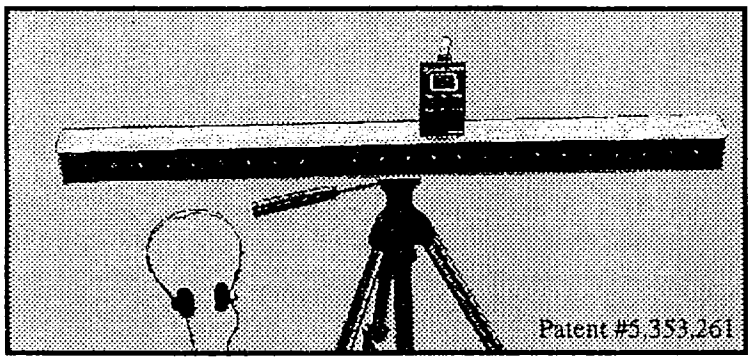

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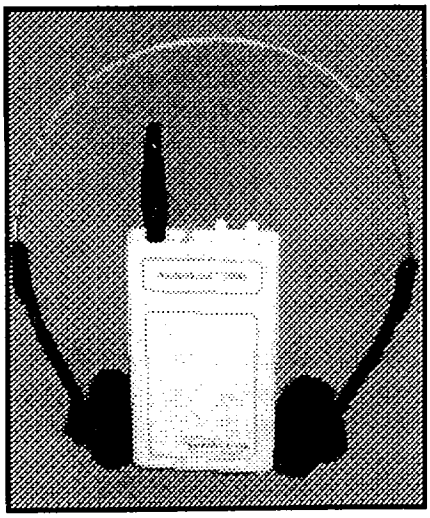

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Combining EMDR with Relapse Prevention Programs to Enhance Treatment Outcomes with Sex Offenders

Tim McMulin, LSCSW, CTS
Certified Trauma Specialist

There have been numerous barriers to the development of comprehensive and successful treatment for sex offenders. One of the primary barriers involves societal views of offenders as being incorrigible and first and foremost deserving of punishment. Offenders themselves have fed that view because of the seemingly impenetrable defense mechanisms they develop to maintain a sense of safety from others as well as their own thoughts, feelings, and memories. Other barriers to development of comprehensive treatment models involve the failure of traditional psychodynamic techniques, which focus primarily on resolving intrapsychic conflicts, to provide cost effective, adequate, and reliable treatment results (Lockhart, Saunders, & Cleveland, 1989).

These types of barriers and outcomes have contributed to the development of numerous treatment programs that focus primarily on the cognitive/behaviorally-based relapse prevention techniques. The overriding goals of such programs are usually to decrease future perpetrations by helping the offenders become aware of and develop alternate responses to the triggers associated with their deviant cycle and to develop empathy for their victims and others (Nelson, Miner, Marques, Russell, & Achterkirchen, 1989). Partly due to the lack of effectiveness of psychodynamic approaches and partly because of societal appeals for punitive measures, any focus on the offenders' own histories of victimization has often been viewed as tertiary, or even coddling the offenders by excusing their offending behavior because they themselves were once victims. Hence, facilitating the reprocessing of the offenders' own histories of victimization often is not viewed as integral to offenders being able to develop empathy for others. Nor is much consideration given to the role that such processing would play in the development of the motivation necessary to understand, alter, and continuously monitor their maladaptive behaviors for the rest of their lives (Lockhart, et al, 1989).

Since this author began offering services to offenders in 1989, several patterns associated with these treatment concerns emerged:

- Most of the offenders were themselves victims of various types of abuse, often including sexual abuse.
- Of the offenders who were victimized, most were either blamed by their primary care-takers for their victimization or the offenders kept it secret because of their fear that they would be blamed for their own victimization.
- Most of the offenders identified at an early age with the behaviors of their own perpetrators that were motivated by power and control.
- Most of the offenders were attempting to meet very basic human needs through distorted desires that were often associated with their own unresolved victimizations.
- Most of the offenders have addictive personalities and utilize various forms of dissociation throughout their lives.
- Most of the offenders find their offending behaviors ego dystonic and, as such, utilize a combination of cognitive distortions to rationalize their behaviors and then a form of dissociative amnesia to alter or block out various details of their offenses.

These findings coincide with those of Lockhart, et al., (1989) and O'Brien and Bera (1986) who noted that most adult sex offenders began their offenses as teenagers. Along with Longo's (1982) study of 16- to 19-year-old sex offenders that concluded that most had learned of sexual matters before puberty and had sexual encounters with adults at least eight years older than themselves, these findings are supplemented by Burgess, Hartman & McCormick's (1988) study of child sex rings, which determined that the longer the children were abused and the more the children were blamed by their primary caretakers for their victimization, the greater was the probability that the children would develop severe aggressive, antisocial, and sexually promiscuous behaviors as they aged.

Like Burgess et al., (1988), Taska, Feiring & Lewis (1997) found that perpetrating children had higher levels of shame, self-blame, and dissociative tendencies regarding their own history of victimizations than children who had also been victimized but who were not known to have become perpetrators. "Self-medication, dissociation and acting out behaviors" were strategies identified with individuals who had repeatedly experienced the intense negative states of shame and self-blame (Taska et al., 1997, p. 16). The study then concluded that "treatment interventions which address shame, stigmatization and attribution directly may produce greater improvements in and/or reduce the likelihood of these children's acting out behaviors" (Taska et al., 1997, p. 17).

It is the intention of this article to offer an alternate approach to sex offender treatment that incorporates the foundation of relapse prevention techniques, along with the more psychodynamic therapeutic stance that unresolved traumatic events of childhood often lead to later

maladaptive, compulsive, and addictive behaviors. And, as such, that having offender treatment focus on relapse prevention techniques, without addressing and resolving the origins of the offenders' maladaptive urges and behaviors, only leads to frequent treatment failures and additional victimizations due to the continued post treatment internal cueing occurring within the offenders (McMulin, 1994a). To address this perceived shortcoming in offender treatment along with the above stated patterns associated with offenders, the following protocol, which incorporates the use of Eye Movement Desensitization and Reprocessing (EMDR) as a cost-effective and reliable trauma resolution technique (Shapiro, 1996), (Wilson, Becker, and Tinker, 1995) was developed and successfully utilized to supplement offender treatment models based on relapse prevention techniques.

The protocol is a viewing technique that is a variation of the Traumatic Incident Reduction (TIR) protocol (French, 1991) and it is to be used prior to and in combination with (Wolf, 1997) the regular EMDR protocol (Shapiro, 1995). Due to the average offender's aversion to the reprocessing of experiences and behaviors, it is recommended to use more eye movements (EMs), approximately 50 to 60 per set versus 24, to encourage a more complete reprocessing per set. This melding of the protocols from these two trauma resolution techniques helps bypass the muting effect that the offenders' defenses have on their ability and motivation to accurately reprocess various traumatic incidents from their own histories of victimizations as well as their perpetrations.

Viewing Protocol Prior to Using EMDR with Sex Offenders

The purpose of this protocol is to help the offenders access their affective responses more effectively prior to obtaining their initial Subjective Units of Disturbance scale (SUDs) levels (McMulin, 1997).

- Establish the earliest and/or most emotionally significant incident to the offender.
- Describe the technique as viewing a movie or video silently to themselves and then sharing it with the clinician.
- Help the offender establish a starting and an ending point to the incident. If the incident had some sort of associated events in close time proximity to the primary event, then also include those (e.g., client discloses an event two weeks later to his family and is blamed or rejected by them, or attending a funeral after the death of a loved one). If there is a time gap between primary and associated events (i.e., two weeks), the offender can just skip over the time gap like a movie fast-forwarding to a future scene.
- Inform the offender that these reference points are flexible and may extend either way as the offender remembers more material associated with the event.
- Establish a time frame for the incident (e.g., 15 minutes, three hours, two weeks, etc.).
- Ask the offender to go to the start of the incident and freeze frame it (put movie on still pause) and share everything they are aware of at the start of the incident only (try to incorporate as many of their senses as possible). Encourage offender to be aware of their thoughts and feelings at the time of the incident.
- Repeat that you want the offenders to view the incident silently to themselves as though they are watching a movie. Inform them that, as they do the silent viewing, they are to be especially aware of what they were thinking and feeling as the event was occurring.
- After they finish the silent viewing, tell them that you will ask them, "What happened and how did you respond/react to it?" Again, stress that you want them to focus not only on the actions of the event but also on their responses to it at the time. The offender is then to verbally share all of the details they can remember of the event from start to finish.
- Instruct the offender to go to the start of the incident and watch the incident all the way through without interruption until they reach the end and to inform you when they reach the end. If the offenders stop for any reason, you can process why they stopped and have them restart the tape where they left off.
- You may note that, as the offender proceeds through the viewing, they will often have noticeable rapid eye movements (REMs), body movements, involuntary utterances, etc.
- When the offender finishes sharing the incident with you, you can then proceed to the normal EMDR protocol.

Again, the primary benefits of including this viewing protocol prior to EMDR with offenders are more effective accessing of the offenders' affective responses, more realistic SUDs responses, and EMDR sessions that are more effective and efficient.

Points in Treatment for Use of the Viewing Protocol with EMDR

The various times in treatment that the use of this viewing technique in combination with EMDR have proven therapeutically beneficial are as follows:

After the offenders have been able to acknowledge the details of their offense(s) and the various triggers associated with their deviant cycle. It is used at this time to address the offender's own histories of various victimizations which tends to increase offender empathy for self and others and to develop appropriate responsibility for their own victimizations as well as their perpetrations. This is done only after they can fully describe their deviant cycle, because addressing these issues sooner tends to encourage

(Continued on page 22)

(Treatment of Sex Offenders - Continued from page 21)
offenders to assume a victim stance and avoid accepting responsibility for their perpetrations (i.e., I perpetrated only because I was a victim).

After the offenders have developed a relapse plan for their deviant cycle , the protocol can be used to help them desensitize any of the triggers they have identified as being associated with their offense(s). This is very similar to A.J. Popky's (1998) addiction cessation protocol. This helps offenders feel less compelled to follow old scripts (urges) regarding certain triggers (Price, 1998a).

After the offenders have completed a Victim Empathy Letter (Bays, Freeman-Longo, Montgomery-Logan, 1990) in which they assume the role of their victim writing a letter to the offender regarding how they (the victim) felt about the offender before, during, and after the offense(s) and how it has affected their view of themselves, life, others, etc., as well as an Apology Letter (Freeman-Longo, Bays, Bear, 1996) to the victim, the protocol can be used to address the offenders' history of perpetration.

Many offenders show initial improvement after using the first application of the protocol described above, but then develop a secondary depression with associated maladaptive behaviors. This is because they tend to identify themselves with their own perpetrators, not out of a distorted power and control stance, but as being an evil person who deserves to be punished and perhaps even die for what they have done. The use of the protocol at this point helps the offenders clarify the difference between toxic shame, (e.g., I am a mistake) with no hope for redemption, and healthy shame, (e.g., I made mistakes and I have the power to make different choices so as to avoid similar mistakes in the future) (Bradshaw, 1988).

The protocol is used after the Victim Empathy Letter and the Apology Letter so as to avoid muting the effects of those particular exercises (which are often cathartic in and of themselves for the well-prepared offender) and to decrease the triggering affect that toxic shame has on the offenders' deviant cycle.

During the latter stages of treatment where adaptive skills are being reiterated and rehearsed, the protocol is used to install future templates that include the utilization of these new adaptive skills. This enables the offenders to have a sense of efficacy regarding the skills they have been learning in treatment and thereby be more inclined to incorporate them into their daily living.

In the early stages of treatment for offenders who are not so much antisocial as relying on a form of dissociative amnesia to block out details of their offense(s) that they find particularly ego dystonic, the viewing protocol can also be used. The viewing protocol can be used repeatedly in these situations, to help the offenders clarify the details of their (usually most recent) offense(s). Or, if only tidbits of new information emerge with the viewing protocol alone, then the EMDR protocol can be incorporated focusing on any new information that emerged with the viewing protocol. This approach allows many offenders to break through their denial long before they might have otherwise and, after memories of their most recent offense are clarified, memories associated with any other offenses often self-correct without further intervention.

The final application of the viewing protocol is to be used once the offenders have achieved the therapeutically desired level of empathy and remorse using a covert sensitization technique which this author refers to as the Thought Stopper Exercise (Lockhart et al, 1989). An example of how this author has adapted the Thought Stopper Exercise follows.

Use of the Thought Stopper Exercise

After completing the initial assessment phase of treatment, introduce the offender to the Thought Stopper Exercise that they will be expected to use weekly throughout the duration of the treatment program.

PART 1. (Using a male offender as an example.) The offender is asked to think about his most recent victim and what he found attractive about his victim. Then he should think about what they would like to do to their victim in general (e.g., "I want to fondle her vagina."). He should think of actually approaching his victim to reoffend. Before he is able to touch his victim, the victim looks him in the eyes and says something like, "Stop, [name of offender], I know what you are going to do. Why are you doing this to me?" or other appropriate statements. The police come and arrest the offender. As the police take him the squad car, the people whom the offender feels closest to see him being put into the police car and know why he is being arrested. Finally, the offender envisions himself in prison thinking about how he has affected his victim, the victim's family, the offender's family, and finally the offender himself.

[This part of the exercise does several things: 1) It helps the offender who is minimizing his offense to regain more details of the offense and to develop more empathy for his victim(s). 2) It gives an offender who is overcome by toxic shame the opportunity to face his mistake and realize that he is developing a tool to help avoid reoffending. 3) It retrains the body's hormonal system to associate the offense with negative emotional feedback versus sexual stimulation. 4) It allows the therapist to monitor the client's responses over time to determine what the offender found most distressing (e.g., the effect to the victim, public shame, being incarcerated, etc.). This, in turn, helps the therapist determine whether the offender is developing a greater capacity for empathy. Repeated focusing on the effects on the victim and others indicates increased empathy by the offender. The therapist should not give feedback on what the offender focuses on or it may contaminate future responses due to the offender's attempts to give the "right" answer.]

PART 2. If the offender has done Part 1 correctly, he should be experiencing some degree of cognitive dissonance for

hours or even days. After the dissonance dissipates, he is to fantasize about a loving nurturing sexual encounter with an age-appropriate partner. This fantasy should include no thoughts of bondage, denigration, or force, and should be completed by having sex with someone with whom the offenders have an established relationship, or by masturbating if they are not in a relationship or if their partner is not interested at the time.

[This part of the exercise gives the offender practice in taking personal responsibility for his own sexual needs in an adaptive way versus relying solely on another person to meet sexual and emotional needs. It also allows the offender to focus on what a loving nurturing relationship might look and feel like, and makes it easier for them to achieve such a relationship in the future (McMulin, 1994b).

The offender is required to share the outcome of their Thought Stopper Exercise during the check-in portion of each treatment session. After the offender has shared his Thought Stopper the therapist is to ask, "What stood out for you?" or "What distressed you the most when you did the exercise?" Once the offender has achieved a level of empathy that repeatedly and realistically focuses on the effects of the offenses on their victims and others, then the protocol can be used to help install this heightened sense of empathy and awareness. Use of the protocol in this fashion reinforces the effects achieved in the first application of the protocol described above and increases the client's motivation for positive change in their lives. Incorporating this variation of the EMDR protocol with adaptive fantasies has some historic precedent in the works of Stava (1984), who combined hypnotic uncovering techniques to expose the repressed traumatic material of pedophiles with adaptive sexual fantasies to achieve desired treatment results.

Results of the Protocol

Variations of the above protocol have been used with offenders in outpatient as well as institutional settings. Non-empirically measured outcomes associated with offenders in this writer's outpatient treatment program who have successfully completed the protocol regimen as compared to offenders who have not, or who have attended other treatment programs include probation officers reporting that the offenders show significant improvement. Those completing the protocol regimen are more compliant, express more empathy and remorse regarding their offenses, express more appreciation for the treatment process, have lower incidents of associated addictive behaviors, express a more positive outlook for their futures, and had no known new offenses for approximately a two-year period.

Empirical studies in the institutional setting are being arranged by Price (1998b) who has been achieving similar results utilizing the protocols with sex offenders in the Canadian Correctional System. These studies are targeted to have a five-year follow-up period incorporating feedback from questionnaires given to the offenders' parole officers.

Preliminary results suggest that combining this variation of the EMDR protocol with a relapse prevention framework seems to address the treatment concerns cited at the beginning of this article as well as producing results that exceed relapse prevention approaches alone. By helping reprocess the offenders' previously unresolved traumatic issues associated with their offenses, the protocol significantly decreases the offenders' urges to respond to established triggers. It also enables the offenders to move beyond relapse prevention to become more of an emotionally integrated and behaviorally adaptive individual than they themselves initially believed possible. As with any treatment intervention, this protocol is bound to be proven to have certain limitations as to the scope of offender populations to which it is found to be efficacious.

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HEURISTICS

David L. Wilson, Ph.D.

Most of the published research on EMDR to date has focused on the "domain of verification"—many case studies on EMDR applied to different clinical issues, some reports on a series of cases, a few well controlled outcome studies, a very few component analyses (See Shapiro, 1995, 1996). This work in the domain of verification is necessary to corroborate clinical impressions and legitimize our work in the eyes of the academic and research community. However, in recent years this emphasis on the "domain of verification" seems to have overshadowed exploration in the "domain of discovery."

In the early 90's, in the early days of EMDR, there was much excitement and enthusiasm among the students of Dr. Shapiro, a sense of helping to develop and shape a possible breakthrough in psychotherapy. No one really knew how and why EMDR worked, or the span and limits of its applications. Consequently, there was a great sense of adventure, of exploring into unchartered territory, of new developments emerging before our very eyes. In those days, Ron Martinez (1991-92) produced a column on "Innovative Uses" for the *Network Newsletter*. Some ideas which are now incorporated into the standard EMDR protocol were first introduced in Ron's column.

Of late, there has been an increasing trend toward systematizing and codifying EMDR. Much of this is positive and necessary. You do need to learn and practice scales before you can start playing jazz. At the same time, I think a too rigid standardization is premature. In her training and supervision, Dr. Shapiro has always emphasized that EMDR is not a cookie cutter, the Institute is not a church, and we are not learning catechism. Once proficient with scales, EMDR-trained clinicians are not only expected but encouraged to start playing jazz—to adapt the standard protocol to fit one's own style and to express one's own creativity with respect to special populations and interests. The thing is, clinicians introducing new protocols and variations need to utilize mechanisms, such as systematic clinical observations and formal research, to test these variations. Otherwise, EMDR runs the risk of becoming a deluded hodgepodge of clinical folklore.

The problem, as I see it, is how to maintain the most productive balance between solid research to test already existing EMDR protocols and pushing out into the domain of discovery. In essence, we need to balance innovation with research. Some of us are more talented in one area than another. My own talents run toward innovation, or at least toward generating more ideas than

I will ever be able to test by myself in this lifetime. Like Dr. Shapiro, I have discovered that I want to see a lot of things tested out, but I do not have the personal resources to do all the research that needs to be done. In my opinion, we have just scratched the surface on the possible variations in and applications of EMDR.

Possible Variations

I. The apparent utility of alternating bilateral auditory or tactile stimulation in lieu of eye movements raises many questions:

Is one modality more effective than another?

Is one modality more effective by itself or in combination with one or more other modalities?

Is one modality or another more effective for particular issues?

Is one modality or another more effective for particular people?

What are the effects of variables like speed and angle of presentation in using eye movements? What about rate, tone, content (bells, gongs, drums, etc.), loudness/softness in one ear or the other with auditory input? Location (i.e., acupuncture points), character (taps, vibrations, strokes), and rhythms in tactile stimulation? Are "relaxing effects" different than "accelerated information processing" effects for one modality or another?

There is already considerable clinical folklore in these areas.

With eye movements:

Generally, slower speeds and/or looking downward is more evocative of changes in emotions; faster speeds and/or looking upward is more evocative of changes in thinking; diagonals elicit different kinds of responses than horizontals; verticals are particularly helpful in clearing dizziness/vertigo, and perhaps in working through certain issues, such as very early childhood trauma or fear of heights; a circular movement breaks up fixed ways of seeing things (a la Reich); the horizontal infinity symbol movement particularly relaxing (certainly gives the eyes a break); end points work best for neurologically immature individuals (young children) or neurologically-impaired patients (Alzheimer's, Parkinson's, recovering methamphetamine/cocaine addicts).

With the audio scan:

Slower speeds are more relaxing; faster speeds have more impact on thinking; loud on the right/soft on the left or vice versa may be more relaxing than a uniform volume; different folks prefer different tones for whatever reasons.

With tactile stimulation:

Tapping the palms, back of the hands, knees, hamstrings—all seem to work; bilateral stimulation of acupressure points may be more effective with some issues/patients than with others.

How much of this folklore is really "for sure"? So far as I know, very little. How would you go about testing the effects of these variables? I have been studying the effect of different rates in the different modalities, and between one modality and another, on blood pressure, heart rate, and skin temperature, considering such as operational measures of "relaxation." Are there better or simpler ways to study the matter? How would you proceed?

Given that people may learn more effectively or preferentially in visual, auditory, or kinesthetic modes, and that traumatic events may present more potently to different senses, could we develop tests for these variables and tailor our interventions to the best possible combination for this particular individual who has suffered this specific trauma? What kind of tests would be most appropriate and effective? Again, I have my ideas. I have been using simple self-report on the vividness of imagery in visual, auditory, and tactile modes. How would you approach this area?

II. As David Grand (1997) suggested in connection with the development of the Bio*Lateral* tapes (presenting alternating bilateral auditory stimulation) does it accelerate information processing to have a patient listen to such tapes, or the NeuroTek Audio Scan (1997), during a "talking" (i.e., not focused in the EMDR framework) psychotherapy session? My own clinical experience suggests that this arrangement does "pull" for whatever is emotionally "hot" for the patient (i.e., whatever it is that constitutes "unfinished business" for that patient at that moment). Moreover, there are a surprising number of abreactions in proceeding in this way. Something is going on here. How would you research this area?

III. What about using a splitter (so that two people can listen to the same auditory input at the same time) with the Audio Scan? If patient and therapist are both listening to the same input, does this increase/accelerate attunement, empathy, and encounter? What about having couples listen to the same audio input during couple's therapy? On a non-clinical basis (i.e., trying things out with friends), this procedure does seem to move two people toward a greater congruence in mood, as measured by adjective checklists. Would this accelerate resolution in couples working through issues? At this point, I have no idea how this notion would stand up under rigorous systematic testing.

Anyway, you get the idea. Some of us need to focus on the "domain of verification"—methodologically sound research to see if what we clinically think is so is really so. But some of us need to continue in the "domain of

THE DIVE METHOD

Dean Furukawa, D.S.W.

In life, we find that much of what holds us back is fear. This was the theme of the movie, "Defending Your Life," in which, after dying, the main character must examine his life only to find that he continually made decisions which restrained his personal growth due to his fear and lack of belief in self. Certainly other emotions like shame and guilt, sadness and anger play key parts in the reprocessing of trauma. However, experience has shown that fear is quite often either related to the emotion that is associated with the trauma focus, or the stated emotion turns into fear as reprocessing commences.

Fear poses an interesting paradox, and as Dr. Shapiro has pointed out, sometimes it is the fear of a trauma target rather than the target itself which poses a blockage to reprocessing. Therefore, a method for dealing with anger, for example, may be to focus not on the anger itself, but to ask the client whether there is fear of the anger and, if so, to have the client focus on the fear and not on the anger, the latter of which may subjectively feel too overwhelming to even contemplate dealing with for the client. For example, a client may fear that if his or her anger were to come out in full force, he or she would lose control and it would be dangerous. Experience and clinical applications have shown that by having the client focus on the fear of anger but not on the anger itself, upon reprocessing the fear dissipates and then the anger surfaces, does not feel as scary, and reprocesses more easily, often changing into sadness or grief, and then going to neutral.

Based upon this discovery, I have developed the DIVE method as a corollary to EMDR practice. This method is based upon the experience, both clinical and personal, that often the fear of a fear is worse than the trauma target itself, and the phenomenon that once we confront a personal fear it tends to dissipate, even to the point of the outer condition changing (more on that later). The paradox of fear is that the closer one gets to a personal fear, the more overwhelming and terrifying it feels but, upon confronting the fear, the more formidable it seemed, the greater the relief upon its reprocessing to neutral, and the greater the sense of relief that results.

When one considers the role of bodily and emotional defense mechanisms kicking in to protect and insulate us from a core trauma, we realize that there is no paradox after all. The "attack" of our defense mechanisms intensifies and fear increases as we get closer to a core trauma. At the same time, this self-protective mechanism acts as a buffer, repelling us from releasing the core trauma and insulating us from pain. While this effect is much more intense in traditional talking therapy, high fear and stress levels which are encountered during sessions may result in looping, blockage, or even abreaction even when using EMDR.

A method for dealing with these situations in therapy is to combine EMDR with the DIVE method. This method involves simply having the client visualize the fear as a pool of liquid, giving it a color, and if willing, to have the client see himself

NEW BROCHURE FOR PROFESSIONALS SOON AVAILABLE!

The Public Relations Committee has completed a new brochure about EMDR for mental health practitioners, physicians, and other professionals. The brochure is appropriate for distribution at speaking engagements, grand rounds, and conferences.

Contact the EMDRIA™ office for ordering information at 512-451-5200 or via e-mail at emdria@aol.com. The brochures will also be available for purchase at the 1998 Annual Conference in Baltimore.

(Heuristics - Continued from page 25)

discovery"—to keep pushing into new territory.

An ideal model would be to test innovations as we go along. In that connection, Allen Rubin's "Empirically Validating EMDR with Single-Case Designs"—available through the EMDR Institute—may be helpful.

In acknowledgment of Ron Martinez, I intend to open a space in the *EMDRIA™ Newsletter* for ongoing inquiry into innovations in EMDR. Obviously, I need your help. Send your ideas, innovations, comments, and suggestions to:

David L. Wilson, Ph.D.
6616 Azalea Avenue
Redding, California 96002

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1999 ANNUAL EMDRIA™ CONFERENCE
CALL FOR PAPERS

EMDR INTERNATIONAL ASSOCIATION CONFERENCE

June 4-6, 1999
Chicago, Illinois

SUBMISSION DEADLINE: October 1, 1998

Abstracts are invited for the Annual EMDR International Association Conference. Material should be relevant to the EMDR field and be an original contribution. All presentations should involve participants in a continuing education experience. A variety of innovative and creative programming related to the field of EMDR will be considered. Members and non-members of EMDRIA™ are invited to submit abstracts.

The professionals submitting the abstracts for the program are responsible for contacting all co-presenters and for all details, including abstract submission, communication with presenters, presentation format, audio-visual requests and payment of fees. Presenters pay registration fees, at a reduced rate, if attending any portion of the conference other than their own presentation.

Abstracts must be postmarked no later than October 1, 1998. Notification of acceptance will be made by November 15, 1998.

SUBMISSION GUIDELINES AND INFORMATION

ALL ABSTRACTS WILL BE PEER REVIEWED without the name(s) of the author(s). This "blind" review process will help ensure that the evaluation is fair and equitable, and that factors such as gender, ethnicity, and reputation do not play a role in judging the quality of the submission. Therefore, be certain NOT to identify yourself in any way on the abstract portion of this form.

ABSTRACTS MUST BE TYPED AND SUBMITTED WITH THIS FORM. (Duplicate this form for additional submissions.)

SUBMISSIONS MUST INCLUDE: 1) this completed form, 2) two (2) copies of page three with its attachments, 3) curriculum vitae or resume for EACH PRESENTER, and 4) a biographical sketch for EACH PRESENTER in paragraph format of 100 words or less (this will be published in the Conference Program). Each submission must be signed by the presenter chair. Incorrect or incomplete submissions will be returned and not considered until submitted properly. For questions, call Gayla Brown at the EMDRIA™ Administrative Office at (512) 451-5200.

Mail to: EMDR International Association
P.O. Box 141925
Austin, TX 78714-1925

Please fill in all information requested below for all individuals. Submit any additional pages along with this form in order to provide divisions with complete information on all participating individuals. Information not appearing on this form and its attachments, including degrees and affiliations, will not appear in the Conference Program.

1. **Title:** _____

2. **Format:** _____ Symposium _____ Plenary _____ Workshop _____ Conversation Hour

3. **Length of time requested on program:** ____ Conversation hour ____ 90 min ____ Full day (4.5 hrs. of instruction) ____ Half day (3 hrs. of instruction)

4. **Category(s):** ____ Clinical Adult ____ Clinical Child/Adolescent
   ____ EMDR ____ Clinical Marital/Family
   ____ Advocacy/Grassroots ____ Research

5. **Presenter Listing:** List chair's name first. For each presenter, list name, highest educational degree, all licensure numbers and state, address, zip code, phone number, fax numbers, e-mail address and professional affiliation.

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Address:
Street, City, State, Zip _____

Office Phone ( ) _____ Home Phone ( ) _____ Fax ( ) _____

E-Mail Address _____ Professional Affiliation _____

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6. Abstract: Limited to 250 words. Please type abstract on separate sheet of paper with ONLY the title of presentation and the abstract itself. You may also submit abstract on disk, 3.5" ASCII formatted disk only. Be as specific as possible about the learning that will take place at your presentation. If your presentation is research-based, only completed research with available results may be submitted for a workshop.

7. Learning Objectives: Please type on separate sheet of paper with ONLY the title of presentation and the objectives. List at least three learning objectives, i.e. what participants will know or will be able to do by the end of the presentation. Please indicate how much time is allotted for each objective in minutes. (This information is now required by some CE-granting organizations.)

8. Quiz: Please type on separate sheet of paper with ONLY the title of presentation and the quiz itself. Quiz must contain a minimum of three questions pertaining to your presentation. This may be done in any format you choose, such as True or False, multiple choice, etc. (This information is now required by some CE-granting organizations.) You may submit answers on a separate page.

9. What is new or unique about this material/topic/presentation? Give an example of how the proposed material has been implemented. (Please avoid using identifying information.) NOTE: If your material is a deviation from the standard EMDR protocols, please submit documentation supporting effectiveness.

10. AudioVisual Needs: ____ TV Monitor/VCR ____ Overhead Projector ____ Flip Chart ____ Slide Projector

____ White Board ____ No A/V needed ____ Other _____

11. Presentation may be audiotaped: ____ Yes ____ No

12. This presentation is suitable for:

____ Beginning EMDR Clinicians ____ Intermediate EMDR Clinicians ____ Advanced EMDR Clinicians

13. This is my only submission: ____ Yes ____ No Second Submission Title:_____

14. Please check membership status: ____ EMDRIA™ Member ____ EMDRIA™ Associate Member

____ EMDRIA™ Student Member ____Non Member

15. Describe public speaking experience and expertise with proposed topic:

16. List EMDRIA™ board and committee positions held by each presenter to avoid schedule conflicts with meetings.

PRESENTER AGREEMENT

On behalf of myself and my co-presenters, should this abstract be selected, I/we agree that:

1. Participation in this program does not exempt presenters from paying registration fees if attending other conference sessions.
2. Individual submitting this proposal and signing this form agrees to receive all conference correspondence and accepts responsibility for conveying conference related information to co-presenters.
3. EMDRIA™ may videotape and/or audiotape this entire presentation, including videotape and audiotape excerpts, and distribute the tape for educational purposes with no remuneration or reimbursement to presenter(s).
4. Appropriate "Release of Confidential Information" forms have been obtained for all client materials that will be used or recorded as part of this presentation. The responsibility for protecting client confidentiality rests with the presenter(s).
5. Individuals submitting or included within this proposal have agreed to be present in Chicago, Illinois, during the hour and date assigned to this presentation at the 1999 EMDRIA™ Conference, and conduct this proposed presentation according to the conditions listed above.

SIGNATURE_____ DATE_____

EMDR INTERNATIONAL ASSOCIATION INFORMATION

The EMDR International Association (EMDRIA™) is a nonprofit, mutual benefit corporation and the professional association for EMDR practitioners. The bylaws state, "The primary objective of EMDRIA™ is to establish, maintain and promote the highest standards of excellence and integrity in Eye Movement Desensitization and Reprocessing (EMDR) practice, research and education...". EMDRIA™ maintains a Register of qualified EMDR clinicians; holds an Annual Conference; publishes a Newsletter; provides World Wide Link which includes regional meetings, special presentations, and library; evaluates training programs and develops practice guidelines for the applications of EMDR in various settings; supports EMDR research, advocates for the use of EMDR with health care organizations; and informs the general public about EMDR.

EMDRIA™ is the ongoing support system for EMDR trained practitioners and provides the mechanism for the continued development of EMDR in a professional manner. Through EMDRIA™, practitioners have access to the latest clinical information and research data on EMDR.

Benefits of Membership

* Receive the EMDRIA™ Newsletter, published four times per year
* Listing in the EMDRIA™ Membership Directory, in-print & on the Internet
* Access to the latest developments in the theory & practice of EMDR
* World Wide Link
  - -- participate in regional meetings
  - -- attend special presentations
  - -- library
* Attend the annual conference at a reduced fee
* Reduced application fee for enrollment in the EMDRIA™ Register
* Exchange information with other EMDR professionals
* Membership dues are not deductible as charitable contributions for Federal Income Tax purposes, however, they may be tax deductible as ordinary and necessary business expenses.

EMDR International Association
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CALL FOR PAPERS
1999 Annual Conference

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or herself dive into the pool while initiating a set of eye movements. Locating where the fear lies in the body prior to commencing reprocessing is optional, and is advisable with a client who tends to reprocess somatically as long as it does not distract from the flow of reprocessing.

A client may often report the sensation of diving into the liquid, being bathed in it, seeing and feeling the color engulf him or her. Then, surprisingly, the SUD's level reduces, sometimes gradually, often dramatically, and the visualized color of the fearful thing tends to break up into opaque darkness (nothingness) or sometimes into a lighter color. Subjectively, the vice grip of terror the fear previously had on the client is released, confirming the saying, "Confront a fear and it dissipates."

Of course, the mental status of the client should be assessed prior to utilizing the DIVE method. Generally speaking, the more stable a client is going into reprocessing, the more linear and predictable the reprocessing. I have not experienced any abreactions in my clinical use of this method or in self-use. The first time is the most anxiety-producing, because of our natural tendency to want to flee from a fear, and it is paradoxical to instead DIVE into it. But once this is experienced, and fear is reduced, then one can almost get into a habit of using the DIVE method to confront and move through fears. If a client has a total negative reaction to DIVE, that reaction should be honored and the method should not be forced. Instead, a set of eye movements focusing not on what is in the pool of fear, but on the fear of diving in, may be utilized. Once the fear of the fear is reprocessed, diving in may be a fluid next step. A client resisting the DIVE may have good reason, and may develop useful alternative metaphors for dealing with the pool of fear.

To the extent that our thoughts and emotions can influence and create our external environment, by changing our feelings about our worst fears, outer conditions can also change. Rather than a mind-over-matter belief, it is our fears which often condition our perceptions and it is our perceptions which in turn affect our behaviors. Behaviors go on to affect our decisions and interactions. We find that if we anticipate resistance or obstruction, we in turn often encounter it. Yet sometimes when we face our fear and decide to go through something which was dreaded, it is not as bad as we thought, and sometimes it is much easier. While fear may have kept us from dealing with a fearsome person, sometimes we discover that once we deal with our own fear of the person or situation, we are pleasantly surprised by how the actual encounter went. Even when a dreaded situation is as bad or worse than anticipated, with the experience of the DIVE method under one's belt, there comes an inner conviction (and positive cognition) that "I can get through this."

By confronting our fears, we can transform our lives. As we reprocess more and more of our fears, we begin to become fearless, more resilient, with a greater sense of personal integrity, perhaps even developing a boldness in our lives. "The only thing to fear is fear itself," a quote which came from wartime, but which we can apply to our every day lives as well.

Author's Note: Common sense dictates that reprocessing of fear does not mean to neutralize safety mechanisms which protect us from dangerous external situations. Thus, reprocessing of fear related to an abusive situation for example, will tend to cause a person to leave the abusive situation, rather than to confront the abuser when there is an external threat to life and limb.

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Book Review: *Trauma in the Lives of Children*

Francine Shapiro, Ph.D.Originator of EMDR,
Senior Research Fellow,
Mental Research Institute, Palo Alto, CA

I began my career as a high school English teacher in Brooklyn, in an area now referred to as an "inner city." I particularly remember one student who became an icon for me of the warring elements in this environment. I was teaching a class that was designed for the "slow learners," but also included the "problem students" who had acquired reputations as troublemakers.

When I interviewed one of these students, he said he didn't like to read—the only book he'd ever enjoyed was *The Prophet* by Gibran. So I started feeding him books and he began to open to me. Then one day, while driving home, I saw a young man on the street corner whose face was distorted with hate and rage—one of the most frightening sights I had ever witnessed. As I drove by, the boy saw me looking at him and his face melted into a smile—it was my student. In his environment he had to put on the mask to defend himself. He carried a knife to protect himself, while his beauty remained submerged. He had to do that to survive, and his reputation as a troublemaker in school showed that it was already taking its toll. The memory of this haunted me for years, but *Trauma in the Lives of Children* has given me new hope for all those children caught in the bonds of trauma and pain. I wish this book had been available then.

Trauma in the Lives of Children provides a wonderful description of the field and practical instructions and resources for parents, teachers, and clinicians. There is no doubt that prevention of trauma is the best solution, but prevention is not always possible. This book provides guidelines to recognize the early stages of traumatization and direct ways to intervene before these problems have taken root. If the practice of EMDR has shown us anything over the last ten years, it is that the basis of most adult problems is earlier life experiences. Not only are these traumatizing experiences the cause of suffering in the victims, but they set the stage for revictimization and perpetrator behavior as well. Recent studies have indicated that at least 80 percent of those in prison have these types of experiences in their background.

As Wordsworth wrote so many years ago, "The Child is father of the Man." Each parent, teacher, and clinician can prevent years of suffering, and help stop the cycle of violence, by being sensitively aware of signs of distress, and using the excellent tools Ken Johnson has provided in this volume. The chapter on EMDR offers an excellent overview of how the application of this approach can liberate children from the influences of trauma. But, even more importantly, it provides all clinicians, regardless of their therapeutic specialty, with a wealth of resources and guidelines to involve parents and teachers in an integrated and comprehensive team approach.

I feel that *Trauma in the Lives of Children* will be especially useful to EMDR practitioners who are being called upon to extend their practice to include child patients. While training is available for EMDR applications with children, many therapists need a more general background in therapeutic approaches to treating children. They particularly need a discussion of child therapy approaches compatible with EMDR practice, as well as guidelines for an integrated approach that includes the significant people in the child's system. I believe that is the strength of *Trauma in the Lives of Children.* ⇔

JOIN THE EMDR INSTITUTE DISCUSSION LIST

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

If you have training in EMDR from the EMDR Institute, you are invited to join the EMDR Institute discussion list, the electronic forum on issues related to: clinical applications, theory, and research on Eye Movement Desensitization and Reprocessing; information on training programs of the EMDR Institute and the humanitarian assistance programs of EMDR HAP.

This list is open to any individual subscriber who has taken the EMDR Institute Level I or Level II training, wants to participate and agrees to abide by forum policies. You must have an e-mail account to participate.

Purpose of the Discussion List

The EMDR forum was created to further the understanding and development of the clinical application of EMDR, and to encourage discussion of EMDR theory and research.

Participants in the discussion include clinicians and researchers who have taken the EMDR Institute Level I or Level II training as well as EMDR Institute facilitators and trainers.

Welcome contributions to the discussion include:

- queries and commentaries about clinical protocols and treatment issues
- theoretical issues, published books and articles on EMDR and EMDR related topics
- descriptions or questions about interesting or challenging cases
- innovations in clinical practice supported by outcome data
- questions and commentaries on EMDR-related research
- proposals (including "trial balloon" ideas) for research
- issues on standards of clinical practice and research on EMDR
- discussion of or suggestions for EMDR humanitarian projects
- announcements of EMDR Institute training programs and EMDR conferences
- opportunities for professional presentations on EMDR.

How to Subscribe to the Discussion List

You may subscribe to the list by sending a subscription request to:

LISTSERV@MAELSTROM.STJOHNS.EDU

Leave a blank or enter a hyphen (-) in the subject line. In the e-mail address, enter:

LISTSERV@MAELSTROM.STJOHNS.EDU

In the text of the message, enter:

SUBSCRIBE EMDR Firstname Lastname

Discussion List Leaders

The leaders (list owners) of the EMDR forum are A. J. Popky and Andrew M. Leeds. Questions about subscriptions and e-mail problems should be directed to:

Technical Liaison for List Maintenance:
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17461 Pleasant View Ave
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AJPopky@emdr.org
Phone: (408) 395-8541
Fax: (408) 395-0846

Questions about Discussion List guidelines or topics should be directed to:

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Two-Week Discussions Led by EMDR Institute Staff

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

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

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

If you know a specialty presenter from the conference or a Level I or Level II training you would like to see on the Discussion List as a presenter, please contact them or let me know and I will do what I can to encourage them to participate.

I look forward to seeing you online. ⇔

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EMDRIA™ is governed by a Board of Directors composed of six officers and seven general Directors. The Officers, elected for a one-year term, include President, President-Elect, Secretary, Secretary-Elect, Treasurer, and Treasurer-Elect. Elected officers succeed the present officers once their term has expired. Directors are elected for a three-year term.

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EMDRIA™ NEWSLETTER SUBMISSION INFORMATION

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

- **APA Style** - All articles must be submitted in APA style and format.
- **Submissions Other than Advertisements** - Articles, columns, and other non-advertisement submissions must be provided in electronic format. Files may be submitted on 3½-inch diskette or, ideally, via e-mail. WordPerfect 6.1 for Windows or Microsoft WORD 7.0 or earlier versions are the preferred formats, although a standard text format (i.e., ASCII or Rich Text) may be used. *The file format of each contribution should be specified in the accompanying e-mail or on the diskette.*
- **Submission of Advertisements** - In general, advertisements should be submitted in camera-ready format. Exceptions may be made for text-only ad copy. Various requirements and restrictions apply to advertising for legal and other reasons, so please contact the Editor before preparing your advertisement for submission. Also, please note that, due to the Association's legal status, the *Newsletter* cannot publish pricing information for advertised products or services.
- **Fonts and Other Formatting** - New Times Roman and Arial are the standard fonts for the *Newsletter.* Therefore, text-only submissions should utilize these fonts when possible. In addition, formatting characters such as bolding, italics, graphics, centering and other alignment/justification may not translate properly, so *text should be provided in "plain," unformatted form when possible.*
- **Author's Responsibility** - It is each author's responsibility to ensure that all aspects of submitted articles are correct and in accordance with APA style including: correct spelling and punctuation; accurate quotations that include page numbers, author, and year; and a complete list of references in proper order. (Please refer to the *Publication Manual of the American Psychological Association, 4th Edition*, for specifics.) Contributions should be well-organized and proofread. (It is requested that you make every effort to complete the final draft before submitting your contribution. It may be difficult to incorporate revisions after the editorial process has begun.)
- **Editorial Review** - Please note that all contributions are subject to editorial revision by the Publications Committee and the Editor.
- **Decision to Publish** - The Publications Committee and the Editor cannot guarantee when or if any contribution will be published.

Please submit articles and other contributions to the Editor:

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Don't Forget to Mark Your Calendar and Register for the EMDR International Association Conference on July 10th-12th in Baltimore, Maryland!!!

Inside this Issue of The *EMDRIA™ Newsletter*:

- Study Group Information and Listings
- The EMDRIA™ World Wide Link
- From the International Scene
- Internal Conference Room Ego-State Therapy
- Book Review: *Trauma in the Lives of Children*
- EMDR and Relapse Prevention for Sex Offenders
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- *EMDRIA™ Register* Information and Application
- The EMDR Institute Discussion List
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Coming Events and Deadlines

July 10th-12th

Annual EMDR International Association Conference held in Baltimore, MD

August 20th

Deadline for Contributions to the Fall 1998 *EMDRIA™ Newsletter*

October 1st

Deadline for Abstracts submitted for the 1999 EMDR International Association Conference

December 31st

Deadline for Submissions to the *EMDRIA™ Register*