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Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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Table of Contents

Stray Thoughts ... Francine Shapiro, Ph.D. ... 1
Tidbits ... George Anderheggen, Ph.D. ... 3
Submission and Deadline Information ... 3
Assessind Dynamics and Expectations to Insure Positive EMDR Outcome
Jim Dayton, MSW, Terry Cassity, MSW ... 4
Ideas for Using EMDR with Dissociative States
Audrey Cook, M.Phil. ... 5
Recall of Near Death Experience During EMDR
David Donaldson, Ph.D. ... 6
Intermittant Use of EMDR With a Central American Trauma Survivor
George Gafner, CISW ... 7
Using EMDR with "Children: Cleaning Up" Afterwards
Ricky Greenwald, Psy.D. ... 8
Summary Positive Cognitions: A Protocol for Terminating EMDR Interventions ... William Larsen, MFCC ... 9
News from the EMDR Research Center ... 9
Case Report: Treating a Toddler with EMDR
Joan Lovett, MD ... 10
Computer Metaphor for EMDR ... Arnold (AJ) Popky, MA ... 10
International Update ... Francine Shapiro, Ph.D. ... 11
EMDR and Shame: a Brief Report ... William Zangwill, Ph.D ... 13
Containers: The Use of Cognitive Interweave with Cognitions Obtained at Intake ... Elizabeth West, MA ... 13
EMDR Help Wanted ... 14
California EMDR Study Groups ... 15
International and National Regional Network Coordinators ... 16
EMDR and the Internet ... A. J. Popky ... 16

STRAY THOUGHTS

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AFFECT, IMAGERY, AND MEMORY

It has appeared to me that affect plays a pivotal, and perhaps under appreciated, role in the information processing we observe in EMDR therapy. I have found that the ability to achieve positive treatment effects is not based on the ability to retrieve images, but rather on the ability to tap into the network of dysfunctional material through the affect and connected body sensations. As I have explored in earlier Newsletters, in the Accelerated Information Processing model, the dysfunctional information is typified by its storage in state-specific form, along with its inability to link up with more adaptive information characterized by different affect. In either case, the parallel positive or negative cognitions are merely constructions which are simply verbal manifestations of the affect. These verbalizations allow the dysfunctionally stored information to be more readily accessed which, in turn, stimulates physical sensations that can be both focal points for the client during processing, and indications of the degree of treatment success.

Many aspects of the controversy over sexual abuse memories have been troubling. A recent court case in Pennsylvania was decided against a psychiatrist. The client came to the clinician charging that her parents had molested her and, after evaluating the sequalea, the psychiatrist made a diagnosis of PTSD. The client later recanted the story and the psychiatrist was found negligent for having failed to investigate further the "truth" of the charges against the parents. The legal system, therefore, seems to make clinicians responsible for the client's memories and disclosures.

We have certainly all heard of cases where clinicians (some under trained in and misinformed about the methods they were using) seemed to have flagrantly contaminated their client's memories. These stories have been horrifying to many clinicians who are quite capable of using hypnosis without leading their clients and who attempt to stay out of the way of their client's disclosure process. Nevertheless, regardless of the competency of the clinician, it is important to remember that clients may have been previously contaminated by faulty therapy, media exposure, a variety of misleading self-help books, or by means of vicarious trauma. It is, of course, necessary that we give unconditional support to our clients in all aspects of the therapeutic process.

However, it is equally clear that clinicians should actively inform their clients of the fallibility of memory and for clinicians to maintain a non-judgmental stance. The court case in Pennsylvania makes the meaning of "non-judgmental" even more problematic. Balancing forensic and clinical realities appears to be one of the challenges of the 1990s. (1)

Given the present controversy regarding false/delayed memory, and all of the unfortunate polarization that has occurred within the psychological community, it has been especially unsettling to hear of some clinicians who tout the ability of EMDR to aid memory recovery. The problem is that while emotional and physical memories may be retrieved, we cannot conclude that the visual images that accompany them are anything more than cognitive constructions. The following quotation may be useful for better conceptualizing the issues:

"The distinction between declarative memory and emotional memory is an important one. W.J. Jacobs of the University of British Columbia and Lynn Nadel of the University of Arizona have argued that we are unable to remember traumatic events that take place early in life because the hippocampus has not yet matured to the point of forming consciously accessible memories. The emotional memory system, which may develop earlier, clearly forms and stores its unconscious memories of these events. And for this reason, the trauma may affect mental and behavioral functions in later life, albeit through processes that remain inaccessible to consciousness." (LeDoux, 1994, p.57)

What then should we conclude if the client reports images that they believe have emerged from the first months of their life? I believe that the most responsible stance is that although some traumatic experience may have actually occurred, the client's cognitive construction may or may not accurately describe it. Some clinicians have argued, however, that if the details of the trauma are specified, a perpetrator "identified," and symptoms cease, then the remission of the pathology is itself proof of the accuracy of the memory. However, I would like to suggest instead that the client's construction may have served a metaphoric function for him or her and, as with traditional guided imagery techniques, the clinician's use of the metaphor (whether provided by client or clinician) may have led to the symptom remission. Certainly we know that a client can find meaning in metaphors like Milton Erickson's "tomato plants" or that an agent of change can be imaginally specified through an "inner helper," "angel child," or "February Man;" all of which can assist in alleviating symptoms. Thus, it may be that the identification of a supposed abuse scenario taps into the dysfunctional affect, which offers a parallel cognitive construction, and the therapeutic effect emerges as a function of the clinician's use of the treatment methods. In other words, why should one imagined scenario work less well than any other salient metaphoric construction?

It has become increasingly clear to me over the years that imagined scenes may be merely representations of the client's feelings. For instance, one client reported a "memory" of being in diapers while cowering from her mother while in the living room. However, on closer examination, the image did not make sense to her because she had not lived in the house that contained that living room until much later in life. During processing, she reported seeing herself as much older, and arguing with her mother. The image of herself in diapers appeared connected to her remembered feelings of vulnerability, rather than to an actual event. Likewise, it is reasonable to argue that images of various kinds of physical abuse may be cognitive constructions of incidents of emotional abuse. Or perhaps the image of abuse is accurate. How can we claim to know either way with certainty—and does it really matter if processing the affect results in the remediation of the symptoms? In other words, I believe that positions which declare that the historical accuracy of delayed reports of abuse is always or never the clinical reality underlying symptoms are equally indefensible. I do not believe that sexual abuse survivors are eagerly reporting wish-fulfilling fantasies. However, the image of a memory fragment should be treated with care by the clinician, and the appropriate cautions communicated to clients because of the realities of memory fallibility. Anyone who promised clinicians "a rose garden," conveniently neglected to mention the hidden thorns.

Similarly, what do we do with clients who present us with "memories" of birth trauma? On the one hand, I would be astounded if the birth process did not leave some form of imprint on the nervous system. I believe further (as indicated by the previously quoted article) that it is quite possible for this physiological response to establish a foundation for a variety of future perceptions. However, I also think that the birth experience is an emotional and physical response that does not become associated with words, beliefs, and images until later in life. Now, if a client came for therapy because he or she was extremely anxious due to a number of achievement-related issues, how should we treat him or her? The client might reveal a cognition such as "I can't achieve," "I have to suffer to achieve," or even "I will die before I can reach my goal." If the clinician helps the client to access the dysfunctional material that appears to be at the root of the problem, it might be discovered to be comprised of childhood experiences of failure, disappointment, sickness, hardship, etc. But what if the client remembers that he or she was born almost strangled by the umbilical cord? Does this mean that this was the actual cause of the negative belief, or did the negative belief become associated with the physiologically recorded response at a later date? Or is the memory of the event merely a cognitive construction of the affect?

A remission in symptoms as a result of processing does not prove that the event is the cause, or that it even occurred. It may simply mean that the affect and physical sensations have provided access to the network of dysfunctional material which could be imaginally represented in this way, or in any number of other ways. This phenomenon can be further illustrated by many clinicians' reports of clients who have processed targets by revealing imagery consisting almost entirely of different patterns of colors. Some of these clinicians have asked me if it was "alright" to continue EMDR. My answer is that if the information is processing—(i.e., the client is reporting more adaptive emotions, cognitions, and physical sensations, and most importantly, behaviors)—then continue; if it is not, then do something different. The point is that all we and the client have are imaginal representations that correspond to affect, sensations, and beliefs. We can not know if they are also based in historical reality unless there is independent corroboration in the present. The good news is that we do not need to know the truth of the matter in order to help the client to heal. The bad news is that sometimes we get seduced into concluding that because the client has improved, he or she must have provided an accurate report of the traumatic event. The worst news is when we think we or the clients must know the truth if they are to get better. I believe that we would be much better off if during the therapeutic process, we aimed our attention more at the client's affect and less on his or her imagery. Therefore, my usual clinical response to the client reporting the emergence of horrific images or destructive cognitions is to provide every non-verbal indicator of unconditional support I can muster, and to ask the question "Where do you feel it in your body?"

(1) Treating Abuse Today is an excellent resource for staying abreast of the legal and clinical issues involved in the false/delayed memory controversy. Call 800/847-3964 for more information.

Reference

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EMDR Network Newsletter Submission Information

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

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

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

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

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

TIDBITS

George C. Anderheggen, Ph.D.
Newtown, CT

After my Level I and Level II trainings, I got so involved with the desensitization component that for a few months, I skipped the reprocessing. What I learned from this serious mistake cannot be underlined too many times!

After using EMDR, my clients felt much relief and were much improved, but in 4 to 6 weeks they were a bit down and depressed. Their self-esteem was being diminished by both the inner negative cognition that I had failed to take into consideration, and not undertaking the reprocessing with the positive cognition. I was fortunate enough to still be seeing these clients and we were able to reconstruct the target from my notes, do the positive cognition, and with some work, obtain a VoC of 7.

I am not disappointed that I made this error as it taught me the importance of taking enough time to not just get the target and its SUDs reduced. Additionally, I also realized the important of obtaining the negative cognition and the positive cognition and dealing with them.

I hope my experience can assist

you. I have now been using EMDR with great success for 6 months. It is not a cookie cutter and is not a substitute for a full knowledge of the therapeutic process, but it is a very fine tool. I have used it with MPD and Dissociative Disorders and agree with Dr. Shapiro that you know how to work with these populations before trying EMDR with them. EMDR has worked well with sexual disorders as well as with PTSD from both current and old trauma. I am very pleased and am now very comfortable with using it.

Assessing Dynamics and Expectations to Insure Positive EMDR Outcome

Jim Dayton, MSW
Terry Cassity, MSW

An acrophobic professional requested EMDR to enhance his participation in a ropes course offered by his program for substance abusers. The presenting material was his first ropes experience during which he became paralyzed on a ladder 10 feet above the ground. He was determined to allow himself to fall off and trust his team members to lower him safely. The incongruency between this belief and his internal psychic disturbance was the target of the initial EMDR session.

The presenting picture was the exact moment of paralysis. The negative cognition was that he would die, and the desired cognition was that he would complete the ropes course (VoC=2). His emotions were fear and terror, his body sensation was generalized tension, and his SUDs was a 9. He requested that EMDR be scheduled the day before he participated in his second ropes program. He was specifically interested in testing EMDR as a treatment procedure that would be effective in resolving his own problem and in helping clientele in his program.

The first couple of sets of saccades produced nothing. Then the direction of the eye movements was changed and processing began. The initial picture changed to a childhood experience in which he was with younger children locked in a car outside a tavern frequented by his parents. The necessity of comforting upset siblings and the implied responsibility was associated with additional childhood memories. The thoughts, emotions, and physical sensations of that experience were desensitized as processing continued. He explained how he used his imagination to help him detach and dissociate from the traumatic situation. At this time, the SUDs level had decreased to a 2 and the VoC increased to a 6. Further eye movements produced no additional change. It was assumed by the subject and the clinician that the reported measurements were ecological representations of the reality of the presenting material. The installation of the positive cognition and a body scan free of tension were effects of the EMDR session that would be verified the following day.

The subject was filmed taking the ropes course the next day and showed marked improvement and decreased physiologic arousal. It was interesting to observe that his difficulty arose when he looked down and his eyes involuntarily produced a set of rapid eye movements accompanied by a temporary hesitation to continue the course. Instead of completing the course as planned, and walking the 30-foot beam, the subject climbed halfway down the ladder before allowing the group to suspend him with the ropes.

The second EMDR session was requested to further decrease the much improved, but residual, affect experienced during the ropes course. When asked to bring up any of the original material of the previous ropes experience, the subject was unable to do so. Using the videotape, the subject viewed his moment of hesitation and the affect was captured and then targeted. We decided to forego formulating new cognitions and began immediately with eye movements. New memories emerged about his place in his family and he processed a number of fantasies which had enabled him to survive the experiences of his young life. These fantasies appeared to have helped to establish a coping behavior and a belief that he could change his life by personal determination and professional and academic achievement. These successes and accomplishments were used in a metaphor emphasizing his present level of success and his courage and desire for self-improvement. A final series of eye movements had the subject voluntarily falling off the beam during the ropes course. His anxiety appeared to have resolved and a final body scan was free of tension.

Several weeks later, the subject participated in a third ropes course and he discovered a return to the initial state of distress. At that point, the clinician and the subject began to thoroughly review the treatment sessions for possible mistakes using EMDR. The following conclusions were made regarding the experience:

1. The initial EMDR session used a magical desired cognition based upon the subject's old childhood fantasies and coping strategies. When this cognition was installed, the subject's distress decreased, as it had in the past, but only temporarily. This conclusion also demonstrated that one should not dismiss the reality of the task to be accomplished. How many persons could climb 30 feet in the air while suspended by a rope, and fall off a beam without experiencing marked anxiety and physical sensations even if there were no associations with trauma?

This mistake clearly indicates seeing reality and the need for completing a thorough psychosocial assessment before proceeding with EMDR.

It demonstrates the precautions in setting negative and positive cognitions which Dr. Leeds has addressed in his presentation, "Case Formulation of Positive and Negative Cognitions, EMDR Conference, 1994." Rather than jumping from "I'm going to die" to "I'm going to complete the course," a more realistic positive cognition, i.e., "I'll do the best I can," would have been more appropriate.

2. The session was compromised by some demand characteristics. There was an expectation that a single session would change a whole set of previous experiences. Also, both participants assumed the subject would complete the ropes course the following day, so that when the subject felt a lingering sense of discomfort a few days after the second EMDR session, he dismissed it without reporting back for additional processing.

3. Using the videotape to tap into distressing affect, while helpful in establishing a link between the first and second session, may also have overwhelmed the subject emotionally. Mental and emotional blocking may have indicated the presence of material he was not ready to address at the time.

In summary, when a clinician has difficulty with EMDR, he or she should make sure that he or she has done a complete psychosocial assessment of the client. As the process unfolds, he or she needs to determine that his or her therapeutic interventions will not reinforce the problem.

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Ideas for Using EMDR With Dissociative States

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I have been using EMDR with many of my clients; a number of whom had been sexually assaulted as children and have suffered other childhood trauma. While it is very helpful for most clients, I have found that some, who had suffered repeated and early abuse, are overwhelmed with the material that they uncovered using EMDR in its original form. I have tried a couple of techniques for altering EMDR which have been very helpful to some clients. Interestingly, many clients can return to the original version once their anxiety levels have been lowered.

I use slow passes through negative cognitions and states with these clients—looking for "stuck spots"; either reoccurring blinking, skipped over spots, or places where the eyes return after a series of saccades Thomson, 1993). I encourage my clients to hold their eyes in this "stuck" place and close their eyes. Almost always their eyes blink rapidly, and I believe the processing continues. The clients report that they are getting sensations, pictures, and cognitions just as they did with the eye movements, but they are more able to stay with the event. They are much less likely to "chain" events of abuse and become overwhelmed by the horrible movie that is playing before them.

After perhaps a couple of these sets, the client is less likely to exhibit the stuck spots, and "usual" EMDR is commenced. I look for stuck spots in saccades in all directions and in circles by using the technique described by Thomson (1993) of "opening up" the stuck spot by pushing at the edges of the spot with circular movements. A light stick has been very helpful for this technique.

Another technique which has been very helpful for clients suffering dissociative states is exploring the stuck spot one hemisphere at a time. When it seems that a client is unable to name a feeling, or continually dissociates into either numbness or another state, I have been using a "one-eye-at-a-time" tool. First, I find the stuck spot, then ask the client to describe the sensation or emotion with one eye covered, and then with the other eye covered. With dissociated clients, the states are quite different, and often contradictory. For example: the stuck spot with the left eye may be angry, while with the other eye it may be helplessness. Clients can notice the differences between eyes, and also that they have an "objective" third observation. This has been very helpful for individuals with disassociated early trauma, as well as for MPD clients. The dissociated clients report both eyes having the same response after several sets, while the MPD clients almost always continue to report different responses by eye. After the stuck spot for each eye has been "opened up," I continue with both eyes open until a lower SUDs level is reached.

Finally, I have found a tool that has been very helpful in assisting clients to return from dissociated states quickly when EMDR is being slowed by numbing. I ask clients to hold pencils in both hands and simultaneously write continuous figure eights. I tap one hand to signal to reverse the flow of writing, and then the other. This is a rather silly exercise which produces lots of laughs, but it does return quickly many clients to integrated functioning. Obviously, lots of humor helps the process to be non-judgmental and useful.

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Recall of Near-Death Experience During EMDR

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Interest in near-death experiences has grown considerably since the publication in 1975 of Life After Life, by Raymond A. Moody, Jr., M.D. On Death and Dying (Kubler Ross), published in 1969, was the first modern attempt to examine patients' reports of being out of their bodies when they were near death. Some reported encountering beings of light, dead relatives, beautiful vistas, and a sense of being unconditionally loved.

Written and oral tradition on after-death experience goes back to the beginning of human history, including such works as The Tibetan Book of the Dead, The Bible, and speculations by Plato and Socrates. Maurice Rawlings, M.D., a cardiologist, in his book Beyond Death's Door, lists 49 books and articles on the subject. He believes we are hearing more about this because of modern medicine's increased capacity to literally drag people back from death's door, giving us a larger pool of people whom have had near-death experiences to report.

Explanations of near-death experience range all the way from speculation that it is the production of an anoxic brain to belief that survivors are reporting objectively true experiences of the realities that lie beyond this world. Popular works on near-death experiences, such as the best-seller, Embraced by the Light, by Betty Eadie, typically report beautiful positive experiences, while The Bible, The Tibetan Book of the Dead, and Medieval literature report that there are also hellish experiences.

Rawlings reports that about half of his patients' spontaneous reports given within minutes of revivification describe positive experiences, while half report hellish experiences. Those reporting negative experiences do not remember them longer than 20 minutes, while memories of positive experiences may endure a lifetime. He speculates that dissociative mechanisms take over to suppress memories of experiences too horrible to consciously tolerate.

Despite all that has been written on near-death experiences, nowhere in the literature is it reported that near-death experiences have been recovered later by a person who does not initially remember or even suspect having had one. It is the purpose of this paper to report such an event as a serendipitous side effect of using EMDR for entirely different therapeutic reasons.

The client initially came to me for marriage counseling in 1982 and terminated after her divorce. I had not seen her for about 5 years, when a friend of hers phoned to report that she was in a coma at Denver General Hospital as the result of a bicycle accident. She had been riding on the Cherry Creek bike path in Denver when a jogger's Labrador, off leash, cut in front of her, causing her to pitch over the guardrail and land head-first in the grass 15 feet below. She remained comatose for 5 days. After 3 months of extensive rehabilitation therapy, she was discharged from Denver General Hospital and returned home to live with her teenage son.

About one year after the accident, she called to ask if I could help her. She found herself blowing up at the slightest provocation—a reaction which had not been present before the accident. The client reported that her neurologist attributed it to the brain damage she sustained from the accident. She also complained of having nightmares and not being able to sleep on the 23rd of each month (the date when the accident happened).

I began by describing and demonstrating EMDR to her and then asked her to start by picturing herself riding on the bike path with her girlfriend just before the accident. After completing the first set of eye movements, she described having seen herself riding along enjoying the day with her friend when the Lab cut in front of her. During the second series, her jaw suddenly dropped and her eyes immobilized.

She finally blurted, "Is that possible?"

I asked, "Is what possible?"

"Well, I pitch over the railing headfirst and hit on the grass down below by the creek. People run up to me. I'm in a fetal position. They roll me on my back, and my friend is by the left side of my head and panicked. A guy is working on me holding my head. He has long hair and is wearing a t-shirt or sweat shirt of dark colors. But I'm above the railing looking down at myself."

She went on to describe an IV being hooked up, being placed on a stretcher by people in white coats, and being loaded into an ambulance which was down on the path. "I go to the hospital emergency room. Sometimes I'm inside, and sometimes I'm outside the ambulance." She maintained a tone of awe throughout her narration as we alternated sets of EMDR with her narration of what she was seeing. She described seeing her family in the ER with her and being transferred to the ICU where she experienced rejoining her body.

The patient said she had never heard of anyone leaving his or her body and feared she must be crazy. She appeared quite relieved when I told her that others had reported similar experiences.

One week later, using EMDR, we reviewed the bicycle accident, the trip to the ER, and seeing her family at the hospital. As the client began reporting the scene, she added details not reported in the first session. When

she revisited the ER scene, she suddenly stopped talking. "David, everything is glowing with light," she said.

She reported having been in a place of inexpressible beauty, then said, "There were six other spirits with me: my two grandmothers, my grandfather, the baby my mother lost at 7 months pregnancy, mother's father, and dad's brother (all had died previously). We all talked and it was wonderful. They were not in human form, but looked like puffy white clouds on a spring day with the light shining through. We communicated mentally. They were so loving and caring. It seemed that if I would cross over to their side, I would be in the next dimension. Then this amazing bright light appeared and engulfed me. I experienced the most incredible unconditional love and understanding. I wanted to remain there forever and be engulfed in that pure love."

She said she did not want to come back. "After all, my son would be with his dad." She and the person of light then discussed whether she should stay or come back, finally deciding to come back because her son needed her.

We then went through the entire experience two more times, during which her attention shifted to her original agenda, the explosive symptoms. She reported reexperiencing the explosive feelings when the physical therapist tilted her body as she had been tilted when she was pitching over the rail. She then connected explosive feelings with other situations in which she feared loss of control. She reported a SUDs of 0 to all target issues at the end of the second session.

Later, she reported by phone that the explosiveness was gone and her anger was more normal. She was free of the nightmares and resting comfortably through the night of the 23rd of each month, the anniversary of her bicycle accident.

One year later, she came to see me again. A year of vigorous workouts in the gym had restored most of her former ease and grace of movement.

"My son is graduating from high school," she said. "I feel like I am totally starting over." She described a quality of contentment in her life she had never before felt, attributing it to the near-death experience she had recovered during EMDR. She had become a volunteer at a hospice and described helping people and their families through the dying experience. She said she had lost all fear of death and had in fact come to see the deathbed as a sacred place. "I can share the gift of having seen the other side of dying."

Intermittent Use of EMDR With a Central American Trauma Survivor

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Ross and Gonsalves (1993) reported on the use of EMDR in their seventh session of brief therapy with a Guatemalan who had faced persecution and trauma prior to fleeing to the U.S. They opted for EMDR at that juncture in therapy because of a need to reduce the intensity of the client's symptoms. Following one session of EMDR, which the client said was "like magic," the 42-year-old man described improved sleep, an overall decrease in PTSD symptoms, and a reframing of past political persecution.

The purpose of this report is to recount a similar application of EMDR within a general psychotherapeutic framework. The author will also offer some impressions and recommendations for working with Central American refugees.

Maria Garcia (not her real name), a 35-year-old woman from Guatemala, is a client in the Refugee Clinic operated by the University of Arizona's Department of Family and Community Medicine. The author is one of three Spanish-speaking mental health practitioners who volunteer for the clinic, which is a regular rotation for medical students and residents.

The client's husband disappeared and is presumed dead. She has been in the U.S. for six years, speaks little English, and works as a hotel maid. She and her 10-year-old son reside in a house shared by three families. Maria had not had any previous mental health treatment when she was referred. She had recently been started on Welbutrin and reported improved sleep, but continued to be bothered by symptoms of avoidance and arousal and had chronic suicidal thoughts. Her general presentation was one of moderately retarded depression. She employed poor eye contact and a barely audible voice. She described herself as a social isolate, with "I don't want to be so shy" as a goal elicited in the first session.

Sessions 2 through 4 were spent on shyness—examining, exploring, reframing, and beginning to alter this symptom, which was lifelong (although worse with current PTSD and depression). At the same time, the author attempted hypnosis, which was unsuccessful as the client was unable to concentrate. Attempts at attentional absorption via several routes were unsuccessful.

By the fifth session, the author had received Level I training and EMDR was initiated. Maria's target image (SUDs = 10) was the military's burning a pile of dead children with gasoline after airplanes had bombed a school. Neither a negative belief statement nor a positive cognition could be elicited. Emotions were anxiety, sadness, and fear, and body sensations were cited as headaches and tightness in the chest. The client asked to stop after a series of 3 sets of eye movements (SEM), which resulted in no change in the SUDs.

Maria returned to the next session 2 weeks later with a brighter mood, neater dress, and said she felt better. This time she cited, "I'm worthless" as a negative self-statement, and "I can change in my own way" as a positive cognition. Rather than start with the target image, the client was asked to concentrate on emotions and body sensations. A series of 4 SEM decreased the SUDs to a 4, and increased the VoC to a 6. Two subsequent sessions of EMDR over the next month yielded a SUDs of 3 and VoC of 5. The VoC was installed, EMDR terminated, and "standard" therapy was resumed.

The client now showed broader affect and her concentration was improved. She responded well to role rehearsal and other aspects of assertive training. Trance was induced by absorbing her attention in the flame of a saint candle while she counted slowly backward from 100. As she counted, the therapist gave ego-enhancing suggestions with therapeutic stories. She learned to apply self-hypnosis to contain negative affect, and she declined further abreactive and reframing work around her trauma. Three months later, her SUDs was still a 3 and the VoC remained a 5.

In using EMDR cross-culturally, Marquis (1993) stresses the importance of adapting the method to Latinos. For those with little education, she suggests therapists hold their hands apart to suggest SUDs level. Also, she works with clients' positive images, as they are more likely to have these images instead of positive cognitions.

Some of these clients believe that EMDR is magic. However, these clients are also likely to view psychotherapy or medical treatment in a similar light. Psychoeducational material such as informative booklets on PTSD can be helpful. Also, we can help these clients hasten their adjustment by strongly encouraging and supporting their learning English.

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Using EMDR With Children: "Cleaning Up" Afterwards

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Trumansburg, New York

Since describing an evolving approach to using EMDR with children (Greenwald, 1993), I have become aware of a subtle problem in confirming that a child has completed the processing of a memory. This may occur whether the full adult protocol is used, or a more abbreviated imagery-focused adaptation is chosen.

When you have been using EMDR with a child and he or she announces that the SUDs is "0," he or she is probably telling the truth—but use caution. With children, the usual means of gauging completion of the SUDs, the body scan, and, to a lesser extent the VoC, may be insufficient. Some children may compartmentalize aspects of their disturbing memory, and be unaware that portions remain unprocessed. Furthermore, even after using EMDR successfully on much of the memory, the child may still prefer to "forget about" other parts of it, and fail to mention that those parts are still disturbing.

I discovered the above by accident. After working through a memory of an assault by a stranger, I asked a young adolescent if he was looking forward to testifying against the assailant. He blanched. It was necessary to process additional aspects of the memory which had not previously been identified as distressing, including the location of the assault and the person of the assailant. Subsequently, only minimal therapeutic preparation for the trial was necessary.

Since then, when working with children, I have routinely "gone fishing" for other potentially distressing aspects of the memory after the SUDs has reportedly been reduced. Every so often, this pays off. Fairly quickly, one can systematically ask a series of questions that address the various elements of the memory which are likely to be distressing. For example, following EMDR work with the memory of an auto accident, I might say the following:

"I am going to ask you about different parts of the memory, to see if any parts of it still bother you. What about when you got into the car that day, think about that. Does that feel bad? What about watching your mother drive? What about when the other car hit yours? What about all that noise? The broken glass . . . going to the hospital . . . having your baseball jacket get thrown out at the hospital . . . sleeping over at the hospital . . . when you were alone there . . . the needles . . . what anyone said to you after . . . wondering if it was your fault . . . What about when you get into a car now?"

Using EMDR with children can be very fast-paced and confusing, and there is a risk of sloppiness. This extra "clean-up" effort at the end can help to ensure that the job is really complete.

References

Greenwald, R. (1993). Using EMDR with children. Available from EMDR, P.O. Box 51010, Pacific Grove, CA 93950-6010, with formal training.

Summary Positive Cognitions: A Protocol for Terminating EMDR Interventions

William Larsen, MFCC

In my practice, EMDR is mainly utilized as a close-ended intervention of a set number of sessions. In working with so structured an application, I have developed a specific termination protocol that has proven extremely valuable in maximizing therapeutic gains.

In essence, this involves a session-by-session review of the recent intervention for the purpose of formulating a "Summary Positive Cognition" (PC). As Shapiro has noted in trainings, the positive cognitions that emerge in a series of EMDR sessions have an evolutionary quality that moves ever toward a purely self-affirmative and functionally adaptive belief. As the definitive marker of the client's progress, a "Summary PC" (as described below) can be seen as not only a synthesis of the previous cognitions, but as a literally new ego state arising out of both the newly completed work and the termination process itself. Also, it often reveals incipient therapeutic tasks emerging into the client's foreground.

In the final session, which has been set aside for the termination protocol, the client reports as usual on journal work and what has emerged since the previous meeting. If something momentous has occurred, it is dealt with and desensitized. (On rare occasions, the new material is significant enough to warrant a full session and a delay in the termination date.) The termination protocol begins with a general overview of the client's original goals and focuses on salient issues and core themes. The following steps are then followed:

1. Starting with the original therapeutic issue and target image, the client and I review in a global fashion the progress of the EMDR intervention.

2. I read the client's PCs in chronological order, and the client copies them in his or her journal. In this process, attention is paid to a brief reminiscence of each session focusing on the central features of that work, the evolutionary trend of the positive cognitions, and the client's <u>present</u> level of acceptance of each cognition.

3. The PCs are installed, in chronological order, and any "glitch points" that interfere with the installation are desensitized in the same way as in the peak performance protocol.

4. At the end of this process, the client is asked to sit with her or his experience and allow a "summary positive cognition" to emerge. This is explained as a cognition that encompasses the ideal aspects of all the cognitions and summarizes the new experiential frame of the client following the series of EMDR sessions (there can be a completely new wording or a variance of an earlier cognition).

What emerges as a Summary Cognition at this point is often a formulation that is both more internal and purely positive than previous cognitions, and also announces the more refined therapeutic tasks lying ahead. "I can take care of myself" might become, "I can trust my ability to notice and honor my inner needs," or "I can safely feel and satisfy my longing for intimacy." That is, as with Maslow's (1970) hierarchy of needs, therapeutic growth results in issues of defense and survival giving way to the fulfillment of longing and creativity. Often, this new cognition is not accepted at a level 7 VoC, with the typical reason being "I still need to practice this." I then have the client frame a PC around his or her willingness and ability to do so and install that cognition.

The last step involves having the client imagine a situation in which she or he is functioning at an optimal level (whatever that may be), and complete the imagery with attention directed to the <u>sensations</u> of doing so. I then install this gestalt, and ask the client to sit with the experience as long as it is pleasurable.

In summary, formalizing the completion of an EMDR intervention has effectively served to augment the shift to self-affirmative beliefs, delineate the client's present level of adaptive functionality, and identify emergent therapeutic tasks made possible by the EMDR work. EMDR is by nature an interactive process, and I gratefully acknowledge the collaborative assistance of two exceptionally sophisticated clients in the development of this protocol. There is clearly much work to be done in the area of termination procedure, and I invite comments and suggestions as to how this protocol can be modified for greater efficacy.

References

Maslow, A. H. (1970). <u>Motivation and personality</u>. New York: Harper & Row.

News From the EMDR Research Center

Clifford Levin, Ph.D.
Mental Research Center
Palo Alto, CA

The EMDR Research Center at the MRI, Palo Alto, California, has now been in operation for over one year. At present, our senior staff is comprised of Clifford Levin, Ph.D., (director), Lois Allen-Byrd, Ph.D., (assistant director), Eirin Gould, M.A., (outside consultant), and Francine Shapiro (consultant); the interns are A. J. Popky, M.A., and Amy Filiatrault. In recent months, we have been conducting single-case, repeated-measures EMDR research with survivors of natural disasters and other traumatic events. We are offering up to ten

sessions of free therapy in return for the subject's willingness to complete our rather lengthy questionnaires up to ten times (three times prior to treatment, three times during treatment, and four times post-treatment) during his or her participation in the research project. If you would like to refer a survivor of a traumatic event to this project, please feel free to give our number as listed above.

A. J. Popky has developed an EMDR cessation protocol for smoking and other addictions. He and other EMDR therapists nationwide report excellent results to date, the EMDR Research Center will begin accepting referrals immediately. The treatment will last five to ten sessions and will cost $50 per session (an adjusted fee is possible in case of financial need). All subjects will have to be willing to provide long-term follow-up data on the success or failure of the method. Furthermore, all prospective subjects will be screened for severe mental illness and/or severe dissociative disorder. It is the Center's belief that it would be unsafe to practice EMDR with these populations unless they were being seen within the context of long-term treatment.

We at the EMDR Research Center are constantly striving to further our understanding of the effective practice of EMDR with a variety of trauma survivors. If you are interested in our work, please give me a call, at (415) 326-6465, and schedule a visit to the center. I guarantee it will be an experience to remember.

Case Report: Treating a Toddler with EMDR

Joan M. Lovett, M.D.

A 20-month-old Chinese boy was referred to me by his pediatrician because of symptoms which began immediately after an automobile accident. The accident occurred when a car spun out of control on the freeway and smashed into the side of a car driven by the child's uncle. All of the doors of the car were temporarily jammed, and the family panicked when they could not get out. The uncle sustained some physical injuries, but did not require hospitalization. The toddler was examined by his pediatrician and did not have any signs of a physical injury. However, for the month following the accident, the toddler awakened crying several times nightly. During the day he was irritable, cried easily, and was frequently angry.

This toddler had lived with his aunt, uncle, and two cousins since he was one year old, when his parents left him in their care. His caretakers described him as a good-natured boy until the automobile accident. He knew only two words in English—"good boy"—and spoke single words in Chinese.

I asked the boy's aunt and uncle to use toy cars to demonstrate how the accident occurred and I wrote down the sequence of events. I decided to use alternative movements on the toddler to desensitize the car accident, and to reprocess the traumatic event by using "good boy" as the positive cognition. I explained EMDR to the boy's aunt and uncle by telling them that if their nephew could see, hear, and feel the retelling of the accident while being tapped on alternating sides of his body, then he would feel better. I taught the toddler to slap my hands alternately as I repeated "good boy" ("good boy" is a fine "safe place" for a toddler—he smiled throughout). Next, he sat on his aunt's lap while his uncle dramatically told the details of the accident in Chinese. This is the sequence his aunt and uncle and I established in English and they recounted in Chinese: 1) "good boy" (he happily demonstrated alternate hand slapping), 2) "car ride" (he grabbed two toy cars and I used a third car to tap his knees alternately for the rest of the session, 3) "big boom!" (he became anxious), 4) "scared," 5) "crying," 6) "everything is okay," 7) "don't worry," 8) "we're all fine," 9) "go home," 10) "good boy!"

After this single session, lasting 45 minutes, the toddler reestablished his normal sleep pattern and resumed his usual disposition. His pediatrician reports that he is well six months after treatment.

COMPUTER METAPHOR FOR EMDR

Arnold (AJ) Popky, MA
EMDR Research Center
Mental Research Institute
Palo Alto, CA

Clients and participants have asked for a simple explanation of how EMDR works. Since my previous life was in high technology electronics and computers, I devised the following metaphor for my own understanding of the process. With the growing popularity of personal computers, more people have become computer literate and seem to understand this metaphor.

Information is stored and processed in the brain in a similar way to information in computer memory. Information comes into computers through input devices such as the keyboard, a modem, or a mouse. It then moves into a type of memory called Random Access Memory (RAM) and is acted on or processed by the computer's central processor or brain. The information is processed freely in RAM, constantly changing, and is usually combined with additional information brought in from storage devices such as floppy or hard disks. The information can also be sent out to the screen, printer, other output devices, or stored on disk. The information flows freely from input and is processed in and through RAM.

There is another type of computer memory called Programmable Read Only Memory (PROM). When information is introduced into PROM, an electrical charge is applied <u>at the same time</u>. This electrical charge causes the information to be locked in

memory. It can be moved around, but cannot be easily processed or changed. Whenever that memory location is addressed or stimulated, the locked information will always appear at the output. In order to change or reprogram PROM, new information must be held at the input and an electrical charge introduced simultaneously.

The brain shares some similarities with how information is processed and stored in computers. The brain receives information into memory (pictures, sensations, odors, and tastes) through our own input devices (eyes, ears, nose, mouth, nerve endings, etc.). The brain processes this information, sometimes combining or comparing it with previously stored information. The results can then be stored in memory or outputted through actions or speech. In normal times, information is taken in, processed, and allowed to process freely from input to memory through to output in a completely "normal" manner without being corrupted and dysfunctional. However, when trauma occurs, an electrical energy locks the information associated with the event (pictures, words, smells, etc.), along with any dysfunctional beliefs in its own biochemical envelope in memory (PROM). Whenever that location in memory is stimulated (by the picture, sounds, smells, etc.), the locked information (negative cognition) is accessed and the resultant output is the negative affect. For example, suppose that a young girl is raped by a fat, bald man with a red cap and a mustache. The rape experience may then be locked into memory (PROM) by the shock of the trauma, accompanied by pictures, sounds, smells, and other associated senses. The rape could then be reexperienced whenever she sees a man, a fat man, a bald man, a man with a mustache, or a man with a red hat, or any combination of the above.

With EMDR, we ask the client to access the event by bringing up the pictures, negative words, feelings, and body sensations and simultaneously moving his or her eyes rapidly back and forth. These rapid eye movements cause neuronal bursts (electrical energy), allowing the negatively charged experience (negative cognition) held in memory (PROM) to be processed and replaced with a positive representation (positive cognition), thus moving from dysfunctional to functional.

INTERNATIONAL UPDATE

Francine Shapiro, Ph.D.
Mental Research Institute
Palo Alto, CA

The most exciting news of the year is that Geoffry White of Los Angeles has been successful in his year-long quest and has managed to find a home for two EMDR trainings in the Balkans. Geoffry was relentless, perservering through countless interviews, false leads, and massive bureaucracy. The world would be much improved if there were more people like him.

The plan is to send EMDR trainers Steven Silver, Ph.D., and Gerald Puk, Ph.D., to Zagreb in Croatia early in 1995. Both Drs. Silver and Puk are donating their time and the EMDR Institute is underwriting the other costs of travel and training. We are all thrilled to be able to do something to help alleviate the terrible suffering in that part of the world. We are also hoping to provide similar trainings in other trouble spots around the globe. We are presently trying to arrange suitable locations in Russia, the Mid-East, and Africa. If any of you have contacts in these areas and can assist in our outreach, please let us know. Roger Solomon, Ph.D., just finished conducting an EMDR training in Kuwait, and it is clear that there is a vital need to help not only the POWs, but those suffering from vicarious traumatization—which includes members of the helping professions.

In 1994, EMDR trainings were given for the first time in France, England, Norway, the Netherlands, and China. We flew facilitators and trainers over from the United States and it was wonderful to see the camaraderie that developed through the shared desire to help alleviate clients' suffering. Except for having to be careful about certain words having slang connotations, or metaphors that are meaningless outside the US, like "stop on a dime," the clinical issues are much the same as here, and the cross-cultural application of EMDR is apparent. It's not always comforting, however, to discover all the world-wide common denominators. For instance, when I was explaining the "memory unfolding phenomena" that we see in EMDR, where a victim of a boating accident may start by seeing himself go down for the third time and then, as EMDR, is initiated, the memory completes itself until he is safe on the shore, I generally caution clinicians that the aftermath of a trauma can be just as devastating as the trauma itself. For instance, "The victim of a rape may feel just as violated by the experience at the hospital or police station." It was saddening to see the clinicians in trainings throughout Europe nod with recognition just as they do in the U.S.

From all reports, the EMDR presentations at a number of major conferences in 1994 were well received and often attendance was standing room only. Presentations presently scheduled for 1995 include: American Psychiatric Association, American Psychological Association winter meeting (New Orleans), Family Therapy Networker, American Association of Psychotherapists, International Stress conferences (Amsterdam and Paris), Anxiety Disorder Association of America, and Japan Association of Brief Psychotherapy. I would appreciate it if presenters sent in a list of accepted presentations to professional organizations so that we can publish a complete compilation. This will allow network members to alert their colleagues of opportunities to attend to gain useful information about EMDR and decide if they want to pur-

sue further education about it.

There continues to be a great need for presentations at all levels of the professional community, from local chapter meetings and state conventions through national and international conferences. In order to assist any of you who are interested in sharing your case material and experiences in these forums, presentation packets (which include descriptions of the current state of research and publications) are available from the EMDR Institute office. More submissions to organizations such as AABT, SEPI, as well as to cognitive, psychodynamic, family therapy, and trauma conferences, are vitally needed. In addition, presentations to lay organizations are becoming necessary to address the proliferation of "Eye Movement Therapy" courses that have been springing up. A number of clinicians have been misled into taking these courses, which merely show people how to move their fingers. A number of lay people are also hanging out shingles as "Eye Movement Therapists." Prospective clients need to be informed that EMDR is a great deal more than just eye movement, and that it should be performed by a licensed, trained clinician. This can be done through presentations to various local clubs and charitable organizations.

The potential for haphazard trainings will become even greater once the book is published, but as I mentioned in the last Newsletter, an EPIC task force is presently reviewing guidelines for professional standards in teaching EMDR. Once again, input is welcome from anyone with expertise in the area of the dissemination of specialty area education.

There have been a number of requests for information regarding the publication date of the EMDR text and the possibility of including an EMDR course in college curricula. Guilford expects the book to be available in mid-April. We are planning on a mailing to get the book to all past participants at reduced price, and as quickly as possible. The book is quite hefty, explores all the aspects of EMDR, from client selection through implementation and integration within a comprehensive treatment plan, and was planned as a companion to supervised practica. I intended it to be used as a text for a full semester course, and as a detailed handbook for the EMDR-trained clinician.

In addition, I will be giving a space-limited, three-hour workshop at the EMDR International Conference in June for those with university affiliations who are planning to teach an EMDR course, and are interested in including information, metaphors, and examples that parallel the EMDR Institute's formal training. One of my aims over the past five years has been to create a common vocabulary and frame of reference for EMDR practitioners. Everyone who attended the EMDR Institute training can communicate their own innovations, insights, or counter-examples aided by the shared knowledge of particular cases, and procedures. For instance, the example I gave earlier in this column regarding "memory unfolding" has been illustrated by same examples in all of the workshops. I would like to assist others who feel it is worthwhile to offer the opportunity for maintaining the continuity. The three-hour course will also explicate in greater detail my reasons for each of the aspects of the model and method. Because space is limited, please send in a request on university letterhead, stating your affiliation and the nature of the proposed course in EMDR, along with your conference registration. The meeting will also give us an opportunity to brainstorm ways in which we can further assist the educational process.

There is a good chance that the book will be published before you receive another Newsletter. I had expected to finish sooner, but was prevented from doing so by ill health. Its publication in April will mark five years since I introduced EMDR training in the U.S. and will initiate a number of changes in the way EMDR information is disseminated worldwide. Therefore, I've decided to address briefly, and hopefully for the last time, some of the more troubling issues that have arisen. I hope its publication will stop many of the attacks and accusations, but that is certainly not why I wrote it. Rather, the book was written to assist clinicians that have already been trained in EMDR, and prepare the way for the widespread training of clinicians throughout the university system and by responsible members of our profession who are qualified to teach. My reasons for being undeterred by attacks over the past years is that I could not find any that appeared to be in the interest of clients, or of science. For instance, the accusation that the training agreements have stifled research is untenable because more controlled research has been done on EMDR than on all of the other methods used in trauma combined. Further, we have always publicly encouraged research and even trained most investigators for free.

The accusation that the training agreements created an inappropriate "closed" system has been astonishing and disappointing to me. I had thought it was obviously the course necessary to prevent misuse of the work (and, in any case, a course I was obliged to take under APA code 1.16). The agreements were indeed implemented to keep EMDR "closed" — to lay practitioners and therapists and researchers who have been instructed incorrectly by learning it "second, third, or even fourth hand." This measure was considered especially important until standards of care within the professional community had been established.

The goal to keep EMDR out of the hands of non-professionals was accomplished because it was only after the recent (unsolicited) massive media exposure that lay practitioners have actually become a problem. The attempt to safeguard the quality of

research has borne mixed fruit in that, contrary to APA codes which call for researchers to be "trained and supervised" in the method tested, much of EMDR research has been conducted by people using the early, and now out of date, 1989 articles. The good news is that the published literature can be divided between those who have been trained and those who have not been trained. The bad news is that the existence of the latter group points to the need for the professional community to do some real soul-searching regarding the lack of adherence to its own ethics codes in both research and clinical practice. I believe that the same lack of quality control has led to the managed care and "false memory" debacles which have resulted in outside influences trying to take over that function.

Finally, in regards to the claim that my motives have been entrepreneurial, I can understand the tendency for people to count the heads of participants and multiply by the workshop fee. However, I came into the field of psychology after a bout with cancer in 1979 and I do not know anyone who walks away from that disease believing that the purpose of life is to make money. On a practical level, the actual motivation (and attendant expenses) should be obvious if you try to recall any other trainings you have attended that provide such a high ratio of facilitators to participants. I can only ask the attackers to examine their own motives.

In the past five years I have had the opportunity to meet clinicians of courage and vision—people with loving hearts who have reveled in the changes they saw in their clients and who have enthusiastically done their best to make EMDR as widely available as possible. Unfortunately, I have also met clinicians who have wanted to keep EMDR a well-kept secret so they could be the only ones in their area who provided, and therefore profited from it. The bottom line is that in every group there will be variability, a mixture of "light" and "shadow". As EMDR moves into the next stage of development, there will be many independent trainings, organizations, and schools of thought. I have done what my conscience dictated in trying to disseminate EMDR responsibly and ethically. I can only hope that heart, conscience, and ethics will hold greater sway than politics and ego in the continued development of EMDR in the years to come.

" I do not know what your destiny will be, but one thing I know: The only ones among you who will be really happy are those who have sought and found how to serve"—Albert Schweitzer

EMDR AND SHAME: A BRIEF REPORT

William Zangwill, Ph.D.
New York, NY

One of the most difficult issues in an EMDR session is when a patient is not able to "let go" and experience the process. There are a variety of reasons for this happening, one of which involves the shame patients sometimes feel in both reexperiencing the memories and of sharing them with us. Despite assurances that they do not have to share content, some patients have still reported difficulty in letting past material arise to be reprocessed because of fear of embarrassment and humiliation.

When this occurred in two recent cases, I found the finger snapping procedure to be quite helpful. Thinking that if they had their eyes closed they might feel less vulnerable to shame, being judged, etc., I asked the patients if it would be easier for them if they closed their eyes while I moved my hand rapidly back and forth on either side of their head and snapped my fingers. Both said that it would be and proceeded to reprocess the material much more effectively. In fact, in one case, the patient asked me to close my eyes as well while I did the finger snapping. She asked me to do this because, "If your eyes are closed, I won't have to worry if anything really ugly comes out. You won't be able to see it." Because I have a very good relationship with this patient, and because there was absolutely no evidence of a dissociative disorder, I acceded to her request. (Subsequently, she has been able to process material both with her eyes closed and open.)

In both cases, the patients reported that closing their eyes reduced the shame and fear of humiliation that they had felt when their eyes were open. They reported feeling less on the spot and less concerned with how I might react. Has anyone else had similar results?

CONTAINERS: THE USE OF COGNITIVE INTERWEAVES WITH COGNITIONS OBTAINED AT INTAKE

Elizabeth West, MA

Collecting information properly at intake is one of the most important steps we can make in preparing to use EMDR with our patients. A thorough psychosocial history and interview help to highlight many possible targets and events by which an effective course of treatment may be created. During this preliminary phase, we are also looking for the patient's self-described strengths, weaknesses, goals, expectations, motivations, support systems, and limitations. It is possible, given the aforementioned areas of interest, that abreactive material may arise before the completion of intake. If this happens, what steps may be taken?

In a recent intake session, a new patient introduced a series of negative cognitions regarding some current and past events. I noted these self-statements for use in a future

EMDR session. Between appointments, the patient escalated into an agitated state and began to use some self-prescribed relaxation techniques and available support systems to manage the flood of material. After receiving a crisis call, I attempted to introduce a positive cognition that directly opposed a negative intake cognition. I encouraged the patient to focus on the positive cognition until our next session. After using cognitive interweave, the patient was better able to develop a positive cognition of her own and gradually contained the agitation until the next session.

In this case, the positive cognition and cognitive interweave created a temporary container for the patient's distress until it was safe to proceed with EMDR in a later session. The patient also noted that it was particularly helpful to bring up the positive cognition just before sleep because it reinforced her future hopes and ambitions. It may be speculated that the natural eye movements during her sleep state further actualized the positive cognition.

Negative and positive cognitions can "book-end" goals within a treatment map. Developing and using a positive cognition as a container gives the client a sense of control over his or her therapy while converging responsibility with that of the therapist. Even when a patient has difficulty grasping the positive cognition, the therapist can use a cognitive interweave to educate the patient until actual desensitization and installation are possible.

Fluent in a 2nd Language?

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

Published?

If you are an EMDR trained clinician and have had any books published, please send, title, publication date, etc. to the EMDR office.

EMDR HELP WANTED

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

EMDR Research/Training Institute

The EMDR Research/Training Center at MRI is looking for individuals who want to take part in two research projects; (1) Victims of natural disasters and (2) Smoking cessation. Any therapists who have clients interested in participating, please call *Cliff Levin, Ph.D. (415) 326-6465.*

Babies

Anyone using EMDR and/or other body-mind therapies to remove traumatic sequelae in babies in their first year of life (e.g., birth trauma, suctioning, heelsticking [for blood tests] circumcision, etc.). Contact: *Sheryll Thomson, 1641 Hopkin St., Berkeley, CA 94707, (510) 525-8031.*

Success with Schizophrenics?

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

RET/EMDR

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

Public Education and Awareness Committee

We are developing generic letters, brochures, & packets for use by all EMDR clinicians to send to local media (newspapers, radio and TV stations. If you have developed this type of media and would care to share, please send samples to: *Donna Raposa, PO Box 724, Aptos, CA 95001.*

Research Subjects Needed

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

Spiritual Insights

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

CALIFORNIA EMDR STUDY GROUPS

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

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

CERRITOS/CENTRAL CITIES
Pauline Hume (213) 869-0055
Pat Sonnenburg (310) 924-7307
Coordinating a new group. Open

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

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

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

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

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

Nancy Stark, MFCC (209) 292-1700
James Shepard, MFCC
Meets every other Friday. Call for information.

FULLERTON
Curtis Rouanzoin (714) 680-0663
Jocelyne Shiromoto (714) 965-1550
Meets 2nd Tuesday from 9:30 - 11:30 AM.

HUNTINGTON BEACH
Jocelyne Shiromoto (714) 965-1550
Open. Call for time.

IRVINE
Charles Wilkerson (714) 543-8251
Meets 2nd Thursday of month. Primarily case discussion. Open. Call for directions.

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

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

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

MARIN COUNTY
Gilda Meyers (415) 472-2765
Steve Bodian (415) 454-6149
1 Friday per month. 10am - 11:30am. Call for information.

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

NAPA
Marguerite McCorkle (707) 226-5056

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

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

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

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

RIVERSIDE/SAN BERNARDINO
Byron Perkins (909) 732-2142
Meets 3rd Friday of every month, 9:30am - 11:00am.

SACRAMENTO
Bea Favre, Psy.D. (916) 972-9408
Connie Sears (916) 483-6059
Meets third Friday of every month 1:00 - 3:00pm.
At 2740 Fulton Ave., Sacramento, CA 95821

SAN DIEGO
Jim Fox, MFCC (619) 260-0414
Meets second Friday of Each Month, 9:30am - 11:00am.

Arthur T. Horvath, Ph.D. (619) 455-0042
Call about meeting times and places.

Mary Anderson (619) 434-4422
Meets 2nd Friday of every month from 9:00 - 10:30am. Primarily case discussion. Call regarding availability.

Elizabeth Snyker (619) 942-6347
Meets 3rd Wednesday of every month, 9:00am - 10:30am.
191 Calle Magdelena St., Ste. 230, Encenitas, 92024.

SAN FRANCISCO
Sylvia Mills (415) 221-3030
Meets Friday, call for next date. Potluck dinner and case discussion. New members welcome.

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

SAN LUIS OBISPO
Marilyn Rice, Ph.D. (805) 438-3850
Meets fourth Sunday of each month. Call for details.

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

SANTA CRUZ AREA
Linda Neider, MA, ATR, MFCC (408) 475-2849
Meets every month on a Friday (Call for time) Case discussion.

SARATOGA/W. SAN JOSE
Dwight Goodwin (408) 241-0198
Meets alternate Fridays, 9:30am - 11:30am.

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

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

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

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

WOODLAND HILLS/NORTHRIDGE/WESTWOOD
Ron Doctor (818) 342-6370
Ginger Gilson (818) 342-6370
Seeking new members. Contact Ginger.

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

EMDR Joins the Internet

A. J. Popky

We are in the process of registering a domain name for EMDR with zNET as the provider. The domain name, when assigned, will be emdr.org. As soon as registration is completed, we will begin working on the design of a home page for the world wide web. Initial discussions include; providing gateways to information and discussions based various levels 1) accessability to information to the general public, 2) trained EMDR therapists, and 3) Network members. We also plan to have specialty areas for on line discussions between therapists.

This is the ground floor of the planning and design phase of EMDR availability in the internet, and we would like your ideas on form and content to include. Please address your suggestions to me at: *ajpopky@znet.com.*

I will begin to assemble a phone book of email addresses of network members. When our domain name is registered and assigned. I will notify you of our new email address at that time.

REGIONAL NETWORK COORDINATORS - USA

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

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

EMDR International Coordinators

Country	Coordinator	City	Phone
ARGENTINA	Pablo Solvey, MD	Buenos Aires	(541) 831-6133
	Raquel Solvey, MD	Buenos Aires	(541) 831-6133
AUSTRALIA	Gary Fulcher, Ph.D.	Burwood, NSW	(61)(2) 747-5611
CANADA	Sheldon Walker, MS	Calgary, ALB	(403) 294-3200
	Marchall Wilensky, Ph.D., R. Psych.	Vancouver, BC	(604) 682-1909
ENGLAND	John Spector, Consultant, Clin. Psych.	London	(44)(9)(2) 321-7554
FRANCE	Francois Bonnel, MD	Aix En Provence	(33)(4) 224-9088
GERMANY	Arne Hofmann, MD	Oberursel	(49)(61) 712-04361
ISRAEL	Elan Shapiro, MA	Ramat Yishay	(97)(2) 483-2760
NETHERLANDS	Ad de Jongh, Psych.	Amsterdam	(31)(20)(5) 188-232
NORWAY	Atle Dyregrov, Ph.D.	Soreidgrend Bergen	(47)(55) 293-940
SOUTH AFRICA	Reyhana Seedat, FMT	Durban, Natal	(27)(31) 303-1661
UKRAINE	Dr. Alexander Bondarenko	Kiev	(7)(044) 293-0854

1995 EMDR International Conference
June 23,24,25 in Santa Monica, CA