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Message from the President: More Steps Forward

Daniel T. Merlis, M.S.W.

This is my final *Newsletter* message to the membership before turning over the helm to the next President, David Wilson, Ph.D. This has been a year of considerable growth for the organization, with structures now solidly in place to insure educational, marketing, and public relations support to all member EMDR clinicians.

The most significant development this year has been the implementation of the Certification Program for EMDR clinicians which has generated an enormous positive response from membership. At the same time, we appreciate the feedback from some members who have mixed feelings about the program, and we acknowledge that we have expressed and explored many of the same concerns raised about the burdens it might create for some clinicians. We want to assure all members that we intend to be fair and flexible in dealing with unusual situations clinicians might have with regard to accessing training and supervision, and we will work with clinicians to problem-solve and find workable solutions. We also understand this process will be a dynamic one and expect that policies will need to be revised over time in response to changing needs and circumstances.

We regard this as a beginning to help insure that the research and practice of EMDR will be conducted by those who are willing to commit themselves to continued development of their EMDR practice skills over time. Certification will increase the likelihood, although it will certainly not guarantee, that a certified clinician has a thorough understanding of the EMDR method, the appropriate use of the method, indications and contraindications for EMDR, and how best to implement EMDR with special treatment populations. Thus, a potential client will be able to distinguish between clinicians who have completed training in EMDR and those who have learned eye movement techniques from body workers, hypnotists, and various and sundry other individuals who fail to appreciate the power and complexity of the method. The latter trainings bear no relationship whatsoever to what we would recognize as EMDR training.

It is EMDRIA's intention to be inclusive, *not* exclusive. We are offering certification to many thousands of EMDR clinicians. We understand that there will be different skill levels represented in the early phase-in of this process but we also believe that many who commit to certification will be more serious in their study of EMDR and more likely to upgrade their skill and knowledge base than those

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From the International Scene

Marilyn Luber, Ph.D.
Marluber@aol.com

The EMDR community is far ranging and engaged in many different activities to promote the healing of individuals, groups, and communities all over the world. Elaine Alvarez, my close friend and colleague, is one of the EMDRIA members who helped make this possible. I first met Elaine in an extraordinary study group hosted by Neal Daniels that we both attended at the Philadelphia Veterans' Administration. On a weekly basis, we had the chance to share our latest discoveries about EMDR, as well as our excitement and enthusiasm. It was there that I first became aware of Elaine's creativity, expertise, and delight in the practice of psychotherapy.

Elaine received her MSW from New York University and did postgraduate work at UC-Berkeley and Santa Cruz. Her professional career has focused on two types of populations: the poor and American Veterans. She was the Clinical Director of a program for quality care for the poor in San Francisco where she worked for seven years. This was followed by a stint as the Veterans' Administration's team leader in Oakland where, during the 1970's, she was the first woman to head a Veteran's Readjustment Counseling Service, a program that reached out to Vietnam Veterans. As the Director of the agency, she arranged for a conference to help other professionals understand what was then referred to as "The Post-Vietnam Syndrome."

Elaine's work with combat veterans was the catalyst for her own personal evolution. As her patients explored their shaken belief systems, she found herself challenged and compelled to delve into a deeper understanding of her values. In her pursuit of understanding herself and the world, she discovered Buddhism and began to study Vipassana—an insight form of meditation. By thus deepening her understanding of human nature, she began to integrate spirituality into "the therapeutic chamber" and felt she became "a transpersonal therapist." Elaine's work with veterans resulted in the expansion of her meditation practice, her use of self in treatment, and the search for cutting-edge methods.

By the time Elaine learned EMDR, she had already explored a wide and varying range of methods of working with trauma and had plateaued in her ability to change the trauma symptoms she encountered. After she began to use EMDR, she saw a phenomenal change in her work with veteran survivors of war and expanded her practice to include work with men and women who have been sexually, physically, and emotionally abused.

Since Elaine was interested in working with the poor from the time she began her career in mental health, she has become aware that the middle-class, privileged group have access to cutting-edge methods far sooner than the less privileged. Through Elaine's work with the Humanitarian Assistance Program—through the EMDR Institute—she has found a way to minister to people spanning the socioeconomic classes and ethnic diversity. In her job as the Special Projects Director for HAP, she supported and encouraged trained EMDR mental health workers to move into communities with special needs and offer their training skills. She acknowledges her debt to her friend and former colleague in the Bay area, Pat Reynolds, who was the Director of Health for the city and county of San Francisco and facilitated the agency's receptivity to proposals made by local EMDR practitioners to offer training. She also highlights the excellent training provided by Linda Cohn in San Francisco.

Another of Elaine's projects concerned women who had lost children to gun violence. She is particularly moved by a woman who had been in deep mourning for 13 years and—with the use of EMDR—found closure and was able to move on as did her son and son's girlfriend, results that have been sustained based on a six month follow-up. Also, she remembers the response of a man jailed for murder who reported that she "must have done something" to him because he found himself thinking at a much deeper level than he had ever known.

As a member of the board of HAP and as a HAP trainer, Elaine has twice visited Bangladesh, with her colleague Susan Rogers, to do an initial evaluation and to serve as team leader to train our Bangladesh colleagues. After her most recent trip, she recommended that there be far less lecturing and much more focus on small groups and practicums.

Currently, Elaine is in charge of the Stabilization Unit at the Inpatient PTSD unit run by Dr. Steven Silver in Coatesville, PA. She also has a small private practice.

Many of us know Elaine as a gifted facilitator for

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Regional Meeting Coordinating Committee Report

Jocelyne Shiromoto, LCSW

Approved Regional Meetings

As I write this, we have 38 EMDRIA Regional Coordinators signed on, and more continue to trickle in. All of the currently-organized EMDRIA Regional Meetings are listed at the end of this article. These Regional Meetings are also listed on our Website.

We would like to welcome the following new Regional Meetings: Massachusetts; Buffalo, NY; Mid-Hudson Valley, NY; Syracuse, NY; Ohio; Pennsylvania; Chicago, Illinois; and Texas. We now have 14 Regional Meetings and are expecting from ten to 15 more.

If you are interested in forming a Regional Meeting and you are EMDR-trained, a member of EMDRIA, and are licensed in the state in which you want to hold your meetings, please contact the EMDRIA office at 512-451-5200 or EMDRIA@aol.com and request a Coordinator's packet.

EMDR Certification

As many of you know, EMDR certification is here. We are requiring all EMDRIA Regional Coordinators to be EMDR-certified by January 1, 2000. If you have not received a certification application, please contact the EMDRIA office. EMDR consultation status will not be required, but consultation status will certainly benefit EMDRIA Regional Coordinators as well as the membership.

EMDRIA Credits

If you are a Regional Coordinator and have not received your EMDRIA Credits packet to apply for providership, please contact the EMDRIA office to request one. EMDR certification is now available, and it will be a great advantage to our membership if Regional Meetings provide the opportunity for members to receive EMDRIA Credits and thus earn re-certification. EMDRIA has attempted to make this process for Coordinators as painless as possible—if you have any questions, please contact me.

Regional Coordinators Annual Meeting

It's that time of year again! We are having our 2nd Annual Regional Coordinators Sack Lunch Meeting at the 1999 EMDR International Association Conference, Saturday June 19th from 12:00 noon until 1:30 p.m. To make the process easier for you, sack lunches and drinks will be available for purchase at the meeting room this year.

Co-Chair Resignation

Our Co-Chair to the EMDRIA Regional Coordinating Committee, Liz Snyker, has resigned and is going on to other EMDR endeavors. She will be involved with the HAP trainings, particularly in South America. Liz has been on the Committee from the beginning and has been a significant contributor in the evolution of the Regional Meetings. We would like to thank her for her time, contribution, and support to this never-ending challenge . . . and wish her well.

As always, should you have any questions, suggestions, praise, or even complaints, please contact any of the following Committee Members preferably by e-mail). Until next time . . .

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[Please see next page for a list of Regional Meetings.]

(Regional Coordinating Committee - Continued from page 3)

EMDRIA Regional Meetings

Colorado

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THE INTERN CONNECTION

Nicole Nestor, M.A. and
Lee D. Ockenden, M.A.

For the past few years, EMDRIA has been striving to establish international standards for the training of clinicians in EMDR and to serve as a professional support organization for these mental health professionals. Presently, EMDRIA has approved more than 20 instructors at universities and colleges to teach and train students EMDR within an academic curriculum.n students EMDR within an academic curriculum.

As the growth of pre-licensed clinicians continue, there may be a need to develop "intern support services." In other words . . . it may be time for interns to get connected!

Support for Interns

We believe the answer to this need is to develop a support network for the EMDR-trained interns that we refer to as "The EMDRIA Intern Connection." We propose creating (through various media) a network of pre-licensed individuals for the purpose of providing resources based on suggestions and results gathered from a survey we will make available at the 1999 EMDR International Conference. After the conference, a copy of the survey can be requested by calling the EMDRIA office at 512-451-5200. (The results of the survey will be made available in future editions of this column.)

The Intern Connection" will offer support from interns to other interns, and we would begin by establishing a directory of EMDRIA-approved EMDR trained supervisors willing to provide EMDR supervision to interns. Although EMDRIA's current support services (Membership, Annual Conference, Regional Meetings, *Newsletter*, *Directory*) are available to interns, we crave a semblance of the camaraderie and community shared by licensed therapists. Of course, this craving will likely vanish on the day we become licensed but, until then, we feel that the future licensed practitioners of EMDR would benefit from a support network of this nature.

"The Intern Connection" will soon materialize in the form of an additional link to the existing EMDRIA website and will continue to contribute a column to the *EMDRIA Newsletter*. As we are in our formative stages, we are open to (and desirous of) feedback regarding other intern additional support services that may be of interest to interns/ pre-licensed clinicians, and we welcome any and all pertinent questions.

We will also be recruiting Committee Members based on geographic region and ability to contribute to the intern network. Please express your interest through either of the e-mail addresses given below. We will continue to keep you informed as this exciting development continues. Look and listen for us at the 1999 Annual EMDR International Association Conference, June 18-20, in Las Vegas, Nevada.

To Contact Us

For any questions or feedback, please contact:

- Nicole Nestor, M.A., a graduate of Hope International University. Nicole works as a registered MFT intern in the practice of Linda L. Vanderlaan, Ph.D. in Corona, California and can be contacted at nicstor@earthlink.net.
- Lee D. Ockenden, M.A. is also a graduate of Hope International University. Lee works as a registered MFT intern in the practice of Curtis C. Rouanzoin, Ph.D. and Associates in Fullerton, California. and can be contacted at LOcke10075@aol.com.

[The EMDRIA "Intern Connection" is a subcommittee of the Regional Coordinating Committee, chaired by Jocelyne R. Shiromoto, L.C.S.W.]

CALL FOR PAPERS FOR *THE EMDRIA NEWSLETTER*

The EMDRIA Publications Committee is engaged in a continuous process of gathering EMDR-related papers of interest to our membership.

Next deadline for submissions:

July 20, 1999

Please see page 23 of this issue for Submission Guidelines.

(International Scene - Continued from page 2)
the EMDR Institute who lends her insight, skill and humor to the seminars she attends. Although Elaine's time is amply filled by her VA and EMDR activities, she is an avid lover of the arts, including theater, dance, and jazz. Most days, however, she can be found at home with her new addition, Jockey, a champagne-colored French poodle.

Thank you Elaine for your devotion, creativity and vision on behalf of us all.

News from around the world:

- **Armenia:** Edmund Gergerian reports that he has been putting together the Armenian translation of the Level I Manual that should be ready in June 1999. In July, he plans to continue to train the 21 Armenian clinicians who completed part of an EMDR course last year. He anticipates 18 to 21 clinicians will begin training in June in Yerevan, Armenia. Edmund has included a third practicum for each level and Lisa Papazian will serve as his assistant.
- **Australia:** Mark Grant writes that EMDRAA is in the process of affiliating with EMDRIA. They continue to print their newsletter and, in April, published a special issue devoted to the legal status of memories obtained under EMDR and the legal status of such memories. EMDR continues to receive mention in the Australian media and one of EMDRAA's members recently appeared on TV in a debate about the use of EMDR with phobias. The national TV broadcaster in Australia is preparing a special program as part of a health series about psychoneuroimmunology, including the story of a woman helped to overcome the pain and trauma of a motor vehicle accident through EMDR.
- **Finland:** Soili Poijula continues to support the development of therapists in Finland. Roger Solomon has been providing beginning and advanced trainings on a yearly basis. Soili proudly reports that there is now a network of more than 100 EMDR therapists and ten local facilitators.
- **Germany:** The Psychoanalytic/Psychotherapy Conference will be held this year in Lindau, Germany

Post Your EMDR Study Group in the Next *EMDRIA Newsletter*!

If you have an existing Study Group—or will be starting a Study Group—and want it posted in the next *EMDRIA Newsletter*, please submit it to the EMDRIA administration office by July 20, 1999. When submitting your Study Group, please provide the following information (by mailing/faxing this form to the EMDRIA office or e-mailing the information to the *Newsletter* Editor at superVisns@aol.com).

Contact Name: ______________________________

Study Group Frequency: (Specify monthly, weekly, bimonthly, etc. and day and time group is held.)

____

City: ______________ State/Province: ______________

Phone: ____________ Fax: ____________ E-mail: ____________

(Please see page 38 of this issue for current postings to the Study Group Listing.)

on Lake Constance. Veronika Nolte writes that "anything that's good—old or new—in the field is being presented and taught by known scientists, psychoanalysts, and psychotherapists like Prof. Dr. Verena Kast, Prof. Dr. P. Buchheim, Prof. Dr. M. Czierpka, Prof. Dr. L. Wurmser, and many others. Dr. Luise Reddemann and Prof. Dr. Ulrich Sachsse were asked to speak about their treatment of severely traumatized clients two years ago and their presentation was so well received that they have continued to be invited back. This year, one of the topics is EMDR, and that is why Dr. Francine Shapiro was asked to join also."

- **Holland:** Ad de Jongh reports that Dr. Gerry Puk trained Dutch therapists last October and Dr. David Grand did a well-received presentation for the Dutch network. Ad de Jongh, Erik ten Broeke, and Monique Renssen wrote an article on EMDR and phobias which will appear in the *Journal of Anxiety Disorders.*
- **Israel:** Elan Shapiro e-mails from Israel that EMDR-IS is planning a beginning level EMDR course in June with Dr. Roger Solomon, and there seem to be signs of interest from more and more important Israeli colleagues. Dr. Udi Oren spoke to an audience of 60 at the Psychiatric Department at El HaShomer Hospital, along with a psychiatrist and psychologist who reported the changes they had witnessed in the chronic PTSD patients they had referred to Dr. Oren. Dr Gary Quinn gave a very successful workshop on EMDR and trauma at the annual Hypnosis Society meeting.
- **Japan:** Masaya Ichii writes that 52 new therapists were trained and 35 participants completed their training in the beginning of March through the training expertise of Dr. Andrew Leeds. He noted that in the Japanese journal, *Kokoro no rinsho, a ra karuto,* there were 14 EMDR articles, making it the first journal to introduce EMDR as an important topic in Japan. The main topic was "EMDR, Is It a Miracle?," and the journal also included an interview with Dr. Francine Shapiro by a Japanese psychiatrist.
- **South Africa:** Dr. Gerry Puk is planning to teach EMDR seminars in South Africa in July.
- **South and Central America:** John Hartung writes that he is going to do a follow-up training in Nicaragua, with plans to travel to Ecuador this year. The latest draft of the advanced EMDR manual in Spanish is completed and he will initiate its use in Nicaragua.
- **Sweden:** The first national EMDR-Sweden meeting was held in April 1999. There are approximately 200 trained clinicians and considerable interest in new trainings. Also worth noting is the successful use of EMDR with survivors of a large fire on the West Coast of Sweden, in which 60 children were burned to death.
- **Ukraine:** Alex Bondarenko reports that he has completed the Russian translation of Dr. Francine Shapiro's text on EMDR.
- **United Kingdom/Ireland:** Sandi Richman reports that EMDR has been incorporated into a program of treatment at the Maudsley. John Spector e-mails that he did a 5-minute feature on the BBC radio concerning EMDR with Dr. Douglas Duckworth. There is a great demand for training and there will be beginning and advanced training in September and a further training in Scotland in the year 2000. Interest in children and EMDR is "booming." John also reports that his major review called "The current status of EMDR" will be appearing in *The Journal of Clinical Psychology & Psychotherapy* in July.

As always, I look forward to hearing about your work and accomplishments. Please send them to me at marluber@aol.com.

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OUR APOLOGIES FOR THE DELAY

Due to unforeseen delays with the printing process, requests for the EMDRIA Member Presentation Packet and the Brochure for Professionals have not to fulfilled as quickly as we had planned.

Please be patient—both the Brochure for Professionals and the Presentation Packets are coming.

—The Public/Professional Relations Committee and the EMDRIA Office

EMDR IN THE TREATMENT OF PAIN

Mark Grant, MA
Markgra@ozemail.com.au

Since its inception as a treatment for trauma there have been various reports including conference presentations and case-studies of EMDR being effective in the treatment of various kinds of pain (Grant, 1999; Hekmat, Groth & Rogers, 1994; McCann, 1992; Wilson Becker & Tinker, 1997). EMDR presents itself as worthy of consideration in the treatment of pain because of the similarities between pain and trauma. Firstly, pain is a kind of trauma since it represents an unpleasant, unavoidable and fearful event for most sufferers. Secondly, building on the research of van der Kolk, recent findings regarding the neurological underpinnings of pain suggest that many of the same parts of the brain that are involved in trauma are also involved in pain (e.g., Lenz, Gracely, Zirh, Romanoski, Staats, & Dougherty, 1997).

There are also many significant differences between pain and trauma, and it is necessary to have an appreciation of these when approaching the treatment of pain. Firstly, chronic pain differs from other psychological problems because of its dual status as a medical problem. This has many implications for its treatment as a psychological problem. For example, despite the acceptance that pain is a psycho-medico problem, treatment continues to be separated along psychological and medical lines (Laynne, 1997). Psychological treatment is normally only introduced following the failure of medical treatment to control the pain. The effect of this is that, as a result of undergoing lengthy and ineffective medical treatments, many chronic pain patients are depressed by the time they seek treatment(cf., Jackson, 1992; Romano & Turner 1985). Pain that is not accompanied by clear physical pathology is also often dismissed or psycho-pathologized (Eccleston, Amanda, Williams & Stainton-Rogers, 1997; Jackson, 1992).

Traditional psychological approaches have also perpetrated pathologizing myths and assumptions about pain sufferers. Concepts like "compensation neurosis," the "pain-prone personality," and secondary gain permeate pain-management literature despite having little or no scientific support. For example, in their 1996 text "Psychological Approaches to Pain Management," Gatchel & Turk allege that workers' compensation is a "powerful predictor variable" in treatment (Gatchel & Turk, 1996, p. 40). However, my recent review indicates the majority of research indicates there is no correlation between compensation and treatment outcome (Solomon & Tunks, 1991; Burns, Sherman, Devine, Mahoney & Rawl, 1995; Gallagher, 1995; Schmidt, Gierlings & Peters, 1989). Operant models even advocate ignoring pain and focusing on coping. Not surprisingly, these approaches suffer from high relapse rates—up to 70 percent (e.g., Bradley, Young, Anderson, Turner, Agudelo, McDaniel, Lutz, Silbret and Olasahn, 1983; Semble, Morgan, 1987; Turk & and Rudy, 1991). Gamsa (1994) has suggested the lack of attention of these approaches to pain relief may account for their poor efficacy. (For a more extensive treatment of some of the myths and assumptions associated with pain, see Grant, 1999.)

The situation is further complicated by extensive medical mismanagement of chronic pain. Medical mismanagement is widespread (Hitchcock, 1994; Salerno & Willens, 1997) and has been cited as a factor in exacerbating chronic pain sufferers distress and disability (Pither & Nicholas 1991). Examples of medical mismanagement include misdiagnosis, which has been found to be as high as 47 percent (e.g., Rao, Rhea & Novelline, 1998) and under-medication, which has been found in more than 50 percent of cases (e.g., Hitchcock, 1994). Given the trend toward dismissing pain in the absence of pathology, there is also a danger that patients may feel blamed for their problems and that important self-report information can be dismissed. Eccleston et. al., (1997) noted that pain patients are confused and angry at treatment which seems to focus on their own behavior and at being blamed for their own suffering and misery.

An approach is indicated that ensures both the medical and the psychological needs of the client are addressed—specifically, providing adequate medical investigations and treatment and ensuring that pain is not excessive. Following this, psychological interventions should address the affective, somatic and cognitive dimensions of the problem. Numerous commentators have recommended this kind of approach (Barber, 1997). EMDR incorporates an assessment phase, and a treatment which focuses affective, somatic and cognitive aspects of the presenting problem (Shapiro, 1995).

The combination of medical and psychological factors associated with pain determines the goals of psychological treatment of pain. These may be summarized as:

1. Ensure pain is within tolerable levels of severity.
2. Review medical diagnosis and patients attitude to their diagnosis.
3. Identify and prioritize "targets" for EMDR reprocessing.
4. Facilitate relaxation and change in pain sensations.
5. Develop psychological pain-management resources.

The first task is to determine whether the pain is being adequately managed. It is necessary to distinguish between tolerable and intolerable levels of distress. Patients with excessive levels of physical discomfort are frequently

anxious and dysphoric (Gatchel & Turk, 1996), which may mitigate against their ability to engage in psychological treatment. Thus, the first task of the psychologist is to ensure that the patient's pain is under adequate control. Patients in extreme pain, with significant emotional distress, may be unable to perform the focusing and concentration that psychological pain-management requires.

The presence of a medical diagnosis, together with the patient's attitude to it, must be considered. It is important for clients to have a believable diagnosis because this has been shown to harness healing resources. For example, the presence of a diagnosis has been found to be a strong predictor of recovery (Brown, 1998). The absence of a believable diagnosis is associated with increased suffering and delayed recovery (Brown, 1998). The therapist should therefore ask the client about his or her diagnosis and how believable it is to them. If clients report uncertainty or dissatisfaction, it can be addressed in a number of ways (e.g., interviewing the client about his or her contact with treating medical specialists, ensuring adequate medical investigations, liaison with treating specialists, etc.) To attempt therapy when pain is excessive or is considered by the sufferer to be a signal of undiagnosed physical pathology is akin to attempting to treat a sexual abuse victim while they are still living with the perpetrator. The client's unresolved safety issues will maintain the anxiety and confound the treatment. Only after it is established that the patient's pain is within tolerable limits and the client is accepting of the diagnosis, is it appropriate to commence psychological interventions designed to change his or her pain experience.

The third task of treatment marks the beginning of psychological attempts to transform the pain experience. This begins with the identification and prioritization of specific issues to be addressed in treatment. Chronic pain sufferers are invariably seeking pain relief, better control over their pain, and relief from suffering associated with pain; however, each patient has different priorities according to his or her personality, life circumstances, degree of suffering, and distress, etc. It is thus necessary to elicit each patient's priorities according to individual needs.

The fourth task is the desensitization and reprocessing stage. Here the patient focuses on the pain whilst also attending to the bilateral stimulation (EMs). Following each set of bilateral stimulation, the therapist helps the patient notice whatever changes have occurred and facilitates cognitive interpretation of those. For example, following bilateral stimulation the therapist asks the client, "What do you notice now?" A client might report feeling the pain is softer or smaller and the client's belief about his or her ability to control the pain might change from "I'm helpless" to "I can learn to control my pain."

The fifth and final task is to integrate the changes in physical sensations the patient has reported cognitively. This is achieved by inviting the patient to create associations between the feelings of relief and memories of situations or things that remind her or him of the feeling. I designed a set of questions designed to facilitate these associations—i.e., "So what's there now where the pain was before?" and "What does that feeling remind you of?"

For example, in response to noticing that the pain feels softer, a patient might think of cotton wool. Patients' responses are developed and reinforced by instructing them to "think of that," whilst simultaneously attending to further bilateral stimulation. Typically, patients report a strengthening of whatever positive changes previously noted. They are then instructed to practice at home by thinking of the anti-pain imagery whilst attending to bilateral stimulation. This may be achieved through self-stimulation in the form of tapping or by listening to pre-recorded stereo audio tones.

Starting Treatment

Treatment begins by obtaining a description of the pain. Many clients find this difficult but this can be overcome by either instructing them to describe the pain is sensory terms (size, shape, color, etc.) or asking them to draw their pain. Drawing has been found to be effective in accessing affect that may be otherwise inaccessible (Golomb, 1992) The client is then instructed to "focus on your pain whilst attending to the bilateral stimulation (EMs) and notice any changes that occur." At the end of each set of EMs, the client is asked "What do you notice now?" Where a positive response is made, the client is instructed to Ajust notice that" and further sets of EMs are introduced, this is repeated until a significant degree of pain reduction is reported.

The client is then assisted to develop a positive visualization based around this. This is achieved by instructing the subject to "notice that feeling and think of something it reminds you of." For example, a feeling of softness might generate an image of a cloud or cotton wool. This is reinforced with more sets of EMs until a reasonably stable positive set of feelings and images was reported.

Where subjects reported "no change" or negative feelings, after the bilateral stimulation additional "cognitive interweave" techniques (see Shapiro 1995) such as questioning and direct suggestions can be used to help elicit positive changes. Processing with bilateral stimulation continues as long as the client continues to report positive changes. Following successful treatment sessions, the client is instructed to practice thinking of the positive imagery whilst attending to bilateral stimulation (self-tapping).

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Strengthening Affect Tolerance and Adult Perspective through Construction of Imagined Dissociative Avoidance

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Some clients, because of very difficult life experience, have low affect tolerance; that is, they are unable to endure, even briefly, their own intensely disturbing post-traumatic images and affect. For these clients, the therapeutic benefits of EMDR are blocked because of an automatic response of overwhelming terror and disorientation, often accompanied by a loss of objectivity or adult perspective. For these individuals, the experience is not so much one of remembering, but of emotionally reliving their trauma. Understandably, when this occurs, the client may begin to "numb out," dissociate, or consciously avoid thinking of the material.

In these situations, pre-EMDR work with self-soothing procedures and resource installation can be very helpful, but sometimes is not enough. For example, individuals diagnosed with Borderline Personality Disorder may be able to identify past traumatic events, but often have difficulty with affect regulation and are therefore more likely to avoid their own disturbing images in order to maintain emotional control. With these and other clients, the memory network of their traumatic images may link in such a way that the thought of one event triggers many disturbing thoughts, which flood into awareness. In these instances, a careful period of preparation is necessary prior to EMDR, to ensure that the process is not overwhelming and retraumatizing for the client.

This article describes a method that may make EMDR processing easier for clients who are terrified and avoidant of their own affect. The method starts with the observation (made previously by Milton Erickson (1979) and NLP theorists (e.g., Cameron-Bandler, 1985)) that dissociation, whatever its destructive effects as a psychological defense, DOES have the specific positive effect of reducing the immediate intensity of disturbing emotions. Erickson often utilized the general principle of "prescribing the symptom" to a client (i.e., suggesting that the client deliberately engage in the problematic behavior) as a way to bring the problem into the therapeutic process and facilitate resolution. This approach can be used with those clients who protect themselves with dissociative, avoidant defenses.

With many affect-avoidant individuals, it can be very useful to construct dissociative images in the therapy session and then, in this context, ask the client to give information about their avoidance wish or urge with regard to the disturbing material. This two-stage procedure has been very useful with a number of clients in helping them to buffer and soften consciously experienced emotion, thus allowing effective EMDR processing to occur sooner in the therapy process.

For example, a woman in her mid-thirties was experiencing extreme stress from several sources. Within the previous year, she had been assaulted and severely injured by her ex-husband. Her parents had recently "disowned" her, due to her decision to no longer hold their religious beliefs. She was about to be laid off from her job of 14 years, and her romantic partner just told her that their 8-month relationship was over.

During less stressful times, EMDR had been very helpful to her, and she was returning to therapy with the strong hope that it would be helpful again. But when she attempted to visualize the most distressing image (of wanting to call her partner following the rejection), she said (sobbing and covering her face), "I can't think of that! It's just too hard!" In spite of her wish to use EMDR, she seemed on the edge of dissociating to escape the pain of this image. Her pain was emotionally linked to childhood experiences of loneliness and parental abandonment, and she was having trouble keeping an objective, adult perspective on what had occurred.

I encouraged her to get away from this image, take some deep breaths, and ground herself back in the therapy room. She was able to utilize previously learned mindfulness and relaxation skills. After a minute or so, I said, "Let's try something that might make this a little easier. Use your imagination to see a big movie theater, with the lights still on before the movie begins, and you the only person in the theater. You have the whole place to yourself. In a few minutes, a movie will begin, and it will be a movie of last week, when you wanted to make that phone call. Now, use your imagination again, and be the person up in the projection booth, running the movie. From a little window, you are unable to see the screen, but you can look out to see the seats of the theater, and the one person down there, you, about to watch the movie. Can you visualize this? . . . Okay, the movie is about to start, and here is a question: As you picture this theater, with the movie now starting, what is good about being in the projection booth instead of down there watching this movie?"

She responded, "It would be too hard to watch that movie. It's almost too hard to watch myself crying down there."

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A Case Study in the Application of EMDR for Paranoid Schizophrenia

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Eye Movement Desensitization and Reprocessing (EMDR) has shown dramatic effect in dealing with various types of trauma, with the definition of trauma encompassing much more than catastrophic occurrences or events. How a person reacts to trauma is equally broad in its display, manifestations, and consequences for every individual. This is a story of Anna, and her life as it is affected by trauma and mental illness. It testifies to the power of EMDR and, even more importantly, to the capacity of the individual to achieve inner healing.

Meeting Anna

I met Anna during my senior year as an undergraduate majoring in psychology, after taking a job in a group home for the chronically mentally ill. Anna had lived in the home approximately six months when I arrived. She was a star resident, following all the rules, showing initiative, and attending social functions. At 48, she had lived with her diagnosis for 30 years, narrowing her life to one of isolation, loneliness, and fear. When the time came for her to leave, we were all happy for her for she had made a relatively smooth transition, was engaged to be married, and seemed happier than ever.

Anna returned to the group home a year later. This time, her symptoms were floridly psychotic. She experienced visual hallucinations of death masks floating in the air. She believed the Mafia was "out to get her" and she was being forced to hitchhike to Chicago. People shining flashlights were peeking through her window at night.

Anna beat on her legs with her fists in fear and frustration. "I gave birth to five babies and they're under the bed!" she'd scream. "The doctor inserted sperm into me during the examination!" During one incident, Anna came out of her room screaming and clutching her stomach. "I've been stabbed! Somebody do something, I'm bleeding!"

Anna went through a myriad of medication changes, but nothing stopped the onslaught of psychosis. She would often lie in her bed, locked in her room for days at a time. Her fiancé called almost every day, but Anna refused to take his calls. She remained in this state for three months before slowly showing some improvement, but did not resume prior functioning.

Resuming Treatment

One and a half years later, I resumed working as a graduate student with Anna. She continued to experience auditory hallucinations and paranoid delusions, and chose to isolate whenever possible to avoid escalating her anxiety when she felt people were talking about her. Interestingly, Anna was hard of hearing and wore a hearing aid in each ear. Although her inability to hear normal conversation without her aids was demonstrated to her, she had no difficulty "hearing" others plot against her. At one time, I considered that Anna's auditory hallucinations were a result of her moderate deafness, and encouraged her to wear her hearing aids at all times unless sleeping. It is theorized that sensory deprivation may contribute to "release hallucinations," but wearing hearing aids contributed little to no relief from her torment.

Noting Significant Differences

As a graduate student, I had the opportunity to complete Level II EMDR Institute training and eagerly read everything I could to learn more about this way of doing therapy. I joined the Discussion List on the Internet, actively sought consultation on the list, and ensured that I received supervision from someone who was Level II trained and had several years of experience using EMDR (a facilitator was more than 125 miles away). I was aware that Anna did not fit the typical profile of EMDR clientele, but I had worked with other clients diagnosed with paranoid schizophrenia and saw significant differences in Anna.

Her negative symptoms seemed more indicative of post psychotic depressive disorder of schizophrenia. She isolated herself, out of anxiety and paranoia, rather than the usual reasons for isolation seen in schizophrenia, such as lack of interest in socialization or activities. She displayed symptoms of depression such as sadness and a tremendous amount of shame and guilt, as well as low self-esteem. She was afraid others were talking about her, but it always seemed based on her feelings of guilt and shame. So was she experiencing paranoia in the usual sense? Was she even suffering from paranoid schizophrenia?

Her history revealed the same theme occurring in delusions since the age of 18. When younger, Anna did not hear voices, but rather a variety of noises such as clapping and gunshots. The voices began about five years earlier and worsened during her last psychotic break. In questioning her about her shame and guilt, she indicated abuse as a child. Age of onset for Anna was 18, somewhat earlier than the typical age of onset for paranoid schizophrenia. She spoke of anxiety and panic attacks occurring around the age of eight and her refusal to go to school for three months. What happened to Anna as a child that caused her to experience anxiety and panic attacks that continued to contribute to her isolation as an adult?

What if her delusions and auditory hallucinations were based on trauma? Her symptoms were clearly exacerbated under stress, and being anxious was one of the stressors.

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EMDR: The Problem of Looping in the Present

Dean Kelii Furukawa, D.S.W.

EMDR tends to work most efficiently and effectively when the core trauma is accessed and is targeted for reprocessing. The standard protocol of asking the client to recall the "first and the worst" incidence of a series of related traumas works effectively in tracking down a core trauma. When the original core has been identified, reprocessing tends to proceed smoothly and fluidly. There are times, however, when a client is mainly concerned with a present issue or experience and is unable or unwilling to explore earlier life experiences, as per the standard protocol.

Sometimes, upon starting reprocessing and using a current stressful situation as the target, the focus will "flip," following along a link, to other previous traumas. This following of links typically proceeds until the flipping accesses the "first and the worst" core trauma, and then the SUDs reduces. Once the core trauma has been accessed and treated, the linked traumas may reprocess. From this pattern of reprocessing, it seems that an initial core trauma can shock and overwhelm the psychic machinery, becoming lodged in the emotions and memory. A core trauma can constitute the first domino in a pattern of predisposed vulnerability to later, related traumas.

The Problem of Looping in the Present

One problem experienced in clinical practice is that sometimes a client may choose to target a current stressful situation which is other than the core trauma. Marty Jones, an EMDR Facilitator from the state of Washington, pointed out this tendency during an EMDR Level I training we facilitated. What follows in this pattern of reprocessing is a type of looping in the present, in which reprocessing may "bounce around" from one current life stressor to another in seemingly random fashion, but does not access the core trauma, while the client's SUDs level does not significantly reduce.

This kind of looping can be frustrating for both client and therapist. Although the core trauma may eventually be accessed, if it is not located, EMDR may be deemed ineffective and discontinued with that client. In essence, the therapist has done all the "right moves," but the reprocessing becomes stuck, looping in the present.

The standard EMDR protocol specifies returning to the original target and asking whether there is any change in the way the original target is perceived by the client, and then proceeding with any perceived change as the re-entry point for reprocessing. However, with looping in the present, the client usually reports no change, and the SUDs level does not reduce, so reprocessing only results in repeated looping in the present.

Tendency to Project Past Core Trauma Upon a Current Stressor

One theory which might be used to help conceptualize looping in the present is Freud's defense mechanism of projection. Freud (1926) recognized that patients undergoing analysis needed resistances such as the repression of threatening memories as protection against pain and that the defenses were like skin. The client may be unaware of projecting an anxiety-provoking past core trauma onto a current situation. This projection is the superimposing of a threatening stimulus or situation upon a less threatening object or situation, thus reducing anxiety but blocking the client from retracing the link back to the "first and the worst" incidence of a trauma.

Because the client only seems to be aware of the current situation as causing the stress, the current life situation appears to constitute the core, while in actuality it is only a trigger linked to the earlier core trauma. The verification is that when focusing on the current stressor, reprocessing flips to other current stressors but reprocessing does not progress—perhaps access to the core is being defended and blocked—and the SUDs level does not substantially decrease. Other factors may inhibit a client from targeting a core trauma. This could include, for example, a "wait and see" attitude of a client not sufficiently trusting the effectiveness of a new treatment method such as EMDR, and withholding a known core trauma from the therapist. Regarding the problem of looping in the present, I will focus on that which is blocked to the client's conscious awareness.

Methods to Track Down Core Trauma

Tracing Back the Negative Feeling

One way to trace back to the "first and the worst" incidence of a trauma is taught in EMDR training: have the client focus on the stressful situation and concentrate on the image, the negative cognition, the emotion, and the sensation. Then search for "where you first learned to feel this way." This is a highly effective way to locate the source material.

Listing the Five or Ten Worst Traumas

Another way to trace back a trauma to its core incidence is to ask a client to list his or her five or ten worst traumas, and then go back and have the client assign SUDs levels to each one. The client and therapist then select a trauma from the list to focus on, using the SUDs ratings to help select the best focus to with which to begin.

If a current life stressor from the list appears that it may be related to a prior trauma and the prior trauma has a higher SUDS rating, then it is best to start with the earlier, higher SUDs-rated trauma. If the two traumas are related,

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N=1: The 1st Guinea Pig's Report of Its Experiences with Experimental Software for Self-Administering EMDR

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http://www.trauma-response.com

Learning EMDR: Becoming a Guinea Pig

What a weird thing -that was my first thought, as I read a short notice about EMDR for the first time. At work in a psychiatric/psychotherapeutic day treatment programme, the number of multiple-traumatized patients increased rapidly. One patient decided to climb the roof and jumped, nearly to her death, driven by the memories of long-ago cruelties her father had done to her. With this in mind, I was conscious of urgently needing a method to treat these patients and finding something to manage the challenges of intrusive pictures and memories.

I took a second, but more practical look at EMDR and joined a Level I Training with considerable skepticism. That first EMDR training with Marilyn Luber in 1998 impressed me deeply, mostly the practical lessons of working with a little story from my own history and sensing the deep impact of this.

Self-Administration: The Idea

More in-depth reading about the subject of self-administration strengthened my decision to learn something new, not only for my patients, but also for myself. Self-administration of EMDR is described as extremely beneficial (Shapiro, 1995, p. 236). I started by using corners of my office to provide visual bilateral stimulation, then tried other ways, using points on the wall. I came to the realization that these methods were too uncomfortable and, on the spur of the moment, asked my computer-mad son to build a small software-programme to run on my PC.

My son converted my idea into reality—at first very primitive software with two arrows alternating right and left on the screen, nothing more than a PC equivalent of a metronome (Shapiro, 1994). The pace of displaying right/left alternation of rising arrows was not working well, so my son made improvements. When the next test started, I liked it except for the on-going problem that remained was the uncomfortable feeling of having the keep my face near the screen and not knowing the risks of doing so.

Starting as a Guinea Pig

Soon, the first challenge emerged for me at work: a demonstrative suicidal attempt by a patient really affected me. At home, self-administration with my little software program was a great experience, definitely providing greater distance from the clinical incident, while balancing my mind and opening my eyes and ears to my family.

I began using the program daily back home and began a log to gather my impressions of this kind of self-administration. (This report is based mainly on this log.) After a few days of writing, I understood that this small software programme might well prove to be a preventive tool for clinicians.

Inside Pace-Outside Speed

Having exhausted the software knowledge of my son, a close engineer friend with more software experience became interested. He expanded the possibilities of the software rapidly, allowing me to determine exactly the numbers of exposures as well as their speed. As the guinea pig, I tried very slow eye movements, but the only effect was that I became annoyed at the one-second exposition rate because it did not match my inner pace. I increased the speed to 0,2 or 0,3 second and got very strange impressions. After using it for some days, I observed shifts in body feelings and perception. For example, the right and left side of my face felt differently, sometimes bigger or smaller than one another. The arrows seemed to acquire shadows.

I varied the different speed settings and got the idea there are two distinctly different speeds --an inner pace for the subject and the outer speed of the software beats. To be effective, both rates must match each other: Too slow becomes annoying, while too fast is uncomfortable.

From Experiences to Instructions

Given the effects I was experiencing, I had to change the settings of exposition until I arrived at a speed which corresponded exactly with my personal course of experiencing and found my speed to be about 0,5 second. The following weeks went by in the same fashion—writing the log, thinking of my experiences and writing them down as instructions for the next guinea pigs to utilize. Discussions on the benefits of contra-lateral stimulation in long-term patients in the EMDR mailing-list inspired me to add sound and to synchronize arrows and tones.

Hand Washing and Teeth Brushing

Meanwhile, I got more and more used to working with EMDR in my clinical setting. Back home with the software, I processed the personal impact of some

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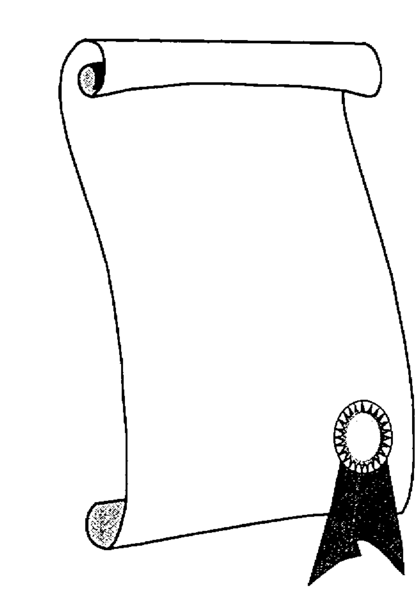
(Message from the President - Continued from page 1)
who choose not to do so. Our goal is to encourage and support the long-term development of EMDR therapists.

Among the many challenges my successor will face in the coming year will be to steer the growth of EMDRIA towards becoming a truly international organization. Some non-U.S. members have expressed concern that EMDRIA is not doing enough to support EMDR clinicians who live and practice in areas of the world outside the United States. We take this concern very seriously and have resolved to move ahead vigorously to establish affiliations with international groups of EMDR clinicians. Applications for affiliation have been sent to key groups around the globe. We will require that an affiliate group be operated as a non-profit organization with democratic elections and by-laws which are substantially in accord with our own. Some groups might choose not to affiliate with EMDRIA because of these requirements, but we believe that in time we will develop affiliations in all quarters.

We seek to communicate our positive intent to internationalize by planning to hold our 2000 Annual Conference in Canada in co-sponsorship with the EMDR Association of Canada. We are actively pursuing Newsletter contributions from EMDR practitioners from around the world and we seek international expertise to contribute to our committees. I envision that, in the very near future, we will have elections with an international slate of candidates for Officers and Board of Directors positions.

That brings me to my final subject—the EMDRIA election. This year, we enter the election with only one candidate for President and one for Treasurer. We have tried to solicit active EMDRIA people to consider running for these positions but, understandably, most realize the enormous time and personal and family sacrifice these positions require and elect to serve in other capacities. This year we were fortunate to find two very good souls to run for these most challenging positions of President and Treasurer. Please support these and the other candidates by taking the time to vote. A strong voter turnout represents an involved membership and sustains the morale of our many dedicated volunteers.

As a former President of EMDRIA, Steve Lazrove, said to me eons ago when I was contemplating accepting the nomination for President, "Dan, from a Buddhist perspective, serving as President is a purification process." Well, Steve, I think I might be able to slip through the eye of a needle now . . . Hope to see you in Las Vegas where I will pass the needle to Dave Wilson . . . !



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EMDRIA now has a formal application process for those who are interested in having workshops/trainings approved for EMDRIA Credits.

Please call Gayla Brown at the EMDRIA Administrative Office, 512-451-5200, for more information or to request your EMDRIA Credit Packet.

(Treatment of Pain - Continued from page 9)

Case Example

A 40-year-old mother of two with chronic pain and PTSD, "Sue" worked in a leather tannery. About two years prior to seeing me, she had an accident at work when a stand holding several hundred kilograms of animal hides toppled onto her. Her legs were pinned to the ground and she immediately felt excruciating pain. She suffered broken bones in her right foot and damaged nerves and tendons and chronic pain in her legs. She was also severely traumatized by the accident with recurring nightmares, flashbacks and panic attacks. She had to quit her job and underwent various medical investigations and procedures, but nothing seemed to alleviate her pain. She also reported that her treating doctors would not listen when she tried to explain that the site of most pain was not actually her foot but her knee. She had been prescribed pain-killers, but disliked taking pills and only took them when the pain became unbearable. She became very depressed as a result of constant pain, disability and uncertainty, and was referred for psychological treatment as a last resort. Her PTSD had not been identified because she tried to hide it as a means of coping. In addition, there was a compensation case pending. Sue was also unhappy in her marriage and believed her husband was cheating on her. Thus, the issues in this case were:

1. inadequately managed pain
2. uncertainty about diagnosis
3. medical mismanagement
4. communication problems with doctors
5. medication issues (fear of addiction)
6. comorbid psychiatric condition (PTSD)
7. marital problems

Although her medical investigations were not complete, I decided to use EMDR because I believed that the trauma could be resolved, and perhaps the pain could be resolved as well.

The two targets for reprocessing were the accident and Sue's pain. At the second session, I discussed her concerns about her diagnosis and the pain in her knee, and she reported that she was due to see another specialist in a few weeks time, so we left it at that. She indicated that the thing she wanted to feel better about the most was the accident, so we made the trauma the first target for EMDR.

She could easily recall the picture of herself lying on the factory floor underneath all the hides. Her negative cognition was "I could have been killed," and her SUDs rating was 10. Her positive cognition was "I survived," with VoC of 3.

During EMDR, her SUDs went down to about 5 and her negative cognition changed to "I'm helpless." She also reported a significant reduction in the pain she had been experiencing when the session commenced. The session had to be closed down before the reprocessing was complete. I gave her a relaxation tape that incorporates bilateral stimulation for home use.

After her second session of EMDR, Sue reported feeling more relaxed when having to get things down from high places at work, a concern that had really been bothering her, but she still felt some anxiety when remembering the accident. She reported trying the relaxation tape and finding it helpful but not nearly as effective as the therapy. She also reported that in the past week her pain had been much worse, 8 on a scale of 10. She indicated that although she was not totally cured of her PTSD, the pain was bothering her more and asked if we could try the EMDR on her pain.

Sue described her pain as a sensation of burning and pressure, and likened it to a tight, elastic band that was hot. Her negative cognition was; Athere's something wrong" and her SUDs (pain rating) was 8. I targeted the pain by instructing her to "just notice the pain the way you described it and follow my fingers." Following several sets of eye movements, between which she reported decreasing pain and different images, the pain intensity decreased to 1. Next, I asked her to describe the sensations she felt where the pain was previously in order to elicit something positive to use to start constructing a healing resource. She said it felt cooler and like the pressure had eased. I instructed her to "think of that" and did another set of eye-movements. She reported that the feeling was stronger. I asked her to "think about what that feeling is and what it reminds you of." She immediately replied, "a block of ice," so I instructed her to "think of that" and followed this with a few more sets until she had quite a strong association between pairing the block of ice and the feeling of comfort.

In the following sessions, we alternately addressed her trauma and her pain. She reported report good pain relief following sessions, sometimes lasting up to 24 hours, but that the pain would gradually return. It also emerged that she was unhappy in her marriage, she felt ignored by her husband, who worked long hours and Sue was sure was sleeping around. She began to realize she was very unassertive.

By her fifth session, Sue reported a complete cessation of flashbacks about the accident, but recalled being sexually abused as a child. This was painful for her, involving a close relative, and she felt deep shame and guilt about it. She had never told anyone, and had tried not to think about it all her life. In the following five sessions, we addressed both her pain and her abuse.

The pain remitted following sessions, only to return a day or so later. The antidote imagery was only of short-term effectiveness. Sue was scheduled to see a medical specialist about the knee the following week. Nevertheless, I asked her if her knee pain had any meaning to her in terms of physical pathology. I instructed her to "picture the injury that was causing the pain." She was able to do this easily and said that it felt like something was broken, but not a bone. She

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(Case Study - Continued from page 11)
What if she could learn to calm herself and know she was safe? Did Anna have the capacity to follow protocol and establish a safe place? What if she were to do any type of trauma work? Would trauma work cause her to break with reality even more?

Considering EMDR

Many questions ruminated in the recesses of my mind as I contemplated using EMDR with Anna. With concern for her safety foremost in my mind, I decided to proceed for several reasons. In earlier years, Anna had good inter-episode functioning with little residual symptoms. She worked and carried on relationships with family and friends with relative ease. No family history of mental illness was documented, but she stated that alcoholism ran in the family, which may be indicative of self-medication. Affect and cognitive functioning were intact but blunted due to medication. Anna could follow through with goal-directed behavior and actively tried any method introduced to her for self-soothing purposes. Additionally, she had fairly good insight into her illness and educated herself about her medications and illness when given the opportunity.

We had excellent rapport and I knew she would not hesitate to call me if she was having undue problems, even if she did not always trust me due to her paranoia. One difference was that Anna did not smoke cigarettes or otherwise use nicotine. In my experience with people with schizophrenia, Anna was the only one who refrained from smoking. While I would not adhere to non-smoking as criterion for the selection process, it was a notable difference in Anna.

Introducing EMDR

I decided the safest approach in using EMDR was initiating the process through the use of safe place and resource installation exercises. In this manner, I could observe Anna's reaction to EMDR processing and gauge whether they had an effect on her, whether she could follow through with instruction, and whether she had any adverse effects from bilateral stimulation.

After providing Anna with a lengthy explanation of EMDR, we tried various modes of bilateral stimulation to see what was most comfortable for her. She had great difficulty tracking with her eyes, perhaps due to the sometime inherent saccadic eye-tracking problems associated with schizophrenia.

Anna felt most comfortable using a bilateral audio tape and knee tapping and chose and enhanced her own safe place using the audio tape. We followed standard procedure for creating a safe place, and she became visibly relaxed during the exercise. Her breathing slowed, her face softened. She smiled and remarked on how nice it was to relax. We spent two hour-long sessions on Anna's safe place. She also utilized it with success during a two-week period whenever she was feeling anxious. This prompted me to introduce some resource installation and containment exercises, which we worked on for the next four weeks. Anna imagined a concrete-lined room behind bulletproof glass that contained a large steel safe. She placed her symptoms within this safe and locked it tight.

After this exercise, Anna stated, "I hear the voices, but they are only whispering" We returned to the image many times, as the voices managed to eventually "escape" and reach their previous level (sometimes in days, sometimes in hours), depending on Anna's external stressors. I assume these levels returned because her original traumas were not fully processed and the probability that Anna would always react with a level of psychosis under stress. However, I needed to see whether Anna would actively use her safe place and whether she could incorporate the images from the resource installations into her repertoire of coping mechanisms. In my mind's eye, I always pictured a person with schizophrenia having ego-strength that is "broken." Her ego functioning would need to be strengthened to even consider any type of trauma work.

Installing Resources

On the average, Anna was hospitalized once per year, usually around the holidays or shortly thereafter, for unmanageable psychosis. The holidays were only a few months away, so I hoped to slow or possibly stop the inevitable break.

Anna chose an image of "Healthy Anna," who could go to and enjoy social functions without being afraid, for one of her first resource installations.

"What is most distressing to you right now in your life?"

"Being scared."

"Do you have any negative words that go with that feeling?"

"I'm in danger."

"Can you think of a time when you didn't feel that way?"

"When I was a child."

"Can you describe what that was like?"

"I was a little girl at Grandma's house during Christmas. I was so happy then. We had lots of family and food. I picture myself sitting with them, smiling. Nothing bothered me, everything was okay."

"Describe that little girl to me."

"She was pretty small, about six. She wore a dress with pigtails and she is smiling. She's sitting next to the others on the couch and it smells good. It feels good to be at Grandma's."

"What emotions go with that?"

"Mostly happiness."

"Where do you feel that in your body?"

"In my arms and hands."

"What word or phrase would you use to describe all this?"

"I am happy and calm."

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Video Workshop

by Landry Wildwind, LCSW

Adapting EMDR with Depressed and Resistant Clients

Treating Depression and Resistance with Essential Experiences

A nurturing interweave protocol based on developmental & psychodynamic theory.
Taped at December, 1996 EMDR Institute Advanced Applications Training.
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About the Presenter

LANDRY WILDWIND, L.C.S.W., has been has been designing and presenting training materials for clinicians for 30 years and has been in private practice for 15 years. Her practice specialties include: depression, relationship difficulties, success inhibition, midlife, ADD, dissociative and abuse-related disorders.

She was trained in EMDR in 1990, 1991 and 1992. She served as a facilitator from 1990 to 1995, and participated in trainer training for three years with the EMDR Institute. She gave her first EMDR International Conference presentation in 1993 on depression and resistance, with further Conference presentations in 1994, 1995 and 1998. The 1996 workshop video represents six years of development and experience in this specialty area.

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BioLateral™ Sound Recordings: An Effective Alternative to Eye Movements

Invented and Produced by
David Grand, RCSW, EMDR Facilitator

What Are BioLateral™ Sound Recordings?

Bio*Lateral*™ Sound Recordings (or Bio*Lateral*™ for short) are tapes and CDs which can replace eye movements in EMDR stimulation. Their ability to integrate bilateral and psycho-acoustic stimulation is opening new vistas of treatment, healing, relaxation, and meditation. Bio*Lateral*™ offers one of the least costly of all alternative EMDR technologies and can be easily used by clients during, as well as in between, sessions. Through the use of Bio*Lateral*™, clients frequently report experiencing deeper meaning, increased insight, and improved ability to synthesize material.

More than 2000 BioLateral™ tapes and CDs have been sold and are being used around the United States, Canada, Europe, South America, and Australia. After more than two years of use, feedback regarding the efficacy of BioLateral™ tapes continues to reflect excitement and enthusiasm.

How Were BioLateral™ Tapes Developed?

Bio*Lateral*™ tapes were created in a production studio by myself and musician friend, Evan Seinfeld, the lead singer of the rock group Biohazard. Instead of making a tape limited to tones that alternated between the left and right speakers, we decided to incorporate music-like sound. We recorded and experimentally mixed six separate tracks using the healing sounds of ocean waves, a Tibetan bell, an Indian drum, and a synthesizer, utilizing computer technology to encompass frequencies across the sound spectrum. After production, we found that the free-form nature of the production process infused the tapes with human, creative, and spontaneous qualities.

The first tests of Bio*Lateral*™ were performed with friends and family, who uniformly reported they experienced a powerful relaxation effect with both soothing and deep, yet non-agitating, processing. I began using Bio*Lateral*™ with clients in session using a stereo "walkman," providing clients with a Bio*Lateral*™ tape for home use between sessions.

The success of the original tape led to requests for new ones. We accordingly returned to the studio and recorded Bio*Lateral*™ 2–*Going To Wave Lengths*, which combines ocean sounds with a bilateral brush tone and Bio*Lateral*™ 3–*Round the Lake*, which fully integrates the bilateral stimulation into music that sounds both Gaelic and Eastern, and Bio*Lateral*™ 4–*A Simple Progression*, a basic bilateral chorded eight-step progression. Responses to all of the tapes continued to be enthusiastic. I have also recently released a CD, *The Best of* Bio*Lateral*™, which contains tracks of all four Bio*Lateral*™ melodies, digitally remastered for the highest sound quality possible.

How Is BioLateral™ Used?

It is easy to personally evaluate the effectiveness of Bio*Lateral*™—simply sit in a quiet place and think of something that is bothering you at that moment. Work up your own protocol with a SUDS and follow your associations. Then, observe the nature of your processing and occasionally return to target and retake the SUDS. In session, work up or use an existing target and protocol. Then, have clients listen to the tape, again using stereo headphones (no eye movement is necessary). Inform clients that all they have to do is to observe the flow of their processing, although they have the option of keeping their eyes open or closed. You may stop them periodically to check "where they are" or have them stop when they have reached a period of quiescence or have something they want to verbally report.

How Will My Client's Benefit from BioLateral™?

Bio*Lateral*™ tapes and CDs take advantage of the client's ability to process through auditory stimulation and provide an effective, low-cost means of effecting bilateral stimulation, including the following advantages:

- The left/right aural tones produce the same bilateral stimulation as the eye scanning, eliminating the need for eye movement.
- Client eye strain, as well as therapist arm and shoulder stress, are eliminated.
- The passive stimulation of Bio*Lateral*™ tapes tends to reduce client distraction that can result from other methods.
- Clients can choose to process with their eyes closed, allowing for more imagery and deeper processing.
- The tapes and CDs allow each set to continue as long as you or the client chooses. Therapists have reported that educated clients are often better able to determine the length of a set as they are witnessing the processing "from the inside."
- With Bio*Lateral*™ tapes and CDs, sets can last for many minutes and may contain hundreds, and sometimes thousands, of repetitions.

- Bio*Lateral*™ can even be played during a non-EMDR session for deepening the process and enhancing insights.
- A number of therapists have reported that Bio*Lateral* has helped some dissociative clients process with less agitation.
- Clients can listen to Bio*Lateral*™ throughout the session, even when dialoguing with the therapist, often helping clients to experience deeper meaning, greater insight, and synthesis of material.
- Bio*Lateral*™ can be used in between sessions to reduce client agitation, generalized anxiety and panic attacks, insomnia, and to understand and control cravings and compulsive behaviors.

Bio*Lateral*™ Tapes and CD Currently Available

Bio*Lateral*™ 1—*Original Recipe* ($15 each)

Comprised of six separate tracks, experimentally mixed, using the healing sounds of ocean waves, a Tibetan bell, and an Indian drum as well as Evan Seinfeld on the synthesizer. Utilizes computer technology that psycho-acoustically stimulates sound frequencies across the audible sound spectrum. The free-form production process infuses Original Recipe with a natural, creative, and spontaneous essence.

Bio*Lateral*™ 2—*Going To Wave Lengths* ($15 each)

Combines ocean sounds with a bilateral brush tone. Especially helpful for processing with individuals distracted by music. Particularly effective for combining with the client's safe place and reducing insomnia and agitation in between sessions.

Bio*Lateral*™ 3—*Round the Lake* ($15 each)

Fully integrates the bilateral stimulation into lilting, cheerful music with Gaelic and Eastern influences. Includes a background harp with a slow bass guitar tone and Evan Seinfeld on guitar live in studio.

Bio*Lateral*™ 4—*A Simple Progression* ($15 each)

Can be powerful in its evocative simplicity and accordingly should be played on a low volume. Effective with highly distractible clients due to the absence of background sound or music. Utilizes an eight step progression of piano chords simply delivered alternating between left and right ears.

Bio*Lateral*™ 5—*No Frills* ($15 each)

Basic bilateral tone at 120 beats per minute. At low volume simulates rain drops, played louder reminiscent of a conga drum. For those who prefer a faster cadence and uncomplicated sound.

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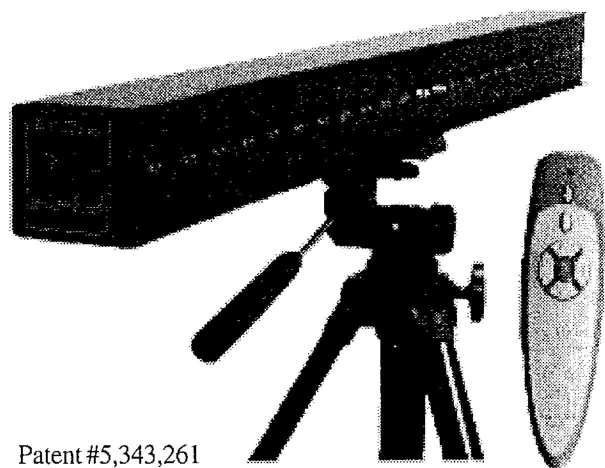

Patent #5,343,261

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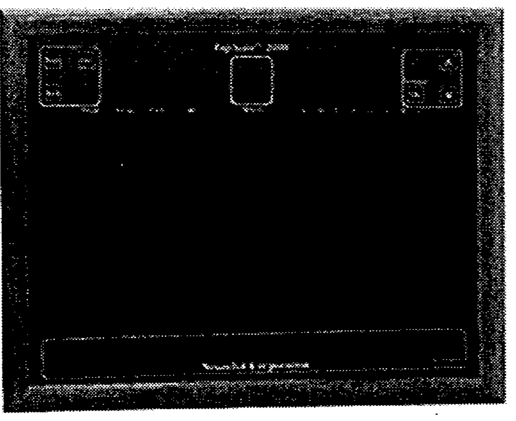

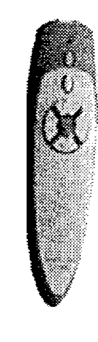

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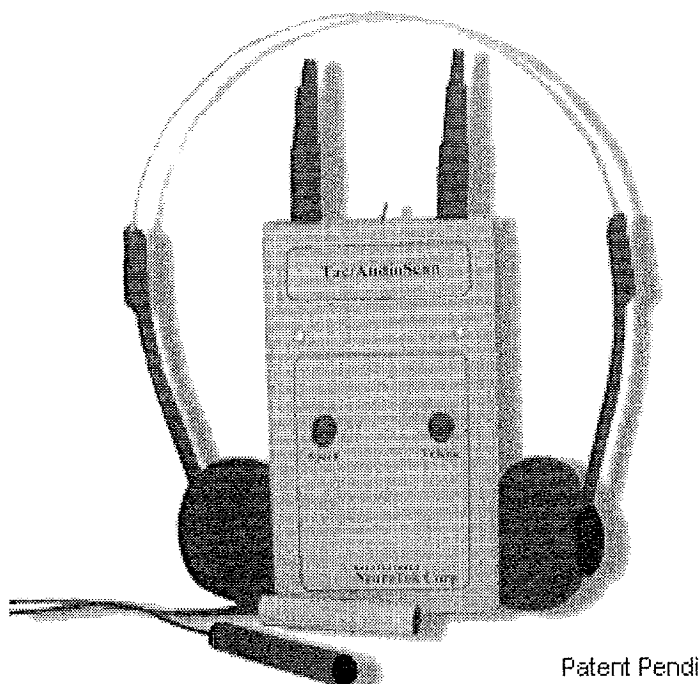

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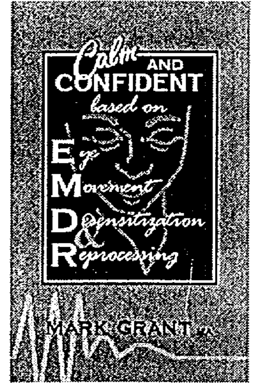

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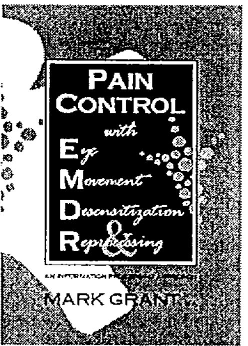

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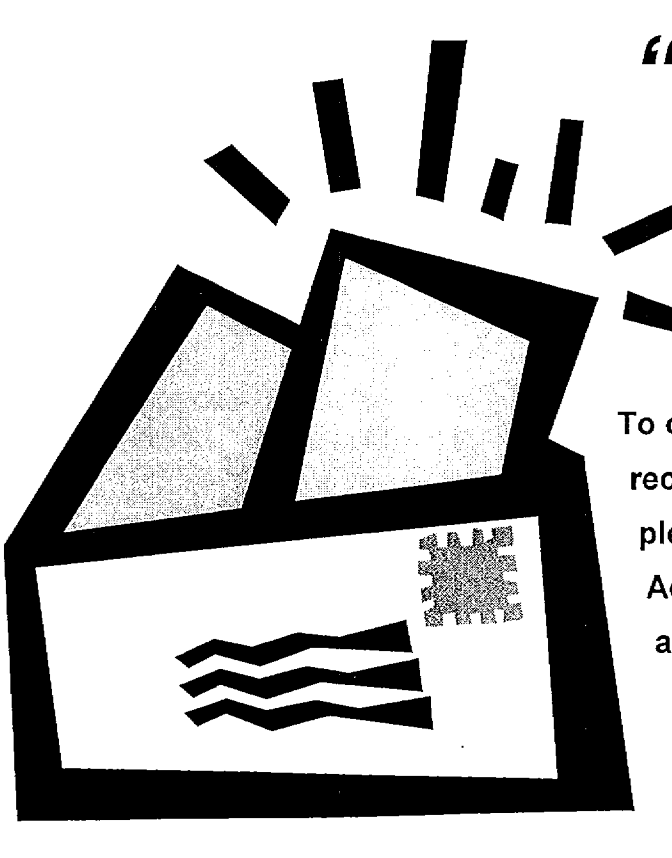

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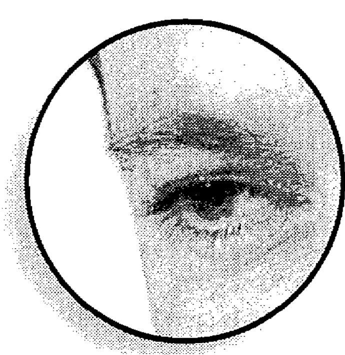
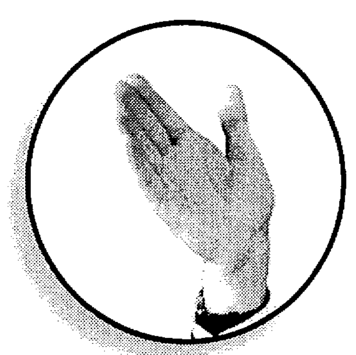

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(Strengthening Affect Tolerance - Continued from page 10)

I said, "Stay with that," and we began sets of eye movements.

Thus the question, inquiring "what's good about" avoiding a disturbing image, elicited information about that disturbing image, and that information could then be processed. With this focus on her wish to avoid disturbance, and the creation of emotional distance through the metaphor of a movie theater, she was able to stay emotionally present, and benefit therapeutically from EMDR.

After several sets of eye movements, the client was clearly feeling less distress. I then returned to target by asking, "What is good, right now, about being in the projection booth?"

The client said, "It's like I'm standing outside the whole thing and I'm not part of it so it doesn't hurt," and I repeated, "Stay with that." After about ten to 15 minutes of additional processing, she was able to think of the rejection incident directly, and move towards resolution in the usual EMDR fashion. By the end of this session, her SUD on this issue was a "3" and went to "0" the next time we met.

The boxes below illustrate the steps of this procedure.

Step 1. Initial attempt to use standard EMDR. When the client attempts to think of the "worst part" of the traumatic event, he or she is overwhelmed and terrified, and reports dissociative numbness. Estimated SUD of "20-30." EMDR cannot and should not proceed.

Step 2. Client is encouraged to construct in imagination one or more levels of dissociative "distancing" from the traumatic event. The client may be asked to be an observer of the trauma, seeing himself or herself and the event from a safer vantage point (i.e., watching a movie of the trauma, or observing the trauma "from today, as the person you are today"). For some clients, one level of deliberate dissociation will provide enough safety to permit processing. For the client in the above example, the image was still too disturbing. Thus, a second level of dissociation was suggested; i.e., the client was asked to *observe the observer*. This created an additional buffer to protect against the intense disturbance of the target image.

Step 3. Client is asked to create, or strengthen, an avoidance defense relative to the constructed dissociative images. This client was asked, "What is good about being in the projection booth?" With another client, a 0-10 scale of avoidance might be used, i.e., "How much, 0-10, do you not want to be down there watching the movie?" or, "When you realize the movie is running, how glad are you, 0-10, that you are in the projection booth where you can't see it?" The client is being asked to focus on the *positive* affect (relief, escape) associated with the avoidance. This affect can be located in body sensations. The focus on avoidance reduces the level of disturbance, and allows the client to remain present for processing. *Combining this avoidance affect with eye movements will typically result in a simultaneous strengthening of objective perspective and desensitization of post-traumatic material.*

Less Disturbing

This method can be tailored to the needs of the individual. For clients who easily loses their adult perspective when thinking of childhood trauma, a question might be, "When you, the adult you are today, see yourself as a child (in an abuse situation), what is good about being you the adult and not that child?" The particular cognitive interweave statements produced by the client in response to this question are often more uniquely valuable, in facilitating processing, than interweaves supplied by the therapist.

An objection might be raised to this method: in asking the client to deliberately dissociate from his or her own traumatic experience, aren't we creating pathology? It is true that dissociation as a general personality defense is harmful, but many clients inaccurately regard their dissociative processes as "morally bad." It can be reassuring for them to see, through the use of the above procedure, that dissociation is simply something they learned to do to protect themselves against painful situations. Through this method, the client is asked to utilize this learned skill for their therapeutic benefit.

A related objection might be that this procedure could the clients' fantasies that they can escape permanently from their traumatic memories, without working them through. This fantasy may express a client's wish, but most people in therapy are able to acknowledge that this "wishing away" approach has been unsuccessful. I generally explain the rationale behind the method before we begin—i.e., that EMDR combines eye movements with "one foot in the present and one foot in the past." The above-described procedure strengthens the individual's ability to remain in the present, so that he or she can then resolve the past. As always, of course, no protocol can be an adequate substitute for clinical judgment and knowing the needs of the person seeking help. For individuals with DID or severe DDNOS, dissociative barriers may need to be strong within the ecology of the personality system and, in these cases, the use of the method as described above would be unwise. But, for many clients with debilitating fear of their own experience, these procedures may be helpful.

References

Cameron-Bandler, Leslie (1985) *Solutions*. San Rafael: Futurepace.

Erickson, M.H. and Rossi, E. (1979) *Hypnotherapy:An exploratory casebook*. New York: Irvington.

⇔

(Treatment of Pain - Continued from page 15)
also realized that she was unhappy with the medical treatment she had received, and that she did not feel that the doctors had been very thorough in their investigations.

The following week, when she visited the specialist, who agreed to an MRI scan of her knee and thus detected a torn ligament in the knee. She realized with surprise how similar this was to what she imagined was wrong, even though she had no way of knowing exactly what was wrong with her knee. There was nothing medically that could be done for her knee, but knowing what was wrong helped her to be able to develop antidote imagery to relieve the pain associated with it.

Over the next few sessions, we developed antidote imagery until Sue finally settled on a "healing hot pack around my leg." Her ability to regulate her pain increased. By the end of treatment, (total of 12 sessions) Sue had almost entire weeks that were pain-free, although she accepted that her knee would need time.

A telephone call 18 months later indicated Sue was still coping well and free of PTSD symptoms. She added that she had instigated legal proceedings against the man who had sexually abused her, a step she could never have imagined prior to therapy. She had also left her unfaithful husband and enrolled in a management course. She added that she had found a new boyfriend "who treats me like a person" and "I have taken life with both hands and I am not going to let anyone else choose the path my life takes."

In this case, EMDR proved to be an efficient and effective approach for a complicated case of chronic pain. The author has also found EMDR extremely effective in the treatment of psychosomatic pain and somatization. For example, complete pain relief was obtained in less than an hour for a woman with severe pain in her jaw, of one-year duration following the death of her son. Her pain was so severe, it prevented her from eating solid foods. Following treatment she reported being able to move her jaw without pain and looking forward eating normally again. Complete and permanent pain relief was obtained in a single session in a woman with chronic shoulder pain associated with tension brought on by situations in which she felt inadequate.

Although these are only case studies, they suggest that EMDR can be effective in various pain complaints. However, unlike what is sometimes reported with trauma (McCann, 1992), one-session "cures" are much less common in the treatment of pain. With complicated chronic pain, often the most that may be hoped for is—significant alleviation and improved coping (Grant 1999). EMDR has not proven to be very effective in cases where the pain was both excessive and inadequately controlled, or in cases in which the pain was "ecological" (signaling undiagnosed pathology) or in which the pain was linked to neuroses the client was not willing or able to address.

In summary, EMDR holds potential as a treatment for various types of pain, within the context of a comprehensive approach to assessment and treatment. The key issues in EMDR treatment of pain are: a good assessment including review of medical interventions; preparedness to address any shortcomings in medical treatment; selection and construction of a good target; ability to maintain processing (cognitive interweave); development of antidote imagery—all within the context of an excellent therapeutic alliance by a knowledgeable therapist. A critical reading of current pain literature is also advised.

References

Barber, Joseph (1997). *Hypnosis and suggestion in the treatment of pain: A clinical guide.* W.W. Norton, New York.

Beals, R.K. (1984). Compensation and recovery from injury. *Western Journal of Medicine*, 40, 276-283.

Bradley, Lawrence A., Young, Larry D., Anderson, Karen O., Turner, Robert A., Agudelo, Carlos A., McDaniel, Lisa K., Pisko, Edward J., Semble, Elliott L., and Morgan Timothy M. (1987). Effects of psychological therapy on pain behavior of rheumatoid arthritis patients. *Arthritis and Rheumatism*, Vol 30, No 10, 1105-1114.

Brown, Walter (1998). The Placebo Effect. *Scientific American*, Vol. 278, No. 1. Jan 1998, 68-73.

Burns, J. W., Sherman, M.L., Devine J., Mahoney N., Rawl, R. (1995). Association between workers compensation and outcome following multidisciplinary treatment for chronic pain: Role of mediators and moderators. *The Clinical Journal of Pain*, 11, 94-102.

Carlson, J.G., Chemtob, C.M., Rusnak, K., & Hedlund, N.L. (1998). Eye movement desensitization & reprocessing for combat-related PTSD. *Psychotherapy*, 33, 185-195.

Davis, G. (1989). The Clinical Assessment of chronic pain in rheumatic disease: Evaluating the use of two instruments. *Journal of Advanced Nursing*, 14, 397-402.

Eccleston C., Amanda, C., De C Williams and Stainton-Rogers, Wendy (1997). Patients and professionals understandings of the causes of chronic pain; blame responsibility and identity protection. *Social Science and Medicine*, Vol. 45, No. 5, 699-709.

Flor Herda, Fydrich, Thomas, and Turk, Dennis C. (1992). Efficacy of multidisciplinary pain treatment centres: A meta-analytic review. *Pain*, 49, 221-230

Fordyce, W.E. (1976). *Behavioral methods for chronic pain and illness*. St. Louis, Mississippi. Mosby.

Gallagher, R.M., Williams, R.A Skelly, J., Haugh, L., Rauh, V., Milhous R and Frymoyer, J. (1995). Workers compensation and return-to-work in low back pain. *Pain*, 61, 299-307.

Gamsa, A. (1994). The role of psychological factors in chronic pain. II. A critical appraisal. *Pain*, 57, 17-29.

Grant, Mark (1999). *Pain control with EMDR.* Mentor

Books, Denver Colorado, USA.

Gatchel Robert J & Turk, Dennis, C. (1996). *Psychological approaches to pain management.* The Guilford Press, New York.

Golomb, Claire (1992). *The child's creation of a pictorial world.* University of California Press, Berkeley.

Hekmat H., Groth, Suzie, & Rogers, Dorothy (1994). Pain ameliorating effect of eye movement desensitization and reprocessing. *Journal of Behavior Therapy and Experimental Psychiatry,* Vol. 25, No. 2., 121-129.

Hitchcock, Laura (1994). The experience of chronic non-malignant pain. *Journal of Pain and Symptom Management,* Vol 9, No. 5, 312-318.

Horn, Sandra & Payne Shiela. (1997). Pain: theory: *research and intervention.* Open University Press, Buckingham, Philadelphia.

Jackson, J.E. (1992). After a while no-one believes you — real and unreal pain, in:. *Pain as human experience: An anthropological perspective.* Eds. M.J. Delveccio, Good P.E., & Klienmann A. University of California Press, Berkeley.

Kerns, R.D, Turk D.C., Holzman A.D., & Rudy, T.E. (1986). Comparison of cognitive-behavioral and behavioral approaches to the outpatient treatment of chronic pain. *Clinical Journal of Pain.* 1. 195-203.

King, Robert (1998). Evidence-based practice: Where's the evidence? The case of cognitive behavior therapy and depression. *Australian Psychologist* Vol. 33, No. 2, 83-88.

Laynne, Viv (1997). Pain management: a survey of psychologists and other health professionals in clinical practice. Field study for Masters of Education in Counseling. University of Canberra, Australia.

Lenz, F.A. Gracely, R.H. Zirh, A.T., Romanoski, A.J., Stats, P & Dougherty, P.M. (1997). The sensory-limbic model suggests testable hypothesis about the learned component of the affective dimension of pain. *Pain Forum,* Vol. 6, No.1, 41-43.

LeDoux, Joseph (1993). Emotional memory systems in the brain. *Behavioral Brain Research,* 58, 69-79.

LeDoux, Joseph (1996b). Emotion, memory and the brain. *Scientific American,* Special Issue: Mysteries of the Mind.

Lutz, R.W., Silbret, M. and Olasahn, N. (1983). Treatment outcome and compliance with therapeutic regimens: long-term follow-up of a multidisciplinary pain program. *Pain,* 17, 301-308.

Marcus, S., Marquis, P., & Sakai C. (1997). Controlled study of treatment of PTSD using EMDR in HMO setting. *Psychotherapy,* 34, 307-315.

McCann, D.L. (1992) Post-traumatic stress disorder due to devastating burns overcome by a single session of eye-movement desensitization. *Journal of Behavior Therapy and Experimental Psychiatry,* 23, 319-323.

Melzack, R. (1987). The Short Form McGill Pain Questionnaire. *Pain,* 30, 191-197

Olin, Jackson & Keating, Caroline (1998). *Rapid Psychological Assessment,* Wiley. New York.

Pilowsky, I and Barrow, C.G. (1992) Predictors of outcome in the treatment of chronic "psychogenic" pain with amitriptyline and brief psychotherapy. *Clinical Journal of Pain,* 8 358-362.

Pither Charles E., & Nicholas, Michael K. (1991) The identification of iatrogenic factors in the development of chronic pain syndromes: abnormal treatment behavior? In: Bond, M.R., & Charlton J.E. (Eds.) Proceedings of the VIth World Congress on Pain.

Rao, Patrick M., Rhea, James T., Novelline, Robert A., Mostafavi, Amy A., McCabe, Charles J. (1998). Effect of computed tomography of the appendix on treatment of patients and use of hospital resources. *New England Journal of Medicine.* Jan 15, Vol. 338, No. 3. 141-146.

Romano, J.M., & Turner, J.A. (1985). Chronic pain and depression: does the evidence support a relationship? *Psychological Bulletin,* 97, 18-34.

Rosensteil Anne K. and Keefe, Francis J. (1983). The use of coping strategies in chronic low back pain patients: relationship to patient characteristics and current adjustment. *Pain,* 17, 33-44

Salerno, Evelyn & Williams, Joyce, S. (1996). *Pain management handbook,* C.V. Mosby, St. Louis.

Schmidt, A.J., Gierlings, R.E.H. & Peters, M.L. (1989). Environmental and interoceptive influences on chronic low back pain behavior. *Pain,* 38, 134-137.

Shapiro, Francine (1989). Eye movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry,* 20, 211-217.

Shapiro, Francine (1995). *Eye movement desensitization & reprocessing: Basic principles protocols and procedures.* Guilford Press, New York.

Solomon, P.,& Tunks E. (1991). The role of litigation in predicting disability outcomes in chronic pain patients. *The Clinical Journal of Pain,* 7:300-304. Raven Press Ltd, NY.

Turk, Dennis C & and Rudy, Thomas E. (1991). Neglected topics in the treatment of chronic pain patients: Relapse, non-compliance and adherence enhancement. *Pain* (44), 5-28.

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(Self-Administration - Continued from page 13)
uncompleted sessions at work. My observation—not particularly astonishing—was that only successful and complete sessions need no further self-administration.

More and more I learned what we all know, but perhaps do not want to know, that working as a clinician can be dangerous (Figley 1995a). Our profession is at high risk and working with traumatized patients probably increases our risk of getting suffering mentally and becoming re-traumatized. The shattering atrocities we face with our patients are impressing us. We are the profession with the greatest likelihood to become secondary victims reexperiencing the trauma events of our patients, developing avoidance behavior and persistent arousal. "There is a cost to caring" (Figley, 1995, p.1), even when we are using such a powerful psychotherapeutic approach as EMDR. Surgeons wash their hands. And what do we? Our souls get flooded with blood, tears, and sweat—and then we go home (Pearlman, Mac Ian 1995; Saakvitne, Pearlman 1995, p.150-177).

Two pictures came up: first, the picture of the hand washing of surgeons and then the picture of brushing one's teeth. Hand washing symbolises cleansing oneself from the daily input of cruelties we gather via our patients. Teeth brushing reminds us that we could do some equally preventive work for ourselves by preparing before starting work (Stamm 1995).

The Past and the Future

The next incident supported this idea. I was faced with having to preside over a school administration council with about 50 members. Using self-administration, the small performance anxiety which I sometimes develop vanished. I decided to use the software in the morning to start the day and again back at home after work—to prepare myself for the clinical challenges of the day and back home to get more distance from psychiatric issues, which kept on bouncing around in my head after work.

No Stress/No Need

I continued my daily routine of using the software at morning (teeth-brushing) and in afternoons after working at the hospital (hand-washing). After some time, I realized that my use decreased during the weekends. Some weekends, I felt no need for self-administration. I tried to continue as per usual, but quickly there was increasing evidence: no stress, no need to use self-administration.

Real and Virtual Little "t's"

During the holidays, I built an iron balcony. Balancing on the top of the frame, three meter above the ground. With little competence with this kind of task, I felt very cautious, but secure, nearly all the time. The whole business was quite a success and nothing unfortunate happened.

At bedtime, however, I suddenly remembered my fantasies and what could have all gone wrong while working—my pre-sleep tiredness vanished completely. I reminded myself that nothing unfortunate happened, no accident, nothing—my son wasn't battered by a suddenly fallen iron. Yet, I wasn't able to get rid of these thoughts.

The pictures of all the negative possibilities of the previous day arose and were driving the last wisps of tiredness away. I used EMDR with eye movements in the corners of the room and after only a few minutes felt sound asleep! This was a great experience.

Obviously, one can be traumatized not only in reality, but also in virtual reality, but I found that, best of all, self-administration can put an end to this. Working as a clinician for years I realized an increasing dislike looking at thrilling TV scenes (Freinkel et al.1994, Mazor 1997) and now I started to process such pictures, too.

Work-Related Issues: Biographic Background

Some team discussions and conflicts back at the hospital were causing me sorrow, so I processed with the software. While following the arrows, new thoughts emerged from my past. I remembered a situation with an elder brother years ago. The feelings connected with these ancient pictures and all the circumstances emerged. A new and entirely different subject had arisen.

I stopped administration at once and followed strictly the eight steps of the EMDR protocol. I formed my Negative Cognition, developed a Positive Cognition, estimated my actual SUDs, and started administration again. The SUDs decreased, as usually seen with my patients. The Positive Cognition changed a bit and, with a body scan, I finished the process. Following the steps of standard protocol, I managed to return to my work-related issues with more success.

In all day use of self-administration, just following all spontaneously arising impulses is really sufficient, but as we know sometimes these small "t's" are connected with underlying events, cognitions, or body sensations. In these cases, which we have to discriminate, the strict use of the standard protocol is essential. I utilized the Level II practicum to process the situation with my brother further.

Habituation?

The weeks went on and the use of the software got routine. Sometimes there were special questions to be processed. Consulting my log, I realized my growing impression that there is a habituation effect. I got annoyed with self-stimulation and really felt no more benefits. My only thesis to understand this development is that there is an habituation effect. To fight this, my friend and I

(Continued on page 32)

The Health Care Committee Needs You!

The EMDRIA Health Care Committee's ultimate goal is industry-wide acceptance of EMDR by the health insurance community. To that end, the Committee is currently moving the process of interaction with the managed care world into higher gear.

Contacts with the MCO world have clearly indicated that we must make direct presentations to managed care decision-makers, and we are developing a protocol to approach, meet, and persuade managed care organizations to accept EMDR as a treatment component. If you would like to participate in the process is invited to e-mail the Chair of the Health Care Committee:

Mark Dworkin, CSW, LCSW
mdwork5144@aol.com

We appreciate your help. Please understand that this will be a time-intensive project, and participants must know the research and be prepared to defend it.

Please Join Us for Lunch . . . if you are interested in volunteering your time to help with the needs of the Health Care Committee

**Saturday, June 19th
1999 Conference
in Las Vegas**

Book Review: Joan Lovett's Small Wonders

Frankie Klaff, PhD, Facilitator

Reading Joan Lovett's *Small Wonders* offers a privileged peek into the office of a gifted therapist. Dr. Lovett, a behavioral pediatrician (Dr. Love-it-all to one of her young patients), provides valuable clinical evidence of the efficacy of EMDR when used with young children and even adults whose current anxieties and phobias are rooted in earlier childhood negative experiences. Tales of children who have had accidents, been abused or traumatized by the simple thoughtless act of a teacher, loss through death, or unpleasant experiences such as head lice are poignantly recounted in a direct and engaging manner.

"Families continue to offer me new mysteries, each story beginning with a familiar theme of distress and confusion" (P.210). The impact of traumas large and small is sometimes not realized until the mystery of a present behavior is unraveled by our intrepid Dr. Lovett. Her investigations reveal the symbolic representations of children's traumas and worries. This detective work demonstrates her skill at revealing complex emotional processes. While judiciously following the protocol guidelines, she embeds EMDR into multi-dimensional therapy that includes elements of psychodynamic and cognitive behavioral principles, using play and family therapy as the contextual model.

Dr. Lovett uses small toys and parental storytelling as the innovative vehicles to apply EMDR. These interventions may appear simple but, like a true magician's craft, require careful strategic planning, timing, and implementation. They provide not only good case history stories but precise directions for her adaptations and techniques of applying EMDR.

Her contribution to the clinical application of EMDR is twofold: readable, engaging stories for the lay public such as parents of children in treatment and a lucid clinical guide for the EMDR therapist working with children.

Reference

Lovett, J. (1999). *Small Wonders*. New York. The Free Press.

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(Case Study - Continued from page 16)

"Okay, and notice where happy and calm is in your body."

"Now, imagine that little girl with her happiness grow larger until you can feel the two of you come together."

"Think of your words happy and calm and where they are in your body. We'll do this a bit longer as long as you feel happy and calm getting stronger."

We proceeded with various permutations and repetitions of this exercise. Anna chose another image of a time when she was ill but much better able to cope with her symptoms, naming the resource "Miss Brave." During this period, Anna began showing significant improvement in social functioning. She went shopping, visited and played cards with others in her building, and went out to eat twice a week.

Recalling Early Trauma

We continued with weekly sessions. Anna began talking about the panic attacks she experienced as a child and how she always felt that she was not good enough to be liked by others—she always felt different. At age nine, Anna missed three months of school because of her feelings of anxiety following an incident of sexual abuse by her grandfather. Her mother walked in during one incident and screamed at Anna for being a bad child. Anna fled up the stairs and cowered behind a dresser while her mother berated her for her sinful, inappropriate behavior.

It seemed a reasonable assumption that this incident was just the beginning of Anna's overwhelming feelings of guilt, her feeling that she was never safe. This may have been the incubus that spurred her eventual breaks with reality with delusions of overwhelming guilt and safety issues. Anna appeared as stable as I had seen her in a long time and was willing to discuss her earlier experiences of abuse, which were never addressed in her long history of treatment. She seemed to understand that these incidents could be linked to her current functioning.

During this period, she also revealed what precipitated her last psychotic break, one from which she had never fully recovered. During her engagement, she was moderately sexually active with her fiancé. He pressed for more sexual involvement, but she was torn between her desires and overwhelming feelings of guilt that sex before marriage was sinful.

As he continued to pressure her, Anna's anxiety rose to levels akin to those in her childhood when she was forced to perform sexual acts on her grandfather. At the same time, she felt sexually aroused, which reinforced how "evil" she was for having such desires.

The picture seemed all too clear. Anna's predisposition and environmental factors placed her in a position where she was forced to break from reality in order to cope. We continued with EMDR and followed protocol for processing trauma. She targeted the incident in which she hid behind the dresser to a SUDS of 0 and VOC of 7 ("I'm a good person."). She continued to function at a higher level and we alternated trauma work using standard EMDR protocol for trauma with resource installation work.

Throughout this time, Anna used her safe place whenever she became overly anxious or scared. She was given a bilateral tape to use at home to facilitate her safe place exercise which helped reduce her anxiety whenever she utilized the exercise. Lessening her anxiety helped Anna cope with voices and delusional thinking.

In mid-November, with the approaching holidays and increasing demand for socialization, Anna began to regress. We ceased the trauma work and focused on resource installations, safe place, and containment exercises. Although Anna showed further isolation due to the anxiety of the holidays, she was able to "hold her own" and avoid hospitalization. This was a new experience for Anna—to be able to stop the downward regressive spiral after it had begun. Anna raised issues of secondary gain. "What if I get better? They'll kick me out of the program!"

Anna and I resumed work after a month long break due to the holidays. That break was significant in helping Anna realize she could cope without our sessions. When we resumed our sessions, we addressed secondary gain issues and continued with trauma work. Checks on original trauma targets remained clear and Anna's symptoms lessened with regard to her behavior. She continued to complain of unremitting voices and paranoid delusions, but it was as if they no longer held the weight they used to. She proceeded to pursue social interests, despite her vocalizations that she could not do so out of fear.

Considering the Broader Implications

A significant factor during this treatment time frame is the fact that Anna received a change in medication right before we resumed our trauma work, so, unfortunately, I cannot definitively attribute the changes (either positive or negative) to EMDR. It is notable, however that in her past history, the same medication was not helpful in reducing her symptoms.

Based on the nature of one case study, one must approach the replication of such with utmost caution. My work with Anna may show that bilateral stimulation and EMDR exercises that do not induce negative affect can be successfully used in symptom management for those suffering from certain forms of psychosis. In cases where symptoms are exacerbated by feelings of anxiety, panic, or fear, EMDR may reduce the need for hospitalization or an increase in neuroleptic medications.

Further studies in this area may show additional benefits or cautions in applying EMDR to this population. It may show that certain persons suffering from psychosis may exhibit onset of symptoms due to genetics and environmental factors related to trauma. If this is true, EMDR may be valuable in helping clients cope with lack of ego-strength and symptom management. At worst, it may facilitate a further break from

reality with the possibility of reducing client functioning. At best, it may clear the driving force behind the pathology and cause the symptoms to become minimal or non-existent. It may show that the definition of trauma is not only broad, its manifestations are varied as well.

For Anna, EMDR provided an additional method to help with self-calming, if and when she chooses to do so. It may or may not prove to be equal or superior to other methods available to her. However, unlike other self-soothing methods, it has the potential to access areas of her life that, if processed, may facilitate deeper healing. At this time, it may be too early to tell the full effects EMDR processing on Anna. It is possible we may never know due to the confounds of the study. In hindsight, more accurate information will prove useful in accessing the effects of EMDR and schizophrenia. Diagnostic agreement in cases that present atypically would be conducive to the validity of this and other studies. Continuity in treatment between professionals to better assess the effects of EMDR or medication would also need to be adhered to.

In-house treatment programs may be more amenable to larger scale studies, due to the concentration of criteria-sufficient clients and immediate access to physicians, medications, and 24-hour staffing. As responsible EMDR clinicians, we must err on the side of caution while continuing to push forward in the application of what we are learning and what we know. Although further case studies may result in different outcomes, the Anna's experience opens the door to new thought on the manifestations of trauma in persons prone to mental illness. It also gives us insight into how the accelerated processing model can be utilized in managing symptoms, strengthening inherently weak ego structures, and affecting the outcome of trauma based psychosis.

A Post Script

Anna finished her trauma work following standard protocol with little trouble. In fact, the trauma work we resumed seemed more residual and related more to a situation in her life as an adult. Thereafter, we continued to work using resource installations and strengthening parts of herself that could assist her in coping with stress, feeling healthy, etc.

Unfortunately, Anna continued to hear voices and suffer from paranoid ideation. The voices battled between being healthy and being sick, and Anna vacillated between higher and lower functioning. During times of anxiety, Anna chose to forego use of her bilateral tape to calm herself, even though it consistently helped calm her in the past—seemingly an external manifestation of her inner battle between health and illness.

Eventually, Anna was admitted for hospitalization and received a medication evaluation. Several psychiatrists found her medication regime to be poor at best and, as I write this, Anna is going through medication changes that hopefully benefit her.

The obvious question is: did EMDR do harm in this situation? I believe there will always be those who lay blame wherever it seems easiest. Throughout her treatment, others involved in her care were hesitant to give credence to EMDR for any positive changes, even though changes were significant and much more positive than other treatments.

In fairness, I cannot state with certainty that EMDR was a significant factor in her improvement, although I suspect it was. There were too many other contributing factors that no doubt had an effect on Anna's progress or lack of progress. If we cannot credit EMDR for all of the improvement we see, why would we give EMDR full credit for relapse or failure?

Certainly, many other factors contributed to her hospitalization. Anna's response to EMDR was never one that evoked alarm, but it did elicit some positive indications of healthy progression. Perhaps it puts such clients in a Catch-22 situation. If good therapy (of any type) causes stress (which it invariably will), and stress has the potential to cause some clients to break with reality, should therapy ever be pursued? Even with the use of resource installations, Anna had difficulty with the inherent battle of coming to terms with a possible new identity. At the time of her hospitalization, this was the very issue we were working on.

This case emphasizes the need for access to medical facilities and a solid support network when considering any client with a background similar to Anna's for EMDR. It also brings to point the delicate issue of symptom management versus therapy. Anna was hospitalized previously for numerous other stressors in her life. It may be that her stay will be shorter than others and, indeed, her estimated length of stay is one to two weeks, while she had previously been hospitalized for much longer periods.

Although I was initially discouraged about her hospitalization, I am very much encouraged by the treating physicians who see a tremendous problem with her medication regime and are working to change it. Time will continue to reveal Anna's progress and whether EMDR was helpful in the long run. We may never know the effect EMDR has or will have for Anna and others in similar situations unless controlled studies are performed.

I add this post script as caution to others, not to discourage, but to raise awareness and to help other clinicians anticipate such situations. Anna participated with full informed consent, and I anticipate that, once stabilized, she will again want to continue work toward integrating the parts of herself that are healthy and the parts that battle to stay ill. Anna may have been hospitalized in the past for various reasons but, to my knowledge, she was never admitted for the reasons of her current hospitalization.

For the first time in Anna's life, she struggles not with how she is, but ***who*** she is. Let us hope she finds the strength to face that person, whoever she is . . .

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(Self-Administration - Continued from page 28)
developed the software further and added an automatic application to change the colors each time the programme starts. The potency of the software emerged again.

An Existential Challenge

My employer changed, and the whole administration of the small hospital was merged with another bigger one. Some important people prepared themselves to leave and old bills were delivered --they tried to fire me from my job, although I didn't realize it at first. A nightmare drastically revealed the importance of the subject to me. I really was alarmed, it was really threatening my base of life. A meeting with the new administration loomed a few days ahead, so I tried to process the whole thing with the software.

Starting with recalling the nightmare, I got the connection to this existential challenge. The following processing brought to my mind a first Negative Cognition: "I won't make it" and deep feelings of insecurity and threat. Once again, I used the standard protocol, worked to find a Positive Cognition and got: "I make it." The existential impact of the impending meeting vanished, the SUDs decreased to 2 or 3 and I informed myself in a more realistic manner about the lawsuits. Well-prepared, I went to the meeting—and made it.

New Frontiers

After all the scientific stuff which had been done, I do not believe it is appropriate to continue to call EMDR an experimental approach (Shapiro 1998). And, on the wild side influenced by the more and more establishing EMDR scene, there are a lot of creative people who tried to discover emerging new landscapes behind the scientifically secure country of standard protocol. My deep opinion is that we not only have to discover new approaches of treating disorders, breaking the circle of violence we find in families and society, and fight man-made and natural disasters, but we must shelter ourselves and prevent people at risk from getting traumatized or retraumatized. Why waiting until our clinical job has destroyed us (Stamm 1997)? Shapiro's advice (1995, p.237) "to seek appropriate assistance and not resolve the problem alone" is still salient.

Some months ago, I started as a first guinea pig. Today, I am deeply convinced that therapists can utilize EMDR with such a self-stimulating software application or with one of the other devices as a profound tool to prevent burnout. I hope that the next years will show us that regular self-administration is a slow but profound day-by-day therapeutic tool to shelter ourselves from the atrocities we process with our clients.

References:

Figley, C.R. (Ed.): *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York (Brunner/Mazel) 1995.

Figley, C.R.: Compassion fatigue: Toward a new understanding of the costs of caring. 1995a In: Stamm, B.H. (Ed.): *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* Lutherville (Sidran Press) 1995. p. 3-28.

Freinkel, A.; Koopman, C.; Spiegel, D.: Dissociative symptoms in media eyewitnesses of an execution. In: *American Journal of Psychiatry*, 151,(1994), p. 1335-1339.

Mazor, Aviva; Gampel, Yolanda; Horwitz, Gilit: Interviewers' reactions to holocaust survivors'testimony. In: *Echoes of the Holocaust*, 5. Jg. (1997), Vol. 5, p. 31-54.

McCann, I.L.; Pearlman, L.A.: Vicarious traumatization: A framework for understanding the psychological effects of working with victims. In: *Journal of Traumatic Stress*, 1990, Vol. 3, p. 131-149.

Pearlman, Mac Ian, P.S.: Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. In: Professional Psychology: Research and Practice, 26 (1995), p. 558-565.

Saakvitne, K.W.; Pearlman, L. A.: Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In: Figley, C. (Ed.): *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York(Brunner/ Mazel) 1995, p. 150-177.

Shapiro, F.: Alternative stimuli in the use of EMD(R). In: *Journal of Behavior Therapy and Experimental Psychiatry*, 1994, Vol. 25, p. 89.

Shapiro, F.: *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures.* New York (The Guilford Press) 1995.

Shapiro, F.: Eye movement desensitization and reprocessing (EMDR): Accelerated information processing and affect-driven constructions. In: *Crisis Intervention*, 4(1998), Vol. 2-3, p. 145-157.

Stamm, B.H. (Hrsg.): *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* Lutherville (Sidran Press) 1995.

Stamm, Beth Hudnall: Work-related secondary traumatic stress. In: *PTSD Research Quarterly*, 8(1997), Vol. 2, p. 1-6.

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(Looping in the Present - Continued from page 12)
there is a good chance that, after the earlier core trauma is reprocessed and released, it will "flip," following its link to the later, current life trauma. At that point, the current life trauma can be reprocessed.

An example of this would be a client who listed "stress experienced while driving" and "car accident at age five" to be among the top five stressful traumas. In this case, even though the client did not initially associate the two incidents as being linked, the therapist started with the earlier incident, the car accident at age five. The past incident reprocessed and then the SUDs level went to zero for the current "stress experienced while driving," even though no reprocessing was done with the current stressor. This pattern of reprocessing showed that the trauma at age five was the core, and that the current stressor was the linked trigger.

Dealing with Looping in the Present

When looping in the present is detected, the standard EMDR protocol should be tried first: return to the original focus and determine whether anything has changed and the SUDs has reduced. Then, re-initiate reprocessing.

If this results in continued looping in the present without reduction in the SUDs, stop EMDR and resume the interview of the client to try to locate the core trauma. The therapist simply asks the client if he or she can remember feeling this way before, and what was the earliest instance he or she can recall. What the client reports at this point is usually the core trauma, and it constitutes the new starting focus for resuming reprocessing.

In this situation, it appears that, while the client previously could not recall any earlier trauma, after a few sets of eye movements with looping in the present, the mind has been "loosened up" and the doorway to the link is opened and can subsequently be safely accessed. Reprocessing then flows smoothly and fluidly. There is no prying or forcing—instead, the eye movements only access that which the mind deems ready for reprocessing.

Here is an example of looping in the present and how it was treated. A 30-year-old male reported feeling intense jealousy regarding his girlfriend. He reported that he did not trust her with other men, and could recall no previous time when jealousy had been such a problem in a relationship. He had been married before, but reported that "things simply did not work out." Reprocessing the jealousy looped to other current life stressors such as money pressures, but his SUDs did not reduce, and there was no sense of movement or resolution of his jealousy.

The therapist stopped EMDR and resumed the interview. However, this time when the therapist asked whether the client could recall feeling jealous at a previous time, the client reported that he had felt that way about his ex-wife, who had several affairs which eventually resulted in divorce. Prior to this, he did not feel that information was important and did not associate this prior "baggage" with his current relationship problems. Using the ex-wife's infidelity as the new focus, reprocessing proceeded smoothly. At one point the client nearly doubled over, releasing the pain of the betrayal of his ex-wife's infidelity. The SUDs reduced to zero, and the client then reported feeling much reduced jealousy about his current relationship.

Summary

Clinical experience with EMDR has shown that when accessing a past core trauma is blocked, a client may be limited to focusing stress on a current life situation. Reprocessing focusing on the current stressor may bounce around, looping in the present to other current life stressors. By following the methods outlined above, the earlier core trauma can be identified and accessed, and the problem of looping in the present can be successfully treated.

Once the earlier occurring core trauma has been identified and reprocessed, one gains the insight that the current stressful situation was only a trigger linked to earlier painful traumatic core material. It is likely that the initial trauma was deposited and lodged in the mind/body system during a time of emotional vulnerability, resulting in a predisposition to stress and a reduced threshold to being triggered by current situations with qualities similar to the original trauma.

Rather than changing the standard EMDR protocol, which works well in most cases, this method is a corollary technique for treating the problem of looping in the present.

References

Freud, S. (1926). Inhibitions, symptoms, and anxiety. In J. Strachey (Ed.), *The standard edition* (Vol. 22). London: Hogarth Press.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford Press.

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Criteria for Certification in EMDR & Approved Consultant in EMDR

EMDRIA™ Certified in EMDR: The applicant for this designation must meet the following criteria: 1) show evidence of having completed an EMDRIA™-Approved training program; 2) show evidence of a license/certification/registration as a mental health professional; 3) show documentation that he/she has at least two years experience in their field of license/certification/registration; 4) show documentation that the applicant has conducted at least 50 EMDR sessions with no less than 25 clients; 5) show documentation that he/she has received 20 hours of consultation by an Approved Consultant in EMDR.((See next Section)). At least 10 of these hours must be obtained through individual, (face-to-face) EMDR-focused consultation. (Provisions will be made for those therapists who practice in isolated areas and lack the convenient proximity to an Approved Consultant). The remaining 10 hours may be obtained through small group consultation; 6) provide a letter or letters of recommendation from one or more Approved Consultant(s) in EMDR regarding the applicant's utilization of EMDR while in the consulting relationship; 7) provide two letters of recommendation regarding their professional utilization of EMDR in practice, ethics in practice, and professional character; 8) show completion of at least 12 hours of EMDRIA™ Credits in EMDR during every two year period.

It is the opinion of the EMDRIA™ Board of Directors that current registrants in the EMDRIA™ Register may be *grandparented* as Certified in EMDR (throughout 1999). Upon meeting the above criteria, completing the application, and paying the application fee, the applicant will be designated as **EMDRIA™ Certified in EMDR**.

Certification will be renewed and reviewed every 2 years. This will require documentation of continued education and training (12 EMDRIA™ Credits) and a renewal fee.

EMDRIA™ Approved Consultant in EMDR: The applicant for this designation must meet the following criteria: 1) show evidence of having completed an EMDRIA™-Approved training program; 2) show evidence of a license / certification / registration as a mental health professional; 3) show documentation that he/she has had three years experience after completing an EMDRIA™-Approved program; 4) show documentation that the applicant has conducted at least 300 sessions with no less than 75 clients in which EMDR is utilized; 5) show documentation that the applicant has received 20 hours of EMDR consultation-of-their-consultation (while being in a "Consultation-of-consultation relationship" with an Approved Consultant in EMDR) in the utilization of EMDR in clinical practice. This is similar to the model used by AAMFT in its Approved Supervisor training in which "supervision-of-supervision" groups are utilized. These "consultation-of-consultation" groups in EMDR should be no larger than 4 consultants-in-training at any one time; 6) provide a letter or letters of recommendation from one or more Approved Consultant(s) in EMDR regarding the quality of the applicant's consultation in EMDR to others; 7) provide two letters of recommendation regarding their professional utilization of EMDR in clinical practice, their consultation abilities, ethics in practice, and professional character; 8) Completion of at least 12 hours of EMDRIA™ Credits in EMDR during every 2 year period.

Upon meeting these requirements, completing the application, and paying an application fee, the applicant would receive the designation as an **EMDRIA™ Approved Consultant**. This designation subsumes the category of EMDRIA™ Certified in EMDR. So, an Approved Consultant is automatically EMDRIA™ Certified in EMDR and would receive both designations. This qualifies them to consult with those seeking certification in EMDR. An individual who is already Certified in EMDR must still pay full applicant cost to be elevated to the status of Approved Consultant.

It is the opinion of the EMDRIA™ Board of Directors that individuals who have acquired such designation, are currently practicing, and in good standing as Instructor, Trainer, or Facilitator, in various EMDRIA™ approved training programs, may be grandparented as EMDRIA™ Approved Consultants (throughout 1999). Trainers, Facilitators, and Instructors will need to complete and submit an application and appropriate fees. Two letters of recommendation are also required, stating that the applicant is currently a trainer/consultant of an organization that is currently in good standing as an approved training organization through EMDRIA™ that attest to the applicant's knowledge and teaching skills in EMDR, as well as consultative abilities. The designation of Approved Consultant will be reviewed and renewed every 2 years. This will require documentation of continued education and training (12 EMDRIA™ Credits) and a renewal fee.

Fee structure for Certification in EMDR and/or Approved Consultant applicants: (one time application and processing fee)

		After July 1, 1999
• **Certification in EMDR**		
EMDRIA™ member and listed in the Register	$90	$100
EMDRIA™ member and not listed in the Register	$135	$150
Not a member of EMDRIA™	$270	$300
• **Approved Consultants in EMDR**		
EMDRIA™ member and listed in the Register	$180	$200
EMDRIA™ member and not listed in the Register	$225	$250
Not a member of EMDRIA™	$360	$400

After the grandparenting period (1999), applicants for the above designations will be supplied with the necessary forms, from the Central Office, to begin the process for certification or for receiving the Approved Consultant status. Throughout 1999, applicants may apply for the above designations by providing documentation that they meet the criteria for grandparenting.

Application for EMDRIA™ Certification in EMDR

Last Name________________ First Name________________ MI________

Address________________________________

City________________ State________ Zip________ Country________

Tel________________ Fax________________ Email________________

ADDITIONAL Address________________________________

City________________ State________ Zip________ Country________

Tel________________ Fax________________

** If you are currently listed in the 1998 Register and wish to be GRANDPARENTED in, please complete this top section ONLY and return with the appropriate fee as listed below.

Highest Degree Obtained (MA, MSW, Ph.D., M.D., etc.)________________

Institution where received________________ Date________

1) EMDRIA™ APPROVED TRAINING (Level I AND Level II from the EMDR Institute OR other EMDRIA™ approved Institutes, OR completed a minimum of 18 didactic and 13 supervised hours in an academic institution)

☐ Attach copy of your certificate of completion (certificate must list total hours and be signed by the instructor).

2) LICENSE/CERTIFICATION

☐ Attach copy of your License or Certification to practice independently.

Mental Health Profession________________ ID#________

State or Country Issued________________

3) I have at least two years experience in my field of license/certification/registration. ☐ YES ☐ NO

☐ Attach notarized documentation supporting this statement.

4) I have conducted at least 50 EMDR sessions with no less than 25 clients. ☐ YES ☐ NO

☐ Attach notarized documentation supporting this statement.

5) I have received 20 hours of consultation by an Approved Consultant in EMDR. ☐ YES ☐ NO

☐ Attach notarized documentation supporting this statement.
NOTE: At least 10 of these hours must be obtained through individual, face-to-face, EMDR-focused consultation. The remaining 10 hours may be obtained through small group consultation.

6) ☐ Attach letter or letters of recommendation from one or more Approved Consultant(s) in EMDR, regarding the utilization of EMDR while in the consulting group.

7) ☐ Attach two (2) letters of recommendation regarding your professional utilization of EMDR in practice, ethics in practice, and professional character.

8) ☐ Attach certificates of completion of EMDRIA™ Credits. (You must complete 12 hours of EMDRIA™ Credits in EMDR for every two-year period.)

EMDR International Association

PO Box 141925
Austin, Texas 78731
Tel: (512) 451-5200
Fax: (512) 451-5256
Email: emdria@aol.com
Website: www.emdria.org

FEES:				
EMDRIA™ member and listed in the Register	before 7/1/99	$ 90	after 7/1/99	$100
EMDRIA™ member and not listed in the Register	before 7/1/99	$135	after 7/1/99	$150
Not a member of EMDRIA™	before 7/1/99	$270	after 7/1/99	$300

☐ VISA ☐ MasterCard ☐ Check #________(made payable to EMDRIA™)

Card #________________

Exp. Date________ Name on card________________

Signature________________

Application for EMDRIA™ Approved Consultant

Last Name________________ First Name____________ MI______

Address____________________

City____________ State______ Zip______ Country________

Tel__________ Fax__________ Email__________

ADDITIONAL Address____________________

City____________ State______ Zip______ Country________

Tel__________ Fax__________ ** If you have acquired such designation, are currently practicing, and in good standing as Instructor, Trainer, Facilitator, in various EMDRIA approved training programs, and wish to be considered for GRANDPARENTING, please complete this top section ONLY, include the appropriate fee as listed below, and attach two letters of recommendation stating that you are currently a trainer/consultant of an organization that is currently in good standing as an approved training organization through EMDRIA™ that attest to your knowledge and teaching skills in EMDR, as well as consultation abilities.

Highest Degree Obtained (MA, MSW, Ph.D., M.D., etc.)________________

Institution where received________________ Date__________

1) **EMDRIA™ APPROVED TRAINING** (Level I AND Level II from the EMDR Institute OR other EMDRIA™ approved Institutes, OR completed a minimum of 18 didactic and 13 supervised hours in an academic institution)

   ☐ Attach copy of your certificate of completion (certificate must list total hours and be signed by the instructor).

2) **LICENSE/CERTIFICATION**

   ☐ Attach copy of your License or Certification to practice independently **and** a copy of your current curriculum vitae.

   Mental Health Profession________________ ID#__________

   State or Country Issued________________

3) **I have at least three years experience after completing an EMDRIA™ Approved program.** ☐ YES ☐ NO

   ☐ Attach notarized documentation supporting this statement.

4) **I have conducted at least 300 EMDR sessions with no less than 75 clients.** ☐ YES ☐ NO

   ☐ Attach notarized documentation supporting this statement.

5) **I have received 20 hours of consultation-of-consultation in the utilization of EMDR in clinical practice by an Approved Consultant in EMDR.** ☐ YES ☐ NO

   ☐ Attach notarized documentation supporting this statement.
   NOTE: These "consultation-of-consultation" groups in EMDR should be no larger than 4 consultants-in-training at any one time.

6) ☐ **Attach letter or letters of recommendation from one or more Approved Consultant(s) in EMDR, regarding the quality of the your consultation in EMDR to others.**

7) ☐ **Attach two (2) letters of recommendation regarding your professional utilization of EMDR in clinical practice, consultation abilities, ethics in practice, and professional character.**

8) ☐ **Attach certificates of completion of EMDRIA™ Credits. (You must complete 12 hours of EMDRIA™ Credits in EMDR for every two-year period.)**

EMDR International Association

PO Box 141925
Austin, Texas 78731
Tel: (512) 451-5200
Fax: (512) 451-5256
Email: emdria@aol.com
Website: www.emdria.org

FEES:				
EMDRIA™ member and listed in the Register	before 7/1/99	$180	after 7/1/99	$200
EMDRIA™ member and not listed in the Register	before 7/1/99	$225	after 7/1/99	$250
Not a member of EMDRIA™	before 7/1/99	$360	after 7/1/99	$400

☐ VISA ☐ [MasterCard] ☐ Check #______(made payable to EMDRIA™)

Card #________________

Exp. Date________ Name on card__________

Signature________________

Study Group Directory

This Directory is provided to give EMDR-trained clinicians an opportunity to join a Study Group in their area. These are "no fee" discussion meetings. If you would like to join a Study Group, please contact the group leader in your area.

[Please Note: Although Study Groups are listed in this EMDRIA™ Newsletter, these groups are not an affiliation of EMDRIA, nor does EMDRIA warrant or otherwise assume responsibility for content of meetings nor competency of group leaders.]

UNITED STATES

Alaska

Anchorage, AK Larry Holman
T: 907-272-7002 F: 907-272-2851
E-mail: lholman@alaska.net

Arkansas

Fayettevile, AR Frances Woods, Ph.D.
T: 501-442-2457
Last Fri each month, 12-2pm

Arizona

Prescot, AZ Laurie Tetreault, MA
T: 520-717-4901 F: 520-776-7366
E-mail: tetro@northlink.com
Northern AZ Level II monthly, Fri 10:30-12pm

Tucson, AZ Mary Jane Pringle
T: 520 322-9194 F: 520-621-2994
E-mail: PringleMJ@aol.com
Monthly, 3rd Mon 12:15-1:45pm

California

Southern CA (Santa Barbara-San Diego)
Advanced EMDR Clinician Study Group
Jocelyne Shiromoto
T: 714-764-3419
E-mail: shiroflex@aol.com
Every two months. Location rotates.

Corona, CA
(Riverside to San Bernadino)
Linda Vanderlaan
T: 909-279-7099 F: 909-279-4837
E-mail: Lvanderlan@aol.com
1st Fri each month, 9:30-11am

Fullerton, CA Curt Rouanzoin
T: 714-680-0663 F: 714-680-0570
E-mail: CCRounzun@aol.com
2nd Tues each month, 9:30-11am

Irvine, CA Lois Bregman
T: 714-262-3266 F: 714-262-3299
4th Fri each month, 9:30-11am

San Anselmo, CA (Northern CA)
Phyllis Galanis
T: 415-924-2613 F: 415-924-8358
E-mail: Pgal100@aol.com
Meets monthly on Fri

San Diego, CA Liz Snyker
& Carol Seidenwurm
T: 760-942-6347 & 760-944-7273
E-mail: esnyker@bigfoot.com
1st Sat each month, 9-10:30am

San Jose, CA Sherrill Nielsen
T: 408-225-5126 F: 408-365-3539
Monthly on Fri 10:30am

Ventura, CA Susan Pembroke
T: 805-659-4401

Colorado

Boulder, CO Keith Andresen
T: 303-443-5682 F: 303-443-5682
E-mail: kandre1041@aol.com

Denver, CO Laura Knutson
T: 303-753-8850 F: 303-753-4650
E-mail: lauknutson@aol.com

Connecticut

Hartford, CT David Russell
T: 860-233-7887
Bi-monthly, 2nd Sat, 10am-12pm

Delaware

Wilmington, DE Frankie Klaff
T: 410-392-6086
E-mail: klaf54944@dpnet.net
3rd Fri each month, 12-1:30pm

Florida

Orlando, FL Carl Nickeson
T: 407-898-8544 F: 407-898-9384
3rd Tues each month, 8:30-10am

Pompano Beach, FL Brenda Starr
T: 954-974-8329 F: 954-629-4779
E-mail: bastarr@loveable.com
Every 4 to 6 weeks, Fri 12-1:30pm

Tampa, FL Carol Crow
T: 813-915-1038 F: 813-914-0468
E-mail: cjcrow@juno.com
3rd Tues each month, 10:30am

Hawaii

Honolulu, HI Silke Vogelmann-Sine
& Larry Sine
T: 808-531-1232 F: 808-523-9275
E-mail: silke@silke.com -and-
sine@sineposta.com

Darlene Wade & Terry Wade
T: 808-545-7706 F: 808-545-5020
E-mail: wadeandwade@compuserve.com

Illinois

Chicago, IL Howard Lipke
T: 847-537-7423
E-mail: HLipke@aol.com

Kansas

Overland Pass, KS (Greater Kansas City)
Lawrence Nieters
T: 913-469-6069
E-mail: lnieters@juno.com
2nd Thurs each month, 8:30-10am

Kentucky

Louisville, KY Judith Daniel
T: (502) 459-7917
E-mail: JDaniel404@aol.com
Meetings held monthly

Maryland

Baltimore, MD Catherine S. Weber
T: 410-744-0869 F: 410-448-2005
E-mail: csweber@erols.com

Massachusetts

Brookline, MA (Boston, Cambridge Area)
Nancy Cetlin & Pat Thatcher
T: 781-237-0424 F: 617-731-3813
E-mail: Patthatch@earthlink.net -or-
ncetlin@earthlink.net
Monthly, Mondays, 10am-12 noon

Michigan

Ann Arbor, MI Zona Scheiner
T: 734-572-0888 F: 734-663-9789
E-mail: zonagse@aol.com
Monthly, Fri afternoons

Ann Arbor, MI Cam Vozar
T: 734-747-9073 / 734-996-9100x232
E-mail: CVozar@aol.com
Last Fri each month, 2pm

Bloomfield Hills, MI Eileen Freedland
T: 248-647-0050 F: 248-683-7010

Grand Rapids, MI
Rick Newberry, MSW, ACSW
T: 616-774-0633 F: 616-774-0771
E:newb@iserve.net
3rd Tues each month, 8am

Traverse City, MI
Donald Jaquish, HCSW, BCD
T: 616-935-3570 F: 616-946-6638
E-mail: donald418@aol.com
Meets monthly

Minnesota

St. Paul, MN Chris Baldwin
T: 612-825-4407 F: 612-825-0768
E-mail: baldwoo2@maroorto.tc.umn.edu

Missouri

St. Louis, MO Carmeline Utz
T: 314-781-8882
E-mail: carmu@stlnet.com

Montana

Missoula, MT Nancy Errebo
T: 406-721-4918
E-mail: nerrbo@montana.com
1st Mon each month, 11:15a.m to 1pm

Nevada

Las Vegas, NV Deborah Roberts
T: 702-458-7774 F: 702-458-0081
E-mail: jwroberts@net-tek.net
3rd Thurs each month, 8-10am

New Jersey

Barbara Korzun
T: 609-895-1070 F: 215-862-9370
E-mail: bkorzun@dplus.net
1st Fri each month,9:30-11:30am

New Mexico

Peggy Moore
T: 505-255-8682 ext. 145 F: 505-255-7890
E-mail: pvmoore@unm.edu

New York

Albany, NY June Morier
T: 518-381-9222 F: 518-447-0429
E-mail: morierj@aol.com
1st Fri each month, 12 noon

Fayetteville / Syracuse, NY Maudie Ritchie
T: 315-251-0909 F: 315-637-2643
E-mail: msritchie@aol.com
1st Mon each month, 12-1:30pm

Great Neck, NY Lillian Gross
T: 516-466-6360 F: 516-466-2763
E-mail: DRLillian@aol.com

New York City, NY William Zangwill
T: 212-663-2989 F: 212-663-2989
E-mail: WZANGWILL@aol.com
2nd Fri each month, 11:30am-1pm

Gina Colelli, CSW
T: 212-866-0022 F: 212-932-2563
E-mail: Galto10@aol.com
2nd Fri every other month, 9-10:30am

Pawling, NY Gina Colelli, CSW
T: 914-855-7190 F: 212-932-2563
E-mail: Galto10@aol.com
1st Mon every other month 9-10:30am

Southampton, NY Marcia Schwartz
T: 516-287-3758
Monthly on Sat, 11:30am-1:30pm

North Carolina

Chapel Hill-Carrboro, NC
Ann Waldon, CCSW & Nancy Ciocci, CCSW
T: 919-932-3908
E-mail: awaldon@intrex.net

Chapel Hill, NC Gary Peterson, MD
T: 919-929-1171 F: 919-929-1174
E-mail: gpeterson@SEInstitute.com
Thurs 3/11,4/8,5/13,6/10,7/8,8/12 from 7-9pm

Wilmington, NC Elizabeth Garzarelli
T: 910-251-2106 F: 910-251-2107
E-mail: agate@isaac.net
Monthly, Fri afternoons

Ohio

Cincinnati, OH Irene Giessl, Ed.D.
T: 513-221-2001 F: 513-961-6162
E-mail: MGCmsac@prodigy.com

Oklahoma

Oklahoma City, OK Joe Westerheide, Ph.D.
T: 405-840-9000
Monthly, 2nd Fri, 3-4:30pm

Tulsa, OK G.J. Ann Taylor
T: 918-743-6694 F: 918-743-6695
E-mail: ATaylor@busprod.com
Tues, 7:30am

Oregon

Bend, OR (Central Oregon) Karen Forte
T: 541-388-0095
E-mail: kforte@bendnet.com
Monthly, Tues, 12:15-2pm

Pennsylvania

Bloomsburg, PA Dorothy Ashman
T: 717-387-1832 F: 717-387-5103
E-mail: kent@csrlink.net
2nd Friday of every month, 8-9:30 am

Tennessee

Nashville, TN Bea Scarlata
T: 615-370-9451 F: 615-370-4382
E-mail: BSScarlata@aol.com
Group 1: 1st Tues each month, 9:30-11am
Group 2: 3rd or 4th Fri each month, 6-8pm

Texas

Fort Worth, TX Janet Ragsdale
T: 817-336-7925 F: 817-336-7925

Houston, TX David J. Ogren, Ph.D.
T: 713-622-1278 F: 713-622-1054
E-mail: Dogren@aol.com
-OR-
Vivian Freytag, MA, LPC
T: 713-526-8696
1st Thursday each month, 11am

Hurst, TX William Gumm
T: 817-589-1419 F: 817-589-7918

Richardson, TX Sharon Ormsby, M.Ed., LPC
T: 972-238-1198 F: 972-475-6957
Meets monthly

San Antonio, TX Shirley Jean Schmidt
T: 210-561-9200 Page: 210-603-6793
E-mail: sjschmid@netxpress.com
4th Tues each month, 12:15-1:45pm

Virginia

Virginia Beach, VA Steve Katz or Dave Paige
T: 757-623-5979
E-mail: dpaige9806@aol.com
1st Fri each month, noon

Richmond, VA Marilyn Spiro
T: 804-282-6165 F: 804-282-3038
E-mail: jspiro@atlas.vcu.edu

Washington

Gig Harbor, WA Rosalie Thomas
T: 253-851-3808 x1131 F: 253-851-3188
E-mail: rthomas@harbornet.com
1st Fri each month, 10am

Spokane, WA Marty Jones
T: 509-685-1436
E-mail: martyj@plixx.com
Monthly, 1st Mon (except July/Aug) 11am-1pm

Olympia, WA Diana Cushing
T: 360-786-5009

Wisconsin

Eau Claire, WI Sandra Helpsmeet
T: 715-874-6646
E-mail: helpsmeet@usa.net
Quarterly, Sat 9-12 noon

Madison, WI Arden Mahlberg
T: 608-255-9330 F: 608-255-7810
E-mail: AFMahlberg@aol.com
Bimonthly, 3rd Tues, 12:15-1:30pm

Milwaukee, WI Wendy Freitag
T: 414-453-6330
E-mail: WF1705@aol.com

OUTSIDE THE UNITED STATES

Canada

Vancouver, B.C. Lee Nicolas
T: 604-844-3873
E-mail: lnichola@eciad.bc.ca
1st Mon each month, 11:30am-1pm

Germany

Kasseland Christa Diegelmann &
Margaret Isermann
T: 49-561-35006 F: 49-561-35030
E-mail: IDinstitut@aol.com
Meetings on 3/19, 5/28, 8/27, 11/12, 7-9pm.

Israel

Raanana Udi Oren
T: 972-9-7454291
E-mail: udioren@inter.net.il
2nd or 3rd Fri each month, 9:30am-12pm

Tivon (Haifa and Northern Region)
Elan Shapiro, Yair Emanuel,
& Esti Bar-Sadeh
T: +(0)4-983 2760 F: + (0)4-953 0048
E-mail: elan@mofet.macam98.ac.il
1st Wed each month, 8-10pm

SUBMIT YOUR STUDY GROUP

To maintain a current Study Group list, please provide the EMDRIA administrative office with up-to-date information about your group.

A form for that purpose is provided on page 6, or you can submit information by e-mail to the EMDRIA office at EMDRIA@aol.com or to the *EMDRIA Newsletter* editor at superVisns@aol.com.

Officers, Directors, & Committees

EMDRIA™ is governed by a Board of Directors composed of six Officers and seven general Directors. The Officers, elected for a one-year term, include President, President-Elect, Secretary, Secretary-Elect, Treasurer, and Treasurer-Elect. Elected officers succeed the present officers after their term has expired. Directors are elected for a three-year term.

OFFICERS & DIRECTORS

PRESIDENT
Daniel T. Merlis, M.S.W.
4709 Chestnut Street
Bethesda, MD 20814-3725
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Fax: 301-718-9718
DanMerlis@aol.com

PAST PRESIDENT
Curtis C. Rouanzoin, Ph.D.
2500 E. Nutwood Ave.,
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Work: 714-680-0663
Fax: 714-680-0570
ccrounzun@aol.com

PRESIDENT-ELECT
David L. Wilson, Ph.D.
616 Azalea Avenue
Redding, CA 96002
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Fax: 530-223-0977
dwilson@awwwsome.com

SECRETARY
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Fax: 414-797-0358
WJFreitag@aol.com

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Darlene Wade, M.S.W.
1188 Bishop Street #3205
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295 Franklin Street
Napa, CA 94559
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Fax: 707-226-5056

TREASURER-ELECT
Byron Perkins, Psy.D.
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rickygr@childtrauma.com

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Fax: 919-966-7984
gpeterson@pol.net

DIRECTOR
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7700 Clayton Road, #101
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Work: 314-644-1241
Fax: 314-644-6988

COMMITTEES

AWARDS
Curtis C. Rouanzoin, Ph.D.
See Officers List.

CONFERENCE
Carol York, M.S.S.W.
EMDRIA
P.O. Box 141925
Austin, TX 78714-1925
Tel: 512-451-5200
Fax: 512-451-5256
emdria@aol.com

FINANCE
Marguerite McCorkle, Ph.D.
See Officers List.

HEALTH CARE
Mark Dworkin, CSW, LCSW
251 Mercury Street
East Meadow, NY 11554
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Fax 516-579-0171
mdwork5144@aol.com

INTERNATIONAL
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Philadelphia, PA 19103
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Fax: 215-545-7245
marluber@aol.com

LONG-RANGE PLANNING
Curtis C. Rouanzoin, Ph.D.
See Officers List.

MEMBERSHIP
Darlene Wade, M.S.W.
See Officers List.

NOMINATIONS & ELECTIONS
Curtis C. Rouanzoin, Ph.D.
See Officers List.

PERSONNEL
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This issue includes applications for EMDRIA Certification for Therapists in EMDR and EMDRIA-approved Consultants in EMDR.

Inside this Issue of *The EMDRIA Newsletter*:

- Message from the President
- Update from the EMDRIA International Scene
- Regional Meeting Coordinating Committee Report
- Healthcare Committee Announcement
- Introduction of the Intern Connection Subcommittee
- International Study Group Directory
- EMDR in the Treatment of Pain
- Strengthening Affect Tolerance and Adult Perspective
- Case Study in the Application of EMDR for Schizophrenia
- EMDR and Looping in the Present
- Experimental Software for Self Administration of EMDR
- Applications for EMDRIA Certification for Therapists
- Application for EMDRIA-Approved Consultants in EMDR
- Products/Services to Enhance EMDR Practice

Events and Deadlines

June 18-20, 1999

1999 Annual EMDR International Association Conference in Las Vegas

June 19, 1999

2nd Annual Regional Coordinators Sack Lunch in Las Vegas

June 19, 1999

Healthcare Committee Lunch Meeting (for volunteers interested in helping with the Committee) in Las Vegas

July 20, 1999

Deadline for submissions for September 1999 issue of *The EMDRIA Newsletter*