EMDRIA NEWSLETTER

ISSUE 5 OCTOBER, 1997

In This Issue

A Message from the President: Focusing on the Year Ahead

Curtis C. Rouanzoin, Ph.D.

I would like to take this opportunity, in my first letter as your President, to thank all of you for the superb conference in July. The workshops, plenary speakers, and all the participants from around the world made this year's conference a huge success. I hope to see all of you again next year in Baltimore.

As most of you know, our elections were delayed due to the U.S. Postal Service. Although the election ballots were sent by first-class mail, the Postal Service sent them bulk mail. At last, we can provide you with the final results of the election:

Dan Merlis	President-Elect
Marguerite McCorkle	Treasurer-Elect
Wendy Freitag	Secretary-Elect
Cliff Straehley	Board Member
Sandra Paulsen	Board Member
Landry Wildwind	Board Member

As you may remember, members were asked to vote for two new Board Members. Since a current Board Member (Marguerite McCorkle) was elected to the office of Treasurer-Elect, a third Board seat was opened and we consequently have three new Board Members.

I want to welcome the new Officers and Board Members and thank all those who ran. I also want to express my heart-felt thanks to two of our officers whose terms expired in July: Patti Levin (Treasurer) and Lois Allen-Byrd (Secretary).

The primary focus for me this year will be getting the World Wide Network functioning in regional locations and getting educational publications (i..e., "What is EMDR?" and others) into the hands of our members. Our international representative, Marilyn Luber, has been working tirelessly to keep our international members aware of events in the United States and encouraging their input as to how we can support them and meet their regional needs. With the Membership Committee (under the leadership of Darlene Wade), Dave Wilson has been working to produce new membership applications, develop a video regarding EMDRIA to be used at EMDR trainings, and to develop informational brochures.

And the list of contributors to EMDRIA's development goes on. Jennifer Turner continues to monitor our Website. Jocelyne Shiromoto has been working closely with the World Wide Network (and Liz Snyker) to produce a handbook to aid in the development of regional meetings. We can thank Elaine Alvarez as she continues to create programs and services for the underserved populations and humanitarian outreach. Marguerite McCorkle has been interviewing and developing criteria for a new newsletter editor and this publication reflects her efforts and Brad Wasserman's initial effort in that role.

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From the Editor

Brad Wasserman, LCSW-C

As the first edition following EMDRIA's transition to a new Board of Directors, this *EMDRIA Newsletter* includes several other beginnings.

It introduces Marilyn Luber's "From the International Scene" column, in which many of the exciting efforts and events concerning EMDR and EMDRIA are presented. Andrew Leeds' concerted efforts to introduce *Newsletter* readers to the EMDR Institute Discussion List have finally reached fruition. In addition to an overview of the Discussion List (an Internet forum for EMDR professionals to exchange information on EMDR-related topics), there is a schedule of upcoming Two-Week Discussion List specialty topics, and an enlightening Discussion List exchange on EMDR in the treatment of nailbiting. Bessel van der Kolk and Patti Levin provide their first update on their research involving changes in the brain following EMDR sessions. And Alan Cohen's case study includes an engrossing narrative of his use of EMDR to treat a severely traumatized patient in a hospital setting in Upper Galilee, Israel. (Francine Shapiro's "Stray Thoughts" column will return in the next issue and "Clinical Notes" and other previous columns will reappear as contributions permit.)

This issue of the *Newsletter* also includes the first "ViewPoints" column--"A Context for EMDRIA" by David Wilson. We hope the column will serve as a medium for interested parties to express their ideas, convictions, and contemplations on EMDR, the Association, and related topics.

As membership expands and the Association increases its influence and credibility within the therapeutic community, our goal is to make the *EMDRIA Newsletter* a reflection of EMDRIA and its members. To that end, we hope the *Newsletter* provides a forum for members to express their unique perspectives and experiences and we look forward to receiving your articles and other contributions.

Events and Deadlines

Several EMDRIA events and deadlines are worth recounting. The announcement of the 1998 EMDR International Association Conference, scheduled in July, can be found on page 12. The deadline for the Call for Papers for the 1998 Conference is November 15, with the form used to submit abstracts available on page 9. Also, readers who meet the listing criteria for *The EMDRIA Register* are encouraged to complete the application on page 27 before the December 31st deadline.

Contributions to the next *EMDRIA Newsletter* are due on November 30th. Articles for the following issue should be received by February 15th, 1998.

(Continued from page 1)

EMDR practitioners are indebted to the contributions of Mark Dworkin and Christine Wilson, who have developed a packet of material that can be sent to any HMO or insurance company that refuses to pay for EMDR. (If you are refused payment for EMDR treatment, please contact the central EMDRIA office and the EMDR packet will be sent to the organization that denies coverage.) We are developing a base of information on the reasons for such refusals and will seek to educate those organizations about the most recent studies and developments in EMDR. I continue to review applications of those who want EMDRIA approval to teach EMDR in educational or special settings. You can find those who have gone through the approval process on our Web page at www.emdria.org.

Finally, I want to personally thank you , the Members, for your support of EMDRIA. As a still-infant organization, we have had to crawl before we could walk.Under the expert leadership of Past-President Steve Lazrove, we are on much better footing for this coming year. Carol York, Jennifer Turner, and Gayla Brown, at our central office in Austin, Texas, have taken the "nuts and bolts" of the organization and streamlined our operation—they have truly been a God-send. Their attention to detail and their professionalism have allowed the Officers and Board Members to begin to focus on long-term goals, allowing us to return our focus on EMDRIA's vision and strategic planning without floundering in daily details.

Membership renewal forms will be sent to you soon. Please encourage others to join EMDRIA. It is only through a strong organization that we can ensure the on-going integrity of EMDR throughout the world.

Already, attempts have been made to have EMDR taught by untrained clinicians. Already, some have tried to water down EMDR and advertise it to the public as the next "cure all" for everything. Already, I have seen several patients who were treated with "EMDR" and did not have a positive therapeutic experience. Only after the fact did I learn that their therapists were never trained nor supervised in EMDR and never sought consultation or kept pace with its development.

These kinds of concerns are the very reasons that EMDRIA came into existence. We can educate the public about appropriate EMDR treatment.—but this critical goal depends on a strong membership that is committed to our ideals.

In closing, I want to thank the membership for the opportunity you have given me to act as your President. I am open to your input, and I vow to serve with your interests and the interests of EMDR as my highest priorities.

From the International Scene

Marilyn Luber
Marluber@aol.com

As chairman of EMDRIA's International Committee and a member of the Board of Directors it has been my privilege to get to know and work with many of our members from all over the world. This column is dedicated to the celebration of our members' participation in the international community of our professional organizations and our own EMDRIA structures.

First, I would like to introduce the members of the International Committee: Donna D'Aloia (USA), Franz Ebner (Germany), Mark Grant (Australia), David Hart (Canada), Arne Hofmann (Germany), John Hartung (USA), Ad de Jongh (Holland), Richard Mitchell (Europe), Udi Oren (Israel), Sandra Paulsen (USA), and Graciela Rodriguez (Argentina/Australia). Although we have not had formal meetings, other than those at the EMDRIA conferences, we will begin to communicate via an International Internet Forum established for this purpose by our computer wizard, David Hart. Perhaps we can trail-blaze a new medium for international harmony!

There are formal, established EMDRIA groups in Australia, Belgium, Canada, Germany, the United Kingdom, and Ireland. Israel and France are newly incorporated as non-profit organizations and will be formalizing their EMDRIA status. Informal groups include Argentina, Finland, Hungary, Sarejevo, Mexico, The Netherlands, South Africa and the Ukraine. Establishing a chapter or running a group is a huge undertaking of time, energy, and funds, and I would like to thank all of those individuals and teams who have engaged in this task. They deserve recognition for their dedication and the huge amount of work they have donated to EMDRIA and its members. We are happy to welcome any other regions of the world who would like to become part of our network.

Members of our international community are making an impact in many ways. The following are some of their many contributions:

Australia: Mark Grant developed INTERACT (the Newsletter of EMDRIA Australasia).

Belgium: Marc Van Knippenberg has worked with survivors of the Dutroux affair.

Canada: EMDR-trained therapists responded to a quick call to action during the Winnipeg flood.

Europe: The idea for EMDR Europe was born this past September in London. The founding group is hoping to have a constitution drawn by the end of December.

Finland: Soili Poijula's will be presenting a symposium (From Psychological Debriefing to Post-traumatic Therapies) at the World Conference of Mental Health Societies in Finland (1,200 participants will attend the conference)

France: Francois Bonnel demonstrated indomitable spirit and effort in organizing his team for EMDR-France.

Germany: Arne Hofmann was asked to be a member of the Task Force that is developing guidelines for the treatment of PTSD in Germany and Professor Wolfgang Schroeder received a contract from Thieme Publishing House to translate Francine Shapiro's *Eye Movement Desensitization and Reprocessing.*

Holland: Ad de Jongh presented EMDR to the EU (European Union) and is writing a book on EMDR in Dutch.

Israel: There are many accounts by Israeli therapists, such as Alan Cohen, Yair Emmanuel, Mooli Lahad, and Gary Quinn, having success using EMDR with survivors of terrorist activity.

South and Central America: John Hartung, Michael Galvin, Graciela Rodriguez, Pablo Solvey, and Raquel Solvey have shown amazing stamina and spirit in presenting five trainings in this area.

Ukraine: Alexander Bondarenko is in the process of translating Francine Shapiro's text into Russian.

United Kingdom/Ireland: John Spector spoke on the BBC about EMDR and David Blore established an electronic European magazine:

http://www.geocities.com/HotSprings/Spa/1999

Please let me hear from you concerning your accomplishments.

VIEWPOINT: A CONTEXT FOR EMDRIA

David L. Wilson, Ph.D.

Editor's Note: *The ViewPoint column is designed to provide an opportunity for individuals to present their ideas, opinions, concerns, and reflections on EMDR, EMDRIA, and related topics. As the name implies, interested members are encouraged to express their viewpoints through this forum. Please note that contributions to this column represent the opinions of the author(s) and do not necessarily represent the views of other individuals, the Board of Directors, or other groups associated with EMDRIA.*

Following are excerpts from Dr. Wilson's opening remarks to the EMDRIA Officers, Directors, and Committee Chairs on the first Annual Forward (as distinct from Retreat) for Long Range Planning, before the 1997 Conference in San Francisco.

Before we turn to the many tasks we need to complete today, I want to put our work with EMDRIA in context.

Many have noted how many people involved with EMDR and EMDRIA have a deep spiritual side. This spiritual aspect may be against a backdrop of a Jewish humanistic tradition, Roman Catholicism, a Protestant tradition of service, Zen Buddhism, or 12-step work, or--for some of us--a hybrid of one or more of these traditions. But whatever the background, many of us--while not particularly religious--have strong spiritual commitments.

I say what draws us to EMDR is that we see the possibility of inventing a new possibility for being human beings. We see the possibility of human beings living a life not given by one's history, but by a freedom to be. We see the possibility of human beings not living a life given by history, but by values: openness, honesty, integrity, compassion, service, love. We see this possibility in our work with our patients, with our colleagues in EMDR, and with ourselves.

The world calls for EMDR. Somewhere around now, the rules for living successfully on this planet have changed: from you *or* me--a world based on competition for domination--to you *and* me--a world based on cooperation and mutual empowerment.

The problem is that you and I are born into a psychology in which what I call "You" is there, over there, and what I call "I" is in here, and we are separate. That sense of separation is a formidable illusion. Yet we have seen, or at least glimpsed, the true nature of reality--which is that we are all one and related.

In that reality, if any one of us suffers, we all suffer. If you fail at your job, I have failed at my job; if I am to succeed, you must succeed. In that reality, you *and* me, a *team* is not just an aggregate of individuals, but a unit in which everyone *is* the team, everyone is equally responsible, and the success or failure of the team is a function of everyone in it. In that reality, *management* is not using force to get people to do things, but creating a space to allow each person to contribute to their fullest. In that reality, *leadership* is not a matter of special personal qualities, but the willingness to take a stand for something and to be committed to that commitment over time.

We need to create a Hundred-Year Plan for EMDRIA. That is five generations, 100 presidents, 100 conventions.

I don't know what that will look like.

In 100 years, we may not be the Eye Movement Desensitization and Reprocessing International Association. We may be Emotional Mental Deprogramming and Redemption, Transformational Technologies, or the Society for Amygdaloid Interventions.

I don't what that will look like in 100 years.

I do see what some of the principles will have to be for EMDRIA to be an alive, potent organization in 100 years:

1. We will have to be committed to our commitment over time, which is to develop research, and promote innovative and effective psychotherapeutic interventions.

2. We will have to be resistant to orthodoxy and open to innovation and change.

3. We will have to have organizational structures in place to continue our work long after we are gone.

4. We will have to be willing to recreate and reinvent ourselves over and over.

The EMDR Institute Discussion List

Andrew M. Leeds, Ph.D.

- Have you ever wished you could peek into other clinicians' offices to see how they use EMDR? Do you ever have questions about how to adapt EMDR to meet the special needs of certain challenging clients, but you don't want to wait until the next monthly study group meeting? Or is there no study group in your area, but you would still like to consult with some colleagues who are using EMDR?
- Have you recently taken the EMDR Institute Level 1 training and have questions about the procedural steps? Are you having problems getting appropriate negative and positive cognitions with some clients and want guidance? Are you Level 2 trained but still not sure how to use the cognitive interweave with a combat veteran you are seeing?
- Has there been a disaster in your area and you wonder how to find consultants to work with local EMDR-trained clinicians who want telephone support as they provide post-disaster volunteer and treatment services to survivors and their families? Have you decided you want to help with fund raising efforts for EMDR HAP but you've misplaced the contact information for the HAP office?
- Do you work with a specialty population and wish there were other clinicians with more experience with your specialty population with whom you could discuss these cases? Are you looking for an expert to consult with on a certain case but aren't sure how to find someone? Do you need to find an experienced EMDR-trained clinician to whom you can send a client in Lincoln, Nebraska, in Victoria, British Columbia or in Frankfurt, Germany?
- Are you planning to attend the EMDRIA Conference but want to find someone with whom to share a hotel room? Do you want a list of the most current references on the use of EMDR? Are you considering doing a research project on EMDR and want to find research consultants or suggestions to assure your results will be as useful as possible?

Now there is an easy and quick way to get help with all these questions and more: the EMDR Institute Discussion List.

What is the EMDR Institute Discussion List?

The EMDR Institute Discussion List is a text-based electronic forum for discussions on issues related to: clinical applications, theory, and research on Eye Movement Desensitization and Reprocessing; information on training programs of the EMDR Institute and the Humanitarian Assistance Programs of EMDR (HAP).

History and Development of the Discussion List

The EMDR Institute Discussion List was created by A. J. Popky and Andrew Leeds in May of 1996. A. J. and I had talked since 1992 of creating an Internet-based service similar to the early EMDR Institute Network Newsletter that would support graduates of EMDR Institute programs. In 1996, A. J. and I found Beverly Jamison who agreed to help us establish the EMDR Institute Discussion List at St Johns University which sponsors a number of professional electronic forums. The EMDR Institute Discussion List remain grateful to St Johns University in New York city for their support. With Beverly Jamison's help, A. J. and I were able to get the Discussion List started. In the first year, subscriptions rose to more than 500 EMDR-trained clinicians worldwide.

Who can subscribe and what do you mean when you say the Discussion List is free?

The Discussion List is open to any individual subscriber who has taken the EMDR Institute Level 1 or Level 2 training, wants to participate, and agrees to abide by forum policies. Graduates of Institute-approved University courses are also eligible to subscribe. The Discussion List is an EMDR Institute alumni support service, not an EMDRIA membership benefit or service. Graduates of other EMDRIA-approved training programs are not eligible to subscribe until they take an Institute sponsored Level 1 or Level 2 course. You must have an e-mail account to participate; however other than the fees you pay for your e-mail account, there is no cost to subscribe to the EMDR Institute Discussion List.

Purpose of the Discussion List

The EMDR forum was created to further the understanding and development of the clinical application of EMDR, and to encourage discussion of EMDR theory and research. Participants in the discussion include clinicians and researchers who have taken at least the EMDR Institute Level I training, those with Level II training, and EMDR Institute facilitators and trainers.

Welcome contributions to the discussion include:

- queries and commentaries about clinical protocols

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(Continued from page 5)
and treatment issues

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

How to Subscribe to the EMDR Discussion List

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

LISTSERV@MAELSTROM.STJOHNS.EDU

Leave the subject line blank (or, if your e-mail program won't let you send e-mail with a blank line, simply insert a hyphen { -} in the subject line.

In the e-mail address, enter:

LISTSERV@MAELSTROM.STJOHNS.EDU

In the message area, provide us with your name by including one line of text which reads:

SUBSCRIBE EMDR [your Firstname Lastname]

Please keep in mind that the list is maintained by unpaid volunteers, so it may take several days from the time you send in your subscription request for the Discussion List's e-mail to begin reaching your e-mail box.

List Policies and Guidelines

Considerable thought and effort went into writing a set of guidelines for the EMDR Institute Discussion List. After your eligibility has been verified and your subscription has been processed, you will automatically receive a copy of a document describing these list policies. Although subscriptions can only be created by the list owners, you can temporarily suspend e-mail from the list or end your subscription at any time. Instructions on how to modify or end your subscription will be e-mailed to you with your subscription confirmation.

How much e-mail will I receive from the Discussion List?

Currently, e-mail volume ranges from two to 10 pieces per day, with four pieces of e-mail the mean. Instead of several separate e-mail messages each day, you can set your subscription to send you one daily digest containing all of the e-mail for that day.

Leaders for the Discussion List

The leaders (list owners) of the EMDR forum are A. J. Popky, M.A. and Andrew M. Leeds, Ph.D. A. J. Popky is the technical liaison for list maintenance. If you have questions about how to subscribe or need to change your e-mail account address or have any e-mail problems, please contact A. J. Popky.

Andrew Leeds (the author of this piece) is the list moderator. As list moderator, he reads all the mail after it appears on the list. He encourages discussion and writes responses on questions that have gone unanswered, suggests new topics for consideration and ensures that the tone of the discussion remains cordial and collegial. The prevailing view of list subscribers is that the EMDR Discussion List is a friendly, safe, and professional forum in which participants can freely discuss their questions.

Please try to abide by the division of labor for the Discussion List. Problems regarding subscribing, changing your subscription e-mail account; and related issues should be directed to A. J. Popky. On the other hand, if you have questions about list guidelines or topics please direct these inquires to Andrew Leeds as the list moderator.

EMDR Discussion List Technical Liaison

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Research Underway at the Trauma Center

Bessel van der Kolk M.D.
and Patti Levin, Psy.D.

With the generous funding from EMDRIA, we are continuing our investigation into brain changes following three to five sessions of EMDR. The small sample of patients on whom we have pre-post treatment SPECT scans (n=6) demonstrated that their improvement is reflected by increased activation of the anterior cingulate and of the left prefrontal cortex. This seems to indicate that, at least in humans, the filter that ultimately interprets incoming stimuli for whether they are traumatic or not is not set at the level of the amygdala, but in a more frontal region of the brain. LeDoux demonstrated that in animals emotional memories seem to be indelible; they could not be modified over time (LeDoux, 1991). Our preliminary scans suggest that improvement of PTSD symptoms may not be mediated by decreased activation of the amygdala, but by an increased activation of the anterior cingulate and the prefrontal area which become capable of distinguishing between real threats and traumatic reminders that are no longer relevat to current experience. Obviously the processes and structures involved in recovery from trauma deserve a great deal more attention.

Clearly, this is exciting research. We believe that what we are seeing represents what a successful therapy of PTSD looks like in brain imaging. Other treatment outcome measures support this belief and delineate the psychological changes that occur after EMDR. We hope to keep the EMDRIA community informed as our research results unfold. Stay tuned. . .

Assistance Needed for Research Project

Urgently Needed:

Typescripts or tapes of EMDR sessions (client and therapist names deleted) to be used as archival data in a study investigating the reliability of a newly-developed EMDR research measure.

Please Contact:

Carolyn Weitzman, LPCC
9625 Morrow Avenue NE
Albuquerque, NM 87112-2951
Telephone: 505-299-8325
Fax: 505-332-3924
E-mail: BBragg6228@aol.com

Case Study: EMDR in Hospital Intervention

Alan Cohen, M.Sc., Psychologist,
Community Stress Prevention Center
Kiryat Shmona, Upper Galilee, Israel

Introduction

The therapeutic effectiveness of EMDR has been well documented since 1989 (Shapiro; 1989, Puk 1991; Lipke & 1992; Pellicer 1993; Rothbaum et al, 1995; Lahad & Cohen, 1997,) but the technique is far from reaching optimal utilization in the clinical and psychological world. The following is a case in which the improvement of the patient was rapid, possibly even astounding to those who are unfamiliar with EMDR. The implications of this treatment for me, however, were much further reaching. Many of the points outlined in theoretical training sessions were brought home most strongly and many more priceless pieces of advice for those who wish to be of assistance to someone involved in a traumatic incident were made clearly apparent.

One of the major achievements of EMDR is that it allows the patient to make his own connections regarding events in his life. These intervention sessions allowed me to experience this first-hand and to realize the importance of many simple rules regarding the practice of EMDR when in contact with the trauma victim.

The EMDR procedure is best-described in Shapiro's (1995) definitive Eye Movement Desensitization and Reprocessing, and I will simply reiterate one of the major points I stress to patients when beginning a session. I explain that sometimes, traumatic memories are, as it were, locked in a particular place in the brain and make no connections with other parts of the brain, be they feelings, information or pictures. Indeed, irrational thoughts and feelings can often coexist quite happily with hard facts to the contrary. The process that we are about to embark upon will allow the growth of new pathways and enable some kind of information filing process to take place, such that the irrational thoughts and feelings will be integrated into a much larger system-the patient's brain.

The Case

His story is an epic in itself worthy of a main feature in *The Reader's Digest*. I was greeted by Mike (a pseudonym), a well-built man lying in his hospital bed with clear evidence of serious operations on both legs. A

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1998 ANNUAL EMDRIA CONFERENCE
CALL FOR PAPERS

EMDR INTERNATIONAL ASSOCIATION CONFERENCE

July 10-12, 1998
Baltimore, Maryland

SUBMISSION DEADLINE: November 15, 1997

Abstracts are invited for the EMDR International Association, Inc. Annual Conference. Material should be relevant to the EMDR field and be an original contribution. All presentations should involve participants in a continuing education experience. A variety of innovative and creative programming related to the field of EMDR will be considered. Members and non members of EMDRIA are invited to submit abstracts.

The professionals submitting the abstracts for the program are responsible for contacting all co-presenters and for all details, including abstract submission, communication with presenters, presentation format, audio-visual requests and payment of fees. Presenters pay registration fees, at a reduced rate, if attending any portion of the conference other than their own presentation.

Abstracts must be postmarked no later than November 15, 1997. Notification of acceptance will be made by December 15, 1997.

SUBMISSION GUIDELINES AND INFORMATION

ALL ABSTRACTS WILL BE PEER REVIEWED without the name(s) of the author(s). This "blind" review process will help ensure that the evaluation is fair and equitable, and that factors such as gender, ethnicity, and reputation do not play a role in judging the quality of the submission. Therefore, be certain NOT to identify yourself in any way on the abstract portion of this form.

ABSTRACTS MUST BE TYPED AND SUBMITTED WITH THIS FORM. (Duplicate this form for additional submissions.)

SUBMISSIONS MUST INCLUDE this completed form, five copies of page three with its attachments, and a curriculum vitae or resume for each presenter. All submissions must be signed by the submitter. Incorrect or incomplete submissions will be returned and not considered until submitted properly.

Mail to: EMDR International Association, Inc.
P.O. Box 140824
Austin, TX 78714-0824

Call for Papers *(continued)*

Please fill in all information requested below for all individuals. Submit any additional pages along with this form in order to provide divisions with complete information on all participating individuals. Information not appearing on this form and its attachments, including degrees and affiliations, will not appear in the Conference Program.

1. Title: _____

2. Format: _____ Symposium _____ Plenary _____ Workshop _____ Conversation Hour

3. Length of program time requested: ____ Conversation hour ____ 90 min ____ Full day ____ Half day

4. Category(s):

____ Clinical Adult ____ Clinical Child/Adolescent

____ EMDR ____ Clinical Marital/Family

____ Advocacy/Grassroots ____ Research

5. Presenter Listing: List chair's name first. For each presenter, list name, highest educational degree, all licensure numbers and state, address, zip code, phone number, fax numbers, e-mail address and professional affiliation.

Presenter (Chair) Name_____Degree_____Licensure-State_____

Address:
Street, City, State, Zip_____

Office Phone ( )_____Home Phone ( )_____Fax ( )_____

E-Mail Address_____Professional Affiliation_____

Presenter Name_____Degree_____Licensure-State_____

Address:
Street, City, State, Zip_____

Office Phone ( )_____Home Phone ( )_____Fax ( )_____

E-Mail Address_____Professional Affiliation_____

Presenter Name_____Degree_____Licensure-State_____

Address:
Street, City, State, Zip_____

Office Phone ( )_____Home Phone ( )_____Fax ( )_____

E-Mail Address_____Professional Affiliation_____

Call for Papers (*continued*)

6. Abstract: Limited to 250 words. Please type abstract on separate sheet of paper with ONLY the title of presentation and the abstract itself. You may also submit abstract on 3½-inch disk, ASCII format only. Be as specific as possible about the learning that will take place at your presentation. If your presentation is research-based, only completed research with available results may be submitted for a workshop. This abstract will be printed and available at the conference.

7. Learning Objectives: Please type on separate sheet of paper with ONLY the title of presentation and the objectives. List at least three learning objectives, i.e., what participants will know or will be able to do by the end of the presentation. (This information is now required by some CE-granting organizations.)

8. Quiz: Please type on separate sheet of paper with ONLY the title of presentation and the quiz itself. Quiz must contain a minimum of three questions pertaining to your presentation. This may be done in any format you choose, such as True or False, multiple choice, etc. (This information is now required by some CE-granting organizations.) You may submit answers on a separate page.

9. What is new or unique about this material/topic/presentation? Give an example of how the proposed material has been implemented. (Please avoid using identifying information.) NOTE: If your material is a deviation from the standard EMDR protocols, please submit documentation supporting effectiveness.

10. Audio Visual Needs: ____ TV Monitor/VCR ____ Overhead Projector ____ Flip Chart ____ Slide Projector

____ White Board ____ No Audio Visual needed ____ Other:_____

11. Presentation may be audiotaped: ____ Yes ____ No

12. This presentation is suitable for:

____ Beginning EMDR Clinicians ____ Intermediate EMDR Clinicians ____ Advanced EMDR Clinicians

13. This is my only submission: ____ Yes ____ No Second Submission Title: _____

_____

14. Membership status: ___ EMDRIA Member ____ Student Affiliate ____ Non member

15. Describe public speaking experience and expertise with proposed topic:

16. List EMDRIA board and committee positions held by each presenter to avoid schedule conflicts with meetings.

PRESENTER AGREEMENT

On behalf of myself and my co-presenters, should this abstract be selected, I/we agree that:

- Participation in this program does not exempt presenters from paying registration fees if attending other conference sessions.
- Individual submitting this proposal and signing this form agrees to receive all conference correspondence and accepts responsibility for conveying conference related information to co-presenters.
- EMDRIA may videotape and/or audiotape this entire presentation, including videotape and audiotape excerpts, and distribute the tape for educational purposes with no remuneration or reimbursement to presenter(s).
- Appropriate "Release of Confidential Information" forms have been obtained for all client materials that will be used or recorded as part of this presentation. The responsibility for protecting client confidentiality rests with the presenter(s).
- Individuals submitting or included within this proposal agree to be present in Baltimore, Maryland, during the hour and date assigned to this presentation at the 1998 EMDRIA Conference, and conduct this proposed presentation according to the conditions listed above.

SIGNATURE_____ DATE_____

EMDR International Association, Inc. Information

EMDRIA is a nonprofit, public benefit corporation, which is the association for EMDR practitioners. To quote from our bylaws, "The primary objective of EMDRIA is to establish, maintain and promote the highest standards of excellence and integrity in Eye Movement Desensitization and Reprocessing (EMDR) practice, research and education..." To that end, EMDRIA evaluates training programs, maintains a Register of qualified EMDR clinicians, holds an annual conference, publishes a newsletter, supports a network of regional EMDR study groups, develops practice guidelines for the application of EMDR in various settings, supports research in EMDR, advocates for the use of EMDR with managed care companies and other health care providers, and informs the general public about EMDR.

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strong handshake belied the complex feelings behind his gesture. Mike informed me that he was very keen to receive proper psychological help as it was more than five weeks since his accident. He described himself as a "broken vessel."

Mike, a 46-year old married kibbutznik with three children, had just finished a long and tiring term of office in a responsible job. At last free of these responsibilities, he decided to indulge himself in a short trip to a wild area of his kibbutz, in order to take a young raven from its nest for his son. (Ravens, he told me, can be very easily trained to talk.) He had observed a nest high in a eucalyptus tree in a particularly inaccessible area, across brambles and thickets, some 60 yards from the nearest path.

Clambering up the tree, at a height of about 12 meters he was level with the nest when he sighted a viper in an "S" position and ready to strike. The next thing he knew was that he was in the brambles in a ditch at the foot of the tree, with searing pains in both legs. With calm and cool precision he remembered his army training and checked the rest of his body for breaks and bleeding. His arms, face and back were seemingly intact. Mike made splints for his legs from surrounding twigs. He quickly realized that, if he were to stay put, no one would find him and he would certainly die. The time was 14:07 and he decided that he must be found before nightfall, about five hours later, if he were to survive.

Thus began a grueling and bitterly painful crawl towards the path using arms and teeth to pull himself along inch by inch. About two hours later, almost at the path, he fell on his back into a shallow ditch and was completely covered by brambles. No amount of effort could free him. He prayed, made vows, shouted, cursed, before giving up and deciding to wait in the hope someone would come near. Mike floated in and out of consciousness, constantly aware of the searing pain and a strong but impossible urge to urinate.

One of his cries for help reminded him of the biblical story of Joshua who commanded the sun to stand still in Givon so that he could complete his mission. Mike's prayers, however, went unanswered and the sun continued to move. At about 18:00, Mike gave up all hope of being found. At night he knew he would die. Pictures of his funeral procession passed before his eyes. He found a pencil and scribbled a note to his family on a scrap of paper: "I did not commit suicide, I fell."

With seeping strength, he waited for the end. As darkness approached, he heard voices nearby. Now, his own voice failed him. The others spotted his moped and started their search in earnest. Mike managed to put a piece of cloth on a twig and raised it above the brambles. His brother caught sight of it and was with him in an instant.

It was obvious that Mike's three rescuers could not even begin to move him, so help was sought. The kibbutz doctor was soon on the scene. Mike pleaded for pain killers, but the doctor told him that he needed every piece of information in order to help him. It was another hour before 10 strong people were able to painfully extricate Mike from the ditch and onto a stretcher. The journey to the first aid station in Kiryat Shmona was excruciating agony, and the x-rays and journey to Tsfat Hospital were no different. Mike was operated upon for several hours that night.

His telling of the story was accompanied by much sobbing, and at times it was very difficult for him to continue. Mike explained that he was subject to constant swings in mood, crying at many thoughts and even at the sight of his son when he came to visit. The best advice people could give him was to "be a man," or to "pull yourself together." In a moment of particular anguish, he cried out "I don't want to keep on living like this." This was taken to be a death wish and Mike was placed on anti-depressant drugs by the psychiatrist.

Mike expressed a great fear of the outside world, to the extent that he could not stand to have the bars on the side of his bed lowered. Each physiotherapy session was a major struggle. He could not stand physical contact of any sort, even though only his legs were causing him physical pain.

The Funeral

This was the starting point for the intervention. We started the procedure by establishing a "safe place" to which he could retreat in his mind to find comfort, if need be. I asked him which particular thought or memory he would like to begin with and Mike suggested to first address his fear of the outside world.

Then, when I requested that he take a picture which summarized this fear, he immediately started to recount the sequence of his own funeral procession. Whilst doing the Eye Movements (EM), he described in great detail and through heavy sobs, the funeral, who was there, and how it proceeded. (Mike had been responsible for burials on the kibbutz for many years).

At a certain point, Mike stopped and said, "It finishes here."

"Carry on," I said, motioning him to continue EM.

He carried on and at the end of the next series he said, "That's odd. In my thoughts, I always get to a particular point and return to the beginning. They don't actually bury me."

"Where are you?" I asked, starting another series of EM and Mike replied "I am at the side, watching. "A smile appeared on his face. "How did I get there? It's not my funeral," he exclaimed. Then in a cheerful tone, he asked "Why isn't my son crying? Up to this moment it has bothered me terribly that he didn't cry at my funeral.

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Now, it's merely a curiosity."

I told him that he should think about it later, but he should know that sometimes, emotions are so high that people cannot even cry. This sequence started out at a level of 10/10 subjective units of discomfort, (SUDs). Ten minutes later, we were at level 1. On to the next problem.

Sun at Givon, Stand Still

The next scene was a return to the ditch where he at first awaited rescue and then expected death. Mike started the description, quickly assuming a more childish tone of voice and soon the tears were flowing. After each series of EM, he told how he reached the ditch after an excruciating inch-by-inch crawl and struggled to get out. He relived the vows, curses, shouts, and, in particular, the prayers.

When he recounted how he prayed for the sun to stand in its tracks and how he felt deserted by God when it did not happen, I asked, "Did God answer your prayers?"

"Then or now?" he responded.

"Think about it," I offered and began another series of EM.

The smile returned immediately after the EM and Mike said (once again, in a changed tone), "Then, I thought not, but now, definitely, yes." From a starting SUDs of 9, we were down to 0—the return to the original picture caused him no discomfort.

"I Can't Stand It When Someone Touches Me"

More than five weeks after the accident, Mike remained extremely sensitive about being touched. He admitted that even the strong handshake he gave me when we met caused him discomfort. He had good reason to keep people away from his legs, as they were still painful, but it bothered him that any other form of physical contact caused him anxiety. Admittedly, matters had improved, but physical contact continued to be disturbing (5 on the SUDs scale).

The presenting picture accompanying the unpleasant sensation of being touched was the rescue, the extrication from the ditch. Once again, with EM we went through that part of the incident. He recounted, between EM series, how painful the rescue was and how seriously people hurt him, however well-intentioned they might have been.

"They didn't understand that even sheets have weight." Every time someone just picked up the sheet to look, it caused intense agony. Every bump in the way was anticipated by shouts and groans and the ride to the hospital was no better. His wife sat in the ambulance caressing him and even this caused agony, but he could not tell her this, as she only wanted to comfort him. I reinforced how important it was that he continue to guard his legs, but to notice how the pain in the rest of his body had stopped. The connection that Mike made between not being able to tell his loved one how much it hurt then and how he did not like to be touched now seemed to bring relief. Indeed, on return to the original picture, there was no discomfort. To confirm this, I firmly shook his hand and Mike reported no unpleasant sensation!

Two and a quarter hours after our initial meeting, it was time to draw the session to a close. I reminded Mike about his safe place, and at his request scheduled another appointment.

Meeting Number Two

We began with an update on the changes over the last two days. Friends had reported that Mike sounded different, more cheerful on the telephone. Visitors said he looked different, that there was "a special kind of light in his eyes." Mike himself said that he felt "terribly well." His fear of the outside world was gone and he had cooperated with the physiotherapist when previously he had resisted. (Note that we had not worked explicitly on this scenario of the fear of the outside.) Mike had been able to receive an injection "without hysterics," and possibly, most notably, there had been a sharp reduction in the number of times he had burst into tears. He was able to look at his son without crying (or wondering why his son did not cry at his funeral).

Mike remembered that a religious friend had recently come to visit him and had tried to talk to him about "the hidden ways of the Lord" but his comments had not "gone along the right channels." I repeat this comment verbatim because I see the importance of "the right channels" and, even more so, the importance of having the patient himself forge and navigate these channels.

Seeing Himself Lying in a Ditch

The first issue dealt with in the second session was a picture which had been appearing over the past few days that caused great discomfort (7 on the SUDs scale). Mike could see himself lying on his back in the ditch, a meter from the path, covered by brambles (the whole picture was a shade of blue). The physical sensation accompanying the picture was once of nausea and uneasiness. The negative statement accompanying the picture was, "I don't have the strength to save myself." Mike once more slipped easily into the childish tone of voice and heavy sobs.

Once into the EM, Mike connected the picture with the "encouragement" he was receiving from friends and family in the more difficult stages: "be a man" and "pull yourself together." Mike understood the implications

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behind this advice: you are not a man, you are not coping.

Then followed a change to an assertive tone and a smile as he exclaimed, "Well done, Mike, for getting that far. Look what you accomplished!" He then went on to say the attitude of always looking at his shortcomings instead of his successes was typical of him. If 200 kibbutz members were in favor of his proposal and six were against, it would be the six that worried him, not the many who gave him encouragement. Then came a positive decision to see the optimistic side of the situation. "I saved my life and acted with courage," was his new view.

Interestingly, enough Mike made another connection. He remembered lying in the ditch cursing his "fat body" that was unable to pull himself an inch further. This, he surmised was why during the first few days when he was able to eat in hospital, he ate sparingly and why the thought of lying in the ditch upset his stomach.

For the purposes of the work, it really does not matter if these connections are true, what is important, is the fact that they are generated by the patient and he sees them as meaningful.

The Fear of Anything Out of the Ordinary

Mike then carried on to his fear that any time there was a slight change in his temperature or blood pressure, something was terribly wrong. There was no associated picture, just a physical sensation of tension throughout his body. The negative thought accompanying the situation was, "There is an infection, it will hurt." His positive cognition was, "This is just the body's way of looking after itself." Another strong association was the word "pus" and the discomfort felt was extreme. I requested that he visualize a television screening with fuzzy reception, awaiting a picture, and concentrate on the word and the physical sensation.

After one set of EM, the tears flowed quickly and heavily. Between sobs, he stated that he saw a picture on the screen and I asked Mike to observe the picture and continue to do the EM. The picture was one of intense humiliation. Soon after the operations on his legs Mike started physiotherapy. After two days Mike complained of pains in his knee and was told by staff that the pain would dissipate but it worsened. The staff said he was "just looking for attention." With relatives and friends around him day and night, nothing could have been further from the truth or more hurtful. He was not believed and, furthermore, he was told to learn to suffer and to be a man—blow upon blow!

After four days of pain, in the early hours of the morning the wound on his knee burst and a half- liter of pus was discharged, with the staff reluctantly acknowledging that his complaints were legitimate. Apologies did not help at this stage. Continuing the EM, Mike came to the conclusion that people probably meant well, but had no idea what to do. Once reconciled with this thought, the memory of the pain went down to 0.5; the memory of the humiliation was still quite painful (4) but he felt he could deal with it. We reinforced the fact that he was in no way to blame for this episode.

At this point, the time had run out for this session. Mike assured me that he used his "safe place" whenever he felt the need and he would look out for other situations and thoughts which caused him sudden and sharp changes in mood. Mike also made a point that he would ask the psychiatrist to take him off the anti-depressant medication prescribed.

The Third Meeting

I was greeted at the start of the third meeting by a smiling Mike who reported that there was further significant improvement. Interestingly, he noted that he had started to notice colors, how green the trees were, and smells that had previously never drawn his attention. In general conversation, Mike remarked that he was still concerned every time he went outside in a wheelchair, lest someone should get too close to his legs. This appeared to me to be a rational worry, even if it was taken to an extreme (such as insisting that double doors be open whenever possible). Mike told me that he occasionally woke up after a nightmare, but did not recall his dreams and he had little trouble falling asleep again. The frightening day-dreams had disappeared and he no longer feared taking a nap during the daytime.

Fear of the Fear

In reply to my question, "What still disturbs you?," Mike replied, "Once I was afraid of night time. I needed a light next to me all the time and, if I woke up, people told me it was nearly morning, regardless of the actual time. Now what bothers me is the memory of that fear. Nights themselves do not bother me." I asked that he concentrate on that thought and started EM.

Tears began to flow. Two strong physical sensations were identified, nausea and tension throughout his body. The picture which quickly became clearer was one of awakening after an operation with a total sense of disorientation and amnesia, not remembering who or where he was. Sometimes he was treated in full seriousness by a friend, and at other times someone would make light of the situation and chuckle. Now Mike understood that this had offended him deeply, even though he could see now that they meant no harm. He also noted that too much information was also deleterious (interestingly replicating Janis' 1975 findings regarding the optimum amount of information hospitalized people should have). This series of EM brought relief to Mike's physical sensations regarding the memory.

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Mike then told me about his new daily timetable which he had drawn up at his own initiative. People had tried before to organize him, but nothing came of it until Mike decided it was time for a timetable. Now the days had structure and Mike felt that he could tolerate the hospital for as long as was necessary to recover. Previously, he counted the minutes and every unexpected change was viewed as a serious setback. On that positive note, the third session came to a close.

Concluding Remarks

I view the procedure over these three meetings as one which enabled the patient to make connections and put some order into the traumatic experiences. I must emphasize the instructions at the EMDR seminar, "If things start to move, get out of the way, but be there to guide the movement in the right direction." This seems to be what happened in Mike's case. Traumatic memories were put in a larger context and conclusions were drawn. What is important here is not whether these conclusions are valid or universally true, but that they fit for the patient.

The conclusions for the orthodox medical establishment are pointed. Appropriate and timely use of this method may save great suffering, speed up many therapeutic procedures (physiotherapy, occupational therapy etc.), and save money in the prescription of costly psychiatric drugs. The real mission ahead is to bring these findings to the health system and increase medical awareness of the method and its uses.

Conclusions for friends and family of the patient are equally far-reaching. What one should and should not say to the patient is vital in all stages of trauma and recovery. Even talking the "same language" as the patient is very important if a connection is to be made and full psychological recuperation is to be brought about.

It should be mentioned that EMDR was used in these circumstances as an intervention tool, rather than a long-term therapeutic program. If longer term aspects were to be considered, such as the reintegration of the patient into his family and coming to terms with (hopefully temporary) disabilities, a slightly different approach would have to be taken.

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A Discussion Thread from the EMDR Institute Discussion List: Applications of EMDR with Nailbiting

Compiled by
Andrew Leeds, List Moderator

Introduction to Discussion

To provide a sense of the kind of discussions that take place on the EMDR Institute Discussion list, I have selected the following threaded discussion for readers of the EMDRIA Newsletter. Note that EMDR Institute Discussion List policies prohibit the forwarding or reprinting of comments sent to the Discussion List without the permission of the author. I have obtained permission from all the authors for their comments to be printed in the EMDRIA newsletter in their entirety. In some cases, I have edited out quotations of earlier comments for purposes of brevity and have noted these instances in square brackets.

Please keep in mind a few general points in reading these comments. Comments on the Discussion List are often written quickly and without careful editing or proofing. I have left many errors in the text to convey the flavor of the discussion. The sequence in which comments appear in this article may be slightly different than they were for some of the contributors or subscribers at the time of the discussion.

—Andrew Leeds, Lis Moderator.
—ALeeds@Concentric.net

FROM: Marshall Wilensky, Ph.D
Vancouver, B.C
wilensky@UNIXG.UBC.CA

I'd appreciate hearing any thoughts on EMDR with nailbiting. I've done it with triticholimania and used to do hypnosis for nailbiting. For Picture -do you find it better with working on the urge or on the image of the fingers? Already have good rapport with client and have had success with EMDR around performance anxiety and self esteem issues related to bad school experiences.

FROM: Ricky Greenwald
Trumansburg, NY
rickygr@CLARITYCONNECT.COM

A goofy but sometimes effective intervention: Personify/anthropomorphize the protagonists in the conflict. If the urge had a physical form, who/what would it be? (e.g., "a big bully") Get as many details as possible, e.g., what does it say, etc. Can then use a self-image or an idealized self-image to defend against [the bully] such as a boxer, a sword fighter, etc: What would be the best way to beat [the bully]? Then, during eye movements, imagine the personified urge arriving, and the personified defender defending. Should be quite an action-packed flick! Can also integrate cognitions, e.g., "I can beat this bully."

I like to end such movies, by the way, with an imaginal reward or sense of well-being, so that successful defense against the urge is associated with reinforcement. In the above example, the ending to the movie might be an announcer crying "The winner!" and cheers all around. In general, the more your client can generate the content, the better off you are.

This is, of course, a potentially superficial intervention in that underlying factors may not be addressed; perhaps the nail-biting is a symptom of underlying stress? However, this type of thing does work sometimes, and there is nothing to prevent you from addressing underlying stress regardless. If you try this, let me know how it goes, ok?

FROM: Mary Kay Neumann, MSSW
Madison, WI
mkkim@INXPRESS.NET

Using David Calof's (editor of Treating Abuse Today) definition of self-mutilation, he considers nailbiting to be included in the myriad of behaviors that sexual abuse survivors use to hurt themselves. Ergo, the core of the problem is very likely to be trauma based, and not as superficial as it may appear.

FROM: A.J. Popky
Monte Sereno, CA
ajpopky@EMDR.ORG

I would classify it as and addictive behavior and treat it as such and target the triggers that bring on the urge or desire to nailbite.

[(1) A.J., in giving permission for printing, pointed out that this comment does not cover the full addiction protocol.]

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FROM: Harry D. Corsover, Ph.D
Evergreen, CO
corsazzi@IDCOMM.COM

At the risk of getting into the kind of process we've encountered here before . . . Even if we accept the idea that nailbiting is the kind of thing sexual abuse survivors tend to do to hurt themselves, I don't think it follows that this problem is therefore very likely to be trauma-based. It is a consideration to be aware of, certainly. However, we would have to have credible data showing that nailbiting is more likely to be trauma based than anxiety based to come to such a conclusion. The correlation may be very high in one direction without being very high in the other.

FROM: Mary Kay Neumann, MSSW
Madison, WI
mkkim@INXPRESS.NET (2)

Yes, I agree I overstated it as "very likely," when I should have said, "very possible." Because nailbiting is one of those socially acceptable habits that isn't typically viewed as potentially self mutilation, I wanted to make the point that it may not be quite as benign as some of the previous posts suggested.

[(2) Mary Kay Neuman no longer had an e-mail account at the time this article was prepared.]

FROM: Philip H. Friedman, Ph.D
Plymouth Meeting, PA
PhilF101@aol.com

Harry, I would agree with you here. It would be wise to treat nailbiting as a habit and look for the emotional, cognitive and physical triggers for it individually for each person. It may be connected with earlier trauma in some cases. It would not IMHO be wise to assume that, however.

FROM: Andrew Leeds, Ph.D
Santa Rosa, CA
ALeeds@Concentric.net

Mary Kay, I would be interested in any research data to support your claim that nailbiting per se is "very likely to be trauma based." Being ignorant of the research data on this issue, I believe nonetheless it is best to be extremely cautious in making inferences about a traumagenic origin to nailbiting. While I agree that in some cases, nailbiting could be a form of self-harming behavior generated as a reenactment or dissociative coping process, it is such a common problem that I would need to see the research data before I would be comfortable with this inference based merely on a single symptom.

FROM: Barbara Madani
Burnaby, B.C., Canada
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I recently treated someone for nailbiting and was surprised how quickly the habit was eliminated. We targeted the urge and immediately the NC that came up was " I'm bad" accompanied initially by feelings of anxiety in the stomach. The processing led to memories of being shamed by mother (e.g. being called "poison") for not constantly working around the house and not doing tasks perfectly enough. The client also remembered having been tied to the playpen. Within six sessions the client's nails had begun to grow, s(he) had become more assertive with boundaries and was finally able to begin to lead a more balanced life with time to "just sit" without feeling useless and ashamed. A visit with mother did not lead to a set-back or return of nail-biting.

FROM: Don Rosenberg
Milwaukee, WI
Don729@aol.com

I wrote about two cases of hair pulling and nailbiting last month. In both I viewed the problem as one of habit (urge) control. Talking to other EMDR therapists, I found limited results when targeting the symptom itself in habit or compulsive behaviors. I explained that by viewing the habit as a defense; EMDR works effectively when targeting underlying memories and images, so I wouldn't expect the same level of success when targeting symptoms or defenses.

I used the Level of Urge [0-10] rather than the SUDS when targeting habits. In the hair pulling, the client virtually had no eye lashes or eye brows due to pulling. We identified discriminative stimuli, such as criticisms by mother of the client's appearance (there had been an excessive focus throughout the client's life by her mother on small imperfections in the client's grooming or appearance), putting on make-up, wearing contacts, hiding behind large glasses. For each we identified NC, PC, emotion, and LOU levels. We also identified the feeling she would have if her hands remained in her lap while the urge built up. Then each of these became targets until the LOUs were reduced to 0 or 1 and the PC had a VoC = 6-7. The PC was also connected to images of having full eyebrows and eye lashes, using mascara,

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being noticed positively by her husband, feeling exposed (no glasses).

The three weeks after the one session, her hair pulling was rated 95% improved. After her first contact with her mother, she regressed for one week to 25% improvement. After another EMDR session (her 3rd), it was at 75%. The 4th visit for EMDR took place only this week so I don't have more follow up. The client now wears contacts which expose her appearance and she has stopped combing her hair over her forehead to mask her eye brows.

I did refer her for medication in the first visit 12 weeks ago. She has been on Prozac, 20 mg. She reports obvious improvements in mood. However, the first EMDR session took place after 4 weeks on Prozac with no improvement in hair pulling at that point.

In a severe nailbiting case, the client identified a variety of social phobic symptoms which had been targeted previously in EMDR sessions. Then she brought in the nailbiting, both as a habit problem and as a social phobic matter (i.e., humiliation, withdrawal). The same method was used, identifying LOUs for keeping her hand in her lap, restrained arms when she had an urge to bite, nervousness, social situations, and other discriminative stimuli for biting. We also identified positive images, such as getting a manicure, showing off her nails, seeing her hands with nail polish while dialing a phone or using a pen. Each of these was used as a target. After one session, she grew nails for the first time and went for her first manicure.

There was a single regression, which, like the previous case, was connected with a stressor. I reframed and normalized this and then proceeded with additional EMDR. There has been no regression in the past 6 weeks.

I have tried the same approach under hypnosis rather than with eye movements. This was a woman who refused eye movement therapy. While I tried to duplicate the method as well as possible merely through suggestion, there was no improvement.

FROM: Frances R. Yoeli
Emek Bet Shean, Israel
yoelifam@NETVISION.NET.IL

Hi Marsha, it's me again. I have a client to try EMDR on nailbiting. I have worked with her on other issues but not yet on the nailbiting. she goes up and down with that according to her phobias. Will share when I try it. I will probably focus on the nailbiting urge first though could also start from the disgust at the results of the nailbiting. I think the nailbiting itself would just loop from finger to finger.

[Moderator: Extended quotations of the previous comments by Marshall Wilensky have been removed.]

FROM: Don Rosenberg
Milwaukee, WI
Don729@aol.com

Frances, the disgust is the emotion or possibly the NC, therefore, not the target. The biting is the defensive behavior, so targeting it may not get at reprocessing the underlying network of associations. The urge is the target . . . including the present experience of it, its first appearance, etc. Particularly, I suggest intensifying the urge and using EMs on that.

FROM: Frances R. Yoeli
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I am going to try and think this out loud as I write -the nailbiting is the act. That could be targeted. The self-disgust is what follows that act AFTER the feeling of satisfying the "uncontrollable" urge to nailbite. the NC would be I am disgusting. The emotion might be shame, frustration, sadness, anger, depression, despair, self hate. The body sensation might be located in the fingernails, mouth or any other place which could also be targeted.

I like the way you are thinking but in this case I see the client as not recognizing from whence cameth the urge and I think I might probably consider targeting an early scene or recollection of herself actually biting her nails with the recumbent horror of discovering herself doing it "unconsciously" — she recognizes that she is biting her nails only when she bites through the skin and wounds herself.

The urge for her doesn't seem recognizable yet. I think the nailbiting is done in a state of unawareness because the urge is itself disguised and the entire act becomes something similar to breathing.

FROM: Don Rosenberg
Milwaukee, WI
Don729@aol.com

The disgust is the emotion or possibly the NC, therefore, not the target. The biting is the defensive behavior, so targeting it may not get at reprocessing the underlying network of associations. The urge is the target . . . including the present experience of it, its first appearance, etc. Particularly, I suggest intensifying the urge and using EMs on that.

FROM: Frances R. Yoeli,
Emek Bet Shean, Israel

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I look forward to your thinking on the above—actually I think that any of the points could be targeted effectively -- I wonder whether out own issues around nailbiting whatever they may be might influence the choice of targets. Which is the most effective target can only be judged through some form of research or hit or miss type techniques. I am rambling on "out loud" Thanks for input to date.

FROM: Harry Corsover
Evergreen, CO
corsazzi@IDCOMM.COM

Frances, while your thoughts may indeed apply to the client in question, I am quite skeptical that they are generalizable to "nailbiters" as a group. In my experience (over 25 years) the same actions or symptoms can have quite different causes and/or meanings. Particularly, I doubt that "self disgust" or "self hate" is a necessary component.

Body sensations and/or tensions do seem to me to be a valid target. I would strongly caution you against making any assumptions regarding what's underneath that. Let it emerge from the client (i.e., follow more than you lead).

FROM: Frances R. Yoeli
Emek Bet Shean, Israel
yoelifam@NETVISION.NET.IL

I have been considering the nailbiting issue more in depth as I plan my strategy. Something has bothered me in terms of the target. yesterday I posted my thoughts as I thought them through -I should like to hear your opinions as I have them more thought through . . . There are several stages in nailbiting -first is the anxiety, depression, fear or whatever tension may instill the inability to cope or the need for escape --> the URGE --> behavior --> satisfaction of the urge and immediate relief of that tension that led to the urge --> self disgust, self hate, etc.

The first phase of tension (anxiety or whatever) is unrecognized and becomes recessed under the urge which most often is also unrecognized by the individual as the individual most often recognizes what he is doing only when he has already begun the biting and the initial tension has been relieved. The satisfaction and tension relief also goes unrecognized by the individual because of the rapid sense of self disgust that maintains the cyclic aspect of the problem.

The only points that we can in fact target are the nailbiting action itself, the self disgust. or the body sensations. In discussing the problem of nailbiting with an acupuncturist --her starting point would be the unrecognized tension which would appear as certain physical symptoms that would lead to the nailbiting. So that in the long run it seems that the best starting point would be the body sensations. I think we often tend too easily to limit the extent to which we discuss the bodily sensations accompanying the discomfit experienced by the client.

Thanks for listening. Comments and reactions to clarify appreciated.

FROM: Don Rosenberg
Milwaukee, WI,
Don729@aol.com

Your analysis reflect on my thoughts about not necessarily targeting the biting per se. The self-hate/ self-disgust could be considered the NC, so a new outcome, the PC would alter the cycle. A new image -- attractive nails, going for a manicure -- would also alter the cycle. Targeting the bodily sensations should also make a difference. For those who are conscious of the urge, target that. I have found that in subsequent sessions, the dynamics behind the arousal of anxiety have become clearer and the nature of the biting as a resolution of an inner conflict became available to target, including the earlier life experiences connected to that conflict.

FROM: Kathy McGuire
Eugene, OR
MCGUIRE_K@4J.LANE.EDU

Ahhh . . . "body sensations." Yes, having the client attend to, sit with, be with the "bodily felt sense" of the whole thing, that's the Focusing piece. In the EMDR where I am myself the client. We spend a large part of the session sitting with, making words and images for the body-sense as essential to finding the exactly right issue, NC, and PC to work with in the eye movements.

New Addition to EMDR Institute Discussion List: Two-week Specialty Topic Discussions Led by Institute Staff

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

In the 16 months since its founding in May 1996, discussion threads on the EMDR list have mostly arisen at random in response to inquiries from list subscribers. Occasionally, I've prompted discussion in certain areas. Last August, I had an idea to supplement and strengthen the general discussions and case inquiries with a series of parallel threads on a specialty topic led by a guest presenter.

I extended an invitation to a number of EMDR Institute staff members who have presented on specialty topics at Level 2 trainings or at the annual conference. I asked these EMDR clinicians to volunteer to take a two-week active role in leading a discussion on the EMDR discussion list on a specialty topic in their area of expertise. I am delighted that several have agreed to support this experiment with two weeks of focused discussion on a topic of special interest.

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

If you know a specialty presenter from the conference or a Level 2 training you'd like to see on the discussion list as a guest presenter, please contact them or let me know and I'll do what I can to encourage them to participate.

I look forward to seeing you online.

Schedule for Two-Week Specialty Topics

Start Date of Two-week Discussion	Name of Guest Consultant	Discussion Topic
November 1, 1997	Nancy Errebo, Psy.D. and Libby Call, Ph.D.	Embracing Change: Introducing EMDR into Your System(s)
November 15, 1997	David Grand, Ph.D.	EMDR Treatment of Longer-Term Complex Cases
December 1, 1997	tba	
December 15, 1997	tba	
January 1, 1998	tba	
January 15, 1998	Silke Vogelmann-Sine, Ph.D., CSAC, NCACI	Chemical Dependency Protocol
February 1, 1998	Ad de Jongh, Ph.D	Specific phobias
February 15, 1998	tba	

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AFFIDAVIT: I declare that I have conducted at least 50 EMDR sessions with at least 25 clients and have participated in peer and/or other supervision/consultation with at least 10 cases of my own or others.

Signature_____ Date_____

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

- All articles must be submitted in APA style and format.
- Articles, columns, advertisements, and other submissions must be provided in electronic format. They may be submitted on 3½-inch diskette or, ideally, as an attachment via e-mail. WordPerfect 6.1 for Windows or Microsoft WORD 7.0 or earlier versions are the preferred formats, although a standard text format (i.e., ASCII or Rich Text) may be used. The electronic format of each contribution should be specified in the accompanying e-mail or on the diskette.
- It is the author's responsibility to ensure that all aspects of submitted articles are correct and in accordance with APA style including: correct spelling and punctuation; accurate quotations that include page numbers, author, and year; and a complete list of references in proper order. (Please refer to the *Publication Manual of the American Psychological Association, 4th Edition*, for specifics.)
- Contributions should be well-organized and proofread. (It is requested that you make every attempt to complete the final draft before submitting your contribution. It may be difficult to incorporate revisions after the editorial process has begun.)
- Please note that all contributions are subject to editorial revision by the Publications Committee and the Editor.
- The Publications Committee and the Editor cannot guarantee when or if any contribution will be published.

Please submit articles and other contributions to the Editor:

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