1994 Issue 1

Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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STRAY THOUGHTS

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I thought it might be interesting to review some of the prevalent theories regarding the effectiveness of EMDR.

1) Procedural Elements—As a quick review, any assessment of therapeutic effectiveness must take into account the procedural elements involved in the therapy. Many aspects of EMDR are geared to incorporate a feeling of self-efficacy. To name but a few:

(a) Clients are assisted in the repeated creation and discarding of their traumatic imagery which may communicate to them a sense of perceived mastery in the ability to mentally circumscribe and manipulate the internal disturbing stimulus.

In addition, focusing attention on the disturbing material for short spans of time--while receiving reassuring therapeutic statements from the clinician, and becoming aware of the safety of the clinical context--may allow counter-conditioning to take place. At the very least, the short bursts of attention to the traumatic memories affords a therapeutic context that may provide the benefits of repeated exposure which is antithetical to the avoidance reactions that are part of and maintain the pathology.

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(b) Clients are encouraged to remain in contact for a prescribed amount of time with the physical sensations that are created by the traumatic imagery. This contact may allow them to identify and separate the physiological sensory effects of the trauma from the cognitively laden, affective interpretations of these sensations which can constitute the labeling of and identification with an emotion, such as "I am afraid," or "I am angry." Clients can identify themselves as larger than the pathological cognition by observing their own reaction. They are doing this by shifting their focus from an overwhelming feeling of fear to "I am feeling sensations

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in my stomach which are associated with a feeling of fear. Now, I am feeling sensations in my chest which are associated with feelings of fear..." This cognitive separation allows the clients to recognize the changeability of the sensations which can increase their sense of self-awareness and self-efficacy. These short periods of attention to sensations may afford the same benefits of counter-conditioning and exposure mentioned above.

(c) Assisting clients to identify the negative self-assessment regarding the trauma may allow them to perceive its irrationality. The restructuring and reframing processes inherent in formulating the positive cognitions can also assist the therapeutic process. The focused case formulation also increases in treatment efficacy.

(d) The focused alignment of the primary aspects of the trauma through the image, negative cognition, and attention to physical sensation assists in the accessing of the dysfunctional information. This state-specific information is then linked to emotionally corrective information through the positive cognition.

(e) The instructions to "Just notice" the trauma and attendant disturbance increase the counter-conditioning and exposure benefits by preventing the client from becoming "afraid of the fear" which has contributed to the on-going distress. The ability to do this may be facilitated by the eye movements themselves.

2) Eye Movements — In my original papers, I quoted some conjectures by Pavlov, regarding general clinical effects. According to Pavlov the essence of any treatment is the restoration of a neurological balance. This view is certainly consistent with the positions of major historical figures, such as Freud as well as Janet and present neurological and biochemical experts. If this assumption is valid, and clinical observations indicate that EMDR affords rapid and consistent positive treatment effects, by this definition, EMDR must therefore assist in a rebalancing or stimulation of the processing system. In this regard, I posited that the eye movement might have a direct effect on cortical functions. Two independent theories have been offered based upon primary research in the areas of neurobiology. Both posit bihemispheric involvement as a causative element.

Examination of EMDR clients by means of quantitative analysis of electroencephalography (QEEG) has shown a normalization in the synchronization of slower brain wave activity in the two cortical hemispheres. Gregory Nicosia, Ph.D., presented this data at the 1994 EMDR Conference. The normalization of depressed functioning shown in post-EMDR treatment corresponds to clinically observed memory retrieval and information processing. Nicosia posits that the phase relationship of the two hemispheres is disrupted by the suppression of REM caused by the norepinephrine released during trauma. The interhemispheric asynchrony prevents integrative memory processing. He suggests that the eye movements in EMDR resynchronize the activity of the two hemispheres because the rhythmic and repetitive alternation mimics the activity of pacemaker mechanisms within the cortex which exist for this purpose, but which were suppressed by the trauma.

The notion of synchronized hemispheric activation producing beneficial information-processing effects is supported by independent research

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NATIONAL NETWORK MEETINGS

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1994 EMDR Network Schedule

Saturday, Sept. 17th **9:30am to 4:00pm**

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

9:30-10:00am Registration & coffee

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

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

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

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

on the differential effects of gaze manipulation on positive and negative assessments. A number of studies have been done by Roger Drake at Western State College of Colorado (article enclosed in this mailing). The results have shown that directing the gaze of a number of right-handed subjects to objects on the right resulted in more positive responses than directing their gaze to the left. The research was based on hypotheses involving hemisphere asymmetry in emotional processing. It was posited that the left hemisphere processes positive information, while the right hemisphere processes negative affect. These studies provide some support for Nicosia's suggestion that alternating the activation of the hemispheres might induce integrative information processing.

Just as observations of EMDR treatments have found positive clinical effects with the use of alternating hand and audio tones, so have recent studies regarding lateral activation of positive and negative reactions found predicted effects by the use of audition and physical manipulation.

One conclusion that might be drawn from this research is that the type of stimulation is not as important as the attention itself. Hemispheric activation is clearly induced by simple lateral attention, whether or not any lateral motoric activity takes place. For instance, several studies in perceptual psychology have demonstrated that the initiation of a saccadic eye movement causes the subject to feel that it has been completed, even if the movement has not actually been made. For example, if the eye muscles are immobilized and subjects try to turn the eyes to one side, they feel as if the eyes have moved even though they have not. In short, when it comes to saccadic eye movements, we are aware of the intention, not the act. This finding is consistent with Howard Lipke's hypothesis that the orienting response alone, and not any specific movement, is necessary for the activation of information processing mechanisms. Mark Russell had also suggested that self-focused attention was needed for therapeutic effects.

If alternate hemispheric activity is one of the factors in EMDR effects, many more stimuli besides eye movements, hand taps, and audiotones can be expected to have an effect. In fact, because the optic nerve is linked to both hemispheres, it may turn out that a forced focus on a single point may induce processing shifts. Alternatively, it may be that rhythmic stimulation alone is conducive to therapeutic effects.

In either instance, the clinical objective would be to maintain the client's awareness of the trauma information while activating the processing mechanism by the continual activation from bursts of concentrated attention. Presumably, then, the best alternative stimuli would be those that allow the processing effect to occur while the clinician monitors the client's simultaneous attention to the trauma, and the present reinforcers which assist the therapeutic effect.

A more integrative analysis may be in order. The most simplistic way of describing possible EMDR effects is that the trauma has remained unprocessed because the immediate biochemical responses have left it isolated in neurobiological stasis. When asking the client to follow a finger, attend to a hand tap, audiotone, or even a fixed point on a wall, active information processing is initiated to attend to the present stimuli. Regardless of the present stimulus, if the client is asked to attend simultaneously to the trauma memory, the active information-processing mechanism is linked to the target event and that can process as well. This processing mechanism is physiologically configured to take the information to an adaptive resolution.

Perhaps the accelerated processing occurs because of the continued realignment and guidance to the appropriate targets by the clinician and the other procedural elements that prevent client avoidance. We have seen clinically that the amount of time necessary for positive treatment effects is less then that needed for simple exposure, so some other mechanism must be at work. However, the actual neurological concomitants may not be discovered within this generation.

In the meanwhile, clinical observations of EMDR effects may assist researchers in the areas of neurobiology and memory to a greater understanding of physiological processes. The rapid treatment effects afforded by EMDR offer an opportunity to observe the standard patterns of memory association and emotional/cognitive processing, as well as the differential effects of the standard procedure with long-standing and more recent memories. In many ways, EMDR may offer a window into the brain.

HOW DOES EMDR WORK, ANYWAY?

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The following speculations are submitted to stimulate discussion and perhaps research about some of the primary neuropsychological processes involved in Eye Movement Desensitization and Reprocessing (EMDR).

The development of EMDR is rooted in problem and trauma resolution (Shapiro, 1993). The major neurotransmitter (NT) for trauma is our fight or flight substance, norepinephrine (NE) or adrenaline. Hold this thought.

The superficial physical aspects of EMDR therapy seem much like a waking version of rapid eye movements, or REM sleep. The phase of sleep known as REM, or D-sleep, is associated with dreaming. It seems to play a role in the integration of emotional material with memories of other experiences and allows habituation to the anxiety-producing value of the material (Carlson, 1981). The importance of the process is suggested by the results of sleep deprivation experiments which produce a range of effects from cognitive confusion and emotional lability to hallucinations.

Sleep is a busy time involving a number of mid- and hind-brain structures and mechanisms including the ascending reticular activating system (ARAS), the pons, and the locus coeruleus (LC). The ARAS is a widely connected and disorderly structure critical for wakefulness and alertness. Activated by practically any sensory stimulus, it subsequently diffusely activates the entire cerebral cortex. Important to REM sleep is the hind brain structure, LC.

A major contribution of the LC to REM sleep is activation of another set of neurons, the Gigantocellular Tegmental Field (FTG) neurons. These are very large cells located in the general region of the LC, in the reticular formation of the pons, and may provide executive control of D-sleep. They branch diffusely so that a single FTG unit can affect large cortical and subcortical areas.

An important mechanism during REM sleep (at least in cats, but not yet confirmed in humans) involves a distinctive pattern of high amplitude electrical potentials in three areas: the reticular formation of the pons (P), the lateral geniculate (G) nucleus of the thalamus, and the occipital cortex (O); collectively known as PGO waves. They seem to originate in the FTG neurons of the pons and occur just before the start of REM sleep and continue during the REM period. Each PGO is synchronized with an eye movement. The conclusion is that the FTG cells drive the PGO waves and seem to generate REM sleep.

Recall that REM deprivation is not completely compensated with return to uninterrupted sleep. However, there does appear to be almost complete compensation for lost PGO waves with REM periods of extremely dense PGO activity. Interestingly, during REM deprivation, PGO waves emerge at non-REM sleep states and even during wakefulness and are sometimes associated with strange behaviors, such as hallucinations. It seems there may be a need for a certain number of PGO waves per day.

The FTG cells are activated at two times. First, they are highly active during REM sleep. Second, they are also activated when there are muscle and eye movements during wakefulness.

In the LC, an almost exclusive NE-based structure, there are two types of neurons. The first type <u>increases</u> activity during REM sleep and results in motor inhibition. The other kind <u>greatly decreases</u> activity, presumably associated with <u>dysinhibition</u> of the FTG cells. Just prior to sleep, the second type of cells in the LC decrease function, remove inhibition from the FTG, leading to REM. At the end of REM sleep, the second type increase their function and FTG cells decrease activity (Kalat, 1984).

Given the involvement of the ARAS, it seems reasonable to assume that other sensory channels may activate the FTG/PGO activity and stimulate information integration in the cortical areas. In a sense, REM is analogous with the blinking LED on a computer hard drive: a sign that the process is working, but not the process itself.

Biochemically, the shift to REM sleep is interrupted by increasing the amount of adrenaline, as with amphetamines. <u>The presence or increase of NE tends to inhibit REM sleep</u>.

Now back to our thought that has been "on hold." High stress and/or trauma levels increase the presence of NE, perhaps to a veritable flood. As this occurs, FTG and PGO activity decreases, or perhaps fails in more extreme cases, and REM sleep is inactive, or insufficiently active, along with the information processing of the emotional material. Hence, events are "stuck" in the neural system.

Along comes EMDR which produces waking eye movement (or bilateral auditory or kinesthetic stimulation),

activating FTG/PGO waves throughout cortical areas. With directed attention using targets, selective information storage areas throughout cortical regions are activated via the ARAS, quite possibly involving hippocampal activity, and the information reprocessed.

Lesions or dysfunction in orbital frontal or inferotemporal areas adjacent to the hippocampus may interfere with EMDR effects. As we learn about the monoaminergic genetic variants present in a high percentage of PTSD (Cummings, 1993), we can predict significant individual differences in the capacity to process emotional material, specifically to habituate to anxiety and so in responsiveness to EMDR stimulation.

As mentioned, these are quite preliminary speculations based on a small clinical sampling and a cursory review of the literature (by a busy clinician). I welcome responses and challenges to increase our understanding of this process.

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ENHANCED EMDR OUTCOME THROUGH ADDITIONAL SACCADES: CASE STUDY

Joann Leone, M.D.
Jim Dayton, M.S.W.

A 47-year-old, self-employed businessman, referred for treatment after a near fatal heart attack, was treated with EMDR 6 months after the trauma, and 4 months following his introduction to psychotherapy. Although financially successful, he continued to be "driven" toward seeking acclamation from his colleagues. The physician who made the referral did so on the assumption that tis client required a significant life style change to decrease stress and workaholic behavior.

The presenting EMDR target was his emergency room experience following the heart attack. He saw himself on a gurney with four intravenous lines inserted in his arm. He saw the physicians and the nurses shaking their heads as if medical interventions were hopeless. The negative cognition was, "I'm dead," the desired cognition was, "I have been given another chance to live." The VoC was 4 and the SUDs was 6. The base emotions were fear and terror, and were felt as a constriction in the chest.

The following is a summary of the client's experience with EMDR.

EM (Eye Movements)> The client viewed the medical staff as they attempted to make a decision for intervention. He reported feeling a warming of his chest.

EM> Even though processing was continuing by lateral movement, the therapist changed to circular direction. This was done to facilitate the client's involvement in the procedure. The client stated, "This is weird" and reported envisioning the therapist's fingers going through his eyes and through the brain layers to pull the traumatic memory out of his head. "You've saved my life" was the following statement.

EM> The feeling in the client's chest expanded to a bright warm light throughout his entire body.

EM> The radiating feeling drained out through his extremities. The SUDs level was reported at 0 and the VoC increased to 7. After completing the body scan, he reported a feeling of total relaxation and heaviness.

EM> The client reported sinking in the chair and having a sense of total well being. He discussed his previous reservations about treatment and how he now realized that treatment had been a totally satisfying experience. He expressed concern that the therapist should lose weight so as not to experience a heart attack or have medical problems.

EM> The client reported nothing from the body scan and that the SUDs/VoC were at optimum treatment levels.

At this point, the psychiatrist and social worker directing the EMDR treatment continued a series of eye movements to reinforce the progress in the session and to orient toward future goals and progress.

EM> The client saw his body developing and strengthening in a manner to prevent future heart attacks.

EM> He saw himself on a road with many curves without being able to see the end.

EM> He saw that it was not important to see the end (symbolic of the representation of goals), that life should be enjoyed, and that every curve was the opportunity to view life. During this set of eye movements, words and phrases the client said during the EMDR procedure (e.g., God has given me another chance—I'm doing all the doctors asked. I've changed my diet and life style.) were woven in by the therapists. This appeared to validate

the client's perception and reprocessing.

EM> The client reported feelings of complete well being and satisfaction.

Session ended.

The authors noticed that the additional sets of eye movements (after the client attained a SUDs of 0, a VoC of 7, and the acceptable body scan), along with the orientation toward future goals and progress, seemed to enhance the outcome of treatment for this client.

BEYOND DEFICIENCY MOTIVATION: EMDR, PEAK EXPERIENCES, AND TRANSCENDENCE

Elke Maxwell
Homebush, NSW

When I initially heard of EMDR, I was totally uninterested. I was happy with my repertoire of skills and simply could not be bothered. However, the reports of colleagues who had the training were so exceptional I thought it was time to have a look. I still was not prepared to waste my precious hours on a training, and my way around this was to experience EMDR myself. I had genuine difficulties isolating a problem since I was at a particularly fulfilling stage of my life; however, I finally settled on a minor irritation that I was having with one of my clients. That session, plus two others, moved me very rapidly to a decision to move into private practice, to implementing that decision, and to currently experiencing a life of ease, gentle pacing, and tranquility that I had no previous vision of being possible. In fact, there has been a total life style transformation. I now work only three days a week, have time to follow the joyous explorations of my toddler for hours, am writing a novel, and am experiencing considerable relaxation of the Puritan work ethic. The starting point had been a life style I had previously perceived as fulfilling and perfectly fine.

My experiences during my own EMDR work involved reliving personal traumas, witnessing the traumas of others, and reliving personal life stages and life dilemmas. In addition, I had what Maslow called "peak experiences." I accepted for the first time life exactly as it was with all of its pain and horrors, without minimizing that pain, and even appreciating the place of pain in my life. I accepted that each person needs both the experience of pain and healing and that everything has its rightful purpose and place in the universe. The beauty and intensity of this experience is difficult to verbalize, but its impact was that everything is alright as it is, in a mysterious and profound way.

Since my own work, I have completed both Level I and Level II trainings and have used EMDR with a self-actualizing population. All of the participants were adjusted personalities who continued to lead responsible lives. However, as a result of the EMDR experiences, their lives had been upgraded, qualitatively, several notches. Many of them experienced similar, though uniquely personal, peak experiences, such as:

1. The interconnectedness and rightness of everything that had happened in their lives (even events they had previously classified as mistakes or slack or resistance) accompanied by such statements as, "I see now why I had to do such-and-such." This was an understanding of the unique meaning of their lives.

2. Experiences centering around their personal creativity (eg., its extent and depth), how it had been unacknowledged (even discounted), and sorrow at this. Such experiences were followed by the actual resurgence of creativity in their lives.

3. Changes in their understanding of love and peace and experiencing these concepts on a new level as total emotional, conceptual, physical experiences.

4. Novel, creative work-related insights. One woman had the experience during EMDR that EMDR worked because it unified right brain and left brain consciousness.

5. Intense abreactions about clients resulting in more relaxed and effective counseling.

These results suggest that some changes may be necessary in the way we think about therapeutic goals and the end of therapy (e.g., where adjustment to current social expectations is seen as sufficient, or relief from deficiency is accepted as the therapeutic goal). There appears to be a push to terminate counseling as if counseling implies a deficiency and that client independence is the triumph over such deficiency. My observations suggest that perhaps we shortchange ourselves of considerable potential expansion with this point of termination, possibly in reaction to the undercurrent of social shame around counseling. Perhaps so much more is possible than we think.

(Case studies of the particular EMDR treatments are available on request. If you are interested in this extension of EMDR, have questions, or would like to talk about this, do not hesitate to contact me at: 23/26 Hornsey Rd., Homebush, NSW 2140.)

TRAUMA AND SELF-TRUST: EMDR CAN HELP

Scott Nelson, Ph.D., M.F.C.C.

Self-trust and trust of others are core issues that emerge time and time again in individual and relationship therapy. In the broadest sense, trust implies instinctive, unquestioning belief and reliance upon something or someone. We require some measure of this trust to function even minimally. Specifically, and in terms of our everyday experience, self-trust at least encompasses the ability to:

1)Trust awareness of external reality (people, places, things, degree of safety, etc.).
2)Trust awareness of internal reality (visual images, feelings, motives, thoughts, body sensations).
3)Trust personal control of expression, actions, thoughts, motives, body experience, impulses.
4)Trust ability to sustain/meet personal needs.
5)Trust our knowledge of past and present events.

There are many factors that contribute to the difficulty of trusting self and others in the aftermath of trauma. Each of the following factors can be directly affected by EMDR treatment.

False or distorted reality presented by socialization agents to the victim, particularly young children under conditions of duress, can be introjected as "true" and lead to dysfunctional identity formation and reality testing. In this situation, the individual has a distorted perspective which, when it collides with more accurate reality representations, can further create a sense of reality which is not trustworthy.

The genuine response that a victim of trauma experiences is often dystonic with the wishes of the perpetrator. In such circumstance, the perpetrator may actively deny or invalidate children's thoughts and feelings with such expressions as, "Don't cry. You should be happy I'm giving you this attention." This denial and invalidation is, of course, hammered home with threats of loss of love of the parent through abandonment, rejection and shaming, or threat of bodily harm.

Simultaneous to whatever pain a victim may experience as the direct result of physical and emotional trauma, is the profoundly disturbing feeling of being out of control of his or her life situation. One response to the stress of being out of control is to volitionally, inappropriately attribute blame for the trauma to one's self, thereby maintaining a sense, albeit false, that one is in control. In working with adult survivors of childhood trauma, the decision to accept this culpability is often lost in time, leaving the individual simply feeling perpetually guilty for his or her own traumatization. This belief contributes further to his or her inability to trust him/herself because: 1) such action is contra-survival and 2) it is a false foundation for a labyrinth of self-defining thoughts and feelings that have played out since the traumatic events occurred.

Another obvious way in which trauma victims become confused about their ability to trust themselves is through the use of amnesiac and distorting defensive strategies to psychologically protect themselves during and after the traumatic events. Dissociation, repression, and denial all lead to large chunks of lost self-awareness (and awareness of other). Also, what might be considered "strategic" emotions such as depression, confusion, and projected anger can lead to a decrease of self-awareness. Given that self-awareness is a cornerstone of self-trust, such defensive strategies are directly linked to a decrease in the ability for self-trust.

Another aspect of the traumatic experience is that, due to strong desires for "everything to be OK," victims of trauma repeatedly place themselves in a position of danger. Thus, they develop a history for failure in judgment. Linked to the defensive strategies, these anti-survival and unsafe actions lead survivors to maintain an enduring distrust for their own ability to "do what is right" for themselves.

Each of these common assaults to self-trust are related to many of the negative cognitions and affects which are regularly the targets of EMDR interventions. When the negative cognitions and affects are reprocessed, the general effect can be seen as an increase in the patient's ability to trust his or her own sensory and cognitive awareness. In part, this increase in the ability to trust one's self in the process of desensitizing traumatic experiences may explain the generalizability of EMDR interventions. Take, for example, a situation in which the patient reprocesses a negative cognition that he or she failed to adequately protect him or herself at the time of the assault. If he or she acquires the alternate positive belief that he or she did the best he or she could do, this will no doubt go a long way towards increasing the overarching "sense" of trust in him or herself in the present and future.

Case Example

The following case example illustrates the usefulness of EMDR in the restoration of trust of self long lost in the aftermath of childhood sexual and physical abuse.

Tina, a 38-year-old woman, came for treatment because she was afraid that innocent, but annoying, behaviors of her young son would "open the floodgates of rage and make me hurt him." Severely sexually and physically abused by her uncle as a child, Tina developed an extreme mistrust of herself and others.

Tina's inability to trust herself was related to three elements of her traumatic childhood through young adult experience. First, when she was being assaulted by her uncle, Tina complained to her parents. They invali-

dated her feelings and thoughts by telling her not to complain because her uncle was having more difficult problems than hers.

Second, as the trauma intensified and included threats against herself and her sister, she defended herself by dissociating. As a result, Tina has significant parts of her experience "missing." When asked to report her experience, she often says "I'm not sure how I felt and I just can't tell what I'm going to feel next."

Finally, as she approached young adulthood, Tina began to feel intense anger at what had happened to her; simultaneously, she began using her anger as a way of protecting herself. Eventually she was unable to distinguish between appropriate, situation specific anger, and the anger she felt as a protection against a perceived threat. "Anger allowed me to survive—it is now difficult for me not to be angry—anger is connected with self protection. If someone even slights me in a minor way, it gets blown into a major issue of betrayal."

EMDR was used to desensitize and reprocess her experience of initial fear, her negative cognition of "I must be bad," her intensified fear (which led to dissociation from aspects of herself), and, as the assaults became more violent, her belief that she had to remain angry and on the defensive in order to be safe in adulthood. Finally, her fear that she would be harmful to her son disappeared with the increase in her self-trust and self-esteem.

In a follow-up discussion, Tina said that the EMDR sessions improved her ability to assess and set reasonable, situation appropriate boundaries for herself and her son. This boundary definition, in turn, increased her sense of self-trust or safety with her internal self.

In that a "sense" of basic trust in one's self and in others is the foundation to living comfortably in the world, interventions that lead to greater ability to trust self are sorely needed. The use of EMDR in the case of Tina and many others has proven of great benefit in restoring greater trust in self via the reprocessing of self-depreciating cognitions and clarification of heretofore distorted memory and affects.

HEALING THE HEART: EMDR IN POST-UNIFICATION MPD THERAPY

Thomas Tudor, Ph.D.
Cherry Hill, NJ

Multiple Personality Disorder (MPD) represents the most severe form of the Dissociative Disorders. The predominant symptoms are disturbances in the normally integrative functions of identity and memory (American Psychiatric Association, 1987). There has been an explosion of interest in the disorder since about 1984 (Putnam, 1989; Ross, 1989), with many articles focusing upon phenomena, diagnosis, and treatment. The treatment articles have focused primarily upon the challenging issues that have to be dealt with prior to the eventual unification of the mind, as represented by the fusions of the various alter personalities. Relatively little has been written about the post-unification phase of treatment, except that treatment does not end with unification (Kluft, 1988).

The following is a discussion of a case in which EMDR was used in the post-unification phase of MPD therapy.

Sally is a 34-year-old, Caucasian female, who has been in therapy with me for 5 years. She had been in therapy in another state for 2 years and had begun to consider the diagnosis of MPD by the time she, her husband, and young daughter moved to my area. The diagnosis of MPD was confirmed. Her therapy went exceedingly well, due partly to a stable marriage, her high level of intelligence, the lack of her having to hold a job, the opportunity to meet two times per week, her lack of an Axis II diagnosis, the absence of any family of origin contact, and a therapist experienced in the treatment of MPD. In a 5-year period, there were only two crisis sessions, rare inter-session telephone contact, no need for medication, no hospitalizations, and no suicidal or self-mutilation behavior. Thirty-one alters were identified, worked with intensively, and systematically fused. A history of sadistic sexual, physical, and psychological abuse had been revealed, with the primary abuser being her stepfather. The abuse had occurred between the ages of 3 and her early 20s.

After 3 1/2 years of therapy, what tentatively was thought to be the final alter was fused. Therapy became more supportive in nature as various issues regarding integration and life without dissociation were addressed. Eleven months later, another minor alter was discovered, and was fused after 5 more months of work. Two months after this fusion, Sally reported that life was going quite well. In fact, despite the discovery of the most recent alter, she had been reporting considerable contentment for about 1 1/2 years. She was feeling increasingly assertive, her self-esteem seemed high, and she was writing her first novel with eagerness. From all outward appearances, she was thriving.

At this point, I asked her if, after all of the therapy work, there were any memories that still haunted her. She affirmed that there was one that stood out. When she was about 10, she and her family were vacationing at a lake with some friends of the family. Her stepfather became incensed over some aspect of her behavior, so he took her alone into the woods and, after viciously verbally assaulting her, proceeded to sodomize her as a further and explicit punishment. I proposed the idea of using EMDR to address that memory, and she agreed. Her Negative Cognition was, "I am stupid,

I made a mistake, I deserved it, I am dirty and contaminated." Her Positive Cognition was, "I am clean, smart, pretty, and don't deserve to be hurt." The VoC was 2, the SUDs was 6.5, the emotion was fear, and her body sensations were pain in the rectum, tingling feelings in the cheeks and forehead, and a knot in the stomach.

Associations during eye movements rather quickly proceeded to a level of fear, shame, and dirtiness unsuspected by this therapist. Statements included, "I didn't want to exist. I don't deserve to exist now either. I have to keep his secret and my secret. I won't be able to get away from him. I must always be prepared for a lunatic. I won't ever have anything good. I'm ruined, nobody ever will want to touch or love me." After these bleak statements, more positive associations began, and some limited cognitive interweave was used. By the end of the EMDR session, she felt absolved of her guilt and shame, thought that she mattered as a person, felt that she was a moral, lovable person, and that it was now safe. Her final VoC was 6, her SUDs was .5, and her body was relaxed and without pain.

The next two sessions subsequent to her EMDR session revealed a quantum leap in her self-esteem, as manifested by feelings of pride, spontaneous and non-laborious assertiveness, less reactivity to other people's "garbage," and an increased awareness of certain marital issues that needed addressing (to which she had been oblivious). She stated that before EMDR, she had resigned herself to a certain level of lingering emotional and self-esteem problems. Now she realized that she did not have to feel badly at all about what others had done to her. She reported a deeper feeling of choice in her life than ever before, and an increased ability to take care of herself emotionally.

What surprised this therapist was the amount of fear, shame, and feeling of contamination that lingered just below the surface in this highly functioning patient whose therapy had gone so unusually well. Even after the memories of abuse had been uncovered and carefully worked through, yet another level existed. EMDR proved highly effective in uncovering this level and quickly facilitated its resolution. Perhaps if EMDR had been used in the pre-unification phase of her therapy, these issues would have come to the surface and been dealt with more fully.

After the above issues were resolved, I asked Sally what else still might be bothering her. She responded that she felt ashamed about having been a multiple. Again I was surprised, given her level of sophistication and that for 5 years I had been directly, and by implication, giving her the message that her dissociative response to her traumatic childhood was a considerable accomplishment of coping. Apparently, my message had not been internalized.

She agreed to the use of EMDR regarding this issue. Her Negative Cognition was, "I was weak, I should have been stronger." Her Positive Cognition was, "I was sane and strong as I responded to an insane situation." Within one session, her SUDs fell from 6 to 0, her VoC rose from 2 to 7, and she gained considerable insight regarding why she dissociated and how dissociation allowed her to retain her personal integrity while living among abusive people. No cognitive interweave was used during the EMDR. She reported being stunned by her own insights, saying she never could have arrived at such awareness by merely thinking about it on her own.

I submit that EMDR may prove useful in the post-unification phase of MPD therapy. In this case, it offered a way to address feelings that lingered even after the standard abreaction and therapeutic techniques had been applied. It also helped this client resolve a more general self-esteem issue regarding her former multiplicity. When I asked Sally why she had never brought up in therapy her lingering feelings of shame and fear, she replied: "After I realized what my diagnosis was, I knew that my mind could be fixed, but I also knew that my heart could not." Now she has changed her mind and her heart.

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EMDR WITH PANIC DISORDER PATIENTS WHO INHIBIT ANXIETY REACTIONS

Judith D. Wilcox, Ed.D.

Introducing EMDR to panic disorder patients who have been educated in methods that reduce anxiety responses can pose some interesting challenges. Several patients who had been in therapy with me for a year or more had learned quite well the skills of using deep breathing, relaxation, and cognitive pattern interruption techniques to inhibit their anxiety reactions. I discovered how well they internalized these strategies as we began the EMDR work in our attempts to clear the root causes of their panic disorder.

With two patients in particular, a pattern began to emerge. We would begin

with the disturbing memories, some minimal cognitive and emotional processing would take place, and then they would report "nothing" coming up. Their nonverbal cues prior to this included some mild agitation and then stillness. Initially, I began to suspect that they were going through a dissociative reaction phase in their processing so I just kept going with them, only to discover that, unlike other patients who would dissociate and move through this phase into deeper memory processing, these panic disorder patients would continue to report "nothing" happening. They would then become bored and discouraged and feel like they were failing in the process. The phenomenon was quite puzzling until I began to question them more specifically about what they were experiencing prior to the "nothing" experience. One woman finally solved the puzzle. She said quite simply, "Oh, well, when I start to feel anxious, I just tell myself to relax and the anxious feelings and thoughts go away."

With this answer in mind, I have now begun to request that panic disorder patients trained in relaxation responses and cognitive pattern interruption techniques consciously choose not to access these responses while doing EMDR work. I explain to them the need to experience the full range of thoughts, emotions, and physical sensations that can arise in the process of clearing disturbing thoughts and memories. This seems to work well with these patients who can then successfully process the traumatic material that precipitated their panic disorder, significantly decrease the frequency of their panic attacks and agoraphobic reactions, expand their range of activities, and increase their self-esteem over a relatively short period of time.

1994
SUBMISSIONS
JULY 28
OCTOBER 18
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AN INTERESTING OBSERVATION

Edith Ankersmit, LCSW

Toward the end of a powerful session, my client closed her eyes and laid her hands lightly on her lap. Immediately, they began a fluttering, spontaneous movement: left hand, right hand. While this was occurring, my client was mostly silent and was processing some very important material. The cognition she ended up with was that she had a right to be scared and desperate as a child. Not surprisingly, this new way of thinking was very important to her.

She told me that the hand movements were entirely involuntary, and that they felt much the same as the eye movements. Somehow, it seems, her body and mind took over with my just silently being present with her.

I present this information with no conclusions, but with simply the desire to share it with my peers. I wonder if others have had similar experiences.

THE THERAPEUTIC RELATIONSHIP AND EMDR

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Given the diversity of the therapists who are interested in EMDR, an old debate may be fruitfully revived. Does therapy consist of task-oriented collaborative consultation and guidance, or is the negotiation of the therapeutic relationship itself the primary task? To the extent that EMDR may constitute a new treatment context, the role of the therapeutic relationship in EMDR treatment is of particular interest. How much of EMDR is inside the client, and how much is between the client and the therapist? Is successful EMDR simply a function of the client's (guided) internal processing, or is it somehow dependent upon the quality of the therapeutic relationship, or is it both.

While keeping the above in mind, this discussion will pertain to the brief, focused treatment of traumatic memories in which EMDR is the featured modality.

Rather than arguing for the primacy of either the internal processing or the therapeutic relationship elements of EMDR treatment, the intent here is to explore the interplay between them. It would be useful to be able to recognize when reliance upon the client's internal processing may be insufficient and additional relational interventions are necessary. The client's "prevailing sense of safety"—that is, the client's sense of safety in the moment—will be proposed as the key to determining the extent to which the quality of the therapeutic relationship may become a more important factor. Examples that follow are from actual cases known to the author which have been altered to protect confidentiality.

It seems that when the work of EMDR is primarily internal, a basic, collaborative therapeutic alliance should be sufficient for success, assuming client motivation and therapist competence. The primary job of the EMDR therapist is to guide the client; a view which is often expressed with comments like, "I feel like I'm not doing anything but getting out of the way." The facilitating effect of EMDR on internal processing appears to be so robust that it may be successful even when the therapist fails to "get out of the way." One client whose therapist was overly intrusive (incessant commentary during eye movements) made the following observation:

I had to kind of block out what she [the therapist] was saying, and just stay with what was going on inside of me. I kept wishing she'd just shut up. I got alot out of it [the EMDR], but I had to ignore her to do it.

Doubtless many clients have benefited from EMDR treatment despite imperfect therapist/client relations. On the other hand, sometimes relationship factors do seem to preclude successful processing. For example, a colleague attending an EMDR Level I training reported the following:

On the first day I did my practicum with people I really didn't connect with. When it was my turn to experience EMDR as a client, nothing much happened. I was kind of disillusioned. The next day I got in a group with people I liked and did some really good work with an upsetting memory. I guess I just didn't feel that comfortable "opening up" in the first group.

Relationship factors may also affect the client's willingness to continue when the discomfort level increases, or when additional upsetting memories spontaneously emerge. It would seem that the relationship can function as a gate keeper to internal processing—that is, whether EMDR continues or is even initiated. However, short of failure or refusal, more subtle forms of non-participation may also occur. For example, a colleague who had a successful EMDR experience in the Level I training, and then engaged a therapist for an additional EMDR session, reported the following:

We worked on a bunch of memories, including my being the object of bullying, vandalism, and robbery. The theme was, People who don't care about me might hurt me. The EMDR seemed to work alright, but it felt superficial compared to my prior experience with it. I wasn't very emotional in the session, but then I went home and cried with my wife. The therapist was good, technically, but I didn't have the feeling that he really cared about me.

This client only partially participated in the treatment as evidenced by his withholding his emotional responses until after the session. His sense of vulnerability with "people who don't care about me" may have interfered with the processing since the therapist was perceived to be uncaring, and therefore, of potential harm to the client (based on the theme of his memories). In this case, the material being processed was not addressed because of the relationship dynamics that were occurring. (Clients may often rely on the meta-messages conveyed by the therapist, or even purposefully test the therapist, in deciding whether to present sensitive material.)

Given the focus on internal processing that characterizes EMDR, it might be tempting to overlook the importance of the role of the therapeutic relationship, especially in brief treatment. The numerous single-session successes reported (e.g., Boore, 1993; Shapiro, 1989; Solomon, 1993) in the EMDR treatment of motivated clients with identified traumatic memories have even led one writer to the conclusion that "clinical rapport was not a necessity" (Boore, 1993, p. 42) in such cases. However, it should be considered that relationship factors such as rapport and sense of safety are probably equally necessary with "easy" clients.

What makes facing a traumatic memory potentially healing? One difference between EMDR and the reexperiencing of a flashback or a nightmare is that with EMDR, the client not only may reexperience the event, but may also be observing it from a safe place. From this safe place, the client can, perhaps for the first time, face the memory without feeling overwhelmed. This is what allows the working through. The therapeutic relationship must constitute such a safe place, particularly by avoiding replication of threatening features of the targeted traumatic memory. The relative importance of the therapeutic relationship in the brief EMDR treatment context can be judged according to the client's prevailing sense of safety. The extent of relationship-oriented interventions required to create a safe context would be a function of a number of factors including the nature of the traumatic memory, therapist-client match, and perhaps the client's general sense of security or safety. (There are many safety-enhancing interventions which address the internal state rather than the therapeutic relationship, e.g., Greenwald, 1993.)

While examples abound which support both the "internal processing" and the "relationship dependent" viewpoints, it is the integration and balance of these elements which are most important. The desired internal processing of EMDR happens within the context of the therapeutic relationship. The targeted material will be more difficult to address if there are deficits within the treatment context. This may be especially important regarding client control of pacing, as many traumatic memories include intense feelings of helplessness. The process of the therapy should be guided by the demands inherent in the content, and be responsive to the client's prevailing sense of safety.

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THE POSITIVE CORE

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Since I completed the EMDR Level II training last summer, I have been, on occasion, using the technique described below. To date, (I have found that it has always "worked.") The technique involves creating what I term a "positive core." I have found that some of the very damaged people I see in practice who respond well to EMDR are left with a feeling of emptiness. (The group of clients with whom I have used this have had in common the fact that their parents were unrelentingly critical or absent.) It is as if the trauma defined who they were and once it is "gone," they are not sure what is left. They are feeling "good" or "relieved," but not "great." This technique seems to clean up the loose ends and put all the positive cognitions and metabolized memories into an integrated sense of self, and leaves the clients feeling great.

This is what I say to these clients:

"Imagine a newborn baby. When I hold a newborn baby I see what I call a 'positive life force.' Depending on your religion or other belief system, you may call it something else. Except for the in utero and birth experiences, that child has been untouched by the external world. I believe that in order to live, the child instinctively protects the life force. If the child loses the life force, he or she dies. Therefore, every living person still has within himself or herself a positive life force. As the child grows and develops, he or she experiences events that cause him or her to create defenses around the life force. That happens to everyone. However, the more trauma the child experiences, the stronger the defenses. The life force can also be nurtured. Some children have parents who nurture the life force, others do not.

"I want you to think of a visual image to represent your life force. In other words, I want you to be able to imagine yourself with this life force inside of you. This is very personal. Some of the images others have come up with are: a sparkler, a tree trunk, a rock, a bright light. I want you to choose an image that fits for you. Think about this until our next session. This is a fun assignment. Your image should be one that makes you feel good."

Obviously, if the client is having trouble with this concept, you have to walk him or her through it more gradually; however, most of the clients with whom I do this work are able to catch on pretty quickly.

At the next session, we talk about the "image" he or she has chosen. If a decision has not been made, we spend some time trying to come up with an image. (I believe that having the "right" image is like having the "right" positive cognition.) I use hand tapping because I have found that it works more easily since there is so much visualization involved in this technique. I then say something like the following:

"Imagine yourself as a newborn baby. (For women, I can start in utero; men, however, seem to have a hard time visualizing this, so I start with newborn baby.) Now imagine the positive life force inside that baby, that . . . (whatever image they have chosen). Do you have that image? O.K. Now I want you to imagine that baby, with that positive life force, embarking on a long journey through life. It's as though you are traveling through life on a fast moving train. The train is you and your positive life force traveling through life. The experiences you have had are the countryside the train is traveling through. Now I am going to have you close your eyes soon and begin. I will have you imagine yourself as that baby with the positive life force. The idea is to have you take that positive life force through life. I want you to recall whatever positive or negative events come to mind. Proceed slowly and thoroughly. If you find yourself trying to skip an event, open your eyes so we can further explore that event. If you can't get beyond a certain event, open your eyes and we will do what needs to be done there."

I then have the client close his or her eyes and I start the hand tapping. I provide some initial assistance in setting up the visualization to make sure he or she is "on the train." I instruct the client to open his or her eyes if he or she gets stuck somewhere or when finished (that is, the client has brought himself or herself to the present date). The client always has permission to open his or her eyes if a "break" is desired. Most importantly, I instruct the client to stop if there is any reason whatsoever that the "train" cannot move smoothly through his or her life. I mention physical tension as something to monitor, but I do not focus on it because I want the focus to be on the "positive life force." By this point in treatment, these clients seem to be self-monitoring—both in and out of session. I then continue hand tapping until the client opens his or her eyes.

If the client opens his or her eyes before completing the process, we "go with" whatever has come up, using "standard" EMDR protocols (those using bilateral hand movements). (I use standard eye movements rather than hand tapping to separate the two processes.) For example, one 40-year-old woman with whom I had worked extensively over childhood trauma memories (beginning at about age 4 and continuing to the present) was unable to get beyond the age of 2. Although she had no conscious memories of herself at age 2, she was aware of some events that had happened at that time. When she tried to work through these events, she experienced some physical tension and thoughts about "what that must have been like." We were then able to use standard EMDR and then put her "back on the train." (When we stop like that, I have the client start the train at least one year prior to the point at which he or she stopped.)

Sometimes this process of "creating a positive core" can be done in one session, sometimes in more than one, depending on the scheduling circumstances and the amount of material to be covered.

I have only used this technique with clients who lack a sense of "positive core" or say they do not know "who they are" now that they are not preoccupied with their trauma. Every client who has gone through this process has spontaneously said he or she felt great afterwards. I tell them that nothing has changed, only their viewpoint. Instead of seeing themselves as their present-day self going back and working through past painful experiences, they can now see themselves as an infant growing and developing into adulthood, surviving the traumatic experiences with their positive life force intact.

This technique seems to neatly wrap up the EMDR work in that it cleans up any missed pieces, brings out many positive memories that might not have been triggered by the standard EMDR work, and leaves the client with a positive sense of "self," "identity," or whatever other term we tend to use for that feeling of being an "OK person," rather than a person who has "survived OK." I always emphasize to clients that they have **always** had the inner strength they now feel. We have not created the inner strength; we have simply drawn their attention to it.

MISTAKES TO AVOID IN USING EMDR OR "DO WHAT I SAY, NOT WHAT I'VE DONE"

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Part 1: Before the Eye Movements

There are a number of people involved with EMDR who have specialties in various areas including children, veterans, sexual abuse, peak performance, smoking cessation, etc. Though I have my own areas of clinical specialization, when it comes to EMDR, my particular area of expertise seems to be in the area of What NOT To Do. In this first of a two-part article, I want to review many of the mistakes that I and others have made using EMDR. While this list is probably most helpful for those beginning to use EMDR, I have found it useful for experienced clinicians as well.

To be successful using EMDR (or any therapeutic procedure), you must know your patient well, establish a good relationship, and thoroughly know the procedure that you are using. What follows is my compilation of important issues that need to be addressed to give you and your patients the best chance of succeeding with EMDR.

Prior to Using EMDR

Insufficient history taking. When I first began using EMDR, I was so excited about the method that I often tried to use it too soon in my work with patients. By too soon I mean using it before I thoroughly knew my patients and their circumstances. Until you understand your patients, the issues they face currently, and the schemas and themes that have been operating throughout their lives, do not use EMDR. If you cannot literally picture the problems they are having, when they are likely to occur, with what people, and in what situations, keep asking questions (e.g., Have they had major traumas and what were they? Are there any memory gaps? What schemas and themes have been and continue to operate in their lives?). This knowledge will help you make educated guesses as to what issues to pursue and to which situations patients are most likely to be sensitive.

Proceeding prior to establishing a good therapeutic relationship. Establishing a good therapeutic relationship is obviously important in any therapy, but especially so in EMDR. EMDR has worked best with my patients when they have been able to "let go." Several patients who initially had trouble letting go used the image of Pandora's Box to explain this reluctance, this fear that if they open the door to their fears and emotions, they will never be able to close it again. As many of us have experienced, the initial flood of feelings and physical sensations that can erupt when a memory is triggered can be overwhelming. The more our patients trust us and feel that we both care for them and know what we are doing, the easier it will be for them to benefit from EMDR. Patients need to feel that if they open Pandora's Box, you will be able to help them close it.

Insufficient explanation and rationale for EMDR. Most therapies (and religions) share a number of common elements. Two of the most important are the story of creation and an explanation of how the world works. An explanation and rationale that explains the method and how it addresses your patient's problems is crucial. It provides a cognitive structure that can help patients better understand their experiences; perhaps view their past and current reactions to situations in a less punitive light; and increase their ability to generalize the gains they make.

Once you have addressed the issues above, there are several other aspects prior to beginning the eye movements where therapists often stumble. These are discussed below.

Incomplete initial set-up. Most clinicians are good at getting their patients to focus on a specific issue and a representative picture or scene. However, problems often develop in obtaining clear cognitions. Two of these problem areas are: 1) lack of proper focus on the Negative Cognition and 2) a vague or inappropriate Positive Cognition. When a patient has chosen a disturbing image or issue, it is important to help him or her discover the residue that remains in the form of a negative self-statement(s). How is he or she criticizing

himself or herself now? In what areas does he or she feel lacking? The negative cognition should be in present tense, specific, and concrete. Once a clear negative cognition has been developed, make sure that you do not use a vague or inappropriate Positive Cognition. Patients need to accept that while we cannot change history, we can help them to be more fair to themselves and to change how they have evaluated a specific painful experience. As Shapiro has often stated, you want to help your patients develop positive cognitions that are realizable and specific, but also generalizable. "I learned something from the experience" is oft more realistic and obtainable than, "I'll never make a mistake again."

At this point, let us assume you have obtained most of the background information that you need and the specific information related to a painful memory. Let us now move on to specific issues involved in initiating the eye movements with your patients. As you begin to arrange the chairs and work with your patient for the first time, it is important that you continue to demonstrate your concern for patient comfort and safety.

Ensuring patient comfort and safety. There are a number of things to consider with respect to providing safety and comfort for your patients before initiating EMDR. First, it is very important that they are comfortable. Check the seating, the lighting, that there are tissues nearby, that you are sitting off to the side, etc. Second, you have moved your hand to let them choose the most comfortable distance, i.e., how close or far away from their faces they want your hand to be. Third, you have given them permission to stop for any reason and have agreed upon a stop signal. Patients have to know that the brakes work and that they can put their foot on the pedal any time they want if they are going to feel safe. Fourth, you have established an image of a safe place. This is extremely helpful at the end of a session, but also if the patient needs to take a break during an EMDR session. Sometimes, sadly, you will have patients who cannot come up with an image of any place or person that feels safe. Clearly, this is a message to take extra time to meet their needs for safety and to explore their current resources before continuing. Fifth, with these patients in particular, but also in general, I now take extra care to make sure that patients have adequate relaxation skills before proceeding. Whether it be in the form of meditation or using a tape that you have given them, it is important that patients have some way of handling the stresses that might develop between sessions.

Advantages and disadvantages of beginning with an issue that has a high SUDs level. Having been trained behaviorally, I would start with an issue at a 4 to 5 SUDs level, assuming that it would be easier for patients to proceed to more difficult material later. However, Shapiro raised a concern about this approach. "What happens," she asked, "if you start with something the patient feels is at a 4 to 5 SUDs level and it suddenly increases to a 9 or 10 SUDs level, or shifts to a different issue at a much higher SUDs level?" If that happened, the patient might feel overwhelmed, out of control, etc. Now, I discuss this issue (i.e., that the SUDs level may change or different issues may arise) with my patients and let them choose which issue, at which SUDs level, they would like to work with first. This discussion has the obvious advantage of giving patients the utmost control while preparing them for the fact that things may get more intense than they had expected. By preparing them for the worst (or at least the most intense), patients seem less distressed when they experience the initial material at a higher level than they had expected.

Summary

I have listed the most common mistakes that clinicians make in the initial stage of using EMDR. While following the above does not guarantee success with any particular patient or any particular issue, addressing these issues will help you and your patients avoid mistakes that might hinder your progress. If you carefully collect the information you need on your patient's history and current functioning, establish a good therapeutic relationship, and prepare the patient for the EMDR procedure with care and consideration, you will be ready to worry about the issues I raise in my next article: mistakes we make during the eye movements and the closing portions of an EMDR session.

Thanks to: Howard Lipke, Francine Shapiro, Landry Wildwind, and Eirin Gould for their helpful comments and suggestions.

INTERNATIONAL UPDATE

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The Annual EMDR Conference in March was an exhilarating experience. The feedback from the participants was exceptional and universally positive regarding the calibre of the presentations. In addition, I was very pleased to present a number of awards. Joseph Wolpe, M.D., accepted the Ron A. Martinez Memorial Award for outstanding contribution to EMDR (which I discussed in the last Network Newsletter). Donald Weston, Ph.D., received the Debra P. Shapiro Memorial Award for research in the area of psychophysiology. He is doing some wonderful clinical studies on the effect of EMDR treatment with clients with HIV/AIDS. His proposal, based on his research, was accepted for presentation at the Psychology of Health, Immunity and Disease Conference in Hilton Head Island, South Carolina this December. I gave this research award in memory of my sister who died at age nine from a disease we

would now view as stress-related. I hope that we can always remember that research is not about subjects, or about "populations," but rather about the hope of helping to alleviate human suffering.

Special research awards were also presented for outstanding contributions in the way of consultation and research assistance to Sandra Foster, Ph.D., Gary Fulcher, Ph.D., Howard Lipke, Ph.D., and Steven Silver, Ph.D. They have all put in countless hours helping researchers design studies and write up their results and their efforts are greatly cherished. A research awards was also presented to Sandra Wilson whose dissertation research will make a major contribution to EMDR. She coordinated the study of 80 trauma subjects and the efforts of five clinicians: Michael Galvin, Ph.D., John Hartung, Ph.D., Jim Knipe, Ph.D., Laura Knutson, M.S.W., Beverly Schoninger, M.A., Bob Tinker, Ph.D., and two researchers, Lee Becker, Ph.D., and Craig Gillete Ph.D. The research will be presented at Division 12 of APA this summer and should make a major impact. It is an extremely well controlled study that finds significance at .001 on all standard psychometrics used, including all of the subscales of the SCL-90R. Also honored was David Wilson, Ph.D., for his excellent study of PTSD subjects using physiological measures. Its publication should be a major contribution to the literature.

While excellent studies have been completed, unfortunately, it takes approximately two years to get the information into print. In the meanwhile, studies by untrained researchers continue to be published which call into question EMDR's efficacy. I know this is causing a lot of consternation among clinicians, and rightly so. Once again, please write up your cases and submit them to professional newsletters and journals. All clinicians are already doing multiple baseline work. Take SUDs and Impact of Event scale measures on four to six unrelated memories. Reprocess the first three and measure all six. Then reprocess the other three and measure them all again. Write up the results with a short introduction about EMDR and end with some of the clinical anecdotal material. That can be a publishable article. As a clinician, you are taking the measures and doing the reprocessing anyway. If you are in an EMDR study group, you can combine measurements and the task of writing. It can accomplish quite a bit in helping to get the word out responsibly in professional circles.

Until there is an high level of saturation in the professional literature, EMDR will be subject to unwarranted attacks. The recent article in Newsweek is another example of misrepresentation. The reports of the Pittman study that compared EMDR with and without eye movement was quoted as indicating that EMDR is "snake oil." The reporter did not mention that the control included hand waving (which stimulates the retina) and hand-tapping, which we have been using clinically for years, and that the fidelity checks of treatment integrity showed a positive correlation between how well the method was done and the magnitude of treatment effects. Making EMDR sound like exposure plus eye movement is a misconception being promulgated by some behaviorists that are not trained in the method. Unfortunately, it is the state of the world. Hopefully, as EMDR gains greater acceptance through the publication of the appropriate research, we can make some needed changes in the way clinical research is uniformly done, and the way new methods are evaluated. Clearly, the field of psychology is not, presently, responsibly fulfilling its mandate. My endless gratitude goes to all of you who are attempting to do responsible research under incredible odds.

Media attention has been widespread in the last few months. For a real example of "yellow journalism," take a look at the Psychology Today article. The reporter informed me at the start of the interview that "the best psychologist in the country was Oprah Winfrey." I can hardly find a shred of truth in the entire article -- so I will let it speak for itself. Obviously she spoke to few clinicians actually using EMDR, and no clients.

Most of the articles we have seen so far have been much more responsibly done than Newsweek and Psychology Today. To date, there are articles already published in: New York Magazine (cover story), Washington Post, Family Therapy Networker, and the Honolulu Times. The Washington Post story was sent out on the Associate Press wire and does an excellent job of surveying the field. Sometime in July or August there will also be a segment on EMDR on 20/20 the TV News Magazine show. After the Washington Post story appeared, practically every news program asked to do a show. We chose 20/20 because the producers appeared to be the most sincerely interested in doing a responsible job. They will not know until the week it is aired when it will actually appear, so I suggest looking at Friday TV listings, or taping all of them just in case.

A presentation at the Eastern Regional Conference on Abuse and Multiple Personality was very well received. I spoke on the overview of EMDR, and Cathy Fine, Ph.D., did a magnificent job of delineating the applications to dissociative disorders. Then Walter Young, M.D., and David Calof joined us for a question and answer panel. I want to thank all three of them for an excellent job and a wonderful contribution. This should help to overcome some of the misconceptions regarding EMDR as it applies to dissociative disorders.

The text on EMDR that I am authoring should be in print by Guilford Press by January 1995. It is called Eye Movement Desensitization and Reprocessing: Basic Principle, Protocols and Procedures. We will make it available to Network members at a reduced cost and will let you know as soon as it is available. Its purpose is to act as a textbook for teaching the method and as a clinical handbook for

those already trained, because it expands greatly on a number of topics only touched upon in the trainings. It does not take the place of training, but should augment supervised practica.

During the next few months we will be meeting with a number of different EMDR committees to determine how to authorize the use of the textbook throughout the universities, and mental health agencies. There has been a proposal to have a special training for people with academic positions who would like to include EMDR training as part of a graduate curriculum. Please contact me if you are interested in this possibility for 1995.

In addition, because the text will be widely available, we will need to make some accommodations for expanding the role of the Network and delineating certain standards of practice. Any of you who have expertise or previous experience in any of these areas can certainly help formulate the policies. This is brand new territory and we want to make sure that clients remain protected while training becomes more widely available. By the time the book is published, 9,500 clinicians will have been officially trained. This should establish an appropriate baseline of clinical practice and client success ratio.

One EMDR training committee has recommended that people who have read the book, and been supervised by a trained supervisor, be given an equivalency test in order to enter the Network and advanced EMDR trainings. Other committees have recommended certification programs. Please write to me if you have suggestions or expertise in regards to this area of consideration.

In the meanwhile, authorized workshops are being done only by trainers selected and especially trained by me for that purpose. They are: Eirin Gould, Andrew Leeds, Howard Lipke, Barbara Parrett, Gerald Puk, Steven Silver, Roger Solomon, Kay Werk, and William Zangwill. The trainings they conduct include trained facilitators and cover the appropriate material regarding client safety and procedures. All of the brochures for their trainings have the EMDR Institute logo and the Pacific Grove address. The only exceptions are trainings they are doing outside the US or ones that are being included with trauma conferences; the office can give out information which those are.

Any other trainings you may hear of being done by people who are not qualified to teach EMDR for a variety of reasons. Although my name may appear on their fliers, it is being done inappropriately, and without my permission. Unfortunately, as the media attention grows, these rare instances may increase and will need to be dealt with accordingly. In the meanwhile, however, it is important that you offer your colleagues the opportunity for informed consent. If you hear they are planning to attend, or have attended an unauthorized training, you should let them know the circumstances so they can make an informed decision about attending, or working with clients.

This year there have been two legal decisions regarding the use of EMDR. I was asked to appear as an expert witness for a case in Coleville, Washington. The defense had introduced the evaluation of a psychologist who was untrained in EMDR who stated that EMDR was like hypnosis and could implant false memories. I testified to the contrary armed with a recent study by Gregory Nicosia, Ph.D., who used evaluated EEG readings of EMDR clients compared to those under hypnosis. The hypnosis subjects showed a pronounced theta and alpha and the EMDR EEG showed a client within the accepted parameters for a waking state. Consequently, according to this evaluation, EMDR is not hypnosis and does not produce the suggestibility necessary to "implant false memories." The judge's ruling supported this position. It is now a legal precedent in the United States. There is also a legal ruling in Australia where the judge also decided that EMDR did not distort memory.

In this present psychological climate, it is mandatory that EMDR be done properly, without trolling for memories to keep it separate from the problems run into by hypnosis and "memory uncovering." There are bound to be other forensic challenges to EMDR, and we need to be prepared to meet them.

This year there are EMDR presentations at the annual conferences of the International Society for Traumatic Stress Studies, International Society for the Study of Multiple Personality and Dissociation, Ericksonian Foundation, International Conference of Psychoneuroimmunology, California Marriage Family Therapy, American Society of Marriage Family Therapy, Family Therapy Network, and the Society for the Exploration of Psychological Integration. However, it is important that presentations be made at many more conferences by clinicians and researchers actually trained in the method. Unfortunately, there have been reports of presentations by untrained clinicians that have misrepresented the way the method is actually used in clinical practice.

Please contact the office for presentation packets if you are interested in helping to responsibly disseminate the information. I know how precious time is when you are in clinical practice, but just think of the numbers of people you will be impacting. You get to be the reason that so many more clients can be helped. Please send me a listing of your name, presentation title, and the conference so we can publish a complete listing.

As you may know by now, in March 1994, I was awarded the Distinguished Scientific Achievement Award by the California Psychological Association. I accepted it "on behalf of all EMDR therapists who are currently converting science into practice." EMDR is where it is today because of you.

FROM THE EDITOR

The EMDR Newsletter is in its fourth year of publication and is a wonderful forum to use to impart EMDR-related information. The primary purpose of the Newsletter is to provide EMDR-trained clinicians with the opportunity to share with, and learn from, the experiences of others.

The following is a brief list of general topics that have generated interest among readers.

Innovations: EMDR continues to evolve in order to meet the demands of client needs. Always welcome are suggestions of new and different ways to apply EMDR.

Red Flags: This includes cautions regarding certain clinical populations, suggested safeguards, contraindications, etc.

Book Reviews: This includes any books that may be relevant to neurophysiology, learning theory, memory theory, PTSD, etc., or any books that you think would be of interest to practitioners of EMDR.

Protocols: If you have designed a protocol for a specific population or issue, please let us know.

International Update: Let us know what is happening with EMDR internationally (e.g., conferences, publications, awards, etc.).

Help Wanted: This is a column that can be used to advertise research projects, groups, etc.

Tidbits: This column is for brief (one page or less) comments, ideas, suggestions, etc., about EMDR.

Case Study: This is a description of a case in which EMDR was used either as the sole treatment method, or in conjunction with another modality.

Theory: Francine Shapiro, Ph.D., has developed a model based on information processing and neuropsychological activity. If you have other ideas on why/how EMDR works, please let us know.

Research Reports: Results from research studies are vital to the continued growth and understanding of EMDR and are welcome contributions to the Newsletter.

Controversy: EMDR has generated some controversy since its inception. Bringing it to the attention of our readers encourages debates which, in turn, stimulate thinking.

This list is by no means exhaustive and other ideas and suggestions are welcome.

EMDR HELP WANTED

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

EMDR Research/Training Center

The EMDR Research/Training Center at MRI is looking for individuals who want to take part in a research project regarding smoking cessation. Any therapists who have clients interested in participating, please call *Cliff Levin, Ph.D. (415) 326-6465.*

Memorable Cases

If you have treated any memorable cases we would like to hear from you. We are recording case histories of EMDR treatment to share with each other and for possible publication. Please send 2 copies, preferably triple spaced, concise, and according to the following outline:

Presenting problem
Background History
Treatment
Outcome
Follow Up
Comments

Also please include your therapeutic approach (eg. Cognitive, Psychodynamic, etc.).
Send to:

Dr. Steve Lazrove
254 College St. Ste. 502
New Haven, CT 06510
Fax: (203) 865-7550

or call:

Frankie Klaff (410) 392-6086

Published?

If you are an EMDR trained clinician and have had any books published, please contact the EMDR office at *(408) 372-3900.*

Fluent in a 2nd Language?

If any EMDR trained therapists are fluent in a second language, please contact the EMDR office at *(408) 372-3900.*

Success with Schizophrenics?

Anyone having success treating schizophrenia using EMDR, please contact: *Carol A. Anderson, 4781 E. Gettysburg Rd., Fresno, CA 93726, (209) 445 8522*

Addictions, Smoking, Weight

Several therapists have contacted me regarding success in the use of my smoking protocol with other addictions. This has confirmed results I notice with many of my clients with histories of abusing heroin, crack, methamphetamine, marijuana and even food. I would appreciate receiving feedback (success and failures) from any therapist using my smoking protocol. *Arnold J. Popky, MA, 17461 Pleasant View Ave., Monte Sereno, CA 95030.*

Spiritual Insights

Some therapists have noticed that their clients reported experiencing spiritual openings or insights during or after EMDR sessions. If you have seen this and would like to share these vignettes, please write up your case and send them to:

Laurel Parnell, Ph.D.
22 Von Ct.
Fairfax, CA 94930
(415) 454-2084

The following is a list of published articles and selected presentations that may be helpful for citation purposes. I have excluded from this list all of my panels and presentations as being both too numerous and redundant.

Please send all panels and presentations, upon acceptance, to the Newsletter for future publication. In addition to new articles, we can include those topics not already covered in the bibliography, and mention the others in a separate section.

I want to thank all of you who have taken the time and energy to help in the dissemination of EMDR. It cannot continue to flourish in mainstream psychology and eventually in the universities without your efforts. *FS*

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CALIFORNIA EMDR STUDY GROUPS

Norva Accornero, LCSW California Network Coordinator (408) 354-4048

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

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

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

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

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

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

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

James Shephard (209) 292-1700
Coordinating new group. Open

FULLERTON
Jocelyne Shiromoto (714) 965-1550
Curt Rouanzoin (714) 680-0663
Meets 2nd Tues. 9:30-11:30

IRVINE
Judy L. Alpert (714) 841-2296
Meets 2nd Thurs of month. Primarly case discussions.
Open. Call for directions.

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

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

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

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

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

MONTEREY
Glenn Leonoff (408) 373-6042
Robbie Dunton (408) 372-3900
Coordinating a new group. Open

NAPA
Marguerite McCorkle (707) 226-5056
Open.

NEVADA CITY/GRASS VALLEY
Judith Jones (916) 477-2857
Call for time. Open

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

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

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

RIVERSIDE/SAN BERNADINO
Byron Perkins (909) 732-2142
3rd Fri. 9:30-11:00am

SACRAMENTO
Bea Favre (916) 972-9408
Connie Sears (916) 483-6059
Meets 3rd Fri. 1:00-3:00 2740 Fulton St. Sacramento

SAN DIEGO
Jim Fox (619) 260-0414
Meets 2nd Fri. 9:30-11:00am. Primarily case discussion. Call

Arthur Horvath (619) 445-0042
Mary Anderson (619) 434-4422
Meets 2nd Fri. 9:00-10:30. Case discussion. Call.

Elizabeth Snyker (619) 942-6347
meets 3rd Wed. 9:00-10:30191 Calle Magdelena #230,Encenitas

SAN FRANCISCO
Sylvia Mills (415) 221-3030
Call. Case discussion

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

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

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

SARATOGA/W. SAN JOSE
Dwight Goodwin (408) 241-0198
1st. Fri. 9:30-11:30. Open

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

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

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

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

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

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

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

1994 LEVEL I BASIC TRAININGS

Listed below in the shaded areas are seminars conducted by Francine Shapiro, Ph.D.
Other seminars listed will be conducted by EMDR senior trainers.

Date	*Location*
July 23/24 Sat./Sun.	San Bernardino, CA Ramada Hotel
Aug. 6/7 Sat./Sun.	Portland, OR Sheraton Portland Airport Hotel
Aug. 29/30 Mon./Tues.	Sydney, NSW. Australia Ritz Carlton, Double Bay
Aug. 29/30 Mon./Tues.	Perth, West Australia Perth Hotel
August TBA	Melbourne, Victoria, Australia TBA
Sept. 9/10 Fri./Sat.	San Francisco, CA Clarion Hotel
Sept. 10/11 Sat./Sun.	Washington, DC Embassy Row Hotel
Sept. 10/11 Sat./Sun.	Minneapolis, MN Radisson Hotel & Conf.Cntr.
Sept. 16/17 Fri./Sat.	Mt. Pleasant, MI Holiday Inn
Sept. 23/24 Fri./Sat.	London, England London Regents Park Hilton
Sept. 23/24 Fri./Sat.	Phoenix, AZ Sunburst Hotel
Sept. 24/25 Sat./Sun.	Aix-en-Provence, France Hotel Pullman Roi Rene
Sept. 30/Oct. 1 Fri./Sat./Sun.	Amsterdam, The Netherlands Grand Hotel Krasnapolsky
Sept. 30/Oct.1 Fri./Sat.	Atlanta, GA Holiday Inn Dunwoody
Oct. 7/8 Fri./Sat.	San Antonio, TX TBA
Oct. 21/22 Fri./Sat.	San Jose, CA Sunnyvale Hilton

1994 LEVEL II TRAININGS

Jul. 30/31 Sat./Sun.	Denver, CO Hyatt Regency Tech. Ctr.
Aug. 27/28 Sat./Sun	Sydney, NSW, Australia Ritz Carlton, Double Bay
Aug. 5/6 Fri./Sat.	Los Angeles, CA Sheraton, LA Airport
Oct. 15/16 Sat./Sun.	Seattle, WA Seattle Hilton Airport
Nov. 5/6 Sat./Sun.	New York Loews New York
Nov. 12/13 Sat./Sun.	Chicago, IL Marriott Oakbrook
Dec. 2/3 Fri./Sat.	San Jose, CA Sunnyvale Hilton

All Level II seminars presented by Dr. Francine Shapiro.

EMDR Network Newsletter Submission Information

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

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

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

AUDIO TAPE ORDER FORM
1994 EMDR CONFERENCE
Research & Clinical Applications

Tapes cost $ 9.00. Full Set Price $ 430
Shipping: US & Canada $ 1.25 per tape, $ 15 Maximum
International $ 2.00 per tape, $ 30 Maximum

EMDR 94

Please Circle Code # Below

L115	Welcome & Closing	FRANCINE SHAPIRO, Ph.D.
L116a (4 tapes)	MRI Brief Therapy	RICHARD FISCH, MD
L117a (4 tapes)	Chronic Depression	LANDRY WILDWIND, LCSW
L118a (4 tapes)	Dissociative Disorders	WALTER YOUNG, MD
L119a (4 tapes)	Sexual Abuse	SCOTT NELSON, Ph.D. / MARGOT SILK FORREST/ EIRIN GOULD, LMFT / DEBBIE KORN, Psy.D.
L120a (4 tapes)	Children:	
	Traumatized Children	JEAN SUTTON, LCSW
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ACKNOWLEDGMENT AND CONSENT FORM

Below you will find an example of the types of things that we think clients should know in order to have informed consent before initiating EMDR treatment. This sample format is not meant to be the definitive answer for an EMDR informed consent nor is it endorsed by EMDR Network, Inc.: rather it is offered here as one example of what can be included in such a document.

Because the laws governing the use and effect of such documents vary from state to state, it is **IMPERATIVE THAT YOU OBTAIN A LEGAL CONSULT BEFORE USING ANY SUCH DOCUMENT.**

CONSENT FOR
EYE MOVEMENT DESENSITIZATION AND REPROCESSING TREATMENT

I have been advised and understand that Eye Movement Desensitization and Reprocessing (EMDR) is a new treatment approach that has not been widely validated by research. I have been informed that initial studies have shown EMDR has produced promising results in reducing anxiety and in reducing post-traumatic stress symptoms, such as intrusive thoughts, nightmares, and flashbacks . I have also been advised that, although there are currently no known serious side effects to EMDR, there is minimal data as to its efficacy or safety.

I have also been specifically advised of the following:

(a) Distressing unresolved memories may surface through the use of the EMDR procedure.
(b) Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.
(c) Subsequent to the treatment session, the processing of incidents/material may continue, and other dreams, memories, flashbacks, feelings, etc., may surface.

Before commencing EMDR treatment, I have thoroughly considered all of the above, I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR treatment, and by my signature below I hereby consent to receiving EMDR treatment.

My signature on this Acknowledgment and Consent is free from pressure or influence from any person or entity.

Date: _____ Client Signature:_____

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