EMDRIA NEWSLETTER

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In This Issue

A Message From the President: Catching Up with Business

Curtis C. Rouanzoin, Ph.D.

It has been a very busy and productive time for the Board of EMDRIA, which has given rise to the four issues addressed in this column.

To begin, the EMDR International Association has successfully filed for an IRS designation of 501 C6 (professional, membership organization). The C6 designation allows us to provide many functions for members that were otherwise prohibited as a 501 C3 organization. For example, we are now authorized to actively pursue regional meetings and develop other membership benefits that were not previously available to us.

We retain our 501 C3 designation, and therefore can continue to perform public interest education, research, and other charitable activities. Having both designations allows us to use the strengths of each to accomplish the mission of EMDRIA. But it also means that the Board has had to develop another set of Articles of Incorporation and Bylaws and have the support of legal counsel to ensure that otherwise unforeseen problems are dealt with fully. To that end, I want to thank the Board members, Carol York and the Austin crew (Jennifer and Gayla), Charles Thoeming (our wonderful attorney), and Ken Gorence (our CPA) for all their extra, hard, and time-pressured work. The good news is that all the work is finished!

Secondly, I would like to offer some thoughts about the use of EMDR. From my first training in EMDR several years ago through the dozens of additional trainings I attended as Facilitator for the EMDR Institute, I remember Francine Shapiro and other senior trainers often saying that, "EMDR is not a magic bullet. It must be incorporated into a comprehensive treatment plan for the patient." Over the years, I have repeatedly advised therapists to do traditional psychotherapy with patients who need a consistent, nurturing, and boundary-setting relationship to develop and grow. A case in point involved a therapist I was supervising who was working with an angry and acting-out 14-year-old male. The therapist was frustrated as he was unable to get much movement in the patient and wondered what else he could accomplish with EMDR to overcome the roadblocks.

I advised him to do family therapy and address the system problem. In his zeal to end the boy's acting out, the therapist had missed the bigger picture—the family system that contributed to the problem.

Our exuberance for a method can easily blind us to the other issues that must be addressed. As a great man once said, "Give a boy a hammer and it seems that everything he encounters is in need of a nail." We must all bear that in mind and remember that EMDR is best utilized as a part of a comprehensive treatment plan.

My third point revolves around several e-mails the central office of EMDRIA and I received urging us to address the use of EMDR in the NBC series, "The Profiler." In one episode, the protagonist (a forensic psychologist), waved her

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STRAY THOUGHTS

Francine Shapiro, Ph.D.
Mental Research Institute

The End of an Era

The field of psychology has suffered the loss of four of its pioneers.

It is with deep sorrow that I announce the death of Joseph Wolpe, M.D., a good friend and a luminary in the field of psychology. The passing of Dr. Wolpe leaves behind an entire field of cognitive-behavioral psychology which will always be in his debt. Although he protested the movement toward cognitivist thinking, his efforts laid the groundwork for the acceptance of behavioral thought and empirically-based psychology in America. He was the first recipient of the Ron Martinez Memorial Award for his special contribution in disseminating and supporting EMDR. All EMDR clinicians are familiar with his work in their use of the Subjective Units of Disturbance, or SUD, scale.

I well remember the first time we met. I had come to his office in Philadelphia to demonstrate EMDR (then called "EMD") and to show him the data I had recently collected on its use. He was immediately interested and intrigued. I was struck by how open he was to a method that, if validated, might seriously threaten his own creation, "systematic desensitization." Since I had not heretofore experienced a great deal of open-armed interest when speaking about EMDR to others in the field, I commented on his graciousness. To this he responded, "I don't care if it's *psychoanalysis*; if it helps people, I want to know about it." This from a man who had been castigated as unethical by numerous analysts and, indeed, the entire psychodynamic community for his "heretical" views. Despite his resistance to my subsequent addition of "R" onto "EMD" and my expounding upon the reprocessing aspects of the methodology, he never faltered in his support and interest. The world has lost a wonderful man.

Those who have read the introduction of my first book will note that my first two influences in the field of psychology were Joseph Wolpe and Andrew Salter. Salter was a non-academic who blazed the trail for the acceptance of behavioral therapy by the general public. His book, *Conditioned Reflex Therapy*, was a classic and an eye opener to those of us interested in a replicable way of intervening that would allow for a rapid attainment of mental health. Salter's death last year was doubly sad because it occurred just before the behavioral community, which had ignored him partly because of his non-academic affiliation, was able to honor him. A tribute to him by the Association for the Advancement of Behavior Therapy (AABT) was planned, but he never got to receive it. When I first met him, he warned me of the likely forthcoming academic reception to EMDR, based on his own experiences. Despite his travails, however, he seemed to retain his good humor, and his favorite motto was, "Don't let the pagans get you down."

Sadly, Wolpe also missed the tribute planned for him at this year's AABT meeting. He was too sick to attend and died without really knowing how many staunch supporters he had. For both of them, I know, the primary concern was that their work had made a difference in alleviating suffering. The passing of these two men truly mark the end of an era in behavioral psychology.

The field has also suffered from deaths of Viktor Frankl and Hans Eysenck this past year. Eysenck fought against the predominantly psychodynamic schema in Europe to propose a nature-based theory of personality and may be best known for the phrase, "If it cannot be measured, it does not exist." He expressed his interest in EMDR and was unfortunately unable to attend the European trainings. Regardless of whether one agrees with his views, his persistence in the face of adversity in bringing forth new ideas is to be greatly admired. And, of course, no one could possibly typify this position more than Viktor Frankl.

I wanted to meet Victor Frankl during my stay in Europe, but the person I asked to forward his address to me failed to respond. When I returned home I received an apology and the news that he had died at the end of the summer. A number of people in the EMDR community are exploring the application of EMDR with holocaust survivors, which I consider to be a testament to his memory. We hope that at least the second-generation holocaust survivors can be liberated from the inherited pain and suffering.

In his seminal work, *Man's Search for Meaning*, a pivotal thought expressed by Victor Frankl is that true meaning and satisfaction in life is to be found only by transcending the common into a sense of greater purpose. Another central conviction is that one is free to choose one's attitude in any circumstance. Both these ideas have direct pertinence to EMDR, as most clinicians practicing the method will attest. To watch clients break through the experiences locked inside them and progress to a sense of personal meaning and liberation is a true privilege. The field of psychology has suffered a tremendous loss with his passing and I shall always regret that I never met him.

It is intriguing to think about the contributions of these pioneers, and of how we can learn and benefit from their achievements. Clearly, persistence, curiosity, and openness typified them all. The willingness to pursue unconventional avenues and to face all opposition is another aspect of their heritage. I would also like to think

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that we incorporate aspects of all their ideologies into our EMDR work. There is a respect for nature and the physiological underpinnings of our clients, along with a recognition of the position of experiences and learned behavior. And, finally, there is the belief that we can facilitate the stimulation of our clients physiological systems and assist them in the reprocessing of the constricting experiences which have held them back and separate them from joy, intimacy, and accomplishment in the present. This transcendence to a higher meaning, and the liberation from suffering into a meaningful present through the reprocessing of the experiences, makes both nature and nurture not a prison sentence, but rather the springboard for all future action.

New Advances

The accelerated information processing model that was advanced to explain EMDR practices has posited that pathologies are largely based upon experiences that are dysfunctionally stored in the brain. Specifically, one can conceptualize these disturbing experiences as "small t" trauma, since they cannot be used to diagnose Posttraumatic Stress Disorder, even though they have a negative and debilitating effect upon self and psyche. While there are now numerous studies supporting EMDR's effectiveness with PTSD, there is a dearth of articles published in professional journals regarding its use with other disorders. (Internet users can access the most current list of articles at http://www.emdr.com.)

A happy addition to the EMDR literature is a newly published article on the use of EMDR with seven consecutive cases of Body Dysmorphic Disorder. In this disorder, people believe that a part of their body is deformed, ugly, or despicable in some way. The following is the abstract of the article:

> "Body dysmorphic disorder is an illness of generally chronic course which can lead to significant impairment of social functioning, unnecessary plastic surgery and even suicide. It is little understood and treatment regimens have been of uncertain efficacy. Eye Movement Desensitization and Reprocessing (EMDR) is a newly developed psychotherapeutic procedure used in the treatment of posttraumatic stress disorder, grief reactions, and generalized anxiety. In this paper, we describe its use in seven consecutive cases of body dysmorphic disorder. Improvements were obtained in six of the seven patients, five of whom had a complete resolution of their symptoms."

Brown, K.W., McGoldrick, T. & Buchanan, R. (1997) Body dysmorphic disorder: Seven cases treated with eye movement desensitization and reprocessing. *Behavioural and Cognitive Psychotherapy*, **25**, 203-207.

The cases were successfully treated in one to three sessions of EMDR. The findings support the hypotheses that disturbing experiences are at the root of this disorder, and that sufficient processing can change the self-denigrating beliefs and eliminate the symptoms.

As we know, one of the primary tenets of the accelerated information processing model that guides EMDR practice is that even disturbances that from an objective point of view appear trivial can be subjectively traumatic and cause pathology. For instance, in one case, a woman spent many hours a day plucking all the visible hair from her body because she believed her body was totally covered with hair. It turned out that this belief stemmed from a passing disparaging remark by an aunt about her underarm hair. In deference to Eysenck, one might conjecture upon the type of physiologically-based personality predisposition that would cause this interaction with the perceived experience. However, regardless of this possibility, it is important to note that a liberation from the pathology is possible at a relatively rapid rate.

Not only is the clinical success with these cases predictable from the information processing model, but the Brown et al. study assists in opening a new avenue of treatment for this and related disorders. The only subject in the study who reported no response was unable to engage in EMDR treatment. Hopefully, these findings will inspire rigorous controlled research using EMDR for this previously resistant population. I would also like to point out that the published report of the seven consecutive cases is within the capacity of all practicing clinicians. Therefore, those of you who are having positive results in EMDR applications other than PTSD would greatly assist the process of acceptance and normalization of the method if you would consider documenting and publishing your work.

Please do not underemphasize the impact you can have on the field of psychology, and on the ability to help alleviate suffering worldwide. A manual of single-subject designs (written by Allen Rubin) is available at cost through EMDR Institute. However, even a documentation of simple pre-post findings, such as the ones you have available for insurance purposes would be acceptable for most non-PTSD population publications. Many people are available to assist you in writing up your findings. To contact such people, all you need to do is send an inquiry to the EMDRIA research committee.

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The Purpose of Science

During a recent dialogue, an interlocutor quoted a favorite teacher of his who, as he put it, "took fiendish delight in debunking myths ("What fools YOU mortals be!")" and saw science as the cure for the boundless distortions that are part and parcel of the uniquely human power to make and grasp symbols. Forty years after his lecture, I can still hear his rhetorical question/ mantra, uttered in a tone that would do justice to Howard Stern: "Do you REALLY suppose that an ape can believe in holy water?" This was said in a way that made it clear that the ape was on the right side of the argument. For him the essence of science was doubt and he coined a verb to describe that essence: Science is NOT-knowing. Since he asked for my observations, my reply was:

"I wholeheartedly agree that the tools of scientific investigation are crucial to eliminate error and objectively evaluate that which can be observed in order to counteract the possible distortion caused by subjective interpretation. However, to my way of thinking, the essence of science is investigation, not doubt. If science is used in the service of humanity, its mandate is to explore and expand the bounds of knowledge. The springboard is then curiosity and the goal is KNOWING. If doubt becomes the driving force of science then it often is subverted to the goal of debunking anything that cannot currently be measured or explained. Science then takes on the stature of religion and the dominant myth that is accepted is that one should not entertain, accept, or believe that which cannot be currently proven. Unfortunately, this eliminates from the arena all those things for which there are so far insufficient theory, measurements, and conceptual frameworks.

If one is an ape, one is reduced to that which can be understood and conceptualized in that framework. If one is a human being, there is the ability to apprehend the ineffable and the possible. The goal is to develop the tools of science to understand the governing principles of mind, body, and natureCfrom the subatomic to the universal. While an ape might not believe in holy water, neither would it believe in, nor be able to conceptualize the atom. And without the capacity for symbolic thought and conceptualization beyond the realm of what is known, all progress ceases."

I would enjoy interacting with others. You can address questions to me on the Internet at http:// www.behavior.net, or submit questions to me (which will be answered in future newsletters) in care of the EMDR Institute (P.O. Box 51010, Pacific Grove, CA 93950). ⇔

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fingers before the face of a client. Her police colleagues inquired about what she was doing and her supervisor informed them that she was using EMDR—Eye Movement Desensitization and Reprocessing—a method used to deprogram cult members (or something like that).

My initial reaction was, "Well, you know you've made it when TV distorts your method." But after several e-mails from concerned members, I sent an e-mail to NBC and "The Profiler" show. I congratulated them on keeping current in the rapidly changing field of psychology and offered a free copy of Shapiro's case study book. I told them it would allow the writers to see how EMDR is best used. I informed them that the book would be a great resource for future episodes should they choose to highlight EMDR again, as it would offer them a more accurate portrayal of EMDR in actual practice. I also offered Francine's or my input gratis should NBC be in the need of accurate input for their show.

Since psychotherapy as a whole and psychotherapists in particular are often portrayed on TV and in movies as sick and pathetic creatures, we probably got off easy. I will keep you informed if anything comes of it.

Lastly, your Membership Applications appear on page 15. Please join as soon as possible. The changes in our IRS status will allow us to serve you more effectively. In addition, the conference brochures will be arriving soon. I think you will all be delighted by the quality of presentations we will have this year.

Until next time . . . ⇔

A Note of Appreciation . . .

I would like to express my thanks to the EMDR community for its wonderful response to my ad in the December issue of *The EMDRIA Newsletter*. In that issue, I requested transcripts or tapes for an EMDR research project and the support has been terrific.

With heartfelt appreciation,
Carolyn Weitzman, LPCC

FROM THE DESK OF . . .

Carol York, MSSW, LMSW-ACP
Executive Director, EMDRIA

Happy New Year to all! We have been very busy and have some new changes. We have completed the formalization of a second organization, EMDR International Association, a professional organization for those trained and/or interested in EMDR. The Membership Application has been included in this issue for your convenience, in the event you have not received one as yet.

Our original organization, Eye Movement Desensitization and Reprocessing International Association is still in operation. As you know, it is a charitable organization that educates and disseminates information for the public good and supports scientific research and humanitarian efforts in EMDR. The Association is also responsible for the production of informational materials regarding EMDR, such as the "What is EMDR?" brochure now available.

By having two organizations, we can increase our services and efforts on behalf of EMDR, those trained in EMDR, and those receiving EMDR therapy. We are excited about all the possibilities and hope you will join us and help us grow.

The following address and phone numbers should be used to contact the Administrative Office regarding membership, conference, newsletter, World Wide Link, or any other administrative matters:

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P.O. Box 141925
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Website: www.emdria.org

The following address and phone numbers should be used to contact the Administrative Office regarding, brochure orders, charitable needs or donations, and research or education questions or information:

Eye Movement Desensitization and Reprocessing International Association
P.O. Box 140824
Austin, TX 78714-0824
Phone: (512) 302-9943
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FROM THE INTERNATIONAL SCENE

Marilyn Luber, Ph.D.
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Nineteen ninety-eight has begun and we look forward to a year filled with exciting events regarding the use of EMDR around the world. Particularly noteworthy is our members' dedication to excellent clinical work and research and their pursuit of these goals as they translate them into their regions' cultures, languages, and mores.

One member who is an example of excellence in these areas is David Blore. David comes from Nottinghamshire and is an enthusiastic member of the EMDR Association of the United Kingdom and Ireland. He is a nurse and has advanced degrees in advanced professional practise (with a dissertation on EMDR) and in cognitive behavioural psychotherapy.

Originally from Birmingham, England, David went to Leicester to obtain his nursing credentials. David not only became a nurse in Leicester; he also met and married his wife, Susan, and brought their children, Simon and Yvonne, into the world there.

Although EMDR and psychotherapy are his passions, David has many interesting and unusual hobbies. He collects philosophy and psychology hardback books from 1880-1940 and recently acquired a first edition of Pavlov's 1927 English translation of the Russian. As David puts it, the volume is "the one everyone quotes but probably has never seen!" His other pastimes include learning Dutch from our colleague Ad de Jongh from Holland, computers, astronomy, listening to music and watching cricket and Formula 1 motor racing on TV! His ambition is to write his memoirs and spend more time traveling in Northern Europe.

David is a versatile clinician, a supervisor of nurses, and a facilitator for the EMDR Institute. David's major focus has been working with coal-miners. In fact, he was the first European to present at a Level II training in London, presenting a lecture entitled *Tips from the Pits: A Proposal for an Extended Single Trauma Protocol for Using EMDR.* He has published about this subject—along with other topics—and even received a celebration pewter tankard after making his first trip down a 700-metre shaft with a miner who had a fear of heights. The colliery manager was so impressed by his effort to return his miner to work that he inscribed the tankard for him!

One of David's major contributions to the EMDR world is his electronic journal. *The EMDR Practitioner*, (formerly *Eye to Eye*), The Electronic Journal of EMDR Europe can be accessed at: Http://www.geocities.com/HotSprings/Spa/ 1999. *(Continued on page 6)*

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David explains the genesis of his magazine in the following manner: "Rapid dissemination of information has traditionally been a problem where a field of expertise is developing quickly. I saw a role in utilising the Internet to 'keep the EMDR family together' (altruistic motive). I'm enthusiastic about EMDR (hedonistic motive)."

David's latest adventure will be to visit to Moscow in April to lecture at the Moscow Centre of Psychology and Psychotherapy on the use of EMDR amongst traumatized miners. We all look forward to hearing about his trip upon his return.

News from Around the World

Australia: The large Australian organization is in the middle of incorporating. They are delighted to announce that they sponsored a debate between Francine Shapiro, Ph.D. and a local academic Professor David Kavagh on March 3rd at Sydney University about EMDR and the research issues it raises.

Belgium: Marc Van Knippenberg is pleased at the growing strength of the Association of EMDR Therapists. In conjunction with the Rotary Club Antwerp in Rwanda, Marc will direct a project in October 1998 concerning the efficacy of using EMDR with people traumatized by the genocide in Rwanda.

Brazil: Graciela Rodriguez introduced EMDR to Brazil in the fall and trained 24 people who are also interested in becoming members of EMDRIA.

Canada: David Hart continues to work tirelessly in the service of EMDRAC, EMDRIA and the upholding of the integrity of EMDR. (Thank you, David!) He reports that the EMDR Association of Canada was incorporated on January 27, 1998. They have 180 members and will be more active in recruiting now that their status as an organization is established. The west coast members are joining forces with the North West Connection, an enthusiastic group of facilitators from Seattle and states adjoining Washington. EMDR clinicians from Alberta and British Columbia will go to Seattle in the fall and will play host the next year in Vancouver.

Europe: A variety of trainings will be given in Europe. Please consult David Blore's *"The EMDR Practitioner"* for dates at http:/www.geocities.com/HotSprings/Spa/1999.

France: Francois Bonnel reports that he and his team have done "an amazing job" getting EMDR going in France. The French group numbers 120 members, and they are planning the first EMDR Conference France in 1998.

Germany: According to Arne Hofmann, EMDR has become part of a national training curriculum for trauma-therapists. The training will include teaching clinicians assessment of trauma and specialized populations and how to stabilize and help patients process the trauma. Dr. Hofmann's group is establishing a network of centers, including a clearinghouse to accredit the trainings and the therapists who attend them in Germany.

Holland: There will be a Level I training in Amsterdam April 23-25.

Israel: Gary Quinn informs us that he spoke to the Hypnosis Society in Jerusalem and was well-received. They have also been given official approval to work with individually-approved workers at Bituach Leumi for five sessions.

Latin America: The latest news comes from John Hartung who, along with Michael Galvin, has been training mental health workers in Latin America for several years. Their team of facilitators and other trainers such as Graciela Rodriguez have taught in Argentina, Brazil, Chile, Columbia, Mexico. Contacts have been made in Costa Rica, Peru, Paraguay, Nicaragua and Ecuador. Ana Mari Andreu is conducting her study of EMDR with trauma victims in Guatemala and is replicating the Colorado Springs study. Additionally, nine facilitators in training completed a first course in Argentina.

Malaysia: Graciela Rodriguez taught ten therapists in Singapore. Their first red badge is Kokkwang Lim, Ph.D., a clinical psychologist. Kokkwang was trained in the United States in 1995.

Nepal: Mark Van Ommeren is currently in Nepal and hopes that the Center for Victims of Torture will become members of EMDRIA.

Switzerland: Charlotte Bucheli-Egger reports that a positive article on EMDR appeared in the "Schweizerische Aerztezeitschrift" which is the official journal received by all Swiss medical doctors. EMDR has begun to be promoted by highly qualified EMDR teachers in Swiss University Institutes and clinical hospitals. EMDR-trained therapists are hoping to build a network among EMDR therapists in Switzerland.

United Kingdom/Ireland: Mark the dates of September 6-8, 1998 for the Conference of the International Association of Cognitive and Behavioural Therapy in Cork, Ireland. The keynote speaker will be Dr. Francine Shapiro and the conference organizer is Desmond Poole.

United States: This month, Daniel Benor is lecturing in Australia on spirituality and psychotherapy. He is focusing on varieties of healing--including EMDR--that can help people increase their spiritual awareness.

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EMDR: Getting Started

Guidelines for Clinicians in Selecting Clients for Initial Application of EMDR following EMDR Level I Training and Preceding Level II Training

Andrew M. Leeds, Ph.D.
Senior Trainer, EMDR Institute

These suggested guidelines are offered in response to the many questions raised by clinicians recently trained in EMDR about getting started with using EMDR in clinical practice. Because of the wide variation in clinical background, theoretical orientation, length of experience, learning style, and clinical settings of those who attend EMDR training, these are general guidelines that will be more or less useful for different clinicians.

The standard EMDR protocol focuses on the resolution of specific, stressful life events. Please keep in mind that a disturbing memory may be a major Trauma (big "T" trauma) or it may be a relatively minor trauma (small "t" trauma). Following the Level I training, clinicians are advised to start using EMDR with at least 20 to 30 reprocessing sessions focused on milder clinical presentations before returning for the Level II training. Reading Francine Shapiro's 1995 text (*Eye Movement Desensitization and Reprocessing*, Guilford Press) is considered essential for an adequate understanding and developing skill with EMDR before returning for the Level II training. Attending a peer study group or obtaining group or individual consultation is also recommended to help clinicians to gain a deeper understanding of how and when to apply EMDR.

There are numerous dilemmas and potential pitfalls for clinicians beginning to use EMDR. This article will not attempt to address all of these issues, but will focus on client selection issues that may help clinicians achieve better treatment outcomes, make the Level II training a more useful learning experience, and help develop the skills needed to use EMDR effectively and with confidence.

Level I Training: Preparation and Expectations

The Level I training provides an initial platform for clinical application of EMDR. The aim in the initial post-Level I sessions is for clinicians to provide effective EMDR sessions to clients while gaining more confidence with the procedural steps and learning to easily recognize typical treatment effects. Then, when you have learned to readily differentiate typical treatment effects from blocked responses, you are advised to complete the basic training cycle at a Level II training which will cover advanced treatment strategies for challenging treatment situations.

Expect some incomplete treatment sessions after the Level I training. Feedback from thousands of EMDR-trained clinicians indicates that even when the client selection guidelines presented in the Level I training are followed, Level I-trained clinicians will have incomplete treatments with a significant percentage of clients. This underscores the need to complete the basic training in EMDR by taking the Level II training to refine the understanding of material taught in the Level I and acquire more advanced EMDR skills useful for blocked responses and in a range of diagnoses beyond PTSD.

Some clinicians believe that they should not start using EMDR at all until after they have taken the Level II training, but this is not the optimum strategy for most clinicians. The Level I training teaches clinicians to "stay out of the way" and make the fewest possible interventions during sets of eye movements (SEM) or other alternating stimulation, while the Level II training covers a more active strategy.

Most clinicians find it challenging to learn to "stay out of the way" and allow each client's therapy to unfold in its own way. Taking the Level II training, without first having an initial range of experiences applying the fundamentals of EMDR as taught in the Level I, can lead clinicians habitually to take too active a role and thereby divert clients from optimal treatment results. Taking the Level II training, without an initial set of EMDR application experiences, can also leave clinicians confused by the new material and needing to focus on mastering basic EMDR skills in the practice exercises, in which the aim is to apply more advanced strategies.

Be alert to family of origin issues in selecting clients for initial EMDR application. When clinicians with recent EMDR training are selecting clients for EMDR reprocessing sessions, there are general criteria to consider. Clients with family of origin problems that include physical or sexual abuse, verbal abuse, or neglect of basic physical or emotional needs of themselves, their siblings, or one of their primary care givers should be postponed until the clinician has more experience with simpler cases and preferably has taken the Level II training.

Do sufficient history-taking to determine that risk factors are not present before proceeding with trauma-focused reprocessing. Since clients with significant dysfunction in their family of origin may minimize their known histories of neglect or abuse due to shame over their past, direct, specific questioning about family circumstances and specific risk factors (such as use of physical punishment and childhood sexual experiences) may be necessary to identify clients with these types of issues in their history. In addition, since clients with

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complex PTSD generally avoid reminders of their traumatic memories and may have extensive memory lapses, even direct questioning may not always reveal early trauma and neglect.

Therefore, when the clinician is unable to obtain an adequate history or detects significant inconsistencies or minimization, the clinician is advised to select other clients for initial experiences in gaining confidence with EMDR reprocessing. After the clinician has more experience and confidence in typical reprocessing responses, a wider range of clients can be considered for EMDR reprocessing.

Three Classes of Clients and Targets for Initial EMDR Application

Clinicians are advised to focus on three general classes of clients and targets for their initial 20 to 30 EMDR reprocessing sessions. These clients are most likely to respond positively to the protocols taught in the Level I training and are least likely to require use of the advanced EMDR skills covered in the Level II training. These three classes of clients are described below, along with case examples for each and some general readiness criteria for trauma-focused reprocessing.

The case examples illustrate typical EMDR treatment effects with three types of uncomplicated clinical presentations. Keep in mind that, in any given case, what appears to be uncomplicated can change as new memories or aspects of the case are revealed during reprocessing. These case examples are composites and are intended to illustrate treatment possibilities.

Case Type 1: Clients without Significant Pathology

Clients without significant psychopathology whose history reflects a generally sound childhood can benefit with enhanced self-esteem, self-confidence and greater freedom to pursue their goals by working on mildly disturbing memories (small "t" trauma).

Fred was a 28-year-old shift supervisor at a production facility who, after six years of experience as an assembly worker, had been promoted four months earlier. He was referred by the company Employee Assistance Program Coordinator for time-limited treatment with a preliminary diagnosis of an Adjustment Disorder with Anxious Mood. According the EAP coordinator, after the initial excitement and enthusiasm about his promotion passed, Fred started to experience irritability at work and home and developed a mild sleep disorder. His on-the-job irritability with those he supervised led to a discussion with his manager followed by two meetings with the EAP Coordinator who made the referral for treatment. The goal of treatment was to help Fred adjust to his new responsibilities.

The EAP Coordinator helped enroll Fred in a set of supervisor training programs scheduled to begin in two weeks, so his need for skills enhancement would be addressed in those training sessions. The EAP coordinator suggested that the clinician might use EMDR to help Fred adjust to his new work responsibilities and gave Fred a copy of the EMDRIA brochure on EMDR.

The Level I EMDR-trained clinician determined in the history-taking that Fred was the second of four children from an intact, inner-city family. Two of Fred's siblings were employed and the third was a full time homemaker. Fred had a stable work history since completing high school and had no history of substance abuse or previous psychotherapy. His DES score was 8. Other than the specific symptoms reported with his work adjustment problems, there were no signs of other psychopathology. His hobbies included playing golf with his fiancée and fishing.

In the first session, after discussing his problems adjusting to his new position, the clinician helped Fred identify the job-related situations that most stimulated his increased anxiety. These included: leading production team meetings; giving corrective feedback, and making written comments in personnel files. A consistent limiting belief was triggered in each of these situations which Fred identified as: "It's not safe to make a mistake." He said he would rather believe "It's safe to make mistakes" and "I can handle my responsibilities well." While focusing on a recent awkward moment at a production team meeting, his pretreatment VoC on this preferred belief was between 2 and 3. His predominant feeling was anxiety with a sense of dread and he said he couldn't understand why he felt that way. His SUD level for this memory was between 6 and 7 and Fred felt the distress in his chest.

The clinician then taught Fred the safe place exercise and asked him to practice it the following week and to use it whenever these feelings were triggered. He gave Fred a description of the EMDR process they planned to use in their second session and the metaphor of being on the train and "just noticing the scenery passing by."

At the second session, the clinician reviewed what they had discussed at the first meeting. He asked Fred to consider when he might have ever felt this way before with the same body sensation and the same negative thought: "It's not safe to make a mistake." Fred then described a troubling incident from age ten. His older brother was away at a sports camp and his mother asked Fred to babysit his younger brother and sister one afternoon for a few hours while she went to the doctor. He had never babysat before and was very proud to be given that responsibility. As it turned out, Fred's mother had a

serious case of pneumonia which was successfully treated with antibiotics and did not require hospitalization. While she was at the doctor's office, Fred fixed his brother and sister lunch, played games with them, and gave them a bath.

His mother came home tired, feverish, and worried whether the medication would be sufficient or if she would require hospitalization, something the family could not afford. She uncharacteristically yelled at Fred for leaving bath water in the tub and on the floor in the bathroom and for leaving a sharp knife on the kitchen counter where his younger brother might have been able to grab it. Fred's mother also described in particularly vivid terms what might have happened to his younger brother if he had gotten hold of the knife.

Fred's pride at his first opportunity to take care of his brother and sister was punctured by her harsh words and he felt a great deal shame and disappointment in himself. For days after, as he helped his mother around the house while she rested in bed, he brooded about the frightening images of his brother getting the knife and hurting himself or his baby sister.

The negative and positive cognitions for this memory were the same as for the current stimuli of the production team meeting. The VoC was 2 and the SUD was 7. The babysitting memory was reprocessing with the standard protocol. First the clinician targeted the babysitting memory, reprocessing until the SUD was reduced to 0, the preferred cognition was installed to a 7, and a body scan revealed no residual physical distress. Then they reprocessed the production team meeting to a 0 SUD, 7 VoC, and clear body scan. Upon checking the other current stimuli, only one had any residual distress. This was also targeted and reprocessed.

The second session was closed with a debriefing and a request to log any significant memories, thoughts or dreams. In the third session, Fred reported no new disturbing memories or dreams. He reported he had slept soundly all week and had been much more self-confident and relaxed at the production team meeting. He also said his fiancée told him he seemed happier and more at ease all week. His first supervision training session that week had been an enjoyable experience and he felt a sense of pride and increased confidence about his new responsibilities. Fred said that he was slightly anxious about his responsibility to do a series of performance reviews for his production workers in a few weeks, something he had not done before. He added that he would soon be taking a training program that should help him with the instruction he would need to be successful.

The targets from the previous session were checked and both his memory and all current stimuli remained at a 0 SUD with a 7 VoC on the PC. A future template was installed regarding Fred's ability to learn the skills he needed to be confident with conducting the performance reviews. The third session was concluded successfully and Fred was told that he was welcome to call for a follow-up appointment should he experience any other difficulties. They made plans to check in briefly by phone in two weeks to see how Fred was doing. At follow-up, Fred reported that he was "doing great" and felt no need for further sessions. The next week, the EAP Coordinator called the clinician to thank him for helping Fred with his adjustment to his new responsibilities and to discuss another possible referral.

Case Type 2: Clients with Specific Phobias

Clients with specific phobias who do not suffer from another significant disorder (such as generalized anxiety disorder, social phobia, agoraphobia or another more serious disorder) and whose history shows a generally sound childhood can benefit from the phobia protocol.

Stewart was an auto mechanic, married with two children. His wife recently won a family vacation through a sales promotion at her job and the family had an opportunity to take a vacation overseas, something they could never otherwise have afforded. The trip, however, would require Stewart to get a vaccination and he was so terrified of inoculations that he refused to go to the doctor. Rather than fight about this with his wife any further, he agreed to see the clinician they had gone to two years before for marriage counseling.

The clinician was unaware of Stewart's needle phobia during the few sessions of marriage counseling, which were focused on issues related to their son's school problems. The clinician had recently taken Level I training in EMDR and thought that it might be the best way to help Stewart over this problem. The clinician knew most of Stewart's family history, but now learned that his injection phobia had begun when he underwent a series of injections at age eight to treat a severe allergy which had caused several emergency room visits when Stewart had suddenly become so asthmatic he was unable to breathe. As a young boy, Stewart had somehow concluded that the cause of his allergic reactions was the shots themselves even though as an adult he knew better. The mere thought of getting a shot made Stewart the adult fearful and begin to cough and wheeze.

The clinician asked Stewart to bring his inhaler, which Stewart used only on rare occasions during mild asthmatic reactions, to the next session. The clinician gave Stewart basic information about EMDR and the metaphor of being on the train. The clinician taught Stewart about the safe

(Continued on page 10)

(Getting Started - Continued from page 9)
place and installed it with eye movements. Stewart responded positively to the installation of the safe place and said he was looking forward to the next session.

At the second session, they targeted the memory of the injections Stewart received as a boy. Stewart's picture was the image of the doctor holding the needle preparing to insert it into his arm. The NC was: "I'm going to die." The PC was: "I'm safe and the injection keeps me healthy." The VoC was 2. The SUD was 8. Stewart felt intense anxiety in his chest and throat and had some difficulty breathing.

As they began the EM, the sensations in Stewart's chest became more intense at first and then, after the third SEM, Stewart said it was suddenly as if he was looking at the picture through the wrong end of telescope. It suddenly looked far away and unimportant. He started to laugh and then briefly cried, saying "It's over. It's in the past. I'm not afraid any more." The SUD was found to be 0 and the clinician completed the installation and the body scan.

With half of the session time remaining, the clinician decided to do the rest of the phobia protocol including contracting for Stewart to get the injection in two weeks. They did a future template in which Stewart imagined going to the doctor's office and getting the shot. Stewart said he felt no distress at all when he imagined this; in fact, he imagined talking with the doctor during the inoculation about how pleased he was with his wife for being so successful at work and winning the vacation for the family.

Stewart called the clinician three weeks later to say that the injection had gone fine and, although his arm was a bit sore a day or two later, it was a small price to pay for the chance to go with his children on such a special trip.

Case Type 3: Clients with Single Episode PTSD

Clients with single episode PTSD whose history shows a generally sound childhood and a good premorbid history are good candidates for EMDR.

Kathy was always an upbeat person who saw the bright side of things, until she witnessed a hold up by two armed men in a convenience store in which she was shopping six months ago. Over the next few weeks, she developed sleeping problems and gradually became more fearful and moody. While visiting the doctor's office for her daughter's checkup and immunization, she mentioned her problems to her family doctor. The doctor referred her to an EMDR (Level I) trained clinician for specific treatment.

At intake, the clinician administered the DES, the SCL-90R, the IES and a standard history-taking form. Kathy's DES score was 22. Her IES was in the clinical range at 24. Her SCL-90R Global Severity Index was 67 with elevations on a number of subscales including anxiety and depression. Her history showed no previous psychopathology and good adjustments to previous life challenges, including the death of her grandmother when she was 14 and a miscarriage during her first pregnancy.

The clinician learned that, in addition to developing disturbed sleep and nightmares, Kathy had gradually become generally fearful about going driving or shopping, worrying that she would encounter men with guns committing a crime. She lived in a low crime neighborhood and was safe in her home. She knew her fears were irrational, but was unable to shake them.

The clinician taught Kathy a structured relaxation exercise in the first session and also normalized her symptoms by giving her basic information about acute and posttraumatic stress responses and the changes trauma produces in the nervous system. At the second visit, the clinician learned that the relaxation exercise had helped a bit at home, but it failed to help when Kathy went out. The clinician normalized this response and gave Kathy information about overall treatment strategies including imaginal exposure, narrative and cognitive methods and EMDR, and the potential risks and benefits of each. Kathy mentioned that, if EMDR could work faster, she wanted to try EMDR first.

After further explanation of EMDR procedures, the clinician taught Kathy the safe place exercise, adding eye movements to enhance the experience and then asking Kathy to imagine using the safe place exercise at home and in the car. Kathy said she found the safe place exercise much more helpful than the progressive relaxation exercise of the first session and would use it during the week.

At the third visit, Kathy reported using the safe place exercise several times during the week and finding it helpful. In fact, she slept all night the night after the second session, but returned to troubled, light sleep and disturbing dreams the rest of the week. Kathy wanted to talk about some parts of the holdup that had not discussed during the first visit and, near the end of the third session, said she wanted to do some reprocessing on the holdup memory during the next session.

Near the end of that session, the clinician helped Kathy identify the picture, NC, PC, VoC, specific emotion, SUD and body location for the holdup memory. The NC was, "I'm not safe." The PC was, "It's over. I'm safe now." The VoC was 2, the SUD 9, the emotion fear in the belly. They then brought the session to a close with the safe place exercise and a reminder to keep a log.

In the fourth session, Kathy worked on the holdup memory with EMDR. The SUD and VoC were at the same

(Continued from page 10)
level at the start of the session as the previous week. After 40 minutes of EMDR, the SUD was reduced to 2 and the VoC had increased to 5. The clinician used the safe place exercise to help Kathy eliminate the residual distress and reminded her about keeping a log that week.

At the start the fifth session, Kathy reported sleeping through every night but the night before the fifth session. That night, she had a strange dream in which she yelled at the holdup men, something she had not done during the original event, because it would have been far too dangerous. The clinician suggested resuming the reprocessing at that point, focusing on the dream. They began with the dream image and returned to focus on the memory of the holdup, which was then rapidly treated to resolution with a 0 SUDS, 7 VoC, and a clear body scan.

In the following session, Kathy reported good sleep and a return to better spirits than she had felt in many months. She went shopping on her own for the first time in many weeks and experienced no fear in the car or in the stores. The clinician asked Kathy to imagine returning to the store in which the holdup took place and found a SUD of 5. They did a future template for visiting that store again, which processed uneventfully to resolution. Kathy asked to skip the next week and to return in two weeks for a follow-up visit.

At the follow-up visit two weeks later, Kathy reported feeling fine and was amazed at how long she had allowed the holdup to bother her. She thanked the clinician for the treatment and said she did not feel in need of further sessions. A phone call from the clinician six weeks later found Kathy as her formerly cheerful self, making plans for her summer vacation.

Recognizing Lack of Client Readiness for Trauma-Focused Reprocessing

While these case examples show clients with uncomplicated histories and comprehensive, rapid treatment effects, many clients present with more complex histories or need more sessions to build trust and reprocess their material. When clinicians with recent EMDR training are selecting clients for their first 20 to 30 EMDR reprocessing sessions, there are general criteria to consider to exclude more complex cases until the clinician has gained more skill and confidence in EMDR:

- Clients with family of origin problems that include physical or sexual abuse, verbal abuse, or neglect of basic physical or emotional needs of themselves, their siblings, or one of their primary caregivers should be postponed until the clinician has had more experience with simpler cases and preferably has taken the Level II training.
- Sufficient history-taking should be obtained to determine that these risk factors are not present before proceeding with trauma-focused reprocessing.
- Indications of missing resources may suggest the existence of more complex issues requiring Level II training and a need to postpone trauma reprocessing.

The following criteria should be considered as potential evidence that the client is not ready for trauma-focused reprocessing regardless of a clinician's EMDR training level. Alternate treatment approaches focused on client stabilization should be employed with these clients. A future article will address the use of EMDR Resource Development and Installation protocols with these clients:

- The client reports or is observed in the office being flooded with feelings of anxiety, fear or distress and is not able to identify the eliciting stimuli.
- Standard self-care and affect modulation methods, such as structured relaxation and guided imagery methods (such as safe place) do not alleviate client distress in the office or are not useful to the client between treatment session. This inability to modulate affect leaves the client vulnerable to emotional flooding during and between treatment sessions.
- The client is alexithymic (cannot name and describe feelings).
- The client shows persistent depressed mood (dysthymia), low self-esteem and cognitive distortions, but may not complain of depression because the client considers these symptoms normal.
- The client has many incomplete projects and avoids dealing with significant areas of concern. The clinician may suspect the client has more areas of dissatisfaction than have been reported.
- The client has episodes in which they cannot speak or can barely articulate their thoughts. The client appears confused or overwhelmed by emotional states at these times.
- The client cannot give coherent narrative accounts of events of the week (even with clinician prompting) such as stressful interactions with family members or co-workers. Instead, the client gives fragmentary accounts of these situations and then lapses into vague self-critical comments.
- The client shows poor impulse control (over money, anger, substance use, sexuality), is accident prone, tends to be manipulated by others, functions significantly below intellectual or work potential, avoids interpersonal conflict, is unable to achieve or maintain emotional intimacy, or shows alternating approach-avoidance behavior with personal goals or relationships. ⇔

INTERNATIONAL UPDATE

Francine Shapiro, Ph.D.
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Recent Research

We have reached the stage of research where ten articles purporting to test the efficacy of EMDR with phobias have been published. Unfortunately, not one of the articles has used the full phobia protocol described in my 1995 textbook. Recent additions to the literature claim to have used the protocols (Muris & Merckelbach, 1997; Muris, Merckelbach, Holdrinet & Sijsenaar, 1998; Muris, Merckelbach, Van Haaften & Mayer, 1997), but a blind review by four clinicians and researchers have clearly indicated otherwise. Unfortunately, these new articles have appeared in *Behavioural and Cognitive Psychotherapy, British Journal of Psychiatry*, and *The Journal of Consulting and Clinical Psychology*. Those interested may compare the protocol and procedures used, and those actually described in my textbook.

As I have mentioned numerous times before, it is vital that clinicians not only become vocal regarding clinical validity standards for research, but that they take an active role in research projects. A manual for conducting single-subject research is available at cost from the EMDR Institute. Written by Allen Rubin, Ph.D., the manual makes the projects easily understood and attainable for the average clinician.

Please consider doing research on the various EMDR protocols. There is an EMDRIA Research Committee to help you and numerous individuals to network with to assist in drafting your research. The future of EMDR practice is fully in the hands of the clinicians and those researchers dedicated to clinically valid assessment. If you are obtaining positive results with the protocols, please extend yourself to help demonstrate the applicability in the professional literature.

In Latin America

The Latin American EMDR training team is doing a fantastic job of disseminating the method in many pro bono arenas. The team consists of John Hartung as team leader; trainers Pablo Solvey, Raquel Solvey, Graciela Rodriquez, Michael Galvin, and Donna Bruzzese; and facilitators Priscilla Marquis, Laurel Parnell, Liz Snyker, Christie Sprowls, Cathy Wickham, and Barbara Zelwer. The most recent venture was a training in Colombia sponsored by Forjar, coordinated by Karen Correa and Linda Vanderlaan. At an EMDR Congress focusing on ending the cycle of violence, all eyes were again spilling over at a wonderful video, and a plea by one of the children for clinicians to help others who were suffering. This was particularly touching, because Linda Vandarlaan had worked with the child to eliminate her phantom limb pain. And, as she had predicted, "Tina" was indeed running and playing with other children again, pain-free and wearing a prosthesis.

Recent Efforts of HAP

As part of an EMDR Humanitarian Assistance Programs intervention, Gerry Puk trained about 80 mental health professionals from counseling agencies throughout Long Island in early November. This training was designed to provide access to EMDR to under served client populations in the New York area. HAP volunteer Carol Forgash, one of the training's coordinators, said the agencies served an extremely diverse group of low-income clients living in sectors with a high a incidence of substance abuse and violence of all kinds. The HAP training was limited to therapists whose agencies agreed to integrate EMDR into their treatment programs and could not afford to send them to commercial trainings. Elaine Alvarez and David Grand also arranged pro bono trainings for clinicians in Bedford Stuyvesant in Brooklyn. They worked with an organization called PURGE, headed by women who lost children to drive-by shootings and are attempting to eliminate guns from the inner cities. Additional trainings for this under-served population have been arranged for Oakland and San Francisco with Karin Kleiner and Linda Cohn serving as coordinators.

Because of HAP, survivors of extensive flooding in Fargo, North Dakota now have access to EMDR. Will Zangwill trained about 20 mental health professionals in Fargo late this year. A second training, scheduled to coincide with the one-year anniversary of the evacuation of Grand Forks, is in the planning stages. Barbara Korzun was the HAP coordinator for the project and networked with a number of agencies to make it happen.

The accompanying grid (on the facing page) indicates the number of projects HAP has completed in the last two years. All of the HAP work was done with volunteer labor and money donated by clinicians trained in EMDR. Unfortunately, the need has far outstripped our resources. The recent controlled studies have definitively shown that EMDR can vastly eliminate suffering and help stop the cycle of violence worldwide. However, the very global nature of our work makes us unsuited for most corporate donors, and we therefore have to rely on individuals. We are trying to raise funds to help incorporate EMDR into prisons, inner-city schools, and mental health agencies to help stop the violence on a domestic level. In addition, the international pro bono trainings help stop the violence worldwide. At this time, we have requests for joint trainings with both Israeli and Palestinian clinicians, as well as requests from Serbia, Sarajevo, South Africa, and many more. We simply have not had the funds to service these areas.

Please consider donating to HAP. Because HAP is non-profit (501 c 3), your contribution is tax-deductible. We are happy to send attractive donor cards to people to let them know that a donation has been made in their names. Please consider giving, not only around the holidays, but all the year through. In addition, if you are working with perpetrators or in the prison systems, please sign up for the HAP database. We are in the process of establishing a network of clinicians to share resources and design the most efficient protocols. ⇔

EMDR Humanitarian Assistance Programs (HAP)

Completed during the Past Two Years

SITUATION	LOCATION	SERVICE
Hurricane Andrew	Florida, USA	Clinical Intervention
Balkans War	Zagreb, Croatia	Training
Balkans War	Sarajevo, Bosnia	Training
Terrorist Bombing	Oklahoma City, Oklahoma, USA	Clinical Intervention, Training
Humanitarian	US Department of Veterans Affairs	Training
Civil War	Belfast, Northern Ireland (included trainees from Dunblane, Scotland)	Training
Rwanda	Nairobi, Kenya	Training
Humanitarian	Kiev, Ukraine	Training
Humanitarian	Colombia	Training
Combat Stress	US Army	Training
Balkans War	Belgrade, Serbia	Planning Stage
Humanitarian	Budapest, Hungary	Training
Humanitarian	Navajo Nations, USA	Training Scheduled
Humanitarian	Estonia	Planning Stage
TWA Flight 800	Montoursville, Pennsylvania, USA	Training
Flood Victims	Fargo, North Dakota, USA	Training
Humanitarian	Mid-East	Training
Inner City	New York, New York, USA	Training
Inner City	Washington, D.C, USA	Training Planned
Inner City	Oakland, California, USA	Training Planned
Humanitarian	Poland	Training Planned
Humanitarian	South Africa	Training Planned
Humanitarian	San Salvador, El Salvador	Training

EMDRIA World Wide Link (WWL)

Jocelyne Shiromoto, LCSW

As a founding Board member of EMDRIA, I would like to express my warmest appreciation to all who have given us your trust, patience and support through the most difficult "developmental stages" of this organization. I am sure that none of us ever imagined how much blood, sweat, and tears it would take. I am personally grateful to all who have given their time and talent to this ever so challenging and important endeavor of establishing EMDRIA.

A Little Background

As you may know, EMDRIA has had to re-organize its infrastructure to meet legal and IRS requirements. The re-organization has contributed to some confusion, especially around member support services. Until now, EMDRIA has not been legally structured to accommodate mutual benefits and supportive services for its members. As Carol York mentions elsewhere in this issue, we are pleased to announce that we are now prepared to do so.

In the past few months, the EMDRIA World Wide Link Committee has been busy developing a structure within EMDRIA that will provide regional support and on-going education for EMDRIA members. I would like to use this column to offer some history to hopefully resolve whatever confusion remains around this issue.

Before EMDRIA was born, EMDR clinician support services were provided by the non-profit organization, EMDR Network, Inc. The EMDR Network was established by Francine Shapiro to complement her for-profit training organization, the EMDR Institute. For its members, the EMDR Network provided a newsletter and national network meetings (in the San Francisco area) to exchange innovations in the clinical application of EMDR. It also encouraged those trained from the Institute to have study groups within their areas. The EMDR Network listed study groups in its newsletter as a courtesy to the membership. As the EMDR Network grew, trained clinicians began to volunteer to coordinate network regional meetings in other locations throughout the country and the world, with study groups remaining separate from the regional meetings.

When EMDRIA began to develop, it made sense for the EMDR Network to eventually relinquish the responsibilities of support services to EMDRIA. Until EMDRIA was able to assume that responsibility, some support services remained in limbo, especially the regional meetings. Nonetheless, many regional meetings continued to meet while waiting to be under the auspices of EMDRIA.

Since the term "Network" was used for EMDR Network, Inc., EMDRIA was legally required to use another term that also helped to lessen the confusion of "who's doing what"—thus, the development of the name "EMDRIA World Wide Link." To be consistent with our mission, we attempted to develop a supportive format for clinicians to continue to disseminate useful EMDR information while maintaining and promoting the highest standard of excellence and integrity in the practice of EMDR.

Functions of the World Wide Link

The primary function of the World Wide Link (WWL) is to support and facilitate the exchange of EMDR innovations and information among local, regional, national, and international professional communities. Its format is consistent with EMDRIA's bylaws and legal obligations.

The World Wide Link provides and consists of the following:

1. WWL Regional Meetings - These are non-profit local meetings comprised of EMDRIA members who meet at regular intervals for the purpose of enhancing their skills with EMDR through a variety of experiences that can include case presentations, discussions of clinical applications, research developments and updates, special presentations, special topic discussion groups, or practicum experience. These meetings are voluntarily coordinated by EMDRIA members under the auspices of EMDRIA. Guidelines and applications for coordinators are available through our administrative office. Those currently coordinating similar meetings are encouraged to apply.

2. EMDRIA Speakers Bureau - This is a list of EMDRIA members approved to provide voluntary EMDR special presentations (not trainings) to professional and non-professional communities. An application form is available through our administrative office.

3. Special Presentations - These are members from the Speakers Bureau who present "EMDR Special Presentations" at regional meetings and/or at other professional and non-professional settings.

4. EMDRIA Library - The Library is in the process of being developed. The plan is to make a collection of EMDR-related information—including research, professional and lay articles, journals, videos, and other educational materials—available to professionals and the public.

5. Opportunities for EMDR Continuing Education Experience (CEE's) - As you may know, EMDRIA will be making an inclusive professional *EMDR Register* available, with the re-application process conducted every two years. To re-apply, applicants will need proof of EMDR continuing education. Within its structure, EMDRIA is

(Continued on page 19)

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EMDR IN RECENT PRINT AND VIDEO

Francine Shapiro, Ph.D.
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Books

Sections on EMDR have appeared in the following recently-published books:

- ***Using Stories and Humor to Grab Your Audience by Joanna Slan. The text has been recommended by Toastmasters International and National Speakers Association as an aid to public speaking.***
- ***Winning! How Teens (and Other Humans) Can Beat Anger and Depression: A Handbook for Teens, Teachers, Parents, Therapists, and Counselors by Lew Hamburger.***
- ***Your Perfect Right: A Guide to Assertive Living by Robert Alberti & Michael Emmons.***
- ***Interviewing Strategies for Helpers: Fundamental Skills and Cognitive Behavioral Interventions by Sherry and Bill Cormier.***

Articles

Two recently-published articles may be of interest:

- ***Controlled Study of Treatment of PTSD using EMDR in an HMO* by Marcus and Marquis**

  Abstract: Sixty-seven individuals diagnosed with Post-Traumatic Stress Disorder (PTSD) were randomly assigned to either Eye Movement Desensitization and Reprocessing (EMDR) treatment or Standard Care (SC) treatment. Participants were assessed pretreatment, after three sessions, and at the completion of treatment using the Symptom Checklist-90, Beck Depression Inventory, Impact of Event Scale, Modified PTSD Scale, Spielberger State-Trait Anxiety Inventory, and Subjective Units of Disturbance. In addition, an independent evaluator assessed participants using DSM-III-R criteria for PTSD including Global Assessment of Functioning at three data points. The individuals in the EMDR treatment group showed significantly greater improvement with greater rapidity than those in the SC treatment group on measures of PTSD, depression, anxiety, and general symptoms. Participants who received EMDR treatment used fewer medication appointments for their psychological symptoms and needed fewer psychotherapy appointments.

  Reference: Marcus, S.V., Marquis, P & Sakai, C. (1997) Controlled study of treatment of PTSD using EMDR in an HMO setting. *Psychotherapy,* **34**, 307-315.

- ***Body Dysmorphic Disorder: Seven Cases Treated with Eye Movement Desensitization and Reprocessing***

  Abstract: Body dysmorphic disorder is an illness of generally chronic course which can lead to significant impairment of social functioning, unnecessary plastic surgery and even suicide. It is little understood and treatment regimens have been of uncertain efficacy. Eye Movement Desensitization and Reprocessing (EMDR) is a newly-developed psychotherapeutic procedure used in the treatment of posttraumatic stress disorder, grief reactions and generalized anxiety. In this paper, its use is described in seven consecutive cases of body dysmorphic disorder. Improvements were obtained in six of seven patients, five of whom had a complete resolution of their symptoms. The EMDR treatment time was 1-3 sessions. It appears as though directly targeting the precipitating event and/or intrusive imagery with EMDR can assist in the remediation of the disorder.

  Reference: Brown, K.W., McGoldrick, T & Buchanan, R. (1997) Body dysmorphic disorder: Seven cases treated with eye movement desensitization and reprocessing. *Behavioural & Cognitive Psychotherapy*, **25**, 203-207.

A recent article describes the prevalence of body dysmorphia in anxiety-disordered patients (Wilhelm, Otto, Zucker & Pollack, 1997, Journal of Anxiety Disorders). Clinicians presently treating body dysmorphic disorder can add to the knowledge base by using Allen Rubin's manual to document cases. Please remember that any four cases of EMDR compared to any presently used treatment can place EMDR on the Empirically Supported Treatment List as "probably efficacious." Any two independent case series of 10 or more can place EMDR on the list as "well-established."

You are all doing quantifiable clinical work. Please consider adding to the larger knowledge base by officially documenting your work.

Other Recent Publications

The following have also recently been published:

- ***Eye Movement Desensitization and Reprocessing (EMDR) Treatment for Combat-Related Post-traumatic Stress Disorder.***

Summary: 75% of the combat veterans suffering PTSD since the Vietnam war no longer maintained the PTSD diagnosis after twelve sessions. This is the only study of EMDR with combat veterans using an acceptable level of fidelity, and a clinically valid number of sessions. Other studies of combat veterans have attempted to test the effects of EMDR using only two sessions, or focusing on only one or two memories. We need more studies that evaluate EMDR appropriately with this population of multiply-traumatized victims.

Reference: Carlson, J., Chemtob, C., Rusnak, K., Hedlund, N., and Muraoka, M. (1998). Eye movement desensitization and reprocessing (EMDR) treatment for combat-related posttraumatic stress disorder, *Journal of Traumatic Stress*, **11**, 3-24.

- ***Brief Psychological Intervention with Traumatized Young Women: The Efficacy of Eye Movement Desensitization and Reprocessing***

  Summary: Two sessions of EMDR brought the subjects to within one standard deviation of the norm. The effect sizes were twice as large as the active listening control. This study has exciting implications for prevention as early traumatization creates a high risk factor for later victimization.

  Reference: Scheck, M., Schaeffer, J. & Gillette, C. (1998) Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. *Journal of Traumatic Stress*, **11**, 25-44.

- ***Comparative Efficacy of Treatments for Posttraumatic Stress Disorder: A Meta-analysis.***

  A meta-analysis of all known treatments for PTSD found that the best treatments for PTSD were EMDR and behavior therapy. The effect sizes of EMDR were equal to those of behavior therapy, although the EMDR treatment time was only one-third the number of sessions.

  Reference: Van Etten, M. & Taylor, S. (in press). Comparative efficacy of treatments for posttraumatic stress disorder: a meta-analysis. *Clinical Psychology & Psychotherapy.*

Videotape Series

I am happy to announce a new videotape about EMDR in the American Psychological Association Psychotherapy Videotape Series: *EMDR for Trauma: Eye Movement Desensitization and Reprocessing.*

Purpose of the Series: The American Psychological Association Psychotherapy Videotape Series II presents distinguished psychotherapists of different theoretical orientations demonstrating specific treatments for specific problems and populations. Designed for clinical training as well as for continuing education, the videotapes show spontaneous and unscripted sessions, typically representing the third or fourth session in an ongoing course of psychotherapy and typically lasting 40 to 50 minutes. The clients are portrayed by professional actors on the basis of real case material. (Note: The tape (Item # 4310440) can be ordered through APA Press at 800-374-2721 or via their Internet address: order@apa.org.) ⇔

~

Mark Your Calendar
to Join Us For..

The

1998 EMDR International Association Conference

July 10th-12th

EMDR ~ Treatment & Transformation

at

The Omni Inner Harbor Hotel
101 West Fayette Street
Baltimore, Maryland 21201
(410) 752-1100

Look for the Conference Brochure coming soon.

If you are interested in renting Exhibitor Space, please contact Wendy Freitag at 414-797-0315.

~

(World Wide Link - Continued from page 14)
facilitating a process to provide CEE's to those who attend the EMDRIA Annual Conference, regional meetings, special presentations, or any other EMDRIA-approved workshops or presentations from other entities. The designated number of CEE's needed for the registry within a period of two years is tentatively twelve (12). The number of CEE's earned through each educational experience is in the process of being determined, as well as the translation of earned CEU's to CEE's when EMDR practitioners attend other trainings or other events through other entities that can be approved by EMDRIA.

6. EMDRIA Newsletter Listings of "Not for Fee" Study Groups - EMDRIA "encourages" those formally trained in EMDR to attend Study Groups, however, *Study Groups are not under the auspices* of EMDRIA*. Study Groups are defined as any individuals who come together after EMDR training to continue their "studies" of EMDR to develop confidence and competency in EMDR clinical applications. As a benefit to EMDRIA's members, Study Groups can be listed in future issues of *The EMDRIA Newsletter* (please see form below).

NOTE: For those outside of the United States, optional formats will be made available to respond to the individual needs of each economy, culture, and legal professional system.

World Wide Link Committee Members

We look forward to helping you implement all the above and to your continued patience and support. If you have questions or concerns, please contact our administrative office or any of our World Wide Link Committee members listed below:

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

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

If you have an existing Study Group or will be starting a Study Group and want it posted in the next *EMDRIA Newsletter*, please submit it to the EMDRIA administration office by May 31, 1998. When submitting your Study Group, please provide the following information (by completing and sending this form or providing the information in another format.):

My Name: _____

Study Group Date: _____ Day: _____ Time: _____

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

City: _____ State: _____ (no street address necessary)

Phone: _____ Fax: _____ Email: _____

EMDR AND BIBLIOTHERAPY

Kate Cohen-Posey, MS, LMHC LMFT

I fell in love with EMDR after my Level I training in October of 1995 and have used it as much as possible since. Using it with people who have experienced trauma is like having a front row seat to the healing processes of the universe. I no longer struggle with the perennial question: "What do I do next?" When processing becomes stuck, cognitive interweaves usually come to me during an eye movement set.

There may be presenting problems (other than PTSD) that may yield far less dramatic results than, or which may not require, EMDR. What people may need first is information about the distress they are experiencing. This article explores (1) how bibliotherapy can support the psycho-educational processes that occur in therapy, (2) how psycho-education fits within full EMDR protocol, and (3) theoretical underpinnings for the need for psycho-education for various disorders.

Theory

The Accelerated Information Processing model explains that the perceptions, images, sensations and thoughts that occur during a traumatic event become "locked" in our nervous system due to possible changes in neurotransmitters that accompany the experience. Although we may acquire adaptive information later in life, excitatory state-specific material continues to be triggered by a variety of internal and external stimuli.

To borrow a terminology from cybernetics, during a traumatic incident, it is as though a file is opened on our hard drive with faulty or outdated information ("I'm not safe" / "I caused this" / "I'm powerless"). Even though we may sometimes open a file with adaptive information, when certain stressors are present, we click on the primitive, out-dated file containing negative cognitions. During EMDR, adaptive information is "cut and pasted" into the primitive file and negative cognitions can be "over-written" when the file is saved.

Our problem as therapists is that we do not have access to "the hard drive directory." We do not know how many megabytes are in the "It's My Fault" file or how much information is available to cut and paste from an "It's Not My Fault" file. When working with trauma, there are usually files with accurate information: "It's Over," "I'm Safe," "I Have Choices," "It's Not My Fault," etc. However, the highly-charged files opened during the trauma are frozen and require processing before more recent files can be accessed.

Unlike trauma, other presenting problems may not have any files opened with adaptive information about the issue or such files may contain little data. A parent who flies into a powerless rage (oxymoron intended) when her child is non-compliant may simply not have data stored in an "I Can Do Something" file, or an "I'm Not Important" file may click on in charged situations that blocks access to the adaptive information.

Psycho-Education and EMDR Treatment

The first interface between EMDR and the need for psycho-education is to determine if the *lack* of adaptive information *or* if the *presence* of charged cognitions are limiting functioning. If the angry parent above resists a behavior prescription to withhold all privileges from a non-compliant child and immediately returns them when a task is completed, it is likely that a negative cognition is operating. When a spouse does not follow through on useful behavior changes that would help her husband be more helpful, cognitions like, "I cannot upset anyone" or "I'm responsible for everything" may be present. During preparation and assessment phases of treatment, it can be tremendously useful to learn how well clients can respond to direct suggestions to determine the need for dynamic processing.

Other disorders require therapists to help clients build a store of adaptive information before any processing begins. Before doing EMDR, it helps those with panic disorder to understand how their symptoms are the body's natural responses to a surge of adrenaline[2]. Then, while processing trigger situations (confinement, being away from a place of safety, conflict, public exposure, etc.), the client will have less need of or be more receptive to cognitive interweaves from the therapist. A chronically angry client may need considerable education from his therapist before he can identify that his demands for order, cleanliness, etc., are the results of OCD and are worth targeting.

After processing traumatic material (both T & t), clients may need to acquire skills they never learned while laboring under the effects of a particular negative cognition. A client who was humiliated as a child may have no idea how to defuse or deflect unwarranted criticism even after the charge of the initial disgrace has been removed. In fact, such techniques as acting as if, labeling disappointment, agreeing with possibilities, etc., are not widely known in our culture and there is not even a "collective unconscious" from which to draw.

The Value of Bibliotherapy

If therapists are perfectly capable of educating their clients, what is the need for bibliotherapy and what is the advantage of having it readily available in your office?

Witness the following scenes that took place with my clients during the week prior to writing this article:

- After eliminating sexual dysfunction (with EMDR) resulting from an early incident of abuse, "Jane" reported that she still frequently felt anger in the pit of her stomach. After a set of eye movements, she recalled noticing the anger when her daughter began "bringing home" B's instead of A's and when her husband sat on the sofa after she tidied it. She was shown a checklist from *Not Again*[4] identifying several ordering, contamination, and repeating compulsions in which she engaged. She was amazed to think that she could have OCD, although she admitted to

washing her hands and dishes in Clorox.

- "Linda," who complained that she could not get her husband to listen to John Gray's tape of *Mars and Venus in the Bedroom*, literally grabbed *Couple Magic*[5] from my hands and begged to buy a copy when she was shown three pages summarizing Gray's main points.
- A mother, distraught over her three-year-old's oppositional behavior, was given *Powerful Parenting*[6] to read while I worked with her son. She was eager to take it home so she could have a handy reference for responding to back talk.
- After experiencing profound relaxation during a safe place exercise, a client asked, "Do you have anything I can read to practice this at home?"

As these examples and other points in this article suggest, psycho-education through bibliotherapy is a powerful tool that can accomplish the following:

- It can be used diagnostically to assess any negative cognitions that might be interfering with a client's ability to respond to direct interventions.
- It is efficient, allowing therapists to focus on dynamic processes in treatment while clients study needed information on their own.
- It builds stores of adaptive information that clients can access during processing.
- It provides a visual that reinforces therapists' spoken words. Many people have to be exposed to new ideas from several sources before those ideas can become truthful for them.
- It is a resource that refreshes clinicians' memories and helps them design treatment programs for complex problems as they review materials with clients.

Without perhaps being aware of it, many clinicians use bibliotherapy frequently. They may mention books they know contain valuable ideas for clients, or they may have a store of handouts readily available. Like all other therapeutic interventions, bibliotherapy becomes a more powerful tool when used with precision. We live in an age of information and should give some thought to how to co-opt the ever-expanding availability of hard data into our treatment protocols.

NOTE: *Golden Nuggets Press (see ad this page) is dedicated to developing psycho-educational materials for clinicians and innovating ways the written word can assist therapy.*

ENDNOTES:

[1]F. Shapiro, *Eye Movement Desensitization and Reprocessing* (New York: Guilford, 1995), p.30.

[2]K. Cohen-Posey, *Peace is on the Other Side* (Haines City, FL: Golden Nuggets Press, 1997), pp. 2-6.

[3]K. Cohen-Posey, *How to Handle Bullies, Teasers and Other Meanies* (Lakeland, FL: Rainbow Books, Inc., 1995).

[4]K. Cohen-Posey, *Not Again* (Haines City, FL: Golden Nuggets Press, 1996) centerfold.

[5]K. Cohen-Posey, *Couple Magic* (Haines City, FL: Golden Nuggets Press, 1997) pp. 9, 20.

[6]K. Cohen-Posey, *Powerful Parenting* (Haines City, FL: Golden Nuggets Press, 1995).

⇔

BioLateral Sound Recordings: An Effective Alternative to Eye Movements

Invented and Produced by
David Grand, RCSW, EMDR Facilitator

What Are BioLateral Sound Recordings?

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

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

How Were BioLateral Tapes Developed?

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

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

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

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

How Is BioLateral Used?

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

How Will My Client's Benefit from BioLateral?

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

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

- With Bio*Lateral* tapes and CDs, sets can last for many minutes and may contain hundreds, and sometimes thousands, of repetitions.
- Bio*Lateral* can even be played during a non-EMDR session for deepening the process and enhancing insights.
- A number of therapists have reported that Bio*Lateral* has helped some dissociative clients process with less agitation.
- Clients can listen to Bio*Lateral* throughout the session, even when dialoguing with the therapist, often helping clients to experience deeper meaning, greater insight, and synthesis of material.
- Bio*Lateral* can be used in between sessions to reduce client agitation, generalized anxiety and panic attacks, insomnia, and to understand and control cravings and compulsive behaviors.

BIO*LATERAL* TAPES AND CD CURRENTLY AVAILABLE

Bio*Lateral* 1—*Original Recipe*

Comprised of six separate tracks, experimentally mixed, using the healing sounds of ocean waves, a Tibetan bell, and an Indian drum as well as Evan Seinfeld on the synthesizer. The tape also utilizes used computer technology that helped to cover frequencies across the sound spectrum. The free-form production process infused Original Recipe with a human, creative, and spontaneous essence.

Bio*Lateral* 2—*Going To Wave Lengths*

Combines ocean sounds with a bilateral brush tone. This tape is especially helpful for processing with clients who are easily distracted and is particularly effective for reducing insomnia and agitation in between sessions.

Bio*Lateral* 3—*Round the Lake*

Fully integrates the bilateral stimulation into music which sounds both Gaelic and Eastern. It includes a background harp with bass guitar tone and Evan Seinfeld live in studio on guitar.

Bio*Lateral* 4—*A Simple Progression*

Presents a soothing and pleasant alternative to the monotonal audio machines. Effective with highly distractible clients due to the absence of background sound or music. Utilizes an eight-step progression of piano chords simply delivered alternating between left and right ears.

JUST RELEASED IN CD FORMAT! . . . *The Best of* Bio*Lateral*

Contains all four Bio*Lateral* varieties (Original Recipe, Going to Wave Lengths, Round the Lake, and A Simple Progression) on one CD, digitally remastered for the highest sound quality possible. Clients can easily choose which Bio*Lateral* melodies they want to listen to, in or out of session. (Set CD player to repeat for continuous use of one melody.)

For More Information on Pricing and Other Bio*Lateral* Services:

Please visit our website at WWW.BIOLATERAL.COM or contact David Grand at:

E-mail: DGrand1952@aol.com
Telephone: (516) 785-0460
Fax: (516) 799-7625
2415 Jerusalem Avenue
Suite 105
Bellmore, NY 11710

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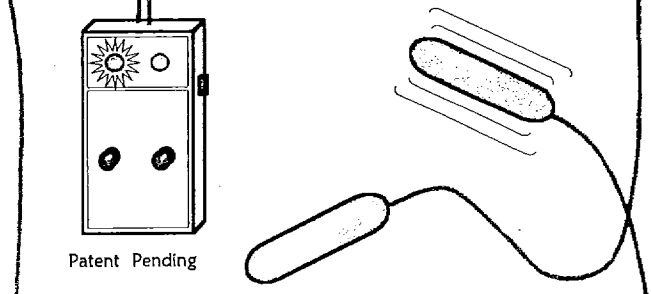
TheraTapper™

For EMDR® Therapy

A convenient alternative to manual tapping.



Patent Pending

SchmidtWerks, LLC
Shirley Jean Schmidt, MA, LPC, President
8535 Wurzbach Rd, Suite 215
San Antonio, Texas 78240

◈ ◈ ◈

To hear a recorded message anytime of pricing & ordering information, call **(210) 561-7881** or e-mail us at **sjschmid@netxpress.com**

The TheraTapper consists of a small hand-held control box (with two knobs and two blinking lights) connected to two small canisters by two 6-foot wires. The canisters, which fit easily into the client's hands, briefly pulse in an alternating fashion, first one, then the other. Two control knobs adjust the tactile experience to suit each client. One knob adjusts the pulse length (short to long), the other adjusts the rate of alternating pulses (slow to fast). Two small lights at the top of the TheraTapper blink on and off in an alternating fashion with each pulse, giving real-time visual feedback about the length and rate of the stimulations. A power switch on the side operates independently of the two knobs so settings remain fixed when the box is turned off and on between sets. It operates efficiently with two AA batteries. It is lightweight and portable, and can easily fit in a purse.

- ◈ Passive stimulation; requires no effort from client
- ◈ Non-intrusive of personal space
- ◈ Safer for sexual abuse survivors than therapist touch
- ◈ Client and therapist can easily dialogue during sets
- ◈ Sets can be very long without strain to client or therapist
- ◈ Processing with eyes closed can lead to deeper processing
- ◈ Canisters can be placed anywhere, in hands, pockets, etc.
- ◈ Tactile stimulation seems to be reassuring and grounding
- ◈ Soft and subtle audio stimulation comes with each pulse
- ◈ No stress to therapist neck, back, wrists, etc.
- ◈ Kids think it's fun
- ◈ Take notes during sets
- ◈ Inexpensive, cost effective

What EMDR® Therapists Say About The TheraTapper™

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

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

"Many thanks for introducing me to the TheraTapper - a wonderful technical support. It is an excellent alternative to manual tapping, because not only is it less intrusive with regards to personal space & boundary issues, I find it to be much more comfortable for the client as well as for the clinician. As a bonus, the low "buzzing" serves as a subliminal auditory stimulus. The TheraTapper is small, compact and easily transported."
Sharon Toole, Toronto

"I have used my TheraTapper with kids and found it to work effectively."
Carol York, MSW, Austin

"I'm probably one of the first users of TheraTapper and have used it now on four patients. Each of them had been reluctant or unable to respond to eye movements or any kind of physical touch -- such was the severity of their trauma. The TheraTapper performed its task well. I was able to maintain the alternating movement for as long as there seemed to be visible signs of something internal happening. In two cases, my clients talked throughout the sets, producing far more information than could ever have been retrieved in that time, and processing it as well. The other two preferred closed eyes and silence. All four showed improvement and relief over several sessions. I'm happy with this tool."
Irene R. Mazer, PhD, Puget Sound

"I use it occasionally rather than regularly but with excellent results when I do. I find most clients prefer audio but there are some who seem not to be able to process this way. This is when the TheraTapper really scores. For a few, it has been the only way they can process - with excellent results - clearly superior to other methods in these few cases. Also, I find that I am personally less responsive to the visual methods if I have something I wish to process. I relax well with audio, but for me the tactile works better for processing."
Philip Dutton, Consultant Clinical Psychologist, Central Scotland UK

"I have wrist problems which were exacerbated by manual tapping. I am grateful the TheraTapper allows me to provide tactile stimulation without straining my wrists. I am also finding the TheraTapper to be a great aid in just helping clients relax as we discuss issues."
Elise Orman, PhD, Austin

How to Join the EMDR Institute Discussion List

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

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

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

Purpose of the Discussion List

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

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

Welcome contributions to the discussion include:

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

How to Subscribe to the Discussion List

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

LISTSERV@MAELSTROM.STJOHNS.EDU

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

LISTSERV@MAELSTROM.STJOHNS.EDU

In the text of the message, enter:

SUBSCRIBE EMDR Firstname Lastname

Discussion List Leaders

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

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

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Phone: (707) 579-9457

Two-Week Discussions Led by EMDR Institute Staff

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

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

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

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

I look forward to seeing you online. ⇔

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E-mail: EMDRIA@aol.com
Web: www.emdria.org

Call for Nominations for EMDRIA Board of Directors

Nominations are now being accepted for positions on the Board of Directors of EMDRIA. There are three vacancies on the Board and three offices to be filled: President-Elect, Secretary-Elect, and Treasurer-Elect.

The EMDR International Association Board is a working board and Directors are responsible for the development of policy, programs and financial matters of the association. Directors meet by conference call every other month (and the executive committee meets monthly and as needed). They act as Chairpersons or Board Liaisons to the committees created by the Board. Terms for Board Members are three years. Officers elect serve one year in the "elect" position until assuming the full office the following year.

The Nomination Committee is currently preparing an election slate. Members are encouraged to contact one of the following Committee Members if they wish to place a name in nomination:

Peggy Moore
Chairman and Secretary of EMDRIA
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pvmoore@unm.edu

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Marluber@aol.com

Kay Werk
(614)274-3803
kaywerk@freewwweb.com

Promote Your Business, Practice, or Product at the 1998 EMDR International Association Conference

The perfect way to bring attention to your business, practice, or product is to advertise in the program materials distributed during on-site registration for the 1998 Conference. Although space is limited, business card ads and advertising inserts to be included with the registration packet are still available. We also invite you to participate as an exhibitor at the Conference.

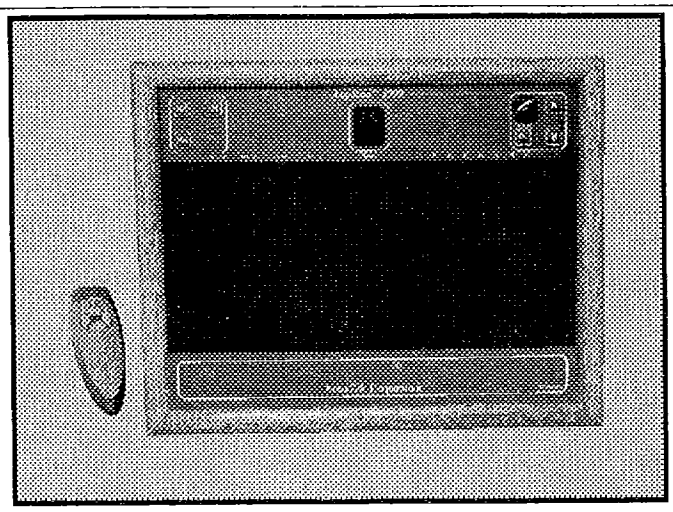
For more information on advertising space in the Conference Program, please contact Gayla Brown at the EMDRIA office at (512) 451-5200.
For more information on available exhibitor space at the Conference, please contact Wendy Freitag at (414) 390-1356.

NeuroTek Corporation

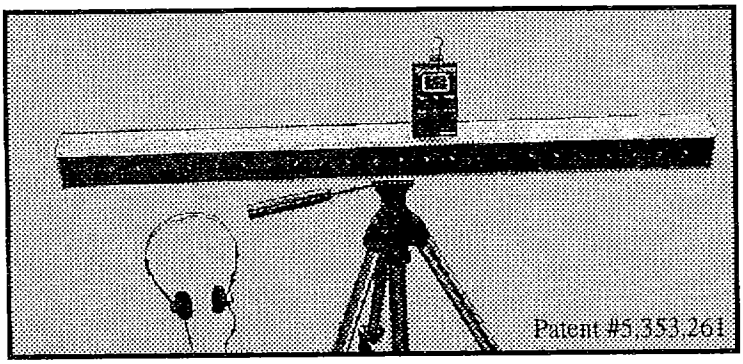
Meet The EMDR Clinician's Assistants

The LapScan™ 2000

- 4 Visual eye movement patterns
  - Horizontal line
  - Diagonal line
  - Circular pattern
  - Infinity - figure 8
- 8 Different tones for auditory stimulation
  - Ideal for vision impaired clients
- Headphones & cordless remote control included.
- Great for portable applications.
- Use the built in battery or plug it into the wall.
- Attractive 12" x 15" oak framed enclosure.
- Optional carrying case available.



The LapScan™ 2000



The EyeScan™ 2000S

The *Original* EyeScan™ 2000S

- 24 scanning lights for visual stimulation.
- Alternate ends only mode.
- Alternating tones are synchronized with lights.
- Wide range of speeds.
- Use with or without sound.
- Counter keeps track of repetitions per set.
- Tripod mounting allows diagonal scanning.
- Headphones and tripod included.
- Optional carrying case available.

The AudioScan™ 2000

- Sound only version of EyeScan.
- Compact, lightweight design.
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- Developed for vision impaired clients.
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- Easy to use anywhere.
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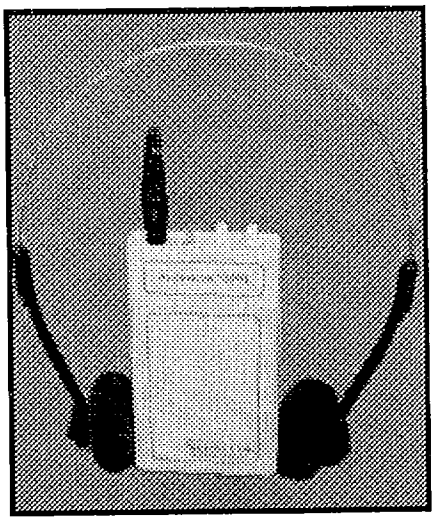

The AudioScan™ 2000

With hands-off administration of EMDR, the clinician is free to observe the client's behavior closely and take notes. These EMDR instruments also help prevent clinician fatigue and lower distractions for the client. They are effective therapeutic tools and only available from NeuroTek.

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Specializing in quality EMDR therapy products since 1992.

A portion from the sales of all EMDR instruments goes towards further EMDR research.

IDENTIFYING BLOCKING BELIEFS WORKSHEET

Problem I Want to Solve _____

	Feels Completely False ——> ——>Feels Completely True 1 2 3 4 5 6 7
I'm embarrassed that I have this problem.	
I will never get over this problem.	
I'm not sure I want to get over this problem.	
If I solve this problem, I will feel deprived.	
I don't have the strength or the will power to solve this problem.	
If I really talk about this problem, something bad will happen.	
This is a problem that can only be solved by someone else.	
If I ever solve this problem, I will lose a part of who I really am.	
I don't want to think about this problem any more.	
I should solve this problem, but I don't always do what I should.	
I like people who have this problem better than people who don't.	
It could be dangerous for me to get over this problem.	
When I try to think about this problem, I can't keep my mind on it.	
I say I want to solve this problem, but I never do.	
It could be bad for someone else for me to get over this problem.	
If I get over this problem, I can never go back to having it again.	
I don't deserve to get over this problem.	
This problem is bigger than I am.	
If I got over this problem, it would go against my values.	
Someone in my life hates this problem.	
There are some good things about having this problem.	
Frankly, I don't have a problem.	
I've had this problem so long, I could never completely solve it.	
I have to wait to solve this problem.	
If I solve this problem, I could lose a lot.	
If I solve this problem, it will be mainly for someone else.	

REFERENCE:

Popky, A.J., Smoking Protocol, EMDR Annual Conference, Sunnyvale, CA, 1994.

(Reprinted with corrections from December 1997 EMDRIA Newsletter. Please refer to Jim Knipe's article regarding use of this worksheet.)

EMDRIA Newsletter Advertising Rates

DISPLAY ADVERTISING (Effective March 1, 1998)

	1 ISSUE		2 ISSUES		3 ISSUES	
	Member	Non-Member	Member	Non-Member	Member	Non-Member
¼-Page	$80	$100	$100	$120	$120	$140
½-Page	$100	$120	$120	$140	$140	$160
Full-Page	$120	$140	$140	$160	$160	$180
Two Page	$175	$200	$200	$225	$225	$250

INSERTS

	Member	Non-Member
Per Issue/Per Sheet	$100	$125

CLASSIFIED ADS (3 ¼" X 2")

	Member	Non-Member
Per Issue	$30	$60

Please refer to the Newsletter Submission Requirements provided in this issue for specific information on drafting, formatting, and submitting ads.

EMDRIA NEWSLETTER SUBMISSION INFORMATION

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

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

Please submit articles and other contributions to the Editor:

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DEADLINE FOR NEXT NEWSLETTER

MAY 31, 1998

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If you have not joined EMDRIA™ for 1998, this will be your last *Newsletter!*
Please see the Membership Application on page 15.

Inside this Issue of *The EMDRIA™ Newsletter:*

Coming Events and Deadlines

May 31st

Contributions to next *Newsletter*

Submissions of EMDR Study Group Information

July 10th-12th

Annual EMDR International Association Conference

August 20th

Contributions to Fall 1998 *Newsletter*

September 6th-8th

Conference of the International Association of Cognitive and Behavioural Therapy in Cork, Ireland