EMDRIA NEWSLETTER

New EMDRIA Definition of EMDR

The EMDR Definition Expert Panel arrives at a consensus and the EMDRIA Board has endorsed the new Definition of EMDR

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SEPTEMBER 2011

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Announcements & Information

President's Message

From the Board Room

BY URI BERGMANN, PH.D.
EMDRIA PRESIDENT

We have just returned from the 15th Annual EMDRIA Conference. Many said this was one of the best Conferences to date. We were privileged to listen to high caliber plenaries and presentations throughout the Conference. I want to extend thanks to all those who prepared and presented, the Conference Committee and Administrative staff who work all year to create this event, to the many volunteers that helped things run smoothly, as well as to the 859 attendees from 50 U.S. states and 63 international attendees from 15 countries!

Conference Highlights

We hosted an International Meeting where representatives from worldwide EMDR Associations joined to update each other on their growth and development and discuss various challenges and concerns they face in their regions. We also initiated a formal EMDR World Forum, wherein the presidents of EMDRIA, EMDR Europe, EMDR Asia, and EMDR Iberoamerica will meet regularly, either in person or by teleconference, to discuss the issues that impact our regional and national EMDR societies.

Many new members attended the General Membership Meeting. It was gratifying to see such an interest. The Board of Directors presented the responses and actions taken from last year's member survey (see page 10 for more information). Members had the opportunity to share current concerns.

As many previous presidents have noted, one of the greatest highlights of this Conference for me was to stand at the podium on Friday morning to give my welcoming address to 922 people. The energy in the room was stunning! To see this gathering of devoted, concerned, bright, vigorous and warm people who all share a common goal was profoundly inspiring! Thank you to all of you who made it. For those that could not, I hope that you can join us at our next Conference.

To all of you of you have volunteered years and years of service to this organization to ensure EMDR's strength and stability, I wish to offer my gratitude and thanks. We still have a journey ahead of us, which is moving rapidly and requires a lot more committed and compassionate people to carry it out. There are so many ways to be a part of EMDRIA's growth. Please consider joining us, and allow yourself be curious to see where you might want to get involved in this momentum.

Again, thank you again for all of your support and encouragement of me and of EMDRIA! Make sure you plan to be in Washington, D.C. next year for another fabulous Conference! See you there! ❖

ANNOUNCEMENTS

Call for Board of Director Nominations...

The EMDRIA Board is soliciting Director nominations for the Spring 2012 Election. The elected directors will serve a four-year term starting in January of 2013. In order to be qualified for the Directorship, you must be a Full or Associate Member of EMDRIA, and it is suggested that you have served on an EMDRIA committee for at least one year and/or demonstrated equivalent services for other EMDR or similar organizations, and demonstrate a clear and unambiguous commitment to and identification with EMDRIA. If you are interested in serving on the Board, please email Gayla Turner at gturner@emdria.org to request an application packet. Completed applications are due by February 15, 2012!

2011 EMDRIA Conference Certificates...

Your Conference certificates will be available for printing on Monday, September 19th. Please note that we are not mailing out certificates; we have software that allows you to print your own certificates directly from our website. You will only receive credit for those workshops you attended in their entirety. We are unable to award partial credit for any workshops where you were significantly late or left early. If you have any questions regarding your certificates, please email Paula Camacho at pcamacho@emdria.org.

2011 EMDRIA Conference Award Recipients...

Outgoing Board Members - Uri Bergmann, Ph.D. and Gary Peterson, M.D.
EMDRIA Special Recognition Award - Robert Gelbach, Ph.D.
EMDRIA Outstanding Research Award - Ad de Jongh, Ph.D.
EMDRIA Outstanding Service Award - Irene Giessl, Ed.D.
EMDRIA Poster Winner - Pei-li Wu, Ph.D.

Online Version of the Journal Now Available...

Volume 5, Number 3 of the Journal of EMDR Practice and Research is now available online. To access the Journal online at any time, just login to the Members Only Area of the website. Hard copies of the Journal were mailed at the beginning of the month.

EMDR Documentary Film...

A preview of EMDR, a documentary film, produced by Michael Burns was shown at the Conference. The documentary is scheduled to be released in November. Michael would appreciate donations to help fund his finishing work on the film. If you are interested, please send your check payable to Michael Burns at PO Box 661, Vernon, CT 06066. For more information about the movie, visit www.emdrmovie.com/interview.html.

Resources for Approved Consultants...

Did you know that EMDRIA has a listserv specifically for EMDRIA Approved Consultants? Approved Consultants can discuss topics related to consultation such as treatment planning, educational focus and ways to teach EMDR related information. Please email Sarah Tolino at stolino@emdria.org for more details on the EMDRIA Approved Consultant listserv.

Foundation Board Sets Fundraising Goal of $125,000...

Please help the EMDR Research Foundation Board reach its goal of raising $125,000 this year. As of August 24th, the EMDR Research Foundation has raised $31,605. Please take a moment to donate! Remember, your donations are tax-deductible! Please visit the Foundation website (www.emdrresearchfoundation.org) for updates on fundraising status. Give in honor of your friends, colleagues, clients and family members. Support EMDR research by a tax-deductible gift to the EMDR Research Foundation.

EMDRIA Office Closed...

Please be aware that the EMDRIA office will be closed on November 24th and 25th for the Thanksgiving holiday.

New EMDRIA Staff Member...

EMDRIA is pleased to welcome Sarah Tolino as Education and Training Coordinator. Sarah previously held this position with EMDRIA and returns to replace Laura Chism who has accepted a position as training coordinator of an alcohol and drug treatment center.

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Executive Director's Message

The **2011 EMDRIA Conference** was an exciting event in which more than 900 EMDR clinicians from around the world gathered in Southern California to hear interesting presentations, view an EMDR documentary, and network with other EMDR professionals. This was the largest attendance in five years. The EMDR Research Foundation (formerly called EMDRIA Foundation) had a major presence at the Conference with its new vision, plans and fundraising efforts. If you missed the Conference, some of the workshops were video recorded for Regional Meetings and many more have the handouts and audio recordings available for purchase. We hope to see many of you in October 2012 for the Conference in the Washington DC area.

Earlier this year EMDRIA launched its **new website and new membership software** system. We hope you will take advantage of the new features that allow you to provide more information about you and your practice for clients and prospective clients. EMDRIA also hopes to gain new members because the new software allows for a 12-month membership to begin the day one joins. EMDRIA already has reached an all-time record number of members.

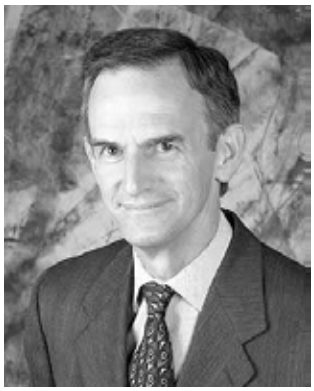
Make it easier for clients and other therapists to find you!
One of the great features of our new membership database is that it allows you to list the area(s) that you specialize in, the populations that you serve, and languages spoken. This can be very helpful when a prospective client is looking for an EMDR therapist. Review your Member Profile and make sure this information is included. We hope you will take the time to update these areas of your Member Profile.

We want to know more about our membership!
One of the goals of our organization is to increase diversity among our membership. In order to help us know more about the diversity of our membership, please tell us a little bit about you by completing the section of your profile called "About You".

EMDRIA is thankful for members who volunteer their time in planning programs, implementing standards, developing brochures and presentations, and identifying new member benefits. Volunteers serve as Regional Coordinators, Special Interest Group Chairs and Officers, Listserv moderators, administrative committee members and Board members. We hope you will identify an area that interests you and volunteer. Volunteers allow EMDRIA to better serve the EMDR community and those in need of EMDR services.

Studies have shown that people who give, live longer. Now, a new study shows why people volunteer—not whether they volunteer—is what really counts. People who volunteer because they want to help others, live longer than people who don't volunteer at all, University of Michigan researchers found. But those who volunteer mainly for some sort of personal benefit live no longer than non-volunteers, on average. The study is published in Health Psychology, a journal of the American Psychological Association.

BY SCOTT BLECH, CAE
EXECUTIVE DIRECTOR



A major focus of EMDRIA education committees (Standards & Training and Conference) during the last quarter of the year is to determine any needed changes in policies and procedures in response to the revised EMDRIA Definition of EMDR that the EMDRIA Board of Directors recently published (it is available on the website). The Committees will be implementing the Board directive to approve programs that include modifications to the Definition that are justified with appropriate literature review and/or scholarly consensus and/or empirical research.

Also in the last quarter of this year, the Regional Coordinating Committee has plans to release new DVD programs for Regional Network Meetings; these programs are recordings of sessions from the 2011 EMDRIA Conference. The Membership Committee will continue its efforts to increase the diversity of EMDRIA and to develop an EMDR presentation for university audiences.

Please contact me or the EMDRIA staff if you are interested in volunteering or would like our assistance. Thank you for all that you do as members of EMDRIA and the EMDR community. ❖

EMDR Research Foundation President's Message

"Build It...and They Will Come!"

BY WENDY FREITAG, Ph.D.
EMDR RESEARCH
FOUNDATION PRESIDENT

WOW! Again this year I left the EMDRIA Conference with excitement in my bones and gratitude in my heart. The Foundation's fundraising efforts were a huge success. However, more than that, there was a genuine interest from our constituents about what we are doing and how they can help. Our call for volunteers to help with social media set-up, grant writing, data gathering, and translating research findings met with 20+ offers and we're still counting. Our exhibit booth was a "buzz" with inquiries to buy raffle tickets, hear about volunteer opportunities or learn more about becoming a charter member of our newly launched program, the "Visionary Alliance."

If you were not able to attend the recent Conference, you missed a great professional meeting. The EMDRIA Conference Committee and staff deserve recognition for another great Success! The workshops were informative, there was great synergy among the attendees and we were all inspired by Dr. Francine Shapiro's presence and plenary. There is always a notable difference in the energy at the conference when Dr. Shapiro attends and addresses us with her motivating words. She excites and encourages the audience with the amazing accounts of what is being accomplished in the world with EMDR. This year again she provided the context for why the Foundation's mission is so important, offered her full support, and loudly encouraged the community to do the same. Dr. Shapiro, we are grateful for the blessing you gave us and for your support in our mission and fundraising efforts.

At the Conference Awards Dinner, Chris Lee, Ph.D. of Australia was given special recognition by the Foundation Board. SAMHSA finally recognized EMDR as an evidenced-based practice, in part to Chris' tireless efforts and perseverance. His determination along with evidence from high quality research studies made that possible. This will benefit us in our practices and can positively impact how EMDR is viewed by larger scientific and professional organizations. It is with great pleasure and appreciation that we recognized Chris for his hard work.

As I mentioned above, the Foundation initiated our "Visionary Alliance." This program offers constituents the opportunity to give a sustaining pledge by automatic monthly donations. Many EMDR therapists feel there is no way to "pay back" for all the benefits received due to EMDR, so enrolling in this program is a way to "pay it forward." Your monthly donations will provide a predictable, continuous stream of income that will give the Foundation leverage when pursuing funding from larger organizations and granting agencies and foundations. Through the end of the year, for as little as $15 a month you can become a Charter Member. At that time, all member's names will be entered into a drawing for very nice prizes donated by community members and EMDRIA Conference vendors who want to be a part of this effort. You might be wondering "what does it mean" to be a charter member or "what do I get" by joining the "Visionary Alliance?" Other than the opportunity to win a prize, there are no immediate, tangible benefits. However, when the Foundation is funding large scale research projects to the tune of thousands of dollars a year, you will have the satisfaction of knowing you were part of the ground swell that made it possible. Please consider becoming a "give as you earn" donor by donating one EMDR session or a portion of a session per month to support EMDR research.

Members of the Foundation Board are often asked questions like, "where is my money going", "why won't you fund this or that project", or "can you help me with my research design or statistical analyses?" We are certain in the short run we cannot and will not meet all the valid and important research needs that are presented to us. However, we are strong in our conviction that the Foundation will be a long standing, highly successful enterprise. Therefore, our current strategies are to ensure the ultimate goal of providing deep, broad support for EMDR research for a very long time to come.

To that end, the Board held a strategic planning meeting which produced our Vision Statement, a new Mission Statement and five goals (with action steps) to be met by 2016. At the meeting the Board also changed our name to the **EMDR Research Foundation**. We believe we are the 'Foundation of EMDR Research' so this better reflects who we are and what we are all about. We want our message to be up front, loud and clear. We also have a new website, at www.emdrresearchfoundation.org. Take a peak and if you've already donated in 2011, you might just see your name scrolling on the homepage.

Our Vision: *The EMDR Research Foundation envisions a world where people are transformed to wellness and vibrancy by effective, compassionate mental health treatment that is driven by quality research.*

Our Mission: *The EMDR Research Foundation promotes health and growth of human beings through the support of quality research, evidence-based practice, and compassionate, well-informed clinicians.*

To realize this Vision and Mission, here are the goals we set forward:

Goal 1: To see a 10% increase of EMDR research in academic journals, university curricula, and access to funding.
Goal 2: To annually reach 10,000 clinicians with information on clinically-relevant EMDR research.
Goal 3: Annually, the Foundation will meet self-stated targets for Board composition and Board/volunteer skill sets.
Goal 4: To annually publish clear guidelines for funding quality EMDR research to ensure maximum contribution to a body of research.
Goal 5: To provide one new non-monetary research resource per year for current and potential EMDR researchers.

These goals are all about our continued growth, being clear about who we are and what we do, and strengthening the support we offer. The policies we develop and our decisions in the present are done with our investment for a very long successful future.

Before closing, I would like to share another highlight with you. In our efforts to strengthen and support quality research we decide to provided specific feedback to each of the research teams who submitted proposals in February, but were not selected for an award. We did this with the hope that this feedback would facilitate these teams in submitting a stronger proposal in the next funding cycle. Also in response to numerous requests for funding this year, the Board decided to offer a second funding cycle with a submission deadline of 9/15/11 and an award date of 11/15/11. We heard from one of the teams that the feedback they were given assisted them in resubmitting their proposal. We wish them and all teams who submit proposals the very best in the decision process.

In closing, I offer my thanks for your patience with us as we grow, for your support both financially and volunteering your time and expertise, and spreading the word about the Vision and Mission of the EMDR Research Foundation. We hope you consider becoming a Charter Member of the Visionary Alliance or perhaps, consider volunteering to become an integral part of the solution.

"Happy are those who dream dreams and are ready to pay the price to make them come true."
~Leon J. Suenes

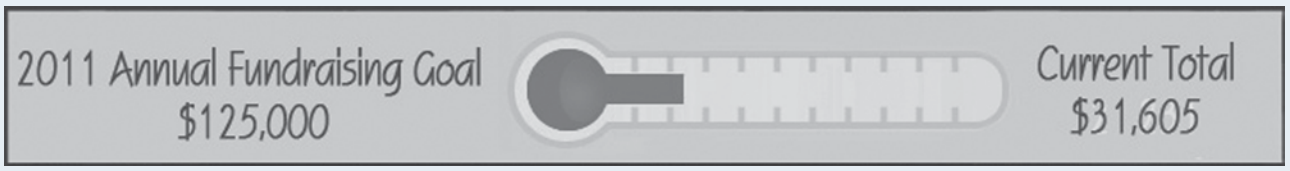
2011 Fundraising Goal | $125,000

The EMDR Research Foundation is a nonprofit, charitable organization created to further the development of EMDR through research and the education of mental health professionals and the public.

The Foundation is funded by voluntary contributions from EMDRIA members and other supporters of EMDR. The Foundation is recognized by the IRS to be exempt from Federal income tax under section 501 (c) (3) of the Internal Revenue Code. Contributions are tax deductible under section 170 of the Code. Contributions can be made by mailing a check made payable to:

EMDR Research Foundation
5806 Mesa Drive, Suite 360
Austin, TX 78731-3785

Contributions can also be made online at:
www.emdrresearchfoundation.org



Take a moment to donate now! Remember, your donations are tax-deductible! Please check the EMDR Research Foundation website for updates on fundraising status. Give in honor of your friends, colleagues, clients and family members. Support EMDR research by a tax-deductible gift to the EMDR Research Foundation.

The Conference Corner

BY PAULA CAMACHO, EVENT PLANNER

Thank you to all of you who were able to attend the 2011 EMDRIA Conference: *"Healing the Many Faces of Trauma"* in Orange County. It was a huge success thanks to all of you. We had 922 attendees this year and we hope to see more in Washington, D.C. in 2012!

We would like to express our appreciation to our Guest Speakers, Presenters, Sponsors, Exhibitors, Student Monitors, Attendee Monitors, and Volunteers at this year's Conference. Each year, the Conference gets better, and we couldn't do it with out each and every one of you and your help and support!

The majority of the workshops at this year's Conference were audio recorded by Convention Media. You can purchase Audiotapes and CD's from this year's Conference online at www.conventionmedia.net or you can call (800) 388-5709. You have the option to purchase a complete set of Conference recordings synchronized with handouts and PowerPoint presentations, a complete set of Conference recordings on MP3 audio CD, a complete set of Conference recordings on audio CD, or individual sessions.

Conference attendees received a complimentary Conference Handout CD at the Conference, but for those who didn't attend, it is now available for purchase. Please visit the EMDRIA Store on our web site for more information, including the table of contents, which indicates the session handouts included, or you can call the EMDRIA office and place an order over the phone at 866.451.5200.

We anticipate that your Conference certificates will be available for printing on Monday, September 19th. Once they are available, we will send you an email with instructions on how to access them. Please note that we are not mailing out certificates; we have software that allows you to print your own certificates directly from our website. You will only receive credit for those workshops you attended in their entirety. We are unable to award partial credit for any workshops where you were significantly late or left early. If you have any questions regarding your certificates, please email me at pcamacho@emdria.org.

Planning for next year's Conference has already begun! The 2012 EMDRIA Conference "EMDR & Attachment: Healing Developmental Trauma" is sure to be exciting and well attended, so please mark your calendars today! It will be held October 4th – 7th in Washington, D.C., at the Crystal Gateway Marriott.

We are pleased to announce that Dr. Rachel Yehuda will be presenting at Friday's Plenary. In addition, due to the remarkable reviews from his Plenary Session held at the 2010 EMDRIA Conference, we confirmed Dr. Colin Ross as our Saturday Plenary speaker. The Conference program will then come to a strong finish on Sunday with an outstanding Plenary presented by Dr. Francine Shapiro.

Don't miss the chance to present alongside this fantastic line-up of speakers! You are invited to apply to present at the 2012 EMDRIA Conference. Material should be relevant to the EMDR field and be an original contribution. Members and non-members of EMDRIA are invited to submit. Share your best practices and new techniques with other therapists in the industry, helping them to understand the new research and clinical practices in EMDR and how to help treat all types of trauma. EMDRIA's goal is to offer continuing education that helps promote and maintain the integrity of EMDR.

Please help us accomplish our goal by submitting your presentation today! **The deadline to submit is December 9th.** The Call for Presentations Application is available on our website, www.emdriaconference.com. We ask that all submissions be completed online. If you need assistance and/or have questions, please contact me at pcamacho@emdria.org.

We hope to see you at one of our future Conferences. Stay tuned for more information! ❖

...Being a Part of Something Bigger Than Myself...

FROM THE EMDRIA BOARD OF DIRECTORS

When asked in a recent survey of former EMDRIA Board Members, "What did you like the most about being on the Board?", Zona Scheiner responded that it was "The camaraderie, the friendship, the excitement and the fulfillment of being a part of something bigger than myself and my world." Barbara Hensley felt that it was "The camaraderie and the life-long friendships I have as a result, and what we were able to accomplish in such a short period of time because of our mutual belief in something great." Similarly, David Sherwood reported that it was the "Working together on mutual goals, the general attitude of mutual respect…the way we managed to balance serious work and playful humor." Sue Hoffman felt that it was "The vehicle to give back and develop the spread of EMDR." She further elaborated that she "enjoyed the ethical and interpersonal challenges of working with clinicians who were able to disagree in service of a greater goal." Another former member reported that "I loved the hard work that the Board required. I learned about leadership and governance. I loved that the meetings took me out of my world and allowed me to experience colleagues all over the country." These are some pretty impressive responses from some of the many former Board members we have come to know and respect.

These are just a few of the responses that we recently received on a survey of former Board members reflecting upon their reasons for being on the Board and how their experience on the Board has affected them personally.

The Board has an ongoing commitment to the recruitment of members and seeking members of the EMDRIA community with leadership skills and a desire to serve. One of the members said it best that "The work requires a personality that both enjoys board work and has skills beyond being a therapist and knowing EMDR. Boards work better with a variety of background strengths and information."

Interestingly, when asked what motivated former members to be on the Board, Jim Gach echoed the response of nearly all the respondents when he replied that there was a "perceived need to give back to the EMDR community because of the positive input of EMDR on my practice." Of the twenty-four former Board members who responded to our survey, nineteen responded that they personally knew someone on the Board who encouraged them to be a Board member.

This is a wonderful time to think seriously about "being a part of something bigger than myself". EMDRIA is continuing to grow and has more new members than ever. There continues to be work to do. Participation on the Board is an opportunity to be a part of its formative growth and advancement of EMDR worldwide. There is dire need for diversity both on our Board and in our membership. If you are not sure you have anything to contribute just remember these words of Barbara Hensley, "Friends encouraged me to run. I was reluctant at first but I wanted to give back some of what EMDR has given me both personally and professionally."

If you are thinking about participation on the Board don't hesitate to contact Gayla Turner (GTurner@emdria.org) for a Board Member Application. All applications need to be submitted to the EMDRIA office by February 15, 2012. Please feel free to contact any of the current Board members or even one of our former board members for more information in helping you decide "to throw your hat into the ring." ❖

Summary of 2010 EMDRIA Survey

Last summer, the EMDRIA Board initiated a survey to assess the goals, directions, and priorities, known as Ends, which make EMDRIA membership worthwhile. Additionally, we examined your opinions about the most desirable future for EMDRIA over the next five years. Over 10% of the membership completed the survey, which is considered an adequate representative sample of our general membership of over 4,000 members. Each survey item yielded a quantitative measure and also provided room for written comments.

We are excited to share this information with you. You have the opportunity to learn who we are as EMDRIA members and how we feel about ourselves as an organization. Our thanks go to all of you who made this happen!

You are also welcome to access the Summary and Full Report. The full report is 17 pages long and can be found at http://www.emdria.org/associations/12049/files/EndsSurveyReport2010.pdf.

The Board of Directors has taken the survey results and used them to revise the overall goals, or Ends, of EMDRIA as an organization. While the first two priorities identified in the 2010 survey remained the same as they did five years ago, the second pair of goals represented a new direction and a significant change in how EMDR is advanced and promoted into the awareness of the general population. The revision of these Ends policies will be shared with you within the next several months, and your input and collaboration has allowed us to shape our organization for the years to come.

If you have any additional comments based on your Survey results and our interpretation of the rich information you provided, please contact any board member, and we will be happy to respond to your comments.

Thank you, again, for the direction you have provided for all of us.

Sincerely,

The EMDRIA Board of Directors

Summary of 2010 EMDRIA Survey

Overall, the feedback from EMDRIA's membership was quite positive, with a majority of respondents reporting very high satisfaction with how EMDRIA is meeting its goals.

Organization is consistently achieving this.	Organization is above average in achieving this.	Organization is average in achieving this.	Organization is below average in achieving this.	Organization is consistently not achieving this.	No opinion: Do not know if organization is achieving this.

59% of all Ends Statements were rated Above Average or Consistently Achieving on the five-point rating scale shown above. Only 7% of all Ends Statements were rated Below Average or Consistently Not Achieving. Overall, there was a moderate correlation between the most "Consistently Achieved" goals and the "Most Important" goals for the organization, showing that EMDRIA appears to be devoting the majority of our resources to the most important concerns for members.

Very Important	Important	Moderately Important	Not Very Important	Not Important At All

The **most important priorities** for EMDRIA membership now:

1. I am able to make a successful transition from EMDR training to practice – (80% rated as Very Important & 96% total as VI or Important)
2. EMDRIA advocates for the recognition of the efficacy of EMDR – (75% Very Important)
3. Mental Health practitioners recognize EMDR as consistent with best practices – (73% Very Important)
4. I am able to implement, practice, and continue to grow in EMDR skills & understanding as new knowledge in related fields grows – (70% Very Important)

Despite the high overall satisfaction rating, a minority of members raised a number of concerns that were quite significant and noteworthy.

The **most negative** ratings in the statistical measures (Below Average or Not Achieving) were:

1. Mental Health practitioners recognize EMDR as consistent with best practices – 18%
2. I have access to innovative programs, which may show promise – 14%
3. I am provided connection with a supportive, knowledgeable, & vital community of peers – 12%

The most salient dissatisfaction expressed by concerned "small clusters" was reflected in the written comments. **Cost** is the biggest concern including the conference, travel, and time away from work. Clinicians want **local access to workshops** that provide credits so they do not have to travel and take time off from work, and video presentations they can get EMDRIA credit. They also want easier access to getting EMDRIA credits for regional meetings. If they attend the Conference, they want **new speakers & material** presented. They are interested in more advanced workshops than on a basic level. There is also concern that EMDRIA is **too narrowly focused on a single model of EMDR treatment**, which stifles innovation and connection to other clinical fields, such as energy psychology, somatic experiencing, brainspotting, or CBT. There is a concern that **clinicians are not receiving the support they need to participate in research studies**. There is also concern that the **quality of research needs to improve** to be credible.

The **priorities for the future** were listed by the membership in the following rank order:

1) Education/Training and **2) Research** have remained as the top EMDRIA functions over the past five years, and they are likely to remain as the cornerstone of our EMDRIA Membership. The third issue is rising as a major concern for Members: **3) Working with Recognized Professional Organizations to Accept EMDR**, reflecting the accelerated awareness of how EMDR fits within the overall constellation of psychotherapy techniques. The fourth issue, **4) Marketing/Advocating in such a way that EMDR becomes common knowledge to the public**, is weighing more heavily on EMDRIA Members than ever before.

To read the full EMDRIA Ends Survey Report, please visit http://www.emdria.org/associations/12049/files/EndsSurveyReport2010.pdf.

IN CELEBRATION OF:

BY MARILYN LUBER, Ph.D.

DAVID SERVAN-SCHREIBER

On July 24, 2011, our friend and colleague, David Servan-Schreiber died at 50 years of age. He was a leader in our field. He brought his special talents to the understanding of healing and went beyond the usual Western medical framework in which he was educated. His interest in alternative ways of healing began after he was on a mission for Doctors Without Borders in Tibet and learned about meditation, acupuncture and nutrition and deepened after an early occurrence of brain cancer at the age of 31. He pursued and wrote about treatments that supported healing of the whole person and in so doing revolutionized the thinking of the French-speaking world. This celebration of David's life is an updated version of an article that I wrote for this newsletter in 2003 and includes the many contributions he has done since that time and the reminiscences of some of the many colleagues who loved and respected him.

There is a man who is taking the French-speaking world by storm and his name is David Servan-Schreiber. He has written a best selling book called "Guerir: le stress, l'anxiete et la depression sans medicaments ni psychanalyse" (The English title will be: "The Instinct to Heal: Curing stress, anxiety and depression"). However, we know David as a valued member of our international EMDR community.

David first learned about EMDR during a lecture by Francine Shapiro. He became curious about EMDR and went on to take an EMDR Institute basic training in January 1998. During the training, he saw Robert Tinker's "The Mary Tape" about a woman dealing with issues of death and dying and was touched by it. Although skeptical if EMDR could really work, he went back to his office and used EMDR right away. He said the following:

"It worked from the first day and I was hooked. That's the story! I think that it happens to everybody. It is surprising to see something work so well. After years of doing therapy, I never experienced somebody leaving my office and not feeling like the same person. People would feel better but that was nothing like what I saw with EMDR. Also, what happens with it made me feel less helpless and I felt more effective."

David's first encounter with wanting to help others was when he was 2 years old. He was playing with his friends at a playground in Neuilly, a suburb of Paris, and there was another 2 year old there with thick glasses. David remembers that he wanted to help him. In fact, he says that the feeling of wanting to help others when they are in misery has been a feeling that has never left him.

At first, he thought that he would follow in the footsteps of his great grandfather who was one of the first surgeons in France. He began his medical training at the Faculty of Medicine, Necker-Enfants Malades at the University of Paris. However, every summer during college, his other interests, computers and film, brought him to a university in North America to learn about these areas of interest. During that time, he learned how Americans were taught medicine and decided to transfer to The School of Medicine at Laval University in Quebec. While doing a clinical rotation at Stanford in conjunction with Laval U, he fell in love with Psychiatry. David said:

"What could be better than to listen to people telling the story of their lives? It was like going to the movies!"

Furthermore, he said that there was an aspect of EMDR that was similar to surgery:

"You are working with one lesion at a time and you are cleaning it out with EMDR like you would a lesion."

After medical school, he decided to do a bi-disciplinary internship in Internal Medicine and Psychiatry at the Royal Victoria Hospital at McGill University. The following year he completed a Fellowship in the field of Artificial Intelligence in Medicine at Western Psychiatric Institute and Clinic and the School of Computer Science at Carnegie Mellon University, in Pittsburgh. He thought that his career would be about "information and how to improve medicine by how people make decisions and he would capture it in computer expert systems". Several years later he completed his Ph.D. in Cognitive Neuroscience at the School of Computer Science at the same University. It was an exciting time where David had the opportunity to combine his love of Psychiatry, Artificial Intelligence and Neuroscience. He was part of the group that developed a

way to model neural networks on computers so that it would be possible to understand how thoughts and emotions arose from interactions between neurons and then gave rise to behavior. He worked under the Nobel Prize Scientist, Dr. Herbert Simon, and Dr. Jay McClelland. His thesis was a great success and was published in Science, August 1990 under the title "A network model of catecholamine effects: Gain, signal-to-noise ratio and behavior."

In 1991, David began working with Doctors Without Borders in Iraqi Kurdistan after the first Persian Gulf War, as well as in Tajikistan, India and Kosovo. David provided medical and psychiatric support in these areas. Also, he was a Founding Board member of the United States branch of Doctors Without Borders. This international group was awarded the Nobel Peace Prize in 1999.

David started an NIH lab for clinical applications of Cognitive Neuroscience at Carnegie Mellon and the University of Pittsburgh that he co-directed for 8 years. During this time, he finished his Residency in Psychiatry at Western Psychiatric Institute and Clinic at the University of Pittsburgh. Throughout his research career, David published more than 90 papers in diverse areas of knowledge such as engineering; artificial intelligence and medical management; a system for sexually dysfunctional couples; computerized psychotherapy; language learning; schizophrenia; human brain mapping; fear conditioning; neuroleptic effects on learned behaviors; Anxiety Disorders; Dopamine and the mechanisms of cognition; computational modeling of emotion; etc. He won many awards in recognition of his research skills. The problem was that the more successful he became in research the less clinical work that he did. When he understood that his career would continue to move in this direction, he reflected on what was happening and decided that because teaching residents about Clinical Psychiatry was the best part of his work, it was time to make a change. He said that this was very hard to do and that it was the first time that anyone sent money back to NIH!

David joined the Shadyside Hospital Staff and became the Chief of Psychiatry. He was appointed the Director of Psychiatric Services for the new Center for Complementary Medicine and later became its Medical Director. While he worked with people with medical conditions, he began to understand the importance of the mind-body connection. As he began to use this principle to organize his thinking about human behavior, he had more powerful results with his patients. The Center for Complementary Medicine was one of the very first university-affiliated units involved in the use of complementary-based medicine.

In the new millennium, David became an EMDRIA Instructor and taught EMDR at the University of Pittsburgh and McGill University. A year later, he became an EMDR Institute Trainer and offered the first EMDR trainings taught in French. By 2003, David had trained 250-300 therapists in France and was in the process of creating a group of French-speaking Facilitators and Supervisors to support the growing number of clinicians in the French-speaking world. He was asked to take part in a Cognitive Therapy course at the University of Lyon where he was training medical students, psychiatrists, and therapists. Also, he helped to develop a university degree in Clinical Traumatology as part of a 2-year program at the University of Paris V; the basic training there included EMDR.

In September, 2001, David wanted to assimilate all that he was learning and took a sabbatical to integrate his thinking, returning home to Paris, where he had grown up. Through his book "Guerir" (www.guerir.org), he pulled all of this information together into a coherent body of work.

"I think that EMDR is at the forefront of this movement. This realization is going on worldwide. The new medicine of the 21st century will capitalize on the powerful healing connection between the mind and body. They should continue to do what they are doing because they are pioneers."

"Guerir" was published in March 2003 and changed the way the French-speaking people conceptualized healing. David has used studies published in some of the most prestigious scientific journals such as "General Psychiatry", "Lancet," and the "Journal of New England" to give support to the importance of natural treatment methods for stress, anxiety and depression. His thesis was that these natural methods all tap into the body and the emotional brain to help bring it into balance and that the emotional brain was more connected to the body and its experiences than it was to language and reason. David is a firm believer in the benefit of pets when it comes to stress and anxiety. He has a cat and enjoys cooking and playing cards with his friends on Sunday night as a way to deal with his own stress.

To the EMDR community David wants to say:

"I think that EMDR is at the forefront of this movement. This realization is going on worldwide. The new medicine of the 21st century will capitalize on the powerful healing connection between the mind and body. They should continue to do what they are doing because they are pioneers."

Over the next 8 years, David wrote two more books. "Anticancer: A New Way of Life (2007)," has been translated into 36 languages, and looked at the benefits of a healthy diet and balanced lifestyle, including nutrition, exercise, emotional well-being and environmental awareness to prevent and battle cancer. In 2010, he found out that he had another brain tumor – he called it "The Big One"– and he wrote his third book, "Not the Last Goodbye: On life, death, healing, & Cancer," with Ursula Gauthier, a journalist. In this book, David has shared this final passage of his life. He deals with the complex questions of life and death and shares his own experience to assist us in addressing our joys and fears about our own journey of life.

All of David's endeavors show his dedication to science and his need to go beyond existing dogma to look for a new

a profound understanding of human nature, but, also, the rare capacity to truly listen, understand and through his compassion to assist us in uncovering a healthier way of being. David has often been at the forefront of controversial issues. He is one of the scientists who spoke out on the potential dangers of cell phones and the importance of vitamin D.

David was an Adjunct Professor in the Section of Integrative Medicine, Department of General Oncology, at The University of Texas M.D. Anderson Cancer Center and a member of the Board of the Society for Integrative Oncology. Through "Anticancer," the M.D. Anderson Cancer Center found a way to advance the goals of the Integrative Medicine Program run by Lorenzo Cohen, Ph.D. They have been interested in supporting "the development and testing of a novel, comprehensive integrative oncology intervention." The model David outlined in "Anticancer" was the type of standardized integrative oncology program for which they were looking and now has evolved into a $5 million research program supported by the Servan-Schreiber/ Cohen Anticancer Fund (for more information http://www.mdanderson.org/how-you-can-help/make-a-donation/the-servan-schreiber/cohen-anticancer-fund.html).

As a result of David's emphasis on research, a major part of the EMDR French Institute's mission is to support research. Annually, the Institute prepares a summary of the latest EMDR research, translates articles into French and encourages research during their trainings. Since 2002, David has been responsible for the EMDR French Institute's EMDR training curriculum. Since he started training in French, more than 1700 French-speaking mental health practitioners have been trained. EMDR Basic trainings are currently taking place at the University of Lyon and at the University of Metz.

David has been a recipient of many awards throughout the course of his career. As a student, he received the following awards: Award of Best Paper, Joint National Congress of the American Association for Medical Systems and Informatics (1984); Individual Fellowship Award, National Institute of Mental Health (1988); Lauréat de la Faculté de Médecine de Paris (1989); Outstanding Resident in Psychiatry Award, National Institute of Mental Health (1991); Laughlin Fellow of the American College of Psychiatrists (1992); Fellow of the Summer Institute of the McDonnell-Pew Foundation for Cognitive Neuroscience (1993); and the Young Investigator Award, National Association for Research in Schizophrenia and Affective Disorders Research Scientist Career Development Award, National Institute of Mental Health (1994). As his career continued, he was given these awards: Mead Johnson Award, American College of Neuropsychopharmacology (1995); UPMC Shadyside Hospital Recognition Award (2000); Pennsylvania Psychiatric Society Presidential Award for Outsanding Career in Psychiatry (2002); William Cooper award - Hillman Cancer Center, University of Pittsburgh (2005); and the Board of the Prince Louis de Polignac Foundation Award (2009).

David is survived by his wife (Gwenaëlle Briseul), his 3 children (Hugo, Charlie, and Ana), his three brothers and his mother.

Memories of David

Robbie Dunton (Administrative Director of the EMDR Institute):

David Servan-Schreiber is an inspiration to people throughout the world and his achievements will impact the lives of many forever. The EMDR community will miss him terribly. I feel blessed to have known him and to enjoy the love and joy that he so freely shared with those around him. Through his videos, books and lectures he shared his compassion for others and his dynamic ability to put his knowledge and experience into words. I have recommended his books to friends and family, and look forward to reading his third book when it becomes available in English. He accomplished so much in his 50 years!

Udi Oren (President of EMDR Europe and EMDR European Trainer):

Writing about David in the past tense seems unreal and makes me very, very sad. David Servan-Schreiber has been one of the most significant contributors to the development of EMDR in the last decade. In this short period, he wrote his bestseller book "The Instinct to Heal" that introduced EMDR to over a million readers around the world. He was the force behind the growth of EMDR in France and in the French-speaking world. He conducted EMDR-focused research, and was the President of the EMDR France Association as well as an important voice on the EMDR Europe Board.

David was a friend and a colleague who both supported the growth of EMDR, as well as put it into the larger perspective of the changes taking place in medicine. This combination of an insider/outsider view of EMDR is a very unique one, and was only one of the ways in which David's ability to integrate different "worlds" came into life. He will be remembered by all who knew him for his courage, his wisdom, his warm loving smile, and his all-embracing leadership. David was a good, great, and inspiring man-the kind of man you wish the world would have more of, and one you miss tremendously once he is gone.

Ludwig Cornil (EMDR European Trainer; Director of the EMDR Institute Belgium):

David has meant a lot to me personally and to the development of EMDR in Belgium. About 10 years ago, it was David and Arne Hofmann, who supported me when I created the Belgian EMDR-Institute. I still remember my first meeting with David. This was before his first book, "The Instinct to Heal" was published and I didn't know his personal history, so I was rather confused about his 'strange' behavior. He was drinking "green tea" in front of the audience and ordering different kinds of fish in a restaurant that did not specialize in fish but served typical Belgian food that we had planned for him to taste. During the training, he took a little nap after lunch and did some meditation. He was

already living the book he was going to write afterwards. I also remember the participants of the training being touched as he gave a specialty workshop on "EMDR and Mourning," as he had a lot of experience in palliative care. From the beginning his humanity emanated from his being. As he became too occupied with his first book, he took an enormous risk and he asked me – a man from the Flemish-speaking part of Belgium- to do a Part 1 training in Paris! In the end, it worked out and I am grateful to David because he clearly conveyed his trust in me to the participants when he introduced me to them. He kept his faith after that first training and allowed me to grow, for which I will be forever grateful.

David had a mission in life and he used all his talents to accomplish it. I experienced him as one of the steadiest people I know. It is rare to meet people like David in one's lifetime, and, each time we do, it is a blessing. David's form has disappeared, but his energy has been transmitted to every person he has touched. I am sad and happy at the same time, sad that he's gone, but also really happy when I let his image appear before my mind's eye and I hear his voice in my head.

Martine Ircane (EMDR European Trainer - France):

David brought an ethical and human dimension to medicine, healthcare and teaching that demystified behavioral psychology, psychiatry and brought everyone access to the benefits of psychotherapy. To EMDR, he brought his own careful, integrated approach that included his medical, psychiatric, and interpersonal gifts, including the knowledge of the mind and body. We thank him for being the first psychiatrist to teach about EMDR at the University of Lyon (since 2004) in the CBT program and sharing this information with HAP. I want to thank him especially for his trust in me during the time that he supported me as a new EMDR trainer. I will never forget those moments that we shared of laughter during our many voyages. Also, I will never forget his kindness and his smile. We will miss him. GOOD BYE AND THANK YOU, DAVID. (translated)

Judith Black (EMDR Canadian Facilitator):

We, in the Quebec EMDR community will remember David fondly and with special gratitude. Following the publication of his first book, "Guérir", and the "Anticancer," he made numerous visits to Québec, gave many interviews and was a much sought after lecturer. This had a marked impact on the interest in EMDR, both on behalf of clinicians and the public. As a result, many additional local clinicians, sought training in EMDR. Many are continuing to this day as active participants locally, in EMDR Canada and in the International EMDR community. In spite of his growing renown, he remained humble, approachable, caring, and genuine. We bid you David: "Un gros merci et Adieu."

Sandra Kaplan (EMDR Institute Trainer):

David Servan-Schreiber was a very special person. His book: The "Instinct to Heal" took France by storm. He brought EMDR therapy and EMDR training to France. Over the nine years that I knew him, I was touched that he would make sure I understood what was being discussed in French. Adjectives to describe David Servan-Schreiber: elegant, thoughtful, sensitive, creative, brilliant, energetic, inspiring. It was my good fortune to have known and worked with him.

Delphine Pécoul (Assistant to David Servan-Schreiber):

David voulait vraiement que toute une génération de jeunes chercheurs suivent le mouvement et continuent de chercher, d'avoir des idées, de rassembler ce qui s'était fait et d'oser sortir des chemins battus.

David souhaitait également que les projets dans lesquels il s'est beaucoup investi puissent continuer, sans lui. C'est ce que nous allons faire, notamment avec l'Institut Français d'EMDR, qui continue de fonctionner, dans le même état d'esprit (qualité des formations proposées, aide à la recherche, aide aux projets humanitaires, aide aux développement de formations universitaires), grace à l'équipe de l'Institut, qui est très soudée et mobilisée, en lien avec l'association EMDR France et l'association EMDR Europe, et avec le soutien de Francine Shapiro.

(David truly wanted a generation of young scholars to follow suit and to continue to search, to have ideas, to study what has been done and to dare to go beyond the road already traveled. Also, David hoped that the projects in which he had invested so much continue, even without him. This is what we are doing, especially through the EMDR French Institute which will continue to function in the same spirit (quality of proposed trainings, research support; assistance for humanitarian projects, and support for trainings in universities) with the EMDR French Institute Team, who are committed and active, in solidarity with the EMDR Europe Association and with the support of Francine Shapiro)

Francine Shapiro:

It is impossible for me to adequately express my feelings about the loss of David. In his service to humanity, he was a light to the world in so many ways. He was a wonderful, wise and compassionate man whom we will sorely miss. I am forever grateful for having known him.

In closing, a final message from David in his own words:

"Death is part of life; it happens to everyone, profit from now, do the important things." ❖

Updated EMDRIA Definition of EMDR

SUMMARY OF THE EMDRIA DELPHI SURVEY: THE EMDR DEFINITION

The purpose of this study was to refine and achieve consensus on the EMDRIA Definition of Eye Movement Desensitization and Reprocessing (EMDR). The EMDRIA Definition of EMDR is important because it is used to guide the development of Educational Programs, Standards and Training for clinicians, EMDRIA policies, and in addition, provides information to clients, other health providers, insurers, and the public. It is therefore essential that the definition reflect accuracy, scientific integrity, specificity, breadth, and relevance to guide practice standards, education, research, and policy for the EMDRIA community. The impetus for the revision of the Definition of EMDR stemmed from ongoing member feedback about inconsistencies and contradictions in the Definition. Some members reported that the Definition was too rigid and prescriptive, and curbed innovation and flexibility; while others believed it was not strict enough. In addition, others said that it did not account for recent research in information processing and EMDR. A central issue revolved around whether the Adaptive Information Processing (AIP) model should be the guiding framework for EMDR practice and research.

Revision of the EMDR Definition began in 2008 when the President of the EMDRIA Board appointed a subgroup of 5 Board members to form the Education Task Group (ETG). Over the next 2 years, Board members and the ETG examined research and theory on neuroscience and information processing and EMDR methodology and practice. 24 experts in EMDR research, theory and practice from the U.S.A., as well as the international community, were identified and asked to provide feedback anonymously on the then current Definition especially with respect to the AIP model guiding EMDR. This qualitative data was summarized and incorporated into the revised Definition. After the publication of the revised Definition in 2009, numerous members voiced concern about various aspects of the Definition. EMDRIA's Administrative Committees reviewed the 2009 Definition with the Research Committee and the Standards & Training Committee providing input and suggested changes, which were incorporated into a further revision.

The EMDRIA Board approved the Delphi Survey in order to achieve consensus of this revised Definition of EMDR. A web-based modified Delphi Survey methodology was used to gain consensus on the Definition. The goal was to seek at least a 70% majority agreement within 3 rounds. After Institutional Review Board approval was obtained, the invitation to participate was sent to 50 national and international Expert Panel members who were identified by the Board as those who have conducted or published EMDR research and/or are EMDR trainers and/or facilitators and who are considered well-known to the EMDRIA community. There was a 62% response rate with 31 of the 50 invited members of the Expert Panel who agreed to participate. Round # 1 was a qualitative survey asking Expert Panel members whether they agreed or disagreed on each paragraph of the Definition and asked respondents to state the reasons for their agreement or disagreement. Round #1 results achieved 70% or greater consensus on 15 out of the 25 paragraphs.

For Round #2, the edited consensus paragraphs and the 10 non- consensus paragraphs, with the comments from Round #1, were sent to the Expert Panel. Panel members were asked to consider others' responses and to indicate again agreement or disagreement on each item and to add any comments about their rationale for agreement or disagreement. Results from Round #2 found that all 10 non- consensus paragraphs achieved less consensus in Round #2 with 65.46% consensus in Round 1 vs. 46.89% consensus in Round #2. Based on the Panel's responses and comments, the ETG revised these paragraphs for Round #3.

Round #3 was then sent to participants and consisted of a 5 point Likert type survey asking respondents to rate each paragraph with respect to that paragraph's relevance, accuracy and specificity. In addition, Round #3 asked participants to rate the overall comprehensiveness and scientific accuracy of the Definition as a whole. Results from Round #3 found consensus on all paragraphs for relevance (86%), accuracy (85%), and specificity (86%) with 87% agreement on the overall comprehensiveness of the Definition and 70% agreement on the scientific accuracy of the Definition. Thus, the results from Round #3 indicated greater than 70% consensus for all ratings on allparagraphs of the Definition. The respondents were also asked for comments on the overall Delphi process as well as content comments.

After review of the relevant research, further suggestions were incorporated and the Definition was again sent to the Expert Panel requesting response on the comprehensiveness and scientific accuracy of the definition. 78% agreed that the Definition was comprehensive while 70% agreed that it was scientifically accurate with 8% neutral. This reflected a decrease of 9% in comprehensiveness and the same agreement on scientific accuracy from Round #3. The final response rate for the Expert Panel was n = 23 or 46%. A pulse survey was sent to those who did not participate in order to determine the reason for nonparticipation on Round #1 and Round #2. The most common reason for not participating was lack of time.

Updated EMDRIA Definition of EMDR

The Board endorsed the Definition. We are pleased to present the EMDRIA Definition of EMDR and appreciate the participation of the Expert Panel.

Expert Panel Members

Susan Brown, LCSW, BCD
Karen Forte, LCSW, DCSW
John Hartung, Psy.D.
Roy Kiessling, LISW
Andrew Leeds, Ph.D.
Udi Oren, Ph.D.
Rosalie Thomas, RN, Ph.D.
Esly Carvalho, MS, LPC
Ana Gomez, MC, LPC
L. Sue Hoffman, MSSW, LCSW, LMFT
Jim Knipe, Ph.D.
Sushma Mehrotra, clinical psychologist
Curt Rouanzoin, Ph.D.
Bennet Wolper, LMSW
Carol Forgash, MSW, LCSW, BCD
David Grand, Ph.D.
Arne Hofmann, M.D., Ph.D.
Deborah Korn, Psy.D.
Katy Murray, LICSW, BCD
Steven Silver, Ph.D.

Definition of EMDR

Date of Adoption: 5/26/03, 10/18/03, Revised 10/25/09, 06/23/11

1.0A. Purpose of Definition – This definition serves as the foundation for policy development and implementation of EMDRIA's programs in the service of its mission. This definition is intended to support consistency in EMDR training, standards, credentialing, continuing education, and clinical application, while fostering the further evolution of EMDR through a judicious balance of innovation and research. This definition also provides a clear and common frame of reference for EMDR clinicians, consumers, researchers, the media and the general public.

1.0B. Definition - EMDR is an evidence-based psychotherapy for Posttraumatic Stress Disorder (PTSD). In addition, successful outcomes are well-documented in the literature for EMDR treatment of other psychiatric disorders, mental health problems, and somatic symptoms. The model on which EMDR is based, Adaptive Information Processing (AIP), posits that much of psychopathology is due to the maladaptive encoding of and/or incomplete processing of traumatic or disturbing adverse life experiences. This impairs the client's ability to integrate these experiences in an adaptive manner. The eight-phase, three-pronged process of EMDR facilitates the resumption of normal information processing and integration. This treatment approach, which targets past experience, current triggers, and future potential challenges, results in the alleviation of presenting symptoms, a decrease or elimination of distress from the disturbing memory, improved view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers.

BI. Foundational Sources and Principles for Evolution - Shapiro's (2001) Adaptive Information Processing model, guides clinical practice, explains EMDR's effects, and provides a common platform for theoretical discussion. The AIP model provides the framework through which the eight phases and three prongs (past, present, and future) of EMDR are understood and implemented. The evolution and elucidation of both mechanisms and models are ongoing through research and theory development.

BII. Aim of EMDR - In the broadest sense, EMDR is an integrative psychotherapy approach intended to treat psychological disorders, to alleviate human suffering and to assist individuals to fulfill their potential for development, while minimizing risks of harm in its application. For the client, EMDR treatment aims to achieve comprehensive treatment safely, effectively and efficiently, while maintaining client stability.

BIII. Framework - Through EMDR, resolution of traumatic and disturbing adverse life experiences is accomplished with a unique standardized set of procedures and clinical protocols which incorporates dual focus of attention and alternating bilateral visual, auditory and/or tactile stimulation. This process activates the components of the memory of disturbing life events and facilitates the resumption of adaptive information processing and integration. The following are some of the AIP tenets which guide the application of EMDR, i.e., planning treatment and achieving outcomes:

BIIIa. Adverse life experiences can generate effects similar to those of traumatic events recognized by the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) for the diagnosis of Posttraumatic Stress Disorder (PTSD) and trigger or exacerbate a wide range of mental, emotional, somatic, and behavioral disorders. Under optimal conditions, new experiences tend to be assimilated by an information processing system that facilitates their linkage with already existing memory networks associated with similarly categorized

experiences. The linkage of these memory networks tends to create a knowledge base regarding such phenomena as perceptions, attitudes, emotions, sensations and action tendencies.

BIIIb. Traumatic events and/or disturbing adverse life experiences can be encoded maladaptively in memory resulting in inadequate or impaired linkage with memory networks containing more adaptive information. Pathology is thought to result when adaptive information processing is impaired by these experiences which are inadequately processed. Information is maladaptively encoded and linked dysfunctionally within emotional, cognitive, somatosensory, and temporal systems. Memories thereby become susceptible to dysfunctional recall with respect to time, place, and context and may be experienced in fragmented form. Accordingly, new information, positive experiences and affects are unable to functionally connect with the disturbing memory. This impairment in linkage and the resultant inadequate integration contribute to a continuation of symptoms.

BIV. EMDR Psychotherapy Guidelines: EMDR procedures facilitate the effective reprocessing of traumatic events or adverse life experiences and associated beliefs, to an adaptive resolution. Specific procedural steps are used to access and reprocess information which incorporates alternating bilateral visual, auditory, or tactile stimulation. These well-defined treatment procedures and protocols facilitate information reprocessing. EMDR utilizes an 8-phase, 3-pronged, approach to treatment that optimizes sufficient client stabilization before, during, and after the reprocessing of distressing and traumatic memories and associated stimuli. The intent of the EMDR approach to psychotherapy is to facilitate the client's innate ability to heal. Therefore, during memory reprocessing, therapist intervention is kept to the minimum necessary for the continuity of information reprocessing.

BIVa. Based on available relevant research, treatment fidelity to the 8 phases (Shapiro, 2001) produces the best results. However, in certain situations and for some populations, the following procedures may be implemented in more than one way as long as the broad goals of each phase are achieved.

BIVai. In the **Client History Phase (Phase 1)**, the clinician begins the process of treatment planning using the concept of incomplete processing and integration of memories of adverse life experiences. The clinician identifies as complete a clinical picture as is prudent before offering EMDR reprocessing. The clinician determines the suitability of EMDR therapy for the client and for the presenting problem and determines whether the timing is appropriate. Based on the presenting issue, the clinician explores targets for future EMDR reprocessing from negative events in the client's life. The clinician prepares a treatment plan with attention to past and present experiences, and future clinical issues. It is also important to identify positive or adaptive aspects of the client's personality and life experience. The clinician may need to postpone completing a detailed trauma history when working with a client with a complex trauma history until the client has developed adequate affect regulation skills and resources to remain stable. The clinician may need to address any secondary gain issues that might prevent positive treatment effects.

BIVaii. In the **Preparation Phase (Phase 2)**, the clinician discusses the therapeutic framework of EMDR with the client and gives sufficient information so the client can give informed consent. The therapist prepares the client for EMDR reprocessing by establishing a relationship sufficient to give the client a sense of safety and foster the client's ability to tell the therapist what s/he is experiencing throughout the reprocessing. The client develops mastery of skills in self-soothing and in affect regulation as appropriate to facilitate dual awareness during the reprocessing sessions and to maintain stability between sessions. Some clients may require a lengthy preparation phase for adequate stabilization and development of adaptive resources prior to dealing directly with the disturbing memories. It may be important, especially for those clients with complex trauma, to enhance the ability of the individual to experience positive affect through promoting the development and expansion of positive and adaptive memory networks, thus expanding the window of affect tolerance, and stimulating the development of the capacity for relationship.

BIVaiii. In the **Assessment Phase (Phase 3)** the clinician identifies the components of the target/issue and establishes a baseline response. Once the memory or issue (with a specific representative experience) has been identified, the clinician asks the client to select the image or other sensory experience that best represents it. The clinician then asks for a negative belief that expresses the client's currently held maladaptive self-assessment that is related to the experience, a positive belief to begin to stimulate a connection between the experience as it is currently held with the adaptive memory network(s) and the validity of the positive belief, utilizing the 7 point Validity of Cognition (VOC)

scale. Finally, the clinician asks the client to name the emotions evoked when pairing the image or other sensory experience and the negative belief, to rate the level of disturbance utilizing the 0 to 10 Subjective Units of Disturbance (SUD) scale and to identify the location of the physical sensations in the body that are stimulated when concentrating on the experience.

BIVaiv. During the **Desensitization Phase (Phase 4)** the memory is activated and the clinician asks the client to notice his/her experiences while the clinician provides alternating bilateral stimulation. The client then reports these observations. These may include new insights, associations, information, and emotional, sensory, somatic or behavioral shifts. The clinician uses specific procedures and interweaves if processing is blocked. The desensitization process continues until the SUD level is reduced to 0 (or an ecologically valid rating). It is important during this phase to assist the individual in maintaining an appropriate level of arousal and affect tolerance.

BIVav. In the **Installation Phase (Phase 5)**, the therapist first asks the client to check for a potential new positive belief related to the target memory. The client selects a new belief or the previously established positive cognition. The clinician asks him/her to hold this in mind, along with the target memory, and to rate the selected positive belief on the VOC scale of 1 to 7. The therapist then continues alternating bilateral stimulation until the client's rating of the positive belief reaches the level of 7 (or an ecologically valid rating) on the VOC Scale. In the event that disturbing material emerges, the clinician guides the client back to the desensitization phase (Phase 4).

BIVavi. In the **Body Scan Phase (Phase 6)**, the therapist asks the client to hold in mind both the target event and the positive belief and to mentally scan the body. The therapist asks the client to identify any positive or negative bodily sensations. The therapist continues bilateral stimulation when these bodily sensations are present until the client reports only neutral or positive sensations. In the event that disturbing material emerges, in this phase as well, the clinician guides the client back to the desensitization phase (Phase 4).

BIVavii. The **Closure Phase (Phase 7)** occurs at the end of any session in which unprocessed, disturbing material has been activated whether the target has been fully reprocessed or not. The therapist may use a variety of techniques to orient the client fully to the present and facilitate client stability at the completion of the session and between sessions. The therapist informs the client that processing may continue after the session, provides instructions for maintaining stability, and asks the client to observe and log significant observations or new symptoms.

BIVaviii. In the **Reevaluation Phase (Phase 8)**, the clinician, utilizing the EMDR standard three-pronged protocol, assesses the effects of previous reprocessing of targets looking for and targeting residual disturbance, new material which may have emerged, current triggers, anticipated future challenges, and systemic issues. If any residual or new targets are present, these are targeted and Phases 3-8 are repeated.

BV. Innovation, Flexibility and Clinical Judgment as Applied to Particular Clients or Special Populations

BVa. To achieve comprehensive treatment effects a three-pronged basic treatment protocol is generally used so that past events are reprocessed, present triggers desensitized, and future adaptive outcomes explored for related challenges. The timing of addressing all three prongs is determined by client stability, readiness and situation. There may be situations where the order may be altered or prongs may be omitted, based on the clinical picture and the clinician's judgment.

BVb. As a psychotherapy, EMDR unfolds according to the needs, resources, diagnosis, and development of the individual client in the context of the therapeutic relationship. Therefore, the clinician, using clinical judgment, emphasizes elements differently depending on the unique needs of the particular client or the special population. EMDR treatment is not completed in any particular number of sessions. It is central to EMDR that positive results from its application derive from the interaction among the clinician, the therapeutic approach, and the client.

American Psychiatric Association (2000), Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Washington DC.

Shapiro, F. (2001). Eye Movement Desensitization and Reprocessing, 2nd edition, N.Y.: The Guilford Press

RECENT ARTICLES on EMDR

BY ANDREW M. LEEDS, PH.D.

This regular column appears in each quarterly issue of the EMDRIA Newsletter and the EMDR Europe Newsletter. It lists citations, abstracts, and preprint/reprint information—when available—on all EMDR related journal articles. The listings include peer reviewed research reports and case studies directly related to EMDR—whether favorable or not—including original studies, review articles and meta-analyses accepted for publication or that have appeared in the previous six months in scholarly journals. Authors and others aware of articles accepted for publication are invited to submit pre-press or reprint information. Listings in this column will exclude: published comments and most letters to the editor, non-peer reviewed articles, non-English articles unless the abstract is in English, dissertations, and conference presentations, as well as books, book chapters, tapes, CDs, and videos. Please send submissions and corrections to: aleeds@theLeeds.net.

Note: a comprehensive database of all EMDR references from journal articles, dissertations, book chapters, and conference presentations is available in The Francine Shapiro Library hosted by Northern Kentucky University as a service to the EMDR International Association at: http://library.nku.edu/emdr/emdr_data.php. A listing by year of publication of all journal articles related to EMDR from 1989 through 2005 can be found on David Baldwin's award winning web site at: http://www.trauma-pages.com/s/emdr-refs.php. Previous columns from 2005 to the present are available on the EMDRIA web site at: http://emdria.org/displaycommon.cfm?an=1&subarticlenbr=18

Adúriz, M. E., Bluthgen, C., & Knopfler, C. (2011). Helping child flood victims using group EMDR intervention in Argentina: Treatment outcome and gender differences. International Perspectives in Psychology: Research, Practice, Consultation, 1(S), 58. doi:10.1037/2157-3883.1.S.58

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Note: This article is reprinted from the International Journal of Stress Management, 2009, Vol. 16, No. 2, 138 -153.

ABSTRACT A comprehensive group intervention with 124 children who experienced disaster-related trauma during a massive flood in Santa Fe, Argentina, in 2003 is illustrated, utilizing a one-session group eye movement desensitization and reprocessing (EMDR) protocol. A posttreatment session was done 3 months after the treatment intervention to evaluate results. Results of this one-session treatment procedure, utilizing the EMDR-Integrative Group Treatment Protocol, showed statistically significant reduction of symptoms immediately after the intervention. These statistically significant differences were sustained at posttreatment evaluation 3 months later, as measured by psychometric scales, and by clinical and behavioral observation. Data analysis also revealed significant gender differences. Despite methodological limitations, this study supports the efficacy of EMDR group treatment in the amelioration and prevention of posttraumatic stress disorder symptoms, providing an efficient, simple, and economic (in terms of time and resources) tool for disaster-related trauma.

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Bossini, L., Tavanti, M., Calossi, S., Polizzotto, N. R., Vatti, G., Marino, D., & Castrogiovanni, P. (2011). EMDR treatment for posttraumatic stress disorder, with focus on hippocampal volumes: A pilot study. The Journal of Neuropsychiatry and Clinical Neurosciences, 23(2), E1-2. doi:10.1176/appi.neuropsych.23.2.E1

Full text available at: http://neuro.psychiatryonline.org/cgi/content/full/23/2/E1

Letizia Bossini, Dept. of Neuroscience, Psychiatry Division Dept. of Neurological and Behavioral Sciences University of Siena School of Medicine University of Siena School of Medicine Siena, Italy.

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Egli-Bernd, H. (2011). EMDR in dissociative processes within the framework of personality disorders: The impact of cognitions in the EMDR process: The dialogue protocol. Journal of EMDR Practice and Research, 5(3), 131-139. doi:10.1891/1933-3196.5.3.131

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ABSTRACT A theoretical analysis of the psychodynamic dimension of cognitions in the eye movement desensitization and reprocessing (EMDR) protocol can be beneficial in addressing the specific issues affecting the choice of appropriate cognitions in working with clients with personality disorders. This group of patients share the biographic commonality of emotional-narcissistic abuse and neglect in childhood by primary attachment figures and significant others in their lives. Arising from these experiences, a subtle dissociation (in childhood) can cause the development of parts of self with an emotional and cognitive fixation on a self-image. This is defined by the child's attachment figures and other significant people, and has subsequently been internalized by the child themselves. In such cases, the actual goal of treatment is not primarily the event on which the EMDR session is initially focused, but rather the complex emotional and cognitive significance that the event has on the client's self-perception and self-evaluation.

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Jarero, I., Artigas, L., & Luber, M. (2011). The EMDR protocol for recent critical incidents: Application in a disaster mental health continuum of care context. Journal of EMDR Practice and Research, 5(3), 82-94. doi:10.1891/1933-3196.5.3.82

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ABSTRACT This randomized, controlled group field study was conducted subsequent to a 7.2 earthquake in North Baja California,

Mexico. Treatment was provided according to continuum of care principles. Crisis management debriefing was provided to 53 individuals. After this, the 18 individuals who had high scores on the Impact of Event Scale (IES) were then provided with the eye movement desensitization and reprocessing (EMDR) Protocol for Recent Critical Incidents (EMDR-PRECI), a single-session modified EMDR protocol for the treatment of recent trauma. Participants were randomly assigned to two groups: immediate treatment group and waitlist/delayed treatment group. There was no improvement in the waitlist/ delayed treatment group, and scores of the immediate treatment group participants were significantly improved, compared with waitlist/delayed treatment group participants. One session of EMDR-PRECI produced significant improvement on symptoms of posttraumatic stress for both the immediate-treatment and waitlist/delayed treatment groups, with results maintained at 12-week follow-up, even though frightening aftershocks continued to occur frequently. This study provides preliminary evidence in support of the protocol's efficacy in a disaster mental health continuum of care context. More controlled research is recommended to evaluate further the efficacy of this intervention.

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Jordan, J., Titscher, G., & Kirsch, H. (2011). [Treatment manual for psychotherapy of acute and posttraumatic stress disorders after multiple ICD shocks.]. Herzschrittmachertherapie & Elektrophysiologie. doi:10.1007/s00399-011-0148-8

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ABSTRACT In view of the increasing number of implanted defibrillators in all industrial nations, the number of people who have suffered so-called multiple shocks (electrical storm, ES) also increases. Common complaints are severe and continuously recurrent massive anxiety, panic attacks, fear of death, helplessness and hopelessness, depression, nervosity and irritability as well as reclusive and uncontrollable avoidance behaviour, intrusions, nightmares, flashbacks, sleeplessness and the inability to show feelings and limitation of future perspectives. Because people with an ICD are often physically (very) ill and after multiple ICD shocks are additionally very insecure, it would seem logical if the inpatient treatment would be carried out in an institution which has close connections and is also spatially close to a cardiology department. The basis of the diagnostics is the clinical anamnesis and a systematic exploration of the trauma situation and the resulting complaints. As an additional diagnostic element psychological test procedures should be implemented to determine the core symptomatic (anxiety, depression, trauma symptoms). Psychological test procedures should be included in the diagnostics so that at the end of treatment it is obvious even to the patient which alterations have occurred. The core element of inpatient treatment is daily intensive psychotherapy and includes deep psychologically well-founded psychotherapy and behavioral therapeutic-oriented anxiety therapy as well as cognitive restructuring and elements of eye movement desensitization and reprocessing (EMDR). A follow-up examination within 4 months of the multiple shocks episode is recommended because symptoms of posttraumatic stress disorder often occur after a long latent time period.

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June ter heide, F. J., Mooren, T. M., Kleijn, W., de Jongh, A., & Kleber, R. J. (2011). EMDR versus stabilisation in traumatised asylum seekers and refugees: Results of a pilot study. European Journal of Psychotraumatology, 2(5881). doi:10.3402/ejpt.v2i0.5881

Full text available at: http://www.eurojnlofpsychotraumatol.net/index.php/ejpt/article/view/5881

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ABSTRACT Background: Traumatised asylum seekers and refugees are clinically considered a complex population. Discussion exists on whether with this population treatment guidelines for post-traumatic stress disorder (PTSD) should be followed and Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) or Eye Movement Desensitisation and Reprocessing (EMDR) should be applied, or whether a phased model starting with stabilisation is preferable. Some clinicians fear that trauma-focused interventions may lead to unmanageable distress or may be ineffective. While cognitive-behavioural interventions have been found to be effective with traumatised refugees, no studies concerning the efficacy of EMDR with this population have been conducted as yet.

Objective: In preparation for a randomised trial comparing EMDR and stabilisation with traumatised refugees, a pilot study with 20 participants was conducted. The objective was to examine feasibility of participation in a randomised trial for this complex population and to examine acceptability and preliminary efficacy of EMDR.

Design: Participants were randomly allocated to 11 sessions of either EMDR or stabilisation. Symptoms of PTSD (SCID-I, HTQ), depression and anxiety (HSCL-25), and quality of life (WHOQOL-BREF) were assessed at pre- and post-treatment and 3-month follow-up. Results: Participation of traumatised refugees in the study was found feasible, although issues associated with complex traumatisation led to a high pre-treatment attrition and challenges in assessments. Acceptability of EMDR was found equal to that of stabilisation with a high drop-out for both conditions. No participants dropped out of the EMDR condition because of unmanageable

distress. While improvement for EMDR participants was small, EMDR was found to be no less efficacious than stabilisation. Different symptom courses between the two conditions, with EMDR showing some improvement and stabilisation showing some deterioration between pre-treatment and post-treatment, justify the conduct of a full trial.

Conclusion: With some adaptations in study design, inclusion of a greater sample is justifiable to determine which treatment is more suitable for this complex population.

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Karatzias, T., Power, K., Brown, K., McGoldrick, T., Begum, M., Young, J., . . . Adams, S. (2011). A controlled comparison of the effectiveness and efficiency of two psychological therapies for posttraumatic stress disorder: Eye movement desensitization and reprocessing vs. Emotional freedom techniques. The Journal of Nervous and Mental Disease, 199(6), 372-8. doi:10.1097/NMD.0b013e31821cd262

Thanos Karatzias, Faculty of Health, Life and Social Sciences, Edinburgh Napier University, Edinburgh. E-mail: <t.karatzias@napier.ac.uk>

ABSTRACT The present study reports on the first ever controlled comparison between eye movement desensitization and reprocessing (EMDR) and emotional freedom techniques (EFT) for posttraumatic stress disorder. A total of 46 participants were randomized to either EMDR (n = 23) or EFT (n = 23). The participants were assessed at baseline and then reassessed after an 8-week waiting period. Two further blind assessments were conducted at posttreatment and 3-months follow-up. Overall, the results indicated that both interventions produced significant therapeutic gains at posttreatment and follow-up in an equal numberof sessions. Similar treatment effect sizes were observed in both treatment groups. Regarding clinical significant changes, a slightly higher proportion of patients in the EMDR group produced substantial clinical changes compared with the EFT group. Given the speculative nature of the theoretical basis of EFT, a dismantling study on the active ingredients of EFT should be subject to future research.

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Kristjansdottir, K., & Lee, C. W. (2011). A comparison of visual versus auditory concurrent tasks on reducing the distress and vividness of aversive autobiographical memories. Journal of EMDR Practice and Research, 5(2), 34-41. doi:10.1891/1933-3196.5.2.34

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ABSTRACT This study investigated the benefits of eye movement similar to that used in eye movement desensitization and reprocessing (EMDR) on reducing the vividness and emotionality of negative autobiographical memories. It was hypothesized, based on the working memory model, that any task that disrupts working memory would reduce the vividness and emotionality of distressing memories. In addition, it was predicted that the more visual a memory, the greater the reduction in vividness by a concurrent visual task over an auditory task (counting). Thirty-six nonclinical participants were asked to recall an unpleasant autobiographical memory while performing each of three dual-attention tasks: eye movement, listening to counting, or control (short exposure). Results showed that vividness and emotionality ratings of the memory decreased significantly after eye movement and counting, and that eye movement produced the greatest benefit. Furthermore, eye movement facilitated greater decrease in vividness irrespective of the modality of the memory. Although this is not consistent with the hypothesis from a working

memory model of mode-specific effects, it is consistent with a central executive explanation. Implications for enhancing exposure treatment for posttraumatic stress disorder (PTSD) are discussed.

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Laub, B., & Weiner, N. (2011). A developmental/integrative perspective of the recent traumatic episode protocol. Journal of EMDR Practice and Research, 5(2), 57-72. doi:10.1891/1933-3196.5.2.57

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ABSTRACT The recent traumatic episode protocol (R-TEP) is an adaptation of the eye movement desensitization reprocessing (EMDR) standard protocol to the acute phases following trauma. In this article, the R-TEP structure and procedures were analyzed from a developmental/integrative perspective. It is proposed that the therapist's developmental understanding and attunement can enhance the therapeutic dyad and can promote flexible decision making while using the R-TEP procedures. One case illustration of a recent trauma intervention demonstrates the advantage of developmental attunement in using the R-TEP. This perspective enables the therapist to pace the various styles of processing as they relate to the different stages of the memory consolidation process.

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Menon, S. B., & Jayan, C. (2010). Eye movement desensitization and reprocessing: A conceptual framework. Indian Journal of Psychological Medicine, 32(2), 136-40. doi:10.4103/0253-7176.78512

Prof. Sukanya B. Menon Department of Psychology, Prajyoti Niketan College, Pudukad PO, Kerala-680301, India. E-mail: <suni1982@rediffmail.com>

ABSTRACT Eye movement desensitization and reprocessing (EMDR) is a method which was initially used for the treatment of post-traumatic stress disorder. But it is now being used in different therapeutic situations. EMDR is an eight-phase treatment method. History taking, client preparation, assessment, desensitization, installation, body scan, closure and reevaluation of treatment effect are the eight phases of this treatment which are briefly described. A case report is also depicted which indicates the efficacy of EMDR. The areas where EMDR is used and the possible ways through which it is working are also described.

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O'Brien, J. M., & Abel, N. J. (2011). EMDR, addictions, and the stages of change: A road map for intervention. Journal of EMDR Practice and Research, 5(3), 121-130. doi:10.1891/1933-3196.5.3.121

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ABSTRACT A growing body of literature indicates that eye movement desensitization and reprocessing (EMDR) can be useful in the treatment of addictions. When combined with traditional addictions treatment approaches, EMDR can enhance client stability, prevent relapse, and promote recovery. Clinical decision making about when and how to use EMDR techniques with clients who present with addictions is complicated. The purpose of this article is to explore the use of EMDR interventions with clients presenting various levels of awareness of their addiction as well as varied levels of motivationto change. The authors explore the Stages of Change and suggest appropriate pre-EMDR EMDR interventions at each stage.

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Pagani, M., Di Lorenzo, G., Monaco, L., Niolu, C., Siracusano, A., Verardo, A. R., . . . Ammaniti, M. (2011). Pretreatment, intratreatment, and posttreatment EEG imaging of EMDR: Methodology and preliminary results from a single case. Journal of EMDR Practice and Research, 5(2), 42-56. doi:10.1891/1933-3196.5.2.42

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ABSTRACT Electroencephalography (EEG), due to its peculiar time and spatial resolution, was used for the first time to fully monitor neuronal activation during the whole eye movement desensitization and reprocessing (EMDR) session, including the autobiographical script. The present case report describes the dominant cortical activations (Z-score >1.5) during the first EMDR session and in the last session after the client processed the index trauma. During the first EMDR session, prefrontal limbic cortex was essentially activated during script listening and during lateral eye movementsin the desensitization phase of EMDR. In the last EMDR session, the prevalent electrical activity was recorded in temporal, parietal, and occipital cortical regions, with a clear leftward lateralization. These findings suggest a cognitive processing of the traumatic event following successful EMDR therapy and support evidence of distinct neurobiological patterns of brain activations during lateral eye movements in the desensitization phase of EMDR.

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Pratchett, L. C., Daly, K., Bierer, L. M., & Yehuda, R. (2011). New approaches to combining pharmacotherapy and psychotherapy for posttraumatic stress disorder. Expert Opinion on Pharmacotherapy. doi:10.1517/14656566.2011.604030

Laura Pratchett, James J Peters Veterans Affairs Medical Center, Bronx, NY, 10468 , USA +1 718 741 4000 ext.5215. E-mail: <Laura.pratchett@va.gov>

ABSTRACT Introduction: Posttraumatic stress disorder (PTSD) is a complex disorder associated with an intricate biological and psychological symptom profile and various common comorbidities. Despite an existing myriad of evidence-based and experimental treatments, PTSD is often difficult to treat. This reality necessitates a discussion of the potential of emerging treatments.

Areas covered: A literature search using PubMed and PsychInfo was done using the following keywords: randomized clinical trials, treatment guidelines, pharmacotherapy and psychotherapy, all in addition to PTSD. A comprehensive treatment review establishes that early intervention approaches have not yet been found to prevent PTSD in trauma survivors. However, psychotherapy research provides substantial support for cognitive behavioral therapies and eye movement desensitization and reprocessing for chronic PTSD, and psychopharmacological approaches are myriad - although at present there is FDA approval only for sertraline and paroxetine. However, the efficacy of these treatments varies and, unfortunately, not everyone will achieve remission.

Expert opinion: So far, the mental health field has tended to focus on either biological or psychological targets. We propose that maximizing treatment success may require an integrated approach that does not dichotomize biological and psychological aspects. Exciting new developments reflecting this perspective include psychopharmacologic augmentation strategies that enhance the mechanisms of psychotherapy.

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Reicherzer, S. (2011). Eye movement desensitization and reprocessing in counseling a male couple. Journal of EMDR Practice and Research, 5(3), 111-120. doi:10.1891/1933-3196.5.3.111

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ABSTRACT This practice-based article discusses the use of eye movement desensitization and reprocessing (EMDR) in counseling "Paul" and "Eddie" (aliases), a couple for 4 years who presented with what they identified as "communication problems." Through the use of psychosocial assessments of the men's personal histories, it was determined that Paul's experience of feeling controlled and Eddie'sstruggles to believe that he mattered in the relationship were linked to traumatic memories in each man's childhood that related to his sexual identity development. EMDR was used to target the men's traumatic memories, alternating between Paul and Eddie. Following each EMDR treatment series, the work was integrated by talkingthrough how the reprocessed material integrated into the overall couple experience, leading to both men's increased satisfaction in the relationship.

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Samara, Z., Elzinga, B. M., Slagter, H. A., & Nieuwenhuis, S. (2011). Do horizontal saccadic eye movements increase interhemispheric coherence? Investigation of a hypothesized neural mechanism underlying EMDR. Frontiers in Psychiatry / Frontiers Research Foundation, 2, 4. doi:10.3389/fpsyt.2011.00004

Full text article available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3089996/

Zoe Samara, Department of Neuropsychology and Psychopharmacology, Faculty of Psychology and Neuroscience, Maastricht University, PO Box 616, 6200 MD Maastricht, Netherlands. E-mail: <z.samara@maastrichtuniversity.nl>.

ABSTRACT Series of horizontal saccadic eye movements (EMs) are known to improve episodic memory retrieval in healthy adults and to facilitate the processing of traumatic memories in eye movement desensitization and reprocessing (EMDR) therapy. Several authors have proposed that EMs achieve these effects by increasing the functional connectivity of the two brain hemispheres, but direct evidence for this proposal is lacking. The aim of this study was to

investigate whether memory enhancement following bilateral EMs is associated with increased interhemispheric coherence in the electroencephalogram (EEG). Fourteen healthy young adults were asked to freely recall lists of studied neutral and emotional words after a series of bilateral EMs and a control procedure. Baseline EEG activity was recorded before and after the EM and control procedures. Phase and amplitude coherence between bilaterally homologous brain areas were calculated for six frequency bands and electrode pairs across the entire scalp. Behavioral analyses showed that participants recalled more emotional (but not neutral) words following the EM procedure than following the control procedure. However, the EEG analyses indicated no evidence that the EMs altered participants' interhemispheric coherence or that improvements in recall were correlated with such changes in coherence. These findings cast doubt on the interhemispheric interaction hypothesis, and therefore may have important implications for future research on the neurobiological mechanism underlying EMDR.

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Shapiro, E. (2011). Suggestions for teaching the application of eye movements in EMDR. Journal of EMDR Practice and Research, 5(2), 73-77. doi:10.1891/1933-3196.5.2.73

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ABSTRACT Question: As an EMDR consultant and facilitator, I often find that consultees and trainees prefer taps and tones, rather than eye movements, when applying EMDR. Now I am wondering if eye movements are considered superior, and if so, how I can encourage my consultees/trainees to use them.

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Spokes, T., Hofmeyr, M., & Hopkinson, P. (2011). Reducing distress following assault in the workplace. Nursing Times, 107(Online issue). Retrieved from http://www.nursingtimes.net/Journals/2011/08/08/d/d/k/110809ResearchEMDR.pdf

ABSTRACT Background: Nurses working in inpatient mental health settings report high rates of assault and psychological morbidity. Psychological debriefing is the main form of post-incident support, yet its efficacy has been widely questioned.

Aim: To determine whether eye-movement desensitisation and reprocessing (EMDR) therapy is effective in reducing the psychological distress experienced by nurses after an assault at work.

Method: Four participants experiencing post-traumatic stress symptoms following a workplace assault completed between three and five sessions of EMDR. A multiple-baseline, case series design was used, and quantitative and qualitative outcome data were collected.

Results: The results showed a clinically significant reduction in the level of emotional distress associated with traumatic memories, avoidance and intrusion symptoms between the pre and post-treatment data collection points for all participants. There was also an increase in the strength of belief in positive coping cognitions concerning the event following EMDR therapy in all participants. These improvements were maintained at one-month follow-up for three of the four participants. The study results did not show a reduction in general psychological distress.

Conclusion: The value of EMDR as a form of post-incident support lies in its alleviation of specific post-traumatic stress symptoms, rather than in improving general psychological wellbeing. The data must be interpreted with caution, but the positive outcomes suggest the need for further case series research, or a more controlled design with a larger sample.

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Tofani, L. R., & Wheeler, K. (2011). The recent-traumatic episode protocol: Outcome evaluation and analysis of three case studies. Journal of EMDR Practice and Research, 5(3), 95-110. doi:10.1891/1933-3196.5.3.95

Laura Rocchietta Tofani, Family Therapist, EMDR Consultant NHS, Neuropsychiatric Unit, ASL TO4, Ivrea, Italy. E-mail: <laurarocchiettatofani@yahoo.it>

ABSTRACT This article evaluates and illustrates the application of the recent-traumatic episode protocol (R-TEP) with three diverse clients: a child with chronic illness, a woman with a significant loss, and an adolescent who self-harmed. The R-TEP is an adaptation of the Eye Movement Desensitization and Reprocessing (EMDR) protocol for early EMDR intervention. Sessions are presented in detail to highlight the shifts in information processing that occur during treatment. Observed markers used to analyze the flow of processing are identified, which include distancing from the trauma; reduction in negative affect or change in reported emotions; accessing more adaptive information; changes in the Subjective Units of Disturbance scale; and the Validity of Cognition scale and Impact of Event Scale--Revised indicating shifts in perception of the traumatic memory. Pre-post R-TEP treatment gains were noted for all clients, with changes in behavior and functioning. Theoretical underpinnings of the R-TEP are discussed with respect to the reported observations. The specific contribution of the protocol is highlighted, considering its procedural components and related plausible mechanisms of change.

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Triscari, M. T., Faraci, P., D'Angelo, V., Urso, V., & Catalisano, D. (2011). Two treatments for fear of flying compared: Cognitive behavioral therapy combined with systematic desensitization or eye movement desensitization and reprocessing (EMDR). Aviation Psychology and Applied Human Factors, 1(1), 9. doi:10.1027/2192-0923/a00003

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ABSTRACT This study aimed to test a combined treatment with eye movement desensitization and reprocessing (EMDR) and cognitive behavioral therapy (CBT), compared with CBT integrated with systematic desensitization, in reducing fear of flying. Participants were patients with aerophobia, who were randomly assigned to two experimental groups in a before- and after-treatment research design. The Flight Anxiety Situations Questionnaire (FAS) and the Flight Anxiety Modality Questionnaire (FAM) were used. The efficacy of each program was evaluated comparing the pre- and post-treatment levels of fear of flying within subjects. A comparison of the post-treatment scores between subjects was also conducted. Results showed the effectiveness of each model with a significant improvement in the examined psychological outcomes in both groups.

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van den Hout, M. A., Engelhard, I. M., Beetsma, D., Slofstra, C., Hornsveld, H., Houtveen, J., & Leer, A. (2011). EMDR and mindfulness. Eye movements and attentional breathing tax working memory and reduce vividness and emotionality of aversive ideation. Journal of Behavior Therapy and Experimental Psychiatry, 42(4), 423-431. doi:10.1016/j.jbtep.2011.03.004

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ABSTRACT BACKGROUND AND OBJECTIVES: Eye Movement Desensitization and Reprocessing (EMDR) and Mindfulness-Based Cognitive Therapy (MBCT) are effective in reducing the subjective impact of negative ideation. In both treatments, patients are encouraged to engage in a dual-task (eye movements (EM) in the case of EMDR and attentional breathing (AB) in the case of MBCT) while they experience negative thoughts or images. Working memory theory It was hypothesized that both AB and EM tax working memory and that both reduce vividness and emotionality of negative memories.

explains the effects of EM by suggesting that it taxes limited working memory resources, thus rendering the image less vivid and emotional. It was hypothesized that both AB and EM tax working memory and that both reduce vividness and emotionality of negative memories.

METHODS: Working memory taxation by EM and AB was assessed in healthy volunteers by slowing down of reaction times. In a later session, participants retrieved negative memories during recall only, recall + EM and recall + AB (study 1). Under improved conditions the study was replicated (study 2).

RESULTS: In both studies and to the same degree, attentional breathing and eye movements taxed working memory. Both interventions reduced emotionality of memory in study 1 but not in study 2 and reduced vividness in study 2 but not in study 1.

LIMITATIONS: EMDR is more than EM and MBCT is more than AB. Memory effects were assessed by self reports.

CONCLUSIONS: EMDR and MBCT may (partly) derive their beneficial effects from taxing working memory during recall of negative ideation. ❖

JOURNAL OF EMDR PRACTICE AND RESEARCH

CALL FOR PAPERS

You are invited to participate in the *Journal of EMDR Practice and Research,* a quarterly, peer-reviewed publication devoted to integrative, state-of-the-art papers about Eye Movement Desensitization and Reprocessing. It is a broadly conceived interdisciplinary journal that stimulates and communicates research and theory about EMDR, and their application to clinical practice.

For the Journal to be the premiere resource on EMDR, all members of EMDRIA and the mental health community are encouraged to contribute manuscripts.

Manuscript Preparation and Submission

Authors should prepare manuscripts according to the Publication Manual of the American Psychological Association (5th Edition). Manuscripts are generally expected to be 20-25 pages in length. Brief reports will be 10-15 pages in length. All instructions for preparation of the manuscript are contained in the Instructions for Authors on the soon-to-established EMDRIA Journal web page. Manuscripts should be submitted by e-mail, in English, in MS Word format to me (maxfield@rogers.com). The Guideline for Authors is available on the EMDRIA website or by contacting me or the EMDRIA office. If you would like to discuss a possible article, please email me.

Thank you in advance for your participation.

Louise Maxfield, Ph.D., CPsych
Editor, *Journal of EMDR Practice and Research*

Need Submission Ideas?

Case studies

- Assess the applicability of EMDR for a client(s) with a specific disorder or challenging presentation
- Examine changes to the standard protocol using a case series approach

Research studies

- Investigate outcome, by using randomized clinical trials
- Investigate treatment processes
- Evaluate the role of eye movements and bilateral stimulation
- Assess individual factors / personality variables to treatment outcome or process

Clinical contributions

- Discussion of the impact of ethnicity and culture
- Suggestions on how to evaluate client readiness for treatment
- Recommendations for treatment of a specific disorder

Review articles

- Summarize literature and research in a particular domain

Theoretical reviews

- Summarize research and propose hypotheses

EMDR Around the World

BY MARILYN LUBER, PH.D.

AFRICA

LIBERIA

Toby Gbeh is a Baptist minister who left home at nine years of age to seek his education in Monrovia. In 1995, he came to the United States to attend the Hartford Seminary where he earned an MA in Christian-Muslim Relations. When he returned to Liberia in 2005, he joined the faculty of the Liberian Baptist Theological Seminary and was deeply disturbed by the profound effects of trauma on the faces of the students, faculty, caregivers, politicians and pastors in his native land subsequent to 14 years of war. He decided that he needed to do something and began to research what he could do to provide a long-term solution. Through his inquiries, someone told him about EMDR HAP. His goal is to partner with EMDR HAP and the Liberian Baptist Theological Seminary to provide training in trauma and EMDR and create training facilities for Liberians to strengthen their capacity to address the acute shortage of mental health workers in the country.

ASIA

JAPAN

Masaya Ichii reports: "We thank you very much for your kind messages after the March 11th Tohoku earthquake and tsunami. Although the disaster has been a shock and the source of major despair, helplessness and loss among us, we felt empowered by the continuing support from the global EMDR community. You have shown us that the EMDR global society is a strong supportive network and we truly appreciate it. By August 23rd, we had learned that 15,721 people died while 4615 people are still missing; 83,099 people are now living in refugee camps. To make matters worse, the Fukushima nuclear radiation leak is not resolved yet. It is said that it will take another 40 years or more to resolve this terrible situation. We are grateful that none of our JEMDRA members were directly affected although some members lost family or friends; for this we are very sorry.

On May 13-14, we had our 6th annual JEMDRA Conference in Tokyo. To respond to the disasters we changed the main program to introduce the Recent Traumatic Episode Protocol (R-TEP) and the EMDR Integrative Group Therapy Protocol (IGTP), with the assistance of Elan Shapiro, Brurit Laub and Ignacio Jarero with their protocols. In the preparation phase, Derek Farrell, Sushma Mehrotra, Robert Gelbach, Emre Konuk, Marilyn Luber, Nacho Jarero and Elan Shapiro helped us several times via Skype to plan the Conference with this new program in mind. This helped and encouraged us. Shige Ota, Keisuke Nike and myself were the Japanese instructors who learned R-TEP and then instructed others in Japanese. This has led us to organize JEMDRA-HAP (J-HAP).

At the end of May, as the president of JEMDRA, I visited Tohoku for one week. I used the R-TEP and EMDR related stabilization skills for those who needed them. I also was able to connect with reliable medical support groups in the area. At the same time, Bessel van der Kolk visited Tohoku and gave several lectures informing the Japanese people and government about the significance of EMDR. Also, Miyako Shirakawa, a Japanese psychiatrist and EMDR Facilitator, frequently visits a psychiatric hospital in the area to give EMDR consultation. From August 5-7, 73 participants received Part 1 training in the Tohoku area, with 16 being from the devastated area. On August 8th, we trained 48 clinicians in R-TEP, with eight being from the devastated area. In November, we will do Part 2 training in Tohoku. In the meantime, we are providing monthly on-site consultation for the local clinicians for a reduced fee.

Now that we have set up J-HAP, we are determined to help the local clinicians. Our mission is to teach EMDR and give consultation. We would appreciate your help and support in any financial, material, relational and/or spiritual ways you can offer. Your support has been inspirational and deeply meaningful to us all during this time of crisis. We know that Japan is not the only country that is in need at this time and we would be happy to help other countries and their people with EMDR.

Note: You can contribute to J-HAP, by going to www.emdrhap.org and designating your contribution to assistance in Japan.

EUROPE

BOSNIA AND HERZEGOVINA

Michael Paterson reports: "In May, Keith Piper and I went to Tuzla in Bosnia and Herzegovina and delivered a Part 2 training to 18 practitioners. It was very well received. The section on military personnel applied equally as well to their culture as it does to ours."

FRANCE

We want to acknowledge the loss of David Servan-Schreiber, a friend and colleague, who died on July 24, 2011. David was a pioneer, a visionary, a teacher, a researcher, a writer, a husband, a father and a friend. He was the author of "The Instinct to Heal (Guerir)", a book that introduced the French-speaking world to the benefits of complementary medicine including EMDR. We will miss our gifted colleague who has touched us all.

IRAQ

Emre Konuk reports: "Last year the Iraqi Kurdish Psychologists received EMDR training. I am planning to go to Iraq in October to supervise the trainees there."

THE NETHERLANDS

Ad de Jongh received a well-deserved award at this summer's EMDRIA Conference in Anaheim, CA for his outstanding contribution to research in EMDR. He has numerous publications on his own and with co-authors. He is also a teacher who provides the type of support that encourages his students to do research.

TURKEY

Emre Konuk reports: "I was in Cyprus for a Students' Congress that I helped start 15 years ago. Previously, students were not attending nor contributing to the congresses because they were not allowed to participate. Now students organize their own congress and invite me annually to give workshops. I now have the opportunity to meet talented students and continue my relationship.

In conjunction with the Municipality of Istanbul, we have hired, trained and supervised 70 therapists for the Women's Health Centers. The Municipality is funding a specialized center for traumatized (violence, sexual etc.) children and

adolescents. We will train 45 practitioners in the EMDR Basic Training and in Family Therapy. Another project brings three countries together (Turkey, Portugal and Greece) and EMDR Europe as partners to train Mental Health Providers and Consultants in the EMDR Basic Training and Family Therapy. In Turkey, the trainees work for the Child Protection Agency."

UNITED KINGDOM

David Blore reports: "On May 13th, EMDR UK and Ireland set up a Special Interest Group to study Positive Psychology and EMDR. David Blore and Lillian Moore will launch this SIG at the 3rd EMDR Autumn Workshop Conference in Durham, England on October 7th. The workshop, "Positive Psychology and EMDR: An obvious combination?" is the result of David's Ph.D. thesis where he studied 12 clients who were in motor vehicle accidents and subsequently treated with EMDR. Interviews took place as much as 9 years after the completion of EMDR. David found that all 12 clients experienced positive outcomes in their lives to some degree or other, with some making major lifestyle changes. Articles about the SIG will appear in the EMDR UK & Ireland's newsletter: EMDR Now. For further information, contact David Blore at david.blore@btinternet.com"

Paul Miller reports: "Beginning in January 2011, eight multidisciplinary mental health staff and I came together under the umbrella of MIRABILIS Health, which is based in Northern Ireland (UK). This team includes three MD's, two of whom are EMDR trained, and six EMDR therapists. This dynamic group is working enthusiastically to raise the profile of EMDR in Ireland and the UK. Currently, we do research on the application of EMDR in psychosis and in patients with self-harming behaviors. Staff members are on the faculties of The Queen's University of Belfast and The University of Ulster and also have strong links with English EMDR researchers at the University of Birmingham. Both of these research areas have shown positive results. At the 2011 EMDRIA Conference, I gave a plenary address presenting the pilot-study work with a series of three patients with psychotic disorders, which were successfully treated with EMDR as a key part of their treatment plans. The work links with the positive findings in the application of EMDR to psychosis in GB, Holland, Korea, Japan and the USA. Although these areas of application are in their infancy the initial findings are supporting EMDR's application to a number of new therapeutic areas. I am interested to hear from clinicians who are working with psychotic patients, where EMDR has been a part of their treatment plans. I can be reached at mirabilishealth@me.com"

Michael Paterson reports: "I delivered a one day workshop in Manchester, England on "The Use of Ego State Therapy in the Preparation Phase of EMDR for Working with Complex Trauma and Dissociative Disorders." The 44 attendees noted that it proved a useful adjunct to their existing use of EMDR."

NORTH AMERICA

CANADA

Jim Lichti reports: "The Province of Ontario Ministry of Health and Long Term-Care contracted with me to write a proposal for Basic EMDR training for counseling staff in the Network for Sexual Assault/Domestic Violence Treatment Centres (SA/DVTC www.satcontario.com). The Network has 35 hospital-based Centers across Ontario that provide 24/7 emergency care to women, children and men who have been sexually assaulted or who are victims or survivors of domestic violence (intimate partner) abuse. Services include: emergency medical and nursing care, crisis intervention, collection of forensic evidence, medical follow-up and counseling and referral to community resources. The proposal was accepted. In May 2011, Barbara Horne, an EMDRIA Approved Trainer, began training 30 mental health professionals from SA/DVTC across the across the province. This is believed to be the first time in Canada that a government Ministry has agreed to provide EMDR training to staff across an entire sector!"

MEXICO

Ignacio Jarero reports: "During June and July 2011, Susana Uribe, Alaide Miranda and I provided EMDR treatment to the State Attorney General employees who were working with the 251 people who were massacred and their remains found in the clandestine graves in Durango, Mexico. To have a better understanding of the situation before we worked with these first responders, we visited the morgue and the refrigerated trailers where the bodies were being stored. We also saw one of the clandestine graves still open, and the house next door in which the victims were tortured to death in narco-satanic rituals before being buried. For security reasons, the clinicians worked inside the police academy and were provided with training using AR-15 weapons to respond if an armed attack should occur. In June, at the request of the Mexican Department of Defense, AMAMECRISIS trained 160 military personnel with the Protocols for Crisis Intervention in their Trainers Training Program. In July, this team gave a pro-bono workshop to 350 military personnel on "Psycho-emotional Self Care."

UNITED STATES

CALIFORNIA

Sara Gilman reports: "On July 29th, Susan Brown and I spoke to a live audience while being filmed at California Southern, an accredited online university. The Dean, Barbara Grimes, was at the Veterans Mental Health Conference we spoke at and asked us to become a part of their Archived Master Lecture series. It was taped and streamed to their global student body and is now archived (http://web.calsouthern.edu/events/gilmanbrown/). This gave us another opportunity to share our passion for EMDR, emphasizing its usefulness in the treatment of addictions and introducing it to others. This was a 3-hour workshop to over 100 of California's Orange County Mental Health care providers. We addressed the topics: "What is EMDR?", "What is the current research saying?", "EMDR with PTSD and Substance Use Disorder", and "EMDR and The Military: Challenges and Recommendations." Our hope was to educate and inspire clinicians from the county and military about EMDR. The audience was very enthusiastic and many participants asked about training opportunities and others said they were trained years ago and were re-inspired to obtain further training. We are grateful to Dr. Joshua Taylor and Nicole Ramirez from The Center of Excellence and Dr. Chu from the University of California, Irvine for their encouragement and support of this workshop."

FLORIDA

Carol Crow reports: "I am presenting a workshop, "EMDR with Children and Adolescents," at a Regional Meeting in Tampa in December. I'm also presenting, "EMDR: Trauma Resolution and Beyond" to the Suncoast Mental Health Counselors Association in October. We

have an EMDR Institute Training in Tampa February 10-12 and July 20-22, 2012.

MASSACHUSSETTS

Mark Nickerson reports: "Jim Knipe will present "EMDR for Treating Adult Clients with Complex PTSD" at the New England Conference at the University of Massachusetts in Amherst on October 29 – 30."

WASHINGTON

James Cole reports: "First Datta and Wallace (1996) showed that EMDR helped sexual offenders develop greater empathy for their victims. Next, P. Finley (2002) found that only three hours of EMDR significantly reduced sexual offender's tendency to justify their deviant sexual behavior. Then Ricci and Clayton (2008) raised our hope by showing us that on average six hours of EMDR reduced deviant arousal in 9/10 sexual offenders! Deviant arousal is the most accurate clinical measurement for predicting future sexual offenses; these reductions in deviant arousal were maintained at a one-year follow up. The strong positive results led a group of researchers and clinicians including myself, Ron Ricci, Cheryl Clayton and Kate Wheeler to discuss the development of a larger study to validate use of EMDR treatment of sexual offenders. This new study will enroll a larger population of sex offenders, randomize treatment, control fidelity to the protocol, and evaluate participants at 12 and 24 months. The outcomes are expected to open the door to changes in sex offender treatment and reduce the recidivism of sexual abusers. This is not like testing medication; no drug company is rushing to underwrite the study. No one will ever get rich on this process even though it holds hope for saving many children from sexual abuse. If you know someone who has been sexually abused, you know how painful this experience can be and how difficult recovery can be. EMDR HAP has agreed to ear mark funds for this study. If you are interested in supporting this important study, please do so at www.emdrhap.com for the Sexual Offender Research Project Team (SORP).

SOUTH AMERICA

BRAZIL

Esly Carvalho reports: "We are doing EMDR Basic Training in 15 cities in Brazil now. We have a new Part 1 Trainer, Silvia Guz, who will finish her training by the end of this year in order to become a Full Trainer. In light of the upcoming World Cup (2014) and Olympic (2016) events that will be held in Brazil in the next few years, I am happy that my doctoral research proposal on "EMDR and Sports Trauma" has been accepted. Ana Gomez will be in Sao Paulo in September to teach "EMDR for Children and Adolescents.

CHILE

Pablo and Raquel Solvey report: "We are starting to treat the 33 Chilean Miners who almost died last year. We will treat the miners and some 75 family members, some of whom have PTSD."

Have you considered becoming an EMDRIA Volunteer?

Participation by members like you helps keep EMDRIA strong. If you have a special skill, talent, or interest in a particular area you think would be useful or beneficial to EMDRIA, please complete the Volunteer Form on our web site. Log in and then go to the Members Only section. There, you will find a section called Volunteer Opportunities. You can view each Committee to see who the current members are and the purpose of each Committee. Once you determine your area of interest, please complete the Volunteer Form and Annual Statement of Disclosure.

If you prefer, you can call our office Toll Free at (866) 451-5200, and we can send you the information via fax, mail or email.

EMDRIA Credit Programs

To view a list of EMDRIA Approved Distance Learning Workshops, please go here: http://www.emdria.org/displaycommon.cfm?an=1&subarticlenbr=101

(As of September 6, 2011)

Program # / EMDRIA Credits / Title	Provider Name / Presenter(s)	Contact	Telephone	Dates / Location
07003-05 12 Credits *Advanced Seminar on Integrating Ego State Therapy with EMDR*	Farnsworth Lobenstine, LICSW Farnsworth Lobenstine, LICSW	Farnsworth Lobenstine	413.256.3637	September 15, 2011 - June 5, 2012 Amherst, MA
00017-17 12 Credits *Using EMDR as a Contemporary Psychotherapy*	Deany Laliotis, LICSW Deany Laliotis, LICSW	Suzanne Borstein	401.941.2159	September 23-24, 2011 Dedham, MA
06003-25 20 Credits *The Art of EMDR*	Kathleen Martin, LCSW Roger Solomon, Ph.D.	Kathleen Martin	585.271.3050 x7	October 8-11, 2011 Venice, ITALY
RC01004-22 3 Credits *Emotional Addictions and EMDR: "The Pain Bar"*	Southern Maine EMDRIA Regional Mtg. Rudy Skowronski, LCSW	Jane McCarty	207.761.7783	October 21, 2011 Portland, ME
05010-05 13.5 Credits *When There Are No Words: Reprocessing Early Trauma and Neglect in Implicit Memory with EMDR*	Mount Carmel Crime & Trauma Assistance Program Katie O'Shea, MS, LMHC	Deborah Jessie	614.234.3443	October 21-22, 2011 Columbus, OH
09003-011 12 Credits *Mindfulness, Meditation, and EMDR*	Awake Mind, LLC Julie Greene, MA, LPC	Julie Greene	303.544.4705	October 21-22, 2011 Boulder, CO
03002-15 12 Credits *Somatic Interventions and EMDR*	Maiberger Institute Barb Maiberger, MA, LPC	Barb Maiberger	303.875.4033	October 22-23, 2011 Port Jefferson, NY
99003-61 14 Credits *Complex PTSD, Attachment, and Dissociative Symptoms: Treating Children with Pervasive Emotion Dysregulation Using EMDR and Adjunctive Approaches*	EMDR Institute Ana Gomez, LPC, MC	Robbie Dunton	831.761.1040	October 28-29, 2011 Clayton, MO
01007-13 6.5 Credits *Adapting EMDR for Children with Attachment Trauma*	Debra Wesselmann, MS, LIMHP Debra Wesselmann, MS, LIMHP	Debra Wesselmann	402.981.6130	October 29, 2011 Denver, CO
03002-12 12 Credits *Building an EMDR Toolkit: Advanced Skills for Working with Complex Trauma*	Barb Maiberger, MA, LPC Barb Maiberger, MA, LPC and Katie Asmus, MA, LPC, BMP	Barb Maiberger	303.875.4033	October 29-30, 2011 Boulder, CO
07002-09 14 Credits *EMDR for Treating Adult Clients with Complex PTSD*	Mark Nickerson, LICSW Jim Knipe, Ph.D.	Mark Nickerson	413.256.0550	October 29-30, 2011 Amherst, MA
99002-21 14 Credits *When There Are No Words: EMDR for Early Trauma & Neglect Held in Implicit Memory*	Jim Lichti, MSW, RMFT Sandra Paulsen, Ph.D.	Jim Lichti	519.884.8621	October 29-31, 2011 Toronto, ONTARIO
01016-11 12 Credits *Healing the Wounds of Attachment and Repairing the Self*	EMDR Resource Center of Michigan Deany Laliotis, LCSW	Zona Scheiner	734.572.0882 x3	November 4-5, 2011 Ypsilanti, MI
RC08005-04 3.5 Credits *Brief Adjunctive EMDR: How to Work Collaboratively with EMDR Referrals for EMDR - A Panel Discussion*	SW WA EMDRIA Regional Meeting Susan Kravit, LMHC	Katy Murray	360.438.0306	November 5, 2011 Olympia, WA
99003-59 14 Credits *EMDR and Treatment for Problematic Anger, Hostility & Violent Behavior*	EMDR Institute Mark Nickerson, LICSW	Robbie Dunton	831.761.1040	November 5-6, 2011 Atlanta, GA
00018-07 14 Credits *When There Are No Words: EMDR for Early Trauma & Neglect Held in Implicit Memory*	Sandra Paulsen, Ph.D. Sandra Paulsen, Ph.D.	Karen Alter-Reid	203.329.2701	November 11-12, 2011 Stamford, CT

Program # / EMDRIA Credits / Title	Provider Name / Presenter(s)	Contact	Telephone	Dates / Location
06003-31 12 Credits *EMDR with Trauma, PTSD, and Dissociation*	Kathleen Martin, LCSW Kathy Martin, LCSW	Barbara Pierson	612.532.2723	November 11-12, 2011 St. Louis Park, MN
99003-60 14 Credits *Using the EMDR AIP Model for Treating Adult Clients with Complex PTSD*	EMDR Institute Jim Knipe, Ph.D.	Robbie Dunton	831.761.1040	November 12-13, 2011 Chicago, IL
10006-05 14 Credits *EMDR in the Treatment of Complex Trauma with Symptoms of Addictive & Compulsive Behaviors*	Laurie Tetreault, MA, LMFT Susan Brown, LCSW, BCD and AJ Popky, Ph.D., LMFT	Laurie Tetreault	928.771.9422 x3	November 19-20, 2011 Phoenix, AZ
00017-16 12 Credits *Using EMDR as a Contemporary Psychotherapy*	Deany Laliotis, LICSW Deany Laliotis, LICSW	Christine Burris	202.364.3637	December 3-4, 2011 Tallahassee, FL
09003-12 12 Credits *Mindfulness, Meditation, and EMDR*	Awake Mind, LLC Julie Greene, LPC	Julie Greene	303.544.4705	January 27-28, 2012 Tampa, FL
06005-09 14 Credits *When There are No Words: Reprocessing Early Trauma & Neglect in Implicit Memory with EMDR*	Jill Strunk, Ed.D., L.P. Katie O'Shea, MS, LMHC	Jill Strunk	952.936.7547	January 28-29, 2012 St. Louis Park, MN
03016-07 6 Credits *Enhancing EMDR with Energy Psychology*	Phil Manfield, Ph.D. Carol Odsess, Ph.D.	Carol Odsess	510.559.8240	January 28, 2012 Berkeley, CA
06003-32 20 Credits *The Art of EMDR*	Kathleen Martin, LCSW Roger Solomon, Ph.D.	Kathleen Martin	585.271.3050 x7	February 20-24, 2012 Costa Rica
01008-55 6.5 Credits *Fairy Tale Model of Trauma Treatment*	Trauma Institute / Child Trauma Institute Ricky Greenwald, Ph.D.	Karen Steward	413.774.2340	March 2, 2012 Northampton, MA
01008-56 12 Credits *Treating Problem Behaviors*	Trauma Institute / Child Trauma Institute Ricky Greenwald, Ph.D.	Karen Steward	413.774.2340	March 21-23, 2012 Northampton, MA
01008-57 12 Credits *Child / Adolescent Trauma Treatment Intensive*	Trauma Institute / Child Trauma Institute Ricky Greenwald, Ph.D.	Karen Steward	413.774.2340	March 26-30, 2012 Northampton, MA
09003-13 12 Credits *Mindfulness, Meditation, and EMDR*	Awake Mind, LLC Julie Greene, LPC	Julie Greene	303.544.4705	March 30-31, 2012 Austin, TX

EMDRIA Regional Meeting SCHEDULE

(As of September 6, 2011)

These meetings may or may not offer EMDRIA Credits. For Credit information, please refer to the EMDRIA Credit Program Schedule located on the previous page. For the most current information, go to http://www.emdria.org/calendar.cfm

Location / Regional Meeting	Regional Meeting Schedule	Regional Coordinator / Contact Information
CALIFORNIA Northern CA EMDRIA Regional Network	October 7, 2011 November 4, 2011	Phil Manfield | emdrdr@gmail.com
IDAHO Idaho EMDRIA Regional Network	October 7, 2011	Mary Ann Herzing | Maryannh1@mindspring.com

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Location Regional Meeting	Regional Meeting Schedule	Regional Coordinator Contact Information
MAINE		
Southern Maine EMDRIA Regional Network	October 21, 2011	Celia Grand | cgrand@celiagrand.com
MICHIGAN / OHIO		
SE Michigan & NE Ohio EMDRIA Regional Network	November 11, 2011	Deb Kennard | debbiekennard@hotmail.com
MISSOURI		
South Central MO EMDRIA Regional Network	October 15, 2011 November 12, 2011 December 10, 2011	Barbara Welch | barbara.welch@us.army.mil
St. Louis EMDRIA Regional Network	October 1, 2011	Sheri Rezak-Irons | SRIrons@newpathstherapy.com
NEW YORK		
Long Island NY EMDRIA Regional Network	October 21, 2011	Phoebe Kessler | Pkessler1@optonline.net
NORTH CAROLINA		
North Carolina EMDRIA Regional Network	October 12, 2011 November 9, 2011 December 14, 2011	Jan Brittain | janbritta@aol.com
OREGON		
Central Oregon EMDRIA Regional Network	October 11, 2011 November 8, 2011 December 13, 2011	Karen Forte | kforte@bendcable.com
Portland EMDRIA Regional Network	October 28, 2011 December 2, 2011	David Manfield | manfield@comcast.net
Southern Oregon EMDRIA Regional Network	October 9, 2011	Bonnie Holstein | bonnieholstein@gmail.com
PENNSYLVANIA		
Southwestern PA EMDRIA Regional Network	October 22, 2011	Earl Grey | swpaemdria@gmail.com
TEXAS		
Central Texas EMDRIA Regional Network	November 4, 2011	Carol York | cyorkmssw@aol.com
WASHINGTON		
Southwest WA EMDRIA Regional Network	November 5, 2011	Katy Murray | katymurraymsw@comcast.net

WELCOME New EMDRIA Members

Welcome to EMDRIA! We are so pleased that you have chosen to join us as a member of EMDRIA! For those of you who are now Full Members, we hope that you will consider continuing your EMDR education by meeting the additional requirements to become a Certified EMDR Therapist. For more information on Certification, please visit www.emdria.org or email Sarah Tolino at stolino@emdria.org today!

Sheryl Aaron MSW, LICSW
Emily Ann Aber LCSW
Jill Abramson LCSW, CASAC, CSAT
Mary L Akey MA, MFT
James A Akin MSW/LCSW
Judy L Albert MFT, CTS
Patricia H Allocca RN, LCSW
Morrice B Apprey
Jill C. Archer LMHP
Penny S Arnold MSW, L.C.S.W.
Elizabeth Ashman BA (Psych), GradDip EdPsych, MPsych (Couns)
Marianne T Ault-Riche LCSW
Cheryl Ann Ballou PsyD
Nicolette M Banbury MA
Lisa Benjamin-Dancy LCSW
Brent Berman MSW
Sharon K Bien MA, LPC Intern
Maureen Louise Borschel M.A., LMFT
Pamela M Brown MAPS
Shannon Brown M.S.
Stacy Brumage MA, LCPC, CSAT
Bridget A. Burandt MA/LPC
Joy Anne Butler LCSW-R
Sally M Byrom LPC, LMFT
Ana Lucia Gomes Castello Master Degree
Karen Chalmers MS, MFT
Hillary Whitaker Clark Psy.D.
Deborah A Clements LMHC
Katie L Comer LPC
Deborah Courtney MA, LMSW
Denise E Covey LPC
Jennifer Daniels MA, ABD, LCPC
Amy O Davis LPC

New 2011 EMDRIA Members

Maria G Day MS, CAC, LPC
Robert J Day MS, CAC, LPC
Catherine E Deem MA, LPCI
Martine Demeulemeester
Susan Hoskins Dickerson LCSW
Patricia J Doherty MSW, LICSW
Cindee B Dorchak MFT
Aderemi Dosunmu M.D.
Gail Z Eaton MSW, LCSW
ibrahim EKE M.A.
Michael F Elder MFT
Claudia Elizabeth Escorcia Intern, MFT
Anne I. Estes Ph.D.
Peggy fancher LCSW
Gwendolyn Felten M.A., LCPC
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Kathryn Price Foster LMFT
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Pamela French-Stern M.A., BCLPC, D.A.P.A
Bernadine Fried MA
J. Patrick Gannon PhD
Rigel Garibay LPC, LMFT, NCC
Vidal Garibay LPC
Robyn Gobbel LCSW
Yael Gold Ph.D.
Raquel Gossler Psychology
Tobie Grama LCSW
Ruth Ann Graybill MSW, LCSW
Rebecca Jill Greenspoon LCSW
Sharon Grodner Ph.D.
Sandra Livier Guardado
Terri D Gumm LCSW-C
Stacey Elaine Hall LSCSW
Susan A. Halter M.D., LPC-MHSP
Raymond A Hansen MA, LPC, LADC, CEAP
Lou Ellen Hardy MA
Cathryn I. Harris Ph.D.
Wilbert C. Harrison MS
Nancy Catharine Hawke LCSW
ELIZABETH HAYS-LOHREY PsyD
Sally C. Hazard LMFT
Gilly Heaps M.A.
Cindy Heath MS
Lloyd E Henderson Ed.S., MA, LPC
Tami L. Hendrix MA/ LPC
Devorah Herzog LCSW
Mary L Herzog PhD
Cris Higgin LICSW, LMFT
Ingrid T Higgins MFT
Golda Hoffman LCSW
Marcia A Hoffmann MSW
Kathleen Elizabeth Hollwig MS/MFT
Pamela M. Holmes LCSW
Lisa J Hopkins NCC,LCPC,CADC,PCGC
Christian Love Hutcheson
Eric P Hutchinson Ph.D.
Dorothee M Ischler MA, LP, LMFT
Margo M Jacquot Psy.D., CSADC, BCETS
Janet L Johnson LMFT
Sharilyn L Johnson LMFT
Tina M Johnson LICSW
Lauren E. Jones MA, MFT
Shari B. Kaplan LCSW
Tess Keehn LMFT
Felicity Brock Kelcourse PhD
Thomas M Kern MS, CAC, LPC
Joanne F Koster M.Ed., MSW, LCSW
Andrea L Lambert LMFT
Noelle Landay LCSW
Teri A Langan Dee MA LIMHP CPC RPT-S
David G Langford MA
Sally C Lansing LCSW
Kip C Leake
India D Leal M.S., LMFT
Jean Y Lee Psy.D.
Susan S. Lessley MA, LMFT
Michelle R. LeValley Ph.D.
Marc D. Lewkowicz Ph.D.
Aimee E Loth Rozum LMHC
Elizabeth V. Loux Psy.D.
Linda E Maddox MSW, LCSW
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Mark Magulac M.D.
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Christina A Mettert MA Counseling Psychology
DeLois Miller LMSW
Kristin K Miller Ph.D.
April M Minjarez MA, LMFT
jane moffett LCSW-R, SEP,
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Joseph J Nicolosi PhD.
Deborah Jean Nielsen MA , LMFT
Gayle A Norgaard MSW
Doran J Oatman LCSW
Mii Okawara Ph.D
Sharon R Olson M.A., LMHC
Jennifer Onstot MA, MFT
Brad T Overholser MFT
Kathleen B Pae MS, CAC, LPC
Elinor Palmer-Gonzalez LPC
Pattie M Pardini-Barrett MA/MFT
Kate Parkinson MFC
Dara K Pearson MS
Michael D Peck MA, MSW, Ph.D.
Suzanne P Persons Ph.D., LMHC
Colleen Ann Phalen PMH NP
Teri M. Pokrajac Psy.D.
Elizabeth A Powell MFT
Laurel M Quast MSW, LCSW, BCD
Treva R Rawlings LCPC
Marcia J Rennie PhD
Maryanne Susan Rigby MFT
Kelly A Riley LMSW
Elizabeth Rona LMFT
Anne M. Rose MFT
Micki L Ross LCSW
Tony G Rousmaniere Psy.D.
Paula A Roze LCSW
Elizabeth A Sage LICSW, MSWAC
Max E Sager MAC
Linda Sajbel MSW, LCSW, BCD
Renee Sanchez MSC, LCPC, LAC
Anne Schroeder LMFT
Natalia Seijo Psy
Diane Semerak MA, LPC
Ann Marie Semich
Barbara Sheehan-Zeidler MA, LPC
Daniel T Shiode Ph.D.
Marjorie Siegel MSW, LICSW
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