Fall/Winter 1993
Vol. 3 Issue 2

Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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Stray Thoughts
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Cautions

I have compiled the following list that should be kept in mind in regards to client safety factors. It is being included in this column both as a reminder and as an incentive for clinicians to write in with other items they consider important for screening or client care.

1) Level of Rapport with the Client. Will the client feel safe in possibly experiencing high levels of vulnerability, lack of control, the physical sensations of the abuse inherent in the memory being treated, etc.? Will the client be willing to tell you the truth about his or her experience? If, because of insufficient trust or a high susceptibility to demand characteristics, the client inaccurately reports a low level of distress and inappropriately concludes the session, greater mid-session discomfort will probably arise and the client may be forced to deal with abreactive level material without the appropriate support. Suicidal attempts have been reported when the client has withheld information from the clinician.

2) General Physical Impairment. Is the client physically appropriate for the memory reprocessing? Are there debilitating effects of age such as a cardiac or respiratory condition? Equal sensitivity should be given to pregnant women. The effects of the level of emotion arousal on the fetus should be taken into account. While there have been no adverse reports to date, it is always better to use caution. A medical consult would be appropriate.

3) Office Consultation or Inpatient Treatment. What kind of memory should be treated at the office versus inpatient with hospital support? During one reprocessing of a near death experience, the client stopped breathing. The clinician was a psychiatric nurse, however, and had previously made provisions for resuscitation. In another session, a client was being seen on an inpatient basis. During reprocessing of a memory of electrical torture, he began writhing and convulsing in bed as if presently being shocked. The psychiatrist was able to complete the processing, but clearly the experience would have been much more traumatic for both had the client not been in a protected environment. There should always be an assessment of the need for appropriate restraint, medical attention, or medication needs, as in cases of attempting treatment of schizophrenia, active drug or alcohol abusers, or near-death memories; with the physically impaired; or when in doubt regarding suicidal tendencies, lack of ego-strength, or inappropriate life-supports.

4) Neurological Impairment. Possible neurological contraindications should be ascertained. Since the EMDR model posits a stimulation of physiological processes, there should be sensitivity to any history of neurological abnormalities or organic brain damage. It has already been reported in the literature (Rothbaum, 1992) that crack cocaine addicts have received no benefit from EMDR treatment. The marker for this deficit appears to be a metabolic abnormality of the orbito-frontal cortex. While EMDR has been used successfully with clients evincing a range of neurological complaints, caution should be observed when attempting treatment and a medical consult should be considered. There is bound to be some form of brain damage that would cause either no response or extreme discomfort. One instance of required hospitalization for a high level of anxiety has been reported with a client who had abused amphetamines daily for the past 20 years.

5) Epilepsy. While a number of clients with epilepsy have been successfully treated with EMDR, caution should also be observed as a matter of course. Consultation with the client's physician should be an important component of treatment. There have been reports of only two clients having small seizures during session. In one instance, the memory being reprocessed was seizure-related. In that instance, the client came to consciousness within five minutes, washed her face, and went on unbothered. That was the only seizure experience in more than

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a dozen sessions. Another clinician has reported a similar experience, in that a small seizure was stimulated, but, interestingly, the client was never troubled by seizures again.

Also noteworthy is one client who had been successfully treated for a case of PTSD, and attempted the eye movements on her own whenever she had an "aura" or other sign of an oncoming seizure. She discovered that the eye movements enabled her to avoid the attacks. Research in this area would be highly desirable.

6) Eye Problems. There has been one report of a client sustaining severe ocular damage (i.e., blindness) at the hands of an untrained clinician. According to the report, the client reported consistent eye pain, but the clinician, who had no baseline of practice effects, continued the sets of eye movements (SEM). Under no conditions should EMDR be continued if the client reports pain. Should that occur, the client should be sent to the appropriate physician with an accurate description of the kinds of movements that would be required. The physician should assess the physical capacity of the client for these kinds of distinctive movements.

Some clients may be unable to sustain continued SEM. They too should be sent to an ocular specialist for examination and, when appropriate, be instructed in eye exercises to increase the muscle strength necessary for continuous movement. Clients who wear contacts should be cautioned to bring their lens cases so that the contacts can be moved if any sign of dryness or irritation occurs. When eye movements are not possible, as in the above cases, or when blindness includes loss of eye muscles, the clinician can employ alternate forms of stimulation.

7) Drug and Alcohol Abuse. Extreme care must be taken with substance abusers to have appropriate life-supports, such as 12 Step program affiliations, in place before inaugurating EMDR treatment. Clinicians have reported that while some clients easily let go of abuse behavior during treatment, for others, the stimulation of old material causes a reactivation of the activity. Whether this is caused by an attempt to medicate against the stressful material emerging, or because the old desire is being stimulated, clinicians should take special care with this population to brief the client as to potential problems, and set up safeguards against potential abuse.

8) Legal Requirements. If a crime victim or police officer is being treated for a critical incident, it is essential to establish whether a legal deposition, or any specific kind of trial testimony, is required. If during the EMDR treatment the image of the event faded, blurred, or completely disappeared, the client would then be able to tell what occurred, but would not be able to give a vivid, detailed description. In other instances, the client may be able to give a more detailed description of the event and actually see the picture more clearly. However, there is no way of knowing how any particular event will process for any given client. In addition, if the prosecutor needs an hysterical witness on the stand, that will probably not occur post-EMDR treatment. Clients should be informed of these possibilities and encouraged to consult with appropriate parties. At the time of this writing, there has been no test of EMDR in the courts, but the clinician should be cautious. Having videotaped interviews with the client pre-treatment may be useful, but may not be sufficient in any given case.

9) Systems Control. Treating the client also affects the entire family and social structure equilibrium. As the earlier trauma information is processed, and new self-assessments are engendered, client behavior will change spontaneously. If the client is in a dangerous home environment where new assertiveness would be detrimental, care must be taken. As clients begin to open to new choices, skills training (e.g., assertiveness, dating, career) must be available. Clinicians should have the appropriate peer support and training groups arranged at an early stage of treatment. Clients can process material at a sur-

NATIONAL NETWORK MEETINGS

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1993-1994 EMDR Network Schedule

Saturday, Nov. 13th	**9:30am to 4:00pm**
Saturday, Mar. 5th	**12:00 to 2:00pm (at the 94 Conference)**
Saturday, May 21st	**9:30am to 4:00pm**
Saturday, Sept. 17th	**9:30am to 4:00pm**

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

SCHEDULE *for Nov., May, and Sept.*

9:30-10:00am Registration & coffee

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

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

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

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

prisingly fast rate, and they must be able to prepare for the resistance they may encounter in some of their still dysfunctional family members or friends.

10) Secondary Gains. Special care must be made to assess the possible positive consequences or identity needs served by the presenting pathology. Clients may have constellated their existence around the pathology and these factors must be addressed, at least cognitively, before any changes should be expected during the EMDR treatment.

11) Session Time. Is the client's work schedule amenable to session requirements? Clients should have been briefed via informed consent that EMDR sessions may entail emotionally intense work and that no important or long work hours should be scheduled immediately following treatment.

Care must be taken to provide adequate time during each session to process completely the presenting traumatic memory. It is recommended that the initial history-taking be done in a separate session(s) and that subsequent trauma work be assigned to 90-minute sessions. Although long by conventional standards, the 90-minute session provides only adequate time for processing most client traumas. If a single trauma is treated rapidly in a given session, more than one memory may be addressed.

As mentioned earlier, if the trauma is insufficiently processed, the client will most likely be left with a higher level of end- and mid-session disturbance. Under no conditions should a client leave the office during an abreaction. The usual 50-minute client hour will increase the likelihood of the client remaining in distress. Regardless of circumstances, some disorientation may occur post-treatment so that decisions should be made about the appropriateness of driving. Sufficient time must be left at the conclusion of the session to debrief and have the client regain equilibrium.

When material has been insufficiently processed, extremely strong emphasis should be placed on a proper debriefing, and guided visualization techniques or hypnosis should be used to assist the client in regaining emotional balance. It is useful to train clients in self-control techniques before undertaking EMDR treatment. These techniques can be drawn on to close incomplete sessions, and also provide a source of relief for clients if mid-session spontaneous processing causes emotional disturbance.

Even under the best of conditions, there is the possibility that a trauma will be insufficiently processed even in the 90-minute session. Some traumas will take many more than one session to defuse, and some clients will be resistant to single-session treatments. Always use caution if any client remains in distress, and assess any special needs in returning to work or the home environment.

12) Timing. Because of the potential for continued disturbance, reprocessing should not be attempted unless the client is able to come in for additional work. Therefore, initial reprocessing should not be started before vacations of the client or the clinician. Care should be taken to schedule sessions later in the day for clients who have a high level of responsibility; for example, CEOs should not have to return to work after major abreactive sessions.

13) Medication Needs. At times, a client may be currently stabilized on medication, or may be assessed as needing the influence of medication to maintain equilibrium between sessions. Thus far, no medications have been contraindicated, as long as the client's eyes are able to move (e.g., an inability to move has been noted in patients on morphine). However, when clients are on any medication, they should be carefully monitored in order that they may be weaned off at the appropriate time. Clearly, as the dysfunctional material is processed, it alleviates the attendant

anxiety/depression and obviates the need for the drug.

In addition, clinicians should plan to reprocess the presenting traumas once the client is off the medication. It has been found that if a client is asked to reaccess the treated memory at post-medication, it will appear with approximately 50% of the disturbance regenerating. For instance, an initial combat trauma presenting at 10 SUDs will appear as 0 SUDs post-treatment. However, once weaned off medication, the combat memory will elicit a 5 SUDs level. This indicates that there is some residual dysfunction in state-specific form and is in contrast to stable treatment effects with non-medicated patients.

14) Stability. It is vital that the client be assessed for the appropriate stability of ego-factors and external circumstances. Reprocessing of extraneous, earlier trauma should not be attempted if the client is undergoing major areas of pressure, deadlines, or crisis. It is important that appropriate clinical judgment be used regarding the connection of earlier trauma to present life conditions, along with the client's ability to handle the additional disturbance often engendered by the reprocessing. If there are major financial and career deadlines or systems crises, trauma reprocessing generally should not be attempted.

While many of the items listed above are salient to most forms of trauma work (e.g., hypnotic abreactions), they are especially important to keep in mind when attempting any form of EMDR treatment, as even the most innocuous presentation can rapidly shift into an abreaction of early childhood material. Once again, clinicians should please write with any additional red flags or cautions.

References

Rothbaum, B. O. (1992). How does EMDR work? Behavior Therapist, 15, 34.

EMDR: Warts and All

Elan Shapiro, MA
London

After my first training with Francine in 1989, in Israel, I was excited by this promising method and infected with her enthusiasm. I went on to use EMDR whenever I could in my work at the Nazareth Ilite Educational Psychological Service and in my private practice, as well as during my present sabbatical leave in London. I often incorporated EMDR into my work and felt comfortable and confident with a wide range of clients, ages, and difficulties and was ready to explore further with the method. Since my Level II training in November of 1992, I have learned to be more discerning, perhaps even overcautious for the time being, in applying EMDR. Reflecting over my earlier years of bolder and freer uses of EMDR, I did not encounter any negative effects. The worst that happened was that nothing much happened, and this occurred in a minority of cases (perhaps in less than 20%). Even with those cases, I had noticed that there may have been a tendency to underestimate positive effects. One of the subtle difficulties I observed in assessing outcomes was that the cognitive changes that occurred were sometimes so spontaneous and "natural" that the client took them for granted. I first noticed this phenomenon clearly in two cases.

The first case involved a young navy man, 20 years of age, who was referred to me after a crisis in which there had been a suicide gesture. In the course of working with him I identified, amongst other difficulties, a fear of heights which had manifested when he raised a flag on the roof of a building. While raising the flag (which he had been ordered to do), he experienced a panic attack which caused him great concern. He traced the onset of this phobia to an early childhood experience while on holiday with his parents in Japan. He remembered being in a cable car, becoming terrified, and laying on the floor in a panic. Using EMDR on this memory, and subsequently on the flag raising incident, resulted in a much reduced SUDs level and a reasonably confident VoC that he could handle raising the flag. During our next meeting, when I asked him how things had gone, he answered, "Not that well." When I specifically asked about the flag raising, he said, "Oh that, that's nonsense--of course I did it; but I wanted to see if I had overcome my fear so I climbed up a mast on a ship, to the crow's-nest (about 100 feet high), and could only stay there about ten minutes because I felt uncomfortable." I was taken aback at first by his lack of recognition of his conspicuous progress. There are probably other factors involved in his not recognizing his achievements, but I felt that it also had something to do with this "spontaneous" nature of cognitive and affective changes with EMDR.

The second time I identified the spontaneous changes was in 1990, when I was still very eager to try out EMDR on anything that moved (its eyes). This presented itself in the form of a 13 year-old female who had warts covering both of her hands. Although I was ready to take on the challenge, I remained somewhat skeptical. She had 37 warts (we counted and drew them) of over three years duration on both hands and fingers which had not responded to medical treatments (e.g., liquid nitrogen freezing on several occasions had only resulted in discomfort and a return of the warts). This teenager was generally well-adjusted and although did not particularly complain about her warts, did give an initial SUDs rating of 8. For eight Sets of Eye Movements (SEMs), her emotional response to the sight of her warts went up to a charged 9.5 and stayed there as her milder cognition remained, "It's not unbearable, but I would prefer them to go." A brief discussion helped her to recognise her more matching underlying belief of "They're never going to go away!" Two further SEMs began to reveal a chink in this hopeless belief which moved from "nearly no chance" . . .

and "unlikely"... to "I'm half despairing and half hopeful." However, her SUDs remained at 9. I paradoxically suggested that she imagine how it could get worse. One SEM was sufficient for her to access her real anger, forcefully asserting, "I'm fed up with it, I want it to get better!" The SUDs level was still high, but her VoC for the positive belief that they would eventually go away was now 4.5. I decided to switch focus to this positive cognition to see if there could be any movement here. Three more SEMs led to more specific positive cognitions, which she rapidly came to believe with increasing confidence: "One doctor said it would simply disappear during adolescence" . . . "I'm beginning to believe it" . . . "It's already starting"..."There's a possibility, it's my last hope"; going on to "I believe it more now" (VoC 6)... and finally to "I think it will happen before my 14th birthday" (in six weeks time).

Despite her shifts in cognitions and VoC and acknowledging her feelings about the warts, she retained a high SUDs level and was disgusted by them (they were not a pretty sight). This was possibly an honest teenage response standing for an expression like "gross."

However, the high VoC was encouraging. One-half an hour and 16 SEMs had passed and we had to stop. I was left doubting and wondering what else I could have done and thought of coming back to it some time later. As things turned out, this was not necessary.

Within two days, an improvement was observed. After five days, there was noticeable shrinking of most of the warts. After two weeks, there was considerable flattening and many had entirely disappeared. After three weeks, there were residual marks on the skin surface and two or three small remaining warts on the sides of two fingers. Within one month, both hands were entirely healed.

A curious thing about witnessing this astonishing physical change was that I was more excited and surprised than this 13 year-old, who was so cool and laid back about it. She apparently knew it was going to happen and had already taken it for granted.

Until now, over two years later, there has been no recurrence. A plastic surgeon who had seen her warts confirmed that they had been viral and could be regarded as benign tumours.

So what happened here? Did EMDR facilitate a change in her beliefs about her warts, and then somehow her immune system became better able to deal with the virus responsible for them? This, of course, may have obvious implications for other diseases and reminds me of the Simontons' hypothesis linking attitudes to the functioning of the immune system. Furthermore, when reviewing the hypnotic literature, I found it reports that 60-70% of warts respond to suggestive therapy.

Kroger (1977) wrote: "It has long been recognized that wart tumours, even though benign, are due to a viral involvement and often respond to suggestion and/or hypnosis. This noteworthy example of alteration in tissue pathology is pertinent to the discussion of psychophysiologic factors in cancer" (p.284). He went on to write that Simonton's technique of strengthening mental attitudes, inculcating positive attitudes, and bolstering the will to live have had some good results, but a major shortcoming is **"how does one get a person to really believe in positive thinking?"** (italics mine).

EMDR may be able to provide a valuable new way to approach this question.

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Metaphors Describing the EMDR Process

Errol D. Schubot, Ph.D.

I have found it useful to use metaphors in describing EMDR to my clients. I have gathered together several that are from the Training and the Network Newsletter, as well as others that I have developed. Each of these metaphors underscores different positive aspects of using EMDR and have opened my clients to the amazing potential for healing that is provided when working with EMDR.

EMDR Uncovers Hidden Aspects of Your Problem

EMDR is Like Peeling Back Layers on an Onion(2)

There are many layers to every problem that we have, many of which are hidden from view. When the reprocessing begins, the outer layers are peeled away, revealing the deeper layers of the problem. This may come to the surface through memories, thoughts, or changes in sensations in the body.

EMDR is Like Removing a Quilt From the Bed(2)

Once the quilt has been removed, you can see the lumps in the mattress. The lumps represent those aspects of yourself that are ordinarily hidden from view.

EMDR Gets You Unstuck and Allows a Natural Movement Toward Healing

EMDR is Like Opening a Stuck Faucet(2)

Once the faucet is opened, it continues to run. The problem material starts moving and is available for healing. Memories, decisions, and feelings that have been repressed are now available to be experienced and moved through.

EMDR is Like Moving a Log Jam

All the logs you need are in place, but they are compressed and twisted to-

gether and immobile. The reprocessing begins to move just the right log to get the whole pile of logs moving along the river again to their destination.

EMDR is Like the Sun Thawing the Winter Snows

Traumatic and unresolved feelings from your past can be "frozen" in your unconscious mind, so that consciously you are not even aware that they exist. Just as the sunlight in springtime melts the winter snow, allowing it to flow into streams and rivers, EMDR shines a light into the unconscious and begins to thaw out those "frozen" feelings so that they can emerge into awareness and be healed.

EMDR Generates A New Perspective of Your Problem

EMDR Gives the Blind Man Inner Vision

There is the familiar story of the blind men describing the elephant. They each were at a different location at the elephant that led to different conclusions of what an elephant is. One said an elephant was like a wall, another said it was like a sturdy tree trunk, and yet another said it was just like a rope. We are all like the blind men in that our fixed relationship to our problems gives us a narrow viewpoint and can lead to false conclusions. EMDR gives the blind person within us an inner vision that can bring new perspectives to observe our problems. After reprocessing with eye scanning, clients often come up with amazing insights and understandings that they never had and sometimes report that for the first time, they can view the problem more objectively.

EMDR is Like Moving From the Playing Field to the Grandstand

In football, there is a coach that is positioned in the grandstand. From this point of view, he can have a full view of the playing field and can make observations that are impossible for the players in the game. This distance also gives him a potential for greater detachment in making his observations than are the players who are caught in the intense emotion of the competitive struggle. EMDR often provides an experience of separation from an upsetting experience. This distance begins to allow for awareness and observations that were not possible when you were caught up in the trauma.

EMDR Allows You to Go Directly to Your Healing Destination and Eliminate Incorrect Pathways

EMDR is Like Fixing the Switches on a Train Track[1,2]

The process is like taking a train trip. You may know where you want to go and have all the best intentions going straight to, and arriving at, your destination. However, while on the journey, something (triggers) switches the train to another track toward a negative outcome. These specific switches are identified and neutralized by EMDR. The switches are changed so that when those triggers occur in reality, they will not switch the direction of the train. The train can therefore continue successfully along the track toward the desired outcome, while you can relax and enjoy the trip. At each stop along the way (end of a cycle), some of the negative you have been carrying gets off and some of the positive gets on. Some scenery from your life will pass by your observing window, but you can essentially remain safely on the train.

EMDR Creates New Pathways Beyond the Limitations of Your Previous Route

EMDR Facilitates the Creation of New Tracks so that Your Train Can Travel to New Territory[3]

A journey on a train is limited by the route of the tracks. A passenger can go no further than the end of the line. In the same way, your reactions and behaviors are routed by pathways laid down many years ago through childhood experiences and decisions. You are habituated to those familiar ways of responding. EMDR can show you clearly the familiar pathways that you use to process your experiences and then can assist you in creating new pathways and possibilities.

EMDR Accesses the Natural Healing Abilities of Your Deeper Self

EMDR is Like Healing a Wound--Accessing the Natural Healing Properties of the Mind, Body, and Spirit[3]

After a person is wounded, the place of the injury is cleaned or stitched in order to allow the natural healing properties of the body to begin a transformative process. There is information within the cells that immediately begins a process of healing the injured area. If the wound, however, is not properly prepared, this process cannot occur. The healing of a psychic wound may be analogous, in that EMDR elicits the natural healing process of the mind, body, and spirit. When the traumatic experiences are repressed or frozen in time, then this natural healing process cannot occur. EMDR cleanses the psychic wound and stimulates the natural healing abilities of your deeper self to transform the psychological wound.

EMDR Develops the Ability to Let Go

EMDR is Like Wisdom Coming to the Monkey, Guiding Him to Let Go of His Trap

Hunters have used a method of carving out a coconut and putting a banana inside to trap a monkey. The coconut is secured to the ground. When the monkey reaches inside to get the banana, he cannot pull the banana through the opening. Because of the monkey's unwillingness to let go of the banana, he remains trapped and is easy prey for the hunter. We are all like that monkey in our ability to let go of outmoded attitudes, beliefs, and behaviors. EMDR encourages you to let go of the tight grip that you have and release yourself from self-imposed traps. This letting go is an incredibly releasing and freeing experience.

EMDR Installs Positive Behaviors and Allows You to Connect to Useful Resources

Within Yourself

EMDR is Like Working with a Computer in its Ability to Install New Programs and Create Linkage to Other Essential Data in Your Own Computer Banks

Once you have new software for your computer, it is easy to install that program and have it available for use. The latest programs also allow links to be made with other programs so that new data placed in one program are instantly available to all other linked programs. EMDR is capable of facilitating the installation of new programs and abilities in your unconscious mind so that it is available when you need it. EMDR also makes it possible for you to link up to other relevant resources (past learnings, abilities, positive role models) that can be integrated into the healing process.

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(2) Shapiro, F. (1991, August). Worthy Repeating. EMDR Network Newsletter, 1.

(3) Shapiro, F. (1993, May). EMDR Level Basic Workshop.

AWARDS

The Department of Veterans Affairs has awarded Joan Barron, M.N., R.N., C.S., the 1993 VA Service Director's Award in Mental Health and Behavioral Sciences, in recognition of her achievements in enhancing clinical care of veterans being treated in mental health programs. Joan is a Psychiatric Nurse Clinical Specialist at the VA Medical Center in Dayton, Ohio and is coordinator of the EMDR Bulletin Board on the VA Forum.

Exposure/EMDR: Diagnostic Use of Feedback

Frank J. Schlosser, MS

One of the tasks of psychotherapists is to attempt to reduce anxiety in their patients. They determine the level of this anxiety through patient reports, observations of body language, intuition, or results of projective and objective tests. They then gauge therapeutic effectiveness by the amount of anxiety reduction as indicated by these relatively subjective measures. Even behaviorists, who make much use of numbers in their evaluations, are not measuring anxiety but its effect on the client's behavior. It is my contention that subjective measures of anxiety are not appropriate scientific tools and, if we are to progress in the development of more effective techniques for removing or reducing anxiety, we must devise more objective and accurate techniques for measuring this state which we describe ourselves as "treating."

In an attempt to demonstrate that such objective techniques are available and valid, I undertook a study to demonstrate that biofeedback (BFB) monitoring of client stress levels can provide therapists with immediate, continuing, objective information about changing anxiety levels in the patient, thereby facilitating more rapid, accurate diagnosis and therapy. The results of that nine-year study were reported at the 17th Annual Meeting of the Biofeedback Society of America in 1986 in San Francisco. The following is a digest of that report:

Subjects

The total number of subjects was 1266, with 47% adult female, 39% adult male, and 14% children (ages 5 to 17). All were the author's private clients during the previous nine years. The only clients excluded were those who worked primarily with interns using this technique since they were not under the author's constant observations.

Method

During the initial interview and all subsequent sessions, biofeedback instruments were attached to subjects as follows:

1. Frontalis: This placement was used with most subjects (approximately 98%) throughout the study. BFT 401 Electromyograph (EMG) was used during the first six years, and during the final three years an Autogen 1500b EMG was substituted to provide a wider response range.

2. Abdominal wall: During the final six years, Autogen 1100 EMG active electrodes were placed one inch below and three inches to each side of the subject's navel.

3. Ankle: During the second and third years, BFT 401 EMG active electrodes were placed on the anterior surface of both ankles of 2% of subjects. In these cases, this was the only BFB instrument used. During the remaining six years, ankle placements were made with the majority of subjects using the Autogen 1100 EMG.

When the above devices provided unclear results during intake, additional monitoring was obtained, as follows:

1. G&W Pulsewatch (Model 420) was attached to the first finger of the subject's right hand. (Required in less than 3% of cases.)

2. Autogen 3000 Galvanic Skin Response (GSR) was attached to fingers of subject's right hand. (Required in less than 1% of cases.)

Although various BFB applications were used with many subjects, particularly during the early years of the study, typical BFB applications with subjects during the final four years included EMG electrode placement on the frontalis, abdominal wall, and ankle sites, as these were found to produce the most consistent information. It is this data which are summarized in the results.

During the intake interview, subjects discussed the presenting problem and were then asked about other areas of possible anxiety (e.g., feelings of failure, sexual concerns, demonstrated anger, disappointing others, etc.), while levels of BFB indicated stress were observed and correlated with subjects' reports of anxiety. After major anxieties were identified, the nature and anticipated effects of implosive therapy were explained, subjects were introduced to self-hypnosis, and attempts were made to reduce these anxieties primarily through the use of in situ and present time implosive therapy (I.T.). BFB stress levels were monitored during and post-therapy and correlated with subjects' self-reports and therapist observations.

At the close of each session, subjects were congratulated on their performance and their success was demonstrated to them in terms of reduced levels of stress when again confronted with the target anxiety.

Results

1. In 94% of the cases, frontalis activity, with an average baseline of 1.9 mv, was reduced by more than 75% at times during which subject reports, therapist observation, or other BFB displays indicated subjects were in severe stress.

2. 84% of the subjects showed first BFB evidence of increased stress in leg tension (ankle electrodes). Baseline was 2.2 mv with peaks during stress as high as 270.0 mv. Average ankle placement readout peaked at 12 mv. 89% of the subjects showed first BFB evidence of stress/anxiety reduction (decay) in leg tension.

3. BFB indications of increased abdominal muscle activity correlated most closely (96%) with subject reports and therapist observations of anxiety. Baseline here was .7 mv with marked consistency (97%). Peaks attained during implosive therapy varied from 1.2 mv to 14.0 mv with the average peak at 2.9 mv. The majority of subjects peaked within plus or minus 1 mv of 2.9 mv which presents evidence of a normal curve with a skewing factor noted below.

4. Subjects in superior physical condition (athletes or others with daily exercise habits) peaked at the highest mv values and showed the longest elapsed times before onset of stress reduction (decay).

5. Elapsed time between peak mv achievement and beginning of decay varied from 20 seconds to 48 minutes. The average elapsed time is estimated at three minutes, which provides further evidence of a normal curve skewed by subjects discussed in paragraph 4.

6. Anxiety reduction as a result of successful implosive therapy was indicated (93%) by gradual reduction of abdominal wall BFB activity. Sudden reductions in BFB readings in this area were usually found to indicate avoidance behavior. For maximum effect, it was found necessary to continue I.T. stimulation until the mv readout showed reduction (decay) to 33% of the peak value. Auditory stimulation in increasingly graphic detail was necessary in most cases to reach and maintain peaks (i.e., "Think about your wife looking bored, think about her rejecting you, think about her leaving you, think about her divorcing you, etc.") Tears or "I don't care" statements by the subject usually indicated the imminent onset of decay when they occurred after peaking; however, early onset tears were usually found to be avoidance techniques.

7. The effectiveness of therapy in reducing the target anxiety was best determined by:

a. post I.T. drop of abdominal wall electrode output to sub-baseline levels (average .6 mv); and

b. resumption of I.T. stimulation after 20 seconds in sub-baseline phase resulted in maximum peaks of .9 mv (92% of subjects).

8. Post I.T. abdominal wall readouts remaining above baseline were usually (88%) due to subject memories of similar past trauma. These were removed in the majority (85+%) of cases by hypnotic regression and in situ I.T., resulting in sub-baseline readings. In most cases, the correct target memory of the regression could be determined from BFB displays without subject confirmation which was, however, always obtained.

9. In 27% of the subjects, the anxiety was identified as singular and not enmeshed, and it was possible in 90+% of these cases to identify and remove (reduce to levels below the subject's conscious awareness) that anxiety by the end of the initial session.

10. Approximately 7% of subjects were initially unable to develop stress during I.T. despite intense attempts to stimulate the previously identified target anxieties. In the majority of such cases, pre-therapeutic ingestion of mild tranquilizing medication resulted in markedly increased ability to reach adequate stress levels. During the final four months of the project, it was found that these resistant subjects could develop anxiety in the target area without medication if an anxiety-producing topic outside the target area was introduced without overture. For example, if the target area was a husband's infidelity and the subject was too frightened to face this, she might be asked to think about one of her children being severely injured. As soon as she demonstrated anxiety, she was redirected to the spousal infidelity. In the majority of cases, this technique resulted in effective stress levels and successful I.T. results.

11. As verified by subject report, experimenter observation, behavior during subsequent therapy, and post-checks, 78% of the major anxiety causes were correctly identified during the first intake hour, and 92% within the first five hours.

12. The same criteria indicated BFB readouts were 96% accurate in determining implosive therapy intensity levels and effectiveness.

Discussion

1. With the exception noted below, there appears to be a strong positive correlation between BFB indicated stress and subject anxiety. BFB, when used to monitor subjects during therapy, has been shown to provide the therapist with ongoing, relatively accurate, objective information regarding the subject's anxiety level, and thus permitting more rapid, accurate diagnosis and therapy.

2. The use of EMG frontalis placement to obtain readings of subject stress should be questioned. In almost all cases, there appeared to be a strong negative correlation between frontalis mv output and increased subject stress. It is interesting to note that jaw muscle tension, which contributes heavily to frontalis mv output, is associated primarily with aggression, whereas a tense abdominal wall is thought of mainly as a defense posture.

3. The most reliable indications of subject stress in this study were obtained from EMG abdominal wall electrodes.

4. 93% of subjects who were confronted with discrepancies between reported anxiety and BFB-indicated stress levels admitted false reporting, and subsequent discrepancies reduced markedly. Recognition of their vulnerability seemed to collapse their defenses, and therapists using this technique must be prepared for any complications that this may introduce. One of these is instant rapport with marked dependency, which some patients find so frightening they do not appear for second appointments. This is particularly true for, but not exclusive to, adolescent and immature adult males. It is imperative that any patient who has been made consciously aware of a previously unconscious stressor undergo I.T. to reduce that anxiety during the same session.

5. Peaking with subsequent gradual reduction of BFB readings is a more reliable indicator of implosive therapy effectiveness than level of stress attained.

6. There appears to be a strong correlation between abdominal muscle fatigue and absence of anxiety, which would seem to lend support to the James-Lange theory.

7. In many cases where identification and removal of anxiety were accomplished rapidly and thoroughly, subjects frequently interpreted their changed attitudes as resulting from a rational decision on their part. "I just decided to stop being afraid." Discussion of this attitude often revealed a conclusion that since a specific fear has been removed so quickly, that removal "obviously" could not have been the result of therapy.

8. The most beneficial effect is the reduced time necessary for effective therapy. Rapport is immediate. Little time is spent with presenting problems or cover stories, the client's underlying anxiety is open and available, and effects of attempts to relieve it are immediately known.

9. Implosive therapy is aimed solely at the reduction of anxiety in individuals. Systems therapists may argue that the techniques involved here are of little use in dealing with malfunctioning family systems, but it is the anxiety of the individuals in any system that produce the problems. If you reduce the anxiety of any member of a system, do you not also change the system?

10. Suggested Research:

a. More effective electrode placement.

b. Use of computers to provide relative values for each electrode input and averaging.

c. Investigation of EEG BFB diagnostic potential.

Having reached the conclusions presented in that paper, I have, over the past six years, continued using biofeedback to monitor client anxiety levels and the effectiveness of therapy (which in my case is almost always implosive or exposure in nature). I have continued to find such monitoring much more effective than subjective client reports.

After my introduction to EMDR in the Level I workshop in November of 1992, I was excited and, to be honest, almost overwhelmed by the possibilities of an additional and exceedingly effective therapeutic technique. However, in incorporating EMDR into my use of exposure therapy, I have found that client reported SUDs levels are frequently underreported.

In these cases, although the biofeedback instrumentation indicates body tension at levels normally associated with panic, the clients frequently will ignore this tension and report that they feel comfortable. When this discrepancy is brought to their attention, the clients in most cases will agree that they do feel body tension, but do not associate it with their anxiety, although before and after that period they did and do associate the two. I regard this as a kind of disassociation. In cases where I am attempting to use EMDR to produce the increased anxiety necessary for exposure to be effective, and where clients were unable or unwilling to focus on anxiety producing stimulation and, therefore, unable to increase their muscle tension to levels adequate to produce the muscle fatigue necessary for exposure to succeed, the use of EMDR has, in most cases, increased the biofeedback indications of tension to adequate levels and successful conclusions; both in terms of biofeedback readout and client report.

My own use of exposure is based essentially on the James-Lange theory that muscle tension is necessary for the presence of anxiety and observations that appropriate muscle fatigue is a necessary precursor to anxiety removal. In view of the fact that EMDR appears to be effective in removing anxiety without accompanying marked muscle tension and fatigue, I am led to propose that there are three conditions necessary for the installation of post-traumatic stress

syndrome:

1. A cognitive awareness of an event regarded as threatening in the present and potentially in the future.

2. Muscle tension appropriate for fight or flight, but in most cases for defense. In this respect, I wish to point out that in my experience, most PTSD victims do not fight or flee; rather, they are helpless and submissive, and submissiveness among social animals frequently involves displays of helplessness and exposure of vulnerability to the dominant party. This gives an interesting angle of conjecture to my findings that the most relevant tension levels are in the abdominal wall muscles.

3. A third and equally important requirement for the placement of permanent trauma is eye fixation. In anecdotal evidence of this, I submit the tunnel vision that occurs routinely with increased anxiety and the descriptive "thousand-yard stare" of long-term combat veterans.

I assume that these three factors are all necessary for the permanent implantation of trauma in a form not available to the conscious mind (a la PTSD), and that they work together of necessity so that whenever any cognitive awareness of the event is triggered, there must be simultaneous muscle tension and eye fixation for the affect to be felt at a conscious level. If these three do work together in such an established reflex, then if one interfered with muscle tension or eye fixation during a cognitive review of the trauma, the entire reflex deteriorates, the repressive process is inhibited, and cognitive and affective aspects of the trauma are available to the conscious mind for normal out processing.

At this writing, I have only worked with about 20 clients using EMDR and, therefore, can only cite anecdotal evidence. At the beginning, I used EMDR only when hypnotic regression was ineffective in getting the client to reexperience the traumatic event. In each of those cases where I encountered resistance in hypnosis to the development of the necessary levels of anxiety to implode or adequately expose the trauma, the use of EMDR has been effective in producing increased muscle tension and anxiety in the client so that he or she could then proceed to effectively be exposed to the original trauma with subsequent reduction in anxiety levels. Assuming that this theory is accurate, one can move to further propositions, such as the use of Cognitive Interweave is effective perhaps because it exposes the client to any remaining or residual tension associated with the original trauma and reduction through exposure of that tension.

In the use of the emotional bridge in hypnosis to find the origin of the anxiety producing trauma, clients frequently will move back only a few years to a related trauma, and this bridging technique must be used again and again until they arrive at the original anxiety producing trauma. These "screen memories," as it were, must be peeled back like the layers of an onion until one arrives at the heart of the problem. In some cases, in fact in many cases, clients are able to move from the present situation by the bridging technique immediately to the original causation situation. I find a very close parallel in that client who, when using EMDR, must often work his or her way through screening trauma until he or she arrives at the original cause of this anxiety. Again, in some cases in the use of EMDR, the client goes immediately from the present situation to the original trauma. In these cases, however, as is true for my own technique, I have often found it necessary to deal with the traumatic incidents which are related at each level they occur. However, in some cases, both in EMDR and exposure therapy, it is necessary only to remove the original trauma, and all subsequent episodes of this anxiety seem to be stripped of their emotional content and therefore of their effectiveness.

Given the foregoing, it is most important, I feel, for therapists who are using EMDR to recognize that clients are individuals, with individual techniques and patterns for responding to the anxieties in their lives and to their own repressive processes. It is inappropriate to conclude that EMDR does not work or that the client is unable to make use of this method simply because he or she does not respond immediately or with apparent effect.

In several cases I have found that clients who got "stuck" with the normal 20-23 eye movements respond immediately and effectively when eye movements are increased to 60 or 70. That, of course, leads us to further speculation of the possibility that it is not the eye movement itself, but the fatiguing of the muscles involved which is relevant in the decay of the repressing mechanism.

I cannot overstate my excitement at the possibilities which EMDR has opened for exploration. Nor can I overstate my gratitude to Francine, not only for discovering this method, but for fostering controlled exploration into its possibilities.

A New Technique For Closing Out EMDR Sessions

Steven Lazrove, MD

EMDR treats distress primarily by uncovering and resolving the false beliefs that empower painful memories. The goal of an EMDR session is to reduce the distress associated with the memory and to replace the negative cognition with a positive one. The session ideally ends when the SUDs has been reduced to 0 or 1 and the positive cognition is "completely true" (VoC of 7).

I would like to describe an addition to the EMDR protocol that I have found valuable. This intervention is performed at the end of a session, and is

most effective when an issue has been resolved clearly. However, some benefit can be gained even when this goal has not been reached.

Once the traumatic memory has been resolved and the positive cognition installed, the client is requested to close his or her eyes and to look inside himself or herself, and is asked an open-ended question such as "Now what do you see?" or "What is it like?" The answer usually is tentative and noncommittal--for example, "I see me," or "I don't know." This is not unexpected since the question is intentionally vague. Its purpose is not to elicit information, but to create a distracting sense of uncertainty which puzzles the usual defenses. In actuality, this question is a set-up for a follow-up question, which is completely unambiguous: "Do you like what you see?" If the session has reached a good conclusion, most people will answer "Yes," and seem truly to enjoy a sense of well-being. (When the answer to the question is "No," the client is asked, "What stops you from liking yourself?" That answer is used as the leading edge for additional work, either at that time or later.) Once clients say that they like themselves, probe further, "What do you like about yourself?" For each positive answer, ask "Are you sure?" If the answer is "Yes," do a short set of saccades to install it. If the answer is "No," ask "What is stopping you from being sure?" and use this answer to unmask additional negative cognitions. Continue asking "What else do you like about yourself?" until there is a generalization effect. That is, once several positive traits have been affirmed, the client seems to lose patience with particulars and attempts to clarify the issue for the therapist: "I just like myself, that's all." Again, work with this: "Are you sure?" "Do you really like yourself?" "Are you really a nice guy?" If the answer is an unequivocal "Yes," install it. If there is any doubt, try to identify the source and work with the negative cognition using the regular protocol. The final set of saccades should install the most general positive statement that the person can make about himself or herself.

Even when clients are unable to make broad, positive statements about themselves, identifying a single positive trait can be quite helpful. Acutely depressed patients often have difficulty generalizing positive insights. They do note small improvements, however, and the reprocessing continues between sessions. I have the impression that patients go through a learning curve during which they figure out how to use EMDR most effectively.

Part of the evolution of EMDR has been in the way sessions are closed down. Progressively greater emphasis has been placed on ways to "accent the positive," with the use of visualization and other relaxation techniques. The procedure described here can complement any of these other procedures. Additionally, clients report having a newfound "sense of direction," and it is my impression that they utilize the insights obtained during the main part of the EMDR session more effectively when the session ends on a positive note.

Like so many other aspects of EMDR, a definitive answer as to whether this technique really makes a difference can be provided only by controlled studies, but my own experience has been encouraging.

International Update

Francine Shapiro, Ph.D.
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An international update should contain information from a variety of individuals, so I would appreciate it if you sent in reports of any state, regional, national, or international conference presentations. Integrating EMDR into panels on the treatment of clinical populations (e.g., phobia, trauma, depression, etc.) can assist in increasing the visibility and acceptability of the method. We have now trained over 4500 clinicians, but with approximately 126,000 licensed mental health professionals in the United States alone, there is a long way to go. In addition, writing up case reports and articles for psychological association newsletters and presenting at local meetings can assist in disseminating information about EMDR. Please check the contents of the article packets for examples. Journal articles from trained clinicians are also vitally needed.

Two presentations about EMDR were accepted for the 1993 annual conference of the Association for the Advancement of Behavior Therapy. One is a panel on compliance issues including myself; Steven C. Hayes, Ph.D.; Joseph Wolpe, M.D.; and Ron Kaufman, Ph.D. The other is a clinical roundtable on research problems and issues that I am chairing with Ron Kleinknecht, Ph.D., and Gary Fulcher, M.A.

The state of EMDR research is presently in great need of improvement. Of the two controlled studies in print (besides my own), the researchers were not trained in EMDR (Sanderson and Carpenter, 1992) in one, and in the other, the psychometrics used were global measures that could not change if only one memory was reprocessed (Boudewyns, et. al., 1993). All known studies (besides mine) entail component analysis (i.e., EMDR or EMD with and without eye movements). In essence, EMDR competes against itself.

In another study (Pittman, et al., 1993) that was presented at the American Psychiatric Association (APA), the principle investigator neglected to provide a full disclosure of the control, and it was reported as eye fixation when it also included hand-tapping and a hand-waving movement. In other words, three major components of the eye movements were used as

the control. In addition, although we know that hand-tapping can give positive clinical results, the research results were dismissed as akin to placebo effects.

It is essential that researchers understand the nature of EMDR treatment effects before attempting to interpret results. This is particularly problematic, as in the APA case cited above, when the principle investigator was not trained in EMDR and had not used it clinically. While it may prove that having the client do a forced eye-focus is clinically effective in some cases, it should be remembered that forced eye-focus has many factors in common with the eye movement (e.g., dual attention, parallel processing, competing response, rhythmical neuronal bursts), as well as possible engagement of the parasympathetic nervous system and hippocampal activation. It is interesting that researchers neglect these characteristics in their assessments. Hopefully, the report will be rectified, and full disclosure and a more thorough evaluation will be provided in future presentations.

The primary aspect of the Accelerated Information Processing model is the activation of the information processing system. This can obviously be accomplished in many ways. However, clearly we can only make appropriate judgments if researchers are adequately forthcoming regarding the controls actually used in their experiments. In addition, as we all know, there is a great deal more to EMDR than just the eye movement.

"The Continued Phenomena of Subjective Science"

As with a variety of other new methods, EMDR provides a projective screen for many aspects of our profession. At times, it slips from "projective" to "projectile"--as most recently found in new letters from the Behavior Therapist included in this packet. While one is clearly a personal opinion (Denicola, 1993), the second one (Mueser and Herbert, 1993) becomes more problematic because it cites an article addressing methodological flaws in research that in actuality do not necessarily exist. I have decided to address their statements directly because it is highly likely that readers of the EMDR Newsletter may still harbor the same illusions I had about the "guaranteed" factual rendition of any published research or research critiques. The article they cite and authored (JBTEP, Herbert and Meuser [H/M], 1992) contained in a previous packet makes statements that offer an apparently inadequate reading of my study, (JTS, 1989) as follows:

1) "All assessments were based on verbal reports of the patient to the therapist (author), suggesting that demand characteristics could have played a role in the observed improvements" (p.170). In actuality, all changes in pronounced sympomatology (e.g., nightmares, flashbacks, intrusions) were corroborated by spouse, parent, or primary therapist in all but four cases. The chances of demand characteristics causing subjects to fake changes over a three month period appear to be very slight.

2) "EMD procedure was conducted in such a way that all patients were required to demonstrate significant reduction in SUDS ratings and improvements in VCS [VoC] ratings before treatment was terminated" (p.170). This implies that the reduction was forced upon the client. However, the initial article clearly states in the section devoted to possible "Experimenter Bias and Subject Expectancy" that: a) Expectation of effect was countermanded, and "No prior description or rationale for the success of either the treatment or the control procedure was given. However, except for three subjects (one Treatment and two Control) who took two trials to begin desensitization, all subjects began to show effects after one trial of the EMD procedure." (Shapiro, 1989, p. 217); b) Complete desensitization in all but one subject took place in 10-40 minutes. The veteran discussed in the Level I training (i.e., illustrating blocked beliefs) took 90-minutes to desensitize three memories. This amount of time would not seem to overly tax the subjects into demanding conformity. (Clinicians should please remember that only anxiety was being assessed and a full therapeutic intervention should include all dysfunctional emotions.); c) The Control Group was conducted for a comparable period of time with a placebo response occurring in only one subject. In most cases in the Control Group, the amount of disturbance increased dramatically during this period which appeared equivalent to the effects of a modified flooding procedure; and d) The purpose of the two groups was to control for the effects of exposure to the memory for a comparable period -- not for a component analysis.

3) It is suggested that the monitoring of heart-rate may have been a differential factor. However, heart-rate was taken only at the beginning of the procedure. No client approached conditions warranting further monitoring during the procedure.

4) It is stated that the VoC was taken after each set which would increase the pressure to change. However, the VoC was taken only at the onset and installation phase.

5) H/M state that neither objective, nor standardized assessments were made of the symptomatology. However, in regards to this matter, diagnosis was made independently by the primary therapist and the primary intrusive symptom was directly assessed (e.g., mean number of flashbacks pre-treatment was 3 per week). This was sufficient to address the written goal of the study.

The initial study used an inclusion criteria of a traumatic memory (e.g., abuse, combat) and a PTSD symptom (such as nightmare, flashback, or intrusion) of over one year duration. The article states that the "aim of the study was to determine the effective-

ness of the . . procedure on traumatic memory symptomatology". While H/M are certainly entitled to their opinion, the study accomplished this goal to the satisfaction of the reviewers of the Journal of Traumatic Stress--a peer reviewed journal, edited by Charles Figley, Ph.D. who is the senior editor of the Brunner/Mazel psychosocial stress series. In addition, a summary of the study in a subsequent article was requested by Joseph Wolpe, M.D., not only the originator of systematic desensitization, but a past president of Association for the Advancement of Behavior Therapy. The article subsequently won the Pergamon award for the best article published in that journal in 1989.

Other statements in the H/M article not grounded in fact:

1) While they state that training opportunities have become widespread in nine countries, workshop series have been offered only in Israel in 1989, and the US and Australia more recently. However, clinicians from over a dozen countries have flown into the US to be trained.

2) While they state that we "certify" professionals in the method and the "Certificate of Completion" indicates "competence", all trained professionals know this to be inaccurate. Certificates are awarded to indicate attendance or completion of the course only.

3) The Newsletter is cited as a way to "promote" EMDR to clinicians, whereas it is an organ of the EMDR Network which is a non-profit corporation, open by membership only to clinicians who have attended trainings to offer on-going education and professional support.

In regards to their citation of the Boudewyns, et al. study, (tBT, 1993) they fail to note that the psychological measures used would not show great improvement when only one of a dozen problematic combat memories is treated. Further, in addition to mentioning the possibility of a placebo effect, the research article stated that:

1) Both subjects and therapists rated EMDR as affording significantly better treatment effects than the control groups.

2) The reasons given by researchers for lack of response on standardized and physiological measures included a) inappropriateness of using the original script in audio taped form as a testing probe b) tendency for this population "to over report symptoms and negative appraisals . . . on psychological tests" c) the use of "a small sample of chronic, difficult subjects" d) small number of sessions for this population

3) The researchers stated that "we feel that these results are encouraging enough to support the need to carry out controlled outcome studies of EMD (EMD-R) in the future." The positive results of this pilot were sufficient to warrant large scale VA funding for a controlled study now in progress. This study is being done with Howard Lipke as the consultant to offer fidelity checks (i.e., (i.e., how well the method is carried out) which was not done in the pilot.

All of the above is simply to assure Newsletter readers that "saying doesn't make it so." That goes for the H/M critique, along with my, or anyone else's research or evaluation. It will only be the accumulation of clinical experience and studies over the next decade that will hopefully be able to sort through to a semblance of the "Truth". In the meanwhile, the following criteria for studies would seem to be appropriate:

1) Researchers should be adequately trained in EMDR (Level I and II) and use actual clinical protocols. Validity checks should be done by competent EMDR clinicians to check the fidelity of the researcher's use of the method.

2) Appropriate psychometrics that are capable of change when a memory is successfully reprocessed should be used.

3) Standard replication to establish efficacy should be done comparing EMDR to other conventionally used methods before component analysis is attempted.

As far as studies currently underway, or submitted for publication:

1) Dave Wilson's study of PTSD victims using physiological measures has replicated the findings of my study e.g., full desensitization in one session and physiological measures correlating with SUDs and VoC).

2) Steve Silver has done a retrospective analysis of his in-patient PTSD program and compared veterans receiving EMDR, biofeedback, and relaxation training. The EMDR condition was vastly superior across seven out of nine measures.

3) Howard Lipke's survey of EMDR trained clinicians reports on approximately 400 responders who have treated over 10,000 clients with EMDR. Approximately 74% found EMDR to offer greater beneficial therapeutic effects than other methods used. Only 4% found less results.

4) Two studies of treatment with Hurricane Andrew victims are showing highly significant results.

5) Studies with promising preliminary results are currently underway in Colorado (Sandra Wilson), Washington (Roger Solomon), and Temple University (Alan Goldstein).

While these studies wend their way through the publication maze, it is important for EMDR practitioners to remember that while there is not sufficient research to fully validate the method, there is enough to warrant judicious clinical exploration. In fact, while recently doing research review, I discovered that at the time that EMDR was launched in 1989, there were no controlled studies validating flooding. However, it was being used widespread throughout the VA system on the basis of case reports.

In the meanwhile, you provide your own best experiment in comparing clinical results pre- and post-use of EMDR. If you could start using the Impact of Event scale as measures, we may be able to pool vast amounts of data at some time in the future. I highly suggest its use, regardless, as a clinical tool. Finding an elevated score after an EMDR treatment can indicate new memories or perspectives that need to be addressed. It has been included in this packet for those of you who do not have it in your manual. Frank Putnam's Dissociative Experience Scale is also available from the EMDR office for your clinical use. It is now being handed out during the trainings to encourage the screening of every client before attempting EMDR.

The research committee, headed by John Thompson, M.A., is presently formulating a position paper on proposed research that will be distributed to the Network and all interested researchers. In addition, any previously established (i.e., published) researcher interested in doing quality outcome studies can be invited to the EMDR training as a guest. Please have them contact the office. However, what is needed at the present time are quality replication studies (i.e., EMDR compared to another known method)--not component analyses.

"Other Phenomena"

While research is lagging, the use of EMDR in clinical practice appears to be growing, as do reports of it in the literature. For example, Linda Cohn, MFCC, has a chapter included in a book entitled California Art Therapy Trends; the Family Therapy Networker magazine is devoting its November issue to EMDR; and Treating Abuse Today is publishing a two-part interview with me on a variety of clinical issues and applications. This interview was conducted by Sheryll Thomson, MFCC, who also helped to coordinate the Florida hurricane response team. This widespread indication of clinical acceptance and publicity is dovetailing nicely with the wider availability of EMDR workshops. Over the last nine months, I have trained and supervised ten additional trainers. When selected for training, they had used EMDR for over two years and worked as facilitators for at least one-and-a-half years. They will be conducting the standardized EMDR workshops with supervised practica at a number of new locations. Please call the office if you are interested in sponsoring a local training.

I am also attempting to finish a textbook on EMDR which will be published by Guilford Press. My deadline is January of 1994, so that it can be available for the fall semester. A number of trained clinicians with university positions have indicated a desire to include courses on EMDR. I do not consider the book a substitute for supervised practica, but an augmentation with a comprehensive description of model, protocols, and procedures.

To date, we have heard of three new eye movement techniques--two from Oregon and one from Colorado. In addition, there is another workshop purporting to teach "EMD." The techniques are NLP or "New Age" flavored and, in one case, are taught in three hours, and in another, one hour. Unfortunately, clinicians are leaving these trainings and reporting "I've learned the eye-movement thing." Therefore, it is important that any of your clinical colleagues who have gone to these trainings be informed that what they have learned is not the same method that is garnering the successful results throughout the country. A number of misleading statements have been made by some trainers of these other workshops--including that I have collaborated with them. I have not done so. When I first launched EMDR, Emmett Miller, M.D., warned me that there would be three stages. First it would be ignored, then it would be attacked, then it would be imitated. I think we are in a mixture of stages two and three. Because of this problem, we have had the logo trademarked and it will appear on the fliers of all EMDR trainings--both basic and specialized--reviewed and approved by me or one of the EMDR Network's professional support committees. We are trying to strengthen a policy of quality control by reviewing credentials and workshop presentations before they are offered. Please check for the logo, EMDR Institute or EMDR Network, and the Pacific Grove address. No other trainings are recommended--regardless of the claims of the proposed workshop presenters or sponsors. No claims of past or present affiliation or collaboration are warranted to indicate present approval or support of competence without the designations listed above.

"Professional & Clinical Support"

We are presently arranging the program for the 1994 EMDR Conference the first weekend of March. Currently scheduled are presentations by Richard Fisch, M.D., Walter Young, M.D., Catherine Fine, Ph.D., and David Calof. There will be a choice of five day-long workshops on the first day, including, among others, one on treatment of OCD, one on dissociative disorders, one on depression, one on HIV/AIDs, and another on the interface between EMDR and the MRI Brief Therapy model that will be presented by one of its founders. Additional presentations will include the treatment of substance abuse, somatic disorders, motor vehicle trauma, veterans, critical incident, children, sexual abuse, and a variety of research reports. Other presenters and topics are under consideration, so please contact the office with written proposals or requests. We are expecting a sizable international attendance.

I have approved a proposal for case and group consultation by some EMDR facilitators that is being coordinated by Landry Wildwind, L.C.S.W. These consultations are formatted as a bridge between Level I and II or for additional work post-Level II. While we are disseminating

the information as a service to participants in need of additional support, financial and logistical arrangements are completely between consultants and participants.

I would also like to specifically recommend the publications Treating Abuse Today and The Healing Woman Newsletter. We have included subscription information as I consider them to be extremely valuable resources for the trauma specialist. I know the editors of both publications and believe them to be of the highest integrity, with a dedication to the alleviation of client suffering. Both have recently published articles on "false memory" which further indicate the need for enlightened professional support.

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News from the EMDR Research/Training Center

Clifford Levin, Ph.D.

Now you might ask what is the EMDR Research Training Center? Where is it located? What does it do? Might I be interested in its activities?

The EMDR Research/Training Center is directed by Clifford Levin, Ph.D., and is located at the MRI, 555 Middlefield Ave., Palo Alto, CA 94301. Lois Allen-Byrd, Ph.D., and A. J. Popky, MFCC Trainee, are full-time staff members. Francine Shapiro, Ph.D., will be special consultant to the Center and attend approximately every second or third meeting. The Center meets every Tuesday afternoon from 1:00 pm. to approximately 4:00 pm in the well known MRI Brief Therapy observation rooms (that's right, the ones with the one-way mirrors and wonderful audio-visual equipment). The primary purpose of the Center is to conduct quality EMDR research and publish its findings in the professional literature. At present, we are in the preliminary stages of planning a formal outcome study of PTSD in Vietnam veterans, rape survivors, and incest survivors utilizing a multi-session protocol comparing EMDR to an alternative treatment (yet to be determined) and a no treatment control group.

The EMDR Research/Training Center opened its doors in July, 1993. However, at this time, we are not offering programs for the EMDR trained public. (When we begin to do so, the MRI will charge a fee for participation commensurate with other similar programs.) We are beginning to see clients in the center so that we may learn to properly use the equipment and develop cohesion as a research and teaching team. Lois and I, as representatives of the Center, are also involved in the data analysis and write-up of two EMDR studies conducted in South Florida in the aftermath of hurricane Andrew. The first study provided data on SUDs and Impact of Events Scale (IES) measurements on over 100 disaster survivors who were given free EMDR treatment as part of a humanitarian effort sponsored by EMDR practitioners. Although this effort was not planned as a research study per se (thus, the results are not generalizable to other disaster survivor populations), as an evaluation study, EMDR was demonstrated to be efficacious in the relief of certain PTSD symptoms with treatment effects holding at one and three month follow-up.

In August, 1993, I acted as Principal Investigator for a formal outcome study conducted in South Florida. The design for this study allowed for three groups--Experimental Group (EMDR) Alternative Treatment Group (a critical incident type debriefing), and a no treatment Control Group--with approximately 15 subjects in each group. Outcome variables measured are the SCL-90 (Symptom Check List), IES, and SUDs. In addition to these outcome variables, we collected information on the details of the sessions and a wide variety of demographic and questionnaire data. We anticipate that the results of this study will be ready for write up in early 1994 and the initial results look quite favorable for EMDR. Participation in these two South Florida research efforts have helped us to foresee some of the difficulties we will no doubt encounter in the EMDR Research/Training Center and hopefully bypass them.

Might you be interested in participation with the EMDR Center team sometime in the future? Possibly. We have identified four categories of practitioners for whom our services will be particularly well suited.

1) Dissertation Students - the laboratory setting is ideal for conducting dissertation quality research. Dr. Levin has participated as statistician for a variety of research projects and is facile with SPSS for Windows, a computerized statistical package. The student would have the opportunity

to act as a true principal investigator in that he or she could oversee the clinical work of experienced EMDR clinicians and not have to provide all of the "grunt work" him or herself.

2) Research Neophytes - how many of you have always wanted to participate in research so that you might learn the skills to design and conduct your own research studies? Or, how many of you realize that at least minimum research skills will become mandatory to substantiate our effectiveness to the managed health care companies of the future? The EMDR Research/Training Center will provide tutorial services in statistics and research design as needed to suit your research requirements.

3) Experienced Researchers - participate in the Center and learn the latest EMDR innovations and protocols. Statistical consultation will also be available.

4) Clinicians looking for advanced EMDR training - the Center will always be looking to develop new EMDR methods. In addition, you will have the opportunity to be supervised directly by Francine (who has promised to attend from one-third to one-half of the meetings) and the rest of the Center staff. We will also make time at each meeting for consultation on current cases in your private practice.

All clinical work will be conducted one-to-one in an office with the remainder of the team observing from behind the one-way glass. If you think you know what nervous is, try practicing EMDR with Francine watching your every move. It is intimidating, yes, but also incredibly stimulating and educational.

At this time, I would like to hear from people who might have interest in participating in such a project in the future. If you would like further information, or if you would just like to talk about your ideas, please give me a call at (415) 326-6465. I look forward to hearing from you.

Magical Installations Can Empower Clients to Slay Their Dragons

Ricky Greenwald, MA

There are several ways to help clients gain access to the resources necessary for successful processing when it does not occur spontaneously. For example, when two or three sets of eye movements occur with no progress, I occasionally use a "premature" positive installation. By doing so, the source of remaining discomfort may come into sharper focus, revealing an appropriate target for continued processing. Alternatively, the installation may have positive impact, giving the client more freedom from the habitual negative stance, and perhaps additional strength with which to face whatever discomfort still remains. With either outcome, this strategy can be helpful in getting the process back on track. (However, sometimes it does not work, perhaps because the available positive cognition does not have sufficient power to overcome the block.)

Borrowing from my work with children's nightmares (Greenwald, 1993), I have recently experimented with the "premature" installation of visual images at times when the process has bogged down. I say something like this: "I'm going to ask you to do something a little different now. Imagine that this whole event was a dream. If this was a dream, and you were in it, what would you need to be safe?" If there is no immediate response, I will prompt as follows: "Remember, in a dream, you can use magic, whatever it is that you need. "Typically, an answer readily occurs and I proceed to install it in whatever manner is most appropriate. I have tried this several times, with excellent results. Two case examples follow.

A woman who was processing a childhood memory of facing an oncoming tornado was not able to gain a sense of safety or relief and was resisting a variety of strategies. Asked what she would need "in this dream" to feel safe, she immediately answered, "some protective white light." She was asked to visualize her targeted image, but with the white light protecting her, and this was installed. She reported that during installation, she extended this visualization so that she absorbed the light in addition to being surrounded by it. The session progressed quite well from that point. Afterwards, it was suggested that she practice visualizing the light as a relaxation exercise.

An older woman had been haunted by a childhood memory of brutal molestation which had greatly affected her whole life. Despite strong motivation and thorough preparation, she was quite afraid of facing this memory in the EMDR process (although she agreed to try it). The first set was brief and served to increase the vividness of the memory. After the second set, she reported losing the image and associated feelings. A sense of numbness was present, which served as the next target. After the third set, even the numbness was gone, and she appeared quite withdrawn. At this point she was asked "the dream question," and answered immediately, "I would need to be stronger." (Incidentally, strength was not her primary positive cognition.) The therapist then asked, "What image do you have of strength? If I can be an animal, a person, an idea, a place . . . what best represents strength for you?" She immediately named her favorite animal and, with animation, described its "strength behavior" in some detail. She was asked to visualize herself "becoming" the animal (as described in Martinez, 1991), and this was installed. She then reported feeling expansive, strong, and very happy. On returning to the original traumatic image, she was able to proceed with the processing, and the session was quite productive.

In the latter case, without this intervention at my disposal, I would have

had to modify the treatment (e.g., moving to a lower SUDs memory, postponing EMDR until the client could develop more trust in her ability to tolerate discomfort, etc.). The delay would have been frustrating and, after all, unnecessary.

I view the premature positive installation as a means of empowering the client to face his or her fears. It is important to introduce the dream context, so that image selection is not bound by reality demands and is not bound by reality demands. Spontaneous selection should be encouraged over "rational" consideration. The symbol which the client produces may encompass much more meaning and potency than a verbal cognition.

For the client, major trauma work is analogous to what Campbell (1949) called the quest of the hero, involving the symbolic facing of death in order to achieve a rebirth, or integrative healing, experience. To succeed on this quest, the hero must acquire magical tools, or allies with special powers, which, on a psychological level, represent emotional resources previously inaccessible to consciousness. By installing the image which the client spontaneously selects, we can enhance access to the needed inner resource; the magical sword with which the dragon may finally be slain.

References

Campbell, J. (1949). The hero with a thousand faces, Princeton, NJ: Princeton University Press.

Greenwald, R. (1993). Treating children's nightmares with EMDR. EMDR Network Newsletter, 3(1), pp. 7-9.

Martinez, R. (1991). Innovative uses. EMDR Network Newsletter, 1(1), pp. 5-6.

EMDR Newsletter Staff
Editor: Lois Allen-Byrd, Ph.D.
Publisher: A. J. Popky, CHT

CASE HISTORY: A Client Unable to Track

Judith Boore, MA

I recently worked with a woman in her early forties who, for the better part of our sessions, could not track my moving fingers. She presented as highly distraught and reported that her husband of 14 years had just left the marriage the week before our session. This woman, who has been a therapist for nearly two decades, wandered distractedly about my office, touching things, and barely able to speak. She has no known medical problems, other than myopia, and takes no medications. I had used EMDR with her six months earlier on her fear of flying with no noticeable (to me) tracking difficulty, although she commented on how difficult tracking was for her then.

We had three EMDR sessions of one or more hours each on three consecutive days. I used long sets of movements with only occasional rest breaks--a practice I adopted while working with hurricane victims because of time constraints, and because the repressed material emerged so readily that interruptions based on numbers of saccades rather than thematic material seemed inappropriate. My impression was that as her work progressed to more intense issues, she was increasingly less able to track, as if the ability to track was a function of issue intensity. Less intense issues seemed to cause less difficulty tracking. (She agreed with this impression.) There was no indication of dissociation, and she seemed present and focused. She felt, when asked later, that she was focused internally on her work during the difficult tracking times. Her eyes appeared not to move at all for long periods of time, although if I looked very carefully, I could detect minute movements. She inquired periodically as to whether or not she was tracking and reported that she was unable to discern her own eye motion. She also mentioned that she took a professional/observer role toward the experience (in addition to that of a client), and that she felt some concern as to her performance at tracking.

In the first session, I added knee-tapping to the finger motions, concerned that the lack of eye movements would stall the work. In the second session, I devised a number of unusual hand variations to encourage tracking. In the third session, weary of working so hard and mindful of a recent EMDR experiment at Harvard (in which the subjects in the alternative treatment group stared at a fixed point while the finger moved--the assumption presumably being that the client's eyes were not moving), I decided to do nothing extraordinary to encourage tracking. I began to notice that new material surfaced periodically in the client's verbal account of her experience, suggesting that despite the lack of obvious eye movement, she was nonetheless processing. Finally, she described her visual image as retreating into the distance and ultimately disappearing. On follow-up, her distress was dramatically reduced, and she was extremely pleased with the outcome. The rapid surfacing of new material, the reduction and loss of the visual image, and a positive outcome despite the lack of obvious tracking during EMDR work suggest that processing was nonetheless occurring. Although this is only an n of 1, the results give rise to a number of interesting possibilities. For example, it may be that the finger saccade registers on the retina whether or not the eyes appear to move. Once it registers on the sides of the retina, signals may be sent to each side of the brain, again in spite of the lack of eye movement. This may be the activating phenomenon and not the eye movements themselves. Or perhaps eye movement and retinal impulses work in concert. It is also possible that minuscule eye movements may be sufficient, obviating the need to generate a wide saccade in our clients' eye movements, thus sparing the therapist some physical effort.

There may also be a wide variation among clients in the minimum number of saccades needed for processing. This client's minute eye movements may have accomplished the task.

Andrew Sweet, Psy.D., shared some observations on this case. He pointed out that he is not aware of any literature to support the retinal signal model mentioned above. Whatever is occurring is clearly not yet completely understood and needs investigation. He believed that this client may have been dissociating mildly or not attending, which seems to me like a good clinical supposition. It is a possibility that I have considered in spite of my alternative impression that she was not dissociative. It reminds me that dissociation and attention are perhaps best thought of as continua rather than either/or states. Andrew also speculated that eye movements may be useful in bringing up repressed material, but may become irrelevant as the client focuses internally. Finally, he believed that perhaps the most important point to be learned from this case is that creative adaptation to unusual client presentations is the key to utilizing the method.

It may be that we do not have to forego EMDR with clients who have difficulty tracking because processing may be occurring. We do, however, need to consider the possibility of health deficits or criteria that might contraindicate the use of EMDR with these clients. Consultation with the client's ophthalmologist or other specialist would be appropriate. Well-designed studies focusing on these points are needed to answer these questions.

Consent

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

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

Sample Format
Do Not
Copy and Use

CONSENT FOR EYE MOVEMENT DESENSITIZATION AND REPROCESSING TREATMENT

I have been advised and understand that Eye Movement Desensitization and Reprocessing (EMDR) is a new and as yet experimentally unproven treatment approach. I have been informed that initial studies have shown EMDR has produced promising results in reducing anxiety and in reducing post-traumatic stress symptoms, such as intrusive thoughts, nightmares, and flashbacks. I have also been advised that although there are currently no known serious side effects to EMDR, there is minimal data as to its efficacy or safety, and my understanding is therefore deemed to have an experimental status.

I have also been specifically advised of the following:

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

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

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

Date:_____ Client Signature:_____

Each state has its own laws governing the use and effect of documents attempting to limit the liability of professionals, such as this CONSENT. Consult with an attorney regarding the laws applicable in your state ***BEFORE*** *using any such document. This SAMPLE FORMAT is provided for your information only. EMDR NETWORK, INC. does not warrant or represent the suitability of this document, and disclaims any liability stemming from its use. EMDR NETWORK, INC. is not engaged in the practice of law and does not render legal services or give legal advice.*

Innovative Uses: EMDR Body Centered Processing

Keith Andresen, M.A.
Boulder, CO

Soon after I took the Level I training, I read an EMDR Newsletter article by Ron Martinez (August, 1991), in which Ron described having clients touch and press the area of their body where they were feeling emotion. (He said that he got this idea from his familiarity with therapeutic body-work.) Ron reported that 70% of the clients obtained a picture or memory, which they then processed.

Ron's article inspired me to try his suggestion and, based on my own familiarity with therapeutic body-work and interest in the mind/body connection, I have tried other things as well, with some interesting results.

I now think of the body as a full partner with the picture and cognition in the EMDR process. As such, I go into detail about body sensations and experiences with clients, much as we have been trained to do with pictures and cognitions. I have put together a tentative framework to help guide practitioners in more fully utilizing body centered phenomena as part of EMDR.

Level A

Touch or focus on the body brings more information, which is then processed.

1. Touch brings out new information (Martinez, 1991).
2. Posture can help clients get in touch with pictures or memories when the client just has a vague feeling and nothing else. Ask the client, "What posture goes with the experience you are having?" Having the client assume the posture often brings up more information.

Level B

When treating a body experience as a node, process as follows.

1. In addition to having the client focus attention on the body sensation during saccades, have the client touch the place on his or her body where the sensation is and process till there is no more sensation. Touch only during the saccades (in all descriptions following, assume touch or pressure during saccades and cessation of touch or pressure between saccades).
2. Have the client assume a posture associated with the situation and process in that posture until the SUDs levels off.

Level C

Work below the surface of the body. This seems to increase the emergence of information and emotion compared to touch on the surface, and seems to change the SUDs more than touch on the surface.

1. Gently apply pressure to the musculature where a sensation occurs, slowly increase, and process until there is no more sensation (feels neutral) or it feels relaxed.
2. When sensation occurs in the throat area, touch the front of the windpipe gently and process any area of sensitivity until there is no more sensation.
3. In the solar plexus, gently push inwards and process until there is no more sensation or it feels relaxed.

Level D

Processing a pattern of response in the body with little or no use of picture or cognition.

I was working with a client I will call Tom on his chronic anger and easily provoked rage. We had processed 2 to 3 childhood memories which had helped reduce his anger, but he had a difficult response occurring as we worked. Tom involuntarily would tense his whole body and feel like hitting with his left arm whenever he felt any degree of anger, and he would become exhausted during the processing. As we tried to process his father grabbing Tom by the arms as a boy and screaming at Tom not to cry, Tom's intense reactions stopped our progress. In the next session, we decided to treat Tom's body response as the target. He could readily trigger the 'tensing response' by thinking of anything moderately unpleasant. I instructed Tom to trigger his tensing response as mildly as he could and then we processed the body sensations, whatever was most apparent at the time. We would work on each location until it was mostly relaxed or felt neutral. After 2 to 3 locations, I started asking Tom to notice where in his body the tensing response originated. He initially said his shoulders. We then processed as he held his shoulders. Then he said he could tell that it originated between his shoulder blades. We then processed as he held this area. After 2 to 3 sets of saccades, Tom said he could now tell that the response originated in his solar plexus. We processed as he gently pushed into the area of his solar plexus. More emotion emerged as we processed at Tom's solar plexus. At times, he could not control his tensing response and we would have to slow down. Processing the tension in his neck would generally allow him to relax enough to proceed without becoming exhausted. We processed as he held his solar plexus until the area seemed neutral. Tom then reported he felt more relaxed than ever before in his life, and that his mind was quiet for the first time in his life.

The above is a summation of two-and-a-half sessions of EMDR on Tom's tensing response. His response was not gone, but was greatly reduced, and he could usually relax enough to prevent it. Tom reported he was much more relaxed in general and was no longer bursting out in anger as he drove in traffic. We were also then able to process the experience of his father yelling at Tom, with further positive results. I would appreciate comments and questions: (303) 443-5682.

The Importance of Matching Positive Cognition to Client Values

Edith Ankersmit, LCSW
Berkeley, CA

A twenty-four-year-old Catholic woman who came to see me recently was suffering from severe post-abortion depression and guilt. (The abortion had been just one week prior to our visit.) Her presenting symptoms were difficulty eating, sleeping, getting up to clean the house, and flashbacks of the abortion. Although she was not conscious during the procedure, the flashbacks were of the doctor performing the abortion. She also punished herself by looking at a book of embryology and paying particular attention to pictures of the fetus at the stage at which it was aborted.

The history taking revealed a reasonably mentally healthy young woman involved in a destructive marriage. She had three children, ages four, three, and a one-year-old baby whom she was nursing. After much discussion, the negative cognition she finally chose was, "I'm a terrible person," and the positive cognition was, "I had to do it," with a VoC of 1. Upon reflection, I realize that 1 was too low to result in a positive outcome. However, note in the following paragraph how the client led me to help her form a more appropriate positive cognition.

What came up frequently during the eye movements was anger at people for not telling her that the abortion was wrong. We started the work with the image of the doctor performing the abortion. This image gradually faded, as did a sign saying "I have to punish myself." However, she did not experience complete relief and the original positive cognition remained at 1. I then suggested a new positive cognition: "It was wrong. I did it because I felt desperate." She immediately accepted this and added, "I thought I was going to go crazy," and gave the entire new cognition a VoC of 7. She then had a visual picture of herself at home, pregnant, with a one-year-old baby and two small children, no husband to help her, and feeling as if she was going crazy. She was unable to visualize the abortion when she held the new positive cognition in her mind. We ended the session with her seeing her three little children happy.

When I saw her for the second time, all presenting symptoms were gone. However, she did not come in enthusiastically reporting this. I had to question her on each symptom and learned that although she was eating and sleeping well, was busy around the house, had no flashbacks, and did not look through the embryology book, she did not seem to connect EMDR with these improvements. She was still planning to contact a priest, saying she wanted someone to tell her she was wrong. She also had initiated counseling with a Christian group who uses the Bible for post- abortion counseling.

Although on the surface, selecting a positive cognition such as "It was wrong" seems to be antithetical to what we are trying to achieve, I believe that it would have been impossible to achieve these quick and positive results without putting it into the positive cognition, as anything else would have come into direct conflict with this client's value system. Thus, it seems clear that it is essential, when formulating the positive cognition, to take into account the client's value system. This means that the therapist needs to be aware of and sensitive to ethnic, religious, and social values--not only of the group, but of the client's own unique interpretation of these values.

EMDR HELP WANTED

"Help Wanted" is a new column 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.

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

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

RESEARCH WITH ADULT WOMEN WHO HAVE HAD A HISTORY OF SEXUAL ABUSE. Assistance desired on research project from EMDR trained therapists to participate in a comparative outcome study between female AMAC clients treated with EMDR and those treated with conventional therapy alone. Contact: *Nadine Zatlin, MFCC, 670 Brooks St., Laguna Beach, CA 92651; (714) 494-0233.*

The EMDR Research/Training Center at MRI is looking for smokers that want to take part in a research project to quit smoking. Anyone who has clients interested in participating, please call *Cliff Levin at (415) 326-6465 or A. J. Popky at (408) 395-8541.*

EMDR trained clinicians who are interested in Peak Performance, I want to exchange ideas. Please contact *Dr. Mark Huthaite, 27 North Cottages, Napsbury Hospital, London Colony, St. Albans, AL2 1AW.*

If you are interested in sponsoring a training for small groups in your area, please contact *Robbie Dunton at (408) 372-3900.*

CALIFORNIA EMDR STUDY GROUPS

Jean Bitter-Moore, Ph.D. California Network Coordinator (408) 354-4048

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

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

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

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

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

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

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

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

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

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

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

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

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

NAPA
Marguerite McCorkle (707) 226-5056
Open.

NEVADA CITY/GRASS VALLEY
Stephanie Zack (916) 272-6738
Call for time. Open

ORANGE COUNTY/FULLERTON
Curtis Rouanzoin (714) 680-0663
Jocelyne Shiromoto (714) 764-3419
Meets 2nd Tue. from 9:30 - 11:30 AM. Open

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

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

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

SACRAMENTO
Barbara Parrett (916) 737-1789
Coordinating new group. Meets on 2nd Fri. 1-3pm.

SAN DIEGO
Marcee Sherrill (619) 233-0460
Meets 4th Fri. from 9:00-10:30am. Primarily case discussion. Call regarding availability.

SAN FRANCISCO
Stan Yantis (415) 241-5601
Sylvia Mills (415) 221-3030
Meets 1st Wed. 8-10pm., 180 Beaumont St. Please call to confirm. Case discussion and group process. Open.
Open

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

SANTA ANA
Charles Wilkerson (714) 543-8251
Judy L. Albert (714) 841-2296
Meets 2nd and 4th Thurs. of mo. 8:30-10:30am at 1633 E. 4th St. #206. Primarily case discussion. Open

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

SARATOGA/W. SAN JOSE
Dwight Goodwin (408) 241-0198
Meets Fri. 10am-12:30. Open

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

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

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

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

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

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

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

Submission Information

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

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

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

1994
EMDR CONFERENCE
Research and Clinical Applications
March 4, 5, & 6, 1994

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ALL WORKSHOPS WILL EMPHASIZE THE APPLICATION OF EMDR TO SPECIALTY AREAS.

Special Presentations By

DAVID CALOF — CATHERINE FINE, PH.D. — RICHARD FISCH, M.D.
SCOTT NELSON, PH.D. — LANDRY WILDWIND, L.C.S.W. — WALTER YOUNG, M.D.

Additional Presentations On The Use Of EMDR For Treatment With

MRI Brief Therapy	*Dissociative Disorders*	*Chronic Depression*
Sexual Abuse	*Critical Incidents*	*Substance Abuse*
HIV/AIDS	*Research*	*Children*
Somatic Disorders	*Motor Vehicle Trauma*	*Chronic Pain*
Problems & Pitfalls	*Self Harm*	*Art Thearpy*
Smoking	*Sexuality*	*Obsessive Compulsive Disorder*

1994 LEVEL I BASIC TRAININGS

Presented by Francine Shapiro, Ph.D.

Date	Location	Local Sponsor	Phone
Jan. 14/15 Fri./Sat.	**Los Angeles, CA** Sheraton L.A. Airport Hotel	Ron Doctor, PhD Psych. Dept., CA State Univ., Northridge Curt Rouanzoin, PhD Chair, Dept. of Psychology Pacific Christian College, Fullerton	(818) 885-2827 (714) 680-0663
Feb. 11/12 Fri./Sat.	**San Jose, CA** Sunnyvale Hilton	Robbie Dunton, MA Coordinator, EMDR	(408) 372-3900
Mar. 19/20 Fri./Sat.	**New York, NY** Loews NY Hotel	William Zangwill, PhD Gerald Puk, PhD	(212) 663-2989 (914) 635-1300
Apr. 8/9 Fri./Sat.	**San Jose, CA** Red Lion Inn	Robbie Dunton, MA Coordinator, EMDR	(408) 372-3900
Apr. 23/24 Sat./Sun.	**Denver, CO** Sheraton Denver Tech Cntr.		
May 15/16 Sat./Sun.	**Honolulu, HI** Kahala Hilton	Sandra Paulsen, PhD Pacific Inst. of Behavioral Med.	(808) 523-2990
Jun. 4/5 Sat./Sun.	**Chicago, IL** Mariott Oakbrook	Howard Lipke, PhD Dir., Stress Disorder Treatment Ctr. No. Chicago VAMC	(708) 688-1900x4675
Jun 17/18 Sat./Sun.	**Philadelphia, PA** Radisson Hotel Airport	Alan Goldstein, PhD Dir. Agoraphobia/Anxiety Trtmt. Ctr. Temple University Medical School Steve Silver, PhD Dir., Inpatient PTSD Unit Coatesville VAMC	(215) 667-6490 (215) 384-7711x649
Aug. 6/7 Sat./Sun.	**Portland, OR** Sheraton Portland Airport Hotel	Jean Sutton, LCSW David Baldwin, PhD	(503) 452-9625 (503) 686-2598
Sept. 10/11 Fri./Sat.	**San Francisco, CA** Clarion Hotel	Robbie Dunton, MA Coordinator, EMDR	(408) 372-3900
Oct. 21/22 Fri./Sat.	**San Jose, CA** Red Lion Inn	Robbie Dunton, MA Coordinator, EMDR	(408) 372-3900

1994 LEVEL II TRAININGS

Presented by Francine Shapiro, Ph.D.

Apr. 15/16 Fri./Sat.	**San Jose, CA** Sunnyvalle Hilton
Jun. 24/25 Fri./Sat.	**San Francisco, CA** Doubletree SF Airport
Jul. 30/31 Sat./Sun.	**Denver, CO** Hyatt Regency Denver Tech. Ctr.
Oct. 15/16 (Fri.-Sat.)	**Seattle, WA** Sunnyvale Hilton
Nov. 5/6 Sat./Sun.	**New York** Lowes New York
Nov. 12/13 Sat./Sun.	**Philadelphia, PA** Embassy Suites
Dec. 2/3 Fri./Sat.	**San Jose, CA** Sunnyvalle Hilton

- **History-taking and specified questioning for focused identification of problem areas**
- **Closing down "incomplete" sessions**
- **Axis II applications**
- **Integration of EMDR with cognitive therapy**
- **Dissociative & other major disorders**
- **Abreactive responses and alternative strategies**
- **Working with difficult/resistant clients**
- **Integrating "self-control" techniques**
- **Treatment of Process Phobias**

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EMDR Network Newsletter Fall/Winter 1993