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EMDR Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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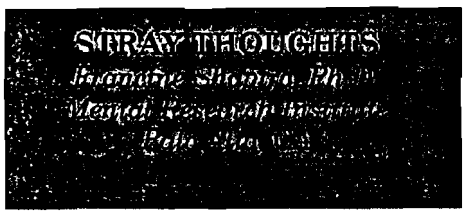

The following is the full text of the Keynote address I only partially gave at the 1993 EMDR Conference. I say only partially gave because one-quarter of the way through, I decided that I could not bear to read it and just went "free form." Upon rereading it, I thought some of the ideas were provocative enough to retain, so here it is.

The Boundaries of Quantum Psychology

We have gone from Kitty Hawk to a man on the moon in only fifty years, and yet we have not had a major paradigm shift in psychology since Freud nearly 100 years ago. Clearly, attitudes change more slowly than technology.

EMDR appears to represent a paradigm shift that has similarities or parallels with the two most significant paradigm shifts in the last one hundred and fifty years—quantum physics and the theory of evolution. However, as the famous physicist, Max Plank, once said:

> *"An important scientific innovation rarely makes its way by gradually winning over and converting its opponents . . . What does happen is that its opponents gradually die out and the growing generation is familiarized with the idea from the beginning"* (The Philosophy of Physics).

This quote has been sent to me by more than one EMDR therapist, for obvious reasons. The problem with accepting a new paradigm appears to be the need for certainty. The model we grew up with is the one which gives us comfort and a sense of surety. Accepting a new paradigm challenges our sense of security, of the known. Just as the abused child clings to what is known, we often cling to our limitations rather than face the unknown of new possibilities.

This clinging to order, rather than facing the chaos of a new beginning, brings us to the threshold of one interesting parallel between EMDR and quantum physics—the concept of certainty. In reference to the Heisenberg Principle of Uncertainty—the unpredictability of sub-atomic particles—Einstein declared his disagreement that the universe could be governed by chance by stating that, "GOD would not roll dice." While I have a great love for Einstein, I would, however, point out that GOD would play dice since he would already know the outcome. How can chance and prediction, chaos and order exist simultaneously? The ultimate message for us is not to be afraid of paradox. Life is a constant juxtaposition of horror and beauty, spaciousness and limitation, chaos and order.

Some people think that by finding the cause and effect of behavior, or reducing behavior to a physiological level, they are taking the mystery from the human mind. However, the mystery of the world does not vanish when cause is sought or found. The search that has led to quantum physics is a perfect example, one which is alive with mystery and paradox. The search for certainty led to the Principle of Uncertainty. To be and not be simultaneously. To be in two places at the same time. Perhaps further investigation will show another level where a pattern again emerges. What seems like chaos at a thread's eye view emerges as pattern when seen from above.

Those who view the physiological causes of pathology as reductive do not see the continued mystery. In EMDR, clearly a form of quantum psychology, consciousness remains free. The body and brain are either playground or prison of consciousness. The equation might read that consciousness plus brain equals "mind." The mind is awash in fear and all of the mechanisms of survival are inherent in the "hard-wiring" of the body. The goal of clinical psychology is to liberate consciousness from these dictates. One of the attributes of quantum psychology is that it has been liberated from the constraints of time.

One of the observations of quantum

PLEASE NOTE: As of August 1, 1993, the Colorado Regional Coordinators will be Laura Knutson, LCSW, (303) 620-7198 and Jana Marzano, LPC, (303)220-1151.

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physics is that an electron can be in two places at the same time. It can move from one orbit around the nucleus to another orbit in "no time." Similarly, this liberation from the temporal, the ability to move rapidly through information and pathology, is a hallmark of EMDR. Critics of both fields point to this as being "incomprehensible" and, therefore, reject them. However, the lack of the ability to comprehend does not and has not dictated the boundaries of reality. For example, the fact that gravity is not yet understood does not in any way limit its obvious presence.

The lack of predictability of individual process is inherent in both fields. In EMDR and quantum physics, neither the path of the particle, nor of the individual, can be ascertained in advance. The unique nature of the experience as the client interacts with the inner world is, however, a sign of the strength, not the limitation of EMDR. The limitations are found only in those clinicians who demand absolute certainty. The only thing certain in quantum physics, or psychology, is that things are uncertain at an individual level. Both can trace a path previously taken, both can evaluate an end-point, but neither is liberated from the power of observation that is inherently part of the process of change. Observation will determine the path of the particle. Observation will determine the transmutation of the inner experience. Interaction is the key in both.

Paradoxically, the demand for absolute certainty in the field of psychology will define our limitations rather than our liberation. This demand for certainty is found in the commitment either to lock-step techniques or to the need for the passage of time itself. Clinicians limited to certain behavioral or psychodynamic viewpoints will take these opposing and yet ultimately equally circumscribed views. Both positions are ultimately detrimental to treating the client as a whole person. Another paradox is that the primary schools of psychology, in diametric opposition, contain inherently the same flaws.

Our role as quantum psychologists is to look for the synthesis and interaction of causes and effects. There is no certainty of an easy answer, but rather the adventure of exploration. Each client is unique, each session is unique; thus, the processing of subjective information parallels the transmutation of consciousness and liberation from prison to playground.

What are the possible limitations to full liberation? How can these questions possibly inform our exploration?

A comprehensive theory of psychology should take into account not only the whole person, but the individual's placement in the continuum of time and space. While humans have developed more complex forms of social structure and technology, the history of humanity is still no more than a blink of time. If life on this planet has been in development for over 3.5 billion years, how can we consider humankind as distinct from this developmental process? Many answers may perhaps be found in the evolutionary nature of the human species.

Perhaps the responses necessary for evolutionary survival can be viewed as hard-wired into the nervous system. Hence, feelings of danger, fear, anger, etc., could be viewed as automatic responses. However, whereas these emotions are built in, the content is acquired by experience. Therefore, the example of the child who reaches out a hand to catch father's arm and is hit in the face, has fear and danger as integral responses. The node is pre-existent, but the contextualization is specified by the experience. Hence, "fear and danger" are linked to "I can't get what I want." Likewise, evolution may have favored a hard-wired response of submission to authority and the need to please because these tendencies increase the likelihood that the child will learn behaviors from the adult of the species that are needed for survival. However, this automatic response may become detrimental when it is connected to actions such as molestation and abuse. Making things worse, the child is likely to take on the blame for

NATIONAL NETWORK MEETINGS

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

1993 EMDR Network Schedule

Saturday, June 26th
Saturday, September 18th
Saturday, November 13th
9:30am to 4:00pm

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

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

9:30-10:00am	Registration & coffee
10:00-11:30am	Special Interest Groups (SIG) meet to share new information.
11:30-1:00pm	Lunch [We suggest a second SIG meeting during lunch.]
1:00-4:00pm	General meeting. Presentations by SIGs and Francine.

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

the parents' flaws. The matter may be further exacerbated by the conflicting automatic responses of unquestioning submission to authority on the one hand and signals of danger on the other. The result is likely to be confusion and psychic conflict as the individual is unable to clearly delineate, and therefore trust, his or her own perceptions.

Ultimately, a susceptibility to a fear response pervades the system and, regardless of the externalized content—loss of job, mortgage due, loss of lover, lack of health, losing in an auction, not being liked—it is the same emotion that is triggered. Some fears are consensus reality based, and appropriate to the physical well-being of the individual. However, other fears are dysfunctional because although the same emotion is triggered, it is contextualized in a manner that is at variance with the well-being of the individual and not necessary for actual self-protection. It is all the same fear, however. This provides another indication that the appropriate focal point should be internal, rather than the constant attempt to reorganize externals (e.g., more money, more possessions, more sex, more attempted control of another's behavior). Thus, paradoxically, the principles of evolution lead us to the principles of spirituality. However, any psychology of the whole person must come to grips with these principles in some form or another.

The same concept of order and oneness—whether viewed through the eyes of spiritual oneness, or the idea of internal hard-wiring towards certain predispositions—is beautifully underscored by the existence of the DSM. What a sense of commonality and psychic linkage that millions of human beings can be categorized with parallel symptomatology and that our internal structures will react in certain predictable patterns, within certain parameters. This is not to say that the free play of consciousness is denigrated. The "observer," as a state of conscious awareness, is distinct from the hard-wired responses of the mind. Whether observing a horror from a dissociated state, or observing the forced configurations of OCD, the notion of hard-wired patterns that interfere with full integration and health is not antithetical to the notion that the individual is larger than the pathologies being presented. Perhaps the observed tendency in EMDR to go to an adaptive resolution—to integrate meaning of an experience and arrive at a state of positive self-enhancement—is also a product of an evolutionary mechanism. Each species is best suited to survive if its behaviors are in harmony with nature and its surroundings. In humans, behaviors flow organically from states of consciousness. Perhaps a state of internal harmony is necessary for the ultimate states of flexibility and external awareness most suited by nature for survival.

Memories allow previous experiences and learnings to inform our present actions. They should be available as a storehouse of knowledge. They are dysfunctional when they intrude on the present, rather than enhance as an impetus to right action. Perhaps EMDR allows us to catalyze evolution. The rape victim goes from shame, to anger, to forgiveness. From internal chaos, to boundaries, to a recognition of the interconnected nature of all creation. From quantum, to Newton, to Einstein ($E=MC^2$).

What are the ultimate limitations of psychology? They will be found in the inability of our profession to practice what it preaches and to stay true to the mandates of exploration and healing. These limitations will be seen through:

1) The clinician who views new possibilities as a narcissistic wound, a challenge to authority rather than focusing on the needs of the clients. 2) Those clinicians through the years who have said to me, "EMDR will put me out of business. How can I let them heal that quickly?" My only response is that there is enough suffering to go around. Perhaps if we

fulfill our mandate to help in the healing, more will come for the assistance. 3) The flaws of research.

A participant once wrote to me: "While I am aware of and subscribe to the position that the practice of the profession cannot wait for the results of research to catch up to it, I also believe that one cannot run so far ahead of scientific research that it can never catch up. That tends to produce a pop psychology as a whole, and ultimately leads to the method falling into disuse because the baby has been thrown out with the bath." I shared his fears, but could not bring myself to discourage clinical exploration. So now we have a field of quantum psychology and Stone Age research which I now call "poor froggy research". Let me tell you why.

There is the tale of a researcher who wanted to investigate frog jumping under certain conditions. He placed the frog on the lab table and said, "Jump, froggy, jump," then clapped his hands loudly. He then measured the results and noted, "Frog with two legs jumps eight feet. Good froggy." He then chopped off one of the frog's legs. Again he said, "Jump, froggy, jump," and clapped his hands. Once again, he measured and noted, "Frog with one leg jumps four feet. Good froggy." Next, he cut off the frog's other leg. Again he said, "Jump, froggy, jump," and clapped his hands. He looked puzzled at the lack of response. Again he said, "Jump, froggy, jump," and clapped his hands. Now he noted sadly, "Frog with no legs deaf. Poor froggy!"

Examples of "poor froggy" research abound. Recent studies have pitted EMDR with eye movements against itself with three other simultaneous forms of stimulation. Significant results were obtained and were called placebo. "Poor froggy!" Another group of researchers, untrained in EMDR, called a successful EMDR treatment a drop of 2 in SUDs level, i.e., 20 SUDs out of 100 (see article packet). Because they could get the same result without eye movements (they used only imagery), they decided that eye movements were not necessary. "Poor froggy!" Another study involved the reprocessing of only one memory in chronic inpatient veterans and saw no shift in the psychometrics (which were not geared to change when only one memory out of a possible 20 in each subject was shifted). "Poor froggy!" "Poor EMDR!" "Poor suffering clients whose clinicians are waiting for research to prove that EMDR is real!"

What is the reality of our profession? When researchers either are not trained in a method, test the wrong components, or use the wrong measurements. When clinicians focus more on the limitations of the past than the possibilities of the future, and focus more on their own limitations than on the needs of their clients.

Reality will be what you make it—a belief in the evolutionary flow of civilization and of consciousness; the belief in the internal health, beauty, and expansiveness of the individual; and a view to assisting in its liberation from the bonds of pain, shame, and fear.

Dave Wilson gave me a quote he said reminded him of the process of EMDR:

> Physical concepts are free creations of the human mind and are not however, it may seem, uniquely determined by the external world. In our endeavor to understand reality, we are somewhat like a man trying to understand the mechanism of a closed watch. He sees the face and the moving hands, even hears its ticking, but he has no way of opening the case. If he is ingenious, he may form some picture of a mechanism which could be responsible for all the things he observes, but he may never be quite sure his picture is the only one which could explain his observations. He will never be able to compare his picture with the real mechanism, and he cannot even imagine the possibility or the meaning of such a comparison (Albert Einstein, 1938).

Essentially, all we have are our models of reality; a heuristic that allows us a grasp of reality, a mirror. Yet, it is not possible for us to know if it is true. A paradigm shift is merely the adoption of a new model, but it can incorporate and synthesize the best of what has been known.

Paradigm shifts need not destroy all that have come before. Quantum mechanics did not denigrate the teachings of Newton or Einstein. Rather, it focused on a different strata, a different aspect of reality. We need to hold gently the paradox of conflicting truths. How else can we understand a reality where Ron Martinez experienced an accident that left him a lifelong quadriplegic, and yet rose to the stature he attained.

A molestation victim recently said to me that profound spiritual teachings were available to her from holding simultaneously the knowledge of the horrors she had undergone and the beauty of her inner being. The truth of a quantum psychology such as EMDR is that it exists. The truth is that there are those I have encountered in my travels who would rather see it as "snake oil" than as a boon to humanity. The truth is that among these people are some of the leaders in the field of psychology and who are in many ways just and honorable people. The truth is—there is no certainty on an individual level. However, there are strata where harmony and beauty prevail. The boundaries of quantum psychology are only our own limitations in holding and promulgating that view. The boundaries of quantum psychology are defined by you. Many blessings as you explore those boundaries.

EMDR CLIENT SAFETY CHECKLIST

Laurel Parnell, Ph.D.
Marin Research Institute
Palo Alto, CA

The idea for a Checklist arose from the concern that clinicians use EMDR competently and ethically. This checklist is one attempt to assist EMDR trained therapists in developing professional attitudes and standards that reflect excellence.

The Checklist directions are simple. Answer each question with careful thought and honesty for each client. If any item is answered with a **NO** response, then: 1) do not use EMDR with this client, 2) seek consultation with a Facilitator or Network colleague, or 3) review the EMDR literature for guidance.

It is my belief that our level of standards and professionalism will be a decisive force in whether or not EMDR is accepted into the therapeutic mainstream.

If you think of any additional items to add to the Checklist, please call me at (415) 326-8752.

EMDR CLIENT SAFETY CHECKLIST

Directions: *Before using EMDR with a client, read the following questions and answer as honestly as possible.*

Clinician	**NO**	**YES**
1. Do I have sufficient training and experience to treat this particular problem?	___	___
2. Do I know how to work through abreactions?	___	___
3. Do I know how to activate reprocessing and avoid retraumatization?	___	___
4. Do I know the standard EMDR protocol?	___	___
5. Do I know how to "read" the "complex network" of physiological cues?	___	___
6. Do I understand the "language" of hand movement (direction, close/distant location, speed, length, sets)?	___	___
7. Have I provided informed consent to my client (i.e., discussed potential risks/benefits)?	___	___
8. Do I know how to effectively debrief a client at the end of a session?	___	___
9. Do I know what to do if session time has ended and the client has not completed resolution?	___	___
10. Do I know when **not** to use EMDR?	___	___

EMDR CLIENT SAFETY CHECKLIST

Client	**NO**	**YES**
1. Is the client sufficiently prepared?	___	___
2. Is the client non-suicidal?	___	___
3. Does the client have sufficient ego strength?	___	___
4. Are the client's treatment needs compatible with EMDR?	___	___
5. Can the client tell you to stop the EMDR procedure at any point if necessary?	___	___
6. Are the client's problems within the therapist's area of expertise?	___	___
7. Does the client have good rapport with the therapist?	___	___
8. Is the client free of medical problems that could impact upon client safety (e.g., eye problems, organic impairment, seizure disorders, pregnancy, chemical toxicity, etc.)?	___	___

If you have answered **NO** to **any** of the above questions, **DO NOT** use EMDR until you have consulted with an experienced EMDR therapist and/or have found a sufficient answer in the EMDR literature.

CLOSING EMDR SESSIONS

Laurel Parnell, Ph.D.

Closing down incomplete sessions is an important part of EMDR work. The following are some techniques that I have found to be useful when sessions need to be closed down.

For clients who are working through significant trauma, I have found it to be very important to set up a special safe place before even beginning the EMDR session. Typically, I put the client in a light trance and then instruct him or her to go to a place where he or she feels safe and secure, where no one and nothing can harm him or her. I then ask the client to imagine a boundary around himself or herself which serves to protect him or her. This boundary can be made of anything that the client is able to conjure up in his or her imagination. After the boundary has been firmly established, I have the client imagine his or her "child" in front of the client sitting in a protected space. A dialogue is initiated, and the client begins to acquaint himself or herself with the child, finding out the child's needs. When this is done and there is a positive relationship, I ask the client to invite the child into his or her circle and have the client hold the child and comfort him or her, and explain that he or she is safe and protected in the client's arms. The idea is to establish a strong sense of safety and security in this place. If needed, the client can

call forth other protective and loving allies to be with him or her, either inside the circle or outside guarding the space. These allies can be friends, relatives, archetypal figures, religious/spiritual figures, or animals.

When this safe place with allies has been firmly established, I tell the client that he or she can always return to this place, that he or she knows the way. If the EMDR processing becomes overwhelming, the client can take a break and return to the safe place for a rest. The allies, including the adult self, can hold the client's hands or be by the client's side during the processing of excruciating memories so that the client will not be alone.

When it is time to close down a session—whether or not it is complete—I often have the client return to the safe place, put up the boundary, hold his or her child, really experience the feelings of safety and security, and be aware that he or she can now have control. The client is able to end the session feeling peaceful and safe. I also repeat positive cognitions discovered during the EMDR processing, along with affirmations I believe will be beneficial to him or her.

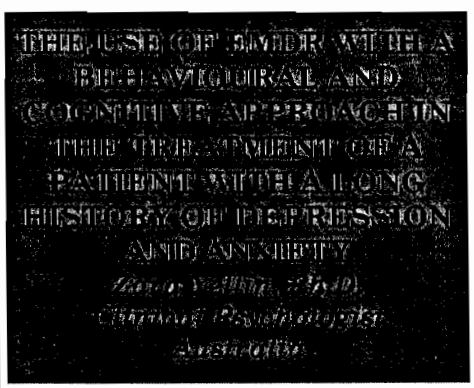
For example, a male client who had been severely abused by both of his parents found it was important to find someone in his life who had loved and protected him. He remembered his grandmother and the loving name she called him. I would call on his memory of her when he became too overwhelmed by the abuse memories and had him keep symbols of her with him. This worked quite well and gave him the strength to face the horror of his past.

A technique I use for a client who tends to enter into a traumatic memory and get stuck looping in the nightmare is to suggest to her in the beginning, when she is in trance in her safe place, that when she remembers the incident it will have a beginning, a middle, and an end, and that it will pass much faster than it did the first time. This has worked like a charm to complete the process and free her from the loop.

For clients who have traumatic memories that keep intruding into their dreams and waking life, I suggest that they imagine putting all of the scary, upsetting memories in a file folder, putting the folder in a file drawer, locking it, and putting the key in a place where they can get it when they choose to open the drawer. They do not have to think about the memories between sessions and can put them away until they see me again. Other images can be used, such as a safe, etc.

I have found it useful for my clients to make tapes of the relaxation and guided imagery to the safe place so that they can play it between sessions to help them through the time before they see me again.

I believe it is crucial to have enough time to close down the session. I often go overtime making sure my clients are together enough to go home. I will suggest that they walk around and get grounded before they get into a car, let them know that they can call me if they need to, and give them times for extra sessions.



I used EMDR with a 45 year-old man called David who presented with a long history of depressive and anxiety episodes, characterized by intense feelings of fear and anger, the latter directed at women whom he had always feared and by whom he felt rejected.

David reported a long history of loneliness and poor self-esteem; something with which he had never been able to come to grips despite his intellectual skills and engineering achievements. He has a history of antidepressant and tranquilizer use, dating back to the early 1970s.

David recently sought help because his jaw clenched up on a business trip. In addition, he was moving, and the sense of chaos and the lack of a secure space plunged him into a sense of despair and of simply being unable to cope.

In summary, David presented as a highly intellectually gifted man with: a) insufficient skills to cope with life stressors, b) a marked psychological vulnerability in his emotional motivational repertoire, and c) a hypothesized biological predisposition to anxiety. He has always lacked a sense of personal security which is due to a seemingly unstable environment and the reinforcement of a diminishing self-concept by virtue of being a de facto full-time patient over the years.

When under stress, or during a difficult life transition, a series of vicious cycles rapidly set inwhereby he experiences a depression-like fatigue, continues to use ineffective coping behaviours, and falls back on relying on medication.

The first approach I used was to provide David with a psychoeducational formulation based on a functional analysis of his presenting problems. Initially I worked this through with him based on a conceptual model of how the above factors interact with each other. I then related his psychological dysfunctions to a specific programme of treatment which primarily revolved around cognitive and behavioural approaches to the building of self-efficacy, anxiety management, and more effective interpersonal relationships.

After three sessions, I introduced

EMDR. David, now using self-management strategies to cope more effectively with anxiety and depression, agreed very enthusiastically to participate. He found it very easy to picture disturbing situations in his life and chose a recent stressful situation involving a female colleague. This situation was still causing him considerable distress, despite his use of cognitive behavioural techniques. The negative cognitions elicited were: 1) I am struggling to survive, 2) I am like a leaf in the wind, and 3) I am helpless. The positive cognitions were: 1) I am the wind that pushes the leaf, 2) I am handling this situation well, and 3) I am in control. His SUDs level was 10, and the VoC was 1.

After the first set of eye movements, he became extremely agitated by an image of his step-father, whom he said he hated because of the way he had abused David and his mother. He indicated at this time considerable pain in his body and, with each successive eye movement sequence, he reported increased anxiety.

I continued to focus on his emotional responses and at one stage, he reported feeling like he was "going to explode." As he began to talk about his anger towards his step-father, the SUDs level began to drop. Then he remembered an incident when his step-father had threatened to kill him and David had stood up to him and said, "You cannot hurt me!" and his step-father had stopped his aggression. At this stage, he began to talk about the fact that he had actually survived and to express compassion towards his step-father. At one stage, he began to laugh as he said, "I am actually a survivor." His SUDs level was now low, and he said he felt quite calm and no longer angry towards his step-father.

With the next set of eye movements, he again became agitated and began to shake and tremble. This aroused a new image, this time relating to his mother. As he focused on this image, he began to sob uncontrollably and uttered the words, "Why did you let him hurt me?" This brought up many scenes relating to his mother and her inability to protect him from his step-father. As he began to reprocess abandonment and rejection issues associated with his mother, he calmed down and he reported his SUDs level was zero.

This whole process took two hours, and when he went back to target he reported a SUDs level of zero and a VoC of 7 in relation to the desired cognitions. At the end of the session, he reported that this was the first time in his life that he had felt calm and relaxed and ready to deal with whatever stressful issues arose.

Follow-up two weeks later showed he was now dealing better with previously anxiety-arousing situations. He reported that he felt more in control and was able to discuss more openly and honestly his own needs, without fear of recrimination from his wife or his colleagues. Relapse training focused on assertion and relaxation.

Follow-up two months later showed that he had maintained his gains and had even bought himself a boat and was enjoying pleasant outings with his wife and family. Previously, he had never had any time for any form of recreation or pleasant activities. He was continuing to use the cognitive behavioural techniques and the insights gained during the sessions. He was no longer using medication and felt confident that he could now deal more comfortably with any potential stressors.

I have provided this example to show that we need to use EMDR carefully and judiciously, whilst plugging it in to our existing work and basing it on a good formulation.

I am sure that without EMDR, the whole process of therapy would have taken much longer considering David's premorbid history and extremely low sense of self-esteem and self-efficacy. (This pattern has long been associated with a poor response to psychotherapy in general [Shapiro, 1987].)

TREATING CHILDREN'S NIGHTMARES WITH EMDR

Ricky Greenwald, M.A.

This article discusses a protocol that I have found particularly useful in the treatment of children's nightmares which have manifested from a recent single traumatic event (e.g., car accidents or hurricanes). The dream imagery seems to consolidate a recent memory so that it functions like an old one; that is, you can often use target images rather than running through a play-by-play of the entire event. I have used this protocol with some of the children (ages six to 11) I met as a Red Cross worker following the recent hurricane in Hawaii. Sessions were under 30 minutes and were conducted in semi-quiet corners with many people nearby. Decreases in SUDs to 0 were consistent, and positive cognitions were successfully installed. Short-term follow-up on two cases showed no recurrence of the nightmares; however, better follow-up and wider applications are needed to further test this approach.

The following will provide some general comments about using EMDR with children and then present the protocol.

Using EMDR with children with a clear target symptom can be very quick and effective. As with adults, rapport (as well as pacing) is critical with children, although the guidelines are somewhat different (e.g., fewer steps, shorter sets, fewer words, playfulness, and flexibility). With children who do not visually track well, use the hand tapping method (e.g., hold your hands out, palms up, and have the child use one hand to tap your palms alternately). Instead of using a numerical SUDs, use other, more concrete methods such as the one described below. For the positive installation, use imagery rather than

verbalization. In addition to what is described below, you can also use prior successes ("how it feels to wake up in a dry bed"), role models such as older siblings or TV heroes (Martinez, 1991), or visualization of imagined success.

Nightmare Protocol

Ally with Parents

It is important for the therapist to be seen as a temporary member of the parental unit. This helps the child trust the therapist and to feel parental support for the participation. It is also important to have the parent present for the introduction to EMDR.

Begin by telling the child, "I was talking with your mom and she was telling me that you've been having some bad dreams since [the hurricane]. Is that true?" Child nods. I then discuss EMDR and explain that it may help with the dreams and ask, "Would you like that?" Child nods. "I'm going to show you how it works with your mom and then let you try it. Okay? Watch now." Face Mom and say, "Okay, now think of the bad part of your dream and follow my fingers with your eyes," and move your hand several times. Then ask the child, "Do you think you could do that?" Child affirms. Once you have completed the demonstration and explanation, find a place to work alone with the child, first showing the parent the location.

Target and SUDs

It is not necessary for the child to tell the whole dream, as long as the upsetting part can be visualized.

"Okay, now do you want to tell me the dream or just think it?" . . . "What's the worst part? How bad does that part feel, show me with your hands—is it really bad like this (hands outstretched), pretty bad (not as wide), or just a little bad (hands almost together)? You show me how bad."

Safety First

Beginning with a positive installation helps a child to feel safe with the therapist and with EMDR, as well as helps the child face the upsetting dream image from a position of safety and strength.

"If you were ever in this dream again, what would you need to feel safe?" If the child does not understand what you mean, give several examples (e.g., a special gun, magic wand, etc.) and say, "So what would be the best thing for you?" Child: "A gun." "Okay, take a good look at that gun, what it looks like, what color it is, how heavy it is, how it feels to hold it, how it feels to use it . . . And follow with your eyes." Then do the eye movements. If the child has trouble tracking, switch to hand tapping.

Breathing

Focusing on breathing is a non-essential step following an EMDR set. Many children enjoy it, and it can be a good basis for further training in relaxation and visualization.

"Now take a big breath in. And when you breathe out, breathe out all the junk." Exaggerate breathing movements along with child. This may be repeated (i.e., two breaths).

Desensitize

Continue with the abbreviated EMDR process. It is often not necessary to ask for feedback other than the SUDs ratings.

"Now look at the worst part of the dream again, got it? Good. And follow with your eyes . . . " Do eye movements. "Take a big breath. And breathe out the junk. Good. Now look at that part of the dream again and show me how bad it feels now." Demonstrate hand spread to remind the child what the variations indicate until the child demonstrates it. "Okay, now let's make it even less bad, okay? Look at that part of the dream again and follow with your eyes . . . " Continue until this target SUDs is 0, as shown by hands held together.

Other Targets

As children may fail to fully articulate their experience, it is important to actively pursue additional upsetting images. Even if a child denies having a "scary" memory, you may persist in asking for it, using wording more acceptable to the child.

"What's the next bad part of the dream?" Allow the child to tell it. "Would your [gun] keep you safe here too?" If yes, proceed with EMDR. If no, find a safety device that applies here and install it. Proceed again with EMDR. Additionally, work with any memories that come up through the dreamwork. Continue until there are no more bad parts to the dream and/or traumatic memory.

Installation

It is important to leave the child in a position of safety, strength, and resourcefulness. This is accomplished with the positive cognition, which may also serve as a check on the completeness of the processing as additional problems could emerge here.

"I don't think you're going to have that dream anymore. But just in case you have another scary dream someday, I want you to be ready so that you can feel safe. Let's practice a little more with that [gun]. Think what it looks like, feels like to hold . . ." Do eye movements. "How do you feel?" "Are we done, or do you want to practice more with that?" Child: "We're done."

Notes and Comments

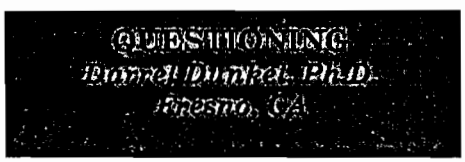
In general, I teach each step as it comes along, keep things moving, and try something different when it slows. Sometimes, I make up an explanation for why the eye movements or the breathing are important; other times, I call it magic, or do not offer an explanation. I do not use every step every time. When working with shy children, I frequently demonstrate with the parents and/or begin with

the more outgoing sibling. Sometimes, if I do not start with a positive installation, the desensitizing procedure bogs down until I introduce the safety feature. The breathing provides an element of playfulness that helps children sustain interest and continue with the activity. Also, in subsequent sessions, the breathing technique can be used to eliminate headaches, master anxiety or fear, etc.

Children are motivated to work on their bad dreams and will stay with the process if you have adequate rapport and pacing. Even unsophisticated, anti-therapy parents accept this treatment for their children if it is presented in plain language and oriented toward results rather than process. With "easy" cases, such as those described above, you can send them happily on their way in very short order. The most surprising outcome: A few of the children spontaneously said "Thank you!"

A Study of EMDR with Children

This protocol incorporates features shared by numerous practitioners around the country and represents the "first fruit" of a study I am currently conducting with children (preadolescent) on the applications of EMDR. If you would consider contributing by discussing your work and/or filling out a questionnaire, please contact me at *483 Bellings Rd., Framingham, MA 01701; (508) 877-8231.*



Stephen Wolinsky (1991) describes a simple technique for dealing with negative cognitions that I have found to be much more effective than those used by cognitive therapists such as Albert Ellis and Aaron Beck, especially when it is combined with EMDR. Wolinsky has clients turn their negative self-statements into questions by putting a question mark at the end of each statement. For example, he has the client change "I'm no good" to "I'm no good?" According to Wolinsky, turning negative thoughts into questions creates doubt, distances the person from the thoughts, and stimulates one to retrieve inner resources that were unavailable a moment before.

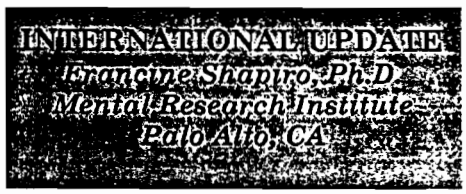
During therapy sessions, I have clients focus on a negative self-statement and put a question mark at the end of it while doing the eye movements. Clients typically report that when doing this, the negative thought immediately loses its power, they have a sense of "waking up," they feel like laughing, and positive thoughts spontaneously appear. A large number of cognitions can be dealt with in one session using this technique. Clients usually find that using this technique on their own, with or without combining it with the eye movements, is both quite helpful and pleasurable and report that it feels good to so quickly let go of negative thoughts. (Jeffrey Young's [1990] 1989 version of his "Schema Questionnaire" is very useful in gathering relevant cognitions with which to work when using this technique.)

References

Wolinsky, S. & Ryan, M. O. (1991). Trances people live: Healing approaches in quantum psychology. Connecticut: Bramble.

Young, J. E. (1990). Cognitive therapy for personality disorders: A schema-focused approach. Florida: Professional Resource Exchange.

Because EPIC wishes to be accessible and available to the EMDR community, we will be meeting at noon during the Network Meetings in order to respond to any professional/ethical concerns. We invite all Network members to join us to discuss a concern, to voice an opinion, or to learn more about EPIC.



The second annual EMDR convention was a tremendous success. There were over three hundred people in attendance, with approximately thirty presentations from which to choose. Participants included EMDR clinicians from England, Germany, and Australia, as well as most of the United States. Even now, we are beginning to work on the next conference, which is currently scheduled for the first weekend in March of 1994.

While a research track was included at the convention, there is a great need for more dedicated research activity. Those of you with expertise in research, including design and evaluation, please contact John Thompson, M.A., who will be coordinating a committee which, in his words, will be formulated "to help put together a solid, fundamental experimental base for EMDR so that this method can be established as having a rightful, legitimate place in psychotherapy." He can be reached at: Institute for Family and Human Relations, 15810 Los Gatos Boulevard, Los Gatos, CA 95032; (408) 356-1911. Gary Fulcher, M.A., will continue to coordinate research efforts outside of the U.S., and "Sam" Foster, Ph.D., will continue to coordinate the entire research data base. Please call the office for contact information.

The Family Networker Conference in Washington, D.C., occurred during the "blizzard of the century"; however, my EMDR presentation was very warmly received. As a follow-up, an article by Cliff Levin, Ph.D., was accepted by the Family Networker magazine, describing a case that was treated with EMDR and MRI brief therapy. It will be included in the EMDR Network packet upon publication.

An EMDR presentation was given at the California Psychological Associa-

tion 1993 Convention by David Wilson, Ph.D., Andrew Leeds, Ph.D., and Virginia Lewis, Ph.D. Anyone needing suggestions or support materials for similar presentations should contact the office.

Earlier submissions and presentations regarding the application of EMDR to MPD have been re-evaluated. A new Dissociative Disorder Task Force for EMDR has been formed and is headed by Walter Young, M.D., and Catherine Fine, Ph.D. The committee will be investigating all aspects of the application of the standard EMDR protocol to MPD in particular and dissociative disorders in general. In the meanwhile, please refer to the "Update and Cautions" material, which covers both guidelines and contact numbers for the consultants, to assist you in present applications to MPD (i.e., Curt Rouanzoin, Ph.D., Gerald Puk, Ph.D., and Marilyn Luber, Ph.D.). Please contact the office if you have not yet received a copy of the "Update."

A new Professional Support Committee has been formed and is being chaired by Andrew Leeds, Ph.D. The purpose of the committee is to offer guidelines and support materials for a variety of purposes, including how to approach managed care companies, informed consent for clients, professional presentations, client brochures, etc. Please send any requests for consideration in care of the office.

For purposes of conference presentations and colleague discussions, we have come to term EMDR as a method. Part of the present controversy and resistance in the field may be due to the reductionist view of the word "technique," or even "procedure." Since the teaching of EMDR entails a theory of the onset and maintenance of pathology, a model of treatment, and a variety of principles and procedures, this seems to aptly fit the definition of method. Please feel free to write to me directly, or to the Newsletter with any views pro or con. I still view EMDR as completely compatible with most present clinical modalities. At one of the future Network meetings, we will also be formulating a panel of clinicians from psychodynamic, behavioral, cognitive, etc., backgrounds to discuss their uses of EMDR.

The linguistic change from "technique," to "procedure," to "method" has been part of the maturation process and development of EMDR. Another sign of maturation has been the variety of presentations at the 1993 conference which included as many opinions regarding when not to use EMDR, as when to employ it. EMDR can only thrive if there is a healthy, ongoing scrutiny and development. However, all clinical cautions must remain in place until the research is complete and it achieves a recognized place in academic settings. My personal goal—which I believe most of us share—is to see EMDR taught judiciously in the universities. To accomplish this goal, we must make sure it does not devolve to the level of a pop psychology which eschews the appropriate clinical concerns and cautions.

If any of your clinical experiences, observations, or informational backgrounds have given you reason to feel concern regarding any outstanding protocol or aspect of the method or teaching of the method, please contact me directly. Just as the trainings need to be a joint participation, so does the ongoing development and evaluation process. Since I was ill during most of last year's training schedule, I was not as available for clinician feedback as I would have liked. Please help me rectify that now, and excuse any apparent lack of responsiveness; it was not intentional—your feedback is extremely valuable.

The news from Australia is that, because the sponsors remained firm regarding enrolling only licensed clinicians, the previously unregistered social workers are talking about becoming officially registered in order to be trained in EMDR. Many of us feel that this is a marvelous reaction, in tune with a needed move towards more quality control in our field. However, the fact that EMDR can even begin to have that kind of impact demands a rigorous adherence to standards of professionalism and integrity in promulgating, demonstrating, presenting, or clinically applying EMDR. The challenge will be to maintain high standards of professional conduct, while simultaneously maintaining a flexible stance regarding innovations or developments of EMDR itself.

Please make sure to evaluate any of your deviations from the standard protocol in terms of more enhanced clinical outcomes. All appropriate clinical cross-checks should be used to decide if the apparent outcome is a true integration, or merely a temporary effect. If you find that anything you are doing seems to work better, or works as well under particular circumstances, please write it up and send it to the Newsletter so it can be shared with other clinicians. The idea of using hand taps and tones under certain circumstances came from observations of other clinicians and has proved extremely useful. Ron Martinez, Ph.D., initiated the "Innovations Column" of the Newsletter and I would like the concept of continued change and flexibility to be part of his legacy.

The second annual EMDR Conference was a resounding success from beginning to end. We had presenters and attendees from as far away as Australia, Germany, and Scotland, and a wide array of topics from which to choose. It was a time to renew old relationships and establish new ones. The energy was high, and the atmosphere was electric with excitement. We were challenged to think, discuss, and process.

Of course, this conference did not "just happen." It was the result of many hours of devoted time and effort by a large number of people. Although time and space prevent me from men-

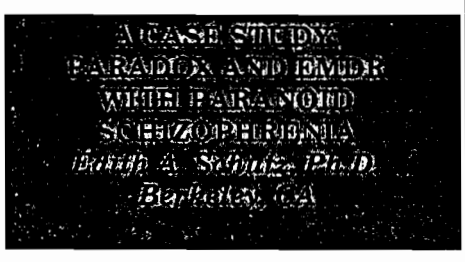
tioning everyone by name, I would like to express my gratitude to those who made the conference so enjoyable.

First, to the presenters—your presentations formed the structure of the conference. The seminars were informative and provided us with the evidence that the potential of EMDR is limited only by our ability to dream, create, and synthesize. My thanks to each and every one of you for contributing to the further use, development, and understanding of EMDR.

Thanks also to Robbie Dutton, A. J. Popky, and staff, Kristina Stone, and Bob Kitchen. Their untiring efforts to ensure that everything ran smoothly masked the time and dedication needed to organize and implement an event of this magnitude.

To the participants, it is your interest in becoming more knowledgeable about EMDR for the benefit of our clients in particular, and the mental health field in general, that made this conference possible.

Finally, special thanks to Francine, without whom this would not have been possible. She is a true visionary with tremendous compassion and a desire to alleviate suffering. To those of us in the mental health field, she challenges, encourages, and supports us in our goals to be the best we can be—for ourselves and our clients.



The client, a 34 year-old woman diagnosed with paranoid schizophrenia, was first hospitalized at age 19. She took hard drugs for about one year at age 24, with the result that she became more paranoid. I started to treat her in June of 1992 and saw her for a total of 13 sessions during the next six months. In January of 1993, I began EMDR, using weekly one-and-one-half-hour sessions. After two sessions, the therapy was temporarily interrupted by a severe paranoid episode which made her feel hopeless. I have now used EMDR with her six times, and two more sessions remain.

Strategic Therapy

As a strategic therapist, I combined paradox, hypnotic suggestions, and EMDR, and used double binding interventions, such as "You can have a breakthrough while you're watching my fingers or taking a deep breath." My sessions were structured, non-adversarial, paradoxical, and I gave assignments.

A Sample of a Composite Paradoxical Session

I introduced the client to paradox by saying that I focus only on the solution, not the problem. The following is an example of what transpired:

C: What will I talk about?
T: Tell me, what would make your life better?
C: To answer that, I'll first have to tell you about my problem.
T: I nodded.
C: (emotionally) I'm a prisoner in my own house. I'm too scared to go out because people say bad things about me to my face. And don't say that you don't believe me! Every therapist tells me the same thing—'You're hallucinating'—and I can't stand to hear that, anymore!
T: I will never tell you that.
C: Good!
T: Are you interested in hearing about those bad things people tell you?
C: Sometimes.
T: When you're not, would you enjoy listening to music?
C: Yes.
T: Do you own a Walkman?
C: No.
T: If you're too scared to go out, tell your husband to buy you one. Then, wear the Walkman, like joggers do, and whenever you choose, you can enjoy the music.
C: That's a good idea. Is that what a solution is?
T: Yes.
C: I'll try it.

Within a week, she was no longer imprisoned in her house and continues to regularly go outside with her Walkman, except for times of acute paranoia. She had made a very dramatic, but limited, gain. Despite this, and other areas of progress, there had been no important shifts in her attitude due, in part, I believe, to my concerns about her emotional safety. I put on the brakes because of my belief that a safer emotional structure was needed to help carry over my client from one week to the next. EMDR has provided that safe emotional structure.

The Positive Impact of EMDR

By the end of the second EMDR session, progress was again underway. The client reported that she no longer awakened at 4:00 a.m. and, in general, felt better. She also thanked me for <u>really</u> helping her, something she had not said for some time. Her third EMDR session came a month later, in March (after the paranoid episode). She agreed to commit to a six-week period of uninterrupted therapy once she was assured of having ample time afterwards to be ill if a paranoid episode occurred—unless we arranged otherwise. (It was my intention to create ambiguity and suggest that something else might come up for which there had been no plans.)

By the fourth EMDR session, she was no longer obsessing at night over how much she hated her parents. She "just gave it up." She now sleeps all night and feels rested when she awakens. She has also overcome her sense of discouragement with medications (she builds up resistance to them) and has found another successful combination. At home, she has been spon-

taneously using EMDR hand movements to process her own thoughts and feelings. She enjoys it and finds it useful. (With respect to this client using EMDR herself, a few things should be mentioned. First, given her paranoia, it was important that she maintain as much control as possible. Second, given the strength of her defenses, I was not concerned about an abreaction. Third, she had a positive identification with the therapist and with EMDR, which she viewed as a tool that could help her. Thus, I felt comfortable with this client doing occasional self-EMDR as I believed that it did not pose any risk to her.)

During the fifth EMDR session, we used EMDR for about one hour. In talking about a secret she was keeping, she began to cry and became upset and angry, telling me how mean and even cruel people are. She was reluctant to tell me the secret so I suggested that she refer to it by a letter (like X) in order to offer her more flexibility in hiding her secret. As she was certain that I could decode all letters of the alphabet, she refused this suggestion. To move past her paranoia, I put her in the double bind of choosing only what she trusted. (I removed all other options.) My intention was twofold: to ensure success and to anchor the feeling of trusting herself.

Setting Up the EMDR Intervention During the Sixth Session

We discussed the best way for her to have a paranoid episode, concluding that each episode was caused by a large or small chemical imbalance and, as such, it might help to notice those signs that indicated both the onset and the end of the episode. She then identified the signs that ushered in and ushered out the episodes—the latter being the reverse of the former.

There were three specific signs: 1) a feeling of spaciness followed by 2) the weird feeling of being an alien from another planet followed by 3) a stranger saying something bad about her as the episode was coming on, and something good about her as the episode was leaving. Through my strong interest, I meant to provide a new anchor of respect to disrupt, confuse, and lessen (and eliminate?) the old anchor of shame. We were then ready to use EMDR and continue the gains from the previous session.

The Success of EMDR

After the new anchors were in place, we used EMDR for about 15 minutes (the time period available) in order to more firmly establish them as the new foundation for developing trust and respect. My hope was that she would feel safe enough to reveal the important secret she was hiding. This proved to be true.

C: I have wanted to believe for a long time now that I was hallucinating instead of that strangers were really saying bad things about me. But if I admitted to hallucinating, that would prove I was schizophrenic. (She began to cry.) I don't want to admit I'm schizophrenic. It's such a terrible disease. But I have to admit it. I'm schizophrenic. There, I admitted it. But I'm embarrassed to be schizophrenic. People disapprove and look down on you. I really suffer.
T: Recall another moment of suffering.
C: When I had come home from the hospital, my father and step-mother didn't want me there. They didn't want to be bothered with me. I wouldn't treat anyone like that. (She started obsessing and I stopped it.)
T: What picture do you see?
C: I'd been in my room for four days. You would think they would come up and at least ask me how I am or if I need anything. (She began to obsess again, this time growing angrier. I again stopped it.)
T: If you were the mother, what would you do?
C: I would knock on the door and ask her if I could come in.
T: What would she say?
C: She'd say . . . I'd say . . . my room's too messy. I'm too embarrassed for you to come in. I'll come out there, instead.
T: What happens then?
C: I go out (shrugs her shoulders, then laughs). It's funny.

The client thanked me again and again for really helping her, as if she could not seem to convince me of how much better she was. Over the preceding few weeks, a feeling of hopefulness began to replace her original feelings of profound despair and resignation. Repeatedly during the first month (even after the Walkman) and intermittently, thereafter, she would lower her head and say, "No one can help me. Even people who want to, like my husband, can't. There isn't anything—not even medications. I'm allergic to all of them. There's just no hope."

The Remarkable EMDR

The structured and sequenced procedures of EMDR enabled me to stop the client's rising obsessive rage in a routine manner. Acting within the safe boundaries of EMDR, the client admitted why she wanted her hallucinations of sadistic acts to be real. For if these sadistic acts were real, they would prove to the world she was sane. However, 30 years ago, when these acts had actually occurred, the world was not watching and her obsessive rage began to bury the truth about her sadistic childhood. There had been no way, at that time, for her to prove her sanity. She has been trapped in a pathological double bind, from which she could not get free.

Then, a major breakthrough occurred. With the help of EMDR, the client revealed her secret, which was her hidden wish to prove her sanity. (Sanity to this client meant normal, not schizophrenic, while insane meant abnormal, schizophrenic. Thus, the words are interchangeable in this case.) I knew then that proving her sanity would be the goal of therapy. That was the piece I did not have until EMDR became available to me. Now, I could interweave paradox and EMDR, combining the childhood

filefolder with my paradoxical strategy. The paradoxical question was: Is the client insane or does she merely appear insane? The answer to that ongoing question has yet to emerge as she continues to peel off her sadistic childhood memories. What will the adaptive solution be? Insanity or the appearance of insanity? (The word sanity is intentionally omitted. The client will notice the absence of that word when she is ready.)

The Client's Growing Independence

The client had learned the EMDR method quickly. She independently began to apply the body scan, saying, for example, "The tension is in my jaw." She also applied the childhood filefolder, making time references such as, "That happened to me 26 years ago when I was eight years old. I know it's not happening now, but it sometimes feels that way." ("Sometimes" is an advance from "usually" and "always.")

For the last few months, the client has been solving many of her immediate problems herself. All of her solutions enable her to take practical, independent action that reduces her burden on her husband. For example, when on a recent vacation, she became terrified of going into a restaurant and walked back to the hotel by herself, listening to the music coming from her Walkman. She was very proud of leaving her husband at the restaurant visiting with relatives. The client is definitely into the solution. She is even becoming her own daily therapist, regularly processing her thoughts and feelings with EMDR hand movements. Despite her severe handicaps, caused by paranoia, here is a woman who now has hope.

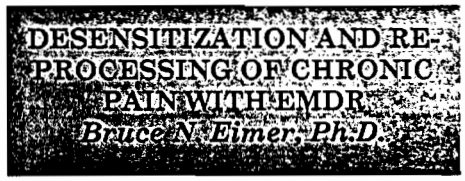
A Comparison: Which People Require EMDR

I have found that EMDR is not for everyone. I have tentatively drawn this conclusion based on my experience with perhaps 30 clients, a very small, but diversified sample. The clients who valued EMDR and profited from it most were confused, immobilized, and directionless in some important area of their lives. Such clients were like amoebae, who flowed in different directions for lack of a supporting structure. EMDR provided that structure, which quickly moved them through their problems, like a fast train on a straight track.

Clients like these, who lacked structure, valued the structure of EMDR, which describes everything as black or white. The dichotomies are crystal clear. You feel safe or in danger; the trauma has occurred in past time, not present time; the body is tense or relaxed; the negative cognition—I was helpless—contrasts sharply with the positive cognition—it is over; today, I can choose. Many clients who had entered with negative feelings exited feeling positive. (This occurred very often.) Such clients were able to process their multi-layered problems in the safety of EMDR's grounded, linear procedures. For me, the logical paradigm of EMDR presented no problem to my paradoxical approach. My interventions fit easily into its logical boundaries, and I could benefit from the advantages EMDR offered.

The clients who had tried EMDR, but then discarded it, had an internal structure of their own. They knew what they wanted, but they did not know how to get it. This group was speeding along the track, but going in the wrong direction, unconsciously sabotaging themselves. For them, EMDR "just got in the way"; they felt my comments were of "more value to them." That made sense, since my paradoxical interventions were already working very well for them without EMDR.

However, my success with clients who had an internal structure did not transfer to those without that structure, like the woman who had paranoid schizophrenia. Using paradox alone, I was not able to disrupt the immediate problem—the secondary gain from her buried secret, which was that of denying she hallucinated in order to prove she was not schizophrenic. However, to disrupt that circular thought pattern, I first had to learn of it. To accomplish that, I needed the combination of EMDR and paradox. (This is not true of all strategic therapists, but it was true of both the client and myself who required the external structure, boundaries, and safety of EMDR.) That structure greatly improved the effectiveness of the therapy and the progress of the client. My experience suggests that paradox and EMDR interweave well. The question is when to combine them. The answer seems to be an individual judgment call, based, perhaps, on the individual requirements for external structure.



Chronic pain is a difficult problem for physicians and mental health practitioners alike (Eimer, 1988). For you to be of any help at all to a chronic pain sufferer, you must assume that the pain is physically real. Only then will you be able to address the psychological components which have to be reprocessed for there to be any notable movement and improvement. Herein, I am construing reprocessing as involving "cognitive restructuring," "reinterpretation," or "reframing" of the meaning and the implications of the lingering chronic pain.

It is essential to note, however, that before the pain and pain-related issues can be completely reprocessed, there has to occur some notable degree of desensitization of the physical and the psychological traumas that I assume make up the patient's pain. The point is that pain patients are highly sensitized to their unremitting pain (Eimer, 1988, 1989, 1992). Additionally, there are psychological components that are either unconscious; suppressed; blocked; or blocking therapeutic movement and, more often than not, physical movement as well (i.e., range of motion, etc.).

Now, lest my basic working assumptions be misconstrued, let me clarify at the outset my belief that it is just as useless to "label" a patient with unremitting pain a "pain prone personality" as it is to label a difficult-to-treat patient a "borderline personality." I find that it is useful to refer to many of the pain patients with whom I work as "painbroken personalities," as this is more likely to validate their experience. Chronic pain patients who are highly sensitized to rejection also readily accept the term "pain-affected disorder" to characterize their condition.

EMDR provides an ideal methodology for desensitizing and then reprocessing the pain-related psycho-physiologic material. In my work with chronic pain patients, I have started to use EMDR along with a few other "more accepted" traditional behavioral treatment modalities (e.g., hypnosis and biofeedback therapy) (Eimer, 1988, 1989, 1990, 1992). To date, I have found that EMDR has often catalyzed movement that truly amazes both my patient and, of course, me.

Acute versus Chronic Pain

Acute pain is the body's signal that something is physically wrong which demands immediate attention. Obviously, this has survival value and is adaptive. However, chronic pain must be understood differently. If all manner of medical attention has been given and the pain continues, then it must represent something else. Certainly, there are things we as yet do not adequately understand and a multitude of things that remain to be discovered and "invented" by medical technology. Yet, this provides all the more experiential material that needs to be reprocessed by the pain sufferer for whom modern medicine has not yet found a "cure." As the pain settles in and becomes a part of a person's life, the person learns how to cope in some way, adaptively or maladaptively. Thus, there are behavioral, affective, sensory, cognitive, imaginal, social, as well as physical components, to an individual's chronic pain. This multi-modal configuration needs to be reprocessed to a more functional level of adaptation.

Good Therapy Follows Good Psychodiagnosis

I want to emphasize that there is no "right" protocol for all types of chronic pain. Effective therapy flows from accurate psychodiagnosis and medical diagnosis (Eimer, 1988, 1992). We certainly should never be treating a chronic pain patient who has not had a thorough medical work-up. Given a comprehensive medical work-up, and then a thorough psychological work-up, the EMDR protocol will vary depending on the psychodiagnostic picture. Remember Francine's reminder that EMDR is not a "cookie cutter." Nevertheless, I want to share an EMDR protocol that is meant to be applied in a flexible manner for helping individuals to better cope with their chronic pain.

Prototypical Types of Chronic Pain Patients

First, it is helpful to keep in mind several prototypical types of chronic pain patients. This is not the place for a detailed discussion on diagnosis, so a brief listing to highlight the categories will do for now. You generally see chronic pain patients who can be sorted into one or more of the following diagnostic categories:

(1) The chronically, intensely angry and hostile patient who, up until seeing you, has not been willing to give up his or her anger.
(2) The hypochondriacal, anxious patient who imagines that his or her pain represents some life-threatening or acute medical problem as of yet undiscovered.
(3) The patient for whom the chronic pain provides some form of "secondary gain."
(4) The post-traumatic stress disordered patient for whom the chronic pain has some unconscious life-preserving adaptive significance (e.g., "I know I'm alive as long as I'm in pain").

(5) The histrionic patient who blows most things out of proportion, including the pain symptoms.
(6) The "objective" pain patient who copes relatively well despite his or her unremitting pain (Eimer, 1992).

You will need to modify the following protocol, depending on how you sort your patient, because the clinically valent EMDR targets are going to differ. The key to finding effective targets for EMDR is to accurately identify the patient's core operating beliefs surrounding the pain and their implications for his or her life and then to uncover the "touchstone memories" for these core operating beliefs. These "touchstones," along with the associated negative beliefs, emotions that are triggered, and sensory experiences associated in memory with the touchstone events at the time, need to be reprocessed with EMDR.

Case Examples

You should not attempt to apply the following EMDR protocol mechanistically. A brief case example will demonstrate why this is so. I am currently treating a married gentleman who has been suffering unremitting and excruciating back and leg pain for approximately three years, ever since a motor vehicle accident in which he was physically injured and severely traumatized. During a series of unfortunate events that followed this motor vehicle accident, he was abused and subsequently further traumatized. To make matters even worse, he later suffered severe iatrogenic side effects from the pharmacotherapy he had received for treatment of his "post-accident depression." This resulted in the development of priapism and subsequent anatomic impotence. Now, this gentleman presents understandably, but very unfortunately, harboring intense rage and hostility which he carries around with him every waking moment. He also has repetitive violent fantasies of taking

his revenge on the people he feels are responsible for his current physical and mental state. This is not your "run of the mill" pain patient.

So far, we have only done one 1.5-hour EMDR session in the four months of weekly psychotherapy sessions we have had. That session, not unexpectedly, brought up some very emotionally moving material. Following this EMDR session, it was our joint consensus that he was not ready to continue with EMDR as he was not and still is not ready or willing to give up his anger or his violent fantasies. We did determine that his pain is intimately linked to this anger complex and so we have not, as of yet, made much progress alleviating the pain.

In this case, EMDR served as a very revealing diagnostic of the clinically valent issues. (Herein, it is important to remind ourselves of Francine's point that EMDR will not take anything away from your patient unless he or she is psychologically ready to let it go.) Clearly, this is an extremely sensitive and difficult case that serves well to illustrate how pointless it is to attempt to use EMDR in the same unvarying way as a "cookie cutter" for all chronic pain patients, or all PTSD patients, etc. A good metaphor for what EMDR is not meant to be is the Pacman model, wherein EMDR is viewed as a technique for gobbling up all of your patient's dysfunctional thoughts, anxiety, phobic responses, chronic pain, or whatever.

With all of this in mind, I do not mechanistically apply the following chronic pain EMDR protocol. Additionally, I have found a promising direction in connecting some of my anxious pain patients to a simple pulse meter that provides auditory real time feedback on heart rate. With these patients, I have been pacing the speed of my finger sweeps to their heart rates. One interesting variation I have tried has been to pace and then lead the patient to a slower, more relaxed heart rate by slowing the pace of my finger movements while we receive ongoing auditory heart rate biofeedback.

Principles to Keep in Mind in Applying EMDR to Alleviate Chronic Pain

(1) You do not want to do all of the steps in one session.

(2) The pain has to be "worked through," and this requires multiple sessions.

(3) EMDR takes the patient out of the "critical thinking mode" and shifts him or her into the "uncritical experiencing mode." This facilitates processing and working through of upsetting material, as well as assimilation and integration of coping lessons.

(4) It is use useful to think of two pain-relevant complexes, which are essentially networks of cognitive and experiential nodules. These are:

(a) the pain complex-belief configuration and
(b) the coping complex of coping beliefs, attitudes, and behaviors.

(5) Therefore, we do EMDR both to:
(a) desensitize and reprocess the pain complex which contains the upsetting and "hot" material and
(b) assimilate and integrate the coping complex.

(6) The pain complex can be thought of as "COMPISS," which stands for:

C—Conflict underlying the maintenance of pain.

O —Organic-physical problems demanding attention or which represent and express indirectly psychological conflict converted into organ language (i.e., body language).

M —Motivation (i.e., secondary gains) to hold on to the pain.

P —Past experiences associated with the pain's origins and onset.

I —Identification with someone (e.g., an abuser, a victim, a pain sufferer).

S —Suggestion or beliefs necessitating pain and suffering.

S—Self-punishment for imagined or real crimes.

(7) The coping complex can be summed up in terms of the four As which represent four strategies of coping beliefs, attitudes, and behaviors:

A —Awareness of, and focusing on, the pain sensations objectively and uncritically, as in meditation.

A —Alteration of the interpretation and experience of the pain sensations. This would include: symptom substitution, transformation, pain displacement, etc.

A—Alleviation and minimization of the unnecessary hurt and suffering. This would include direct suggestions of comfort and pain shrinkage (e.g., hypnotic and waking suggestion, antidote imagery, etc.).

A —Avoidance of the direct experiencing of the pain sensations as through mental and physical escapes and distractions (e.g., relaxation training, hypnotic fantasy, dissociative imagery, etc.).

The Chronic Pain Protocol

INITIAL ASSESSMENT:

(1) Assess the pain complex. Determine the components of the "COMPISS." This can be done through direct, waking inquiry or through trancework (e.g., ideomotor questioning, hypnoanalytic techniques).

(2) Assess the components of the coping complex that are currently in place (Eimer, 1988, 1991, 1992).

(3) Help your patient visualize his or her pain using all relevant sensory modalities.

(4) Get descriptions and pain SUDs ratings for average, least, and worst pain.

(5) Elicit the pain-related negative cognitions, which would mean the patient's self-cognitions relative to suffering, being ill, invalidated, punished, powerless, etc.

GOAL FORMULATION:

(6) At this point, co-develop with your patient alternative positive self-perceptions, cognitions, and coping statements. Another term for this is formulating goals.

(7) Develop "antidote imagery" to the noxious images that the patient has been carrying around psychologically as representative of his or her pain.

(8) Obtain VoCs for the negative cognitions, positive goal cognitions, and antidote images.

EMDR DESENSITIZATION AND REPROCESSING OF THE PAIN COMPLEX:

(9) Do EMDR sets targeting the patient's current pain, associated noxious images, and negative cognitions.

(10) Check in with your patient for minute experiential changes in the physical sensations and pain images after each set of eye movements. For example, look for feedback regarding the experience of the pain moving, changing in intensity, size, form, texture, temperature, etc. Take the pain SUDs ratings. Do eye movement sets with these sensory alterations as the new target. Take your patient through EMDR sets of deliberately intensifying then detensifying the pain to establish self-efficacy and control.

EMDR ASSIMILATION AND INTEGRATION OF THE COPING COMPLEX:

(11) Link up and install the antidote images and relevant positive cognitions of self as coping, etc. For example, do sets of eye movements while the patient repeats to himself or herself positive coping self-statements and while he or she visualizes the pain antidote images.

(12) Take the pain SUDs ratings.

(13) Obtain VoCs for the antidote images (e.g., "how real does it feel?") and for the positive self-cognitions.

FURTHER EMDR REPROCESSING OF THE PAIN COMPLEX AND INTEGRATION OF THE COPING COMPLEX:

(14) Go through the above steps to reprocess your patient's representations of his or her average pain, worst pain, and memories of the first instance or onset of the pain. It is here, when you "age regress" your patient, or even just recall the pain onset events without revivifying, that you often will strike "psychodynamic paydirt" and find a wellspring of material that needs to be reprocessed.

(15) Develop images of your patient engaging in pain-related activities.

(16) Reprocess these images and install comfort images associated with relief-giving activities.

MORE TRADITIONAL DESENSITIZATION WITH EMDR:

(17) Another approach which is not incompatible with numbers 15 and 16 is to have your patient visualize a movie of himself or herself both as dissociated (watching the movie) and associated (actually being in the movie).

(18) Reprocess by stopping and doing the eye movements whenever your patient begins to experience a notable increase in pain intensity or anxiety. Continue with repeated cycles of visualize —> stop —> do EMDR —> visualize . . . until your patient can visualize an entire segment with a notable reduction in pain levels and with a much more neutral attitude.

COGNITIVE INTERWEAVE:

(19) Throughout the desensitization and reprocessing, at clinically sensitive points, you can incorporate cognitive interweave and hypnotic suggestions that are appropriate (e.g., for relaxation, comfort, strength, competence, resourcefulness, coping, and hope).

PATIENT HOMEWORK:

(20) When clinically appropriate, your patient can be taught to do self-EMDR as a coping strategy when the pain becomes intense or just for relaxation. Obviously, astute clinical judgment is advised, as self-EMDR puts many patients at risk for unsupervised abreactions which are not recommended.

(21) Have your patient keep a "pain log," in which he or she is asked to self-monitor pain levels, associated thoughts, feelings, sensations, activities, situations associated with pain intensification, and coping efforts. Also, have your patient log any dream content, emerging memories, upsetting thoughts, etc., in line with the standard EMDR protocol.

Each component of the "COMPISS" and of the "coping complex" can be a fruitful target for EMDR reprocessing. The specific components of each complex, and the pace and sequence for the reprocessing of these components, requires sound clinical judgment and must be individualized. EMDR is proving to be a useful modality when creatively and judiciously applied; however, it must be remembered that it is no "cookie cutter" when applied to desensitizing and reprocessing chronic pain.

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WHENCE EMDR?

Steven Silver, Ph.D.

In the past several years, we have seen EMD evolve into EMDR both in concept and methodology. Training, at both levels, has changed steadily. Presenters at the two annual EMDR conferences have discussed this evolution and, in some cases, have attempted to supply structures upon which EMDR, as well as other therapeutic approaches, could be hung.

The implication of this evolutionary process is revolutionary, although this has not generally been recognized. While there was scarcely a workshop in the most recent conference during which one did not hear the phrase "paradigm shift," few seemed to grasp the point of such a shift. This is ironical considering the almost obsessional use of the phrase among EMDR practitioners to describe a guessed-at neurophysiological process.

If EMDR is indeed indicative of a paradigm shift, then the shift in the structure of psychotherapeutic knowledge will not be to EMDR. This statement may seem on the surface to be heretical and counterintuitive, but a brief examination of the concept of paradigm shifts as described by Kuhn (1972) in his seminal description of scientific revolutions will explain the situation in which we are presently involved and what we might expect in the future.

In the beginning there is chaos; observed phenomena take place with no apparent explanation. Eventually, hypotheses emerge to explain the phenomena (or at least a significant portion of them). Eventually, one stands as both the accepted explanation and, most importantly, the best predictor. Indeed, the strength of the emerging paradigm's ability to predict will generate the acceptance of its explanation, even if—and this is critically important—that explanation is factually wrong. For example, the first models of the solar system described Earth as being at the center of the solar system.

The problem is that until such time as "Ultimate Truth" is discovered, all paradigms will be to some extent flawed. Thus, phenomena exist for which the paradigm will not be able to account. The typical reaction of adherents to a paradigm encountering unexpected phenomena is to at first ignore or discount the phenomena. Eventually, there may be an attempt to suppress knowledge of the new phenomena. The old paradigm may be stretched to accommodate the new phenomena. Eventually, with the addition of new phenomena (you understand such phenomena are not truly "new"; they simply have not been observed or at least not reported) the old paradigm collapses. Chaos ensues as various competing hypotheses try to explain the new phenomena and the process is repeated.

By now the reader is well aware that the above paragraph encompasses the state of psychotherapy today with the emergence of EMDR and is probably a bit impatiently waiting for the point to be made, but it already has. EMDR is a phenomenon, NOT the emergent paradigm that will overthrow the previously existing chaos of conflicting psychotherapeutic hypothesized models. EMDR as a technique is not explainable under any existing psychotherapeutic theory, although many have gone through elaborate distortions to accommodate EMDR. An interesting thing about scientific revolutions is that the new phenomena are phenomena, not phenomenon. A single phenomenon, an isolate, is either a misperception (and really is not anything new) or the first of a new set of phenomena. Thus, EMDR is either an isolated phenomenon, the identification of which as something different is entirely due to misperception (say, for example, as placebo effect) or it is the first of a set of phenomena.

The discussions we have heard about EMDR-like effects being achieved, or partially achieved, by techniques utilizing hand tapping, rhythmic sound, microvoltage stimulation of the brain, and so on, may offer some general directions as to what other phenomena may soon force themselves into view. There will probably be others which we cannot as yet describe. While we do not know their specifics, we can make some reasonable extrapolations as to some attributes they will share, based on what we know thus far.

Before I describe these attributes, allow me to state again that EMDR is a phenomenon, one of a class or set of phenomena. It may very well turn out not to be the most useful or powerful of the techniques to which it is related. It is simply the first one which could not be explained by already existing paradigms (actually, hypotheses, since none of the current theories of psychotherapy has shown itself to be all encompassing). The new phenomena will probably have in common some or all of the following attributes, as well as many of which we are not currently aware. Most prominent of these will be the attribute of neurophysiology. Well, yes, but then so is everything, ultimately. Specifically, the phenomena to be identified will make use of one or more of the following mechanisms physically existing within the human brain. First, their point of intervention will be the stress recovery mechanism, a point Shapiro has repeatedly emphasized. Second, and less emphasized, they will also assist the learning imperative mechanism in its processing of the stressful experience. These mechanisms may or may not be related, although there is much to sug-

gest that they are. In any case, they are proximate to one another metaphysically, if not physically.

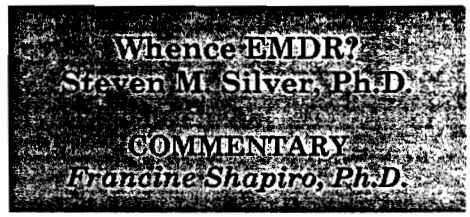
The stress recovery mechanism has been described in terms of its functions, although not as yet as to its physical structure, and need not detain us here. Let me just state that its existence is an evolutionary requirement for any organism having the ability to store experiences and let it go at that. The existence of the learning imperative mechanism is also evolutionary and is also a requirement for any advanced species. While baby spiders are born essentially complete with all of the knowledge they need to function already "hard wired" in (spin webs, mate, and suck juice), human babies come into the world remarkably ignorant and nonfunctional. What little hard wiring they have in place (turning their head to the nipple when their cheeks are stroked, making walking motions when lifted by their hands) is lost as their brains continue to develop. What they have over the baby spider is the capacity for learning. Humans have to be taught virtually everything; this process of learning does not cease when the brain reaches its maximum size (as can be understood by watching human development across time).

We might argue that PTSD is the interaction of the learning imperative mechanism attempting to access a powerful experience while the stress recovery mechanism is jammed (perhaps by the pressure of the learning imperative mechanism) and unable to dissipate the stress generated by the learning process. However that might be, the importance is that these mechanisms exist; we understand the evolutionary imperative which requires their existence and we see the results of their functioning, although we may not knowingly have, as yet, actually observed their structure.

The other members of the set to which EMDR belongs will involve some sort of ability to intervene in these mechanisms and deliberately access their controls. Thus, the new paradigm will be about how this intervention takes place—the process—rather than any one intervention.

During the first morning of the first day of Level One training I attended two years ago, it seemed to me that Dr. Shapiro was being very gentle with the participants. As I heard her describe EMDR in theoretical terms drawn from a variety of theories, I recognized that she was not actually talking about an evolution in psychotherapy, but a revolution. Perhaps out of compassion for the participants, she attempted to assist them in the stretching of their paradigms so as to permit them to recognize the phenomenon of EMDR when they encountered it first on the video tapes and then in themselves. In conversations with her, I suggested that EMDR should not be regarded as a method (in her definition a method is essentially a paradigm as it allows prediction and is complete) rather than a technique. I pointed out that she had, in fact, opened the door to a meta-set, a new paradigm, of which EMDR would likely prove to be but a subset. Thus, terming EMDR a "technique" would recognize it was simply an application of a paradigm whose definition is still being resolved.

For clinicians in the field, the "troops in the trenches," what does all this discussion mean? It means two things, one a warning and one a promise. The warning first. It will be tempting to hold on to EMDR to the exclusion of the emerging of other related phenomena, as other new techniques which belong to the same paradigm come into view. Because we have something which works, we must avoid the temptation to view this as the only thing which works, or which works so effectively. It is possible, perhaps probable, that related techniques will be even more effective. We cannot, as yet, rule out that possibility. The promise is the same as the warning. There will be new phenomena, and some of them may be even better and more useful.



Dr. Silver asked me to comment on his submission. Rather than attempt to make this a "counterpoint," I would like to share the thoughts that reading it has engendered. This is in no way to be considered a definitive statement. Dr. Silver's article is quite provocative and of great service and if EMDR is to thrive, it is essential that trained EMDR practitioners maintain a stance of on-going scrutiny and diversity.

It seems to me that the acceptance of EMDR demands a paradigm shift. The crucial elements of the new paradigm that come to mind are:

1) A release from the temporal: This indicates the ability to facilitate profound therapeutic change in much less time than previously assumed.
2) The possibility of non-intrusive physiological engagement: This suggests that pathologies are represented by information that is physiologically stored which can be accessed and shifted directly without surgery or medication.
3) The information processing system is hard-wired adaptively: Part of the presenting pathology is that the innate mechanism is blocked. Therefore, if the system is catalyzed, it will take the information to an adaptive resolution.
4) The transmutation of embedded information shifts identity constructs: As the information shifts physiologically, there will be a concomitant shift in cognitive structure, behavior, affect, etc.

Paradigm shifts need not destroy previous ones. Quantum physics does not destroy Einsteinian thought; rather, it can direct itself to another strata of information. Essentially, a new paradigm may encompass ear-

lier observed phenomena. However, it is essential that it be explanatory and predictive.

Part of the reason for this dialogue is that perhaps the term "EMDR" is being used for too many things. At present, it is the descriptive term for three strata: technique, method, and meta-set.

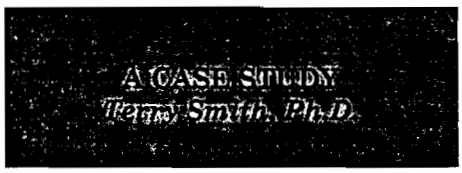
TECHNIQUES

EMDR as a meta-set involves the adoption of the described paradigm shift with subsumed methods and techniques. A better term for it on this level might be Accelerated Information Processing (AIP) treatments. This set of AIP treatments would include EMDR as one method. As a method, EMDR includes principles, procedures, and various protocols for a wide variety of pathologies. Within the set of AIP treatments, other methods will continue to arise which entail different protocols, etc.

The aspect of EMDR which focuses on the eye movements may be justly called a technique. Similar effects may be derived from hand taps, lights, tones, electrical stimulation, etc. These stimuli, perhaps, should be termed the technique. However, the application of these stimuli, if done according to the existing principles, procedures, and protocols of EMDR, still comprise a variation of the method. In addition, the utilization of these stimuli would be distinct from other applications of light, electricity, tones, or neurotransmitters employed in other methods which are contained in the set of AIP treatments.

This means that EMDR can be termed a method which includes techniques of eye movements, hand taps, lights, tones, etc. The observed phenomena which led to the ongoing development of EMDR have pointed to the need to create a set of AIP methods. While EMDR is one treatment method, as Dr. Silver states, we must be open to the development of other methods. It should not be difficult to be open to the evolution of new EMDR techniques, since, in addition to eye movements, the utilization of hand taps and tones are already being taught in the EMDR trainings.

As I have written previously, the accent in EMDR is on change. It would be foolish for any of us to assume that anything developed in 1989 would be the final product of the twenty-first century. Let us just be grateful that we led the way—and let EMDR effects serve as a baseline of client success in an ongoing evaluation.



Following my Level I training, I had a long laundry list of issues that I wanted to tackle with EMDR. Bear in mind that I have received approximately three years of one- to two-times-per-week talk therapy from three different clinicians ranging in orientation, as well as a complete psychoanalysis four times per week for 4.5 years.

As a brief history, when I was 12 years old, I had 12 teeth removed in preparation for orthodonture. I remember this event only as an interesting experience with no recollection of any emotional trauma. As an adult, I had abdominal surgery, during which my jaw was held open too long by the intubation tube and caused some tearing to the muscles and ligaments. This led my chiropractor to refer me to a TMJ dentist and, finally, to an orthodontist. They diagnosed severe TMJ. (TMJ refers to the temporal mandibular joint, a condition primarily arising from grinding teeth during sleep and/or during the day. The jaw becomes sore from the pressure; the disc becomes herniated, compressed, or diseased; teeth become misaligned; and complicated physical symptoms including headaches and low back pain occur.) They said that I had a "4-by-4" extraction as a child; a procedure that would not be performed these days because of the current dental technology. They also explained that my childhood orthodontist used the braces to move my remaining teeth into the spaces left from the missing teeth. My injury caused an imbalance in my occlusion and, coupled with my bruxism at night, my teeth had deviated considerably from "home." (Apparently, one's teeth "know" where they are supposed to be and tend to "go home" if permitted.) I could not even touch the back set of teeth together.

I began EMDR with the focus on my TMJ. As I proceeded through many sets of eye movements, memories were retrieved regarding anger towards my mother as a child. I experienced all of the classic powerlessness, lack of choice/control, and inadequacy we see in many of our patients. Reviewing the movie of my life was easy as I had retrieved and "worked through" that material in my analysis (right!). I sobbed and raged and spit and fumed. Once cleared, the psychologist returned me to the target, my jaw, and isolated memories of childhood emerged—one with respect to a mumps infection during which my jaw was considerably swollen. During one set, my head tilted back, I felt my throat gradually open in a descending direction, my breath switched to automatic, and I had no cognitive experience. We continued the eye movements and my throat began to return to normal in an ascending direction, my breath went back to normal, and my head came down. In my mind, I then knew my body reprocessed the operation during which my jaw was torn, my throat opening as the tube was inserted for breathing, and closing as it was withdrawn. I was sedated so there was no conscious memory. All of this reprocessed quite quickly. During the final sets of eye movements, I found myself experiencing subtle, yet profound, waves of energy moving outward, from the hinge of my jaw towards my chin.

After several sets, that gentle state of calmness followed which we experience as SUDs = 0.

Two fascinating points emerged subsequent to what seemed a rather typical and successful session. First, I had the following dream a few days later:

I got in my new 4-by-4 Blazer and drove into the filling station. In the parking lot was my old white Plymouth. I began pulling the cars out of their spaces and moving them into new spaces. I looked up and someone had stolen my Blazer. I felt deep hurt and resentment.

I did not recognize the significance of this dream as a subconscious symbolic reprocessing of the EMDR session until I wrote it out, seeing the words "4-by-4," "filling station," and "white Plymouth." Can you imagine a patient presenting this dream in a typical therapy session? Who would be able to interpret its meaning without the EMDR background and basic subconscious dream interpretation experience?

Secondly, while my chiropractor was evaluating me following the EMDR session, he said that the disc in my jaw had grown in both size and density some 30%—a feat he believed to be theoretically impossible! My jaw now heals at an accelerated rate.

I submit this as an interesting validation for EMDR as it seems to also have an impact on the body, even one which our physical science colleagues can witness. It would prove useful to develop a research protocol to use in conjunction with TMJ dentists to test my experience.

1993

EMDR Nettwork Newsletter

Publication Dates

Deadline for Submissions

Jul. 15, 1993 for Aug. 20, 1993

Oct. 15, 1993 for Nov. 20, 1993

EPIC: WORK COMPLETED TO DATE

EPIC (EMDR Professional Issues Committee) has been in existence for over one year. We began meeting in November of 1991 and have met approximately 11 times. The purpose of EPIC is to provide a forum for the discussion of ethical and professional concerns that may arise from the use of EMDR. The following is a brief summary of what EPIC has accomplished over the year:

1. Reviewed and accepted Andy Sweet's EMDR Informed Consent form. Recommended to Francine that she take the next step and have the form reviewed by an attorney. (The current ethical guideline is to have written informed consent on new procedures.)

2. Wrote a response to Cory Hammond's critical and erroneous article on EMDR. It was published in the ASCH Newsletter.

3. Recommended an EMDR training committee and proposed several ideas for the committee:

a. Establish protocol for EMDR presentations and handouts;

b. Assist Robbie in an advisory capacity for facilitator training; and

c. Establish guidelines for training films, etc.

4. Responded to a professional/ethical issue regarding impromptu information and training of EMDR given by a Level I trained therapist. Wrote a letter to the therapist.

5. Completed EPIC's Mission Statement (see below) and guideline of tasks under which EPIC will function.

6. Recommended guidelines for facilitator selection and training:

a. All facilitators selected after 1990 will be licensed and insured.

b. New facilitators will serve a probationary period of at least three EMDR training workshops. After this period, they will be reviewed for acceptance as EMDR facilitators.

7. Recommended the following training polices:

a. EMDR participants must be licensed or supervised by a licensed therapist. Verification is mandatory before EMDR workshop enrollment.

b. Certification of completion is now given only after Level II training. This indicates that a therapist has completed all formal EMDR training workshops.

8. Wrote letters in response to correcting misinformation about EMDR and inquiries about facilitator qualifications.

9. Wrote responses to the author of an article on EMDR which included inaccurate and misleading information, as well as to the Change Network Newsletter in which it was published. The publisher agreed to print our response.

10. Recommended to Francine the names of three attorneys to consider for EMDR legal representation.

11. Met with Francine twice to review our recommendations and to discuss any new issues.

12. Initiated a format for EPIC to be available at the Network meetings to increase our availability and effectiveness.

EPIC MISSION STATEMENT

The role of EPIC is to represent the conscientious overview of the clinical uses of EMDR, and to contribute professional standards for the clinical development and evaluation of the benefits and risks of its use. To this end, EPIC will:

1. Provide a forum to address ethical and professional issues in an advisory capacity.

2. Respond to ethical and professional complaints by a review and recommendation process.

3. Recommend policy standards to safeguard ethical/professional practice.

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CALIFORNIA EMDR STUDY GROUPS

Jean Bitter-Moore, Ph.D. California Network Coordinator (408) 354-4048

[Listed alphabeticaly by region]

CENTURY CITY/SANTA MONICA
Robert Goldblatt (213) 917-2277
Coordinating a new group 90067, 90401 zip area for West L.A.

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

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

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

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

EAST BAY/OAKLAND
Hank Ormond (510) 832-2525
Meets one Fri. a mo. Call for time & day. Open

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

HUNTINGTON BEACH
Jocelyne Shiromoto (714) 764-3419
Open. Call for time.

LOS ALTOS/PALO ALTO
John Marquis (415) 965-2422
Meets ad hoc at Pacific Graduate School of Psychology in Palo Alto. Primarily case discussion. Open

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

MANHATTAN/REDONDO BEACH
Randall Jost (213) 539-3682
Coordinating a new group.

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

NEVADA COUNTY
Stephanie Zack (916) 272-6738
Call for time. Open

ORANGE COUNTY/FULLERTON
Curtis Rouanzoin/Jocelyne Shiromoto (714) 680-0663
Meets 2nd Tue. from 9:30 - 11:30 AM. Open

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

PALO ALTO
Ferol Larsen (415) 326-6896
Meets 1st Wed. 10am in MRI conference room. Case discussion.

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

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

SAN DIEGO
Marcee Sherrill (619) 233-0460
Meets 4th Fri. from 9:00-10:30am. Primarily case discussion. Call regarding availability.

SAN FRANCISCO
Sylvia Mills (415) 221-3030
Meets 1st Wed. 8-10pm., 180 Beaumont St. Please call to confirm. Case discussion and group process. Open.
Stan Yantis (415) 241-5601
Open

SAN MATEO/BURLINGAME/REDWOOD CITY
Pat Grabinsky (415) 692-4658
Florence Radin (415) 593-7175
Coordinating a new group. Contact Florence.

SANTA ANA
Charles Wilkerson (714) 543-8251
Judy L. Albert (714) 841-2296
Meets 2nd and 4th Thurs. of mo. 8:30-10:30am at 1633 E. 4th St. #206. Primarily case discussion. Open

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

SARATOGA/W. SAN JOSE
Dwight Goodwin (408) 241-0198
Meets Fri. 10am-12:30. Open

SOLANO/ NAPA COUNTY
Micah Altman (707) 747-9178
Willing to coordinate new group. Call if interested.

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

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

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

UKIAH
Garry A. Flint (707) 468-0418
Meets the last Fri. of mo. from 10am to 12 noon at 101 W. Church St. #10. Open

WOODLAND HILLS/NORTHRIDGE/WESTWOOD
Ron Doctor/Ginger Gilson (818) 907-7506
Seeking new members. Contact Ginger.

If you are interested in coordinating a new study group in your region, please notify the EMDRIA office at:
P.O. Box 51010, Pacific Grove, CA 93950-6010
(408) 372-3900 Fax (408) 647-9881

Submission Information

EMDR has generated a tremendous amount of enthusiasm among practitioners and all of us are anxious to read about the latest developments in, and/or experiences with, this exciting method. Because of this enthusiasm and desire to acquire more knowledge, I believe that it is important to produce a publication that provides a forum for articles that are more formal (e.g., research, protocols, etc.), as well as for those that are less formal (e.g., case studies, innovative ideas, etc.).

To this end, the following represent the guidelines for submissions to the Newsletter: Send articles to Lois Allen-Byrd, Ph.D., Editor, EMDR Newsletter, 555 Middlefield Road, Palo Alto, CA, 94301. Please include home and business telephone numbers, professional degree, location of practice (city and state only), professional affiliation (if applicable—university, if a lecturer or teacher, and/or institute, if an associate). Example: John Smith, Ph.D., John Doe University, Johnson, WA. If possible, please submit articles on a diskette, IBM format. Typed--articles should be double spaced with wide margins. ***APA*** *STANDARD AND STYLE—BOTH TEXT AND REFERENCES SHOULD BE IN ACCORDANCE WITH* ***APA*** *STANDARDS. All submissions are subject to editorial revisions. Proofreading of material is suggested before submission. Authors submitting a manuscript do so with the understanding that, if it is selected for publication, copyright of the article is assigned to the Newsletter.*

Because the Newsletter depends on you, the members of the network, I welcome any suggestions or comments that you may have. If there are any questions regarding the above, I can be reached at (415) 326-6465.

1993 Network Registration Form

(Print following information as you want it to appear in Directory. ___$50 ___$70 (Includes CA Meetings)

Last name:_____First name:_____

Professional Degree:_____City where practicing:_____State:_____Zip:_____

[Mailing address and residence phone number will not appear in directory.]

Mailing Address:_____City:_____State:____Zip:_____

Phone (Bus):_____(Res)_____

Professional Licensing:_____Willing to take referrals:_____yes____no

Specialty Areas:_____

Membership: _____ISTSS_____AABT_____APA_____Other:_____

Academic Affiliation:_____Research Interests:_____

SIGs or special interest areas:_____

EMDR Level: [ ] Level I - Year trained:_____ [ ] Level II - Year:_____ [ ] Facilitator

Comments:_____

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

Check payable to: **EMDR Network✉ P. O. Box 51010 ●Pacific Grove● CA 93950-6010 ☎ (408) 372-3900**

Newsletter

Training Registration Form

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

Name:_____Phone (Bus): _____

Address:_____Phone (Res): _____

City: _____State: _____Zip: _____Prof. Lic. #:_____

COST: $285.00 [$315 postmarked 15 to 30 days before seminar date, $345 less than 14 days before seminar, CEU $10].

Make check payable to: **EMDR**, P.O. Box 51010, Pacific Grove, CA 93950-6010, (408) 372-3900, fax (408) 647-9881

Please circle: **LEVEL I**: Location:_____Date:_____

LEVEL II Location:_____Date:_____

If LEVEL II: Your date of Level I Basic Training:_____Specialty:_____

Additional requests for topics in training:_____

[For Office use Only: Amt_____Ck_____Confrm_____]

Newsletter

Presented by Francine Shapiro, Ph.D.

Date	Location	Local Sponsor	Phone
May 1/2 Sat./Sun.	**Chicago, IL** Holiday Inn Crowne Plaza Northbrook, IL	Howard Lipke, PhD Dir., Stress Disorder Treatment Ctr. No. Chicago VAMC	(708) 688-1900 x4675
May 14/15 Fri./Sat.	**San Jose, CA** Sunnyvale Hilton	Robbie Dunton, MA Coordinator, EMDR	(408) 372-3900
May 22/23 Sat./Sun.	**Honolulu, HI** Pacific Beach Hotel	Sandra Paulsen, PhD Pacific Inst. of Behavioral Med.	(808) 523-2990
June 18/19 Fri./Sat.	**New York, NY** Loews NY Hotel[51st & Lexington]	William Zangwill, PhD Gerald Puk, PhD	(212) 663-2989 (914) 635-1300
June 27/28 Sun./Mon.	**Portland, OR** Sheraton Portland Airport Hotel	Jean Sutton, LCSW David Baldwin, PhD	(503) 452-9625 (503) 686-2598
Sept. 10/11 Fri./Sat.	**San Francisco, CA** Doubletree Hotel SF Airport	Robbie Dunton, MA Coordinator, EMDR	(408) 372-3900
Oct. 2/3 Sat./Sun.	**Seattle, WA** Doubletree Suites at So. Ctr.	Roger Solomon, PhD Dept. Psychologist WA State Patrol	(206) 586-8492
Oct. 16/17 Sat./Sun.	**Philadelphia, PA** Radisson Hotel	Alan Goldstein, PhD Dir. Agoraphobia/Anxiety Trtmt. Ctr. Temple University Medical School Steve Silver, PhD Dir., Inpatient PTSD Unit Coatesville VAMC	(215) 667-6490 (215) 384-7711 x649
Nov. 5/6 Fri./Sat.	**San Jose, CA** Sunnyvale Hilton	Robbie Dunton, MA Coordinator, EMDR	(408) 372-3900
Jan. 14/15, 1994 Fri./Sat.	**Los Angeles, CA** Sheraton L.A. Airport Hotel	Ron Doctor, PhD Psych. Dept., CA State Univ., Northridge Curt Rouanzoin, PhD Chair, Dept. of Psychology Pacific Christian College, Fullerton	(818) 885-2827 (714) 680-0663

Presented by Francine Shapiro, Ph.D.

June 12-13 (Sat.-Sun.)	**Denver, CO** Sheraton Denver Tech. Ctr.
July 10-11 (Sat.-Sun.)	**Chicago, IL** Holiday Inn Crowne Plaza
July 23-24 (Fri.-Sat.)	**San Jose, CA** Sunnyvale Hilton
Nov. 14-15 (Sun.-Mon.)	**Portland, OR** Sheraton Portland Airport Hotel
Dec. 3-4 (Fri.-Sat.)	**San Jose, CA** Sunnyvale Hilton
Dec. 11-12 (Sat.-Sun.)	**Philadelphia, PA** Embassy Suites

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

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EMDR Network
PO Box 51010
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