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Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

 P.O. Box 51010, Pacific Grove, CA 93950-6010 (408) 372-3900 FAX (408) 647-9881

Table of Contents

STRAY THOUGHTS
Francine Shapiro, Ph.D.
Senior Research Fellow
Mental Research Institute
Palo Alto, CA

PROCEDURAL ELEMENTS

Over the years I have been asked a number of times why the EMDR procedural steps are done in the present order. I would like to give a brief summary to clear up any confusion.

The client is asked to start with an image because that allows an initial access to the stored information. The image also is assumed to have within it a summation of the relevant cues. The cognitions are then elicited in order to handle the more "intellectual" or meta-perceptual aspects while the client is relatively disengaged from the material. Once the client has a high level of distress, it is often much more difficult to elicit the positive assessments.

The negative cognition is elicited directly after the image in order to gain access to— and heighten— the strata of dysfunctional information that would be relevant to self-assessment. Identifying the negative cognition at this juncture allows the client to change his/her frame of reference to a point necessary to evaluate it. By this means, s/he begins to see that it is irrational and undeserved. The positive cognition is then elicited because it can more easily be identified before the dysfunctional material is fully accessed and because its direct placement after the negative cognition allows the client to more easily choose a polar opposite. A "No" concept is, of course, associated with a "Yes" concept. It also allows an important change of reference. Even though the positive cognition may not be highly probable during the present state of mind, it also offers a potential light at the end of the tunnel. Eliciting the information also begins to activate those neuro networks that contain the positive information, thereby theoretically making them more accessible for assimilation into the target network.

Asking the client to then pair the image and the negative cognition causes the dysfunctional material to be stimulated to a greater degree, so the clinician would need to have done all the preparation work before hand. The client is then asked to identify the emotion because while it is useful to have a label for clinical purposes, it also demands more of an evaluative/ cognitive assessment. This is followed by the identification of the SUD level—also for evaluative purposes— and then the location of the body sensation. It is preferable to ask for the SUD first, because those clients who have a difficult time locating sensation can often be helped along by asking: "You said you felt a 7 SUD.

Where do you feel the 7?" This final step joins the client's awareness of image, negative cognition, and body sensation so that reprocessing can immediately begin.

While some clinicians report that they prefer doing the steps in a different order, I suggest evaluating the reasons for the present order that I have described and then rethink the variations. If you still believe another way would be better, by all means write to me with your reasons and results.

EMDR has to continue to change and grow for it to remain vital and vibrant.

CLINICAL EVALUATION AND RESEARCH

I want to reemphasize that gross deviations from the procedural steps might best be inaugurated only after sufficient clinical evaluation and research has been done. There are a sufficient number of single-case and case series designs to make an initial investigation feasible. For instance, I have heard clinicians say that they do not use the negative or positive cognition, etc. Please make sure you are making your choices for valid reasons, not simply because it is easier. Most of the steps have multiple reasons for being there. The concise procedural elements not only access material for processing, but serve to aid in clinical containment. The client will generally be less disturbed during and after processing if all the steps and procedural elements are maintained (even if in a different sequence). The eight phases of treatment are also delineated for that purpose.

At the annual EMDR conference we had a "Town Meeting" and panel discussion of "What Can We Learn from the False/Delayed Memory Controversy." I chaired the panel with Walter Young, MD, Wendy Maltz, LCSW, and David Calof. What we need to keep in mind, I believe, is that regardless of what side of the controversy you feel most in tune with, there is hardly any disagreement that there is therapy in our profession, based on clinically unproven conjectures and theories, that has caused harm to clients.

Since EMDR is now in the hands of approximately 14,000 clinicians, it is being used within the context of many different models, by therapists who were schooled with many different presuppositions. I have heard a number of clinicians make statements like: "You have to get worse before you get better; You have to get to the really horrible memory that underlies all of it; You have to reexperience and abreact all the trauma; You have to be in therapy for years to get well and stay well." The different therapists that make some or all of these claims even come from a variety of clinical backgrounds and models of therapy. However, I have not found those presuppositions to be true in my eight years of EMDR practice. Nor have these presuppositions been validated by the work of other EMDR clinicians. If these concepts were true, then by now we would have had reports of clients who were seen in 1987-1991 regressing and becoming highly symptomatic again; yet, the reports I have received show them holding steady.

I think we have to be very wary of molding our EMDR clinical practices to previous models because EMDR with its rapid treatment effects, encourages a paradigm shift. If any clinician believes that a different paradigm is more appropriate, I would only ask that a thorough examination be done by researching the observable treatment effects derived from both models. Controlled research on EMDR has shown that robust effects are maintained after 1 to 3 sessions of treatment (Renfrey & Spates, 1994; Shapiro, 1989; Vaughan, et al., 1994; Wilson, Covi, Foster, & Silver, 1995; Wilson, Becker, & Tinker, in press). Clients are able to leave therapy symptom-free in weeks, or months, of therapy instead of years. Careful clinical evaluation has indicated that even those clients with diagnoses such as dissociative disorders and borderline personality disorder are showing great improvement or complete resolution within much shorter treatment time (e.g., two years) rather than decades of treatment. If variations of model and procedure are not obtaining the same positive results— if the client is undergoing more suffering, more severe abreactions, more decompensation prior to improvement— I would ask the clinician to reexamine his or her premises. I would ask the clinician also to abstain from calling what he or she is doing EMDR—or at least offer clients sufficient opportunity for informed consent by letting them know that the procedure is not being applied as it is taught.

As the originator of EMDR, the textbook I wrote (for now) offers the mental health profession standards of practice in EMDR. It is based on eight years of personal experience developing and refining the method, plus a compilation of cases and reports from trained clinicians and researchers over the past six years. I want to stay open to change and am very wary of any practice that smacks of stultifying orthodoxy. That involves an adherence to "set in stone" EMDR patterns of practice as well. I believe that we are going to have to be very careful in the coming years to avoid adhering to beliefs out of mere tradition, but rather focus on concepts of client safety and enhancement. It is vital that EMDR evolve to another plateau, with input from all of you, so that it is at least as different in 2007 as it is now from 1987. However, let us make sure the changes are beneficial for clients and offer equivalent or better treatment results.

COURAGE, INNOCENCE, AND HOPE

Virginia Denman is the EMDR clinician who opened her Oklahoma City home to the EMDR relief effort. At the EMDR annual conference, she brought a poster that had been made by her state government to recognize the openhearted response of the nation as a whole. The poster was per-

sonally signed by the Governor of Oklahoma and the Mayor of Oklahoma City to give special thanks for the work of the EMDR clinicians. It has a picture of the ribbon worn to remember the bombing: purple for courage, white for innocence, and yellow for hope. The poster says:

For compassion on a national scale—
A vast shining outpouring, unprecedented in its depth, and scope, and need. For countless, tireless hours. For words and tears and prayers received from states united by grief, and a belief in goodness. And for recognizing the strength Oklahomans hold—seeing the courage and caring that lives here, that lives *on*.

Ribbons were sold at the conference to support the relief effort. I saw them on practically everyone's lapel. It is a privilege to be a part of this expanding circle of open-hearted clinicians. Thank you for making it possible.

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EMDR Network Newsletter Submission Information

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

To this end, the following represent the guidelines for submissions to the Newsletter: Send articles to Lois Allen-Byrd, Ph.D., Editor, EMDR Newsletter, 555 Middlefield Road, Palo Alto, CA, 94301. Please include home and business telephone numbers, professional degree, location of practice (city and state only), professional affiliation (if applicable—university, if a lecturer or teacher, and/or institute, if an associate). Example: John Smith, Ph.D., John Doe University, Johnson, WA. If possible, please submit articles on a diskette, IBM format.

ARTICLES SHOULD BE DOUBLE SPACED WITH WIDE MARGINS. APA STANDARD AND STYLE–BOTH TEXT AND REFERENCES MUST BE IN ACCORDANCE WITH APA STANDARDS. ALL SUBMISSIONS ARE SUBJECT TO EDITORIAL REVISIONS.

Proofreading of material is required before submission. Authors submitting a manuscript do so with the understanding that, if it is selected for publication, copyright of the article is assigned to the Newsletter.

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

A CASE OF PAST-LIFE INTERWEAVE

Stephan Bodian, M.A.

Although I spent 10 years as a Buddhist monk and meditation teacher before becoming a therapist, I have always considered myself an agnostic on the issue of reincarnation. So it was much to my surprise, and without any prompting on my part, that one of my clients recently had a past-life experience during an EMDR session and then spontaneously wove the experience into the reprocessing of a childhood memory.

An Italian-American in his early 40s, Peter presented with the problem that he had become deadened to his own emotions because he believed that other people did not welcome his intensity. This deadness had prevented him from becoming deeply involved with a woman; instead, he had a series of superficial affairs that left him feeling unfulfilled and his needs unmet.

In his family of origin, there had always been quite a bit of chaotic, openly expressed emotion which to Peter seemed to be hurtful and out of control. Based on his childhood experiences, he believed that, "If I let myself feel, I'll go out of control." When we targeted this belief, the memory that emerged was of his family, he among them, arguing and yelling at the home of his grandmother.

The feeling was one of deep sadness. The positive cognition was: "It's O.K. to feel. I won't go out of control."

As we began processing, Peter first had a memory of having his feelings squelched as an infant, then a memory of his umbilical cord being cut. Next he was back in the womb, with a peaceful, loving feeling in his heart.

During the next series of eye movements, he had a brief glimpse of a past life in China, then a clear image of himself as an Indian warrior. The warrior, who was preparing for battle, felt angry and powerful, but also peaceful and self-contained. "Anger and peace can go hand in hand," Peter reported realizing.

During the next series, he felt a wave of terror as the battle approached, but the terror quickly turned to a deep feeling of peace. In the next series, Peter was back at his grandmother's house, feeling uneasy that the situation would get out of control. Then his Indian warrior alter-ego appeared in his grandmother's living room, and he realized, "I can be here and love my family, but not get caught up in their drama." The uneasiness changed to peace.

In the next series, Peter imagined himself sitting with a woman, feeling quite comfortable with himself, as he realized, "I can be myself with her and that's O.K." Then he spontaneously shifted to an image of himself with his little daughter on his knee (in reality he has no children). "I have the capacity to be a family man," he reported, as his heart filled with love. "It's O.K. to be a man and have masculine feelings," he said. "It's O.K. to feel. I won't go out of control."

As he felt how true that statement was for him now, he superimposed it over the original memory as he followed my fingers. By this time, the memory had lost all of its charge. "I have a soul," Peter concluded, with a big smile on his face.

This session was the key piece in a series of sessions on the issue of becoming more comfortable with his own emotions. Peter now reports that he finds it much easier to experience and share his feelings, including his angry and aggressive feelings, and as a result, he can be more open and intimate with women than he had been able to in the past.

EYE MOVEMENT: A METHOD OF AXIS ROTATION

Marcia C. Cotton, Ph.D.

I received Level I EMDR Training in November 1993 in Austin and Level II in July 1994 in Denver. The bulk of my clients are adult survivors of childhood trauma with PTSD, DD, or BPD diagnoses.

In using EMDR with these clients, I noticed that they would sometimes get stuck (i.e., not continue to resolution/SUDs=0) after several sets of lateral, side-to-side eye movements. I sensed that they somehow needed to "access more areas of their brain" and so began to experiment with the pattern shown in Figure 1.

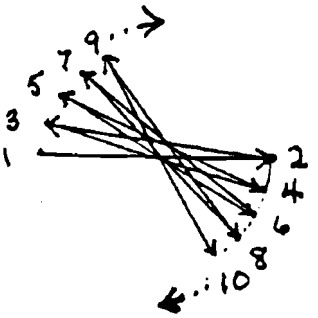

Figure 1. Method of axis rotation for eye movements sets.

I have been using this pattern, or some variation of it, for some time now. With new clients, I usually begin with the conventional horizontal, side-to-side eye movements for the first few sets. This provides a baseline, allowing me to see how they respond in this lateral mode. With these new clients, I will then gradually move to doing some portion of the circle, usually beginning the set with about 12 lateral repetitions and then moving off the horizontal plane only a few degrees of angle for each succeeding repetition, arriving usually to about 45 degrees in 24 to 27 repetitions before taking a break from that set (see Figure 2).

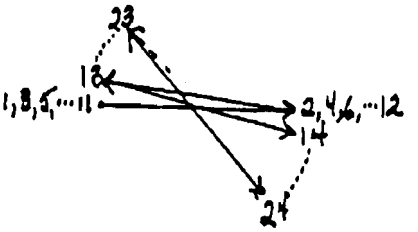

Figure 2. Rotation of EM axis to 45 degrees.

With each succeeding set, I will again begin at "1" and move further and further through the circle, usually achieving the completion of the circle over a course of about three or four sets. I then repeat the complete circle (using from 24 to 48 to sometimes 60+ repetitions per set) for as many sets as needed to move the SUDs to zero.

Having worked with this method of axis rotation for some time, I have noticed quite frequently that many clients will visibly begin to relax (i.e., shoulders sink, face relaxes, client takes a deep breath, client yawns) when the revolving axis approaches or reaches the vertical, up-and-down motion. One client who has had years of experience with many alternative "mind-body" therapies, actually commented that it was at that vertical location that she began to feel the trauma/tension release in her body. She stated that her criteria for treatment effectiveness was experiencing the release in her body, and that when she tracked vertically and then felt her body begin to release, "that was how I knew it was working."

With some clients, I have felt pulled to leave my hand at one angular location (which I will call a "critical degree") or another for a greater portion of the

set. Usually this has occurred at the 30- to 40-degree or 140- to 150-degree angles (see Figure 3). My sense is that they may be accessing something at this angle and need longer to process here. This is entirely speculative (intuitive) and NOT empirically validated, of course.

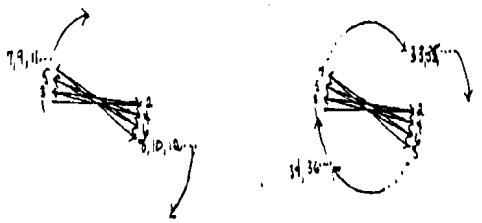

Figure 3. The EM axis is rotated to a "critical degree" and repetitions are done at that angle before completing the full circle of rotation.

With clients who are more experienced in EMDR (i.e., have been doing EMDR comfortably and effectively [SUDs to 0] for a number of sessions), I may begin the session with the circle pattern (or some portion thereof, if their energy dictates) immediately. This is especially true if we are doing ongoing work on some aspect of their trauma. If the client is working at a more cognitive level (e.g., examining a dysfunctional belief), I often stay with lateral, horizontal movements for the full set. If, on the other hand, they are working through residual affect, the full circle has proved time and time again to be especially effective in its thoroughness and completeness of bringing relief/lowering SUDs to zero.

RED FLAG. Because rotation of the axis serves to get clients "unstuck," it may also facilitate their accessing traumatic material sooner than they are ready to handle it. As John Briere (1995) has pointed out, it is absolutely essential to maintain the balance of what he calls "self capacity" and exposure to traumatic affect so as not to exceed what he calls the "therapeutic window" (Briere, 1995; cf. Fine, 1994). Therefore, with clients who have not reported early trauma, but whose symptoms indicate this possibility, I am very careful not to move too far from the horizontal axis too rapidly or too early in treatment. This caveat is equally applicable to clients who acknowledge abuse, but who have dissociated much of the traumatic affect in order to remain functional.

I do, however, use the full 360-degree rotation of the axis when doing installations. This includes work done prior to targeting trauma in order to establish inner resources and build "self capacity" (e.g., safety, self-soothing, and relaxation skills). It also includes using the 360-degree rotation in Phase Five of EMDR Treatment (Shapiro, 1994).

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FINDING THE "PATH" IN PATHOLOGY: AN APPROACH TO COGNITIVE INTERWEAVE

Chad Glang, Ph.D.

One approach to using cognitive interweave is to view the client's symptom as an ineffective attempt to meet a healthy need. If we can correctly identify the underlying need, we can seek a more efficient route toward its fulfillment. I think of this as finding the "path" in pathology. The following two cases illustrate how this strategy can guide the therapist's thinking in utilizing cognitive interweave.

Ellen is a 34-year-old homemaker and mother of two young children. She was feeling deep guilt over an abortion she had at age 20. We targeted the abortion scene and Ellen's SUDs went quickly from 10 to 4. Her cognitions, however, were stuck along the lines of "What does the baby think of me? It hurt and suffered, so I deserve to also."

I had her close her eyes, hold a pillow, and talk to "her baby" (her term). During a strong abreaction, she said things like, "I'm so sorry I did that to you. You'd be swimming, riding your bike, having fun now. I ruined it. I hope someday I can hold you in heaven." It seemed clear that Ellen felt a deep need to maintain contact with this child, and probably had for all these years. The only ways she had found to maintain were through guilt, or anticipating reunification after her own death.

Seeing how tenderly she was holding her "baby" in the moment, and how much love flowed from her as she spoke, I suggested that she try this statement: "I can feel my connection to this baby in a loving way; I don't need to do it through pain." Visibly relieved, Ellen responded, "I like this better!" We were then able to complete the session satisfactorily.

Jack is a 37-year-old brick mason. From his early teens until age 32, he was a heavy drug abuser. His drug career was dangerous by virtue of the quantities and types of chemicals he used, and also because of underworld dealings involving violence and weapons. He had seriously injured others and had been suicidal on several occasions. In spite of all this, he had changed his life significantly and when he sought therapy, he had been stable and supporting his wife and stepchildren for 5 years. Though he had stopped using heroin, hallucinogens, and cocaine, he continued to smoke marijuana several times a week. He

willingly gave this up, however, at my suggestion.

After several successful EMDR sessions dealing with childhood abuse, he was ready to work on his most frightening symptom: the nightmare he continued to have several times a week. Jack's dream took him back to a scene in which he had just purchased a large quantity of cocaine. "I was in my room, shooting up lots of coke and smoking pot. Then I asked myself, 'How much can I do?' I kept injecting until I passed out—twice. Then I shot once more, sure that this one would blow my heart. I passed out again and woke up the next day. I knew I'd nearly killed myself and flushed the rest of the coke down the toilet. It's that last hit that wakes me up screaming, now, drenched in sweat."

Targeting the memory brought up issues of feeling rejected, empty, alone: "Where were my rescuers?" When he seemed stuck in this material, I asked him to picture himself in bed, having just awakened from the nightmare.

Jack: "I'm embarrassed for my wife to know my past still has a hold on me. I like my life now, but I'm afraid if I have one joint, I'll want more. I could slip back, maybe not all the way. I know I'm stronger now, but I obsess anyway."

Therapist: "Perhaps your excessive worry is the way you've found to stay safe."

Jack: "When you say that, I feel instantly more relaxed."

(EM)

Jack: "Yes, more relaxed."

Therapist: "I think your dream may serve as a warning to you. When you get a little scared, the alarm goes off to make sure you don't slip."

Jack: "Yes!"

(EM)

Therapist: "Maybe you could thank your nightmare for the good job it has done keeping you safe, and let it know you can take over now."

Jack: (laughing) "Yeah, thanks! I can take over that job now. I know I'm strong enough."

(EM)

Jack: "I don't need the nightmare anymore. I can do it!"

TARGETING DEFENSIVE AVOIDANCE AND DISSOCIATED NUMBING

Jim Knipe, Ph.D.
Colorado Springs, CO

For some clients (perhaps 10-15%), I have found that the effectiveness of EMDR (Level I, Level II version) is blocked or hindered by defensive processes which may or may not be conscious or voluntary, and which function to protect the individual against unpleasant affect. In such instances, it has frequently been useful to use the 0-10 scale to measure aspects of experience other than unpleasant affect. This is similar to the Level of Urge (LOU) innovation designed by Popky (1994) and used as part of his protocol for the treatment of substance addictions.

Since addictions can be thought of as substance-induced avoidance of feeling, I have tried adapting the LOU to avoidance itself. For example, a woman in her mid-30s, a survivor of childhood sexual abuse, had successfully used EMDR to resolve several troubling present-day situations, but felt extreme terror, which then went to numbness, whenever she contemplated using EMDR with memories of her sexual abuse. Week after week, she would be frustrated by her own quasi-voluntary pattern of avoidance, being late for her session, and then in the session, talking about "easier" problems, and even jokingly expressing a desire to run out of the room. When she tried to force herself to think of the abusive memories she would experience a numbing feeling. At the end of each session, she would express enormous frustration with herself for not "working on the abuse," only to repeat the pattern the following week. Thus, after several weeks, at the beginning of a session I asked her, "When you think about the possibility of using our time today to work on your memories of abuse, how much do you want to talk about something else, 0-10?" She stated that it was a "10" and was able to locate this "10" in her body sensations. We then began the eye movements, and traumatic information began to come up and was metabolized, but in a way that appeared more comfortable and somehow "softened," with the client feeling much more in control. Whenever I went back to target, I would phrase my question in the following way: "When you think of continuing today to work on the issue of your abuse, how much do you want to talk about something else, right now, 0-10?"

What this approach seems to do is allow clients to keep their defense of avoidance as they do the work. What occurs as the level of urge to avoid the trauma drops to 0 is that reality-based and health-inducing information regarding the trauma spontaneously emerges, as is typical in the standard EMDR. The method can be varied according to the particular needs of the client. For example, another client might be asked, "When you picture yourself at age 12 standing there at the door, just after your stepfather told you to come into his bedroom, and you have that vague sense of terror, how much 0-10, do you not want to know what happens next?" The question should be asked in such a way that the client reports his or her feeling-based urge to get away from the affect, not his or her more cognitive "wish" or "desire." Sometimes this requires a bit of discussion so that the client will understand exactly what

information is being requested.

Many clients will attempt to force themselves to bring up traumatic images, but then will involuntarily "get away" from the traumatic feelings by numbing. Often, this numbness will lift away with eye movements if it is targeted like any other body sensation. Sometimes, though, this is ineffective. In such instances, the client is usually able to sense the presence of the traumatic anxiety or helplessness "under" the numbing, or "covered by" the numbing; thus, the client can be asked, "0-10, how much do you want to get away from the anxiety by feeling numb?" Strong dissociative barriers (e.g., numbness without any conscious anxiety or the amnesiac barriers between alters in DID) probably are strong for a good reason within the ecology of the personality system, and for those clients, this method would, in most cases, be unwise. For others, though, targeting avoidance defenses may make the benefits of EMDR more accessible.

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A MODIFICATION OF THE EMDR TRAUMA PROTOCOL

Steve Lazrove, M.D.
New Haven, CT

Trauma produces a change in our sense of self, our sense of the world's meaning, of its safety, of its rationality. For better or worse, the victim of trauma is no longer the same as he or she was prior to the trauma. One of the greatest strengths of EMDR is that it specifically acknowledges the need for cognitive restructuring, as well as serves as a means to that end, formulating negative and positive cognitions. This article points out a heretofore unrecognized obstacle to cognitive restructuring and describes a simple modification of the EMDR trauma protocol that can be quite helpful for restarting stalled processing.

Method

During EMDR, the patient is told to bring up his or her trauma, and as the memory begins to change, is told (connotatively), "Let it go, it's just old stuff." Fine. It is old stuff. Yet to the extent that the person sees the trauma as redefining his or her self, or as necessary to derive new meaning to existence, being told, "Let it go," can be distracting or even harmful. This conflict impedes cognitive processing and can disrupt the progress of the EMDR session.

A number of techniques have been devised to help restart processing (changing the direction or speed of the movements, asking what is keeping the SUDs from going lower or the VoC from becoming higher, using the cognitive interweave, etc.), usually with good results. However, when a patient is having difficulty letting go of some aspect to a trauma, it may be because it has personal meaning. In this situation, the patient is asked the following specific question, "What about what happened do you need to hold on to, and what do you want to let go of?" It is essential that the initial clause use "need" and the second clause "want."

Discussion

Asking, "What about what happened do you need to hold on to, and what do you want to let go of?" accomplishes four goals:

1. It acknowledges that there may be aspects of the trauma that, although painful, carry essential meaning and must be retained.

2. It suggests that not all painful aspects to the trauma are essential and that change is possible.

3. It places control over the decision completely with the patient.

4. The question is self-reflective; to answer it, the patient must go back into the experience, which restarts the processing. Once an answer is offered, the therapist responds with, "Go with that," and continues with the standard protocol. This intervention may be repeated as necessary.

The following is a representative example of the use of this intervention in one type of trauma. Parents dealing with the death of a child often have trouble letting go of painful images. This is not because they are attached to suffering; rather, they are frightened of what will happen if they let go of the memories. For example, they may fear that letting go of the pain will mean that all memories of their child will disappear and that in essence, the child will no longer exist, will cease to have existed, will never have existed. Additionally, by remembering the original pain, their child is kept alive magically because the parent feels the same pain, merged with disbelief, as he or she did the moment he or she learned that the child died. In exchange for the suffering, the parent does not fully have to accept that the child is gone. Asking, "What do you need to hold on to, and what do you want to let go of?" acknowledges that the parent is doing the best that he or she can, and offers a vehicle for synthesis of meaning at a higher level.

As with all therapy, but especially with EMDR, the therapist will hear a spectrum of unique personal responses. One mother said, "I want to remember him the way he was, not as I saw him in the hospital." This response signified that the core memory of the child was intact and that the memories of the suffering were not essential. Another parent explained, "I need to find a place for him in my

heart. That place will always hurt, but I think that is the way it is supposed to be. I'll put my memories of him there. I don't think it would be right if it didn't hurt." It is common for religious or spiritually oriented parents to speak of finally understanding what their child's existence meant, often that they had personally received some gift of insight from the child while alive or after death.

"What do you need to hold on to, and what do you want to let go of?" is a very general question and is useful in conditions other than trauma for restarting stalled processing. It also may assist in obtaining closure when the patient is having trouble generating a positive cognition.

ON CIRCUMCISION, OTHER CHILDHOOD MEDICAL PROCEDURES, and EMDR

Sheryll Stuart Thomson, MFCC

I was using eye movements with a 47-year-old client, Jay (pseudonym), focusing on an unnecessary tonsillectomy when he was about 9 years old. These operations were done on both his older brother and himself—just because this was what was done in those days. He described seeing his brother being wheeled, semi-conscious, out of the operating room with blood coming out of his mouth. He thought to himself, "Well, he's not dead . . . (is he?)." He was then dragged kicking and screaming to the operating room. His parents did not visit him for the 3 days he was in the hospital. He got no ice cream, though he had been promised some. As we were finishing the EMDR processing of this set of incidents, I asked him if he had been circumcised. (I had been meaning to ask about this since he was intensively processing a list of traumas in a short period of time before leaving the state for a new job. I chose this moment "out of the clear blue sky.") He said, "Well, it's funny you ask this because for the last ten minutes I have been feeling a sharp pain all around . . . there" (the head of his penis). As he moved his eyes, focusing on the sharp pain, it got increasingly dull until it went away. (Incidentally, processing this pain may have elicited, or made him feel safe enough to realize, another related fact—his attitude toward his body.)

After moving to his new job, Jay reported, during an EMDR session by phone that his penis felt "unclean" (he may not have been able to report this in person). (Knowing his history, I believe this may be unrelated to circumcision.) This was processed (using my tapping on my telephone receiver and his moving his eyes on his own), and weeks later he reported that he was now able to let any corporate politics roll over him. Before he moved to his new job, he had been extremely anxious about being hurt by corporate politics, and just before this session, he had been feeling uncomfortable about his place there. Now, two months later, he is seen as a kind of guru in this multi-million-dollar business; he feels comfortable and unconflicted about his role and sounds more confident than I can remember hearing him. He has not reported yet on subsequent sexual relations with women.

I later heard on the radio a report (the source of which I have not been able to locate) of a study which suggested that boys who have been circumcised have a harder time with subsequent medical procedures of any kind—including a worse reaction to anesthesia and a slower healing—than boys who have not. (Please let me know if you know where I can find this study.)

It has only been in the last 20 years or so that we have begun looking at babies as sensate, aware beings, capable of learning and of feeling acute pain, even in the womb. Starting from today (for circumcised men or parents of circumcised boys who read this without, hopefully, spending a lot of time on regrets about the past), I suggest that circumcision may be at least something to keep in the backs of our minds when working with any man or boy, if not a target to focus on specifically using EMDR. You can imagine as well as I the implications for a baby of having part of his most tender anatomy cut off—usually while he is wide awake. Men who can remember this procedure say it is extremely painful. Is this the genesis of "castration anxiety?" If so, it would be understandable. How much of the parental bonding does this destroy? What does the baby feel about his body, his wholeness? What does he feel toward doctors or rabbis? How does this affect his temperament, his capacity for close relationships with other human beings? It is possible we have no idea what circumcision does to boys and men because so many have had this procedure that it would be hard to compare.

I know this is a controversial issue and would welcome your thoughts about it, especially about using EMDR with it. Write: 1641 Hopkins St., Berkeley, CA 94707; (510) 525-8081: (510) 527-3081 (home).

TIDBITS

John Marquis, Ph.D.

It has been a part of Level I training for several years to teach a signal for clients to use if they want the therapist to stop the eye movements. I have

EMDR Network Newsletter Staff

Editor: Lois Allen-Byrd, Ph.D.
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Data Entry: Sharon Lucas

found it useful to teach a signal to continue the eye movements at the same time. This is a usual "come on" charade signal—palm up with fingers moving toward the client. It gives clients an even greater sense of control, and proves useful when they have not finished a scene they are picturing, or if they feel the need of continuing to process an abreaction.

I have found it useful to use my left (non-dominant) hand to produce the eye movements. This allows me to write simultaneously with my right hand so that I do not have to interrupt the continuity of movements in order to make a note. It is particularly valuable during prolonged abreactions.

TIDBITS
Chad Glang, Ph.D.

1. The negative cognition-generating question, "What does that say about you?" can be used at any point in the process, especially when the movement turns in a positive direction. For example, a male client was working on the beatings he received from his older brother, who had been beaten by their father. "My brother passed on the abuse, but I didn't turn and find another victim." "And what does that say about you?" "I guess I'm a caring person." EM.

2. This is an example of how new positive cognitions (PCs) can emerge. Rather than understanding this as the PCs changing, and installing just one new PC, I have found it helpful to elicit and install all appropriate PCs at the close of a session. It is as if the client has gotten to a new place, and it can be viewed through many lenses. Some examples:

* A molest survivor, whose presenting problem had been angry withdrawal from husband and children, had as her closing PCs: "When I face the truth, I feel good about myself." "I'm not responsible." "Mom neglected me." "I'm a good person." "I'm a good mom." "I know I can become more relaxed and loving."

* An incest survivor, who had tortured cats with her perpetrator brother, stated her PCs as: "I'm a loving, compassionate person." "I can trust myself with animals." "I can feel at peace when I need to; it's a breath away."

* A woman, after processing a scene of domestic violence, listed her PCs as: "I am really strong." "I'm getting more aware of what's healthy." "I deserve better than I've given myself." "I am committed to learning to assert myself." "I am ready for a healthy relationship."

After installing a collection like these PCs, the picture I have is of the client leaving the office with a bouquet of PCs.

3. Another way to explore the positive possibilities is to watch for expressions of delight, and do a set or two. A caretaking female client had followed an EMDR session by setting limits with her irresponsible daughter. She reported that she had also had a long-overdue confrontation with her husband regarding his driving under the influence. Responding to her beaming expression, I had her do a set, targeting the latter conversation. Her exuberance intensified, and she giggled, "I can fly!" It was useful to then look at some other issues from this point of view.

4. One of the ways I think of EMDR is as a highly efficient means to ask the question, "What is true for you about this?" Wisdom often seems to tumble forth. Though it can be cumbersome, I take nearly verbatim notes. The rhythm which seems least intrusive is to resume eye movements (EM) as soon as the client has spoken, then jot my notes after that set, during the moments the client is resting and gathering words. Sometimes the material seems too good to leave in my file. In these cases, during the follow-up session, I will review the highlights with the client while speaking into a recorder. Almost always, the client has forgotten significant parts. The tape is then a permanent gift from the client to him/herself.

5. When the SUDs will not go below 3 or 4, how can one assess whether the client is stuck or done? Examples I have had: a man who slapped his infant, a parent who had lost a child, a woman grieving an abortion. A question I have found useful is: "If a close friend had told you this story, how disturbing would it be?" If the number is the same, the client has probably achieved an objective view of an intrinsically upsetting issue. If the number is lower, then, "What makes it more upsetting as your own experience?" may help us get moving again.

6. At the end of a client's first experience with EMDR, I like to ask, "What just happened? How would you describe this process?" Some of my favorite answers: "It's a short cut to the center of yourself, and when you come back, you know more than when you started." "It's like a closet door that you open, and stuff piles out. You can't close the door until it's all cleared away." "It stirs up some things, and cures some things." Thus, a new nickname for EMDR: "Stir and Cure."

FROM THE EDITOR

The editor cannot guarantee when, or if, a submission to the Newsletter will be published.

INTERNATIONAL UPDATE

Francine Shapiro, Ph.D.
Senior Research Fellow
Mental Research Institute

The annual EMDR Conference was a gratifying success with approximately 550 people attending. Over 60 clinicians and researchers gave excellent presentations on innovations, advanced clinical applications, and the latest study findings. The overall assessment of participants came out at 4.6 on a 5 point scale. The plan is to move the conference to either the mid-west or east coast in June of 1996.

The opening ceremony of the conference included a presentation of awards to the organizers of the humanitarian relief effort in Oklahoma City after the bombing. Sandra Wilson, Ph.D., has been the central figure of the effort. She flew in after Judy Albert's (MFCC) initial groundbreaking actions (described in the last Newsletter) and has stayed in Oklahoma City since then organizing the community interface, clinical work, and training efforts. To-date, approximately 200 children, rescue workers, victims, colleagues, and mental health providers have been treated by EMDR clinicians who have been flying in at their own expense to provide a week's worth of clinical treatment. They have been hosted by local Oklahoma EMDR clinicians Virginia Denman, Joel Westerheide, and Norma Leslie who have used all their community connections to take care of the support services. It has been a magnificent relief effort. Steve Lazrove, M.D.,has also flown in for two shifts to help in the clinical and organizational work.

REGIONAL NETWORK COORDINATORS - USA

National Coordinator: Norva Accornero, MSW (408) 356-1414

Arizona	Jonathan Brooks, Ph.D.	(602) 493-3110
	Pat Penn, Ph.D.	(602) 770-7407
Arkansas	Stephanie Zack, LCSW	(501) 442-9997
California (Northern)	Norva Accornero, MSW	(408) 356-1414
(Southern)	Curtis Rouanzoin, Ph.D.	(714) 680-0663
	Ron Doctor, Ph.D.	(818) 885-2827
Colorado	Laura Knutson, LPC	(303) 620-7198
	Jana Marzano, MA	(303) 220-1151
Connecticut	SteveLazrove,MD	(203 787-0227
	David Russell, Ph.D.	(203) 231-9191
DC	Deany Laliotis, LPC	(301) 982-9259
	Dan Merlis, LCSW-C	(301) 982-9259
Georgia	Pat Hammett, Ph.D.	(404) 633-4796
Hawaii	Silke Vogelmann-Sine, Ph.D.	(808) 531-1232
Idaho	Dean Funabiki, Ph.D.	(509) 334-0677
Illinois	Howard Lipke, Ph.D.	(708) 537-7243
Maryland	Gene Schwartz, LCSW-C	(410) 889-8338
	Mike Brenner, MD	(410) 771-4438
Massachusetts	Lorie Bollinger, MA	(508) 456-8623
Missouri	Marcia Whisman, LCSW	(314) 644-1241
New York	William Zangwill, Ph.D.	(212) 663-2989
	Gerald Puk, Ph.D.	(914) 635-1300
New Mexico	Peggy Moore, LSW	(505) 255-8682
Ohio	Kay Werk, LISW	(614) 274-7000x349
Oregon	Ann Kafoury, LPC	(503) 291-9343
Pennsylvania	Georgia Sloane, MS	(215) 667-6490
Texas	Carol York, MSW	(512) 343-9550
Utah	Dan Sternberg, Ph.D.	(801) 364-2779
Washington	Steve Riggins, MA	(206) 328-5626

Karin Kleiner's prompt response and immediate recognition of the need for EMDR treatment for OKC residents was a primary impetus to the coordinated effort and made it all possible. The response to a call for assistance to the EMDR facilitators and clinicians was a great success. They responded by flying in for a full week—which meant also sacrificing the income from their private practices for that time. Clinicians who have flown to Oklahoma in cohorts of 2-3 per week include: Judy Albert, Bob Tinker, Karen Kleiner, Stephanie Zack, Johnathen Speare, Ed Hallsten, Ken Vanderlip, Peggy Moore, John Marquis, Mary Moore-Farrell, Helen Hill, Steve Lazrove, Beverly Schoninger, Lillian Sideris, Bob O'Brien, Tanya Russell, Roger Quillen, Kathleen Scott, Laura Knutson, Jim Dayton, Linda Neider-Powel, Linda Grundy, Laurie Tetrault, Howard Lipke, and Kay Werk.

These clinicians deserve all our thanks and respect for their actions. They all seem to feel that the work was rewarding and fulfilling. It gave them a chance to be part of the healing and they are interested in responding again when needed. We would like to have their efforts supplemented by additional EMDR Level II trained clinicians.

In addition,a free EMDR training for

interested Oklahoma City mental health professionals was given by EMDR Institute staff who contributed their time and paid their own way. The Red Cross picked up the expenses for housing and American Airline offered reduced rate fares.

The training was given by Stever Silver, Ph.D. Facilitators who donated their services were: Bob Tinker, John Hartung, Jim Knipe, John Marquis, Stephanie Zack, Laura Knutson, Beverly Schoninger, Lillian Sideris, Steve Lazrove, Kathleen Scott, Donna Bruzzese, and Laurie Tetrault.

Once again, it is gratifying to see the calibre of support offered by these wonderful people. The training was a great success and the Oklahomans who attended were extremely pleased with the training and very gracious and heartfelt in their thanks. It is wonderful to think of EMDR being used by the clinicians in the trenches to serve the long-term needs of clients effected by the horrendous act of terrorism. One client said, "The good is overwhelming the evil that was done." What more could any of us want than to be a part of that. Another training is planned for August taught by Gerald Puk, Ph.D., and I will be conducting a Level II in September. Donations to help the support services in Oklahoma City are still being requested. They are tax deductible for you as a professional expense to support the work of your professional organization. Please make donations payable to: EMDR Network—OKC, P.O. Box 51038, Pacific Grove, CA 93950. All monies will be used exclusively for the clinical relief and professional support work.

The closing awards ceremony at the conference honored Howard Lipke, Ph.D., who received the Ron A. Martinez, Ph.D., Memorial Award for outstanding contribution to EMDR. Howard was the first VA clinician to use EMDR. After reading my 1989 articles, he called California and managed to find one of the combat veteran subjects in order to verify the research results. After hearing the vet confirm them, he flew out at this own expense to be trained and after seeing the results in his own PTSD inpatient unit, he sent messages, and arranged conference calls to tell everyone he could within the VA system of the need to learn the method. The number of VA units who received training is due largely to his efforts, and the efforts of those whose interest was catalyzed by him. Although he became an EMDR training faciliator, he refused to take any money for his work in order to be free from any charges of conflict of interest or financial gain. Howard also published one of the first articles on EMDR in Psychotherapy, conducted a survey of the first 1200 clinicians trained in EMDR and presented the results at APA, has made numerous presentations at the annual conferences of the International Society for Traumatic Stress Studies (and others), and has been a consultant for at least four research projects on EMDR. Needless to say, if more people even approximated his contributions, EMDR would be much further along. Howard received a standing ovation at the presentation which he richly deserved.

Excellence in Research awards were presented to Sandra Wilson, Ph.D., Lee Becker, Ph.D., and Robert Tinker, Ph.D., whose study of 80 trauma victims treated with EMDR was accepted for publication as a featured article in the Journal of Consulting and Clinical Psychology. The effects of the in-press article are already being felt in that an article on the Croatian training, slated for publication in the APA Monitor, was going to be cancelled because of the "controversy" around EMDR—until the editors were informed of its imminent publication. The findings of the study were presented at the American Psychiatric Association this summer and at the EMDR Conference. Tapes of the presentations are available from the respective sponsoring organizations. When the article is published, we will try to get permission to distribute it to all the Network members.

Humanitarian service awards were also presented at the conference to Geoffrey White, Ph.D., Steven Silver, Ph.D., and Gerald Puk, Ph.D., for their efforts in Croatia. As a result of the training Geoffrey arranged, and the wonderful job done by Steve and Gerry, we have been asked to give an additional training in Sarajevo. All three are intending to return this Fall. Many people in the audience were brought to tears by a song Steve wrote about their experience in Zagreb. I believe that we all left the ceremony with an understanding of how the universal experience of fear and loneliness can be transformed into a sense of service to help healing occur worldwide. It not only can be transformed, but it must be transformed. I am sure many of you have noticed that many of the same names keep springing up. Please join them — the rewards are intangible, but inestimable.

Another important event at the EMDR Conference was an almost unanimous vote to turn the EMDR Network into a service organization starting in January 1996. All other functions of the Network will be turned over to the EMDR International Association. One of the projects will be the Humanitarian Assistance Program which was officially codified and launched by those attending a special interest

NOTE!

LEVEL I SCHEDULE CHANGES

The EMDR Level I training has been expanded to include 3 hours more practice time. The workshop schedule includes one evening session.

Day 1:	**6:30PM - 9:30PM evening session**
Day 2:	**9:00AM - 5:30PM**
Day 3:	**9:00AM - 5:30PM**

group at the conference. Steven Silver, Ph.D., is serving as the acting chair of the project and sent me the proposal. The EMDR Humanitarian Assistance Program (EMDR-HAP), would have the responsibility of organizing and providing assistance on a no/low fee basis for humanitarian or emergency need.

EMDR-HAP would provide support through voluntary efforts and contributions for the following types of circumstances: disasters, including both emergency relief and long-term assistance; training of indigenous mental health professionals in areas without resources to make use of usual EMDR training services; providing scholarships for training; and such other activities as would be considered humanitarian and be operated on a non-profit basis.

EMDR-HAP would perform the additional services:

*Develop and maintain a database of EMDR clinicians available for humanitarian efforts.
*Provide coordination of requests for assistance.
*Provide eduation services as needed for EMDR clinicians who are HAP members (e.g., critical incident training).
*Perform outreach education to other professional groups in the field of humanitarian services.
*Encourage the conducting of research and study in the area of EMDR applications to humanitarian situations.
*Serve as a conduit for financial assistance for these activities; ccordinate or assit in fund raising

The goals will be to have in place available personnel and resources in advance, as far as possible, of identified needs.

Once again, please let us know if you can be of any assistance regarding donation of time, effort, or financial support. In addition, HAP will also provide research grants for worthy projects. Once again, the EMDR Network will continue to be an alumni organization of the EMDR Institute. However, as of January 1996, it will be devoted exclusively to humanitarian service. We will also be attempting to raise additional funds for the projects. If you have any ideas or contacts, please let us know.

During the opening ceremony of the conference, Ronald Doctor, Ph.D., announced the inauguration of the EMDR International Association (EMDRIA). In earlier Newsletters I wrote about the need to have a separate professional association in place in order to set standards for the clinical practice and training of EMDR. Now that the book is published, and everyone has been released from their training agreements, there are bound to be a number of excellent— and, unfortunately, some incompetent— trainings done worldwide. The purpose of EMDRIA will be to try to guide both clients and clinicians in the search for well-qualified therapists and trainings. Full membership in EMDRIA will be limited to those clinicians and researchers who have meet appropriate standards of licensure and training. As a professional organization, EMDRIA will also support a number of outreach committees to educate other professionals, insurance and managed care companies, and laypeople about EMDR. In order to maintain the integrity of EMDR practice, a professional organization of this kind is vital.

Some of these activities were previously done by the Network. However, the Network was running at a deficit since it started in our attempt to provide on-going education and support for the trained EMDR clinicians. The Institute has administrated the Network and provided services to underwrite the Network to provide the needed benefits to the members. At this point, there are regional meetings, study group meetings, and consultation services worldwide, and the Network Newsletter has blossomed under the editorship of Lois Allen-Byrd, Ph.D. After this year, the resources of the Institute will be directed to helping to support the humanitarian efforts worldwide. The EMDR clinicians who truly care about EMDR's reception in the world and its use with clients throughout our profession, will be asked to support EMDRIA as a professional organization that will take over all the previous services of the Network (including the annual conference), in addition to setting standards, and offering educational outreach.

When I realized that the publication of the book was going to necessitate a separate organization independent of the Institute and Network—I asked a number of people to organize a Task Force to develop bylaws and establish a viable organization. I asked people who had the least ego, largest heart, previous experience with organizing similar projects or with ethics boards, those in a close enough proximity to meet continually, and with the willingness to make the commitment to get the job done. The initial members of the task force were: Ron Doctor, Marguerite McCorkle, Rodney Nurse, Curt Rouanzoin, and Jocelyne Shiromoto. They were all California based in order to make sure they could consistently attend meetings. Shortly after, David Wilson was invited as a Task Force member. Peggy Thompson organized a meeting in Phoenix with attendance from clinicians throughout the United States. Committee reports were given on outreach and educational proposals. Committee members gave each other and the task force input and reactions to the work already done and a tentative committee structure was established for the new association. A member of that group, Carol York, was asked to actively become involved as tempory membership chair of EMDRIA. Other committees were put on hold until the association became active. In order to get input from the EMDR clinicians trained outside the United States, and to make sure that it was truly an international organization, the task

force voted to bring on board Marilyn Luber who is the EMDR Institute's coordinator of international trainings. She provided them regular input from the clinicians in Europe, Australia, and South America. The result has been a truly international endeavor. Consequently, we now have an organizational structure that people of good faith believe strongly will serve EMDR clinicians and clients worldwide.

While the benefits of EMDRIA will not be fully realized until 1996, when it takes over all Network functions and begins educational outreach, the task force, now the founding board members, is presently asking for members and charter members to provide funds now to the Association to cover the startup costs. The costs of an independent, international, functional, professional, outreach organization far outweigh the costs of the Network—therefore, the dues will be higher. However, they are directly in line with the costs of other professional organizations and with the true costs of the Network. It will give you even more benefits than the Network. Additionally, if you use EMDR extensively in your private practice, it may offer you more benefits than other more generic professional organizations. Clinicians will have the benefit of EMDRIA referrals and validation via the membership directory and continued access to innovative new protocols. Researchers will have a vehicle in which to publish and a professional conference for presentation of papers. If you join EMDRIA before December 31, 1995, you can choose to become a "Charter" Member with some added benefits to full membership. In addition, as a Charter Member, you will have a lifelong designation as one of the founding members of the organization. You can also join as a Full Member, Associate Member, Affiliate Member, or Student Member. All members who join now will have membership through December 31, 1996. Network benefits will continue until December 31, 1995 and then will terminate unless you join EMDRIA as a way to continue these services, including the Newsletter, and information resources.

Please allow the momentum to continue worldwide by supporting the unified effort. What we can accomplish as a single individual can be multiplied a thousandfold if we work together.

EMDR IN BELGRADE, FORMER-YUGOSLAVIA

During February 1995, Barbara Zelwer presented short trainings in Belgrade for mental health professionals and laypersons who work with refugees and people suffering war-related trauma. There are about 800,000 refugees in the Serbian part of former-Yugoslavia. They include Croats and Muslims, as well as Yugoslavs of Serbian extraction who have fled Bosnian and Croatian territories. The ethnic diversity of the refugees is echoed in the diversity of people who work with them. Somehow, for many ordinary people, the ethnic differences do not matter. This is only one small piece of the psychosocial and political puzzle the region represents. Barbara found that many people do not support their government's stance on the war in Bosnia, but feel (and are) helpless to force changes in policy. Mental health workers feel overwhelmed and burned out by the increased amount of emotional disturbance brought on not only by direct experiences of war, but by living at its edge.

Barbara's discussion of the value she has found in EMDR in treating survivors of war and torture in a Central American population in East Oakland generated considerable enthusiasm. She was invited to make a longer presentation at the Friday Morning Seminar for some 60 psychologists and psychiatrists who work at the Belgrade Institute for Mental Health. She is currently trying to arrange for an EMDR training for professionals working with war trauma cases at the Institute's Stress Clinic and other clinics in the area, patterned after the very successful training arranged by Geoff White of Los Angeles and presented in Zagreb, Croatia, by Steve Silver and Gerald Puk.

Barbara welcomes communication with anyone interested in treatment of war trauma/refugees. (Box 7755, Berkeley, CA 94707; phone and fax: (510) 843-0360)

EMDR on the Internet

http://www.octave.com/emdr/

Internet Traumatic Stress list

To register for Charles Figley's traumatic stress list on the internet send an email to: listserv@netcom.com in the body of the message type *subscribe traumatic-stress* and *your name.*

EMDR HELP WANTED

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

Research Subjects Needed

Research subjects needed for PTSD outcome study, using EMDR and another proven treatment for PTSD. Potential subjects must be Kaiser Permanente Health Plan members able to receive treatment in the South Bay Area. They must meet DSM-III-R criteria for PTSD, be stable on medication, not suicidal, have no litigation pending, no drug or alcohol abuse or dependence, no Multiple Personality Disorder or Dissociative Disorder, no psychosis, and must have had symptoms for greater than one month. Since this is a randomized study, subjects may not be assigned to the EMDR condition and therefore, it is important that they are not referred with the intention of receiving EMDR. Benefits to participation are that the individuals will receive careful evaluation, treatment implementation and follow-up, and will add to our knowledge of treatment for PTSD. Once again, it is important to remember that we cannot accept subjects into the study who expect EMDR because they may be randomized to an alternative therapy. All patient referrals must be willing to receive either treatment. For questions and referrals, please call *Linda Kolstad at (408) 236-6763.*

EMDR Research/Training Institute

The EMDR Research/Training Center at MRI is looking for individuals who want to take part in research projects on victims of natural disasters. Please call *Cliff Levin, Ph.D. (415) 326-6465.*

Wanted

EMDR clinicians in the EAST BAY who are willing to donate time a clinical study of the efficacy of using EMDR to treat PTSD. Therapists would treat a minimum of 2 clients for 8 sessions each. Please call:
Barbara Colton (510) 869-5118

Published?

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

Spiritual Insights

If you have clients who have reported experiencing spiritual openings or insights during or after EMDR sessions and would like to share these vignettes, please write up these cases and send them to: *Laurel Parnel, Ph.D. 22 Von Ct, Fairfax, CA 94930. (415) 454-2084*

RET/EMDR

Practitioners interested or experienced in RET/EMDR, please contact: *Dennis Coates, 216 Avenue P South, Saskatoon, Saskatchewan S7M 2W2 (306) 665-2788 or (306) 242-6847*

Managed Care

In speaking to managed care organizations, hospitals, and reluctant-to-believe colleagues, it would be helpful to be able to offer names of recognized institutions which endorse the use of EMDR. I would like to compile lists of treatment facilities, large employers, and insurance companies/managed care organizations that do support its use. These lists could be distributed via network mailings. Please send contributions (including a name/phone/address for verification) to: *Chad Glang, Ph.D., 1027 N. Weber, Colorado Springs, CO 80903.*

Babies

Anyone using EMDR and/or other body-mind therapies with babies, please communicate with me. I am willing to facilitate a round robin exchange of letters from all over the world and I am also interested in an EMDR perinatology study group in the East Bay. Contact: *Sheryll Thomson, 1641 Hopkin St., Berkeley, CA 94707, (510) 525-8081.*

EYE MOVEMENT DESENSITIZATION AND REPROCESSING INTERNATIONAL ASSOCIATION (EMDRIA)

Dear EMDR Practitioner,

The Buddhists' say that life is always changing and fluctuating and that meaningful survival depends on our ability to see these changes, give up the old, and transform it into something new that is responsive to our greater understanding. Likewise, the practice, of and training in, EMDR is going through a radical change in terms of training and organization and this change will affect each of us over the coming years. I am asking for your understanding, considerable patience, and support in this process and in our efforts to anticipate and plan for these changes.

Specifically, training in EMDR is now moving out to individuals and institutions that have little, or perhaps no, connection with Francine Shapiro, Ph.D., the EMDR Institute, or what we have come to know as our EMDR community. Many pressures are forcing this change, but certainly Dr. Shapiro's book has been a major impetus in broadening training sources for EMDR Therapy. Book or no book, however, there is still growing pressure from people not affiliated with the EMDR Institute to provide training, supervision, research and other EMDR related activities. The only way to insure that these activities are going to be of high quality and effectively represent EMDR procedures and applications, is to develop training and application standards. It is essential that these standards come from outside the Shapiro Institute, since the Institute could be seen as having a competitive interest and therefore, any standards it promoted would not be acceptable in the therapeutic and

academic communities. All this is to say that we need to develop an independent association that can house practitioners and researchers from many different EMDR training backgrounds, and yet have high standards for its members. We have now developed such an association and we are asking you to join it and to help us preserve and further the EMDR Therapy that we practice.

The new association is called the **EMDR International Association (EMDRIA).** Bylaws for EMDRIA have been developed and we are in the process of incorporating as a non-profit organization. A few committees have been activated in order to direct initial business that is needed to get a new organization off the ground and to provide services to its members. EMDRIA is international in that it will serve the world-wide EMDR community and hopefully serve as a central organization for maintaining high quality standards, as well as helping each of us continue to improve our skills in EMDR Therapy applications.

EMDRIA has a founding Board of Directors (see below) that has met with Dr. Shapiro to discuss the roles of the Shapiro Institute and EMDRIA in the future. Dr. Shapiro has agreed to relinquish most of the activities associated with the non-profit EMDR Network (a subsidiary of the Shapiro Institute that currently provides support services to clinicians) to EMDRIA on January 1, 1996. At that time, EMDRIA will take over the Newsletter, regional support, and interest group activities, and the conferences. In addition, EMDRIA plans to publish a directory of its membership, sponsor a professional applications journal, serve as a resource to promote EMDR in appropriate professional organizations, become a central organization for the promotion and dissemination of information on EMDR world-wide, and, of course, publish standards of training for EMDR Therapy and ethical standards for its application.

The new Bylaws create an association that is membership-centered and able to accept a broad range of disciplines and levels of training. This structure is in place, but in order to breath life into the structure, we need your support and participation. The first way in which you can support the EMDRIA is to become a member. At this time, we are offering **Charter Membership** to those who enroll by December 31, 1995. To qualify for Charter Membership, you must be have completed Level II training, be licensed and/or have academic/research positions and published research on EMDR in refereed journal. Charter Members are Full Members who, for a slightly extra fee in the beginning, receive this special designation and honor. In addition, future benefits will be available such as, but not limited to, discounts and a Founding Member Certificate. You may also enroll now as a Full (non-Charter), Associate, Affiliate, or Student Member. The Full and Charter Members will have full voting privileges. Other members can still enjoy services of the association, but will not have voting rights.

The second way in which you can support the EMDRIA is to become active in its life. Many people are needed to keep the EMDRIA vibrant and hardy. In the past, Dr. Shapiro and The Institute have been fully responsible for the life of the EMDR community. That has changed and we are now all responsible, including Dr. Shapiro, for its survival. Application forms for membership are included in this Newsletter or by calling the EMDRIA office - (602) 912-5300.

Please join with me, other Board of Directors of the EMDR International Association, the Committee Chairs, and members in supporting this association both financially and with your energies. The integrity and evolution of EMDR Therapy now depends on us!

Sincerely,

Ronald M. Doctor, Ph.D.
Chair, Board of Directors
of EMDRIA
(818) 347-0191

and,

Board of Directors:
Marilyn Luber, Ph.D.,
(215) 545-8296
Marguerite McCorkle, Ph.D.,
(707) 257-8842
Rodney Nurse, Ph.D.,
(510) 254-3606
Curtis C. Rouanzoin, Ph.D.,
(714)680-0663
Jocelyne R. Shiromoto, M.S.W.,
(714) 764-3419
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(719) 634-4444

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(512) 467-1376

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(714) 680-0663
Rodney Nurse, Ph.D.,
(510) 254-3606

THE POETRY OF LOFTUS AND CALOF

William Zangwill, Ph.D.

Recently we received network materials containing tapes by Loftus (1994) and Calof (1994) continuing the debate on the False Memory Issue. If you have not listened to them yet, do, for they each have a form of poetry within. Good poetry does two things well. It helps us reconstruct our experiences and see things in new and different ways. It also stirs our emotions.

Like poets and poetry, Loftus sees memory as influencing the world and being influenced by it. In this process, as in any process performed by fallible human beings, people will make a certain number of errors. We forget, we reinterpret (or misinterpret), and we reconstrue. Like good poetry, sometimes these reinterpretations, these reconstructions deepen our understanding and appreciation of the world around us. While poetry often allows us to see new relationships between the ordinary, it does not mean we see these relationships accurately—just differently.

It is this question of accuracy of memory that concerns Loftus. She claims that research has repeatedly shown that memory is fallible and malleable. Therefore, without corroborating evidence, we cannot accept every account of abuse by our clients as accurate. She did not say that abuse has not occurred. In fact, I clearly heard her say that there is much abuse and that people have benefited from good therapy. Shapiro (1995) would appear to support this view when she said, ". . . all we and the client have are imaginal representations that correspond to affect, sensations, and beliefs. We cannot [emphasis mine] know if they are based on historical realities unless there is independent corroboration" (p. 3).

The client's poetry may stir us, may reinterpret past events in meaningful ways; but often, we do not know if it is accurate or not. Some will have trouble accepting this view, for it makes our lives and the lives of our clients much harder. For what it means is that we shall have to accept the fact that often times, despite our best efforts and the best efforts of our clients, we may not know whether or not particular instances of abuse occurred, or whether there was any physical or sexual abuse at all. If we accept this view that we cannot be sure, we have to resign ourselves to a measure of uncertainty and lack of knowing that can be terribly frustrating. How much more refreshing and invigorating it is to mount the white horse of Truth and Knowing and charge bravely into battle, the defender of the weak and helpless, the noble one. For most of my life, I have envied people who could do this. Who could look at the world or at a particular issue and see nothing but blacks and whites. I envied those who were never weighed down by the grays, the need to see the other side. It must make the world a much simpler place.

When we carry the flag of Truth and Sincerity and show that those who disagree with us are misinformed or evil, then we can invalidate, or at least question, everything they say. Maybe that is why Calof responded to Loftus the way he did. He complained bitterly that the False Memory Syndrome Foundation (FMSF) folks, ". . . express outrage and contempt for their opponents." Then he made over **30** different ad hominem attacks on Loftus in his approximately one-hour-and-fifteen-minute address. (His tape is fascinating, for it is one of the best examples of **projection** that I have ever heard.) It amazed me that a man who repeatedly tried to use guilt by association ("Loftus and her fellow lobbyists," "Loftus and other paid witnesses") and other innuendo (indirectly attempting to link her to a pedophile) could complain, his voice **rising** with indignation, that his opponents', ". . . tone has been ad hominem, anti-empirical, and emotional."

While he claims his opponents are anti-empirical and faults **them** for not doing research on traumatic memory, Calof neglected to cite his own empirical research. The fact is that there is a paucity of good research in this very difficult area. Yet he faults others, like Loftus, who have done an enormous amount of research, because he feels they have not done enough research or the kind he would like. Mr. Calof, about this glass house you live in . . .

Launching another attack on his adversaries, Calof stated that the "Explosion of poorly researched and sensationalistic media stories . . . coupled with the harsh, adversarial tone (of the False Memory Syndrome Foundation and) . . . of its advocates has kept us all so riveted to fast moving daily developments that we've scarcely been able to pause and reflect . . ." He feels that this has created a public crisis of confidence in therapists.

Maybe, the FMSF is totally responsible for this. Maybe, but let us reread this last passage, and leave out the material in parentheses.

Calof stated that the "Explosion of poorly researched and sensationalistic media stories . . . coupled with the harsh, adversarial tone . . . of its advocates has kept us all so riveted to fast moving daily developments that we've scarcely been able to pause and reflect . . ." He feels that this has created a public crisis of confidence in therapists.

Is the FMS Foundation totally responsible for this atmosphere and for this public crisis of confidence in therapists? Not Roseanne with her 17, 21, or whatever number of personalities? Not the million and one dramatic reports of abuse in books, magazines, and on talk shows; not the startling statistics on the supposed number of people who have been abused—statistics made on questionable assumptions using widely varying definitions of abuse? Not the therapists claiming that they can tell in **one** session

whether someone has been abused or not?

A last accusation by Calof . . . In referring to Loftus and others, he accused them of setting up a straw man in the form of "Robust Repression" and refusing to deal with the real issue. Speaking of setting up straw men . . . Calof attempted to mock the False Memory group and their contention that therapists could implant false memories by the following example. "If a person insists they were not abused and I insist they were, they are unlikely to believe me." The implication is that, therefore, when clients do report abuse, it is not because some therapist has dissuaded them from their strongly held beliefs or memories. He is probably right most of the time; but, once again, he missed the point. While a person "who insists they were not abused is more likely not to believe a therapist who tries to insist they were," what about the people who come into our offices every day who are confused? What about those who are not sure if they were abused or not? What if their memories are vague or nonexistent? How susceptible are these patients to suggestion?

Though I clearly have more problems with Calof, Loftus' work certainly has flaws. Calof was right to point out that much of her laboratory work on memory has limited external validity when it comes to traumatic material. There is increasing evidence from the work of LeDoux (1989) and others that emotional experiences are processed differently in the brain than intellectual ones and therefore, may be remembered differently. Also, I feel that she was guilty of a serious logical error when she cited the work of Poole and Lindsey (1995).

Loftus reported that when she first began looking into this issue of false memory, she assumed that there might be a very low percentage of therapists doing this type of work and thus the damage they caused would be limited. However, citing the Poole and Lindsey study, she expressed her concern at the results of the study suggesting as many as 25% of the people surveyed from the National Registry were doing this kind of work and that obviously the negative impact must be far greater than she realized. The error she made is that the question is not how many people might be doing various kinds of experiential work, but how many of them are doing it badly.

These concerns about Loftus' work, notwithstanding, my emphasis in this critique has been on the **manner** in which the debate was conducted. That is why I focused more on Calof's comments. The manner and style of his comments are where the poetry in his work resides. Unfortunately, the poetry is that of Yeats (1920) in The Second Coming:

". . . for the best lack all conviction and the worst are full of passionate intensity."

I do believe that it is not passionate intensity alone that will help our clients, but a passionate commitment to truth and mutual respect. If we cannot discuss our differences with a tone of openness and mutual respect, we are unlikely to make progress in helping our clients. If we cannot agree to disagree civilly, if we are not strong enough to accept our limitations and the ambiguities of life, then this crisis of a lack of confidence in therapists that Calof spoke of will grow stronger—and we shall have earned that lack of confidence.

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A Response to Dr. Zangwill

David L. Calof

I fervently agree with Dr. Zangwill's wise counsel that "we must accept our limitations and the ambiguities of life." For the last two years, I have provided extensive training for trauma and abuse recovery therapists on the countertransference to client doubt, uncertainty, and ambiguity. I have emphasized several key principles in these presentations:

1. Therapists must honestly accept and express that they can neither bear witness to a client's disputed or uncertain memories, nor prove them wrong without independent corroboration.

2. Client doubt and uncertainty relative to recovered memories have a valuable underlying function, whether the memories are true, partially true, or false. The therapist must value and reflect back the client's doubt and uncertainty.

3. Therapists must provide a container in which clients can examine all sides of their conflicts over memories of abuse. Therapists must never take advocate (sic) for one side of the client's conflicts.

4. Therapists should work with clients to identify the underlying motivations, needs, and drives being expressed in the confusion over recovered memories. This is proper "grist for the mill." Therapists should focus on the dynamics surrounding the surfacing and subsequent confusion over memories of abuse more than on the content of memories themselves. This moves the therapy from a forensic quest for veridical truth to a discussion of issues that are more its proper domain: containment, cognitive distortion, secondary gain, and so on.

5. Therapists should confront attempts by clients to export the locus of authority regarding their memories or to place the therapist in the role of arbiter of clients' perception.

6. Therapists should confront client's illogical beliefs and improbable recollections as possible distortions of fact.

7. If the disputed memories are to move from the psychotherapeutic to the forensic domain, therapists should encourage clients to seek corroboration.

As a specialist in the dissociative disorders, I am very familiar with the human capacity to create self-hypnotic "reality" and to distort memory. I have written about my own false memory of childhood (Calof, 1994). In fact, I was an early voice in this polemic about the potential for distortion of memory (see, for example, Calof, 1993). Regrettably, Dr. Zangwill's review places me in two improbable positions: 1) disbelieving that clients are suggestible and vulnerable to the therapist's influence and 2) believing that the media and the False Memory Syndrome Foundation, Inc. are "totally" responsible for creating the present public crisis of confidence in psychotherapy. Both mischaracterize my beliefs. In numerous speeches and seminars (including one at the recent EMDR annual meeting), I cited the many of the field's contributions to the public erosion of confidence, for which the profession must bear total responsibility:

1. Therapists have acted out their inability to contain clients' unmetabolized rage, grief, and desire for revenge and retaliation by encouraging clients to export raw affects into their families or into the legal domain in the form of ill-advised confrontations or legal suits.

2. Therapists have adopted an *in loco parentis* attitude that shifted clients' locus of authority or responsibility to the therapist.

3. Therapists have engaged in premature uncovering and making "memory work," as opposed to personality integration and functionality, the goal of therapy.

4. Therapists have demonized client families through projective identification, splitting, and political correctness.

5. Unrecovered abuse survivor therapists have projected their own unresolved material onto their clients and influenced their clients to vicariously act out their material.

Dr. Zangwill's review does refer to a central point of my talk—the distinction between repression and traumatic dissociation. Unfortunately, the review does not discuss this important issue, which occupied more than a third of my talk, so let me reiterate this crucial point.

FMSF Scientific Advisory Board members (including Loftus, Ofshe, McHugh, and others), in their frequent roles as hired expert witnesses against psychotherapy clients and therapists, tend to root their theoretical objections against traumatic amnesia not in the literature of *dissociation*, but in Freudian *repression*. In circumventing the literature on dissociation, they go so far as to invent *de novo* concepts such as "total" or "robust repression" and "recovered memory therapy." They then attribute these invented concepts to their ideological opponents and proceed to refute them. In railing against these strawmen, they demonstrate little awareness of the rich body of clinical and experimental evidence on traumatic dissociation, dissociative disorders, and psychogenic amnesia that guides their ideological opponents' practice. This confusion of tongues has unnecessarily muddied both professional and public discussions.

Let me summarize the critical distinction between repression and traumatic dissociation. Early in his career, Sigmund Freud recognized dissociation as a fundamental clinical mechanism in his hysterical patients who reported childhood sexual abuse. He noted, "the splitting of consciousness .....exists rudimentarily in every hysteria," and considered "the tendency to this dissociation [to be] the chief phenomena of this neurosis" (1936, p.8). By 1897, however, Freud fundamentally stopped believing his patients reports of childhood sexual trauma. Thus he abandoned the traumatic dissociation framework and subsumed the dissociative phenomena under his new concept of repression: the central psychoanalytic tenet that people tend to inhibit (and consequently tend not to remember) unacceptable wishes, impulses, affects, and especially unacceptable sexual impulses.

We mistake ourselves when we call the dissociation of a traumatic experience "repression." We must learn to distinguish between not remember-

ing (simple forgetting), burying intact memories (repression), and never consciously knowing the whole of a memory (traumatic dissociation). FMSF Scientific Advisory Board members, such as Loftus, simply ignore the well recognized and documented phenomena of dissociation, which we often see in trauma survivors. These phenomena can not be explained by "repression" alone:

-Trance/autohypnosis
-Personality-splitting/compartmentalization
-Automatic behaviors/automatisms
-Derealization and depersonalization
-Amnesia [total, selective, or partial]
-Fugue states
-Somnambulism
-Regression
-Time distortion
-Dissociative identity disorder
-Analgesia/anesthesia
-Sensory delusion/hallucination

Traumatic amnesia and dissociative phenomena long have been recognized as common sequelae to traumatic stressors including disasters, violent crime, assault and sexual assault, torture/mind control, concentration camps, cults, child abuse, vehicular and industrial accidents, life threatening events, multiple traumatic events, combat and war. Psychogenic amnesia has been included in the American Psychiatric Association's compendium of mental disorders since it was first published in 1952 (DSM-I). Despite a rich literature (going back to Charcot's earliest observation in 1872 that his hysterical patient's stream of consciousness often broke into diverse components), Loftus and her fellow FMSF Scientific Advisory Board members insist that trauma clinicians have invented a de novo theory: "robust repression."

Dr. Loftus is forthcoming regarding her lack of knowledge in this area, as in this segment from a recent deposition from a case in which she argues as a paid expert witness against robust repression:

> Q. What is your understanding of the difference between dissociation and repressed memories or repression?
>
> A. I don't know the psychotherapy distinction or whether there's even any agreement about what that is.
>
> Q. In your opinion, would the difference be important in a research setting?
>
> A. I'm interested in the accuracy of memory or the malleability in memory. So, it might be important to somebody else (Loftus, 1993, p. 30-31).

Dr. Loftus ironically overlooks the classic work in dissociation by the founder of her own field of cognitive psychology, the eminent psychologist Clark Hull. In 1933, Hull concluded the first extensive systematic experimental investigation of dissociation. This historic, decade-long study yielded thirty two published scientific papers and a book. Summarizing his results, Hull concluded that ample evidence existed to support the concept of *dissociative states of consciousness*. Hull found that great variations could exist in the range of "functional independence" between dissociative states—ranging from "completely amnestic and severed, to highly associated and interfering." Hull summarized the clinical evidence for complex, dissociative amnesia:

> "Many cases of amnesia have been studied and reported in voluminous detail.... Extensive amnesias are very apt to be associated with shocks of some kind...the shock may be an emotional disturbance or even a moral conflict....cases not infrequently appear in which the patient can recall nothing of what took place during a period of several months or even years" (p. 106).

Having studied the extensive clinical literature on amnesia, Hull gave credence to the wealth of clinical reports demonstrating hypnotic recall of lost and traumatic memories:

> "...if we take the clinical reports at face value, there is a great mass of evidence not only to the effect that the hypnotic trance is able to facilitate recall of memories which have been inhibited by trauma of various kinds, but also that it greatly facilitates the recall of ordinary memories of early childhood" (p. 125-126).

Though he gave them much credence, Hull, like Loftus, was an experimental psychologist and did not accept the clinical reports at face value. Even though he understood that clinical investigators usually obtained corroboration for the refreshed memories they reported, Hull recognized the scientific difficulty of determining the genuineness of the memories reported in the extensive clinical literature. After posing the difficulties with the clinical data, Hull turned to the results of laboratory experiments observing, "Luckily it is not necessary to depend entirely upon such uncertain [clinical] data" (p. 111). Hull cited a variety of experimental evidence he believed "strongly substantiated" his position and reinforced the clinical findings.

"There is some striking experimental evidence which...tends strongly to confirm the clinical observations that hypnosis facilitates the recall of childhood and...other remote memories" (p. 127).

Regrettably, Loftus' latest book *The Myth of Repression* is not subtitled *The Reality of Dissociation.*

While forcefully avoiding the substance of my arguments ("...my emphasis in this critique has been on the **manner** in which the debate was conducted"), Zangwill's review claims I made "over 30 different ad hominem attacks" against Dr. Loftus. It is far

less meticulous, however, in listing them, naming only that I "repeatedly tried to use guilt by association" and "other innuendo (indirectly attempting to link [Loftus] to a pedophile)." Regardless, these charges are serious and deserve a response.

Regarding the claim of guilt by association, the review pulls from context phrases such as "Loftus and her fellow lobbyists," and "Loftus and other paid witnesses." Nonetheless, I stand by each of these statements. In each case, the error of logic or unempirical claim I cited are legion among the FMSF advisory board members who function as paid experts and who are associated with a national lobbying effort to codify their dubious assertions into law.

As for the charge that I attempted to link Dr. Loftus to a pedophile, first let me hasten to say that I have no certainty that the man in question is indeed a pedophile. Having been privately accused by his adult daughter of incest, Chuck Noah, of Seattle, Washington, began a boisterous public effort to proclaim his innocence. It is well known in the Northwest that in this process he joined forces with Loftus. Loftus met with Noah in 1992 and commented favorably on his case to a major Seattle newspaper. At the time, Noah was under a court order to stop harassing his daughter's former therapist and to seek counseling (an order he broke and was subsequently fined for and put on probation). Loftus told the newspaper that she found Noah "'extremely sincere' about his denial of abuse of his daughter" (Penhale, 1992, B1). Commenting in this same story on the daughter's abreactions, and without benefit of any direct examination, Loftus declared, "There is absolutely no scientific evidence that these flashbacks correspond to some specific event" (B1). [1]

Noah and his accusing daughter consider themselves to be recovering alcoholics. Perhaps because Loftus is not a trained clinician, she apparently failed to consider Noah's self-admitted earlier heavy drinking as a factor in the accuracy of his memory or his denial. Even while the FMSF publicly acknowledges a high incidence of alcohol abuse among its members, FMSF scientific advisory board members such as Loftus have not spoken to the possibility that at least some of the "falsely accused" are suffering from alcohol-induced memory defects. Long before the controversy over delayed memory, Loftus observed that alcohol can impair a person's memory *without their knowledge*:

> "It is not uncommon...for people to say, 'I drink because it helps me to forget'...There seems to be very little doubt that regardless of whether a person is an alcoholic, a heavy drinker, or a moderate drinker, the ingestion of a few drinks impairs memory processes...Although most drinkers are unaware that their memory is impaired, laboratory tests demonstrate that alcohol significantly interferes with the efficiency of memory...events experienced under the influence of alcohol cannot be as well remembered as events experienced during the sober state" (1980, p. 88-89).

Loftus' incomplete and public psychological evaluation was a great boon to Noah's cause. Having thus touted Noah's position, Loftus then joined forces with him in secondary roles to organize the local "false memory syndrome" group. Since then she has enjoyed a lucrative referral relationship with Noah and his fellow members.

While I did not attempt to "link [Loftus] to a pedophile" as Dr. Zangwill's review would have us believe, I still consider the association an unsavory one.

In the end, Dr. Zangwill wisely counsels that we must "agree to disagree civilly." I agree, but when Dr. Loftus insists in the media time and again that therapists induce false memories solely for "profit motive," she does little to shed light on the complex transference and counter transferences that shape clients' memories and therapists' responses. With these kinds of ad hominem attacks more the rule than the exception among those associated with the "false memory" movement, there is little hope of elevating the debate.

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Footnote

1 Readers should note that prior to her becoming a member of the False Memory Syndrome Foundation, Inc. Scientific Advisory Board, an organization that generally holds that people do not forget traumatic experiences, Dr. Loftus described the phenomenon of "motivated forgetting" (1980, p. 71-73). She wrote that "forces seem to

operate to help people forget [traumatic experience], especially when such forgetting would make life more bearable" (p. 82). To illustrate this concept, Loftus cited cases of airplane crash survivors who forgot both their crashes and subsequent rescues. She also discusses a case study (from Zimbardo & Rush, 1975) of a college professor who lost her memory traumatically: "It seems that she had suffered an incredible series of traumatic events within the past year climaxing with the breakup of her marriage and the sudden death of her mother before her eyes. Amnesia put all that past ugliness, and more, out of awareness. In its place this motivated forgetting had given her peace of mind" (1980, p. 73). Though the woman dissociated her identity and much of her memory, she held onto her professional knowledge (English literature) "so that she was able to teach again even before the rest of her memory returned" (p. 72). Over time, the patient pieced together the memories that had led to her massive traumatic amnesia. Identifying with the woman's plight, Loftus quotes from Christina Rosetti's *Remember* : "Better by far you should forget and smile than that you should remember and be sad." This sentiment is a far cry from the "false memory syndrome" hypothesis, which holds that people "forget" a happy childhood in order to "remember" terrifying "false" memories.

VISION THERAPY

Greg Gilman, O.D., D.O.S., FCOVD

Vision therapy is a series of clinical procedures that improves the quality of visual skills and vision perception. It has a long clinical history dating back to the previous century. It began in England and France and was originally named orthoptics. The name orthoptics comes from ORTHO meaning straight and OPTICS meaning eyes. Many of the original techniques were dedicated to treating those who had crossed or lazy eyes. In the past 40 years, optometrists have further developed vision therapy procedures for treating vision related learning problems, particularly those visual problems that result in poor reading ability. Behavioral optometrists use vision therapy to improve eye movements, eye coordination, focusing and vision perception. These are the sensory motor components of vision.

Visual skill deficits are almost always present in those who cannot read adequately. Frequently, the vision aspect is just part of the problem, but it is a crucial part. The three basic vision skills necessary for reading are eye movements (tracking), eye teaming, and focusing. These skills are independent of eyesight or 20/20 acuity. Most poor readers have 20/20 eyesight, but still lack the visual skills necessary for reading. The term 20/20 does not mean perfect vision. It only means that a letter 5.5 millimeters high can be seen at 20 feet. Visual acuity (20/20) is a single, small aspect of the totality of vision.

Although many poor readers can see 20/20, they may still have a vision problem that causes them to lose their place while reading. Losing their place occurs because they have not developed an appropriate skill level of eye movements. As long as the eye movement ability is inadequate, they will not be able to keep their place while reading. Consequently, their reading ability is below their intellectual potential. These eye movement skills can easily be improved with vision therapy.

There are many techniques to improve eye movements. One of the most common techniques is using a 4-inch rubber ball suspended on a string from the ceiling at eye level. The ball has 100 press-on letters on its surface. The patient is instructed to keep his or her or head still and track the ball, reading out loud as many letters as possible. The ball is moved in a lateral direction to simulate reading. There are many modifications to this technique to train eye tracking ability.

The other major visual skills of eye teaming and focusing can also be improved with vision therapy. Those who have problems with eye teaming and focusing will often have trouble with reading comprehension, visual comfort, blur, headaches, or generally decreased ability to read efficiently. It is always surprising to find that a large percentage of the population, particularly professionals, do not feel that they read as well as they should. It is often assumed if the intellect is adequate, then reading should be second nature. However, in addition to intellect, reading involves the whole sensory motor visual system. This sensory motor system involves tracking, focusing, eye teaming, and visual perception. Weakness or inadequate ability in any of these sensory motor skills may affect reading, sports, driving, movement, posture, and any activity that has vision as a component.

When the vision skills of tracking, eye teaming, and focusing are improved, perception skills often improve. Perception is understanding input; in this case, visual input, but there is a connection between all perceptual systems. Improving the speed and accuracy of taking in visual information can obviously help reading, but it may also help many other aspects of perception. Helping the individual improve his or her intellectual performance has additional benefits. Some of these enhanced abilities positively affect the ego and self esteem. This is evident in young children who have previously been having learning difficulties. Nothing is more exciting than finding out that "you are not dumb, you were just not perceiving appropriately."

The same situation occurs in adults; we often see them express emotional reactions when they learn to process visual information more efficiently. For example, adults with poor eye teaming and subsequent limited or

nonexistent depth perception have always seen the world flat. Therefore, spatial concepts are confusing to them. When they improve their eye teaming ability, the result is often greatly improved depth perception. With improved understanding of the spatial environment, the emotional changes that occur are sometimes overwhelming, especially when the adult sees depth for the first time. They talk incessantly about how three-dimensional the world now looks. Several patients have written books about these changes that have profoundly changed their lives.

We have identified a visual syndrome called the Streff syndrome. In the past, we assumed this was strictly a sensory motor problem and we prescribed reading glasses and vision therapy with excellent results. We have attempted to differentiate this syndrome from hysterical amblyopia, although we have always known there is a psychological component to the syndrome. It typically occurs in children 6-11 years of age. These children have not had a previous history of vision problems. They are typically better than average students and the ratio of girls to boys is four to one. When they go into the syndrome, their distance vision becomes slightly blurred and their near vision becomes more blurred. They lose color discrimination ability and depth perception, and they are not able to focus accurately, particularly at nearpoint (the reading distance). In addition to the decrease in focusing ability, they also lose the ability to track and eye team accurately. They also exhibit restricted peripheral vision, sometimes tunnel vision. They often become poor students during the time they have the syndrome. The syndrome occurs typically in the late fall and early spring. Part of the therapy for this problem is tracking exercises.

For many of these patients, tracking is very difficult, even though they may previously have had good tracking skills. The reduction in peripheral vision may be part of the reason tracking is so difficult. With tracking exercises, we are working on expanding peripheral vision as much as we are directly improving tracking. In times of high stress, many individuals constrict their peripheral vision. This is accurately documented with threshold visual fields. The same peripheral vision constriction may be true for traumatic stress syndrome clients. I would strongly suspect that many traumatic stress syndrome clients have reduced peripheral vision. As far as I know, this has not yet been researched.

Learning about EMDR makes me wonder what we have actually been treating with the Streff syndrome. We have known it was stress related, but we thought it was simply sensory motor stress. In the last several years, we have found children who have been sexually and physically abused and show the same clinical pattern of excessively reduced vision skills. Sometimes we have done vision therapy in conjunction with psychotherapy for these children. We always do tracking exercises for this problem. And during the tracking training, we are talking to the patient about his physiological feelings. When we get to the point that the child can feel his or her eyes track, team, and focus, we are usually done with therapy. My clinical judgment is that these children were probably helped sooner with the use of both therapies, but there is no research to document this.

The sensory motor triad of eye movements, eye teaming, and focusing are easily measured by behavioral optometrists. We have literally hundreds of methods and instruments to measure these skills. We also know that they are directly related to perception. Sometimes vision therapy is done for the three basic skills only and perception improves. Other times vision therapy is done for the three basic skills and then perceptual training is done. Behavioral optometrists are convinced that these vision skills are necessary for normal physiological and psychological function.

In the past 10 years, we have begun to work with head trauma patients. There is a long history of many head trauma patients who have trouble with short-term memory and reading after head trauma. In the past, these problems were never directly addressed. We now know that many of them have convergence problems after trauma. They have lost the ability to team their eyes together at nearpoint; they can no longer converge their eyes for reading and nearpoint activities. Through previous records, we know that this was not the case before the accident. The good news is that these patients are now receiving vision therapy and regaining their short-term memory and reading ability. This result has come from the combined efforts of behavioral optometrists and occupational therapists. The referral relationship that has been developed has greatly helped many patients.

Recently, a patient was referred to my office by a clinician for vision therapy. The patient had been diagnosed with traumatic stress syndrome. However, the clinician had trouble using EMDR because the patient had exceedingly poor eye movement ability. Her ability was so poor that she tended to move her head rather than her eyes. We know from research that children as early as 42 months of age have the ability to move their eyes separate from head movement (Gilman & Gottfried, 1983). This 44-year-old woman was not able to follow a moving object without moving her head and she exhibited several visual skill deficits. I did conventional vision therapy for eight weekly visits and gave her home vision therapy exercises. We worked on eye movements, eye teaming, focusing, and spatial perception. A significant amount of therapy was dedicated to whole body movement in space. She had difficulty moving and we used prism techniques to help her. At the seventh visit, the patient told me about her traumatic stress situation. I listened

and did not make any comments. I felt that her psychological stress situation would be treated by the referring psychologist. She finished the vision therapy with improved visual skills and she could track sufficiently for EMDR. I noticed that at the third visit she began smiling and seemed more at ease. Upon referral back to the psychologist, I was told that the patient no longer had the traumatic stress syndrome.

The way we see has a lot to do with the way we think. We know that thinking and seeing are related. That is easy to say, but extremely difficult to research (Gilman & Gottfried, 1985). Behavioral optometry has been criticized by medicine for 40 years because we did not have the research to prove what we were doing. However, at this time there is not a school district or remedial teacher in the country that does not understand that tracking (eye movements) is necessary for reading. This is now common knowledge because we fought against the criticism and persisted in what we were doing; we knew that it helped our patients. We are now just beginning to have some of the neurological explanations of why vision therapy works. As clinicians, we feel our first responsibility is to our patients and their problems. Eye movements were first accurately measured in the 1970s, although we have been doing eye movement training since the 1920s. It would have been sad if we had waited for the research BEFORE we used the techniques.

Vision therapy has been researched extensively and we know what it does. We are still trying to determine how it works. EMDR has a similar situation—i.e., the underlying neurological mechanisms are still not well understood. This would appear to open the possibility of mutual benefit from research on the neurological mechanisms of ocular motilities and their correlates. I think there is sufficient common ground for future bridges between vision therapy and EMDR. I would be happy to answer any letters or faxes. Greg Gilman, O.D., P.O. Box 3590, Quincy, CA 95971; phone (916) 283-2206; fax (916) 283-4976.

Additional information may be requested from:

Optometric Extension Program Foundation, 1921 E. Carnegie Avenue, Suite 4L, Santa Ana, CA 92705; phone (714) 250-8070; fax (714) 250-8157.

College of Optometrists in Vision Development, Box 285, Chula Vista, CA 91910.

References

Gilman, G. D., & Gottfried, A. M. (1983). Development of visual skills in infants and young children. American Optometric Association Journal, 54(6), 541-543.

Gilman, G. D., & Gottfried, A. M. (1985). Visual skills and intellectual development: A relationship in young children. American Optometric Association Journal, 56(7), 550-554.

To: Dr. Francine Shapiro
Jim Kohl
Partell Medical Center

This letter was sent to me with a request for information. I am forwarding it to network members for possible brainstorming. Please contact the author directly, and write up any ideas. Jim Kohl, Partel Medical Center, Ste. 300, 2870 S. Maryland Pkwy., Los Vegas, NV 89109.
email: 76357.1414@compuserv.com

In a newspaper account of your link between rapid eye movement therapy and mental illness, I noted your speculative correlate with REM sleep.

In my literature review of psychoneuroendocrinologic studies linking olfaction; genes; nerve cells; hormones; and behavior, I have found support for your speculation. To detail this support fully would take considerable time. I can, however, provide some basics.

There is evidence of changes in gonadotropin releasing hormone (GnRH) pulsatility which occur during REM sleep. Most notably, these changes are associated with the onset of puberty—and with sexuality—as measured in humans by assay of luteinizing hormone (LH). In various mental illnesses, the changes are also apparent (e.g., anorexia nervosa, where LH is used as a predictive index of recovery).

Recent evidence also suggests that mammalian olfactory and visual pathways are linked at the neuronal level. Moreover, humans have been shown to exhibit an LH response to visual stimuli—a neuroendocrine response that can be classically conditioned in other mammals.

The conditioned response typically has been shown to occur with paired olfactory stimuli. I have also read that, in many cases, post-traumatic stress can be triggered by olfactory stimuli; therein lies one link between your work and mine.

It is also interesting to note that many of the pharmacologic therapies used in the treatment of mental illnesses act on the EnRH neuronal system (e.g., dopamine, serotonin, opioids, etc. all act on GnRH secretion), and GnRH is unequivocally required for the release of LH.

I propose that with REM sleep, we incorporate life's experiences that in many cases are associated with LH release. That traumatic experience may incorporate a strongly negative experience with LH secretion—one that could also be reissued from the subconscious during REM sleep or with induction of a similar physiological state by a particular trigger such as olfaction or eye movement—may explain more of the "big picture."

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