EMDRIA

December 2013 The Information Resource for EMDR Therapists Vol 18 Issue 4

Time for Reflection:
The 2013 accomplishments of the EMDR Community

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A word from the President...

Kate Wheeler, Ph.D., APRN, FAAN
EMDRIA President

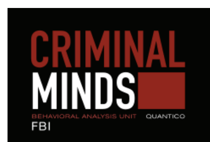
Since this is my last newsletter column of the year as EMDRIA's president, it is a time for reflection. EMDR's 25th anniversary celebration, to be held next year in Denver, presented the opportunity for me to develop a power point for the annual Conference in Austin this past September that chronicled the highlights of EMDR's history. I learned how far we have come since the first EMDR research article that was published by Dr. Francine Shapiro in 1989. As I look back on 2013, a number of seminal indicators seem to herald a shift toward a new paradigm that has gained momentum and perhaps, just maybe we are at the cusp of a scientific revolution?

Thomas Kuhn's classic book *The Structure of Scientific Revolutions* provides a philosophy for how science progresses and tells us that when a new candidate for a paradigm change emerges, a battle ensues over its acceptance. EMDR started as what Kuhn would call an anomaly, that which causes the fundamental assumptions of the dominant paradigm to become subject to widespread doubt. Initially prior to the birth of a new paradigm, scientists try to devise ad hoc modifications of the dominant theory in order to eliminate any apparent conflict. Many scientists continue to persist in the view that the old paradigm will eventually produce a solution to the apparent anomaly. Kuhn's ideas provide an explanation for the resistance and animosity toward EMDR by the establishment. By the establishment, I refer to the Institute of Medicine, federal funding agencies, the Department of Veteran Affairs, and all those who are adamant in distorting the research on EMDR's efficacy and insisting that EMDR is a type of CBT contrary to the differential findings of brain imaging studies, proposed mechanisms of action, and treatment strategies.

As we approach EMDR's 25th birthday, we have become hard to ignore. There is a growing recognition that the current paradigm does not explain the emergence of this unique and powerful therapy. Even though no one knows how any psychotherapy really works, questions are constantly raised about EMDR's mechanisms of action. EMDR has pushed the rules of normal science and as Kuhn would say created a crisis by challenging the status quo. As the supporters of EMDR have increased, a new paradigm has emerged with a specialized journal and articles, professional organizations here in the U.S. and abroad; and a discipline has evolved with the beginning of academic acceptance in some Universities. These accomplishments according to Kuhn are hallmarks of the birth of a new paradigm.

Kuhn also maintains that social factors help explain science's history. With the onslaught of natural disasters, shootings, and wars, the treatment of trauma and trauma-related disorders has assumed new importance. Even the new DSM has created a category for Trauma-Related Disorders; not quite inclusive of what most of us think should be in that category but it is a start toward recognizing that indeed trauma wreaks havoc on mental health and creates disability and mental illness.

Another indicator that EMDR is a therapy whose time has come is the increased public attention, interest and visibility as evidenced by the number of news articles and TV shows about EMDR in 2013. Some of the news shows this past year include KVOA/NBC News in Prescott, Arizona, Hardball with Chris Matthews, KAAL/ABC News Affiliate in Rochester, Minnesota, KSAL in Shreveport, Louisiana, KTSP in Minneapolis, Minnesota, CNN, PBS, 20/20 with Hugh Downs, The Doctors, NCIS Los Angeles and Criminal Minds, a crime show that showed a segment of an EMDR session to assist in solving a crime through memory retrieval. Also, 60 Minutes called me recently for information and said they were thinking of doing a segment on EMDR. EMDR seems to be gaining public acceptance even as we struggle with those colleagues in the scientific community who remain skeptical.



Continued on page 4...

Other noteworthy events in 2013 include the WHO endorsement of EMDR that clearly differentiates EMDR from CBT: *"trauma-focused cognitive behavioral therapy (CBT) and EMDR are the only therapies recommended for children, adolescents and adults with PTSD. However, major differences exist between the two treatments: "Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework."* (p.1). This acknowledgment and the 2013 Lee and Cuipjers published meta-analysis of EMDR studies confirming that the effect of eye movements in processing emotional memories was moderate and significant, clearly differentiates EMDR from CBT and further illustrates the shift toward a new emerging paradigm.

Somehow it is comforting to understand EMDR's evolution in Kuhn's broader context. EMDR created a crisis in normal science and we have weathered the pre-paradigm period and are moving toward greater acceptance, visibility and acceptance. This is how progress in science occurs and new paradigms are born. Next years conference in Denver with the theme "EMDR: Celebrating 25 Years of Healing" is the perfect time to celebrate the birth of a new paradigm. EMDR is grown up now and our ongoing advocacy for research, education and practice will eventually persuade most scientists to switch loyalties or as Kuhn maintains; they will be ignored by members of the new paradigm's established scientific community (us).

So, welcome to the revolution! Now is not the time to be complacent but to join forces with your EMDRIA colleagues in writing letters to advocate for EMDR; join and actively participate on an EMDRIA committee, special interest group, and/or regional network; support the Trauma Recovery/EMDRHAP programs; and contribute money for EMDR research. We have a lot of work to do as we advance our new paradigm. As the outgoing president, I deeply appreciate the opportunity to have served with such hard working Board members, both current and past. Thank you to the members of EMDRIA who have volunteered and given their energy, commitment and time to create such an exciting professional organization. It has been an honor to connect with the good people that EMDRIA attracts. ❖

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Andrew M. Leeds PhD Director
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March 22 and 23, 2014 Hampton Inn and Suites Oakland Airport-Alameda

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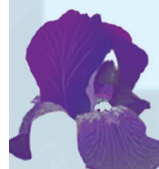

Laurel Parnell, Ph.D.

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Announcements

Call for Board of Director Nominations

The EMDRIA Board is beginning to solicit Director nominations for the Spring 2014 Election. The elected directors will serve a four-year term starting in January of 2015. In order to be qualified for the Directorship, you must be a Full or Associate Member of EMDRIA, and it is suggested that you have served on an EMDRIA committee for at least one year and/or demonstrated equivalent services for other EMDR or similar organizations, and demonstrate a clear and unambiguous commitment to and identification with EMDRIA. If you are interested in serving on the Board, please email Gayla Turner at gturner@emdria.org to request an application packet. Completed applications are due by February 15, 2014.

EMDRIA Office Closed

Please be aware that the EMDRIA Office will be closed the following days:

- Tuesday, December 24th and Wednesday, December 25th for the holidays.
- Wednesday, January 1st for New Year's Day.

EMDR Europe Conference

The 15th Annual EMDR Europe Conference will take place June 26-29, 2014 in Edinburgh, Scotland. The Scientific Committee invites you to submit an abstract by January 13, 2014. For more information on the Conference, please visit www.emdr2014.com.

Need EMDRIA Credits?

If you need EMDRIA Credits and are looking for a workshop in your area, check out our online Calendar of Events. When searching the Calendar of Events, be sure to select "EMDRIA Credit Programs" from drop down menu and then hit the filter button. Don't see anything in your area? Keep checking back as new workshops are received and added to the calendar every week or view the list of Distance Learning Programs that offer EMDRIA Credit.

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4000 G	Yes	Adjustable	Green	Yes	No
4000 GM	Yes	Adjustable	Green	Yes	Yes
4000 B	Yes	Adjustable	Blue	Yes	No
4000 BM	Yes	Adjustable	Blue	Yes	Yes
Deluxe	Yes	Adjustable	Red, Blue & Green	Yes	Yes

NEW!

Look, a Counter

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3 Tac/AudioScan models to choose from

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Advanced	Yes	4	Yes	No	No	Yes
Deluxe	Yes	4	Yes	Yes	Yes	Yes

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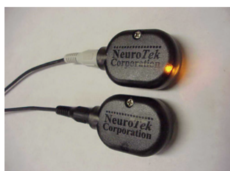

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Executive Director's Message

Mark G. Doherty, CAE
EMDRIA Executive Director

Our Conference in Austin was successful. We had 832 attendees, wonderful plenary speakers, and great workshops. What most of the attendees don't see is all the hard work that goes into the selection process and meeting preparation behind the scenes. The Conference Committee, chaired by Rosalie Thomas, works tirelessly to assure an educational program that meets the needs of our members. Even before a conference starts, the Conference Committee is onto the prep work and selection process for the next year. We've already secured plenary speakers for Denver in 2014. Dr. Francine Shapiro (Friday) Dr. Christine Courtois (Saturday) and Rolf Carriere (Sunday). Plan to come join us in Denver September 18-21, 2014 as we celebrate the 25th anniversary of the publication of Dr. Shapiro's article that introduced EMDR to the world.

This year, we have had a number of active committees that are doing fantastic work. The Advocacy Committee chaired by Jim Cole has been promoting membership activism to contact their US Representatives and Senators to assure that our active duty military and veterans get the proper treatment for post traumatic stress, which includes EMDR as an evidence-based psychotherapy. The Appeals Committee, chaired by Ira Dressner, is studying the need for a specific EMDRIA code of conduct and reviewing the process to handle grievances and appeals.

The Regional Coordinating Committee, chaired by Larry Nieters, has been instrumental in expanding the EMDRIA DVD lending library and building local EMDR communities. Committee members and other Regional Coordinators have been working with community mental health agencies providing low to no cost EMDR continuing education and consultation advice as part of their regional networks.

The Editorial Board of the *Journal of EMDR Practice and Research* headed by Louise Maxfield, Editor-in-Chief, completed another successful year of publishing a number of very fine articles. I also want to thank Andrew Leeds for taking on the role of a Special Issue Editor on the "Future of EMDR."

The Membership Committee, chaired by Brenda Rohren, continues its efforts on the university project and diversity. It is making great progress in creating a PowerPoint presentation to serve as supplemental material for course work at the upper class and graduate level. As part of the PowerPoint, we are going to have video clips to illustrate the eight phases and three prongs of EMDR. Sharon Walker continues to lead the university project.

The Public Practice and Diversity Subcommittee is seeking out and contacting organizations that represent diverse populations of mental health professionals and the clients they serve. PP&D is reaching out to speak, coordinate, and collaborate with EMDRIA's Public Practice and Diversity Special Interest Group, Regional Coordinators, and the board Task Group on Diversity that is becoming an administrative committee chaired by Diane DesPlantes. The subcommittee is developing a protocol to communicate with various organizations/associations and a database to keep track of contacts for follow-up.

With the emphasis on increasing membership at the heart of EMDRIA's strategic plan, the Membership Committee spent a good deal of time discussing and planning how to grow the membership base and improve retention.

The Standards & Training Committee, co-chaired by Jocelyn Barrett and Sharon Rollins, has been very busy. During the first eleven months of the year, 237 (live) advanced workshops were held offering EMDRIA Credits. Fifty-eight of these events were regional networks that borrowed a DVD from our RC Lending Program. There were three conferences held (the EMDR Europe Conference, EMDR Canada Conference, and Western Mass Regional Network Spring Event) and these events included multiple presentations and presenters for attendees. There are 36 distance learning programs available offering EMDRIA Credits. S&T reviewed and approved 80 EMDRIA Credit program applications. Nine new basic training provider applications were approved.

S&T collected a lot of information as part of its effort to review the EMDR Basic Training Curriculum Guidelines and is now finalizing what changes and/or modifications are deemed important in drafting revised BT Curriculum Guidelines. The committee continues deliberating the structure of a review cycle for existing approved EMDR basic trainings. S&T will be setting up a review cycle to periodically evaluate BT programs to assure that they are teaching the latest information on EMDR.

The Core Competency Subcommittee of S&T, chaired by Wendy Freitag, released a draft of its work-in-progress and presented its preliminary findings at our 2013 conference. A great deal of work is being done by the subcommittee to move toward a competency based model for certification in EMDR.

There are numerous volunteer opportunities as can be seen by the activities underway. If interested, contact me at mdoherty@emdria.org to let me know that you'd like to be part of our growing cadre of volunteers. My best to you for a happy holiday season and New Year. ❖

Conference Corner

It was wonderful seeing "all y'all" at the 2013 EMDRIA Conference in our home town of Austin! The plenary sessions got rave reviews this year. If you weren't able to attend, you may want to check the Conference audio recordings to hear Drs. Joan Borysenko, Vincent Felitti, and Robert Stickgold as they seamlessly lead us through the current research on the impact of stress on health and disease, the direct correlation of exposure to Adverse Childhood Experiences with physical and mental health throughout the lifespan and the current research on the mechanism of EMDR therapy. Of course, there were many outstanding workshops as well. Thanks to each of our presenters, volunteers, and our wonderful EMDRIA staff for making the EMDRIA Conference such a success.

We've already begun planning for our big anniversary Conference in Denver, September 18-21, 2014. The theme is **"EMDR: Celebrating 25 Years of Healing Trauma."** EMDR has grown and developed so much in these first 25 years! It's now known and practiced around the world. The Conference Committee wants to highlight the broad applications of EMDR across cultures, diagnostic categories, and throughout the lifespan.

We are excited to announce the line-up of plenary speakers! We have confirmed Francine Shapiro, Ph.D. for Friday's plenary, Christine A. Courtois, Ph.D., ABPP for Saturday and will wrap-up on Sunday with Rolf Carriere. We hope you're planning to join us!

2013 Conference Award Recipients

Francine Shapiro Award | Andrew Leeds, Ph.D.
Outstanding Contribution and Service to EMDRIA | Linda Bowers, MA, LPC
Outstanding Research Award | David P.G. den Berg and Mark van der Gaag (2012), Treating trauma in psychosis with EMDR: A Pilot Study. *Journal of Behavior Therapy and Experimental Psychiatry*, 43 (2012), 644-671.
EMDRIA Outstanding Regional Coordinator | Annie Monaco, LCSW-R - Buffalo EMDRIA Regional Network
Poster Winner | JoAnna Watson Wong, MFT - *"Using EMDR in Internet Video Sessions"*

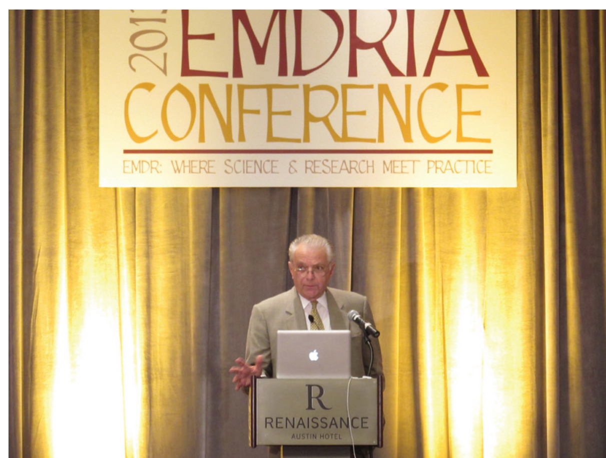
2013 Conference Recordings

Audiotapes and CD's from this year's Conference are available through Convention Media. You have the option to purchase a complete set of Conference recordings synchronized with handouts, a complete set of Conference recordings on MP3 audio CD, a complete set of Conference recordings on audio CD, or individual sessions. There are a few sessions that were not taped at the speaker's request. Please visit www.emdria.org and click on EMDRIA Annual Conference under the Get Involved tab to purchase audio recordings from 2013 or recordings from past EMDRIA Conferences.

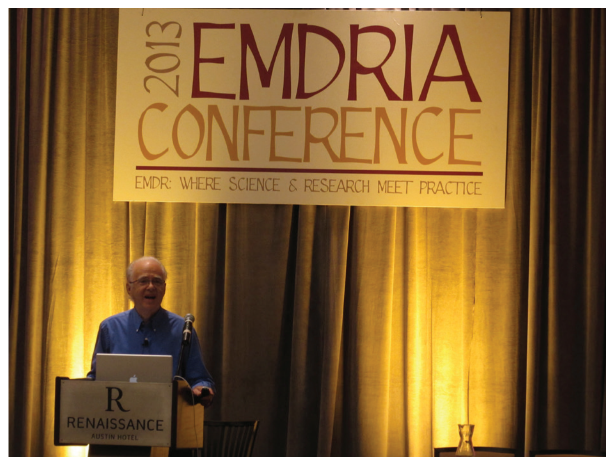
2013 Conference Handouts

For those who didn't attend the 2013 EMDRIA Conference, a Presentation Handout USB is now available for purchase. Past Conference Handout CD's are also available at a reduced price in the EMDRIA Store. Please visit the EMDRIA Store to purchase. ❖

Joan Borysenko, Ph.D.



Vincent Felitti, M.D.



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[ ] Sacramento, CA	Part 1: January 10-13	Part 2: February 21-23
[ ] Columbus, OH	Part 1 January 17-19	Part 2: March 14-17
[ ] Jackson, MS	Part 1: January 24-26	Part 2: March 7-9
[ ] Boca Raton, FL	Part 1: February 28-March 2	Part 2: July 11-13
[ ] Cookeville, TN	Part 1: March 28-30	Part 2: July 11-13
[ ] Des Moines, IA	Part 1: April 4-6	Part 2: May 16-18
[ ] Ashville, NC	Part 1: April 25-27	Part 2: June 5-7
[ ] Santa Maria, CA	Part 1: June 20-22	Part 2: August 1-3
[ ] Birmingham, AL	Part 1: July 24-26	Part 2: August 8-10

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EMDR RESEARCH FOUNDATION

BY WENDY J. FREITAG, PH.D. - *PRESIDENT, EMDR RESEARCH FOUNDATION*

The EMDR Research Foundation is not a part of EMDRIA; this article is published as a service to EMDRIA members.

2013 - Making Things Happen

Since the introduction of the EMDR Research Foundation (ERF) at the 2010 EMDRIA Conference, we've come along way. At the 2013 EMDRIA Conference our presence was expected, our energy was enthusiastic and passionate, and our mission accepted. As always the Conference provided a great time to learn, laugh and renew or make connections with others who are excited about EMDR therapy. We all know the power of this therapy and it provides the unspoken bond we all understand. Advancing the understanding and practice of EMDR therapy along with the essence of ERF creates a synergy like no other! As always the Conference provides the ERF Board members the opportunity to thank our donors and supporters face to face. We can send thank you emails or letters, but for me, there is nothing like personally thanking a donor with a warm handshake or heartfelt hug.

At our exhibit booth, like in years past, we held a raffle and a drawing for new Visionary Alliance (VA) members or those who increased their monthly pledge at our booth. This year Susan Zeichner signed up as a new VA member just minutes before the drawing took place. Susan won the grand prize of the time-share vacation week generously donated by Cynthia Kong and Gerald Puk. Other raffle or drawing winners include Cassandra Gorman, DaLene Forster, E.C. Hurley, Cossette Ahlburn, Robbie Dunton, Mary Ellen Bertling-Sefford, Joe Graca, and Irene Giessl. ***We are grateful to all of you who were entered into the drawing and everyone who played the raffle.*** I want to give special recognition to Irene Giessl, the winner of the Heads and Tails event at the Awards Dinner, who so generously donated her winnings back to the ERF. Thanks so Irene!

Next, I want to acknowledge the generous vendor donors who donating the great prizes. All of these vendors are long-term donors and I am grateful for their continuing support. A big thank to Doug Fisher of Neurotek, Carol Maker from EMDR Therapist Network, John White and Carol Thompson from HeartMath, Tom Isom from Convention Media, Ricky Greenwald from the Child Trauma Institute and Blair Dunn from Mentor books. In addition to Cynthia and Gerald, Katy Murray and Barbara Hensley also made generous donations for our booth activities.

We are all winners with the donations made at the ERF's largest fundraising event. These donations along with those made throughout the year make it possible for the ERF to fund research that is high quality and advances our knowledge of EMDR therapy. The most recent recipient of a $10,000 research award was W. Markus, a Ph.D. candidate from the Netherlands, along with his esteemed research team of Dr. G. de Weert, Dr. C.A.J. de Jong, Dr. E.S. Becker, and Dr. Hellen Hornsveld. The objectives of this study are to determine the acceptability, feasibility and efficacy of EMDR as an intervention to reduce craving and alcohol use in alcohol dependent outpatients and gain insight in working mechanisms. The study design is a randomized controlled trial and it addresses an important and timely area of research – the impact of EMDR therapy on outcomes for persons with alcohol dependence.

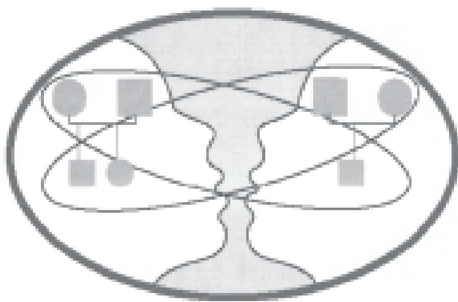
In addition to funding research, another important ERF initiative is the "Translating Research into Practice" (TRIP) Column in the Journal of EMDR Research and Practice. This column is edited by the ERF and provides a link between research findings and their implications on clinical work. It also provides clinicians the opportunity to share how a particular research finding has impacted their work with clients. Please check out the newly updated column, EMDR With Recurrent "Flash-Forwards": Reflections on Engelhard et al. 's 2011 Study. Journal of EMDR Practice and Research, 7(2), 106-111. http://dx.doi.org/10.1891/1933-3196.7.2.106. In this column, Lisa Bellecci-St. Romain references Engelhard et al.'s (2011) study examining the impact of eye movements on recurrent, intrusive visual images about potential future catastrophes-"flash-forwards." Like Lisa, if you have found a research study or article that has been useful in your clinical practice, we would love to hear about your experience. Please contact our Education Committee Chair, Katy Murray (katymurraymsw@comcast.net) to find out how you can be a part of this effort.

The ERF Board is extremely pleased to welcome Karen Forte, MSW from Bend, Oregon to the Board of Directors. Karen is well known to the EMDR community and has been a very active advocate for EMDR therapy locally, nationally and worldwide. Karen created and continues to moderate a listserv for Central Oregon EMDR therapists to keep them informed of EMDR therapy related activities and referral information. She received EMDRIA's "Outstanding Regional Coordinator" Award and served as the Regional Coordinator's Committee Chair and a member of the S&T Committee. As an EMDR HAP (now Trauma Recovery) volunteer, she has been very involved in numerous projects spanning the globe from the USA, Canada, Sri Lanka, Turkey, Bangladesh and Granada. Karen has an impressive list of volunteer activities and memberships in non-EMDR organizations as well. Karen has been a long-standing supporter of the ERF's vision and mission and we are very delighted and fortunate to have her on our team. Welcome Karen!

I would be remiss if I did not mention again our new online donation system. First I want to thank all of you who have transferred your membership to the new system and your continued support of the ERF. We are hoping to have the transfer complete by the end of the year, so for those of you who have not done the transfer yet, we kindly ask your cooperation in this effort. If you have any questions about this you can contact me (wjfreitagphd@gmail.com) or call the office at 512.571.3637 and Angie would be happy to help you. Thank you to all for your effort and patience during the transition.

All in all, 2013 has been a great year for making things happen. The ERF expanded our outreach with the military and general monthly e-newletter, and we exhibited at another mental health conference. We created the Resource Research Directory, a multi-purpose Directory compiled to support clinician's access to information and guide the development of research projects. We also continue to reach clinicians through the newly updated "Translating Research into Practice" column. The ERF awarded funds to two research teams and the first consultation award, all with the purpose of advancing the knowledge and understanding of EMDR therapy. In closing, I offer my sincere gratitude to all of our donors for your sustained financial support and who made these efforts possible and successful. As well, I thank the Board members, who gave another year of unselfish time, effort and money to forge our efforts forward. My wish to everyone is a Blessed Holiday Season and a Peaceful, Prosperous 2014.

"It had long since come to my attention that people of accomplishment rarely sat back and let things happen to them. They went out and happened to things."
— Leonardo da Vinci ❖



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In the Spotlight: Peggy Moore

BY MARILYN LUBER, PH.D.

Turning points in our lives often contain earth-shaking events precipitating a change in worldview some times over time and sometimes in a flash. Margaret, or Peggy as we know her, Vasquez Moore has had a number of these: moving to South America; the death of her father at 8 years of age; moving back to New Mexico; attending the American University of Lebanon at a volatile time; being discriminated against when she returned to a university in the States for being a woman; learning EMDR; and working on the EMDR HAP projects that went to many areas of the Arab-speaking world.

Peggy's family came from the old, the new and the indigenous worlds. Her mother, Rossie Roycraft, was from Northern Wisconsin with family roots in Canada, Ireland and England. The Irish Protestants in her family settled in the northern area of Wisconsin and have reunions in Chippewa Falls, calling themselves the "Irish Settlement." Her father, Daniel Vasquez, had an equally interesting history. His family came from Mexico in 1575 and may have been Conversos (Jews or Muslims who converted to Catholicism in 14th-15th century Spain) who immigrated to the new world and ended up on the Northern Mexican frontier. They remained Catholic until her grandfather converted to Protestantism. In 1933, her mother came to New Mexico as a missionary and started teaching in the mountains for a year. Her father was helping his father on their ranch while also working at the mission. He was smitten and when she returned because of her love for the area and to teach, they were married and began their life together. After her father was awarded a degree in Agriculture, the family went to South America. Peggy was in the process of becoming bilingual when in 1949, the Ambato earthquake in Ecuador occurred. In the aftermath, her father contracted tuberculosis and subsequently became very sick and then died. Her mother was 33 and Peggy was only eight years old. When they returned to the United States, her mother chose to go back to Northern New Mexico (Albuquerque) to be with her husband's extended family, especially her aunt. Peggy's mother got a teaching job where she taught High School English until she retired.

Peggy grew up learning to help other people. Her mother was a very consistent, steady, religious person and that helped her deal with this terrible loss. Peggy had a more difficult time, since her father was her favorite parent. She was very angry at first and had a difficult transition back coping with the loss of her father and returning to life in the United States. One of the consequences was that she never wanted to speak Spanish and, despite some half-hearted attempts, she never did.

She was very active in her church youth group, where she learned to be an active part of a group that was concerned about social justice, helping others and the importance of community. The friends with whom she bonded in Middle School are still her friends today. She went to Cottey College in Missouri run by the international community of the PEO Sisterhood – a group dedicated to providing educational opportunities for female students worldwide. Here was another tight knit community and Peggy thrived in this atmosphere where women were seen as competent leaders. She made friendships there that have lasted throughout her life.

Even though Peggy's journey to Ecuador ended in sorrow, it did whet her appetite for travel. She decided that she would study abroad and spent her junior year in Beirut, Lebanon at the American University of Beirut (AUB). The time away opened her eyes to the diversity of experiences that comes from meeting people from all over the world and living in a different culture. It also exposed her to politics, as her boyfriend and his father were part of the abortive coup attempt in Lebanon at that time. She became interested in Middle Eastern policy and history and even went to Egypt to study ancient history. During her research she walked through the pyramids. She was enjoying life in Lebanon so much that her mother had to come and get her. When she returned to complete her college degree at the University of New Mexico, she had to take more courses to satisfy these interests. She was surprised and angered by the discrimination of a faculty member during her orals when the male student who was being questioned at the same time received the easy questions, while she was grilled on the harder material. Around that time, she reconnected with her good friend, Jim Moore from High School. They began dating and then married.

In 1964, Virginia Satir came to Albuquerque, before she left for graduate school in Indiana. She interviewed a family with whom she had been working as a Child Welfare Worker. It was at that moment that Peggy knew what she wanted to be: a family therapist.

They moved to Indiana where Peggy told her advisors in graduate school about her dream to be a family therapist. She had a great supervisor while she was there and she let her work with families – to the dismay of her field supervisor! She was granted her MSW from the Indiana University's Graduate School of Social Services. She got a job working for the Social Work Department for the State of Indiana and travelled all over Southeastern Indiana for two years until her daughter Daniela was born. When Jim got a job teaching Art History at Wichita State University, they lived there for seven years and their second child, Evan, was born in this city. During that time, she worked Decatoria who had to leave for abroad. Instead of sending the clinic staff/volunteers out of the country to receive their EMDR training, she first with the Model Cities Project at Wichita State University, then as a Medical Social Worker at St. Joseph's Medical Center and later as a School Social Worker Supervisor. While she was at the Medical Center, she worked with parents who lost a child to Sudden Infant Death Syndrome (SIDS). She started a SIDS Support Group and received their Outstanding Service Award (1974) for her work.

When Jim got a job at the Toledo Museum, they moved and Peggy worked at the Michigan School of Social Work as a School Social Worker. After the blizzard of 1978, Peggy decided it was time to return to the warmth of their native state and their families. Jim applied to be the Director of the Albuquerque Museum and when he was hired, they happily moved back to Albuquerque and promptly found an adobe house – where they still live amongst their neighborhood friends. Peggy immediately took a job as a Family Therapist for Hogares, Inc. Following her time at Hogares, Inc. she was a clinician for the New Mexico Children's Psychiatric Hospital, while concurrently working as a School Social Worker for the Albuquerque Public Schools for the Special Education office. She began a private practice in association with the New Mexico Family Institute specializing in Family Therapy and Adolescents (September 1982 – September 1998).

Around this time, to Peggy's delight, David Heard, an accomplished psychologist and family therapist, came to teach at the Department of Psychiatry at the University of New Mexico (UNM). She was even more pleased when Braulio Montalvo moved there from working with Salvatore Minuchin and Jay Haley in Philadelphia to be part of the Family Therapy teaching team. During this time, they worked behind the mirror and many of the luminaries of Family Therapy came to teach and she got to know them all. Then, Peggy began teaching. She became the Director of the Interpersonal Skills Program at UNM for the Department of Pediatrics (August 1985 – February 2004). By February of 1989, Peggy became the Project Director for the New Mexico Family Institute for the Alcohol Abuse Prevention Project. In 1990, she was the Acting Program Director at the UNM's Area Health Education Center and later worked as a Social Worker for the Homebase Family Therapy Program at UNM and later in their Outpatient Services.

It was Braulio Montalvo who introduced Peggy to EMDR. In 1992, they went to Denver to be trained and she said, that "It changed my practice and my life." They continued to use the mirror approach and watched each other and honed their skills. By 1994, Peggy was asked to be a facilitator for the EMDR Institute. As a facilitator, she travelled to assist at trainings. In 1994, she was asked to be at the meeting in Phoenix that was the precursor to the EMDR International Association. She was part of the original Board as Secretary and learned a great deal about beginning an organization.

When she realized that she did not know much about trauma, she joined Charles Figley's listserv and soaked all of the information up. She did the same as well with the EMDR listserv. She then started to think about how to integrate Family Therapy with EMDR and presented in Denver and then in Baltimore on this subject with Peggy Nurse, Ricky Greenwald and Frankie Klaff.

In 1998, she went to assist trainings in Bangladesh and in 2000 was invited to present on "EMDR and Family Therapy" in Turkey. She was so close to Beirut that she had to go so she bought a ticket and spent a week and began a discussion about EMDR there. In 2001, she found out about the trainings scheduled in Ramallah and Gaza and was part of the training team with Roy Kiessling, Jim Knipe, Judith Daniels and Joany Spierings. During their time there, a Palestinian leader was assassinated. The rest of the team was shaken, however, she had experienced difficulties before and this was not like the Civil War that occurred in Lebanon during her time there. She explained that everyone knows everyone else's business and so they knew why the team was there and where they were and what they were doing it. After that, she went to Beirut from Ramallah (no easy task) to assist a woman who wanted more help with EMDR. The woman's family invited her to visit. She spoke about EMDR at St. George's Hospital. She was watching CNN in Beirut preparing to go to Starbucks when she saw the second plane hit the second tower on 9/11. Everything was grounded and through the Vice President of Mideast Airlines, she was able to fly through Frankfurt to Paris to spend time with her daughter who had just moved there to study. This was the exciting start to her career with EMDR HAP.

By 2006, Peggy became an EMDR HAP trainer. It was not until 2007 that Peggy, with the assistance of Bridget Houry from the Lebanese Psychological Society, had her first training in Beirut. Peggy has been part of the group of trainers and facilitators who have helped our colleagues in the Arabic-speaking countries become facilitators and trainers themselves. Mona Zaghrout was one of the major forces in this and had her whole staff from the WMCA in Jerusalem trained in EMDR. Ferdooz Alyssia is in the process of completing her trainer's training and is living in Egypt where she has a grant to train there and is completing her studies along with Suad Mitwali and Khader Rhasas at the Center for the Treatment of Victims of Torture.

Peggy was touched as she heard story after story of people who told their accounts of hardship, such as the young man who had been in a wheelchair and wanted to use EMDR to support his walking again. The next time that Peggy met him he was walking and married. In Ramallah, she heard about people who had been tortured and then helped by their work with EMDR. It is in these moments that Peggy's spirit links with those of her mother and father who both had devoted their lives to helping others.

In 2007, Peggy was presented with the Elizabeth Snyker Memorial Award for Outstanding Volunteer Service through EMDR HAP. Also in that year, she contributed the chapter, "Medical Family Therapy" to Shapiro, Kaslow & Maxfield's edited book, *"Handbook of Family Processes."*

To the EMDR Community Peggy has this to say:

> *"Thank you for being sisters and brothers in arms. EMDR is worldwide. The other amazing thing has been psycho-tourism; working with EMDR has been a wonderful way to see the world. To have colleagues and friends all over the world has been inspirational. I want to thank you all for the incredible hospitality I have received."*

Peggy is an active woman and loves to bike, go cross country, do women's rafting trips and tend to her grandchildren by teaching them all that she has to pass down to them like making sheepskin moccasins. Although her husband is retired, Peggy enjoys her work so much that she is not ready to stop working yet. We are delighted that she is part of our EMDR community. ❖

TRAUMA RECOVERY/HAP UPDATE

BY CAROL R. MARTIN - *EXECUTIVE DIRECTOR, TRAUMA RECOVERY/HAP*

TRAUMA RECOVERY is not a part of EMDRIA; this article is published as a service to EMDRIA members.

Our Mission Remains Unchanged

The EMDR community recently gathered at the annual EMDRIA Conference. We had a chance to renew old friendships, to meet those who have recently joined the EMDR community. For me, this was also an opportunity to listen and learn more about the EMDR community. I want to assure the EMDR community that while our look and logo has changed our mission has not - *to increase the capacity for effective treatment of psychological trauma in underserved communities anywhere in the world*.

But why embark on this name change and branding campaign? We want others outside of the EMDR community to easily understand and appreciate the importance of the training and outreach that we do. We want those outside of the EMDR circle to better understand the effects of trauma and the critical need to address those effects – and to appreciate that there is an opportunity for recovery – called EMDR! So our new look and logo, and the addition of Trauma Recovery to our name, EMDR Humanitarian Assistance Programs, speaks directly to the outcome of our work. And, each time that we use Trauma Recovery and the new logo, it will be used with EMDR Humanitarian Assistance Programs, the organization that means so much to you.

We strongly believe that our new look, logo and name enhancement will help to more quickly communicate our mission with clinicians, victims, donors and government officials. By telling our story more quickly and efficiently, we can create opportunities to help more victims of traumatic stress and help reduce the enormous social burden of post-traumatic stress in communities around the world.

Providing EMDR training remains the cornerstone of Trauma Recovery/HAP's activities. This year, we trained 2,175 people throughout the United States at 74 agencies in 26 states - more than have been trained in any previous year, and the demand is growing. With the help of Elan Shapiro, Brurit Laub, Maria Masciandaro and Betsy Prince, Trauma Recovery/HAP also continued to provide R-TEP trainings, particularly in the wake of disasters. We welcome others to become R-TEP presenters and we also hope that we can provide a broader spectrum of trainings to the agencies that we serve.

We also trained more than 200 participants in other countries throughout the world, assisted by grants that we received. Rosalie Thomas continues her work throughout India and other parts of Asia. Collaborating with Sister Janet in Sri Lanka, we trained more than 20 participants last fall with other trainings planned. Dorothy Ashman provides support and training in Ethiopia. Our collaboration with Kenya Trust also continues. Alice Blanchard visited with us while in Connecticut to discuss next steps in Kenya. Of course, Mona Zaghrout continues to grow the EMDR ranks in the West Bank and Ramallah. Working with Mona, we have plans to extend our trainings to other countries in the Middle East, including Jordan and Egypt.

In January, 2013, the second EMDR Asia will be convening in Manila, Philippines. Given the events over the past weeks, it now seems almost prophetic that the conference is being held in Manila. As with the first EMDR Asia conference, we decided to sponsor the conference and to provide EMDR therapy training to more than 70 clinicians before the conference begins. We continue to build on our commitment to develop and support communities of EMDR therapy in areas where mental health services are lacking and significant trauma and suffering exists. Certainly, the Philippines is one of those places. We will collaborate with other like-minded people throughout the world in an effort to bring hope and healing to those who are suffering. Many of you may want to support this work through your contributions. I will continue to provide updates about the work that is being done to help with this devastating disaster.

One of the most important responsibilities of Trauma Recovery/HAP is to train the trainers who can reach more therapists in agencies targeting underserved communities. We have never had more volunteers asking for trainer training than we have right now.

Certainly, this year has seen growth in recognition for EMDR and for our organization. This would never happen without the generosity and hard work of our volunteers, our donors, and the Trauma Recovery/HAP board and staff. Beginning in January 2014, we will be including short, actionable surveys in our newsletters. As we grow, we want to make sure we keep getting your feedback.

While we have added to our name and changed the look of our materials, our mission remains unchanged. We want to help break the cycle of pain in underserved communities by expanding training in EMDR therapy, increasing the numbers of clients who can find a well-trained EMDR therapist, and helping local clinicians at home and abroad to organize networks capable of responding when disasters strike. ❖

Recent Articles on EMDR

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

Amano, T., Seiyama, A., & Toichi, M. (2013). Brain activity measured with near-infrared spectroscopy during EMDR treatment of phantom limb pain. *Journal of EMDR Practice and Research*, 7(3), 144-153. doi:10.1891/1933-3196.7.3.144

Tamaki Amano, 954-2 Tokiwa, Nojima, Awaji-city, Hyogo 656-726, Japan. E-mail: tamaki_amano@awaji.ac.jp

ABSTRACT

This report describes a female client with phantom limb pain (PLP), who was successfully treated by eye movement desensitization and reprocessing (EMDR) using a PLP protocol, as well as her cerebral activities, measured by near-infrared spectroscopy (NIRS), throughout the therapeutic session. She suffered from paralysis in the left lower limb because of sciatic nerve damage caused by a surgical accident, in which she awoke temporarily from anesthesia during surgery and felt intense fear. When recalling this experience, the superior temporal sulcus was activated. However, at the end of the session, her PLP was almost eliminated, with a generalized decrease in cerebral blood flow. This case suggests the possibility of involvement of a posttraumatic stress disorder (PTSD)-like mechanism in the pathogenesis of PLP, as well as the possible efficacy of EMDR for this type of PLP.

Capezzani, L., Ostacoli, L., Cavallo, M., Carletto, S., Fernandez, I., Solomon, R., . . . Cantelmi, T. (2013). EMDR and CBT for cancer patients: Comparative study of effects on PTSD, anxiety, and depression. *Journal of EMDR Practice and Research*, 7(3), 134-143. doi:10.1891/1933-3196.7.3.134

Liuva Capezzani, UOSD Psichiatria-Area di Supporto alla Persona, IRE-ISG (Istituto Fisioterapici Ospitalieri [IFO]), Via Elio Chianesi, 53, 00144 Roma—Italy. E-mail: Liuva@libero.it or Capezzani@ifo.it

ABSTRACT

This pilot study examined the efficacy of eye movement desensitization and reprocessing (EMDR) treatment compared with cognitive behavioral therapy (CBT) in treating posttraumatic stress disorder (PTSD) in oncology patients in the follow-up phase of the disease. The secondary aim of this study was to assess whether EMDR treatment has a different impact on PTSD in the active treatment or during the follow-up stages of disease. Twenty-one patients in follow-up care were randomly assigned to EMDR or CBT groups, and 10 patients in the active treatment phase were assigned to EMDR group. The Impact of Event Scale—Revised (IES-R) and Clinician-Administered PTSD Scale (CAPS) were used to assess PTSD at pretreatment and 1 month posttreatment. Anxiety, depression, and psychophysiological symptoms were also evaluated. For cancer patients in the follow-up stage, the absence of PTSD after the treatment was associated with a significantly higher likelihood of receiving EMDR rather than CBT. EMDR was significantly more effective than CBT in reducing scores on the IES-R and the CAPS intrusive symptom subscale, whereas anxiety and depression improved equally in both treatment groups. Furthermore, EMDR showed the same efficacy both in the active cancer treatment and during the follow-up of the disease.

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de Bont, P. A., van Minnen, A., & de Jongh, A. (2013). Treating PTSD in patients with psychosis: A within-group controlled feasibility study examining the efficacy and safety of evidence-based PE and EMDR protocols. *Behavior Therapy,* 44(4), 717-730. doi:10.1016/j.beth.2013.07.002

Paul A. J. M. de Bont, Mental Health Centre Land van Cuijken Noord Limburg, PO Box 103, 5830 AC Boxmeer, The Netherlands; e-mail: paj.de.bont@ggzoostbrabant.nl; pajmdebont@gmail.com.

ABSTRACT

The present study uses a within-group controlled design to examine the efficacy and safety of two psychological approaches to posttraumatic stress disorder (PTSD) in 10 patients with a concurrent psychotic disorder. Patients were randomly assigned either to prolonged exposure (PE; N=5) or eye movement desensitization and reprocessing (EMDR; N=5). Before, during, and after treatment, a total of 20 weekly assessments of PTSD symptoms, hallucinations, and delusion

were carried out. Twelve weekly assessments of adverse events took place during the treatment phase. PTSD diagnosis, level of social functioning, psychosis-prone thinking, and general psychopathology were assessed pretreatment, posttreatment, and at three-month follow-up. Throughout the treatment, adverse events were monitored at each session. An intention-to-treat analysis of the 10 patients starting treatment showed that the PTSD treatment protocols of PE and EMDR significantly reduced PTSD symptom severity; PE and EMDR were equally effective and safe. Eight of the 10 patients completed the full intervention period. Seven of the 10 patients (70%) no longer met the diagnostic criteria for PTSD at follow-up. No serious adverse events occurred, nor did patients show any worsening of hallucinations, delusions, psychosis proneness, general psychopathology, or social functioning. The results of this feasibility trial suggest that PTSD patients with comorbid psychotic disorders benefit from trauma-focused treatment approaches such as PE and EMDR.

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de Jongh, A., Ernst, R., Marques, L., & Hornsveld, H. (2013). The impact of eye movements and tones on disturbing memories involving PTSD and other mental disorders. *Journal of Behavior Therapy and Experimental Psychiatry*, 44(4), 477-483. doi:10.1016/j.jbtep.2013.07.002

Ad de Jongh, Department of Behavioural Sciences, Academic Centre for Dentistry Amsterdam (ACTA), Gustav Mahlerlaan 3004, 1081 LA, The Netherlands. E-mail: a.de.jongh@acta.nl

ABSTRACT

BACKGROUND: A wide array of experimental studies are supportive of a working memory explanation for the effects of eye movements in EMDR therapy. The working memory account predicts that, as a consequence of competition in working memory, traumatic memories lose their emotional charge.

METHOD: This study was aimed at investigating (1) the effects of taxing the working memory, as applied in EMDR, during recall of negative memories in 32 patients with posttraumatic stress disorder (PTSD), and 32 patients with other mental disorders, and (2) whether the results would differ between both groups. In a therapeutic session patients were asked to recollect a crucial upsetting memory while, in counterbalanced order (a) performing eye movements, (b) listening to tones and (c) watching a blank wall ('recall only'), each episode lasting 6 min.

RESULTS: Eye movements were found to be more effective in diminishing the emotionality of the memory than 'recall only'. There was a trend showing that tones were less effective than eye movements, but more effective than 'recall only'. The majority of patients (64%) preferred tones to continue with. The effects of taxing working memory on disturbing memories did not differ between PTSD patients and those diagnosed with other conditions.

CONCLUSIONS: The findings provide further evidence for the value of employing eye movements in EMDR treatments. The results also support the notion that EMDR is a suitable option for resolving disturbing memories underlying a broader range of mental health problems than PTSD alone.

Dijkstra, A., & van Asten, R. (2013). The eye movement desensitization and reprocessing procedure prevents defensive processing in health persuasion. *Health Communication*. doi:10.1080/10410236.2013.779558

Arie Dijkstra, Department of Social Psychology, University of Groningen. E-mail: arie.dijkstra@rug.nl

ABSTRACT

In the present study, the method of eye movement desensitization and reprocessing (EMDR) is studied to understand and prevent defensive reactions with regard to a negatively framed message advocating fruit and vegetable consumption. EMDR has been shown to tax the working memory. Participants from a university sample (n = 124) listened to the persuasive message in a randomized laboratory experiment. In the EMDR condition, they were also instructed to follow with their eyes a dot on the computer screen. The dot constantly moved from one side of the screen to the other in 2 seconds. In addition, a self-affirmation procedure was applied in half of the participants. EMDR led to a significant increase in persuasion, only in recipients in whom the persuasive message could be expected to activate defensive self-regulation (in participants with a moderate health value and in participants with low self-esteem). In those with a moderate health value, EMDR increased persuasion, but only when recipients were not affirmed. In addition, EMDR increased persuasion only in recipients with low self-esteem, not in those with high self-esteem. These results showed that EMDR influenced persuasion and in some way lowered defensive reactions. The similarities and differences in effects of EMDR and self-affirmation further increased our insight into the psychology of defensiveness.

Dijkstra, A., & van Asten, R. (2013). The eye movement desensitization and reprocessing procedure prevents defensive processing in health persuasion. *Health Communication*. doi:10.1080/10410236.2013.779558

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Doering, S., Ohlmeier, M. -C., de Jongh, A., Hofmann, A., & Bisping, V. (2013). Efficacy of a trauma-focused treatment approach for dental phobia: A randomized clinical trial. *European Journal of Oral Sciences*, 1-10. doi:10.1111/eos.12090

Prof. Stephan Doering, Department of Psychoanalysis and Psychotherapy, Medical University of Vienna, Währinger Gürtel 18-20, A-1090 Vienna, Austria E-mail: stephan.doering@meduniwien.ac.at

ABSTRACT

It has been hypothesized that treatment specifically focused on resolving memories of negative dental events might be efficacious for the alleviation of anxiety in patients with dental phobia. Thirty-one medication-free patients who met the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) criteria of dental phobia were randomly assigned to either Eye Movement Desensitization and Reprocessing (EMDR) or a waitlist control condition. Dental anxiety was assessed using the Dental Anxiety Questionnaire (DAS), the Dental Fear Survey (DFS), a behavior test, and dental attendance at 1-yr of follow up. Eye Movement Desensitization and Reprocessing was associated with significant reductions of dental anxiety and avoidance behavior as well as in symptoms of post-traumatic stress disorder (PTSD). The effect sizes for the primary outcome measures were d = 2.52 (DAS) and d = 1.87 (DFS). These effects were still significant 3 months (d = 3.28 and d = 2.28, respectively) and 12 months (d = 3.75 and d = 1.79, respectively) after treatment. After 1 yr, 83.3% of the patients were in regular dental treatment (d = 3.20). The findings suggest that therapy aimed at processing memories of past dental events can be helpful for patients with dental phobia.

Faretta, E. (2013). EMDR and cognitive behavioral therapy in the treatment of panic disorder: A comparison. *Journal of EMDR Practice and Research*, 7(3), 121-133. doi:10.1891/1933-3196.7.3.121

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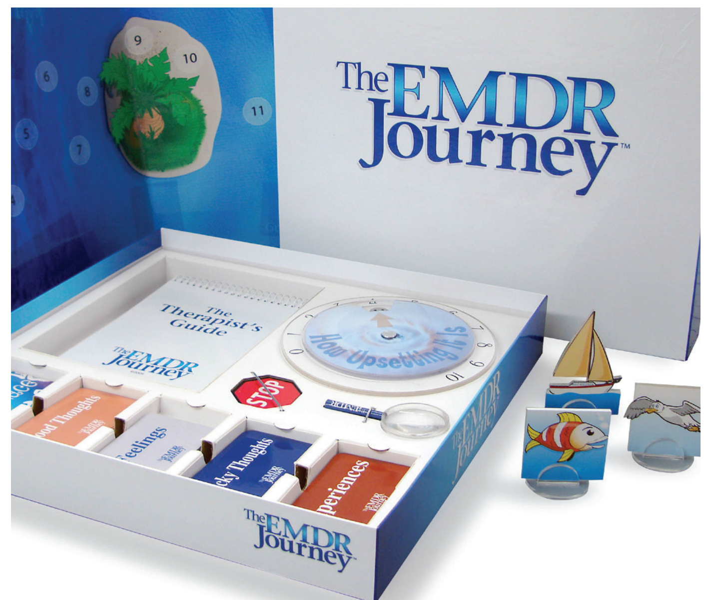

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A pilot comparison was made between two treatments for panic disorder, eye movement desensitization and reprocessing (EMDR) and cognitive behavioral therapy (CBT). Treatment was provided in the private practice settings of 7 credentialed therapists, whose treatment fidelity was monitored throughout the study. Five outcome measures were administered at pretreatment, posttreatment, and 1-year follow-up. There was significant improvement for participants in both groups (N = 19) after 12 sessions of treatment. No significant differences in outcome were seen between the 2 therapies, except for lower frequency of panic attacks reported by those in the EMDR group. The current study reanalyzed the data previously reported in Faretta (2012). Further research in this area is suggested.

Gauvry, S. B., Lesta, P., Alonso, A. L., & Pallia, R. (2013). Complex regional pain syndrome (CRPS), Sudeck's dystrophy: EMDR reprocessing therapy applied to the psychotherapeutic strategy. *Journal of EMDR Practice and Research*, 7(3), 167-172. doi:10.1891/1933-3196.7.3.167

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ABSTRACT

Complex regional pain syndrome (CRPS) Type 1, formerly termed Sudeck's dystrophy, is a disproportionate pain condition after a minor injury in a limb, with sensory, autonomic, motor dysfunction, and muscular atrophy without a demonstrated peripheral nerve injury. In children, its course can be self limiting or evolve chronically and be accompanied with psychological distress and deterioration in life quality. CRPS may occur in association with posttraumatic stress disorder (PTSD) and may benefit from multidisciplinary treatment. The eye movement desensitization and reprocessing (EMDR) approach, with demonstrated efficacy in PTSD, has also been reported to be helpful with chronic pain. The application of EMDR in a case of uncontrolled pain during an adolescent's hospitalization for CRPS is presented and its potential benefits are discussed.

Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2013). Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents (review). *Evidence-based Child Health : A Cochrane Review Journal*, 8(3), 1004-116. doi:10.1002/ebch.1916

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ABSTRACT

BACKGROUND: Post-traumatic stress disorder (PTSD) is highly prevalent in children and adolescents who have experienced trauma and has high personal and health costs. Although a wide range of psychological therapies have been used in the treatment of PTSD there are no systematic reviews of these therapies in children and adolescents.

OBJECTIVES: To examine the effectiveness of psychological therapies in treating children and adolescents who have been diagnosed with PTSD.

SEARCH METHODS: We searched the Cochrane Depression, Anxiety and Neurosis Review Group's Specialised Register (CCDANCTR) to December 2011. The CCDANCTR includes relevant randomised controlled trials from the following bibliographic databases: CENTRAL (the Cochrane Central Register of Controlled Trials) (all years), EMBASE (1974 -), MEDLINE (1950 -) and PsycINFO (1967 -). We also checked reference lists of relevant studies and reviews. We applied no date or language restrictions.

SELECTION CRITERIA: All randomised controlled trials of psychological therapies compared to a control, pharmacological therapy or other treatments in children or adolescents exposed to a traumatic event or diagnosed with PTSD.

DATA COLLECTION AND ANALYSIS: Two members of the review group independently extracted data. If differences were identified, they were resolved by consensus, or referral to the review team. We calculated the odds ratio (OR) for binary outcomes, the standardised mean difference (SMD) for continuous outcomes, and 95% confidence intervals (CI) for both, using a fixed-effect model. If heterogeneity was found we used a random-effects model.

MAIN RESULTS: Fourteen studies including 758 participants were included in this review. The types of trauma participants had been exposed to included sexual abuse, civil violence, natural disaster, domestic violence and motor vehicle accidents. Most participants were clients of a trauma-related support service. The psychological therapies used in these studies were cognitive behavioural therapy (CBT), exposure-based, psychodynamic, narrative, supportive counselling, and eye movement desensitisation and reprocessing (EMDR). Most compared a psychological therapy to a control group. No study compared psychological therapies to pharmacological therapies alone or as an adjunct to a psychological therapy. Across all psychological therapies, improvement was significantly better (three studies, n = 80, OR 4.21, 95% CI 1.12 to 15.85) and symptoms of PTSD (seven studies, n = 271, SMD -0.90, 95% CI -1.24 to -0.42), anxiety (three studies, n = 91, SMD -0.57, 95% CI -1.00 to -0.13) and depression (five studies, n = 156, SMD -0.74, 95% CI -1.11 to -0.36) were significantly lower within a month of completing psychological therapy compared to a control group. The psychological therapy for which there was the best evidence of effectiveness was CBT. Improvement was significantly better for up to a year following treatment (up to one month: two studies, n = 49, OR 8.64, 95% CI 2.01 to 37.14; up

to one year: one study, n = 25, OR 8.00, 95% CI 1.21 to 52.69). PTSD symptom scores were also significantly lower for up to one year (up to one month: three studies, n = 98, SMD -1.34, 95% CI -1.79 to -0.89; up to one year: one study, n = 36, SMD -0.73, 95% CI -1.44 to -0.01), and depression scores were lower for up to a month (three studies, n = 98, SMD -0.80, 95% CI -1.47 to -0.13) in the CBT group compared to a control. No adverse effects were identified. No study was rated as a high risk for selection or detection bias but a minority were rated as a high risk for attrition, reporting and other bias. Most included studies were rated as an unclear risk for selection, detection and attrition bias.

AUTHORS' CONCLUSIONS: There is evidence for the effectiveness of psychological therapies, particularly CBT, for treating PTSD in children and adolescents for up to a month following treatment. At this stage, there is no clear evidence for the effectiveness of one psychological therapy compared to others. There is also not enough evidence to conclude that children and adolescents with particular types of trauma are more or less likely to respond to psychological therapies than others. The findings of this review are limited by the potential for methodological biases, and the small number and generally small size of identified studies. In addition, there was evidence of substantial heterogeneity in some analyses which could not be explained by subgroup or sensitivity analyses. More evidence is required for the effectiveness of all psychological therapies more than one month after treatment. Much more evidence is needed to demonstrate the relative effectiveness of different psychological therapies or the effectiveness of psychological therapies compared to other treatments. More details are required in future trials in regards to the types of trauma that preceded the diagnosis of PTSD and whether the traumas are single event or ongoing. Future studies should also aim to identify the most valid and reliable measures of PTSD symptoms and ensure that all scores, total and sub-scores, are consistently reported.

PLAIN LANGUAGE SUMMARY: Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents Post-traumatic stress disorder (PTSD) is highly prevalent in children and adolescents who have experienced trauma and has high personal and health costs. The aim of this review was to examine the effectiveness of all psychological therapies for the treatment of PTSD in children and adolescents. We searched for all randomised controlled trials comparing psychological therapies to a control, other psychological therapies or other therapies for the treatment of PTSD in children and adolescents aged 3 to 18 years. We identified 14 studies with a total of 758 participants. The types of trauma related to the PTSD were sexual abuse, civil violence, natural disaster, domestic violence and motor vehicle accidents. Most participants were clients of a trauma-related support service. The psychological therapies used in the included studies were cognitive behavioural therapy (CBT), exposure-based, psychodynamic, narrative, supportive counselling, and eye movement desensitisation and reprocessing (EMDR). Most included studies compared a psychological therapy to a control group. No study compared psychological therapies to medications or medications in combination with a psychological therapy. There was fair evidence for the effectiveness of psychological therapies, particularly CBT, for the treatment of PTSD in children and adolescents for up to a month following treatment. More evidence is required for the effectiveness of psychological therapies in the longer term and to be able to compare the effectiveness of one psychological therapy to another. The findings of this review are limited by the potential for bias in the included studies, possible differences between studies which could not be identified, the small number of identified studies and the low number of participants in most studies.

Hašto, J., & Vojtová, H. (2013). Posttraumatic stress disorder: Bio-psycho-social aspects, eye movement desensitization and reprocessing and autogenic training in persistent stress: Case study, part 1. *European Journal of Mental Health*, 8(1), 81-101.

Full text available at: http://www.ejmh.eu/mellekletek/2013_1_81_Hasto_Vojtova.pdf

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ABSTRACT

The inclusion of the diagnostic category Posttraumatic Stress Disorder (PTSD) in both the American and the international diagnostic systems, and the definition of the 'exceptional stressor' has probably contributed to the recent boom in psychotraumatology research. The bio-psycho-social model seems to be the most adequate account with regard to the multiple layers of the problem. The authors provide an overview of recent research findings. Numerous scientific studies have focused on finding effective treatment methods for trauma-related disorders. Both pharmacological and psychotherapeutic approaches have been found effective. Nowadays, the authors consider psychotherapy to be more essential in the treatment approach for traumatogenic disorders.

Konitzer, M., & Jaeger, B. (2013). Stellt shapiros EMDR einen paradigmenwechsel in der psychotherapie dar? Versuch einer konzeptionellen analyse. [Does Shapiro's EMDR make a paradigm shift in psychotherapy? Trying to assess EMDR by conceptual analysis.]. *Psyche: Zeitschrift Für Psychoanalyse Und Ihre Anwendungen*, 67(5), 458-482.

ABSTRACT

Despite of Francine Shapiro's self-explanation EMDR is no paradigm shift in psychotherapy but an eclecticism of Freudian thought, behaviorism, mesmerism and esoterics. The particular metaphorical blend of mechanics and optics is an offspring from early modern times' memorial arts. While this ancient "ars memorativa" tried to enhance memory by mechanical techniques its modern second coming tries to erase

traumatic memory by mechanical means. Such an “ars oblivationis” is lesser based scientifically but in cultural tradition. Moreover Shapiro’s concept shows cultural signs of an “Imitatio Freudi” (Bloom), confirming instead of abolishing the old paradigm.

Novo Navarro, P., Maiche Marini, A., Scott, J., Landin-Romero, R., & Amann, B. L. (2013). No effects of eye movements on the encoding of the visuospatial sketchpad and the phonological loop in healthy participants: Possible implications for eye movement desensitization and reprocessing therapy. *Personality and Individual Differences*, 55(8), 983-988. doi:10.1016/j.paid.2013.08.005

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ABSTRACT

Horizontal eye movement is an essential component of the psychological intervention “eye movement desensitization and reprocessing” (EMDR) used in posttraumatic stress disorder. A hypothesized mechanism of action is an overload of the visuospatial sketchpad and/or the phonological loop of the working memory. The aim is to explore how eye movements affect the information encoding of the visuospatial sketchpad and the phonological loop. Fifty healthy young adults performed two immediate recall tasks from the Wechsler Memory Scale: “Corsi Cubes” and “Digits”. Using a within-participants design, up to 16 repetitions of eight seconds of eye-movement and an eye-rest condition were performed. There were no statistically significant differences between the eye movement and eye rest conditions for either recall task. In our sample of healthy participants, eye movements did not improve the immediate auditory and visual consolidation memory, undermining this hypothesized mechanism of action of EMDR. However, these findings might also be explained by our exclusion of tests that would stimulate autobiographical memory and our use of a non-clinical sample.

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ten Hoor, N. M. (2013). Treating cognitive distortions with EMDR: A case study of a sex offender. *The International Journal of Forensic Mental Health*, 12(2), 139-148. doi:10.1080/14999013.2013.791350

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ABSTRACT

This single-case study illustrates how eye movement desensitization and reprocessing (EMDR) can be of use in the treatment of cognitive distortions in sex offenders who themselves have been victimized in their childhood. A 56-year-old man did not perceive his childhood sexual experiences as negative. As a consequence, he could not see any harm in his own offending in later life. He spent one year in cognitive-behavioral group therapy barely making any progress. After nine EMDR sessions, most cognitive distortions appeared to be resolved. He was able to attend his group sessions in a more open and involved manner.

Tesarz, J., Gerhardt, A., Leisner, S., Janke, S., Hartmann, M., Seidler, G. H., & Eich, W. (2013). Effects of eye movement desensitization and reprocessing (EMDR) on non-specific chronic back pain: A randomized controlled trial with additional exploration of the underlying mechanisms. *BMC Musculoskeletal Disorders*, 14(1), 256. doi:10.1186/1471-2474-14-256

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ABSTRACT

BACKGROUND: Non-specific chronic back pain (CBP) is often accompanied by psychological trauma, but treatment for this associated condition is often insufficient. Nevertheless, despite the common co-occurrence of pain and psychological trauma, a specific trauma-focused approach for treating CBP has been neglected to date. Accordingly, eye movement desensitization and reprocessing (EMDR), originally developed as a treatment approach for posttraumatic stress disorders, is a promising approach for treating CBP in patients who have experienced psychological trauma. Thus, the aim of this study is to determine whether a standardized, short-term EMDR intervention added to treatment as usual (TAU) reduces pain intensity in CBP patients with psychological trauma vs. TAU alone.

METHODS/DESIGN: The study will recruit 40 non-specific CBP patients who have experienced psychological trauma. After a baseline assessment, the patients will be randomized to either an intervention group (n = 20) or a control group (n = 20). Individuals in the EMDR group will receive ten 90-minute sessions of EMDR fortnightly in addition to TAU. The control group will receive TAU alone. The post-treatment assessments will take place two weeks after the last EMDR session and six months later. The primary outcome will be the change in the intensity of CBP within the last four weeks (numeric rating scale 0--10) from the pre-treatment assessment to the post-treatment assessment two weeks after the copletion of treatment. In addition, the patients will undergo a thorough assessment of the change in the experience of pain, disability, trauma-associated distress, mental co-morbidities, resilience, and quality of life to explore distinct treatment effects. To explore the mechanisms of action that are involved, changes in pain perception and pain processing (quantitative sensory testing, conditioned pain

modulation) will also be assessed. The statistical analysis of the primary outcome will be performed on an intention-to-treat basis. The secondary outcomes will be analyzed in an explorative, descriptive manner.

DISCUSSION: This study adapts the standard EMDR treatment for traumatized patients to patients with CBP who have experienced psychological trauma. This specific, mechanism-based approach might benefit patients. Trial registration: This trial has been registered with ClinicalTrials.gov (NCT01850875)

Verstrael, S., Wurff, P. V. D., & Vermetten, C. E. (2013). Eye movement desensitisation and reprocessing (EMDR) as treatment for combat-related PTSD: A meta-analysis. Accepted author version posted online: 01 Aug 2013. doi:10.1080/21635781.2013.827088

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ABSTRACT

INTRODUCTION: Although the symptom presentation of PTSD in the general and military population is very similar, combat-related PTSD is typically thought to be more severe due to the repeated and prolonged exposure of traumatic events. One of the treatments of choice, Eye-Movement Desensitisation and Reprocessing (EMDR) has however not been validated for the military population.

METHOD: A meta-analysis was carried out on literature ranging back to 1987.

RESULTS: The analysis thus far resulted in a failure to support the effectiveness of EMDR in treating PTSD in the military population. Several possible explanations are given, of which the limited amount of well-designed RCTs seems to be the most important one.

CONCLUSION: Until more research is done, EMDR as first treatment of choice for combat-related PTSD should only be used if other treatment protocols have proven unsuccessful.

Zaccagnino, M., & Cussino, M. (2013). EMDR and parenting: A clinical case. *Journal of EMDR Practice and Research*, 7(3), 154-166. doi:10.1891/1933-3196.7.3.154

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ABSTRACT

The theory of attachment underlines how traumatic experiences from the parent's past—when stored in a dysfunctional way—can be reactivated in the parent caregiving system, emerging from an internal working model (IWM) of attachment that holds the memory traces of such traumatic events. This article presents a clinical case report of a mother who was referred to treatment because she presented strong depressive symptoms. Forty sessions were provided, consisting of eye movement desensitization and reprocessing (EMDR) to address maternal trauma issues and cognitive behavioral therapy (CBT) for parenting skill development, debriefing, cognitive restructuring, and psychoeducation. The positive treatment results included distinct evidence of changes in the mother's relationship with her child, and her mental representation of her caregiving system as measured with the Parent Development Interview (Slade et al., 1993).

Zarghi, A., Zali, A., & Tehranidost, M. (2013). Methodological aspects of cognitive rehabilitation with eye movement desensitization and reprocessing (EMDR). *Basic and Clinical Neuroscience,* 4(1), 97-103.

ABSTRACT

A variety of nervous system components such as medulla, pons, midbrain, cerebellum, basal ganglia, parietal, frontal and occipital lobes have role in Eye Movement Desensitization and Reprocessing (EMDR) processes. The eye movement is done simultaneously for attracting client's attention to an external stimulus while concentrating on a certain internal subject. Eye movement guided by therapist is the most common attention stimulus. The role of eye movement has been documented previously in relation with cognitive processing mechanisms. A series of systemic experiments have shown that the eyes' spontaneous movement is associated with emotional and cognitive changes and results in decreased excitement, flexibility in attention, memory processing, and enhanced semantic recalling. Eye movement also decreases the memory's image clarity and the accompanying excitement. By using EMDR, we can reach some parts of memory which were inaccessible before and also emotionally intolerable. Various researches emphasize on the effectiveness of EMDR in treating and curing phobias, pains, and dependent personality disorders. Consequently, due to the involvement of multiple neural system components, this palliative method of treatment can also help to rehabilitate the neuro-cognitive system. ❖

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

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

Manuscript Preparation and Submission

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

Thank you in advance for your participation.

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

Need Submission Ideas?

Case studies

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

Research studies

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

Clinical contributions

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

Review articles

- Summarize literature and research in a particular domain

Theoretical reviews

- Summarize research and propose hypotheses

Putting a Human Face on AIP

BY FRANCINE SHAPIRO, PH.D. - *SPECIAL CONTRIBUTOR*

The adaptive information processing (AIP) model that guides EMDR therapy was formulated in the early '90s and described in detail when the first textbook appeared (Shapiro, 1995). One of the guiding tenets was that a wide range of disturbing life experiences could have effects similar to those of major trauma, and result in lasting negative impacts upon self and psyche. It was also maintained that these disturbing unprocessed events were the foundation of a wide range of diagnoses.

In support of these tenets, research has now indicated that general life experiences can cause even more posttraumatic stress symptoms than major trauma (Mol et al., 2005). Other research has revealed wide spread mental health implications, including: "Harsh physical punishment [i.e., pushing, grabbing, shoving, slapping, hitting] in the absence of child maltreatment is associated with mood disorders, anxiety disorders, substance abuse/dependence, and personality disorders in a general population sample" (Affifi et al., 2012); "Exposure to adverse, stressful events . . .has been linked to socioemotional behavior problems and cognitive deficits." (Obradovic´, et al., 2010); " . . . childhood adversity is strongly associated with increased risk for psychosis" (Vares et al., 2012).

These studies have contributed greatly to our knowledge base. However, I believe the most important research on this topic is the adverse childhood experience (ACE) study by Felitti et al., (1998). The survey examined patients in the Kaiser Permanente Medical Care system and " . . . found a strong dose response relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults." While this research had been largely ignored for a decade, it has recently been garnering greater attention.

While clinicians trained in EMDR therapy through programs certified by national associations such as EMDRIA are well versed in AIP and its clinical implications, the general public and medical practitioners are in need of additional education on this important topic. EMDR therapy and trauma-focused CBT are the only research supported treatments of trauma. However, EMDR therapy offers focused treatment of unprocessed memories without the need of detailed description of the trauma, reliving of the event or daily homework (Shapiro, 2012). A recent meta-analysis has also demonstrated the significant effects of the eye movement component in both clinical and laboratory randomized trials (Lee & Cuijpiers, 2013). However, misinformation about the therapy and ignorance about the pronounced effects of unprocessed memories of adverse life experiences still abounds. How many people are medicated for conditions you know could be helped through EMDR therapy? How many children are being derailed through drugs that treat anxiety and sleep disturbances, rather than being liberated through memory processing? The work of EMDRIA, the EMDR Research Foundation and Trauma Recovery/HAP, in addition to conferences and local presentations by those who practice EMDR therapy, are vital keys to the education process.

As therapists you save lives daily. Research evaluation that substantiates clinical observations can open the doors to ensure that all can be treated. The letter on pages 24-27, written by a patient, puts a human face on the intensity of the needless suffering caused by the lack of understanding, and highlights the important role that the EMDR therapy community can play in both clinical and research outreach. While EMDR therapy is not mentioned in the letter, we all know the power of its focused treatment approach. Although other approaches helped her during her painful five-year journey of recovery, imagine how treatment would have proceeded if you were conducting EMDR therapy with her. Also imagine what the world would be like if all physicians and laypeople were educated about both the negative effects of these unprocessed adverse life experiences and the potential for healing.

READ LETTER ON PAGES 24-27 >>

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Lee, C.W. & Cuijpers, P. (2013). A meta-analysis of the contribution of eye movements in processing emotional memories. Journal of Behavior Therapy & Experimental Psychiatry, 44, 231-239

Felitti, V. J., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. American Journal of Preventive Medicine, 14, 245–258.

Mol, S. S. L., Arntz, A., Metsemakers, J. F. M., Dinant, G., Vilters-Van Montfort, P. A. P., & Knottnerus, A. (2005). Symptoms of post-traumatic stress disorder after non-traumatic events: Evidence from an open population study. British Journal of Psychiatry, 186, 494–499.

Obradovic´, J., Bush, N.R., Stamperdahl, J., Adler, N.E. & Boyce, W.T. (2010). Biological sensitivity to context: The interactive effects of stress reactivity and family adversity on socioemotional behavior and school readiness. Child Development, 1, 270–289.

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clinical contributions

Anonymous

A Patient's Personal Case Study of Adverse Childhood Experiences

Dear Doctor

This powerful letter is quite different from most usual clinical articles, and it is frankly painful to read. It should be considered a "case study," ie, an individual patient report. But this case study is written by a patient, not by a health professional. Dear Doctor has been reviewed by the Editorial Board, who agree that it is a unique accompaniment to "The Effect of Adverse Childhood Experiences upon Adult Health: Turning Gold into Lead" by Vincent J Felitti, MD. It makes the problem (ie, that health professionals often do not recognize the true, underlying basis for the problems they see) much more real and personally accessible.

This writing is strong, highly subjective, and poetic (even with a refrain). Once started, it should be read through to the end—or the essence might be lost. The reader (or, at least, this reader) must, at times, surrender scientific medical objectivity to try to understand how the lens of partial or incomplete comprehension by our patients can recreate what we say. Problems of communication (both ways) are actually the issue.

The writer is a woman who is not currently a Kaiser Permanente Medical Care Program member. The letter was signed. We do not like to publish anonymous articles and, in this instance, the issue of whether to leave in the signature occasioned repeated intense debate among the members of the Editorial Board. The author's words about the matter are memorable:

> ***"I would like to have my full name used for the article. I no longer feel shame about the events of my life. The shame belongs to the perpetrators. Rather, I feel sorrow. They are people who need forgiveness, and I forgive them."***

While we support the author's feelings and admire her courage, we have decided to withhold her identity to preserve the anonymity of any involved persons.

— Arthur Klatsky, MD, Editor

Dear Doctor,

I am your patient. We have known one another for a long time, and I want to thank you for healing me so many times.

At present, you know me only from annual checkups as a healthy 58-year-old, divorced, Caucasian female; 120 lbs, 5'6"; two adult children; parents and all four siblings living; family history of diabetes, epilepsy, alcoholism, bowel cancer, and heart disease; no medications.

You met me first in 1943 in Pennsylvania. I was a normal 5 lb 6 oz infant, born under general anesthesia. My mother nursed me for eight months, and I grew normally. You were surprised and concerned when I returned in six weeks for a well-baby check and immunizations. I had developed an extremely loud heart murmur, but you assured my worried mother no surgery was needed.

After I turned three, you saw me often in New Jersey, Virginia, Alabama, and Massachusetts. I had frequent, severe ENT problems, ear infections, strep throat, double pneumonia, scarlet fever, mumps, measles, chicken pox, "grippe" viruses, and a host of other pediatric problems. It is fair to say that sulfa and penicillin saved my life.

You may have noted in your chart that I was thin, compliant, and quite withdrawn. When I turned seven, you bandaged a deep cut on my thigh.

You surgically removed my tonsils and adenoids.

Later that year, you irradiated a regrowth of my adenoids. You also irradiated my enlarged thymus in a hopeful, experimental procedure. The hypothesis was that removal of the thymus gland would increase my immune system. Unfortunately, it had the reverse effect.

You probably made a note that I missed many months of school each year due to illness and that my lips and fingernails frequently turned blue. You x-rayed my teeth frequently and filled my numerous caries every year for decades.

> ***I want to thank you for healing me so many times.***

You met me at a medical convention when I was a shy, embarrassed 12-year-old. As a group, you examined my heart, amazed at the murmur which could be heard without a stethoscope. You noted my thinness and suggested an enriched diet. You extracted four teeth for my braces.

When I was a pretty, studious, 14-year-old in Louisiana, you bound my fractured left arm to my body for six weeks after I was thrown from a horse. Later that year, you carefully put 167 stitches in my face after I was thrown face first through the passenger side of a non-safety-plate windshield during an automobile collision. Safety belts had not yet been developed. You told me it was a miracle my eyes were not damaged, because the glass cut through both eyelids. The following year in Texas, you removed the keloid scars, but I was no longer pretty. In fact, a priest who came to visit me in the hospital fainted when he saw me.

You treated me for acne.

You catheterized my heart before I went to college and found a persistent superior right vena cava, extra brachial arteries, and a valve defect. You told me not to climb mountains or go deep-sea diving.

You extracted my wisdom teeth.

with an APGAR score of 9. I remained in the hospital for five days, although my son remained in an incubator for another five days. He had severe colic but was otherwise healthy. I nursed him for a year.

Twenty months later, again due to preeclampsia, you put me on complete bed rest at seven months gestation during my second pregnancy. You scheduled me for a second Cesarean, and I delivered a healthy 6 lb, 7 oz, full-term female child.

We met frequently thereafter. My physical health deteriorated from stress as I turned 40 years old with a nursing infant and a toddler. You treated me for bronchitis, "flu" viruses, and a severe breast infection that brought an end to breast-feeding my one-year-old daughter.

I met you again because I could not swallow due to canker sores. You suggested prednisone, which I declined due to side effects. You biopsied tissue on my cervix, breast, ear, and back. You used the term "precancerous cells" but explained that surgery was not needed yet.

I met your colleague, a PhD nutritionist, through the phone book yellow pages and began an intensive vitamin regime that reversed all my symptoms after six months. I knew I was fortunate to be alive.

You immunized my children and treated them for frequent ear infections and sore throats. You treated my son at age four for a strange rectangular patch on his foot, which you diagnosed as cellulitis. You treated my daughter at age four for a kidney infection. After catheterizing her, you found a valve defect between her bladder and kidney.

You examined me when I had a ten-minute episode of intense pain in my vaginal area. You found nothing physically wrong.

You listened patiently as I wept about my failing marriage and alcoholic father and encouraged me to move on. After my divorce, you treated me for pneumonia.

You removed my uterus and ovaries after I bled for two years. You told me I had fibroid tumors. You gave me light general anesthesia for this surgery because I finally told you I was a recovering alcoholic and my body was very sensitive. You listened to my grief at the end of my miracle of childbearing. You prescribed estrogen and ten years later stopped the prescription because of the potential side effects.

You gave me annual general medical checkups, mammograms, colonoscopies, Pap smears, and blood tests. You continued to monitor my heart murmur with annual specialty examinations, electrocardiograms, and echocardiograms.

During my occasional bouts of angina, you would conduct a stress test but could find no reason for the pain. I was not able to buy life insurance because I was a high-risk patient. You were as mystified as I by the occasional sharp pains I felt in different parts of my body, and odd brief periods of malaise.

In 1988, after another automobile accident, you flushed my eyes to remove the glass that flew from an exploded mirror. A car had crossed the highway median and hit mine with such momentum that the other car flipped twice and landed upside-down. You patched my left eye and later found a corneal scar. You commented that I was fortunate to be alive and still sighted and prescribed glasses so I could see more clearly.

Then, in 1989, my life turned upside-down.

Then, in 1989, my life turned upside-down. My postdivorce life finally settled down, and my children began elementary school. I decided to look for the reason for the extensive childhood amnesia and why I felt so miserable despite my comfortable lifestyle. For the first time, I told you about the amnesia and asked you for hypnosis. I then began having frequent nightmares of dying animals and killing fields. Fortunately, you did not prescribe sleep medication.

For therapy, I found a nonphysician who specialized in treating sexually abused women. He did not believe in medicating emotional symptoms but rather, finding the source of the pain. This remarkable therapist, a former police investigator, understood that amnesia occurs for a very good reason. He spoke gently, compassionately, and simply. He had good boundaries, strong ethics, and a spiritual understanding. He knew that his clients may feel fragile but are actually very strong.

He had a program of simple education about amnesia, dissociation, and the chemical changes that take place in the body during trauma, coupled with worksheets for his clients to complete. He led a support group, which I did not take part in.

He knew that his clients may feel fragile but are actually very strong.

I told him about the experience I had at age seven, of being spanked with my pants pulled down. I explained I had talked about this event many times but never felt relief from the pain. I described a nightmare that plagued me, consisting of the sounds of the click of a belt buckle and the zip of a zipper.

One pretty April morning in 1989, I went to the therapist's office. He led me through a relaxation exercise, instructing me to tense, then relax, each major muscle group. He then asked me to go to a well and find the child I used to be, nurture her, and ask her what happened. I did that and found myself as a distraught seven-year-old. I began talking about that day when I was spanked on my bare buttocks.

Suddenly, I began reliving the event. I relived the sharp slaps. I saw the pants legs as my head hung down across the adult's knees. I relived the humiliation and pain.

Then, just as suddenly, I stopped reliving the event. It felt as if I had pressed the "pause" button on an emotional and mental video of my life. I hung there, suspended in the midst of acute pain.

The therapist asked quietly, "Then what happened?" It felt as if I pushed the "play" button. I relived being pulled up by my left arm, and heard the click of a belt buckle and zip of a zipper. I relived the terror as I was pushed to my knees, and the adult sat back down on the edge of the bed. I relived his hand on the

with an APGAR score of 9. I remained in the hospital for five days, although my son remained in an incubator for another five days. He had severe colic but was otherwise healthy. I nursed him for a year.

Twenty months later, again due to preeclampsia, you put me on complete bed rest at seven months, gestation during my second pregnancy. You scheduled me for a second Cesarean, and I delivered a healthy 6 lb, 7 oz, full-term female child.

We met frequently thereafter. My physical health deteriorated from stress as I turned 40 years old with a nursing infant and a toddler. You treated me for bronchitis, "flu" viruses, and a severe breast infection that brought an end to breast-feeding my one-year-old daughter.

I met you again because I could not swallow due to canker sores. You suggested prednisone, which I declined due to side effects. You biopsied tissue on my cervix, breast, ear, and back. You used the term "precancerous cells" but explained that surgery was not needed yet.

I met your colleague, a PhD nutritionist, through the phone book yellow pages and began an intensive vitamin regime that reversed all my symptoms after six months. I knew I was fortunate to be alive.

You immunized my children and treated them for frequent ear infections and sore throats. You treated my son at age four for a strange rectangular patch on his foot, which you diagnosed as cellulitis. You treated my daughter at age four for a kidney infection. After catheterizing her, you found a valve defect between her bladder and kidney.

You examined me when I had a ten-minute episode of intense pain in my vaginal area. You found nothing physically wrong.

You listened patiently as I wept about my failing marriage and alcoholic father and encouraged me to move on. After my divorce, you treated me for pneumonia.

You removed my uterus and ovaries after I bled for two years. You told me I had fibroid tumors. You gave me light general anesthesia for this surgery because I finally told you I was a recovering alcoholic and my body was very sensitive. You listened to my grief at the end of my miracle of childbearing. You prescribed estrogen and ten years later stopped the prescription because of the potential side effects.

You gave me annual general medical checkups, mammograms, colonoscopies, Pap smears, and blood tests. You continued to monitor my heart murmur with annual specialty examinations, electrocardiograms, and echocardiograms.

During my occasional bouts of angina, you would conduct a stress test but could find no reason for the pain. I was not able to buy life insurance because I was a high-risk patient. You were as mystified as I by the occasional sharp pains I felt in different parts of my body, and odd brief periods of malaise.

In 1988, after another automobile accident, you flushed my eyes to remove the glass that flew from an exploded mirror. A car had crossed the highway median and hit mine with such momentum that the other car flipped twice and landed upside-down. You patched my left eye and later found a corneal scar. You commented that I was fortunate to be alive and still sighted and prescribed glasses so I could see more clearly.

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back of my head as he pushed his penis into my mouth and moved my head back and forth. I retasted the ejaculate. I refelt being pushed to the floor, and left, like a used condom, as he went out of the room.

I gagged and wept uncontrollably. And finally, I felt relief from that event. It has not troubled me since that day. A hidden psychological abscess had finally been lanced, and my mind quickly healed itself.

This began a five-year therapy period, during which I was able to fill in many of those blank places in my childhood. Each week I would remember just a little more, no more than I could bear. Some days, I could only relive a few minutes of the past. The pain at times felt unendurable, but the therapist assured me that I would feel better. I would scream with rage and fear on the drive home from his office. That's how I healed from each remembered betrayal.

What I remembered was about my grandfather, who was a physician. He went to war when I was an infant and returned in 1946, when I was three years old. He then began to harm me in every way imaginable. Some of you will not want to believe this. However, children exposed to this kind of abuse are someone's daughters and sons and they will someday be someone's spouse, parent, and patient. Will you recognize them in your practice, or will you look away?

My therapist once wondered aloud why I was not committed to the back ward of a state psychiatric hospital. I answered, "I dissociate well." He and I agreed I was fortunate to be alive.

My therapist once wondered aloud why I was not committed to the back ward of a state psychiatric hospital.

I don't need to go into detail about the crimes and brutalities I endured. I'm sure you've seen patients who experienced similar events, although you may not have recognized them. My purpose is not to shock but to teach that children can display few psychological symptoms; that the body takes the brunt of the psychosomatic effects in those of us who dissociate well.

The purpose of my letter is to tell you what happened a year after I began trauma recovery. I went to see you for my annual cardiology examination. You listened to my heart, as you had for the past four and a half decades in different countries, different states, different hospitals, and different offices. You listened again, not looking at me. Then you did a quick electrocardiogram and glanced at my thick file. And listened again, with a puzzled look on your kind face.

Finally, you looked directly at me and said, "There is no more heart murmur. I can't explain why. But you no longer need to see me for annual examinations."

I applied for a life insurance policy the very next day, which I continue to have as a talisman of healing. My physical health has been excellent, despite other life stresses, ever since I began unearthing the buried events from my childhood that broke my heart. The angina and sharp pains resolved as soon as I remembered the origin of those pains. My emotional health and sense of well-being improves daily.

A physician colleague of yours in the Southern California Permanente Medical Group found that the long-term medical consequences of incest, rape, and molestation are

- chronic depression
- morbid obesity
- marital instability
- high utilization of medical care
- gastrointestinal distress, and
- recurrent headaches.

He also found that the more adverse childhood experiences a person has endured, the higher the rate of

- alcoholism
- drug abuse
- depression
- suicide attempts
- smoking
- poor health
- high number of sexual partners
- sexually transmitted disease
- ischemic heart disease
- cancer
- chronic lung disease
- skeletal fractures, and
- liver disease.

His research is extraordinarily validating to me, since I have a majority of the aftereffects he describes. I believe that by storing the traumatic memories well out of consciousness, my immune system collapsed, resulting in illness and structural damage. The stress of repeated trauma may indeed have blown a hole in my heart valve. By remembering, talking about, and grieving these events, I found that the intense psychological pressure was relieved and my body simply healed itself. Nature prefers homeostasis. Even broken hearts can heal.

Even broken hearts can heal.

At a child abuse conference in Sacramento in the early 1990s, the Psychologist, Dr John Briere, remarked that, if child abuse and neglect were to disappear today, the Diagnostic and Statistical Manual would shrink to the size of a pamphlet in two generations, and the prisons would empty. I agree. As physicians and particularly as pediatricians, you are in a position to help end this epidemic of child abuse. You must do so with great care, because perpetrators have gained inroads in the systems that are supposed to protect children. But you are in a unique position, and I encourage you to work together in this serious matter.

I am writing to thank the hundreds of you who treated me throughout my life, particularly when I was young. I am forever grateful for your concern for my health and well-being and for your gifts of antibiotics. I am even more grateful that you gave me biofeedback and relaxation as an adult rather than medication to blunt symptoms of my childhood traumas, so that the encapsulated, abscessed memories could surface and heal. I am, indeed, fortunate to be alive. ❖

Faces of EMDRIA

Have you ever wondered about your fellow EMDRIA Members? The new "Faces of EMDRIA" Program will highlight member news in the monthly E-News and quarterly in the EMDRIA Newsletter. It's an excellent way for you to get to know your colleagues and network with others. If you would like to be featured, please contact Nicole Evans at nevans@emdria.org for more information.

Name: Katie A. Casey, MA

Location: Antioch, Tennessee

Member Type: Student Member

Why did you join EMDRIA? I joined EMDRIA after my first training with HAP. In talking to the leaders of the training they recommened joining EMDRIA to continue my training in EMDR.

How has membership in EMDRIA been of value to you and your practice? Since I joined while I was a student, EMDRIA helped me focus on where I wanted to go after graduation. Since graduating in May, I have used it to contunue my training and my focus in using EMDR with my clients.

EMDR is... a wonderful and powerful tool that gives me and others the hope of true healing.

Please explain your answer: Both professional and personally, I've seen EMDR work in ways traditional therapy wasn't able. To have something so strong and efficent as a form of therapy, I don't know why more people haven't looked into it more and been trained in it. And from a personal perspective, I wouldn't be where I am with out going through EMDR and for that I am truly greatful.

Why did you choose to get trained in EMDR? In my graduate program, we were required to have a certain number therapy sessions ourselves. The therapist I went to was trained in EMDR and we discussed using it for my time with her. After we finished all the phases, I was amazed by the ease in to comfort and the healing there was from ideas and memories I didn't realize where still effecting me. I knew after experiencing EMDR myself, I had to be trained in it. How could I not after knowing how good and powerful it is?

Please list a few of your most recent accomplishments: In May of this year I graduated with my MA in Counseling. For me this was one of my greatest accomplishments of my life. Since I was 18, I have worked and gone to school full time. At 25, I saw it all come full circle when I graduated—all my hard work showing the greatest result. It is something I was and still am insanely proud of. Since May, I have been lucky enough to get involved with a new practice in Nashville. I know not many master's level therapist have the opportunity like I this: to join a practice, grow my client base, learn from the other great therpists in my group and be able to do this right out of school.

Name: Cynthia M. Gill, MA, LMFT

Location: Chanhassen, Minnesota

Member Type: Full Member since 2012

Contact Information: cynthiagill1972@yahoo.com

Why did you join EMDRIA? I am very enthusiastic about EMDR, I use it a lot and want to learn more to improve my effectiveness with it.

How has membership in EMDRIA been of value to you and your practice? I enjoy reading the research articles online. I find it interesting all the offerings for further instruction that there are, and take advantage of them. The EMDR in the News section in the EMDRIA E-News is one of my favorites.

EMDR is... a breakthrough for healing; a gift I offer to my clients; extremely valuable and refreshingly quicker than talk therapy.

Please explain your answer: I have seen many people get better after using EMDR with them, and it never ceases to amaze me. I believe it is a gift to be able to offer to hopeless people, some who have tried a lot (even years) of other therapy. What a gift to be able to help people reclaim their lives!

Why did you choose to get trained in EMDR? I've always wanted to help trauma victims, and had heard that it was an extremely effective modality for that. The more I read about it the more it made sense. At my internship site, I was able to watch a clinician use it, and I wrote a paper describing it (to help me process what I had observed as I marvelled internally). I told myself "I've got to learn this, make it a top priority."

Please list a few of your most recent accomplishments: My first book *Jump-Starting Boys: Help Your Reluctant Learner Find Success in School and Life* was published July 1, 2013. I also was just hired as a adjunct instructor at Adler Graduate School. I am honored to teach there, where I earned my Master's Degree, being a strong proponent of Adlerian Psychology. Recently I put together a seminar on parenting adopted children, especially those that suffer attachment disruptions. I was able to travel to Rwanda in 2012 and teach this material.

What is something you're passionate about outside your career? Traveling. I love to explore new places and go overseas whenever possible.

Cynthia Gill is a Licensed Marriage and Family Therapist who works with families, individuals and couples. She also teaches seminars on parenting, marriage and relationships. After graduating from Carleton College, in Northfield, MN with her teaching degree in 1976, Cynthia began a 30-year career in education as a high school History and German instructor. Concern for the families and students she encountered led her to pursue a Master's Degree in Adlerian Psychotherapy & Counseling in 2004. Born and raised among Native Americans, Cynthia has also lived and studied in Europe. She enjoys taking groups of students overseas, and has led many youth trips to Russia, Germany, and Latin America. Cynthia is married; she and her husband Jerry have three sons, two daughter-in-laws and five grandchildren.

Name: Steven Marcus, Ph.D.

Location: Los Altos, California

Member Type: Full Member - Charter Member

Contact Information: 650.962.1987 or doctormarcus@sbcglobal.net

Why did you join EMDRIA? To support the growth of EMDR in the professional community. To promote and perpetuate the use of EMDR for clinical and research around the world.

How has membership in EMDRIA been of value to you and your practice? EMDRIA has given me a professional home. The annual Conference offers novel ideas for clinical practice. EMDRIA promotes professional standards and practices. EMDRIA is a professional association that promotes EMDR research and clinical creativity around the world.

EMDR... along with the AIP model provides a novel understanding for the diagnosis and treatment of behavioral and psychological problems.

Please explain your answer: EMDR is unique in utilizing Eye Movements to treat trauma, anxiety, phobia's along with other disorders of mental health. EMDR utilizes the brain's natual healing mechanism. AIP is a new perspective on the etiology of mental disorders. AIP posits the antecedants of psychological problems are physically stored in the memory cells of the central nervous system.

Why did you choose to get trained in EMDR? I took the EMDR training in 1992. Prior to EMDR training I was working with adults traumatized in childhood. I found this work immensely rewarding professionally. I wanted to learn more. I wanted to be trained by Dr. Shapiro.

Please list a few of your most recent accomplishments: I have published three randomized controlled studies on EMDR, two studies on PTSD and one study on using EMDR to treat Migraine Headaches. I am an EMDRIA Approved Consultant. I have been conducting trainings on how to treat Headaches with EMDR in North Anmerica and Europe. I am thrilled by the feedback I receive from participants trained in how to treat headaches with EMDR.

What is something you're passionate about outside your career? I have been meditating twice daily for over 40 years. I have never missed a day. Along with Yoga and breath work, meditation has been the central passion of my life. Meditation is a preparation for both professional activity, social and family life.

Dr. Marcus received his EMDR Training from Dr. Shapiro in 1992. Soon after he became an EMDR Institute Facilitator and assisted at EMDR Trainings. Dr. Marcus is a charter member of EMDRIA and is an EMDRIA Approved Consultant. Dr. Marcus has presented workshops in How to Treat Headaches with EMDR in Australia, Belgium, Canada, Denmark, France, Germany, Israel, Netherlands, Turkey, UK and the USA.Dr. Marcus was on the staff of Kaiser Hospital Psychiatry Dept. for 25 years, specializing in anxiety disorders, trauma, occupational problems, chemical dependency, stress reduction. Dr. Marcus now is in private practice in Los Altos, California, treating anxiety disorders, trauma, occupational problems and headaches.

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors
EMDR International Association and EMDR Research Foundation

We have audited the accompanying combined financial statements of the EMDR International Association and EMDR Research Foundation (both nonprofit organizations), which comprise the combined statement of financial position as of December 31, 2012, and the related combined statements of activities, functional expenses, and cash flows for the year then ended, and the related notes to the financial statements. The prior year "Memorandum Only" totals in the combined financial statements have been derived from the combined financial statements for 2011 which were reviewed by our firm with the report dated March 17, 2012 on those statements.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility
Our responsibility is to express an opinion on these combined financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the combined financial statements referred to above present fairly, in all material respects, the financial position of the EMDR International Association and EMDR Research Foundation as of December 31, 2012, and the changes in its net assets and cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Supplementary Information
Our audit was conducted for the purpose of forming an opinion on the combined financial statements taken as a whole. The information presented in the supplementary information as combining statements, pages 13-14, is presented for purposes of additional analysis and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying

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accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Allman & Associates

Austin, Texas
March 29, 2013

Continued on page 32...

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EMDR INTERNATIONAL ASSOCIATION
& EMDR RESEARCH FOUNDATION
(Nonprofit Corporations)

COMBINED STATEMENT OF FINANCIAL POSITION

As of December 31, 2012

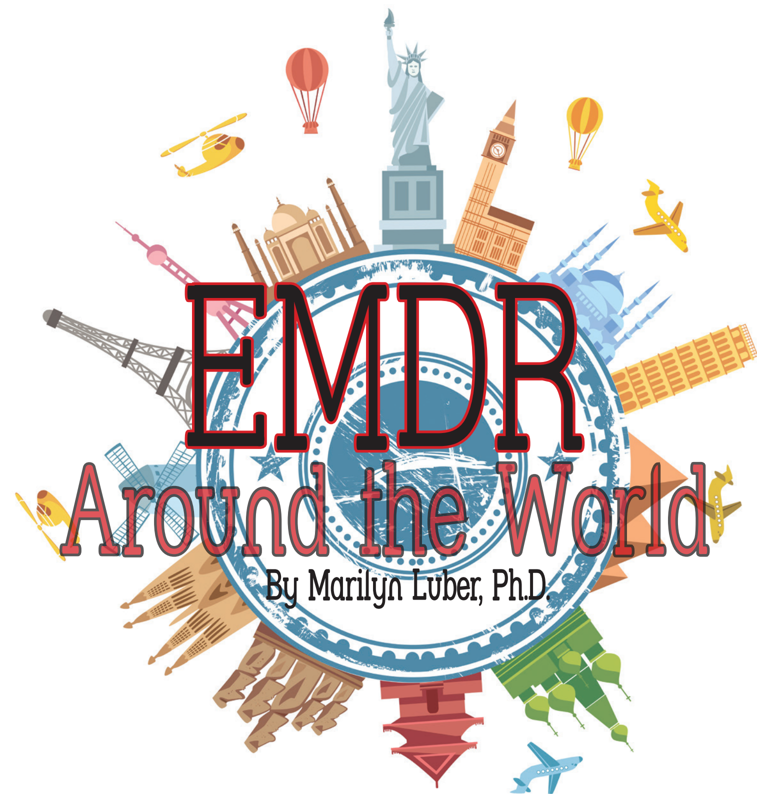
	2012	Memorandum Only 2011
Assets		
Current Assets		
Cash and cash equivalents	$ 447,484	$ 284,421
Investment – certificate of deposit	213,225	212,536
Accounts receivable	6,300	3,023
Prepaid expenses	28,563	32,111
Total Current Assets	695,572	532,091
Fixed Assets		
Furniture and equipment	40,496	40,496
Accumulated depreciation	(39,013)	(38,926)
Net Fixed Assets	1,483	1,570
Total Assets	$ 697,055	$ 533,661
Liabilities and Net Assets		
Current Liabilities		
Accounts payable	$ 5,960	$ 12,359
Accrued vacation	12,416	16,673
Deferred revenue	188,081	146,082
Accrued expenses	221	220
Total Current Liabilities	206,678	175,334
Total Liabilities	206,678	175,334
Net Assets		
Unrestricted	490,377	358,327
Temporarily restricted	-	-
Total Net Assets	490,377	358,327
Total Liabilities and Net Assets	$ 697,055	$ 533,661

EMDR INTERNATIONAL ASSOCIATION
& EMDR RESEARCH FOUNDATION
(Nonprofit Corporations)

COMBINED STATEMENT OF ACTIVITIES

For the Year Ended December 31, 2012

	2012	Memorandum Only 2011
Unrestricted Net Assets:		
Revenue		
Membership dues	$ 562,189	$ 550,752
Conference fees	445,188	396,882
Education and training fees	177,575	170,660
Interest income	690	889
Publications	61,598	60,299
Contributions	121,346	93,023
Total Revenue	1,368,586	1,272,505
Net assets released from restrictions	-	1,779
Total	1,368,586	1,274,284
Expenses		
Program services	898,774	985,577
Management and general	337,762	247,468
Total Expenses	1,236,536	1,233,045
Change in unrestricted net assets	132,050	41,239
Temporarily Restricted Net Assets:		
Contributions received	-	2,471
Net assets released from restrictions	-	(4,250)
Change in temporarily restricted net assets	-	(1,779)
Total change in net assets	132,050	39,460
Net assets, beginning of period	358,327	318,867
Net assets, end of period	$ 490,377	$ 358,327



EMDR EUROPE

Udi Oren reports: "The EMDR Europe board met this fall in Warsaw, Poland. The new national EMDR associations of Russia and Hungary joined EMDR Europe as observers, and are planning to join as full members in 2014. EMDR Europe became a member of the European Federation of Psychological Associations and the NGO Forum for Health. They are also developing stronger ties with ESTSS, ESTD and EABCT. The next EMDR Europe Conference will take place June 27-29, 2014 in Edinburgh. We hope you will all join us for EMDR's 25th anniversary!"

EMDR IBEROAMÉRICA

Esly Carvalho reports: "The 3rd EMDR IBA Conference was a smashing success! Our keynote speakers included Francine Shapiro, Bob Stickgold and Debbie Korn. John Hartung and Ana Gomez also presented plenary sessions and held workshops along with myself and Santiago Jácome. There were about 240 participants in San Jose, Costa Rica, from 21 countries (Andorra, Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Germany, Guatemala, Israel, México, Panamá, Perú, Portugal, Puerto Rico, Uruguay, Spain, United States and Venezuela). The Francine Shapiro Award for research went to the Fundación Latinoamericana y del Caribe Para la Investigación del Trauma Psicológico and the John Hartung Humanitarian Award went to Maria Eugenia Francis for her work with children and adolescents at risk in Venezuela. Gabriela Segura and her team were the shining stars of the Organizing Committee for the Conference. The Book Signing Corner included the following proud authors: Francine Shapiro (*Getting Past your Past /Supera tu Pasado*); Esly Carvalho (*Healing the Folks Who Live Inside/Sanando la Pandilla que Vive Adentro*) and Ana Gomez (*Bad Dark Day, Go Away/ Día Oscuro y Malo...Márchate Lejos: Un Libro Para Niños Sobre el Trauma y el EMDR*). Tina Zampieri signed her books in Portuguese. Alvaro Ayala and his team from Chile wrote and presented a book about how insurance companies can use EMDR therapy for employees who have work-related accidents. I said goodbye as president after two terms (six years) and Santiago Jácome (Ecuador) was elected president, Myriam Calero (Uruguay - vice-president), Belen Roma (Peru – Secretary), John Hartung (treasurer – USA), and Rita Silva e Silva from Brazil (Board Member in charge of the Certification Committee). I will continue in an advisory capacity to the EMDR IBA International Committee and Raquel Hoersting (Brazil) will head the Scientific Committee.

In the last six years, more than 4400 professionals received EMDR therapy training (1500 from Brazil alone). There are now 89 Certified Therapists, 48 Approved Consultants/Facilitators, 16 Trainers (with 11 more coming up through the ranks) and 7 Trainers of Trainers. The next EMDR IBA Conference will be in Buenos Aires, in October of 2016. If there is enough interest, an English track is being considered."

Ignacio Jarero reports: "The Latin American & Caribbean Foundation for Psychological Trauma Research was presented the Francine Shapiro Award by Dr. Shapiro herself, at the 2013 EMDR IBA Conference in Costa Rica. Our young and vibrant Foundation has eight ongoing EMDR Therapy Research Projects (see http://finvesttrauma.org.) My special gratitude goes to Francine Shapiro, Louise Maxfield and to our Foundation researchers for their non-profit and invaluable work."

ALGERIA

Martine Ircane reports: "The HAP Project continues in Algeria. Pascale Amara and I will do supervision with 18 psychiatrists. Eva Zimmermann and Thomas Renz will continue their trainings."

ARGENTINA

Silvia Gauvry reports: "EMDR IBA Argentina co-organized the International Conference of Psychological Trauma, including over 400 attendees with multiple presentations on EMDR therapy including one with Dr. Uri Bergmann. As president of EMDR IBA Argentina, I provided a University postgraduate course in EMDR Therapy delivered in the "Instituto Universitario de Ciencias de la Salud del Hospital Italiano de Buenos Aires" with a module on Psychotraumatology. EMDR IBA Argentina also sponsored and presented on EMDR Therapy at the World Mental Health Conference. Multiple advanced workshops were offered by

myself, Maria Elena Aduriz, Susana Balsamo and Uri Bergmann."

BOSNIA-HERCEGOVINA

Sian Morgan reports: "Approximately 3 years after the HAP UK & Ireland project began, the EMDR Association of Bosnia-Hercegovina was founded. The first President is Mevludin Hasanovic, a Consultant Psychiatrist at the Institute of Psychiatry of Tuzla, an enthusiastic advocate of EMDR and an EMDR Europe Accredited Practitioner. EMDR Trainings were completed in Tuzla and Sarajevo by Dr. Michael Patterson and Sandi Richman. The second cohort completed their training in September 2013 at the Institute of Psychiatry at the University of Sarajevo. Sanja Oakley has played a big part in the success of the project. Originally from Zagreb and now based in St. Louis (USA), she is UK Accredited, a translator, facilitator and supervisor for the project. Our colleagues in Bosnia-Hercegovina are also supported by UK EMDR Consultants who provide regular supervision as volunteers via Skype. This has made a big difference to HAP trainees' confidence, motivation and skill in using EMDR, so we plan to make this an integral part of all our HAP projects. This has contributed to our primary goal of Bosnia-Hercegovina becoming 'EMDR self-sufficient' and a full member of EMDR Europe."

BRASIL

Esly Carvalho reports: "In September, Mark Nickerson presented at the 2nd Brazilian EMDR Conference in Brasilia to 70 people on the issue of domestic violence. During the Conference, the EMDR Brazil Board was re-elected: Silvia Guz, president, Esly Carvalho, vice-president, Secretaries: Silvana Salomoni and Rita Silva e Silva, and Treasurer, Alice Skowronski."

CANADA

Judith Black reports: "Following a very successful EMDR Canada Conference in Banff, we are happy to announce the 2014 EMDR Canada Conference will be May 2-4, 2014 in Quebec City. The theme of the Conference is "EMDR: Interweaving Old & New." Guest speakers include Uri Bergmann of the United States and Ludwig Cornil of Belgium."

Marshall Wilensky reports: "In September, I addressed 25 attendees at the Canadian Society for Clinical Hypnosis - British Columbia Division in Vancouver on EMDR. EMDR as a non-hypnotic process was presented along with the usefulness for hypnotic procedures in client preparation, closure and the floatback/affect bridge relationship to the work of Jack Watkins."

COLOMBIA

Ana Gomez reports: "As the new EMDR IBA coordinator and trainer for Colombia, I recently facilitated the formation of the EMDR Colombia Association with Adriana Escallon elected as president. We have a group of very motivated clinicians. We thank Ignacio Jarero, Lucina Artigas, Gina Sanchez and the entire EMDR Mexico group for all their work to create a solid foundation for EMDR Colombia."

CUBA

Priscilla Marquis reports: "I held a training at the University of Havana in November. It was part three of a three-part training. Dr. Alexis Lorenzo was our host and the head of the faculty of Psychology for the university."

ECUADOR

Santiago Jacome reports: "In Ecuador, the first indigenous psychologist of the Kichwa language (Quichua), Yolanda Caiza, completed the EMDR Basic Training. She belongs to the Tomabela Community. Almost one million natives speak Kichwa as their native language. I am the EMDR Trainer for Ecuador and the newly-elected president of EMDR IBA."

EL SALVADOR

Ligia Barascout De Piedra Santa reports: "El Salvador has its first trainer and two trainers in training."

FRANCE

Michel Silvestre reports: "The book I co-wrote with my friend, Joanne Morris-Smith, *EMDR for the Next Generation: Healing children and families*, will be published in England this year. The French translation will follow."

GERMANY

Arne Hofmann reports: "EMDR Germany is still prospering with 1875 members and nearly as many certified therapists. The interest in EMDR trainings is also growing. The national Conference in Dresden was a huge success with more than 300 participants.

The recognition of EMDR as one of the two therapies for the treatment of PTSD by the World Health Organization (WHO) has improved the recognition of EMDR in Germany as well. This was echoed by an invitation for an EMDR symposium at the National Convention of Psychiatrists in Berlin this year. This is the second time we have been invited to hold an EMDR symposium there and Michael Hase will head our team. We have good connections with some of the major psychotherapy organizations in Germany. Together with the German-speaking ISTSS branch (DeGPT), EMDRIA wrote to the Ministry of Health to improve the status of sexual abuse victims. In November, the Journal for Psychological Psychotherapists (edited by a German national, medical, self-governing body that negotiates all financial issues within the insurance system, a state supported organization and journal) published a good article about EMDR. This is a major victory for us, probably comparable with a publication in JAMA.

Regarding our research projects: two controlled depression studies (from Krefeld and Bad Bevensen) and an RCT study on Adjustment Disorder in Dr. Oppermann's private practice have been finalized. Statistics are done on all three and in the process of being written up. An important university in the south of Germany where one Professor (head of the department) had opposed EMDR actively, in the last years, has turned into a center of EMDR training and research! Two medical departments of that university are currently conducting studies on depression and EMDR, psychosomatic disorders and the mechanism of EMDR using fMRI during an EMDR session. The EMDR mechanism study seems to show that there are more working mechanisms in EMDR than the working memory hypothesis reports. This university is also one of the three German centers that are participating in the multicenter EDEN study on recurrent depression. EDEN is a Depression Research Network, founded at the EMDR Europe Hamburg conference (2010), and includes researchers in Italy, Spain, Turkey and Germany. Currently, researchers in Serbia also want to join.

This autumn, Trauma Aid, the German HAP organization trained the last candidates in the Mekong Project (from Thailand, Cambodia and Indonesia) that began in 2010. A European team trained 30 local clinicians, 13 supervisors and three EMDR trainers. Up to this point, through Trauma Aid, more than 4000 patients were trained - about 2000 with EMDR. The project was supported by Terre des Hommes and the German BMZ/ Ministry of Economic Cooperation. During this training, Parichawan (Ann) Chandarasiri, the first child trainer trained in Asia (Thailand), has finished her training. We congratulate her and also Dagmar Eckers (and others) who did the training."

GUATEMALA

Ligia Barascout De Piedra Santa reports: "In Guatemala we now have the support of the School of Psychologists for the Basic Trainings in EMDR therapy. There is a new trainer and three trainers-in-training in Guatemala. El Salvador also has its first trainer and two trainers-in-training."

ITALY

Julie Stowasser reports: "At the Italian EMDR Conference, we started with Isabel Fernandez, President of EMDR Italy giving members a morning session of Consultation/Supervision in EMDR that included an emphasis about the relationships that clinicians must have and concerns to consider with respect to working with trauma survivors. Following lunch, there was a press conference about EMDR and domestic violence in 'Why use this approach over others?'. As the press conference began, Kyle Scott, Consular General of the American Consulate spoke in Italian, briefly about domestic violence in Italy, followed by Dr. Andrea Mosconi, the head of the Milan Family Therapy Center who introduced me in Italian. I had the floor for a day, with interpreter Francesca and I doing a wonderful dance of words back and forth. That was fun and, after a bit, I forgot where I was, forgot to be intimidated and had a ton of fun. Mark Nickerson and Ron Ricci rounded out what we're calling the 'American Contingency' and spoke the following day on "EMDR and Angry & Hostile Behaviors," and "EMDR and Sex Offenders." Poster presentations included work demonstrating that hemoglobin changes with eye movements and then Dr. Marco Pagani presented on behalf of his group of European researchers who are looking at what is happening in the brain as EMDR is being applied."

ISRAEL

Joseph Nicolosi, Jr. reports: "I taught the workshop, "EMDR and the Treatment of Shame" in Jerusalem to 20 therapists. Topics regarding shame that were discussed included bullying, early rejection from parents and childhood sexual molestation."

LEBANON

Lina Ibrahim reports: "Mona Zaghrout visited in May to do Part 1 EMDR Training and October to do Supervision 1 for the second group of psychologists who are taking the EMDR Basic Training course. We are still searching for funds so that we can bring in Mona and her team of facilitators for Part 2 and Supervision 2."

MIDDLE EAST

Sian Morgan reports: "HAP UK & Ireland are working to coordinate a response for an initial HAP training for participants from Middle Eastern countries affected by recent events. An EMDR Part 1 Training in Arabic will take place in Istanbul, Turkey in December 2013. Mona Zaghrout (Palestine) and Emre Konuk (Turkey) will provide the training in Arabic. We are planning Skype supervision for each participant and welcome support from any EMDR Accredited Arabic-speaking Consultant. This is a needed initiative that we hope will be on-going."

MOROCCO

Martine Ircane reports: "In Marrakech, Morocco, with the French EMDR Institute, I trained 20 therapists: 18 psychiatrics working in hospitals and universities and 2 psychologists. We had a very enjoyable experience."

THE NETHERLANDS

Ad de Jongh reports: "77% of the approximately 3200 Dutch psychologists who use an evidence-based therapy, replied to a survey concerning which therapy they used; 94% used EMDR and only 6% used CBT (PE)." Dutch psychologists who use an evidence-based therapy, replied to a survey concerning which therapy they used; 94% used EMDR and only 6% used CBT (PE)."

PANAMA

Julieta Iau Sung reports: "In Panama, EMDR therapy continues to grow. Basic and advanced trainings were offered. Alaide Miranda (Mexico) presented a workshop on 'Ego State Therapy, Complex Trauma and EMDR Therapy.'"

THE PHILIPPINES

Lourdes Medina reports: “In November, we traveled to Zamboanga to volunteer our services to victims of the war-conflict between rebels and our government soldiers who were caught in the crossfire of the conflict. During this first trip, 7 EMDR-trained clinicians will work with 200 survivors. In December, we will travel to Bohol where there are 430 survivors of the earthquake.

The 2nd EMDR Asia Conference will be held in Manila from January 9-11, 2014. We have 65 mental health professionals registered who will attend the EMDR Basic Training conducted prior to the Conference. In January, we will go to Tacloban and Mindoro to work with the survivors of the typhoon. The newly-trained group will become part of the volunteers who will go to the devastated areas where thousands have lost their loved ones, their homes, and their farms after one of the worst typhoons that devastated the eastern coast of the Philippines. We hope that you will come to the Conference, stay and volunteer to help us in our response, or make a donation to help us address the terrible catastrophe that has recently occurred in our country. We thank Trauma Recovery: EMDR Humanitarian Assistance Programs for their support of the EMDR Basic Training and for offering their services to help you make a donation to support the EMDR Philippines relief effort (see www.emdrhap.org and when asked ‘Please use my donation for’ select ‘International’).”

POLAND

Joseph Nicolosi, Jr. reports: “I conducted a workshop for 30 participants, “EMDR and the Treatment of Shame,” in an old rural Catholic monastery in Poznan, Poland. It was organized by the Foundation for Health Education and Psychotherapy (Stowarzyszenie Rodzina Serca Miłości Ukrzyżowanej), which offers continuing education to therapists.”

UNITED KINGDOM & IRELAND

Liz Royle and Cath Kerr - Directors of KR Trauma Support (UK) report: “In November, we hosted a two-day workshop presented by Carol Forgash on “The EMDR Treatment of Health-Related Problems” in Manchester, UK. It was a vibrant, lively and engaging workshop, and the feedback from the delegates included comments such as “amazing amount of theory and personal insights in two days, Carol brought life to the session, facilitated by laughter.” Another invitation is planned for Carol to present ‘Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy’ in the UK in October of 2014. If you would like to sign up to KR Trauma Support mailing list to be informed of any future workshops please email training@krtraumasupport.co.uk .”

UNITED STATES

Arizona

Ana Gomez reports: “People from all over the world attended my last virtual workshop and it was a wonderful experience. I have several new workshops that will be done virtually and Uri Bergmann will be doing the “The Neurobiology of Information Processing and EMDR: A glimpse inside the brain” in January. I also did several workshops in Minneapolis, Olympia, Arlington, Charlotte, Stamford, Costa Rica, two key notes in Phoenix at trauma and attachment conferences and grand rounds on ‘EMDR Therapy with Children’ at the University of Southern California Keck School of Medicine.”

Laurie Tetreault reports: “Arizona has been busy this year with presentations, written submissions and meetings for clinicians statewide. We have hosted presentations by Carol Forgash, Robert Miller, Susan Brown and Ana Gomez to name a few. We have almost a thousand on our mailing list now and had two regional meetings this year in June and November, with presentations on electronic documentation, ethical issues, CPT code reviews and clinician care, followed by statewide Approved Consultant meetings. Robbie Adler-Tapia’s chapter, ‘Early Mental Health Intervention for First Responders/Protective Service Workers Including Firefighters and Emergency Medical Services (EMS) Professionals’ was included in Marilyn Luber’s upcoming book, *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols and Summary Sheets*. She and Katelyn Baxter-Musser launched a new EMDRIA SIG for those treating First Responders and Protective Service Workers. Carolyn Settle, Robbie Adler-Tapia, and Ana Gomez continue presenting in and out of the country on specialty topics, and all, including myself, have volunteered with HAP in presenting Basic Trainings. Bev Chasse and Julie Miller presented at the EMDRIA Conference in Austin on TRN-related material. Julie Miller and Linda Ouellette formed an EMDR training center in Tucson for southern AZ, and it is available at www.EMDRTucson.com. You can see that AZ is rockin’ and rollin’ with lots going on and new projects constantly in the works!”

California

Sara Gilman reports: “In San Diego, we launched our Trauma Recovery Network with the help of Trauma Recovery, Inc. (EMDR HAP) and other supportive TRN’s. Our Regional Coordinator, Sue Goodell, along with Diana Neuner, got us going and we have a dedicated group of colleagues with many talents and connections in the community. Team members specialize in children, elderly, first responders and other populations. While no city is immune to disaster, in San Diego, we are vulnerable as a military town and a coastal community. Talking to other TRN group members at the EMDRIA Conference was inspiring. What others were able to do after Hurricane Sandy and Sandyhook Elementary was amazing. Nancy Simons of Trauma Recovery/HAP is very helpful in guiding the way to a successful launch. Check it out: http://sandiego-emdr-trn.weebly.com.”

Illinois

Howard Lipke reports: “Philip Manfield gave a highly regarded workshop at our Regional Meeting. My new book, co-authored with Jonathan Houghton and Aaron JL Surrain, *Don’t I have the Right to be Angry? The Heart Program for Veterans and Others*

Who Want to Prevent Destructive Anger is now available from online retailers. Harold Kudler, a Duke psychiatrist, and I co-edit the ISTSS newsletter, 'Stress-Points" available at www.istss.org."

Massachusetts

George Abbott reports: "Our annual spring conference is routinely attended by about 200 people from the east coast. We've had some spectacular plenary address speakers with excellent workshops. This year, Denise Gelinas gave the Plenary, 'Smoke and Mirrors: Procedures for Managing Dissociative Impediments during EMDR Processing Phases.' My workshop, 'Tactical Integration in the Conference Room: A Safer, More Efficient Way Use EMDR in the Treatment of People with Dissociative Disorders,' included a non-verbal sculpture of EMDR treatment of a dissociative mind. Ten attendees created a "sculpture" that illustrated all the major points in the workshop lecture. We have a marvelous, vibrant steering committee, the spring conference, a fall meeting, numerous EMDRIA-approved consultants, two EMDR trainers, numerous facilitators, a dynamic TRN and the incoming EMDRIA Board President! Something in the water up here, I think! I am one of those trainers. This fall, I did three trainings for HAP in St. Louis (during the World Series games there), in Holyoke and in Charlotte, NC. Trainings are rewarding, as they afford us a unique opportunity to bring EMDR to a new set of clinicians and to witness these clinicians light up with realization that they are learning a powerful approach to treatment."

Pennsylvania

Nancy Cetlin reports: "I moved from Boston to Philadelphia last year and am continuing my part-time coaching practice, new training and consultation for EMDR therapists with similar interests, with more performing time for myself. My goal is to help performers of all types break through inhibitions and fears that keep them from reaching optimal, authentic self-expression."

Marilyn Luber reports: "In November, Springer Publishing released *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols and Summary Sheets* to provide a resource for clinicians responding to any type of catastrophe. The 26 chapters include an international perspective on setting up a mental health response, resources, onsite or hospital response, clinician self-care and interventions for individuals, groups, first responders, police, military personnel and underground disasters. Springer, in support of clinicians volunteering to help the survivors of the Boston Marathon, their families and the Boston community, made some of the most pertinent chapters available to EMDR trained clinicians through the Trauma Recovery/HAP website."

Wisconsin

John Schaut reports: "I remain a clinical psychologist and supervisor of interns, externs at Lovell FHCC formerly DVA North Chicago. We treat veteran and active duty patients with combat PTSD. I have a faculty appointment with the Rosalind Franklin University & Medical School and am a mentor for graduate students at the Family Institute at Northwestern University. I use EMDR predominantly and supervise practitioners of EMDR. I also am a case consultant with the National Center for PTSD (NCPTSD) and receive requests to discuss EMDR cases nationally. I am one of the supervisors in Howard Lipke's VA training of staff here as well." ❖

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PROGRAM # EMDRIA CREDITS TITLE	PROVIDER NAME PRESENTERS	CONTACT	PHONE	DATES LOCATION
07005-27 14 Credits	Ana Gomez, MC, LPC Uri Bergmann, Ph.D.	Jim Mason	602.803.1797	Jan 14-Feb 11, 2014 Live Web-Stream
The Neurobiology of Information Processing & EMDR: A Glimpse Inside the Brain				
12002-14 13 Credits	Robert Miller, Ph.D. Robert Miller, Ph.D.	Robert Miller	626.429.4945	January 18-19, 2014 Pasadena, TX
The Feeling-State Theory of Behavioral and Substance Addiction and the FSAP				
RC12102-16 3 Credits	Westchester Co. EMDRIA Regional Network Dean Dickerson - DVD	Robin Gibbs	914.686.9361	January 26, 2014 White Plains, NY
Integrating Neurobiology & EMDR: Part 2 (DVD Presentation)				
13012-02 12 Credits	Deborah S. Kennard, MS, LLP Deborah S. Kennard, MS, LLP	Deb Kennard	734.925.3622	January 31-30, 2014 Honolulu, HI
The Many Layers of EMDR - Going Deeper in Your Practice: A Relational Approach				
RC07001-02 5 Credits	S. Arizona EMDRIA Regional Network Phil Manfield - DVD	Linda Bowers	520.326.5980	January 31, 2014 Tucson, AZ
Dyadic Resourcing (DVD Presentation)				
RC12104-05 2 Credits	Chico, CA EMDRIA Regional Network Dean Dickerson - DVD	Pennisue Hignell	530.891.6767	January 31, 2014 Chico, CA
Integrating Neurobiology & EMDR: Part 4 (DVD Presentation)				
06003-44 20 Credits	Kathleen Martin, LCSW Roger Solomon, Ph.D.	Kathleen Martin	585.473.2119	February 3-7, 2014 Costa Rica
The Art of EMDR				
12002-15 13 Credits	Robert Miller, Ph.D. Robert Miller, Ph.D.	Robert Miller	626.429.4945	February 8-9, 2014 Hawthorne, CA
The Feeling-State Theory of Behavioral and Substance Addiction and the FSAP				
99003-93 14 Credits	EMDR Institute Jennifer Lendl, Ph.D.	EMDR Institute	831.761.1040	Feb 22-23, 2014 San Diego, CA
Integrating Performance Enhancement with Your Current EMDR Clients				
12002-20 13 Credits	Robert Miller, Ph.D. Robert Miller, Ph.D.	Robert Miller	626.429.4945	Feb 22-23, 2014 Tampa, FL
The Feeling-State Theory of Behavioral and Substance Addiction and the FSAP				
13007-04 13 Credits	Steven Marcus, Ph.D. Steven Marcus, Ph.D.	Steven Marcus	650.962.1987	Feb 28 - Mar 1, 2014 Austin, TX
Treating Headaches with EMDR				
03002-28 12 Credits	Maiberger Institute Barb Maiberger, MA, LPC & Arielle Schwartz, Ph.D.	Barb Maiberger	303.834.0515	March 1-2, 2014 Boulder, CO
Attachment and EMDR: Adults				
99003-92 13 Credits	EMDR Institute Uri Bergmann, Ph.D.	EMDR Institute	831.761.1040	March 7-8, 2014 Irving, TX
The Neurobiology of EMDR: A Glimpse Inside the Brain				
99019-57 14 Credits	Andrew Leeds, Ph.D. Dolores Mosquera, Psych. & Anabel Gonzalez, Ph.D.	Andrew Leeds	707.579.9457	Mar 15-16, 2014 Los Angeles, CA
Treating Borderline Personality Disorder with EMDR				

EMDRIA Credit Programs

PROGRAM # / EMDRIA CREDITS / TITLE	PROVIDER NAME / PRESENTERS	CONTACT	PHONE	DATES / LOCATION
12002-22 13 Credits *The Feeling-State Theory of Behavioral and Substance Addiction and the FSAP*	Robert Miller, Ph.D. Robert Miller, Ph.D.	Robert Miller	626.429.4945	Mar 15-16, 2014 Arlington, VA
99019-58 12 Credits *Treating Dissociative Disorders with EMDR: The Progressive Approach*	Andrew Leeds, Ph.D. Anabel Gonzalez, Ph.D & Dolores Mosquera, Psych.	Andrew Leeds	707.579.9457	Mar 22-23, 2014 Alameda, CA
01008-64 12 Credits *Treating Problem Behaviors*	Trauma Institute/Child Trauma Institute Ricky Greenwald, Ph.D.	Karen Steward	413.774.2340	Mar 31 - Apr 3, 2014 Northampton, MA
06003-45 20 Credits *The Art of EMDR*	Kathleen Martin, LCSW Roger Solomon, Ph.D.	Kathleen Martin	585.473.2119	April 11-14, 2014 Thorold, Ontario CANADA
RC12103-12 2 Credits *Integrating Neurobiology & EMDR: Part 3 (DVD Presentation)*	New Haven EMDRIA Regional Meeting Dean Dickerson - DVD	Lynn Persson	203.874.1781	April 19, 2014 New Haven, CT
RC12104-12 2 Credits *Integrating Neurobiology & EMDR: Part 4 (DVD Presentation)*	New Haven EMDRIA Regional Meeting Dean Dickerson - DVD	Lynn Persson	203.874.1781	April 19, 2014 New Haven, CT
03002-25 12 Credits *Addictions and EMDR*	Maiberger Institute Barb Maiberger, MA, LPC & John Gray, LPC	Barb Maiberger	303.834.0515	April 26-27, 2014 Boulder, CO
09003-18 12 Credits *Earning Secure Attachment: EMDR, Mindfulness & Self-Compassion*	Awake Mind, LLC Julie Greene, LPC	Julie Greene	303.641.4997	May 2-3, 2014 Missoula, MT
06005-14 14 Credits *The Embodied Self: Somatic Methods for EMDR Practitioners*	Jill Strunk, Ed.D., L.P. Sandra Paulsen, Ph.D.	Jill Strunk	952.936.7547	May 3-4, 2014 Minnetonka, MN
12002-21 13 Credits *The Feeling-State Theory of Behavioral and Substance Addiction and the FSAP*	Robert Miller, Ph.D. Robert Miller, Ph.D.	Robert Miller	626.429.4945	May 9-10, 2014 Chestnut Hill, MA
03002-26 12 Credits *EMDR Toolkit for Complex PTSD*	Maiberger Institute Barb Maiberger, MA, LPC & Katie Asmus, MA, LPC	Barb Maiberger	303-834-0515	June 28-29, 2014 Boulder, CO
03002-27 12 Credits *Somatic Interventions and EMDR*	Maiberger Institute Barb Maiberger, MA, LPC & Arielle Schwartz, Ph.D.	Barb Maiberger	303.834.0515	July 26-27, 2014 Boulder, CO
06003-46 20 Credits *The Art of EMDR*	Kathleen Martin, LCSW Roger Solomon, Ph.D.	Kathleen Martin	585.473.2119	October 17-20, 2014 Halifax, Nova Scotia

EMDRIA Regional Meetings

LOCATION REGIONAL NETWORK	2013-2014 DATES	REGIONAL COORDINATOR CONTACT INFORMATION
ARIZONA		
Southern Arizona	December 19, January 16, January 31, February 20, March 20, April 17	Linda Bowers | 520.326.5980
CALIFORNIA		
Chico	January 31	Pennisue Hignell | 530.891.6767
Greater Sacramento	December 31	Merrill Powers | 530.852.5066
San Diego County	February 1, March 1, April 5	Sue Goodell | 619.997.5333
CONNECTICUT		
New Haven	December 14, April 14	Lynn Persson | 203.874.1781
NEW YORK		
Long Island	March 28	Phoebe Kessler | 516.946.1222
Westchester County	January 26	Robin Gibbs | 914.686.9361
OREGON		
Central Oregon	January 14, February 11, March 11, April 8	Karen Forte | 541.388.0095
WASHINGTON		
SW Washington	May 3	Katy Murray | 360.438.0306 Susan Kravit | 360.556.6789

Welcome New EMDRIA Members

Matthew A Ackenhausen, LCSW
Nancy G. Aguirre, MA
Betsy S Ahlers, MA, LMFT
Fadya AlBakry, LPC-Intern, LCDC, NCC
Kathy A. Allard, Ph.D., M.S., M.A.
Cheryl K Andrews, LPC
William Arendell, MSW, LCSW
Yvette S. Arnoux, MA, LCPC
Janice Arvin, MA, LPC
Leigh Ashley, MA, LMFT-A
Joan E Ausubel, Ph.D.
Janet Bales, LPC, MHSP
Cynthia Dean Barker, LMFT
Nancy L Barr, MMFT, LMFT
Sandra Marie Beggs, MA, R.Psych (AB), Prov MHC Lis
Susan Marie Beglinger, MS, MFT
Suzanne E Berens, MFT
Karrie Bird, LCPC
Janeen Bennett Bly, MS, LPC
Mary E Bode, MS,LPC
Tom Bolls, MA LPC
Mary H Boone, LCSW, LCDC
Alexandra Brouwer-Wright, LMFT
Christine Brown, LMFT
Jan T Brown, LPC
Michelle M Browning, M.A., LMFT-A
Ralph E Bruneau, PhD
Casey Burnett, MA
Maureen D Burruel, LCSW
Deborah Carnett, M.Ed, M.S., LMHC
Nelda Carpenter, LCSW
Susan J Chamberlin, LMHC
Janet M Chandler, PhD
Sand C Chang, PhD
Beth A Christopherson, LCSW
Janet P. Cleary, MA, LCMHC, MLADC
Jane L Cobb, LCSW, BCD
Kathleen D. Cody, LCSW, CASAC
Kay Colbert, LCSW
Mary Beth Cooke
Camille Cunningham, LMFT
Jacquelyn S Cusick, LCSW
Barbara E Davis, LCSW
Sandy Deas, MS
Jakie M Deese
Bridget DeMarchi, M.S.W.
Victoria Deshong-Hogan, LMFT, LPC
Ron Diliberto, LCSW
Joanne DiNiro, LCSW
David Dockstader
Connie L. Doland, LPC
Brenda Drage-Chan, MAC, LPC-I
Anne Lise DubÃ©, Psychologue
Karen M Elbert, LMSW
James W Ellor, Ph.D., MSW, LCSW, LCPC
Christy Endicott, LICSW
Catherine F Evans, LPCMH
Jennifer Fernandez-Titmus, LCSW
Kevin Fisher, LPC, LCDC
Christine A Ford, LCSW, RN
Bettina Franz, MD, PhD
Larissa L Fravel
Brenda J Fricke, Masters of Arts
Jonna Fries, Psy.D.
Doris Gardner-Wilson, Masters of Social Work
Natalie Garvey, MA
Christina M Giebisch, LCSW
Kay A. Gottrich, MA, LCPC
Victoria V Grantham, MSW LCSW
Todd D Graves, MS, LMFT
Paul B Greenwell, MS/LIMHP
Jeanie Griffin, LPC, MFT,
BC Madison Gulli, MS, CADC-I, MFT-I
Susan D Hagen, Psy.D.
Necia Harp, M.Ed./LPC-S
Helen Elisabeth Harris, EdD, LCSW
Shari Harris, LCSW

Welcome New EMDRIA Members

Wanda M Harris, LCMHC
Debra Sue Hart, MSW, LCSW
Aly Hassan, MD
Dawn F Hedgepeth, LCSW
Jeffery Scott Herman, MA
Pam Hinton, MSW, LCSW
Katherine Holland, MA, LMHC
Sarah Houy, M.A.
Morgan Cosby Howson, MA, MFT
Erik Matthias Huber, MFT
Liza J. Hyatt, LMHC, ATR-BC
Janice Imming-Rogers, MS, RN, APN
Carmel Therese Irving, MSW, LCSW
Jeff R Jeffery, MFT
Mandy J Jordan, Ph.D.
Alice A Justiss, MA, LDN
Karen Lynn Kee, LCPC
Jerry S Kelly, LCSW-R
Nancy Kelly, MA, LPC
Doha Khoury, MSW, LCSW
David E King, LCSW-R
Jean M. Kloska, LMSW, ACSW, CAADC
Jodi L Klugman-Rabb, MFT
Vessela Kouneva, MS, LMFT
Kathy Krueger, MFT
Sharon Ann Lake, MS, LPC
Suzette L Lamb, LPC-S
Shawn W Langford, MA, LPC
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