The
EMDRIA Newsletter

Vol. 6, Issue 4 Quarterly Publication December 2001

From the President: Wendy Freitag, Ph.D.

If Ever….Now is the Time for EMDR

There are so many things I wanted to say in my final letter as President. Reflections, gratitudes, and holiday wishes to mention a few. However, all those seem insignificant relative to the events and aftermath of September 11. It doesn't feel right to combine the two in one letter; therefore, my final thoughts as President are given later in this issue.

On behalf of EMDRIA, I would like to offer heartfelt thoughts and prayers to all of you who were directly affected by the attacks on September 11. Although there are no words to ease your pain, may knowing that you have support and care from people far and wide comfort you in this most difficult of times.

Each and everyone one of us have been affected by the horrible events to some degree or another. As mental health professionals, we had an additional burden of dealing with our own personal reactions, and yet staying focused on the needs of the individuals we serve. As trauma therapists, perhaps we were ahead of the game, in that we were able to identify and normalize the reactions of people around us. We were able to make sense or label what people were experiencing and acknowledge that this typifies the human response to trauma. Nevertheless, it all has been difficult and so unnecessary.

As mental health professionals, our first instinct is to want to HELP! EMDRIA, along with the two other EMDR organizations, were flooded with offers of assistance and service in whatever way possible. All of us can certainly understand that need—the reaction to the helplessness we experienced. Perhaps this is most poignant for the EMDR clinician, who knows the efficiency of EMDR and its significant healing effects. I would imagine many of you experienced what I did soon after September 11. I was asked countless times by clients, colleagues and friends, "When are you going to New York?". For those who equate EMDR with trauma, the question makes sense. However, I believe that although we are fortunate to have EMDR as a healing option, we need to use it at the right time and place. We all know that the effects of this trauma will be long lived and the need for healing will be unending. Therefore, I see our services in continuous demand. Although there was an intense need to want to help immediately after the attacks, we must stay cognizant that the need for EMDR will be ongoing. As one colleague said, "If ever…now is the time for EMDR."

EMDRIA, like other organizations, was not prepared to respond to a tragedy of this magnitude. There are any number of reasons for this, but the important point now is what we have done in its wake. EMDRIA's response to September 11th, the 'Clinician Support Program,' has a couple of different segments and is focused on the clinician. It makes most sense for EMDRIA to direct our response in support of the clinician, given they are our members. The first segment of the program is "Compassion Fatigue Support Groups." These groups are peer support groups for EMDR clinicians responding at all levels. There is more information about these groups and how to get involved, either as a volunteer or a participant, elsewhere in this Newsletter. Another segment of the 'Clinician Support Program' has called upon the EMDRIA Regional Coordinators to offer educational and support meetings in their local communities. It has also created an opportunity to develop the Regional Coordinator program and invite more coordinators into the fold. EMDRIA is providing materials and models for the regional meetings, such as the review of pertinent EMDR protocols, written materials on burnout, vicarious traumatization, and self-care techniques. In addition to these types of meetings, some Regional Coordinators have also offered informational/support meetings to mental health professionals at large in their communities. Given EMDR is the premier trauma

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Highlights

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The EMDRIA Newsletter
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Newsletter deadlines for 2002 are as follows:

January 20th for the March Issue
April 20th for the June Issue
July 20th for the September Issue
October 20th for the December Issue.

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Jennifer Turner, Managing Editor
Email: TurnerBizSvs@aol.com
or
by contacting the Administrative Office

From the Desk of the Executive Director

Carol York, MSSW, LMSW-ACP

September 11th...we will never be the same! That is what they say. The events of that day are etched in our minds and heart. We will always remember where we were, what we were doing when we first heard or saw the news. As the events unfolded, we felt the terror...the terror of when will it stop, how will it stop. We felt the terror of others and the grief and sadness of the loved ones.

September 11th came and went. We are not the same. Our country, our world, is still gripped with fear and terror but we are learning to manage. The issues are complex and complicated. Solutions are not simple nor easy.

As mental health professionals, it has been our mission to help people learn to cope, develop, and grow. Were you able to do that on the day of September 11th? Can you do that now? If nothing else is learned from that memorable day, it is clear that you...we can't do it alone. Reach out to your colleagues, reach out to those you love. There is strength in numbers for good or bad. Let all of us make it for the good!

May each and everyone of you find your peace.

Carol York

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treatment today, it seems fitting that we offer these meetings as a way to promote goodwill among local mental health providers and an understanding of the usefulness of EMDR, when appropriate. If you are interested in becoming a Regional Coordinator and getting involved at this level, please contact Jari Preston, Chairperson, at jaripreston@msn.com or the EMDRIA office.

Another segment of the 'Clinician Support Program' is to provide pertinent information on our website. As many of you know, our website is undergoing a major make-over, under the auspices of Byron Perkins. However, in the meantime you can find pertinent resources, written materials and announcements regarding EMDRIA's response at www.EMDRIA.org.

The 'Clinician Support Program' is only a first look at how best EMDRIA can respond to disasters in the future. Although unfortunate, it has now become a reality and necessity. EMDRIA's Officers and Board of Directors will discuss our future plans in this area at the Long Range Planning meeting in San Diego planned for mid-January 2002. The two-day Long Range Planning meeting will be the first of its kind for EMDRIA and will be held at the Loews Coronado Bay Resort, the location for the 2002 EMDRIA Conference. The meeting will be chaired by the incoming President of EMDRIA, Byron Perkins, Psy.D.

In closing, amidst the horror and devastation of the last few months, some light has emerged and important lessons learned. It is well known that the events of September 11, sent many people back to their place of worship. There we began to re-examine our faith, the importance of spirituality in today's world, our life's priorities, and the things we take for granted. It also provided a time to focus on all that we have to be grateful for. Although these came at an extremely large price, the necessary changes pay tribute to all who died. I would like to extend to you the following prayer, which I found personally helpful and hopeful. I hope you also find comfort in these words.

Blessings to all and Peace on Earth,
Wendy J. Freitag, Ph.D.

In Memory, In Grief, In Hope

September 11, 2001

Divine Spirit of Courage,
Give us courage
to face our fears.

Make us patient and wise in
opposing injustice;
Peaceful when surrounded
by turmoil.

Divine Spirit of Hope
Make us hopeful
in the midst of despair.

Give us strength and tenderness
when caring for others.

Calm our souls
in the midst of chaos.

Clear our minds
when faced with confusion.

Divine Spirit of Forgiveness
Heal us of the pain of
horrifying memories.

Divine Spirit of Healing
And Generosity
Heal division and tension
in our troubled world.

Sooth those who are anxious
and troubled.

Console those who
grieve and ache.

Help us to be tender yet strong
in caring for one another.

Divine Spirit of Wisdom
We praise and thank you for
speaking to us in ways we
least expect.

And for the forgiveness you
give us when our hearts are
filled with resentment.

Amen

Clinician Support Program:
EMDRIA's Response to the Attacks on America

Wendy J Freitag, Ph.D
EMDRIA President on behalf of the EMDRIA "Clinician Support Program" Taskforce

In the aftermath of the tragedies of September 11, EMDRIA, as the professional organization for EMDR therapists, felt it most appropriate to support our members as you cope with these events. In coordination with EMDR HAP and the EMDR Institute, who are focusing on direct service and training of clinicians, EMDRIA will focus on you and your needs in this most difficult of times. EMDRIA has set up a taskforce to look at the many ways we may be of help. The aftermath of these horrendous events will likely push mental health professionals above and beyond the limits of where we have gone before. EMDRIA's taskforce developed the "Clinician Support Program" (CSP), which has three components, to assist you in helping to heal our nation.

Compassionate Fatigue Support Groups
The first component of our CSP is the "Compassionate Fatigue Support Groups" (CFSG), which offers peer support, both virtually, through teleconferencing, or face to face, at no charge. The purpose of these groups is both informational and supportive. It provides an opportunity for sharing your thoughts and feelings about the disaster, the work you are doing, how it is affecting your clients, and how it is affecting you personally. It also provides information about vicarious traumatization, stress-response symptoms, and self-care, as well as a place to share with and learn from colleagues who are doing similar things in similar situations.

The participants for the CFSGs are EMDR therapists who have or are providing direct service, debriefings, processing and/or support sessions, and/or are setting up supportive networks. We have identified three tiers of clinicians who we believe will benefit from peer support. We believe that holding homogeneous groups is the best approach at this point. The tiers have been characterized as:

Tier 1: Any EMDR therapist who has or is working as a volunteer in the "hot spots" (i.e., NY or DC) or immediate surrounding area (e.g., NJ).

Tier 2: Any EMDR therapist who has or is working as a volunteer in the secondary "hot spots" like Boston, Philadelphia and San Francisco.

Tier 3: Any EMDR therapist who has or is working with individuals affected by the 9-11 events.

There are numerous sessions available for participants to choose from, which are scheduled throughout the week and weekends, and at various times in a given day. Participants are able to take part in as many sessions as they like. These sessions will be offered as long as they are necessary. The EMDRIA Administrative Office is coordinating this effort. If you are interested in participating in one of these groups, please contact the office at EMDRIA@aol.com for more information.

No-Fee Consultation Groups
As you read in the EMDR HAP article (on the facing page), it is expected that there will be a sharp increase in the number of people seeking psychotherapy over the next 6 to 12 months, with the effects of this disaster lasting decades. For EMDR therapists working with disaster victims at all levels, no-fee consultation groups will be offered by EMDRIA Approved Consultants. These groups will aid therapists in case conceptualization, consultation, and support. There will be more information to come on the No-Fee Consultation Groups as the need arises.

Regional Coordinating Meetings
As it has already been demonstrated, EMDRIA Regional Meetings for local EMDR therapists have taken place all over the country, both in the "hot spots" and elsewhere. We are finding that these meetings are very well attended and well received. It appears they have provided support for those trained, and using EMDR, and to pique the interest of those trained, but not using it. Therefore a very important third component of the CSP is to support and enhance EMDRIA's Regional Coordinating Program. We believe this is an opportunity to strengthen and enhance this EMDRIA program and support you, our members. We would like to invite all certified therapists to consider becoming a Regional Coordinator if none exist in your area. To facilitate a Regional Meeting in your area, EMDRIA has put together materials that you might find helpful whether you are new or an existing Regional Coordinator. You can contact the EMDRIA office for more information about becoming a Regional Coordinator or to request a packet of information on holding a meeting in your area.

Lastly, we would like to acknowledge every one who has given freely of their time and support of the many programs sponsored by EMDRIA, EMDR HAP and the EMDR Institute.

Questions, suggestions, or for more information, you may contact myself at WJFreitag@aol.com or the EMDRIA Office at EMDRIA@aol.com.

The Disaster Mental Health Recovery Network: EMDR HAP Responds

Jim Knipe, Ph.D. – EMDR –HAP Project Coordinator
Barbara Korzun Psy.D. – EMDR-HAP Executive Director

The Distaster Mental Health Recovery Network is an EMDR Humanitarian Assistance Program, dedicated to meeting the needs of people who are suffering from severe emotional distress following the events of September 11.

With the support of EMDRIA and the EMDR Institute, we are implementing a large-scale, nationwide program to assist individuals who continue to have ongoing emotional disturbance resulting from the terrorist attacks. Over 500 therapists have volunteered to provide pro-bono (no-fee) EMDR treatment to people who are showing symptoms of continuing traumatization. EMDR HAP has previously carried out projects of training and support for therapists in many locations in the US (e.g. following the Oklahoma City bombing and the Columbine shootings) and overseas (e.g. in Bosnia, Northern Ireland, Turkey, Indonesia). The response of EMDR-HAP to the September 11 terrorist attacks is the Disaster Mental Health Recovery Network. This Network will have several components.

The Direct Service Component will respond to individuals immediately impacted by the attacks: those who escaped or were displaced from their homes; those with friends and loved ones who were killed or injured, with particular focus on New York and Washington DC; those who were present during the attacks; rescue personnel and their families and other groups who may be particularly affected by the current situation (e.g. Arab-Americans, airlines personnel, and other groups). This is, of course, a large number of people in need of services, but it is matched by an outpouring of commitment from therapists wishing to contribute to the healing process.

The service provided by EMDR therapists would be specific therapeutic intervention for the post-traumatic disturbance resulting from the terrorist attacks. In other words, the focus would be on resolving the disturbance from these specific events, not on providing a full course of individual psychotherapy. The model here would be the type of service generally offered through an employee assistance program. It can be expected that, in most cases, the particular distress from these recent events could be resolved within 3-4 sessions. Network Clients will be offered 4 sessions following an initial evaluation session.

Given the way that Post-traumatic Stress tends to develop after a disaster, we expect a sharp increase in people seeking psychotherapeutic help 8-12 weeks following the events and around holidays and "anniversaries" (e.g. the six and twelve month marks). We anticipate the possibility of approximately 8000 clients being served during the next 18-24 months, which will be the duration of our formal programmatic efforts. With a disaster of this magnitude, however, the emotional impact & increased need for mental health services will extend for decades.

In response to this need, EMDR-HAP is planning a series of training programs in the New York and Washington, DC areas. One element will be combination EMDR Refresher Courses / Disaster-Related Specialty Trainings. These will include refresher courses in EMDR, for Level I and Level II graduates who have not been using EMDR very frequently and who would like to brush up on their EMDR skills, emphasizing EMDR procedures that are particularly important in response to the present situation: e.g. the use of EMDR with recent events; specific procedures for grief and loss; and EMDR procedures to bolster coping skills and "ego strength". A second element will be Level I and Level II instruction programs for those therapists not previously trained in EMDR that will be providing on-going services to 9/11-related trauma clients. A third training element will be workshops for therapists on how to respond to hidden PTSD: depression, family problems, alcohol problems, exacerbation of personality disorders, difficulty with anger control, etc.

The Staff and Board of EMDR-HAP would like to thank the entire EMDR community for their support and cooperation. We are preparing for the long haul. Together, we can provide the Nation with this invaluable resource and bring EMDR to those that need it most.

Network Contact Numbers:

NYC Coordinator:
Gina Colelli – (917) 626-9117

Long Island Coordinator:
Carol Forgash, CSW, BCD (631) 265-3194

Washington, DC Coordinator:
Deany Laliotis LCSW (301) 718-9700

EMDR-HAP Disaster Line:
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EMDRIA Has Come of Age: Reflections and Gratitudes

A Farewell Message from Wendy J. Freitag, Ph.D., EMDRIA President

Someone once asked me " Which farmer is more likely to plow a straight line, the one who sets his sights on a point out front or the one who frequently looks back to check his progress? For me, it was obvious that the former had a better chance than the latter to successfully meet the challenge. This principle is what guided me through my EMDRIA Presidency. For me, it has been about thriving not just surviving. It has been about maturity not just growth. When I started 15 months ago, my plan was to tighten up EMDRIA's committees, programs, and practices - to strengthen what we had, so we could move forward to the next level. We needed to define ourselves as the professional organization we are. At this year's conference in Austin, it finally felt that EMDRIA had 'Come of Age.' At times, this has meant making choices between progress rather than community, formalization rather than flying by the seat of our pants, and long range planning rather than management by crisis. These growing pains are not comfortable, and the change, although necessary, doesn't always come easy.

Given the rich history of EMDR and its community, progress has some times run counter to the traditions. We all know that "family" traditions are the foundation and roots on which we are built. They are familiar and make us feel good. However, to move forward we need to look ahead rather than back to determine the right path. It has not always been easy and sometimes led to unpopular decisions. Change does that, but I believe when it is done from the right place with honorable intentions, the end result is usually where we need to be.

For those who supported me in my efforts, I am extremely grateful. I have been proud to be the EMDRIA President and I am thankful for the opportunity to have served you. Although I have acknowledged the EMDRIA Staff in previous writings, I would like to take one last opportunity to do so again. EMDRIA's Executive Director, Carol York, and I worked very closely for the last 15 to 18 months. We were a sounding board for each other on a weekly basis. This allowed me to stay abreast of the daily activities, problem solve issues before they got out of hand, and provide support for Carol and her staff. This time with Carol gave me a full understanding and appreciation of her vision for EMDRIA. Although our Officers are important, they come and go each year. On the other hand, the staff remains constant (for the most part), and truly is the glue that keeps us together and moving forward. We, as an organization, are very fortunate to have these dedicated and competent individuals working with us.

Certainly the Executive Committee and Board of Directors deserve recognition from all of us. Although it is part of the commitment to EMDRIA to be available and give of their time, they need to be acknowledged for their willingness to serve the organization. Please take a moment now to review the list of Officers and Directors on page 39. The next time you have the occasion to correspond with any of them, use that opportunity to thank them for their dedication.

I believe the above also goes for those who served as EMDRIA committee chairs and members. As I stated earlier, this year's mission was to tighten up and strengthen our committees and programs. I believe we accomplished this for the most part. (Of course, there is always more to do!) However, we could not have accomplished what we did without these individual's enthusiasm and perseverance.

Another important initiative I wanted to accomplish was to strengthen the relationship among all EMDR-related organizations worldwide. EMDRIA was the first EMDR-related organization to exist, but it has been joined by strong and committed organizations in Argentina, Australia, Canada, Europe, and there are more on the horizon. Although in different stages of development, the important fact is that they exist. At the time of this writing, there is a proposal on the table to form reciprocal agreements among all EMDR-related organizations rather than the affiliate-type relationship, which now exists. It is proposed that representatives from each organization will sit on a "World Council", and together will make decisions about the professionalism of EMDR worldwide. One of the first important goals of the World Council would be to set universal standards for EMDR training, certification, and practice. It is truly a very exciting time for the EMDR Community as a whole.

I cannot close without thanking our beloved Francine Shapiro. For without her and her gift, we would not be here. From a personal standpoint, I cannot imagine, nor do I want to, what my life and practice would be like without EMDR. More importantly, for all those who have and will be healed by EMDR, it is truly a special and wonderful blessing we all share, thanks to Francine's caring, and generosity. Although there are no words to express my gratitude, hopefully my service to EMDRIA is a way to give back for all that I received.

Lastly, I want to acknowledge Jennifer Turner, Managing Editor for her enduring patience with me through these last 15 months.

Finally, all of us are in the midst of our respective holiday seasons. I extend my warmest wishes for a blessed holiday, peaceful times, and a prosperous New Year to come.

Blessings to all and Peace on Earth,
Wendy

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EMDRIA Credit Schedule

as of November 1, 2001

Dates Location No. of EMDRIA Credits	Provider Name Title of Program	Presenter	Contact	Phone No.	Provider # Program #
12/01/01 Los Angeles, CA 7 Credits	The Traumatic Stress Network **Peter Levine: Trauma: Waking the Tiger (Somatic Experiencing)**	Peter Levine, Ph.D.	Linda Vanderlaan	909-279-7099	99013 99013-06
12/8-9/01 San Diego, CA 14 Credits	Andrew Leeds, Ph.D. **Strengthening the Self**	Andrew Leeds, Ph.D.	Andrew Leeds	707-579-9457	99019 99019-18
12/8-9/01 Cincinnati, OH 14 Credits	Roy Kiessling, LISW **Integrating Resource Installation Stratetgies into Your EMDR Practice**	Roy Kiessling, LISW	Roy Kiessling	513-324-3637	00015 00015-10
2/7-10/02 Niagara-on-the-Lake CANADA 21 Credits	Roger Solomon, Ph.D. **EMDR Supervision Retreat**	Roger Solomon, Ph.D.	Kathleen Martin	716-271-3050 Ext. 7	00011 00011-03

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Inquiring Minds: Questions for the Research Committee

Q On Selecting Measures for EMDR Research:

I have a young colleague who is doing her masters thesis at Smith College on the subject of EMDR and has asked for my help in identifying measures useful in assessing outcomes for EMDR treatment. Though I use EMDR with some of my child patients, I have little or no knowledge of the research end of things. I would be extremely grateful for any assistance you could give me on this.

Mary Sue Cherney, LCSW
Clinical Associate,
Duke University Medical Center
Dept of Psychiatry and Behavioral Sciences
Center for Child and Family Health-NC

A This is one of the most commonly asked questions of the committee. Strange as it might seem, there are no specific outcome measures for EMDR. We advise people to use empirically-validated measures for whatever the problem is that they are treating (e.g., trauma, phobia, grief, etc.), so that when we say we are measuring a certain construct, others will believe us because the instrumentation is credible. However, While the psychometric qualities of an instrument are critical to evaluate in choosing a measure, there are many other factors that should be considered in selecting measures; it's not as simple as "what are the most popular measures for X?"

Measure selection is guided by multiple considerations related to: the population you are treating, the symptoms you are targeting in treatment, the theory underlying the reason you are using the selected treatment to target these symptoms, the treatment context/setting, and the stage of your research. These are each addressed below.

Population/Sample: The instruments you select must be appropriate for your sample. It is normally inappropriate to use adult measures with children, to use long paper & pencil measures with poor readers or individuals with poor concentration, etc. Try to find measures that have been validated with people just like those in your sample, on factors such as age, SES, gender, race, ethnicity, diagnosis, and reading level. You'll rarely get a perfect match, but the closer you can get on those factors that seem most relevant to your study, the better.

It is also very important that your assessment scheme be able to specify the nature of your sample, so that others will know how to interpret your findings. This is often done by obtaining a DSM diagnosis; however there are other options. For example, inclusion criteria might be related to status as a participant in a substance abuse or domestic offender program, hospitalization history/ status, or number of school suspensions. Some studies define their sample by a certain score on a standardized measure; however, this is often seen as less than ideal.

Target Symptoms: In order to have the best chance of detecting treatment effects, you want to use measures that are as sensitive as possible to the things that you hope will change. For example, if you are targeting post-traumatic stress and only measuring anxiety and depression, your measures will be relatively insensitive; you must also use a direct measure of post-traumatic stress. Similarly, if you are targeting a specific behavior such as fighting and you use a multi-behavior instrument such as the child behavior check list, any changes on the target behavior will be lost because it has no special prominence in this measure of multiple behaviors; better to use a daily count of fighting incidents.

Underlying Theory: Treatment outcome research has two complementary goals: to improve treatment, and to advance understanding regarding how and why effective treatment works. Therefore any treatment study should incorporate a theoretical framework, and the study should be designed to test the theory as well as the treatment. In some cases this is easy, for example, the same set of instruments can assess whether there is reduced reactivity to the trauma memory (the hypothesized reason for reducing PTSD symptoms), and whether PTSD symptoms have been reduced. Other times, though, there is an intermediate step. For example, if you are treating a "source memory" as part of a strategy to reduce test anxiety, you probably have a theory that the memory was contributing to the test anxiety, and that eliminating the memory-related distress will reduce the tendency to have test anxiety. Therefore your design should include assessment of memory-related distress as well as test anxiety. This will help you to learn not only if your treatment was effective, but if your theory can account for the results you found.

Treatment Context/Setting:

Assessment considerations are often determined by the treatment context and setting. For example, if you are doing a study in a residential treatment center that uses a "point system" to track problem behaviors, it is probably both economical and relevant to use these points as an outcome measure. You also want to consider the assessment burden on the participants and others, try to make things fit into the flow if possible, not disrupt the system too much. Finally, you will almost certainly want to use outcome measures of primary interest to your treatment setting; you want them to care as much about your study as you do.

Stage of Research: EMDR research is never only about EMDR; it's about EMDR for a certain kind of person, problem, and treatment context. The assessment approach should be consistent with the type of information that is required, and the amount of resources that it is appropriate to devote to assessment, given the stage of the research for your target population.

When you are using EMDR in a novel application such as sexual dysfunction, schizophrenia, or bulimia, rich clinical description is essential, although standardized and behavioral measures are also important. Next steps in research might involve multiple standardized psychological and behavioral measures. Finally, a well-funded controlled comparison study might involve those measures plus structured interviews as well. In each case the assessment is appropriate to the type of information, and the level of proof, needed for the stage of research.

For example, while EMDR now has strong empirical support for the treatment of PTSD, no studies have systematically examined it's effectiveness on PTSD-related symptoms of anger, guilt, and mental alienation/defeat. Because behavioral exposure treatment is less effective with these two types of PTSD, demonstrating that EMDR is effective with these symptoms would go a long way to making the case that EMDR is uniquely different from exposure. Therefore, in designing a research study testing EMDR's effectiveness for PTSD, you would want to include some measures of these constructs—ideally those measures that have been shown, in prior research, to predict poor response to exposure treatment.

In closing, there are plenty of finer points to selecting measures for a study, but this covers many of the usual considerations, beyond those of the instrument's psychometrics. In addition, it is still worthwhile to obtain consultation and to review published work in your area of interest before finalizing your design decisions.

From the Managing Editor:
"They Were the Best of Times, and the Worst of Times..."

Jennifer Turner

As the Managing Editor, I would like to apologize for the lateness of this issue. There were many delays in putting together information for you that was current, accurate, and informative. With so many people involved in treating those affected by the events of 9/11, it took longer than expected to go to press.

This issue has been the most difficult Newsletter that I have completed, to date. I find myself tired, emotionally, physically, after reading the many, many stories of those living in and around New York and Washington. I find myself angry at the loss of lives, not only those who were taken from us..but our *way* of life. Our sense of security, our sense of safety. I think twice as I open mail from these areas, my wrist itches, and for a moment I am panicked over the possibility of an illness I had never given a second thought to just a few weeks ago.

Amazingly, though, out of this I found a great sense of pride in our world. I watched with amazement as the world joined hands and pledged to grow from this. The separations disappeared, if even for a moment for some, and we all wept together, our difference flowed away, and we were all just humans, and we all hurt. We prayed for each other, we worked side by side, we vowed to remember..and I think we all will. How amazing to see this in my lifetime. So, yes, our lives have changed, forever. But perhaps, in the midst of this darkness, there will be change…and we will never again take for granted the life we have been given, the gifts we find everyday in our families, our friends, our colleagues….our world. I am so grateful for the gift I see in all of you….the gift of healing. I am so grateful to know that EMDR will do so much for so many, and I am grateful to have been able to share these stories with you.

May peace follow you into this holiday season and into a NEW year.

Jennifer

Do You Have a Research Related Question?

Each issue of the newsletter will feature a question related to EMDR research. If you have a question that you would like to have featured, either e-mail it to the chair,

Nancy Smyth, Ph.D., at njsmyth@buffalo.edu

or send it to EMDRIA's Research Committee, P.O. Box 141925, Austin, Texas 78714-1925.

When you send your question, please let us know if it's okay to publish your name & affiliation (if you don't specify, we'll leave it anonymous).

Announcing...

Membership Renewal Notice!

This is just a reminder that your membership will expire on December 31, 2001. You should have already received a renewal notice by now. If you haven't renewed your membership as yet, we encourage you to do so as soon as possible in order to avoid a lapse in your membership. If you didn't receive a renewal notice or have misplaced it, please feel free to call or email our office, and we will be happy to send another one.

Is your Certification or Approved Consultant status about to expire?

You may want to check the expiration date on your Certificate to find out. Don't forget that you must complete 12 hours of EMDRIA Credit during your two year Certification period. When it is time for you to renew, you will need to submit copies of your certificates for EMDRIA Credits. If you are unsure of your expiration date, please feel free to call or email our office. We will send out renewal notices approximately 90 days prior to your expiration date.

Interested in Advertising in the EMDRIA NEWSLETTER ?

Contact Gayla Turner at the EMDRIA Administrative Office for details.

2002 ADVERTISING/ARTICLE SUBMISSION DEADLINES:

January 20th for the March Issue
April 20th for the June Issue
July 20th for the September Issue
October 20th for the December Issue

Announcing…

Would you like to get more involved in EMDRIA?
Do you have questions about what's involved in becoming more active in EMDRIA?
Have you thought about running for a position on the Board?

If the answer is **"YES"** to any of the above questions
We can help!

IT'S THAT TIME AGAIN! EMDRIA is looking for interested members to become more involved in the organization by running for an office or as a member-at-large. Information is available via an email attachment or the mail by contacting the EMDRIA office at EMDRIA@aol.com or 512-451-5200. This information may answer some of your questions or perhaps pique your interest.

Contact Wendy J. Freitag, Ph.D. at WJF@PrsueExcellence.com or 414-777-1757 if you are interested in running for a position or have additional questions. Thank You.

2002 EMDRIA CONFERENCE
'CALL FOR POSTERS'

June 20-23, 2002 * San Diego, California

SUBMISSION DEADLINE
April 15, 2002

We are soliciting Abstracts for Poster Sessions for the 2002 EMDRIA Conference.

What is a Poster?
Posters are excellent ways to summarize research or single case studies and to present a conceptual model or assessment package. At most professional conferences, Poster Sessions are the primary vehicle for the presentation of new research, case study applications, literature review summaries, and new assessment instruments.

An award for the best poster will be given. If you would like more information on Poster Sessions and/or to receive submission information, please email Nancy Smyth, Ph.D., at njsmyth@buffalo.edu, or call Terri Curtis at our Administrative Office at (512) 451-5200.

IN THE SPOTLIGHT:
Roger Solomon, Ph.D.
by Marilyn Luber, Ph.D.

In this time of increasing worldwide disasters -both natural and man-made- and in the wake of September 11th, I have joined many of my colleagues in thinking about how lucky we are to be able to offer some relief from the grief, loss and trauma that currently fills the worlds of our friends, colleagues, and patients. When I think about critical incidents and the area of trauma and grief, with EMDR, I think of my friend, teacher, and colleague, Roger Solomon.

Roger has had a long history of service and interest in his community. Coming of age in the community-oriented world of Berkeley University, Roger volunteered his services and then received course credit for his work at the Berkeley Community Free Clinic in the early '70's. The Berkeley Free Clinic was an independent entity, funded by donations and grants from the community. He worked as a Psychology Emergency Counselor and dealt with a variety of situations such as LSD and other drug "freak-outs", suicidal individuals, as well as with the gamut of problems experienced by street people. He regards this experience as the best education he ever had. From this experience, Roger began to transform his knowledge and wisdom into practical applications for the people and communities of which he is and was a valued member. He graduated from Berkeley University with a BA in Psychology and was Phi Beta Kappa in 1972.

Armed with a BA from Berkeley and a community outlook, Roger moved on to the University of Chicago where he worked towards an MA in the Social Service Administration. This program enriched his clinical outlook and taught him to be even more practical and again emphasized the importance of a community orientation.

From the West to the Midwest and down into the Deep South, Roger continued his quest for knowledge. He went to Auburn University in Auburn, Alabama because they had a strong, APA-approved, Clinical-Community Psychology Program. One of his professors introduced Roger to Police Psychology because this mentor had established a relationship with the police and assigned him to work in this area. Although Roger had not anticipated moving into this field of psychology, with his interest in people and in the community, he was a natural. During his last year, he had an Assistantship with the Police Department. He was involved with psychological selection of police officers, provided crisis intervention (dealing with psychotic and suicidal situations), and court assessments. He wrote his dissertation on "Social psychological determinants of police behavior", and found that there is a police subculture and that peer influence is a significant determinant of police behavior. In 1977, he interned at Chicago Reed Mental Health Center. He found the work interesting but much preferred "working actively in the community" to sitting in a mental health center. He received his Ph.D. in February 1979,and for the next 15 years, he was a full-time Police Psychologist.

Roger did Postdoctoral work at the Arizona Department of Public Safety (State Police) in Phoenix, AZ, and then moved on to a full-time job at the Colorado Springs Police Department where he remained as a Police Psychologist for the next 9 years.

It was in Colorado that he discovered his interest in trauma. In 1979, an FBI agent approached him to talk to him about trauma in law enforcement. The agent noted that the FBI had heard that 80% of police officers involved in line-of-duty-shootings left law enforcement within the next two years. The FBI agent was interested in what psychologists had to say about this. However, at that time, there was little information on trauma and law enforcement, and Post-traumatic Stress Disorder was not yet an official diagnosis. So, Roger and this agent, Jim Horn, joined forces and did their own research by talking to hundreds of officers who had been involved in these incidents and then set up support programs. They found that whereas the men were reluctant to talk to "head shrinkers", they were interested in talking to each other. So they initiated peer support trainings. Jim and Roger were the only ones providing this service for police in the area and they became known for their work. At the time, the Police Department did not recognize that other types of incidents could be traumatizing. It took several years for departments to recognized that critical incidents included high speed pursuits that resulted in fatalities, multiple fatality accidents, being involved in a fight for one's life, and incidents involving children. Also, they found that an officer did not have to be involved with the trauma directly to experience traumatic effects. Being on scene where another officer had to shoot someone, or was shot, could be traumatizing. Although these are commonly understood principles today, it was a hard fought battle to bring this awareness to departments back then. Roger's friend Jim eventually became the head of the FBI's Critical Incident Program.

By 1984, Roger met Jeffrey Mitchell, founder of the International Critical Incident Stress Foundation (ICISF). Jeff is known for developing Critical Incident Stress Debriefing and conceptualizing Critical Incident Stress Management. A significant contribution of this approach was shifting the focus from individual to a group crisis intervention that included everyone at the scene. This practical approach has been very effective with emergency services and has now expanded to include private industry, military, schools and work place violence.

Roger and Jeff became fast friends and Roger began to incorporate Jeff's methods into the work. They taught together at several workshops on trauma. Roger became a faculty member of the ICISF and currently teaches Critical Incident Stress Management.

In 1988, Roger moved to Washington State where he was a Department Psychologist in the Washington State Patrol for the next six years. There he conducted psychological screenings for law enforcement applicants and selection of SWAT team, bomb squad, and hostage negotiators; provided psychological services (individual, marital and family psychotherapy) to department personnel and their dependents; organized, coordinated, and supervised prevention programs; conducted training at in-services and at the academy levels on psychological issues; and provided organization and program consultation to all bureaus in the department, conducted research and provided operational assistance.

Roger has been consulting with numerous municipal, county, state and federal agencies on critical incident programs and he has provided psychological services after traumatic events. He is well-known for his workshops and seminars nationally and internationally and has taught law enforcement and mental health

professionals in Australia, Canada, Kuwait, The Netherlands, Norway, and Sweden. The topics he teaches include critical incident trauma, and other topics related to police stress and police psychology. In the private sector, he has provided critical incident debriefing for teams involved with major incidents such as airline crashes, major crimes, and disasters. He is an expert witness in civil suits and criminal trials in cases involving law enforcement use of deadly force.

In 1989, Roger took the early EMDR training from Francine Shapiro. He thought this was "a silly-looking method" until he met the veteran that Francine talked about in her presentations while doing a debriefing for the Mental Health Center in Santa Cruz following the 1989 San Francisco earthquake. The veteran was a volunteer counselor working to help people with their responses to the earthquake and told Roger about his EMDR session. Although, at the time, Roger was skeptical , he did believe the veteran himself. He asked the counselor to show him this new method. In Roger's words: "I brought something up that was annoying to me and he did several sets. And, after that, I did not understand how this could have annoyed me in the first place! And then, I realized something shifted …… then I took the training……..and the rest is history!"

When Roger learns something that intrigues him, he practices it and integrates it. In the case of EMDR, he began to sponsor trainings in Washington State. As one of the early qualified members of the EMDR team, Roger was invited to train to become a trainer. After apprenticing with Francine from 1993-1994, Roger became a member of the Senior Faculty of the EMDR Institute and began to teach Level I and in 1998, he began to teach Level 2.

Roger now travels all over the world teaching his many specialties. He has been amongst a number of EMDR Institute and HAP trainers who have traveled extensively to bring EMDR to clinicians in many countries where traumatic events have occurred. Roger has been to India, Israel, The Palestinian Authority, Ukraine, and Rwanda, around the world and to Central Massachusetts in the United States to teach agency clinicians in the HAP Inner City Program. To Roger, these were very meaningful trainings where he could see the purpose of his work. In celebration of his contributions to EMDR, Roger was the recipient of the 1997 Ron Martinez Award.

Roger also provides specialty training in EMDR. He teaches the "Utilization of EMDR with grief", and is currently finishing a protocol. He teaches a two-day course in Critical Incident Stress Management for EMDR Therapists. More recently he has developed a course on "The art of EMDR" which focuses on the subtle, nonverbal indications that material is processing, and how to maximize therapeutic effect by detecting client rhythms and recognizing when processing is taking place.

Roger loves to travel and has been influenced by his introduction to the many different cultures he has visited on a regular basis. He is interested in seeing the differences between cultures but believes that "People are people no matter where one is in the world." New foods, wonderful vistas and meeting so many new people have been some of the benefits that has kept Roger enchanted with his traveling. He also enjoys showing his discoveries to his daughters Rachel and Julia.

For the past three years, Roger has been on the Faculty of The Trauma Center in their Community Services Program led by Robert Macy. This program provides crisis intervention, clinical services, and education programs to the Boston School District and the community. Roger is a lead Instructor of the Critical Incident Stress Intervention workshop certified by The Trauma Center. The CISM course for EMDR therapists is also certified by The Trauma Center.

Roger 's expertise in Critical Incident Stress Management has resulted in a worldwide reputation and he consults with national and international companies and their employees. In Toronto, Roger is working with MEDCAN Health Services. This agency provides disability management and healthcare services to other companies. He is proud of their "soup-to-nuts" Critical Incident Trauma Program which includes the provision of treatment to employees involved in traumatic events, consultation on trauma-related disability, training in critical incident stress management, and consultation to management and nursing staff on psychological issues.

Currently, Roger is engaged in several research projects. In Canada and Germany, Roger and Arne Hofmann are gathering data on the effect of implementing "the one-two punch" (Roger's term for the power of doing first CISD then EMDR), after bank employees have been involved in a bank robbery and meet the criteria for Acute Stress Disorder. Marshall Willensky in Vancouver has been an active part of this project. Roger is collaborating with Theresa McGoldrick on grief research and he is writing a protocol on EMDR and grief based on the work of Theresa Rando. He is gathering research on the effects of a multi-day intervention with police officers who have been involved with traumatic incidents, using the Impact of Events Scale pre and post treatment.

Roger is a well-published psychologist and has written on topics ranging from EMDR to issues related to law enforcement, critical incident stress debriefing, memory impairment, and critical incidents and administrative guidelines for police-related issues.

During the September 11th disaster, Roger was in Turkey. When he returned, he was called to New York City immediately to provide Critical Incident Stress Debriefings and other clinical services to a number of federal law enforcement agencies and some private companies. He reports that he has found EMDR to be very helpful in NYC with Acute Stress Disorder. As an example, Roger tells of a person who is stuck in an experience of extreme fear and the belief "I am going to die". When the images, fear, and belief are intruding significantly on the person's ability to function, EMDR has been helpful in reducing symptoms and facilitating on-going functioning. He says, "EMDR has been a wonderful tool to help people move beyond moments of terror that are frozen in their system". Roger's philosophy is "It is very important to supply appropriate interventions according to the emotional state and phase of recovery of the people involved"……further it is important to provide on-going assessment and support".

Knowing all that Roger has done, I was concerned about how he was taking care of himself in the face of all of the trauma, grief and loss that he has seen, heard and experienced and wondered if he had something to help us as we move through these difficult times. This was his response:

"How have I learned to handle other people's trauma? It has definitely been a learning experience over the years. It is a continual process of learning to deal with my own vulnerability as I deal with other people's vulnerability. The best way I have found to deal with it is to be part of a team, with colleagues that I trust. We can talk, debrief, and take care of each other. In New York, I am working with colleagues whom I have worked with for years, and trust. Another important factor is that I see people get better. When I am working with someone who is traumatized, whether it is a police widow or a WTC survivor, my mindset is that his/her current emotional state is normal and temporary. Things will improve, and I will be part of that forward movement and resolution. This keeps my work meaningful and prevents burn-out. The efficacy of EMDR has played a significant role in the development of this outlook".

We are lucky to have this educated and committed man as part of our EMDR Community.

EMDRIA Committee Reports

EMDRIA Research Committee Update

Nancy J. Smyth, PhD, CSW, Chair

The Research Committee has spent the past year providing onetime and ongoing consultation to people on EMDR research projects, providing feedback on EMDR scholarships, providing a Research Support Listserv for those interested in conducting research, reviewing and organizing the conference research-related activities (symposia, poster sessions, research networking meeting, research award), providing information for the EMDRIA website, writing research-related newsletter articles, and distributing the 2000 Edition of the *Directory of EMDR Researchers and Academics.* In addition, as the EMDR research literature has grown, we have struggled to keep up-to-date with it (but this is a good thing!!).

Questions about any of the above activities or projects can be directed to the committee chair, Nancy J. Smyth, Ph.D, at:
njsmyth@buffalo.edu

Research Committee Members are:

Nancy J. Smyth, Ph.D., CSW, (Chair)
njsmyth@buffalo.edu

Kent E. Bath, Ph.D.
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Ad de Jongh, Ph.D.
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rg@childtrauma.com

Christopher Lee, Ph.D.
Christopher.Lee@health.wa.gov.au

Louise Maxfield, MA
jlmaxfie@flash.lakeheadu.ca

200l Awards and Recognition

Carol York, MSSW, LMSW-ACP
Executive Director

In September's 2001 EMDRIA Newsletter, Jennifer Turner was not mentioned for her outstanding contribution to EMDRIA. Jennifer was awarded this recognition for her instrumental contribution in organizing and developing EMDRIA with me when EMDRIA was moved from Arizona to Austin, Texas. Jennifer had been the office manager in the private practice offices where I formally practiced. She was present when I organized the first EMDRIA Conference. Jennifer left the office manager position and we stayed in touch during the interim. When I was asked to take the position of Executive Director, I solicited Jennifer in helping me take on the task of saving EMDRIA from the state of affairs of that time. Jennifer took the position of Associate Director and with her creativity, flexibility, and dedication, she helped develop and organize EMDRIA as it is today. Without her knowledge and expertise, I, nor the Board could have done what we have done to date. Jennifer left EMDRIA in January, 2001 to pursue her professional dreams as a children's photographer. EMDRIA and the Board of Directors are indebted to Jennifer for her commitment to EMDR and to the growth of this organization. I will be eternally grateful to you, Jennifer, for your knowledge, your enthusiasm, the partnership and friendship that you have shown me, and especially for making work fun.

Special Interest Groups (SIGS)

Zona Scheiner, Ph.D., Chair

Currently Approved SIGS and their chairs:

1) EMDR and Eating Disorders
Chair, Eileen Freedland
Phone: 248-647-0050;
Email Efreedland@earthlink.net

2) EMDR and Energy Medicine and Spirituality
Chair, Irene Siegel
Phone: 631-351-1737;
Email Irene@allocca.com

3) EMDR with Children and Adolescents
Chair, Terry Becker-Fritz
Phone: 614-793-8833
Email: tbf@ee.net

4) EMDR and Medical Illness
Chair, Margarete Isermann
Email: Idinstitut@aol.com

5. EMDR and Peak Performance
Chairs, Nancy Cetlin and Cocoy Garcia
Phone: (Nancy) 781-237-0424
(Cocoy) 619-965-6777
Email: (Nancy) Ncetlin@Earthlink.net
(Cocoy) Cgarcia@Pacbell.net

In addition, there are two officially approved SIGS-in-Formation. They are:

1. EMDR and Psychoanalysis
Chair, Ruth Heber
Email: rthbr@bellatlantic.net

2. EMDR and Writing
Chair, Susan Borkin
Phone: 650-964-3732;
Email: sborkin@lanlogic.net

Did You Know??

EMDRIA finished the year with 3,590 members, worldwide.

CHILD AND ADOLESCENT SPECIAL INTEREST GROUP BECOMES OFFICIAL

By Marsha Heiman, Ph.D.

At the 2001 EMDRIA Conference held in Austin, Texas, the Child and Adolescent Special Interest Group (SIG) became an official entity of EMDRIA. Forty-eight people were in attendance as a Child and Adolescent SIG Executive Group was elected and goals were discussed to give direction and shape to the group's work.

Terry Becker-Fritz, who prior to the Conference took on the leadership role and responsibility of organizing members and filing an application with EMDRIA to become a SIG, was elected to be the Executive Chair of the group. The other chairpersons and working groups of the Child and Adolescent SIG are: Gary Peterson, Communications; Susan Packwood, Budget/Election; Mary Froning, Membership; Marsha Heiman and Laurie Donovan, Publications, and Suzie Carson, Training. The terms of office are three years, however during this start-up period, the terms will be staggered with some Committee Chairs holding office for 2 years and others 3 years, to avoid a total turn over in positions.

The Mission Statement of the Child and Adolescent SIG is as follows:

"The Child and Adolescent SIG of EMDRIA is dedicated to networking and sharing information among professionals engaged in the practice and research of EMDR with children, adolescents, and their families. Through education, advocacy, and collaboration, the Child and Adolescent SIG seeks to enhance the use of and promote the access of EMDR to children and adolescents."

The following goals for our first year are to: 1) structure and organize the Child & Adolescent SIG; 2) build our membership; 3) create a brochure for the public and other professionals explaining the use of EMDR with children and families; 4) create and maintain a child and adolescent discussion list; 5) increase training workshops on the use of EMDR with children and families at the EMDRIA conference; 6) increase the visibility of child and adolescent topics and issues in the EMDRIA newsletter; 7) create a Resource Packet for professionals using EMDR with children and families; and 8) begin the process of developing an annotated bibliography on published articles related to the use of EMDR with children, adolescents, and families.

We encourage EMDRIA members who work with children, adolescents and their families to join the Child and Adolescent SIG. The only requirement is that you are a member of EMDRIA. Currently we have 77 members. Those wishing to join should contact Mary Froning e-mail: maryfroning@compuserve.com or (202) 244-9194.

We also invite current members of the Child and Adolescent SIG to participate in our discussion list. Members can access the list serve through: http://groups.yahoo.com/group/child-sig. To subscribe to the list, go to the website and click on "Join" and follow the instructions. The list is open to Child and Adolescent SIG members only. This discussion list provides a valuable service by allowing professionals to network with one another. We encourage members of the Child and Adolescent SIG to utilize this new and valuable resource. Updates on our activities will be periodically posted on this website.

In keeping with our stated goals, Laurie Donovan will be recruiting and soliciting articles for consideration to the EMDRIA newsletter. If you are interested in submitting articles of potential interests regarding children and adolescents, please contact Laurie Donavan at ldonovan@austin.rr.com.

The Child and Adolescent SIG will meet annually in conjunction with the EMDRIA conference. Our next official meeting will convene in San Diego in June 2002. A description of the tasks and responsibilities of each working group is posted on the discussion list website.

If anyone would like to work on a committee of the Child and Adolescent SIG, please contact the Chair of that particular working group:

Executive Chair:
Terry Becker-Fritz
(e-mail: tbf@ee.net)

Budget/Election Chair:
Susan Packwood
(e-mail: spackwood@hotmail.com)

Communication Chair:
Gary Peterson
(e-mail: gpeterson@pol.net)

Membership Chair:
Mary Froning
(e-mail: maryfroning@compuserve.com)

Publication Co-Chairs:
Marsha Heiman
(e-mail: marslh@aol.com)

Laurie Donovan
(e-mail: ldonovan@austin.rr.com)

Training Chair:
Suzie Carson
(e-mail:scarson@iwaynet.net)

We welcome your input and your participation as our group moves forward.

Australia

Mark Grant speaks to us from Australia:
"I have been meaning to write to you and just say the EMDR community here were saddened by the events of September 11, and send our support and prayers to the many of our association who are involved in helping those affected. Like everywhere in the world at the moment, there is renewed awareness in our country of the effects of terror and trauma and ways of treating these, such as EMDR. The association has fielded an increasing number of requests for referrals to EMDR therapists, particularly from Vietnam Veterans and emergency personnel triggered by the events of Sept 11 and the war".

Belgium

Ludwig Cornil tells us that he thinks that EMDR-Belgium is going in the right direction. They have unified the Flemish and French speaking parts of the country in the common goal of optimally applying EMDR "to help people be freed of their past and move into a future where they can be themselves again". In October 2001, Ludwig is giving a talk about the research on EMDR called "EMDR, science or pseudoscience"? As he went through his preparation, he said "I really feel a deep appreciation and gratitude for all the energy she (Francine Shapiro) invested on her mission". A thought that we in the EMDR community would –I believe- all echo.

Canada

David Hart writes that on October 26-27, the Vancouver EMDR Conference convened. He writes that this particular program is an excellent one and drew participants from neighboring provinces as well as the United States. There were 144 early registrants. EMDRAC administrative business was conducted at this time and a new Board was elected. David is proud that his association continues to grow and now has about 320 members. He adds that "Otherwise, the activity continues to be the unpublicized work of EMDR clinicians doing what they do best: treating their clients with the best available techniques". EMDRAC's website is http://www.emdrac.ca.

Ecuador

Elsy Carvalho reports that she did a presentation at the Third Latin America Congress on Psychotherapy, on "EMDR, pictures and metaphors." This was the first time that EMDR was presented in this type of forum and 450 people were present. The presentation and EMDR were well received and Esly was asked to present her work at the Third World Congress of Psychotherapy when it is given in Vienna, in July 2002. More EMDR trainings will be given in Quito this year taught by John Hartung and Ligia Piedrasanta.

Finland

Soili Poijula, a long time aficionado of EMDR, reports that EMDR-trained therapists are growing due to the active organization that she was seminal in beginning. Their national list serve has been very active of late subsequent to the September 11th disaster. She says "We are now waiting for lessons learned from using EMDR after national trauma and under ongoing threat of terrorism".

France

Sue Rogers states that she, Barbara Korzun and David Servan-Schreiber completed a HAP training in Annecy for the Transcultural Psychosocial Organization. They spent time discussing cross-cultural application of the protocol with participants from Uganda, Burundi, Algeria, Cambodia, Eritrea, Nepal and Suriname. Sue was pleased with this meeting and the fact that they were able to "field test" a new HAP manual and some variations in the protocol.

Germany

Michael Hase writes in that a psychology student has been doing research on ten of his patients. She is interested in how the patients experience the EMDR process. In her very, very preliminary findings, she has described marked effects in his patients' satisfaction with their therapy and an increase in their self-esteem.

Helga Matthess, who has taken on the administration of HHP-Germany, a humanitarian assistance organization, writes that this group has been quite busy. She would like to thank Arne Hofmann for providing free trainings for the HHP guests. Recently, HHP-Germany invited a Croatian and Chinese psychologists to attend EMDR trainings. They are hoping to provide trainings in Croatia and China in 2002. Helga is organizing a curriculum for trauma therapy including EMDR for her analytic institute This will be the first trauma curriculum in an official, government-recognized institute in Germany for psychologists. She is also teaching in the Psychosomatic Department of the University of Cologne.

Recently, there was an EMDR conference in Bielefeld with 80 participants. The program consisted of experienced German EMDR practitioners: Veronika Engel on stabilization; Helga Matthess on PTSD in Cancer patients; Wolfgang Woeller on EMDR with therapy of personality disorders; Michael Meusers on Neurobiology of Trauma; and Toddy Sochaczewsky about structures for the training of child therapists. At the meeting, there was a great deal of discussion about the structure of trainings. Also, the Board was selected: Christine Rost, Franz Ebner, Arne Hofmann, Peter Liebermann, Wolfgang Woeller, and Michael Muesers with Veronika Engl as President. Veronika was unanimously voted into office and Helga thinks "She is integrating a lot and everyone is thankful!" There are now more than 350 members in EMDRIA-Germany. Currently, there is a great deal of preparation in progress for the EMDR European meeting that will be hosted in Frankfurt next May. Christine Rost is the main coordinator.

Luise Reddemann reported that Sam Foster gave "an inspiring presentation" at the "Klinik fur psychotherapeutische und psychosomatische Medizin in Bielefeld this October called "From Trauma to Triumph, Peak Performance and EMDR in the Treatment of Traumatized Patients". Luise's book "Imagination als heilsame Kraft: Zur Behandlung von traumafolgen mit ressourcenorientierten Verfahren" has been selling well in Germany and we are waiting for it to be translated into English.

Holland

Ellen Latenstein has been active subsequent to September 11th. She has been working with 2 people from the Netherlands who were close to the WTC. They were referred to Ellen by the Dutch Institute for Psychotrauma. She has already done CISM and will be using EMDR in the future.

Israel

Rony Berger is the Director of Community Services in Natal and The Israel Trauma

Center for victims of terror and war. He has been training professionals in trauma services on the average of 2-3 workshops per week and has been involved with most of the terror incidents by working with staff and victims.
He is on the international faculty of the NYU Trauma Program and has been involved in the response to the September 11th disaster in the United States. His group in Natal has developed an ecological community-based program with many specific interventions; the latest is called personal debriefing. In December, he will be in New Orleans at ISTSS and later in NYC to do presentations on this new approach.

Alan Cohen came to the United States for the first two weeks in September to talk to Jewish communities, media and special interest groups such as Universities, professionals, concerned Christians, etc. about the effects of terror on Israelis. After September 11th, he reports that the emphasis changed and people were taking a much more active interest in what he had to say. EMDR was one of the trauma treatment methods that Alan mentioned when he was interviewed by the media. "Terror continues here, so I continue to use EMDR with the victims of (one of) the latest incidents in Afula – a terrorist dressed up as a soldier opened fire killing and wounding..." Alan has been working with the victims of the wedding hall disaster. As he says, "as you can imagine even four months later there are still problems".

Fran Fettman was in Israel in August in her capacity of Hadassah Board Member. She spoke to the Assistant Director of Hadassah Ein Karem and to Dr. Estee Gallily, head of Pediatric Psychiatry, about EMDR. They were interested in getting their staff trained and have been referred to the solid staff of EMDR-Israel.

Elan Shapiro is proud of the infrastructure that the hard-working Israeli team has set up so that there are many EMDR clinicians available at this time. Their team is self-sufficient and there is an increasing demand from mainstream mental health care workers. EMDR-Israel is doing in-service training that is structured as a 40-hour course with a follow-up bridge day and supervision to reduce dropouts.

Gary Quinn noted that trainings in EMDR have been frequent in Israel. Udi Oren conducted a training in the North of Israel and Gary will teach in Jerusalem to education psychologists that will include people from Yehuda and Shomrom on the West Bank. Eva Eshkol and Gary are also treating a group from the Versatile Wedding Hall Disaster.

Fran Yoeli tells of an in-house training for the north-western clinics in Israel. She reports that there were 50 participants –mainly educational psychologists- including 20 percent who are Arabs. This was the largest proportion of Arabs at an Israeli training. Her EMDR Consultation group is motivated and "being primed for working with the traumas and anxieties that we are soon going to face even more".

Japan

Masaya Ichii reports that several trainings recently occurred in Japan. He wants to thank "all staff members, including the senior trainer Andrew Leeds, the excellent US guest facilitators Carol York, Curtis Rouanzoin, David Wilson, Rosalie Thomas, Caroline Sakai and the excellent Japanese facilitators, Eiko Sakio, Shigeyuki Ohta, Kiwamu Tanaka, Masako Kitamura, Masamichi Honda and himself".

Lebanon

Peggy Moore writes that during her latest trip to Lebanon, Therese Khalil, the only EMDR-trained therapist in this country, was her hostess. The leading psychiatrist in Lebanon, Dr. Ellie Karam, invited Peggy to speak at the journal club that he leads at St. George's Hospital in Beirut. Dr. Karam was intrigued with EMDR and the work of and endorsement by Bessel van der Kolk. For the next journal club, Dr. Karam has asked his staff to do bibliographic research to discuss the pros and cons of EMDR.

The Palestine Authority

Roy Kiessling reports the following concerning trainings in Gaza and Ramallah: "I continue to marvel at the commitment of the EMDR community and the adaptability of the EMDR process to cultures through out the world. We had a very successful training that was surely enhanced by the EMDR process itself and, personally IMO, from the efforts of our HAP team (Jim Knipe, Judith Daniels, Peggy Moore, and Joany Spierings).

Bill Thompson, the overall event coordinator (trained in EMDR and CISM) has been working since 1995 to schedule these trainings and secure funding (eventually provided by the Palestinian Children's Relief fund headed by Steve Sosebee). In addition to the EMDR Level 1 training, there was a concurrent CISM training being conducted by Mike Murphy, an associate of Bill's and a CISM Certified Trainer.

Jim Knipe was our overall HAP logistics coordinator - greatly beneficial in allowing me to concentrate solely on the Level 1 training duties. Peggy Moore, Judith Daniels and Joany Spierings (along with Jim) worked tirelessly in supporting me and facilitating the small groups (where the EMDR integration really occurs). In addition to the basic Level 1 components we offered specialty workshops on pain (Jim), children (Judith and Peggy) and grief (Joany). Overall we were very excited about the participant's commitment and eagerness to use the information we had provided.

We trained 28 therapists in Gaza (Gaza Strip) and 36 in Ramallah (West Bank) in EMDR. The CISM training was being held concurrent with our EMDR training in the opposite city. Surprisingly, amidst all the potential distracters, the trainees were focused on learning our protocols (both CISM and EMDR) for the 9-day training schedule (four days for each, EMDR & CISM with one day off in between).

The therapists in both areas treat mostly adults, and children suffering from recent and chronic trauma. In many cases, several generations are living within the same home - so the trauma is often multigenerational. Grief, recent trauma, and pain are common place. Issues of low self-esteem and depression are also present. It seems especially difficult for the children in that many of there primary caregivers (and extended family members for that matter) are themselves suffering from PTSD, pain, grief, depression, or a sense of hopelessness.

All-in all, we felt very uplifted by our efforts as well as the enthusiasm and friendliness of the Palestinian participants. We left with great hope that EMDR will greatly assist the Palestinians in their healing process." Judy Daniel's perspective was the following:
"I returned from an EMDR HAP training, two weeks in Palestine, that was a life changing experience for me. Was grounded on the way home in Southern France on Sept. 11. It was a fortunate insulation from the American experience, as I was processing the previous weeks and benefited form the insulation of Europe.

I am still sorting it all out: the amazing cohesion of our team, the receptivity of the Palestinian therapists, the several young children I worked with there, and the extreme examples of trauma that the Palestinian therapists came up with during their practicum. I think the training was a huge and timely success".

Cont. on Pg. 26

Cont from Pg. 25

Bill Thomson wrote a brief summary of the training. Bill was the person responsible for the training and has spent many years in making this happen.

"From August 24 through September 6, 2001, Roy Kiessling, Judith Daniel, Joany Spierings, Peggy Moore and Jim Knipe were in Ramallah and Gaza City (Israel/Palestine) conducting a Level 1 training with Palestinian mental health professionals. Simultaneously, Mike Murphy and Bill Thomson conducted a Critical Incident Stress Management (CISM) Basic Training, certified by the International Critical Incident Stress Foundation. Each training was a total of approximately 16 hours at each venue, and the participants included primarily social workers and psychologists, but also included pharmacists, pediatricians and public health professionals.

Participation at each site was exceptional, with approximately 30 participants in Ramallah and 40 in Gaza City. The students were enthusiastic, with a real eagerness to develop tools to deal with the ongoing trauma being experienced by Palestinian youth. Anticipated language differences were wonderfully handled by translators and did not get in the way of learning or teaching.

The project was under the overall direction of Bill Thomson, and was primarily sponsored by the Palestinian Children's Relief Fund, with significant material contributions from Francine Shapiro and the International Critical Incident Stress Foundation. In addition, contributions were also received from Mike Farrell, the Vidal Sassoon Foundation, Mona Younis of the Joyce Mertz-Gilmore Foundation, and the Palestine Aid Society. We are most appreciative of the efforts of the trainers, participants and contributors, which led to the outstanding success of this project.

Follow up includes ongoing email consultation and plans to provide live supervision and advanced training next summer. In addition, plans are under way to further adapt the training to Arab culture and expand training into other parts of the Arab world."

Poland

Barbara Anderson continues her fine work in Poland with the assistance of Susan Rogers who is a HAP trainer. In early May, they conducted a training in Warsaw. She is looking forward to conducting an advanced training.

Sweden

Kerstin Bergh Johannesson notes that EMDR has received approval by the members of the Psychology Specialist Council. This means that EMDR training will be an elective for the Swedish Clinical Specialist Training Program. In June, Kerstin reports that they had their first Supervisory Training at a beautiful old castle close to Uppsala for 10 participants. Joanne Morris Smith from Great Britain and Reet Oras, a Swedish facilitator, will give a workshop on "Children and EMDR". Debbie Korn will be discussing "Dissociation and EMDR" in a workshop in Stockholm at the end of October.

Switzerland

Hanne Hummel reports that she and Raimund Doerr , although living in Switzerland, are dealing with their own patients who have been traumatized by the events of September 11. They have been interviewed by newspapers on trauma and how to treat trauma. The office of the EMDR Association. (Verein EMDR Schweiz) in Switzerland has a new address: Verein EMDR Schweiz,c/0 Dr. med. Werner Schneider, Hauptstrasse 82, CH- 4132 Muttenz, Switzerland, Tel:+41-461 56 00 Fax: +41-461 56 65 info@emdr-schweiz.ch, www.emdr-schweiz.ch"

United Kingdom

Sandi Richmond has been using a small group format to teach EMDR with great success. The format allows people to practice concepts as they go which helps them master skill sets by the time of a 4-6 week follow-up. Most of the trainees continue in supervision groups so they have great support "to get going". She notes that people are amazed at the results. Sandi conducts 2 supervision groups at the Maudsley and will give a presentation on EMDR at University College, London University.

John Spector proudly reports that the 2nd EMDR Europe Conference was held in London in May and was a great success. The general theme was "Innovations in EMDR" and there were 19 presenters from 12 different countries. There was a separate track on Children and EMDR. Many of the presentations will be reproduced over the year on the EMDR Europe web-site. The annual conference will take place in Frankfurt, Germany in 2002 and in Rome, Italy in 2003.

United States

California

Sam Foster reports that she and Karen Kleiner are consultants to SAGE (Standing Against Global Exploitation), an innovative program that helps women and girls leave prostitution and the sex industry. In August 2001, they organized a presentation on their work with the women and girls in this program. Karen described how EMDR has been used to train volunteer practitioners to treat the underlying trauma that is often found in the participants' histories. SAGE is the recipient of the prestigious Peter Drucker Foundation Award for innovative work by a nonprofit organization and the Oprah Winfrey Angel Award.

Sandra Paulsen writes in that she is having a busy fall presenting on Ego State Therapy in Boston and on EMDR and Dissociation at the ISSD Conference in New Orleans in December.

Liz Snyker and Roy Kiessling conducted a beginning training in June at Camp Pendleton, a major Marine Base in San Diego County for ten staff members of their Treatment and Intervention Unit. They even converted one or two of their diehard skeptics!

Colorado

Sandra Wilson reports that she and Bob are doing their first EMDR child trainer's training for therapists from Germany, England, Israel and possibly from Canada and Sweden.

Florida

Carol Crow has been busy in Tampa. She was on a local feature TV call-in show with a client who was a police officer. The client was very articulate and shared the transformation that was part of his EMDR experience. Even though he was doubtful at first, he was convinced after his treatment with Carol. Carol is looking forward to the first training in Tampa in January 2002. She will present an "Overview of EMDR for Professionals" at her local Counselor's organization in October to alert the Tampa community to EMDR ad the up-coming training.

Sherrie Raz notes that she lives in Boca Raton and is quite concerned about the panic there concerning the Anthrax scare. People have been rushing in to resolve stress reactions. Politically, she is part of a group trying to get legislation to appropriate funds for a Traumatology Institute to train EMDR, Firefighters and Police in Stress Innoculation. She is going to Washington to lobby for funds.

Hawaii

Darlene Wade writes about the effect of September 11th in Hawaii:
"Terry (Wade) and I did 3 days of CISD work

with Northwest Airlines following 9/11. The effects have rippled to our small islands. Our paper reported we are 4th in the country in economic impact from the tragic events of 9/11, behind Las Vegas, Orlando, and Dallas. Our hotels are reporting more than 2 million per day losses and our two large inter-island cruise ships stopped cruising as of today after filing bankruptcy".

Michigan

Zona Scheiner writes that there are 3 regional committee meetings scheduled to meet with therapists who need an opportunity to debrief the events of the last couple of months. Regional Coordinators are in the process of forming a disaster response network. Ann Arbor EMDR therapists are bringing in Roger Solomon to do a training on CISM and EMDR which will increase the availability in the local area for people able to provide disaster treatment in both CISM and EMDR.

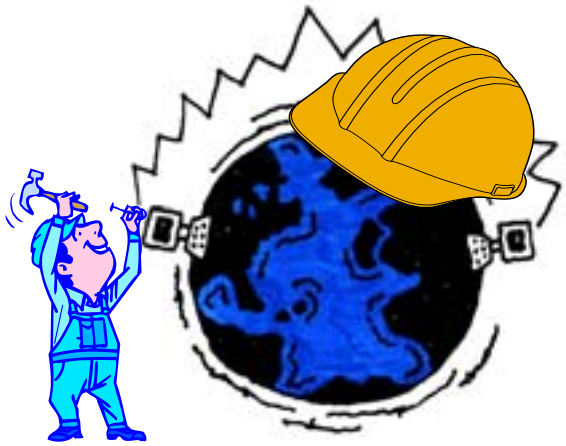
Ohio

Suzi Carson reports from Columbus that in this area there are four trained EMDRIA Consultants. These Consultants have mobilized their Consultation groups to volunteer to donate time to HAP. One of the groups is at Children's Hospital, a center that serves residentially placed children and foster care. Through Suzi's expert support and her consultees willingness to try something, they are overcoming their fear of using EMDR and the patients are doing well. This agency was the first to hire a Senior Trainer from the EMDR Institute and train most of their clinicians (17). Since 1993, Kay Werk has sponsored a monthly EMDR meeting. More clinicians are promoting EMDR and Suzi is delighted that there is a growing group of such well-trained clinicians who are experienced with adults and children. She thinks that in about three more years they will have "an awesome group" here.

William Harrar writes in that he is scheduled to give a presentation to the Association of Counseling Center Faculty (ACCF) in October 2001 on "EMDR and College Students. This association includes professional staff from counseling centers of the Pennsylvania State System of Higher Education (SSHE) across 14 campuses.

There is a flurry of activity at the Coatesville VA where Susan Rogers, Steve Silver and Elaine Alvarez work. Sue notes that she and her team are nearly finished with their data collection for the VA-funded component study of EMDR. She has done two Continuing Education presentations about EMDR there and their research assistant, Melanie Cerone presented on her dissertation, "Eye Movement Desensitization and Reprocessing in the psychological treatment of combat-related guilt: A study of the effect of eye movements ". A poster was presented for ISTSS and will also be presnted in a continuing education session at Coatesville this spring. Steve, Elaine and Sue did their annual HAP VA training in October with participants from 17 VAs. The VAs of Coatesville, Philadelphia, Baltimore and Perry Point "generously" donated to HAP. Sue continues to say that these pro-bono trainings have been running since 1995 at least once a month and are available to any VA clinicians. During October 2001, Sue presented on EMDR research at a VA conference on PTSD in Maryland.

Website Construction Underway



As you may have noticed, the EMDRIA Website is going through some changes, and some areas may not be accessible at times during the next few months. We are in the process of updating and redesigning our entire website in order to be able to disseminate more information about EMDR and our Association and also to make it more user friendly. Please be patient with us for the next few months as we go through these changes. If you need information about something that you cannot find on our website or if you have any questions, please feel free to call our Administrative Office at (512) 451-5200, and someone should be able to assist you. Thank you for your patience.

The Conference Corner...

Gayla Turner,
Conference Coordinator
Associate Director

We are on our way for the 2002 EMDRIA Conference! June is really not that far away. The Registration Brochure is scheduled to be mailed out at the end of January or the first part of February. You should find all the information you need about the schedule and all the events in that brochure. Information will also be available on our website around the same time.

For those of you who have attended our Conference in year's past, you will notice some changes this year. The location of the hotel is isolated from nearby restaurants, shopping, etc. So this year, your lunches will be provided for you and included in the price of your registration, so you will see a slight increase in the registration fees to cover those expenses. We've also decided to hold the annual Awards & Recognition Banquet during the lunchtime on Friday, so that everyone is able to attend. The Pre Conference, which we instituted this past year in Austin, will continue this year. We had such a good response to it last year that we've decided to make it part of our regular schedule.

We are excited about this next Conference and hope that you will all mark your calendars and plan to join us in San Diego, June 20th through June 23rd.

Mark Your Calendars NOW for Next Year!

2002
EMDR International Association Conference

to be held in

San Diego, California

at Loews Coronado Bay Resort
(800) 815-6397

June 20-23, 2002

Letters from New York:

The following are letters received by Marilyn Luber in response to the events of September 11. They are published as received, and show the "emotion and "call to duty" that most clinicians, and the public as a whole, felt in the aftermath of these days. We would like thank each person for their candor in sharing these stories.

Cindy Browning tells us of her experience concerning September 11th:

"On 9/11, I went to pick up my daughter, and because we live in a NYC commuter town, and many folks here work in the financial industry, the scene at the school was unbelievable. There were many fathers there (unusual) and mothers who are ordinarily at work and they were there because they narrowly escaped death themselves or were witnesses to the whole thing first hand. They were all just spewing their stories all over the place. It really seemed like a war zone triage center. They were shell shocked . And, of course, there was the dawning realization about which fathers were not there, the sickening look on the yet unidentified widows' faces....

So I went home and called all local EMDR folk whom I know to be competent and asked them to be ready to volunteer services. All, of course, agreed. I quickly wrote a fact sheet (What are the symptoms of trauma, what is EMDR, & how can I access it?) and began to distribute it to our local folks (Red Cross, EMTs, police, schools, superintendent, local clergy, and the mayors). I was invited to a few town meetings with all emergency personnel so that I could explain this. I've emailed the fact sheet far and wide. Interestingly, it has been a pretty effective means of reaching out to people so far. I've gotten several calls each week since, and have either taken the cases myself or been able to provide referrals for them to the local folks I mentioned. We've gotten folks from each category: Survivors of the tragedy, the bereaved, and emergency service personnel. By week's end, I had joined forces with William in NYC and Barb at HAP and informed folks here that our local effort is part of a larger network as well. My community is so hard hit that I'm still involved in efforts to get the word out about trauma and EMDR (e.g., I have a meeting at a local church after services today for any who are interested in attending).

I have two supervision groups that meet monthly which met the Friday after the tragedy. We spent our time reviewing the recent events protocol and they practiced it with each other. As always, the members found this helpful in dealing with their own trauma about the incidents and felt better prepared to deal with the traumas of their clients. We continued this practice this month at our meetings. I also meet with this group monthly now (pro bono) for consultation.

So far, for now, that is all that is actually happening.

Mark Dworkin CSW, LCSW
The Long Island EMDR Response To The World Trade Center

She was standing on the 15th floor of the Verison Building, on 50th street, facing south, when the unthinkable happened. There was an explosion! One of the World Trade centers was in flames. Billowing smoke poured out of the building. Then to compound this unreality, she witnessed human beings leaping to their death. Standing there with her co-workers, stunned and horrified she whispered, "This cannot be happening; it must be a living nightmare".

Moments later this unbelievable scene grew to proportions unimaginable outside of a horror movie. But this was real. It was all too real, and yet it couldn't be so. But it was, and it became even more traumatizing. They all saw a plane smash into the other World Trade Center, with a fireball coming out the other side.

That evening, after seeing my full load of clients for the day, an old patient called me, imploring me to see this young woman immediately. Though she did not live in my area, she was at her mother's house, in hysterics, just a few short blocks away. Over the next two days I helped her get stabilized, using many advanced EMDR techniques (Thank you Andrew and Debbie)!

She then returned to work and was referred to an EMDR clinician I have known and trusted. She has been doing well since then.

Our nation was caught unprepared. We had never seen the likes of this tragedy on our soil. Many of the Long Island Regional Coordinators met and began developing a treatment delivery system which we are now implementing, with Carol Forgash being the designated Long Island Mental Health EMDR Disaster Response Coordinator for HAP.

Those of us who are Approved Consultants and Instructors for EMDRIA will be assisting our generous clinicians. Carol will be the coordinator of Consultation Groups. Since Uri Bergman, Bev Wright and Carol have been running one in Western Suffolk, it will be the first up and running. I am now negotiating for enough space in central Nassau County. I will be running a consultation group there as well for clinicians who have volunteered to help. As a committee member of the Standards and Training Committee, I asked for clarification as to whether these consultations could be used towards becoming Certified in EMDR. The committee, headed by Curt Rounzoin PH.D gave an immediate and unanimous YES!.

Many clinicians throughout the country have been e-mailing, and calling Carol and myself, and other Regional Coordinators, offering their time and service. I want to acknowledge them on behalf of all of us. We may not need you yet, but when we do, it is heartening and comforting to know you will be there.

Carol Forgash who is the Long Island Disaster MH Recovery Network Coordinator writes:

"Here on Long Island, as in many areas in and around the NYC metropolitan area, we are preparing for the long range situation in which people will be recognizing symptoms of post trauma stress, and requesting treatment in stages over the next two years. Additionally, by readying our database now, offering education and support to each other, we will all get though this time with much less stress to carry. We will also be prepared for the range of disasters which can occur anytime.

Here on Long Island, I connected with the Executive Director of the Long Island Volunteer Center when she called me the day after the WTC tragedy, asking for an EMDR referral for her neighbor who had walked down from the 86th floor of tower one and was already very distressed. I gave her someone in her area, and then asked her if she knew how we could get a permanent data base of EMDR therapists on Long Island for this and future disasters. She volunteered her staff. The next step was to find an agency to take our referral calls and we now have a permanent call center as of this week. The Mental Health Association in Suffolk County

which will field all referrals for EMDR therapy for all of Long Island..(pop. 2.6 million).

We have incurred many losses in communities all across the island and people have already received EMDR treatment. I have seen one person who was evacuated from a nearby building and led people across one of the bridges, urging calmness and strength. She is a current client who had been suffering from panic disorder prior to her treatment with EMDR. She did not experience any panic during this experience. She came in for a regular session in the evening of 9/11 and wanted to process the event (which she was able to do quickly). One week later, she was feeling survivor guilt (SUD of 6), after she heard several days, later that one of her friends died in the tower. One single session was needed to eliminate the problem and she was able to leave on a planned vacation with enthusiasm.

We are very fortunate in our Long Island EMDR community to have many clinicians involved in this project. Uri Bergmann, Mark Dworkin, David Grand, Fran Donovan, John McDonough ,Valerie Sheehan, and Beverly Wright have taken a leadership role with our regional planning and to support HAP. Our plan on Long Island is to offer education and support to level one and two trained EMDR clinicians, as many people will be seeing disaster survivors over the coming months. There will be a variety of groups available in the region. On-going education and therapist support will come through monthly no fee study groups. There will be a debriefing group for any EMDR therapist who wants to process their responses to the events of 9/11.There will be several short term consultation groups for those working with disaster victims, and family members."

Ruth Heber says the following:
"I am on system overload big time. Most of my activities revolve around treating my own patients, all of whom have been impacted in various degrees by the attack on WTC and some pro-bono patients. I have given several workshops on Crisis Intervention, Critical Incident Management, etc. etc., reviews of recent event protocols, trauma protocols, etc., and "debriefing" of therapist who have been secondarily traumatized. A big treatment issue revolves around management of earlier traumas that have been activated through this event and must be dealt with - I'll have much to say about it in the days to come".

MaryAnn Male and Theron C. Male writes in the following:
"On the evening of September 11th we responded to a call to drive to Port Jervis, NY to be ready to do trauma work with clientele of various corporations in New York and New Jersey, who were directly affected by the terrorist attack. For most days of the next three weeks we were privileged to work with three different companies who lost employees, and also had survivors of the attack on the World Trade Center. We worked with hundreds of people who were affected directly or indirectly and traumatized in varying degrees. We saw clients in groups and/or individually. Many of the clients were suffering from Acute Stress Disorder. Survivors had varying responses pending their past trauma profile and their coping styles. In all cases we explained EMDR as a viable solution if their recovery did not progress toward their pre-incident baseline status. We made available to the company and the employees, a list of the "Certified" EMDR therapists in varying locales that would serve the need of the employees. We are still working with one company who is in temporary quarters awaiting their return to their former work place adjacent to "ground zero".

While we have been doing "trauma response" group and individual sessions and not formal therapy, we did make use of our CISM for EMDR Therapists training with Roger Solomon, Ph.D., who has formulated the "One-two Punch" model of utilizing "Mitchell Model Debriefing" with abbreviated EMDR intervention. In a few cases, survivors could not rid themselves of flashback pictures that were intruding throughout their day. In these cases, we gave an in-depth explanation of EMDR. After establishing a "stop" and "safe place" protocol, we did a brief EMDR set on one picture. We explained that it was necessary to continue with an EMDR specialist and did follow up with the employee at a later time. All had a positive experience and said that they would continue with an EMDR therapist. We will be seeing these people again and will continue with the follow up. All were encouraged that they could indeed work through their trauma with EMDR. We continue to find EMDR an invaluable "tool" in various settings regarding healing traumatic experiences from many sources".

Geraldine Costa reacts to September 11th:
"September 11th changed the world and engaged my crisis and EMDR skills "overtime".

As a NYC clinician in Lower Manhattan, we have all been directly effected personally and clinically.

My primary concern was for my private patients whom I contacted immediately to "check-in" and to switch our appointments to telephone sessions, if need be. My office is also in the "below 14th Street restricted zone", travel to and from the area creating anxiety and uncertainty. Knowing I was not far from the WTC area, many former patients called me to insure that "I was all right and to give themselves a chance to "reconnect" immediately to come back in for reprocessing. Others called to bring in their school-aged children for an EMDR check-up. I found I was using more EMDR over-all in my private practice.

Since I am a certified Expert in Traumatic Stress as well as an EMDR clinician, I received many calls to help with the Trauma work. I was called many times by Crisis Care Network to do critical incident debriefing and EMDR at several locations.

I manned a trauma hotline for Corporate Counseling Associates, an EAP for over 130 corporations. I also went with them as a facilitator to a Coping with Crisis meeting for 900 of the 3500 staff of Empire Blue Cross/ Blue Shield which had been housed in the WTC.

Duke University Medical Center contacted me to meet with the regional district managers of Glaxo Smith Kline, the pharmaceutical company. Their sales reps were exhibiting anxiety, emotional paralysis, and "resistance to calling on NYC clients. I did a psycho-educational conference with them on Terrorism, Stages of Traumatic Reaction, and also offered information and treatment resources of biochemical warfare on the general population as a real or imagined trauma.

I introduced EMDR, explaining what it is, how it developed, its underlying bi-lateral neurobiological foundation, and the format of processing. I gave a brief demonstration and took "out of the box" questions! The district managers were encouraged to contact their EAP representative (to whom I had already spoken) about appropriate EMDR referrals.

With the advent of the Anthrax scares, the general anxiety state in NYC has been heightened. Patients are uncovering old fears, earlier traumas, and uncertainties. Of course, EMDR is being used to clear them.

Cont. on Pg. 31

Cont. from Pg 30

In the meantime, I have been putting some of my own issues on hold while doing processing and healing. Away from my work, I feel a profound sense of sadness and loss leading me toward a basic reassessment of my life".

Judith Ruskay Rabinor, the Director of the American Eating Disorders Center of Long Island writes the following:

"Since September 11th, I have been working at Marsh and McLennon, an insurance company that had occupied 7 floors in the WTC and lost 300 of its 1200 employees at that location. I have done crisis intervention with survivors and grief and trauma counseling with co-workers and families of survivors. Larry Wetzler and Nancy Bravman have also worked with Marsh employees".

Sherrie Raz rushed to NYC with her trauma team and writes the following:

"I was up in NY with my team after the attack for one week at ground zero. Really difficult. Two from my team went into the hospital physically ill and 4 had to start on antibiotics. We worked 16-hour days with thousands (literally) in groups and singles. These were survivors and families and those that worked in the building at the time and off time. Also, those in the adjacent buildings who witnessed the attack. We were only 12. I used many of Peter Levine's techniques and a great deal of EMDR with the survivors. Who said it isn't effective immediately? The work was shocking from a research standpoint and how I would have loved to have done some research. As it was, I was terribly occupied and had to take care of my team on top of it all. Much to write. All I can say is that all who have contributed to EMDR techniques can be proud that they have helped so many resolve their immediate pain in this attack. Thank You all for giving me the tools to facilitate people in learning to healing themselves".

Sandra Shapiro recounts that the National Institute of Psychotherapy in NYC has been providing on-going support, lectures, and subsequent pro-bono psychotherapy for people experiencing difficulties after the September 11th disaster.

Beverly Wright reflects on all the work that she and her team have been accomplishing in the New York City area:
"Here in New York there have been a number of facets of our EMDR Disaster Response. Many of us were involved from the beginning doing CISD's with 1) The companies who had employees in the WTC, 2) those who worked in a near-by building and witnessed the plane(s) hit and/or people jumping from the upper levels of the WTC and eventually the building collapsing, 3) those who were evacuating from their buildings and having to run for their lives, 4) those who were part of the rescue efforts (fireman, police and ambulance corp) and saw their "brothers" fall and 5) all the families of those who were killed or were directly involved.

From here the circle of companies requesting counselors moved outward to include those who's client's were in the WTC, those who experienced bomb threats to their companies or a location such as Penn station where they needed to be, as well as those companies that felt that they might be targeted next, such as Federal Courts, the UN etc.

Most of the early work was either straight forward, defusing, or CISD's, and identifying those who might need immediate trauma work to enable them to go back to work, however some of our colleagues had the time and opportunity to use the recent events protocol on site.

Doing these CISD's and recent events work was different for most of us, in that it was the first time we had also been through some degree of the trauma ourselves. My feeling is that as we heard additional aspects of the trauma we shared, it made us more susceptible to vicarious traumatization. As we tried to be there for these employees and their families, we shared many of the trauma symptoms we spoke to them about. While our heads, at times, were in a form of shock or denial, our bodies were not. By the end of the day, my head ached, my stomach was in knots, my back ached and I was utterly exhausted.

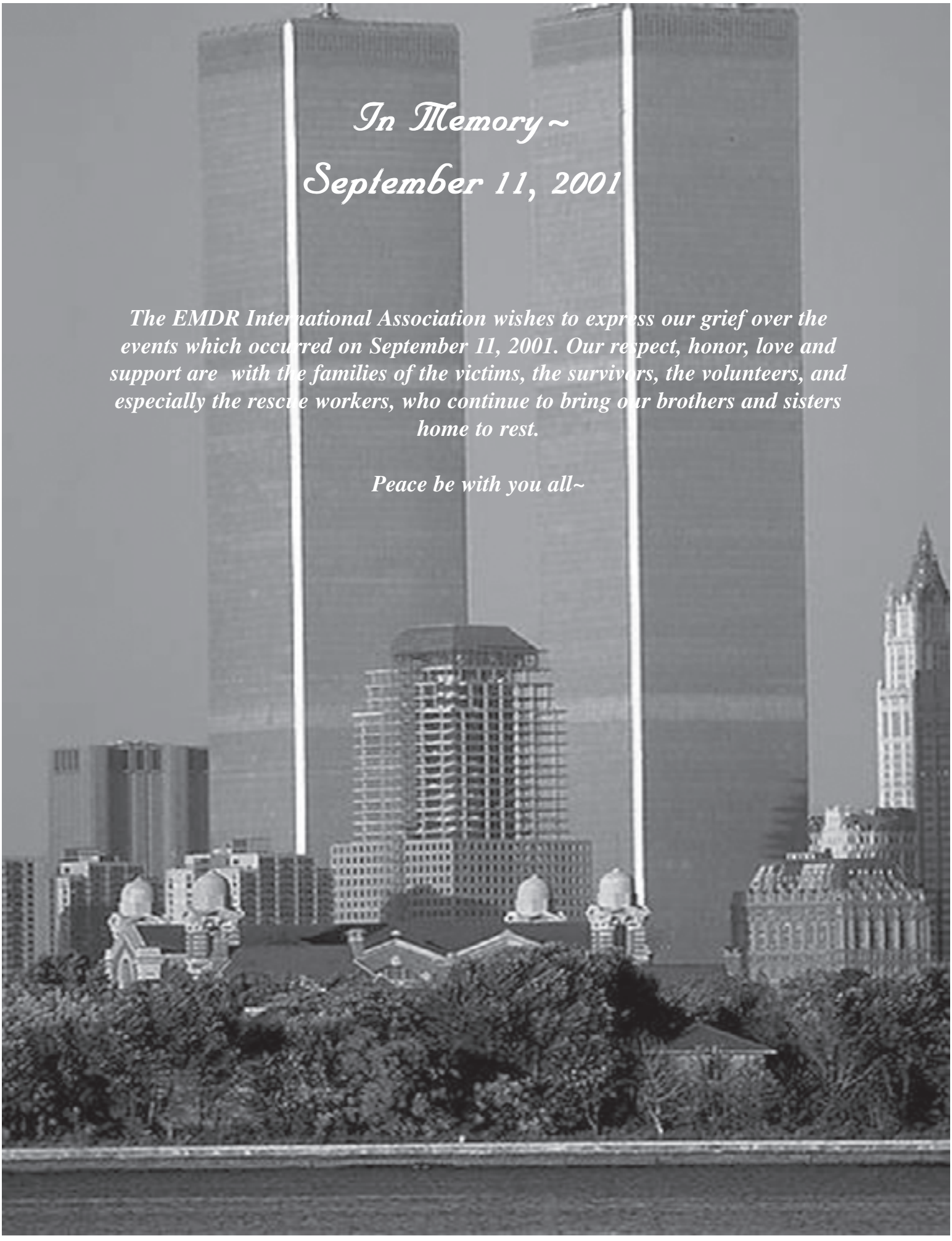
Many of us struggled with when it was time to call a halt to stretching ourselves so thin and exposing ourselves to the reliving of it on a daily basis. Just as we had instructed our groups, we needed to give ourselves mental breaks. That became very hard to do with the continuous news coverage and even back in our offices needing to provide holding environments for our clients. Fortunately, there were also some who thought to provide debriefings for us too.

The second wave of referrals from EAP's began on the second week and continues. Deb Korzun, Gina Colelli, and I discussed ways to assist the EAP's and at the same time introduce EMDR as the preferred method of trauma treatment. Barb is presently putting together a packet that can be sent to any EAP that calls the HAP office. Please pass the word.

In the beginning of November I'll be speaking to the LI EAP Association about EMDR and it's effectiveness for critical Incidents and trauma. I know that many others are also being asked to speak about EMDR at agencies and EAP's. Even insurance companies are no longer saying, "EM...what?"

We're now bracing ourselves for a third wave when the work is done the memorial services are over, the shock has worn off and for many PTSD's symptoms are evident.

We welcome support, prayers, and maybe even relief, at some point. It's so nice to know that there's a wonderful EMDR family out there to lean on".



In Memory ~
September 11, 2001

The EMDR International Association wishes to express our grief over the events which occurred on September 11, 2001. Our respect, honor, love and support are with the families of the victims, the survivors, the volunteers, and especially the rescue workers, who continue to bring our brothers and sisters home to rest.

Peace be with you all~

EXPERIENCES OF EMDR TREATMENT OF WORLD TRADE CENTER SURVIVORS OF SEPTEMBER 11

Uri Bergmann, Ph.D.

My experience in treating the survivors of the World Trade Center (WTC) disaster of September 11 has, to date, been comprised of three groups: those who witnessed the event from the adjacent streets of the Wall Street financial district; those who were in the World Trade Center, on the lower floors of the North Tower (first tower hit) and were able to escape rather quickly from the building; and those who were on the upper floors (75th to 50th), taking a lengthy time to get down the stairs and then witnessing the most horrific of events inside the WTC plaza and in the street, as the towers collapsed. To date, I have treated 21 survivors.

I began to receive calls for appointments on Monday, Sept. 17, 2001, with complaints of acute trauma symptoms and severe phobic reactions vis-a-vis returning to NYC, where their offices were being relocated.

Each of these clients were, initially, scheduled for two hours. Thirty minutes was devoted to history-taking and assessing levels of dissociation, with the remaining 90 minutes used for EMDR treatment. All knew something of EMDR. The initial referrals were from either previous EMDR clients or EAP's, and had been, consequently, briefed on the technique. Subsequent referrals came from the initial group that was treated, as they referred their colleagues and co-workers.

Given my daily practice experience of treating complex trauma including screening for and working with dissociation I felt comfortable modifying my usual evaluation procedure because of severity of symptoms and time constraints including many client's desire to quickly return to work. I spent about 30 minutes taking history, interweaving into the history-taking questions about childhood trauma, memory gaps, chronic psychomatic difficulties, experiences of derealization, depersonalization, fugue states, etc. These questions were taken from the DDIS and SCID-D. Others and I had used this modal for years in the treatment of approximately 150 railroad engineers who were involved in horrific critical incidents. For the first 20 people, "red flags" were not present and I opted for not formally screening for dissociation, but, rather, to assess the levels. The 21st client raised "red flags" and assessment was completed. I will describe my experiences with the first 20, breaking them up into the three groups mentioned above. Finally, I will describe my experience and the modifications that were needed for the 21st, given her history of trauma and dissociative symptoms.

The first group was comprised of those who witnessed the event from the adjacent streets of the Wall Street financial district. They reported seeing the airplanes crash into the towers, people being pushed out of the towers by the planes, people jumping out of the towers into the streets and people striking the street after their falls. They complained of intrusive thoughts and images, sleep disturbances, hyper-arousal, numbness and the phobic reactions vis-a-vis returning from the suburbs to the city. In all these cases the recent-traumatic-event protocol was used, with full desensitization and reprocessing in one 90 minute session. Note, for all three groups EMDR stimulation was continuous, throughout the session, delivered by either a mechanical tapping device or CDs with alternatingly lateralized sound or music. This appears to facilitate continuing information processing that is uninterrupted. It also appears to facilitate a more profound grounding during processing. These clients were seen for a 45 minute follow-up session, a week later, and reported no relapse of their symptoms. They were instructed to call if anything changed. None have, to date.

The second group was comprised of those who were in the World Trade Center, on the lower floors of the North Tower (first tower hit) and were able to escape rather quickly from the building. They reported feeling the sway of the tower as it was hit by the first plane, seeing the second airplane crash into the south tower, seeing people being pushed out of the towers by the planes as they hit, as well a resurgence of memories of the 1993 bombing of the WTC. Their complaints were similar to those of the previous group. In all these cases the recent-traumatic-event protocol was used, with full desensitization and reprocessing in two 90 minute sessions. These people experienced more than the previous group, i.e., frightening experiences as they made their way down the stairwells, the sounds of the tower as it was slowly swaying, buckling and breaking apart and witnessing the first dead bodies in the plaza as they headed or the safety of the streets. After desensitizing and reprocessing the "worst part", there were many other incidents to reprocess as the event was examined frame-by-frame. The event was run-through at full speed for the final desensitization followed by a run-through at full speed for the final installation. These clients were seen for a 45 minute follow-up session, a week later, and reported no relapse of their symptoms. They were instructed to call if anything changed. None have, to date.

The third group was comprised of people who were on the upper floors (75th to 50th), taking a lengthy time to get down the stairs and then witnessing the most horrific of events inside the WTC plaza and in the street, as the towers collapsed. In these cases the recent-traumatic-event protocol was used, with full desensitization and reprocessing in three 90 minute sessions. Again, after desensitizing and reprocessing the "worst part", which took approximately one 90 minute session there were now many more incidents to reprocess as we examined the event frame-by-frame, as well as the run-through at full speed for the final desensitization and the run-through at full speed for the final installation. These clients were seen for a 45 minute follow-up session, a week later, and reported no relapse of their symptoms. They were instructed to call if anything changed. None have, to date.

One person was recently seen with a history of childhood trauma and dissociative symptoms. Her experiences on September 11 were similar to those who were in the World Trade Center, on the lower floors of the North Tower (first tower hit) and was able to escape rather quickly from the building. Like that group she experienced the sway of the tower as it was hit by the first plane, seeing the second airplane crash into the south tower and seeing people being pushed out of the towers by the planes as they hit. As part of her preparation and informed consent, she was informed of the implications of her history vis-à-vis the possible reactions and experiences that she may have and the changes in technique (ego-state work and resource pendulating) that may be necessary. She understood and opted to begin targeting the Sept. 11 material. She was an executive in one of the major brokerage houses in the WTC and was under extreme pressure to return to optimal functioning. We established

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a resource, amplified and grounded it somatically and planned to pendulate back-and-forth from the trauma material to the resource (not when the client became overwhelmed, but rather as a routine rhythm.) After practicing this pendulation, briefly, we began to process the "worst part". Initially, her associations stayed on target. After approximately fifteen minutes they began to wander into childhood experiences and she experienced mild derealization. We increased the resource pendulation. This helped calm and ground her. Given the pressure to resolve this trauma first, if possible, my main intervention was to return her to target when her associations wondered off, at length. This was successful and she continued to desensitize, quickly. By the end of approximately 80 minutes the "worst part" was desensitized to a SUD of 0 and reprocessed to VOC of 7. She is scheduled to be seen again and I anticipate that the remainder of the recent-traumatic-event protocol will be doable in 90 minutes.

I believe that this more complex situation was successful for three reasons. First the discussion, during the preparation phase of dissociation and ego-states established an environment of acceptance and empathy, precluding ego-state sabotage. Second, the use of resource pendulation, which is being discussed by clinicians as a superb tool for enhancing grounding and affect regulation. Third, the use of more frequent returns to target.

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Collapsed Together

by David Grand

~

Crawling on the floor
We lifted our head
To see our mother and father
Pillars of strength
Towering above.

Walking below
We lifted our head
To see our two towers
Pillars of strength
Towering above.

We are orphans now
A murderer's arrows
Pierced the hearts
Of our invincible parents
Who collapsed to the ground.

They are gone
With six thousand souls
The brave and the innocent
We are left
Bleeding in shock and grief.

We soothe the orphans
The widows and the widowers
The parents of the missing
With our healing hands
As we mourn with them.

RESOURCE FOCUSED PROGRESSION

Roy Kiessling, LISW

INTRODUCTION:

The following Resource Focused Progression may be implemented during the Preparation Phase of the Standard EMDR Protocol. These interventions are designed to help stabilize and prepare a client for the traditional EMDR targeting protocol.

These strategies have been developed by a number of EMDR clinicians – I have tried to give credit where credit is due – any omissions are unintentional.

OVERVIEW

Implementing this Progression may or may not follow in the below sequence (clinical assessment and intuition are the primary determinant as to which strategies need to be used, and in which order) for any given client.

Throughout I refer to DAS (Dual Attention Stimulation) in lieu of EMDR, EM's, bi-lateral, etc. which reflects the new information contained in Francine Shapiro's 2nd edition of her book titled: *Eye Movement Desensitization and Reprocessing, Basic Principles, Protocols and Procedures.*

RESOURCE DEVELOPMENT STRATEGY

All the strategies list below follow the basic strategies of Safe Place Development – eliciting an image, enhancing the image (especially the positive affect, feelings, body sensations, posture, etc), anchoring with DAS, and re-scripting recent events to help the client access resources in present time. A great deal of the impact these resources (in my opinion) seems to be due to the re-attuning the client to the positive affects (feelings sensations, emotions, etc.) associated with these resource strategies.

PROGRESSION:

Positive Circling (Strength Circling)
Resource Focusing
Safe Place and/or Container
Wedging
Partnering

Listed below is each intervention of the progression.

POSITIVE CIRCLING:

Developer: This is my interpretation of materials Kay Werk (EMDR Institute Senior Trainer) developed while working with firefighters, EMT"s, etc.

Goal: To help the client re-establish the ability to access positive experiences, feelings, sensations, and emotions (rebuilding the positive affect bridge between past and present) that have been overwhelmed or apparently lost due to the severity of the recent trauma.

When: Client is overwhelmed, in crisis, is resistant to addressing the trauma, needs stabilization, and/or thinks concretely. Client only experiences negative affect and has difficulty discussing or targeting the traumatic material.

Strategy: Begin to attune the client to positive affects (feelings, emotions, sensations, body postures) associated with people, places, and things experienced in their lives. Often these positives are not even remotely connected with the presenting trauma and often tend to be concrete rather than imaged, i.e. the spouse, dog, car, friends, etc.

Implementation: After introducing the DAS mechanics (EM's tapping, sound), have the client think and feel one positive thing in their life. Use short, slow sets of DAS. Record any positive response. Repeat if experience is positive – accessing and enhancing positive feelings, emotions and/or body sensations when available. CAUTION: positive channels may turn negative if pursued too far – use discretion as to how long you stay with any given positive thought.

Repeat, asking for another. Continue circling the client with these positive affects (in effect – creating an affect bridge connecting the client's present experience with positive people, places and things in their lives).

Any negative responses, stop DAS immediately, redirect and refocus attention to positive affects and reintroduce DAS on either previous positive, or next positive image. We do not want the client processing ANY negative or traumatic material.

"What are some of the things in your life you feel good about?"
Any positive, a dog, children spouse, family, etc. install with DAS

"What positive feelings or body sensations are you experiencing as you bring up this image?"
Enhance with DAS. Continue enhancement as long as positive channel continues.

"Tell me about another positive, happy, or pleasant thing, person or experience you've had in your life."

Record each positive

RESOURCE FOCUSING

This is an offshoot of Kay Werk's "Strength Circling" techniques and is similar to Andrew Leed's/Deborah Korn's, et al. standard Resource Installation Strategies.

Goal: The client has some knowledge of existing strengths, yet still presents as being overwhelmed. Re-attuning the client to internal resources and strengthening their awareness helps prepare them for targeting their traumatic issue.

When: The client presents with some degree of stabilization or is able to remember or image past skills and coping strategies

Strategy: Begin exploring with the client times in their lives when they have managed stress, accessed their inner resilience, have done well, felt in control, etc. Install these with DAS.

Implementation: After introducing the DAS mechanics (EM's tapping, sound), have the client think of a time when they felt in control, empowered, or managed a stressful situation (questions may be structured to guide the client to skills that may be helpful in addressing the traumatic issue). Use short, slow sets. Record any positive response. Repeat if experience is positive – access positive body sensation if available. CAUTION: positive channels may turn negative is pursued too far – use discretion as to how long you stay with any given positive thought.

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Con
Process:
"I'd like you to take a moment and think about a time when you handled a stressful situation successfully. As you think of that incident, what positive things do you notice."

Install with DAS. Enhance with DAS - CAUTION: positive channels may turn negative is pursued too far – use discretion as to how long you stay with any given positive thought.
Repeat with each new positive memory

SAFE PLACE

Follow guidelines set forth by Francine Shapiro in her Eye Movement Desensitization and Reprocessing, Basic Principles, Protocols, and Procedures. Second Edition (or in your Level 1 training manual)

CONTAINER

My introduction to this came from an audiotape of an EMDRIA Conference presentation of Landry Wildwind. Follow the same set-up as with the safe place but construct a container instead of a safe place. Container construction should be strong enough to hold in the trauma and have a "one-way" valve leading into the container. (So traumatic material already inside the container can't jump out when other material is either put in or taken out). Have the client describe the container. Enhance positive images, feelings, sensations, etc. as they experience how it is to have a container to hold their traumatic material. Strengthen with DAS, then cue and self-cue as one would with safe place installation. Client may then place the traumatic issues into the container and bring them out (or part of them) in your office. At the completion of the session, client may put material back into the container.

WEDGING

Goal: To have the client focus on past skills, resources, or coping strategies that may be helpful in reprocessing the traumatic material. We hope to create a small "wedge" or toehold into the traumatic material that will begin to give the client enough confidence to address their traumatic material.

Situation: The client has stabilized, but may still be reluctant to address the traumatic material (especially with EMDR).

Strategy
To specifically ask the client what skills they believe they will need to address their traumatic material. These resources may be past experiences, new information, new educational material, friends, hero's etc. that have those skills, etc.

Process:
"What positive resource, skill, or strength will help you to begin thinking about or addressing your traumatic experience?"

[Enhance each with a brief set of DAS's, develop each as much as possible, accessing memories, feelings, and body sensations (which may include body posture or movement]

[Repeat if more than one]

PARTNERING:

Goal: To remind the client of the skills/resources they already have available to help them reprocess their traumatic material.

Strategy: Using the resources developed during the Wedging Phase, remind the client that these skills/resources may accompany them during the reprocessing of their traumatic material.

Implementation: Anytime the client struggles, loops, or begins to abreact, remind them of their resources (just as you would say, *" Remember you're on a train, just watch the scenery"* instead say something like *"Remember, you have these skills with you to help you through this – how can they help?"*

"As we work on your traumatic experience, what skills (resources/strengths) do you feel would be helpful to have in the event the memories becomes overwhelming."
[Record and Enhance each with EM's]

Remember, we usually suggest riding on a train and observing the memories go by like scenery or watching the memories on a VCR, so we can use these later when reprocessing (Partnering)

" Now I would like you to imagine that these skills/strengths are sitting with you on the train or on the sofa as you prepare to watch the traumatic material on your T.V. Remember, you can ask for their help anytime the material becomes too stressful."

You now have a ready made-client constructed – adult perspective to assist in the client's processing of looping or stuck material when the standard mechanical strategies fail. (Changing EM directions, stimuli, processing modality, etc.)

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TEASEPROOFING AS A RESOURCE INSTALLATION FOR ADULTS

David Yarosh, Ph.D.

I came across the "tease-proofing" repertoire in Ricky Greenwald's book Eye Movement Desensitization and Reprocessing (EMDR) in Child and Adolescent Psychotherapy (Greenwald,1999) According to Greenwald , "Tease Proofing includes a series of techniques which help the youth become less reactive to provocation. First the youth is asked to imagine a fantasy scenario in which he is able to overpower his antagonist. Then he is taught to erect an imaginary wall to keep his antagonist's barbs from getting through to him. Finally he is asked to consider, and then picture himself imitating a pro-social role model's effective coping."(Greenwald, in press) The goal is to help the child or adolescent understand the dynamics of teasing so he no longer takes it personally.

I began to wonder if "tease-proofing" might be adapted to some of the more challenging relationship situations I see in my practice involving couples, business partners, parents and their children, and siblings. Following are cases using individual therapy that illustrate the use of "tease-proofing" with EMDR for adults.

"Teasing" occurs in a relationship dyad when A provokes B to deliberately elicit a negative reaction. B may respond by raging or getting depressed but either way, A has "won." A has succeeded in "downloading" the bad feelings he has been carrying around onto B, and B ends up "holding the bag" and feeling bad.

I decided to use Greenwald's tease-proofing repertoire with a woman who has been regularly "teased" by her husband. It's important to mention that she is a hard-working person who has consistently worked for her family's benefit. The husband regularly provokes her by calling her "selfish" and telling her she only thinks of herself. What he meant by that was that he resented her decision to take a photography class as opposed to running an errand for him. Other times, if he were anxious about business, he would insult her.

Before using the "tease-proofing" repertoire with EMDR, no intervention had any effect. For example, neither psychodynamic exploration of her identification with a powerless father nor assertiveness training seemed to help. This time I said to her: "I want to help you cut your reactivity to your husband's provocations. We can try something new that will help you protect yourself."

Therapist: "So let's say I'm your husband and I'm having a bad day. And suppose I've learned that I can get my bad feelings into you and get some relief…":

Client: "Yes, he does that. It's like kicking the dog."

Therapist: "OK, but just because he knows how to unload his bad feelings into you, does that make you a bad person.

Client: "No, of course not."

Therapist: "Think about that." (EM) "So, it's not about you? Not because you're no good?"

Client: "No." (EM)

Therapist: "So they're his bad feelings, not yours?"

Client: "That's right."

Therapist: "I can show you a strategy that will help keep his bad feelings from getting inside of you. What if you could put up a wall to keep his bad feelings out? What would it be made of?"

Client: "A one-way mirror so he can see himself, how stupid he looks."

Therapist: "Good, now picture him calling you selfish, see how it works." (EM) "How'd it go?"

Client: "Well, his words were muffled."

Therapist: "So his bad feelings didn't get inside you?"

Client: "No, it worked."

Therapist: "OK, let's see how you're going to handle it in the future when your husband is having "a bad day and wants to provoke you."

At this point the behavior sequence can be deliberately re-run as a video-tape or movie. First there is the "teasing," then the new response, and finally, the successful outcome. Each segment is followed by eye movements. Then the entire sequence is run as a movie with the therapist doing eye movements and the client signaling when she is done.

If at any point there is disturbance, the client should signal and then that part of the sequence is desensitized. The final image of the successful outcome is particularly important and attention should be given to emotion, bodily feelings and a positive cognition.

Therapist: "So when the words have bounced off the wall and you're standing there untouched, what emotion goes with it?"

Client: "I feel good."

Therapist: "Let yourself feel the good feelings in your body, and let them develop and strengthen."(EM) "And what do you say to yourself? Something like "I can take care of myself" or "I'm in control."

Client: "I can handle this." (EM)

The behavioral outcome of the "tease-proofing" resulted in less reactivity in future interactions with her husband. After protesting her changed behavior and telling her that her therapist was making her "crazy," he became less abusive and more accommodating. Again practicing and repeating an assertive stance has been necessary for the gains to "hold" and while the gains have been promising up to this point, there's no way to know what future interventions will be needed.

Variations

In adapting "tease-proofing" for adults, I have found it useful to introduce the concept of Life Seen From An Adult Perspective. That is, situations are viewed with appropriate responsibility assigned, choices seen as possible, and consequently, safety. The converse is regression or events seen nightmarishly from a child's perspective. I will discuss the concept with the client and then ask them for permission to install a *gatekeeper* to prevent *regressing* from the adult to the child perspective. This is discussed in very specific terms regarding their life situation. I often introduce this procedure somewhere between the first and second time we do the "tease-proofing." In very practical, visual terms it usually comes up because these clients trigger so fast to the provocation that there is no time to put up a wall. The *gatekeeper* slows their reactivity so there is time to put up a wall. I am indebted to Roy Kiessling (Kiessling, 2000) for the concept and part of the mechanics (the flashing red light.)3

To illustrate, I explained to a man whose wife could always get him instantaneously enraged by criticizing his diction: "When you get "teased" by Jill, and you see yourself starting to regress, we're going to install a gatekeeper, something that's going to say STOP!!! Do you want to do it?"

The therapist asks for agreement which sometimes comes immediately, sometimes only with negotiation and then proceeds to install the gatekeeper against regression.

"OK, have you ever been in the country? And do you remember the rail-road crossing and the red lights start to flash, and you hear that sound the BOOM! BOOM! BOOM! and then the gates go down so you don't cross over and get smashed by the train? Can you see the lights? Hear the bells go

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Cont. from Pg. 37

BOOM!BOOM!BOOM! And the gate goes down and the train goes by, and the whistle…toot..toot…?"

This procedure is always fun, very effective, and installed, as above, as a movie with eye movements. I have found with adult clients that it greatly enhances their ability to put the wall up and establish a sense of safety, mastery, and control. I developed this to enhance "tease-proofing" but find that I am now using it in many ways with many clients.

Another variation of Greenwald's protocol (Greenwald, in press) involves a cognitive reframe that stopped a teasing routine between two elderly sisters that had been going on for 60 plus years. I used Greenwald's words almost verbatim, words that had been developed for use with adolescents 4, with this 78 year old woman who has a 73 year old "baby" sister. My client's sister can reduce my client to tears by "getting her goat." It was clear that the sister knew exactly how to enrage her by saying "Do you know you're a very hostile person?" or a few, other well-chosen barbs.

Client: "My sister insulted me again. It ruined my whole week."

Therapist: "You must really admire your sister."

Client: "Why?"

Therapist: "Well, you've put her in charge of you."

Client: "What are you talking about? She'd like to be in charge of me."

Therapist: "Then how come you put her in charge of your feelings? Every time she has a bad day, all she has to do is tease you and she gets your goat."

Client: "Teasing is the right word. That's exactly what she's always done. She's never forgiven me for telling her to get lost when I wanted to be with my friends when she was a child."

Therapist: "OK, suppose I could show you a way to put up a wall." etc.

The behavioral outcome of the "tease-proofing" was a decrease in reactivity on my client's part. She was better able to see her sister as a separate person and no longer took her sister's "teasing" quite as seriously. It's important to note that I used this particular intervention alone, and in subsequent sessions, with the other "tease-proofing" interventions talked about in this paper.

Conclusion

I've tried this procedure with 10 clients with good results. A "good result" is defined by significant improvement with occasional relapses, not 100% perfection. In every case, multiple sessions were necessary to help my client understand the dynamics of teasing, not take the provocation personally and develop mastery at putting up an ego-boundary. In about a third of the cases, the tease-proofing appeared to work but wouldn't "hold" indicating that we needed to go back, take a trauma history and process the disturbing material that was getting triggered. Hopefully, after the early experiences have been reprocessed, we will be able to move back to the current relationship trigger.

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It's Renewal Time!!

This is the last issue of the Newsletter for the 2001 Membership year. Please renew soon if you haven't yet.