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Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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IN MEMORIUM
Ron Martinez, Ph.D.

It is with the deepest sorrow that we announce the passing of Ron Martinez, Ph.D., from a very rapid and virulent form of cancer. Ron was an extraordinary clinician, facilitator, and co-editor of the Network Newsletter. As the keynote speaker at the 1992 EMDR Conference, he illuminated the heart of EMDR. He moved the entire audience to a thunderous standing ovation—for who he was, and what he offered.

Knowing Ron was an honor and a privilege. As a quadriplegic, resulting from a freak accident during adolescence which robbed him of his prized athletic ability, Ron chose a life of service, rather than of self-pity, and was an inspiration to all who knew him. With a quiet sense of surety, he fought for what was truly valuable in life—being open to possibilities with a self-worth born of "love, laughter, and learning." He taught that, regardless of the adversity and the depth of pain, the human spirit can triumph over despair and make an indelible mark on the lives of others. He said he was proud to be a part of the evolution of EMDR and was grateful for what it allowed him to offer his clients, yet he empowered more than he received—as a "light," a support, and a living example of "It's not what happens that matters, but how you deal with it."

He said his final lesson was "All that counts is who you love and who loves you back." Very simple, and yet very hard to fully comprehend and live by—moment by moment, day by day. All I know is that he died as he lived, with grace, peace, and dignity. He passed without fear, knowing it was the right time, and that he had done all he needed to do—comforting those around him with love and compassion. He will be missed. He will not be forgotten.

F.S.

STRAYTHOUGHTS

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Memory Retrieval

It appears as though one of the heritages of the psychodynamic model is the belief in the need for "uncovering memories" as necessary prerequisites for "working them through." Consequently, it appears as though some EMDR-trained clinicians have decided to use a combination of EMDR and hypnosis for "memory retrieval." While hypnosis has been a highly successful and standard form of practice for many years, its interaction effects with EMDR have not been systematically investigated. Therefore, I would like to issue some additional words of caution in this regard, since each clinician is bound to approach issues of possible "repression" and "resistance" in a highly subjective manner. The points are made below in order to highlight factors that might possibly have been forgotten or overlooked by some clinicians in the merging of variant models.

(1) As I have repeatedly mentioned in the trainings, there is no way of knowing whether a memory that emerges is true or not. The very attempt at "memory retrieval" as a goal may set up a frame that a memory exists, that it should be revealed, and that there is a perpetrator. This may be a perfect set-up for a false

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memory syndrome. When a memory is revealed with EMDR, there is a possibility that the event in question was vicariously experienced (e.g., identification with a character in a story) or that it is the result of trickery (e.g., a perpetrator dressed as Satan). Either of the above factors could be responsible for the client's belief that family members participated in a molest.

The "revelations" of horrible abuse can be extremely disturbing to clients. To insist that the memories are true may only add to the distress for some clients. A more appropriate stance may be that we cannot know for sure whether the memories are true or not; therefore, it is important to concentrate more on the present symptomatology or distress. Focusing on the internal reaction to the possible perpetrator will be necessary whether or not the memory is accurate.

(2) The ability to retrieve memories of abuse or large blocks of childhood events is questionable even under the best of circumstances. EMDR is not designed to bring visual memories to the surface, but is rather an attempt to process information that is dysfunctionally stored in the nervous system. Therefore, the concentration is on the symptomatology, and what would be necessary to alleviate the pain experienced in present time. A metaphor that the client may appreciate is that the VCR can be running whether or not the monitor is on. Consequently, there can be a shift in the dysfunctional reactions and triggers without visually accessing the core events that set the problems in motion. An appropriate stance with the client might be a discussion of actual goals in therapy. Would it be appropriate to alleviate the pain without surety of cause? If the client is not in agreement with this, then EMDR should not be offered as the only alternative, as it is by no means certain that the actual memory will surface.

(3) Client readiness should also be a consideration before treatment. When there are a number of "consensus reality" problems in the client's life (e.g., job or family crises), uncovering work should be kept at a minimum. Regardless of the form of therapy, the client should be stabilized in his or her ability to handle his or her present real-life experiences before adding the additional emotional load of early trauma work. The mid-session disturbance caused by the information processing can cause the client to be unable to handle the real fundamental financial and legal needs that are out of his or her control and that he or she cannot put on hold. Please recall that the cautions regarding the use of EMDR with any individual client include the appropriate assessment of all real-life constraints. If the exhaustion or distress that sometimes arise with EMDR would be detrimental to present functioning, then other methods should be used until a more congenial time.

(4) Hypnosis and EMDR may not be an appropriate combination. While light trances are induced in dissociative disorder clients by some clinicians, the use of deep trance may be contra-indicated because the altered state of hypnosis may not permit all the information to be adequately processed. Just as trauma should be retargeted when a client has been weaned off any medication in order to check for any remnants in state specific form, the same may be said of hypnosis. Further, the use of hypnotic suggestion can construct a fantasy that is not amenable to actual processing. Just as indications have been that delusions are not susceptible to change with EMDR until the experiential cause is targeted (e.g., wife leaving by choice as opposed to a kidnap delusion), hypnotically induced fantasies and false memories are likewise not necessarily able to be shifted. Adding EMDR to a hypnotically induced memory may be severely disturbing to the client and not allow adequate resolution.

(5) Signs of prolonged distress and inadequate resolution of memories with EMDR are a sign that other methods

should be used instead. As I stated in the Level I training, there are some clients who will be unable to process memories without the clinician having the information in Level II. Cognitive interweave and additional abreactive strategies are offered in order to deal with many clients who "loop" (i.e., remain on a plateau of information without processing). If you have not taken Level II, and find continued distress in clients with regards to targeted memories, then please discontinue EMDR treatment with them until you attend the second training. If you have taken Level II and find that any clients continue to loop, please discontinue the use of EMDR and send the case to the Newsletter, or bring the case for discussion to the Network meeting, or contact a more experienced consultant. Obviously, EMDR will not work for every client, and as we state in the training, it only takes a few sessions to find out whether it will work or not by the level of processing that occurs. Clearly, months should not go by with the client experiencing pronounced distress before deciding to change methods. If adequate processing is not revealed during the first few sessions, especially if exacerbated disturbance appears, then either the method is being inadequately applied, or it is inappropriate for that client at that time. It may never be appropriate for that particular client.

(6) Be sensitive to the amount of integration that the client needs to deal with the material that surfaces. Many sessions may be used to debrief a new plateau, offer modeling of new behavior, explore present interpersonal needs, identify the pressures in the system, or target dreams and present reactions that have arisen due to the processing of earlier trauma material. Do not continue to target new memories until the previously treated ones and the "reverberations" have been handled. The log is vital for this purpose and should be used to explore the ramifications of the memory work. Just as clients vary in their needs to rest or talk or integrate between sets of eye movements, client needs vary for differing time lengths between sessions of EMDR. Likewise, the client should have an adequate armamentarium of self-control techniques to deal with any discomfort that arises mid-sessions. If the log reveals a great deal of distress, greater measure should be taken to relieve the client from the emotional pressures. Prolonged distress is detrimental to therapeutic effect as it can reinforce the client's feelings of low self-esteem and lack of control.

(7) Remember that EMDR has still not been adequately researched and all your clinical skills are necessary for appropriate assessment of its use with any client or population. Likewise, mixing EMDR and hypnosis or any other technique during sets of eye movements may be detrimental to processing effects. The only adequate judge at this juncture is the subjective response of your individual client. EMDR is "client-centered" in terms of servicing the needs of the client. Using demand characteristics to pressure clients into continuing, or intimating that it is the only way they can be "healed," can easily backfire. Remember, respect for a client's defenses is paramount.

(8) Just as all usual and appropriate clinical cross-checks should be used to ascertain whether or not a revealed memory is "true" or not, so should they be used to determine whether or not a memory has been adequately processed, a dissociation adequately resolved, or a complaint adequately handled. Using a log and an on-going feedback system are necessary to assume full resolution of the presenting complaint after your in-session assessment. No method should be assumed to have been successful without appropriate clinical measures applied over time. Make sure you maintain an open line of communication with clients after treatment so they can report any subsequent problems. Additionally, other memories may surface because of client readiness or particular convergence of triggers (e.g., a molest memory triggered for a client three years after treatment for combat trauma because of seeing his mother at a particular hotel). Clearly, not all dysfunctional material will, or needs to, surface at any given time. In other words, always leave an open door. Please report any unusual findings and responses so that we can all progress in our assessment. We all rely on your clinical findings.

While flexibility and creativity are often keys to exemplary clinical results, please remember that EMDR is new and should be rigorously evaluated by you regarding every new client and distinct clinical presentation. The efficacy of combined methods should be adequately assessed, rather than assumed to be beneficial.

Intensity of Visual Stimulation From the Environment During EMDR

Tom Matthews, Ph.D.

Lowering the intensity of visual stimulation from the environment during EMDR helps some patients tolerate the procedure who otherwise would shut down. Occasionally during EMDR, a patient shuts his or her eyes or complains of discomfort. (I actually had a patient who had his eyes cross spasmodically on two occasions.) In every instance so far, when the patient or I have checked with his or her ophthalmologist, there has been no diagnosed physical basis for the complaint. However, when I encounter this situation, I proceed cautiously thereafter. A variety of simple adjustments to lower the intensity of stimulation during EMDR seems to help. I now shut the

blinds and turn off overhead lights for many sessions because this seems to be generally helpful and preferred by patients. Other EMDR clinicians have told me they do the same, but I have never read this or heard it in a seminar. Also, I shorten the width of the eye movements, slow the rate considerably, and reduce the number of scans per set. With these adjustments, those patients who previously shut down are able to continue with the procedure.

I have too few observations (4 or 5) to make a valid generalization about the characteristics of these patients. However, my impression is that they have the blocking experience at a point when they find themselves at the brink of uncovering repressed material. When we later proceed with EMDR, generally in a later session, I have the distinct impression that they are not ready to explore in the same area again. For example, one depressed patient recalled a history of intrusive suicidal ideation which she found severely ego-dystonic. It was necessary to proceed with conventional supportive therapy for a while to help her prepare to accept those memories.

REVAMP OF LEVEL II TRAINING

At the last Level II training, we asked the participants for suggestions regarding subject matter and format. We have decided to incorporate a number of requests. Starting at the next Level II training, there will be:

a) Two special segments including a choice of specialty presentations;
b) A shortening of the question and answer period in favor of longer didactic presentations;
c) A section on the advanced use of the cognitive interweave;
d) An optional half hour for debriefing of Level I material-including questions regarding the model and components such as the proper selection of negative and positive cognition.

In order to accommodate the addition of the new material, we may have to run overtime or through one of the lunch breaks. We therefore ask you to come prepared for a flexible schedule

F.S.

Graduates of Level I or II may re-attend the trainings at half tuition. Please designate the date of your previous trainings on the registration coupon.

The 1993 EMDR Annual Conference is open to everyone who has completed Level I.

Smoking Cessation Protocol

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This model incorporates EMDR, Ericksonian hypnosis, and other therapeutic modalities. The combined use of the cognitive interweave as taught in the Level II training and an in-depth knowledge of hypnosis are an integral part of the design structure. The model is constructed so that smokers are not consciously or continually aware of any effort involved during the process. In other words, smokers do not have to concentrate on, or think about, not smoking. Many of the smoking cure programs available today (e.g., tapes, gadgets, Smoke Enders, hypnosis, or the patch, etc.) focus on *not smoking* or *quitting smoking*. With these programs, the smokers must think about the effort involved and, from the available literature on how the mind works, we know that where the mind focuses, the mind goes. Working on not smoking focuses the smoker to think about smoking which inevitably brings the urge to smoke.

This model includes techniques to: (1) satisfy those individuals who have the belief that weight gain accompanies quitting smoking and that because of the oral substitution factor, food is substituted for cigarettes; (2) counteract possible effects of nicotine withdrawal; and (3) handle failures. Most smokers are experts at quitting smoking as they have done it many times. These past failures can become self-fulfilling prophesies. By explaining that there is no failure and if they do "fall off the wagon," they should notice the circumstances, and that we will work on these new and emerging triggers at our next meeting. This model evolved from use with a wide range of clients wherein an individual client's belief system is addressed. Because the model is client-centered, the cognitive interweave and hypnotic work are individualized and vary according to client feedback. After many attempts, this combination of methodologies was found to be successful. To date, with approximately 12 smokers, averaging 25 years, 1+ packs a day, none gained appreciable weight or reported problems associated with nicotine withdrawal. Remarkably, clients have commented that they were amazed that there was little or no effort involved. At the end of the day, they noticed that they had cut back appreciably or had not smoked at all, and that there were few or no thoughts about smoking.

The process is like taking a train trip. The smoker may know where he or she wants to go and have all the best intentions going straight to, and arriving at his or her destination (non-smoking). However, while on the journey something (triggers) switches the train to another track toward the negative affect (smoking). This protocol identifies and desensitizes these switches and, using eye movement (EM), desensitizes the triggers and resets or reprocesses the switches so that the train can continue successfully along the track toward the desired behavior while the client relaxes and enjoys the trip.

Protocol

(1) History taking.
(2) Build a positive cognition (PC)
(3) Determine the identifiable (known) smoking triggers.
(4) Desensitize the identifiable triggers.
(5) Install and link the PC.
(6) Hypnosis, time compression, and future projections to uncover and desensitize the hidden triggers.
(7) Install and link the PC.
(8) Close.
(9) Identify and desensitize the emerging triggers.

(1) History taking: Along with the standard cautions and explanation, I investigate: How long have they been smoking? What made them start? What do they get out of it now? How much do they smoke in a day? Have they tried to stop before? What prevented them from succeeding (secondary gain and other blocking beliefs)? What are they saying about themselves regarding their unsuccessful attempts to stop?

(2) Creating the PC: When creating the PC, the following issues are considered: What benefits do they get from smoking? What will being a "slim non-smoker" get them? Is it really what they want? What else could they do to get the same results? Most importantly-how would they know (picture, words, and feelings) when they are a successful, "slim-non-smoker" (PC)?

Picture: It is necessary for the client to have a strong PC (see Andrew Leeds article in this issue), construct a clear picture of themselves as a "slim-non-smoker," and see themselves in that special situation. Whatever their description, I use it to build the mind-body connection (anchor), which is their PC. If they report they want more energy to participate in sports, I have them project into the future, seeing themselves participating most successfully in their sports. At this time, I ask them to see in detail what they would be seeing and to notice how they feel.

I then have them adjust that picture until their feelings peak. The picture-feeling adjustments consist of brightness, focus, contrast, tint, size, distance, etc. I ask for permission to touch them, usually on a knuckle. After every adjustment, when the feelings are strongest, I touch, with pressure, the same place on that knuckle (anchor) and then instruct them to breathe into the feelings and anchor those feelings into their bodies.

Words: I have them listen to what they would be hearing (e.g., what they would be saying to themselves and what others would be saying to and about them.) I then have them adjust the volume, tone, tempo, balance, etc., until those successful feelings peak again and have them breathe more deeply into their feelings, while I again physically touch that knuckle to anchor those feelings into their bodies.

Body Sensations: I have them notice their body sensations and adjust the components, temperature, pressure, beat, etc., until the feelings peak and then again have them breathe deeply into their feelings. I touch their knuckle again to anchor those feelings into their bodies.

It is important that clients have a strong sensory based concept of being completely successful as this is their PC and their goal.

(3) Identify the known triggers: The identifiable trigger points are those known signals that tell one to reach for a cigarette. They could be tied to a place, person, time, emotion, smell, taste, occurrence, or object. During what activities? Where? What do they notice that alerts them to reach for a cigarette? How do they know when to smoke? It is important to remember that if memories of past traumas come up, they be treated as new nodes. These nodes should then be addressed according to the EMDR model taught in the Level I and Level II trainings.

(4) Desensitize the known triggers: For each trigger, I have the clients access the experience, notice what picture comes up, what words, or where they are feeling it in their bodies as well as notice the level of desire. Perform the EM until the desire fades.

(5) Link and install the PC: Have them bring up each trigger again and hold the PC. Perform the EM again.

Repeat for each known trigger and test the results. If the taste or smell of coffee is a trigger, give them a cup and let them smell or taste it while doing the EM. If cigarettes are a trigger, have them hold a pack in their hands. Have them hold a cigarette, smell it, put it into their mouths, light it, even taste it.

(6) Future projections to identify and desensitize hidden triggers: The next part of the protocol is used as a check to determine if all of the triggers have been identified and desensitized. To do this, I put them into trance and experience (using time compression techniques) a day in the future. My instructions state, that at any time they experience the urge or the desire for a cigarette, their eyes will open and will follow my fingers until the urge is desensitized. At that time, their eyes will close and they will continue to experience moving through that day. Each time their eyes open, I perform EM. Repeat for each occurrence when the eyes open.

(7) Link and install the PC with the unconscious triggers: I then have them repeat the day while installing the PC (e.g., touching that knuckle). At this time, I also incorporate suggestions into the trance such as: previous benefits and enjoyment from cigarettes

would decrease; taste and smell would slowly become more unpleasant; and they could instead choose a glass of water or sugarless gum (using Ericksonian elegance).

(8) Closure: I typically make an appointment for two days later and have them keep a log on anything new that comes up. If they experience the need to smoke, they are to sit down, place a hand on each knee, tap each knee alternately, and follow the knee taps moving their eyes back and forth until the desire fades. If they still feel the desire, I let them know that it is OK, and that it is new information emerging. It is important that they know that they have not failed, and that these are new triggers emerging which will be the basis for our work during the next visit. They should also log the details. During each visit, I check for new patterns or trends that have emerged since the previous session and repeat the process on this new information. If they have not smoked, I have them come back the next week and repeat the PC part of the protocol. This seems to strengthen the results.

Trauma/Abuse Memories with a Client Diagnosed with MPD

Marilyn Luber, Ph.D.
Philadelphia, PA

Dissociation is the result of overwhelming trauma. The major feature of patients with Dissociative Disorders is a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness (American Psychiatric Association, 1987). "The task of psychotherapy is to re-associate disrupted memory patterns, to restore a continuity of consciousness, and to assimilate the patient's identity into a unified whole" (Steele, 1988, p. 151).

Sherry is a 37 year-old Caucasian female. She has had difficulty establishing herself in a career in the arts because of her own internal constraints and has therefore worked at many jobs to make ends meet. She has had a series of boyfriends with whom she has interacted; usually with their needs being central and at the expense of her own. She dresses ordinarily in drab, dark clothes, and her affect is blunt. It has only been on rare occasions that I have seen her smile or seem excited about anything. She has reported incidents of sexual abuse by her brother and his friends, her father, a kindergarten teacher, two grade school teachers, and several people in a satanic cult. She has been struggling with depression and tremendous fear of experiencing any kind of pain. She has been taking Prozac for two years for her depression. Sherry has noted that she has a family history of obsessive compulsive disorder, which I think has formed the way she compartmentalized her experience of her multiple trauma. (Her mother performed many classic obsessive compulsive rituals such as hand washing and laundry folding.) Sherry is assiduous in reviewing every possible aspect of "trauma control" prior to beginning an abreaction; in fact, her focusing intently and repetitively on each particular traumatic incident is diagnostic of how painful each experience is to her and how much affect she has associated with it. Although MPD has been thought to be a disorder based on hysteria as the underlying personality structure, evidence has begun to appear (Fink, 1991) suggesting that other personality styles are often a part of the response pattern of those with MPD, including obsessive compulsive styles.

During the course of Sherry's psychotherapy, we have used fractionated abreactions to give her a cognitive framework to address her traumatic material and art work. According to Catherine Fine (1991), a fractionated abreaction is a way to work through traumatic material in small increments. As she noted, "The feelings are slowly reconnected to discrete aspects of the history with cognitive restructuring throughout" (p.672) and is likened to systematic desensitization for mastery of phobic experiences. By using an hypnocognitive framework that allows for a beginning, middle, and end, the patient is able to chart her movement concerning working through the material. Art work has been another important tool in working with Sherry. After doing a formal induction that suggests she go to the incident/affect/sensation that she wants to/or has been working on, she draws on a large tablet of newsprint with crayons. She has used this method to define in pictorial form what she is remembering and to assist her in accessing the affect and sensations in varying intensity as she is ready to process them. Even though she has made progress, I thought introducing EMDR might help facilitate Sherry's process and metabolize the feelings of rage and terror with which she has been working. Although she was concerned about trying something new, she agreed to try out this new modality.

Sherry expressed a great deal of fear about experiencing her feelings, which is consistent with reactions of most patients with MPD. As her initial incident for EMDR, she chose the sensation of a hand on her throat when she felt like she was choking or drowning. She had tight sensations in her chest. Her SUDs was 9.5 and her positive cognition was "I feel courageous and strong" with a VoC of 1. I used a brief hypnotic induction and she went into an altered state, as was her custom. Using another method to dilute affect, called "blending of personalities" (Fine, 1991), I invited those parts of the mind who were involved with this incident to identify themselves and step forward to be part of the process of following the movement of my fingers as they looked through Sherry's eyes. Also, I suggested that those parts of the mind that were further back to look on and follow the movement of my fingers, if they

chose to do so. I emphasized that if at any point that they needed to stop the process, that they only need signal me or stop following the movement of my hand. According to Sherry, everybody was watching.

The first time was an astounding experience for Sherry and for me. She worked hard; in fact, she worked with abandon. The incident that she reported originally evolved into having electric shock applied to her, which seemed to be a more compelling trauma for her. During the process, she contorted her body, flailed her arms and legs, and twitched her head back. She perspired profusely, her face turned bright red, and she displayed an enormous amount of affect. Actually, she looked like she had cerebral palsy. Often, her head was tilted back, so that I had to stand up in order for her to see the movement of my arm.

As the end of the session approached, I ended the eye movement work, thanked the aspects of the mind that participated in the process, and asked if there was anything else that needed to be addressed before we stopped. There was not, so I asked all parts of the mind to step back into a safe place until our next meeting, and I asked Sherry to step forward. It is important to address alters in a respectful manner as a model for how Sherry also can learn to deal with herself/selves. Also, at each step, I encouraged her to take part in her treatment and notice what she needed in order to take care of herself. When asked about it, she replied, "Doing it is not as panicky as I thought." In the subsequent session, she reported, "It feels a bit better, and I'm feeling a bit clearer. Before I felt things would not get better, but now it feels like it's what my body needed to do. I didn't completely realize that before. Now it makes sense. I knew things had to come out of my body, but I thought I'd be crazy or out of control and embarrassed. I did not know how to get to the intensity. I was surprised I didn't get more embarrassed and didn't feel out of control."

I thought she would be extremely upset because of the amount of affect and sheer physical work that she displayed, but she was quite calm. However, as I thought about it, EMDR seemed to help her challenge her belief that she was unable to work with affect or sensation. Here she had found a different way of moving through the material that seemed to offer her more, rather than less, control.

We continued to work with this memory in the structure of the fractionated abreaction and included EMDR for 8 more sessions. She showed much improvement and reported that she was even feeling better and noted that she was seeing "the light at the end of the tunnel." She was able to tolerate the incident and work on it and experience the affect associated with it more intensely. As a result of her subjective experience of having more control, she was more willing to work on the material. Despite all of this, her SUDs did not go down to 0. I attributed this to the fact that there was more trauma that had to be worked through.

I was concerned by Sherry's need to flail and the amounts of energy she displayed as she continued to process the memory. It seemed that she felt that she had to go through every second of the original incident. Therefore, I tried using hypnotic paralysis and time distortion to allow her to move through incidents at an accelerated pace. With the use of the hypnotic paralysis technique, her movements calmed down considerably, but did not disappear. She noted that this procedure was not comfortable for her and we stopped using it. However, from then on, she did not move her body as much. Also, she was not very comfortable in having her memories move 2 to 4 times faster than they had occurred originally, so we stopped this intervention. Nonetheless, I was seeing results. She was more present in her body. She showed much more affect and was addressing transference issues and staying with them. She was able to begin to make clearer distinctions between present time and past incidents. She has begun to wrestle with putting more energy into her career, something which she had not been able to do.

Recently, we have been addressing her strong feelings of anger at people who hurt her. She requested that we use art work to assist her in "getting out" the feelings, as it had been so helpful to her in the past (as described above). She depicted an incident when she was raped and tortured by members of a cult and filled in her feelings of pain, anger, and sadness by the use of strong color depicting those emotional states and sensations. After she completed her first drawing, she requested that we use EMDR to help her process her experience of the incident. Subsequent to the combination of hypnosis, drawing, and EMDR, Sherry's appearance changed. She came in looking more stylish, her hair was different, she was wearing brighter clothes, and she was exhibiting more affect. Though, optimistically, I would like to think that EMDR was responsible for Sherry's noteworthy improvement, it is important to understand that metabolizing of certain traumatic events for patients with a dissociative disorder favors re-configuration of personalities. Only more time will tell whether it was an integration, a re-configuration, or if EMDR resolved such a major trauma that she overcame a hurdle of great importance.

When asked about the difference between straight hypnosis and using EMDR and hypnosis, Sherry reported that when

she did the EMDR work, she felt better when she left the session. Before she felt more on her own. She said, "It was like going into the woods and getting lost. With EMDR, there is more of a path." She noted that having her eyes closed was "scarier." She felt more depressed and despairing when using straight hypnosis. With hypnosis, material would come up and stay, or she would re-dissociate because of the increased intensity. She reported that when in a state of hypnosis, she used to float around, and she would see the scene from points at the top of the room, or she would feel like she were spinning, and she would feel strange.

For Sherry, EMDR allowed her to feel more grounded, especially when used in conjunction with the drawing. The process was more active and helped her move through things. With EMDR, she noted that she could go from one experience to another, feel the feeling, go back to the original feeling and tolerate it more. Her concerns were that, sometimes, the material moved rapidly and she felt that it was beyond her grasp and that she was unable to control the scene. She was concerned that maybe she needed to stop and cry more and was surprised that her tears did not come up again.

From my perspective, there have been many changes in Sherry's physical, emotional, and behavioral responses since we began using EMDR in conjunction with hypnosis and art. Her physical presentation is of a young woman who has a range of affect, and who dresses and grooms herself in a more attractive manner than when she first began treatment. She noted that she has felt more solid, and it is easier for her to motivate herself. She has felt less depressed and less suicidal and stated that she is willing to go into "the very bad feelings."

Sherry has been demonstrating a more consistent functioning of an observing ego. She has been able to have an overall perspective of her situation and has begun to talk about wanting to remember what happened in her past. She has introduced the theme of integration into her art work by drawing alters linking hands or within the same frame of reference. The theme of integration has also come up in her verbalizations, such as talking about how to go about being connected internally.

She has brought aspects of her current life into treatment, rather than keeping them separate as she has done in the past. As she has become more able to master her internal environment, she has been more in control of the material she is working on rather than it carrying her along. She has allowed her boyfriend to get closer by letting him live in her apartment for the past several months. She recently announced that they are considering marriage, and although she had not thought about "the others" as part of this activity, she has begun to think about this situation rather than moving away from looking at it.

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REM Correlated With Emotional Intensity Not Scanning In Dreams

Tom Matthews, Ph.D.

Recent sleep research seems to be consistent with EMDR findings. The standard interpretation of Rapid Eye Movements (REM) during sleep is that they represent the dreamer's visual scanning with the physical movement represented in his or her dream. Recent exploratory research by Hong et al. presented to the Association of Professional Sleep Societies did not find REM correlated with dream "movement" scores. Rather, REM correlated with measures of emotional intensity experienced during the dream and scored as dream themes: anger, verbal aggression, social attack, and surprise. This finding seems consistent with our experience during EMDR.

The fact that eye movements are associated with emotional intensity during both EMDR and REM supports the conclusion that eye movements are closely linked to the cognitive processing of emotionally intense memories. The psychoanalytic understanding of "dream work" is that dreams allow us to do such cognitive-emotional processing, as well as meet other needs. Of course, such processing is the essence of EMDR. Hong and his colleagues at the UCI department of Psychiatry interpret REM as "an index of cortical activation, rather than the result of scanning the dream scenes." The contribution of EMDR is the discovery that by initiating eye movement, we can initiate cognitive processing of emotionally intense memories. This fact points to the conclusion that eye movements are not only "an index," a useful marker, but must be an integral part of

this bio-behavioral phenomenon.

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Thanks to Tom Western at the St. Francis Sleep Disorders Center, To-

EMDR, Grief and Mourning

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In the November, 1992 EMDR training, Dr. Shapiro stated that using EMDR in grief and mourning challenges the concept of how long mourning "should" last. This case example shows how EMDR has assisted in the process of mourning by dealing with some of the self-messages that create pain without denying the reality of the loss experience.

John entered therapy three weeks after the death by AIDS of his partner of seven years. We began doing traditional "grief and mourning" work. In the session after the Level I training, I talked with John about EMDR and reviewed with him an Informed Consent statement.

In our first EMDR session, his negative statement was, "I will never see you again," with a SUDs level of 10. His positive statement was, "I know I will see you again," with a VoC of 3. During this session, he went through the experience of the death of his partner, Ed. John saw himself coming home, trying to move Ed's head so it would be more comfortable and realizing that Ed was dead. Then he saw the first house they lived in and then the second house they had shared. He then said, "Ed left me for a while, but he came back while we lived in that house." He then talked about seeing "A street in Boston (his hometown) at the end of winter. The snow is sooty and there is gravel from sanding the street." His next image was the blue sky of a late winter, early spring day. His SUDs dropped to 6 and his VoC was 5. At the end of this session, he stated that he wanted to use EMDR again. (Reducing the SUDs to 0 or 1 was not anticipated because he was currently experiencing this loss. The next week he was to be home for Thanksgiving.)

When John returned, he began working with the negative statement, "I miss you so much. I don't know what I'll do without you" (SUDs 10). His positive statement was, "I know I'll see you again" (VoC 3.5). Part of his pain was that he had not experienced dreams about Ed and, although he talked to him, did not hear responses in his head.

In this session, his early images were of being in their empty house and walking in rooms at night with no lights on. Then he heard Ed say, "Get over it." In life, Ed dealt with his own feelings in this way, while John is a man very much in touch with his feelings. John felt Ed put his arms around him and say, "I've always said you can do anything you want to do. You know what to do." This experience of being held was very important to John. The next series of eye movements (EM) were a turning point in this work.

The following is an example of how the session proceeded:

"I see myself standing in the glass alcove of our dining room, looking out at the sunshine."(EM)

"I feel very warm. It's a good feeling."(EM)

"This is crazy, but I'm facing Southwest."(EM)

"I'm standing outside an art gallery in Los Angeles. It's a gallery that has paintings and prints of an artist that Ed and I both liked. We often talked about this gallery. We shared this experience although we were never both there at the same time."(EM)

"I heard Ed saying, 'Take care of our things and I will be with you forever." We proceeded to "fix" this statement. His SUDs dropped to 4, and his VoC rose to "6 or 7." In discussing the process at the end of this session, he spoke about how the art gallery image would never have come to mind if we were not using EMDR. My experience was that this was like working with dream material in which the therapist needs to have some understanding of what may be being expressed in these images, but willing to allow the natural healing process.

We have now moved into his anger about his loss, and he is looking realistically at the positive and negative aspects of their relationship. The dynamics of grief and mourning have not been changed, but the process of working with his messages about this experience has been facilitated by EMDR. In this case, EMDR has helped in reducing the pain of grief and mourning.

Observations in Using EMDR in Patients with a History of Sadistic and Ritual Abuse

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For some time, therapists have been struggling with the issues of ritual abuse as they have worked with patients having Multiple Personality Disorder. Recently, a number of therapists who have had extensive experience working with ritual abuse, particularly with patients who have a Multiple Personality Disorder, have put together protocols to be used in treating this disorder. In this section, I would like to point out some

specific issues, and perhaps some cautions, in our thinking concerning EMDR until we gain more information and data about its effective usages and unrecognized side effects.

In my own experience, I have used EMDR with a number of different patients who have histories of ritual abuse, and it appears to have a significantly different impact on the way they do "memory work" compared to patients who seem to abreact in standard ways or who go around and around on a memory merry-go-round without any apparent closure. However, I have not found the procedure to be entirely without complication. Part of this has to do with the continuing availability of the therapist and the need to work more material, while part of it has to do with the extensive nature of the abuse, which is not always available for working through in the course of just a few sessions because of the volume that has to be assimilated and worked through.

As an example, one woman was terrified of moths because they reminded her of hooded things that seemed to have eyes on their wings. As she gradually worked through the images with EMDR, she moved towards a feeling of her basic evil character with a brief identification of what the moths seemed to represent, and how, as a little girl, she was placed under a light at night and they would dive bomb her. Working further, she had a sense of being evil or being the devil, but without the switching that often occurs when differing states emerge. She did this more through a sense of feeling evil rather than switching and going through it.

At the end of two sessions, her SUDs level reduced only mildly. Her VoC, however, arose to a fair level of confidence that she could take care of herself when the moth season arrived. She had no way to test herself until the miller moth season.

Apparently separate was a fear of the moon. She was particularly frightened of the full moon, and we took this specific memory as a starting point for another piece of work. She worked gradually and appeared to be going down a parallel chain that was related to the moths, but there was not enough time to work this session through completely. On return, however, she wanted to work with moth memories further since it was then moth season. After running down to a nodal point with the moths, she suddenly had an association that crossed to the moon and she exclaimed, "I'm not afraid of the moon any longer." She was dramatically relieved of this symptom and surprised at how quickly this moved through her and that it worked with her in a way that other forms of memory had not.

After several months, the symptoms seemed to be relatively stable, although the patient did not at the time want to continue in treatment to see how low her SUDs scale could be reduced. (She was able, when miller moths entered the house, to place soapy water on a table by a lamp to attract the moths which would fly into the water and drown.) The patient was able to specifically focus on symptoms to arrive at a result in a relatively short period of time. It was apparent, however, that there was a great deal of traumatic information that still had not been dealt with and which might continue to keep the SUDs high (despite increasing adaptivity in her validity of cognition about her self-confidence) until increased memories of interconnected associations were worked through. This will remain to be seen.

In a second patient, who reported being kidnapped and traumatized, several traumatic memories were worked through using a specific memory, resulting in dramatically reduced SUDs levels and an increased VoC. As she did this, however, new memories continued to surface as she seemed to "race" through the material to new areas of high anxiety. It was clear she was able to work specific focal memories down to a point of closure, which often happened to be another area of trauma that would need to be resolved in order to get complete resolution of a memory system. She was impressed with the rapidity with which she worked and the lack of need to switch from one state to another.

There was a great deal of inner turmoil which could be visualized as she moved through the material. Her SUDs of the original memory was significantly elevated and she maintained high levels of anxiety even as the memory was worked, suggesting that a variety of pathways needed to be followed up for closure.

A last example is of a woman who had been in treatment for a long time and had gained a great deal of insight from information that had been carried by other altered states. She felt she was on the edge of a breakthrough, wherein she would become aware of a great many issues and her dissociation would begin to dissolve relatively soon, resulting in fusion and integration of altered states. In two sessions, she had some very specific experiences. The most impressive was working through a report of being raped by a devil, told that she was a devil's child, and that she, and any offspring she bore, would be essentially evil in nature. It had appeared to her for a long time that it was the actual devil who had raped her on an altar. She saw all those in the room surrounding her. Following institution of EMDR, there was a sudden awareness by the patient of a major deception. She could recognize that the individual standing over her was wearing makeup and false fingernails he had put on in order to scratch her body, and that the horns on his head did not seem to go all the way through, but came out like something clamped to his head. She then recognized the voice as that of a friend of her father. At this point, the

memory continued in one state, and, in the subsequent memory where EMDR was used, she was aware that the deception in the memory stored in one state was simultaneously coexisting with a different way of viewing the same memory as real through a different state of mind.

There was, in a way, two sets of realities occurring which could not connect and re-assimilate themselves while they were dissociated. She also recognized that instead of being the center of a large group, only a few people were around her, harassing her, while others were laughing and smoking cigarettes. During the last session, however, she went through a massive experience which felt as though all of her dissociative defenses had a kind of "melt down," and she was seeing everything basically the way it was without dissociative separation and protection. At this time, unfortunately, I was away for a few days. The reports from the nursing staff in the hospital were that she was at times relatively disorganized, crawling on the floor, and feeling intensely flooded by the material without adequate insulation to keep her from recognizing the many ways in which she had been hurt, as well as the many deceptive things she had been told. She was enormously relieved, for example, that she would not have borne an evil child of Satan had she become pregnant.

For her, this rapid dissolution of dissociative defenses was enormously helpful and it occurred very quickly. Furthermore, she was not alarmed by the massive regression that took place for a few days while she pulled herself together and dealt with assimilating what it all meant. The nursing staff, on the other hand, rightly felt I had opened too many issues for her without being available to assimilate them more quickly.

The patient herself, however, felt that recognizing her experience without the dissociation was not only welcomed, but also provided a clear improvement and benefit, rather than a complication of therapy. I will stay with that one since it is cosmetically more comfortable for me, but I will also recognize there may be times when one needs to be relatively close to a patient if one expects something of this kind to occur.

There have been a few other patients who have recognized their experiences quite differently, either as deceptions or in some other form, when utilizing EMDR. They all had a sense of a different kind of work and a different way of working the material than was our standard fashion, which was often painfully long.

FRIENDS OF RON MARTINEZ

On December 31, 1992, a group of friends of Ron Martinez, Ph.D., met and consolidated efforts toward assisting in the financial support of him and his family at this time of extreme life crisis. As a result of that meeting, a memorial fund for the benefit of Ron has been established at Peninsula Bank of Commerce.

Gifts to that fund can be made as follows:

MEMORIAL FUND
FOR THE BENEFIT OF
RONALD A. MARTINEZ, Ph.D.

c/o Peninsula Bank of
Commerce
P.O. Box 547
Millbrae, CA 94030
Attention: Diane Gallagher.

We extend a grateful thank you for any support you contribute on behalf of this very special person and his family. F.S.

Update on Florida Disaster Response Effort

Judith Boore, MA
Center for New Beginnings

Hurricane Andrew was perhaps the most devastating natural disaster in recent history, with wind speeds of at least 169 mph., 250,000 homeless, and causing, as of this writing, $30 billion in destruction. By December, there were still large areas of damaged and unusable homes and businesses, traffic and transit problems, frayed tempers and other psychological sequelae. These problems presented a unique opportunity to use EMDR with hurricane survivors. In November and December, eight volunteers joined Ruth K. Grainger, Ph.D., in providing both treatment and the initial work for a pilot study.

Seventy-one survivors were seen in December by Judy Albert,MFCC, John Marquis, Ph.D., John Thompson, MFCC, Ricky Greenwald, MA, and myself. Beginning and ending SUDs (Subjects Units of Disturbance) levels were taken. Substantiating our clinical impressions, the mean SUDs levels declined from 8.2 to 1.4 (n=64).

Survivors were highly motivated to rid themselves of their disturbing symptoms. Their low resistance plus the use of EMDR seemed to lead them through hurricane and aftermath distress in a matter of minutes. At this point, pre-hurricane traumas often surfaced and were also treated with EMDR. Most survivors needed only one session. Those returning for a second session worked on other issues or aspects of the hurricane.

As volunteers, we experienced minimal stress; in part, because the rebuilding effort was well underway, and also because the congenial company of the volunteers and the Grainger family prevented the stress and burnout usually

experienced by disaster workers.

This study suggests that EMDR is an efficient and effective procedure for both the survivors and the disaster relief workers.

Selection Criteria for Negative and Positive Cognitions in EMDR

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Before we proceed with EMDR processing, we select a Negative Cognition (NC) and a more desirable Positive Cognition (PC) that we will install after we have desensitized the client's presenting material. Clinical observations indicate that appropriate selection of the NC and PC is often crucial to the success of EMDR processing. It is not possible to specify all of the factors that need to be considered in selecting the NC and PC for all clinical situations. The focus here will be on common problems encountered by trained EMDR clinicians. I will review several broad principles and four specific selection criteria that the reader might find helpful when eliciting the NC and PC.

The substance of this article is based on the EMDR Level I manual and training as developed by Francine Shapiro, Ph.D., (1990). Additional material and clarification were developed as a result of discussions at an EMDR facilitator training at which the author and two other presenters (Gould and Wildwind, 1992) developed papers on the selection of negative and positive cognitons. I have also drawn on the observations of other clinicians in the practicum portion of the Level I and Level II trainings, and my own experience applying the EMDR method in clinical practice.

Rationale for Negative and Positive Cognitions

In the EMDR model, the negative and positive cognitions and their associated affects are believed to be the gateway to a hypothesized nodal memory network (Reiser, 1990; Shapiro, 1989, 1991). This gateway provides links to thematic and personality issues or schema (Beck, Freeman et al., 1990).

Clarifying the NC serves two major purposes. The first is to establish the PC. The second is as part of the target for processing (with the image and affective component).

While the final version of the PC may differ from the initial version, it is important to select an appropriate PC before processing. In the revised EMDR model, it is hypothesized that information processing is accelerated and that cognitive restructuring takes place somewhat spontaneously as a result of a neural balance induced by saccadic eye movements. A more appropriate PC might emerge spontaneously without preselection. However, clinical observations suggest that selecting the PC in advance of EMDR processing appears to help activate nodal memory elements related to more appropriate cognitions.

Initially, the client is likely to lack a substantive, imaginal reference for the nodal memory elements of the PC. Prior to processing, nodal memory elements that could support the PC are not integrated with the more strongly valanced and activated nodal memory elements of the NC.

When the PC is first selected, the client may relate to it with a sense of limited cognitive relevance or sheer disbelief. Many clients say initially they <u>know</u> the PC is true, but they do not <u>feel</u> it is true. Nevertheless, by asking the client to select and verbalize the PC in advance of EMDR processing, these nodal memory elements are activated in short term memory where they represent the potential for a therapeutic outcome. Later, when the client is intensely involved in the feelings and images of the presenting material, the PC provides a new cognitive reference point that assists in the desensitization and reprocessing of the anxiety producing material.

When to Select the Positive Cognition

When to select the PC is a strategic issue. It is easier for the client, both cognitively and affectively, to consider the PC if the traumatic material is not yet fully activated. A key principle is to develop the PC early in the session before clients are immersed in all the images, feelings, and sensations associated with the NC. Early selection of the PC also allows a simpler procedure by not having to access the imaginal material twice— once before and once after identifying the PC.

To ease selection of the PC, ask for the negative beliefs associated with the presenting material at an early stage in its description. As soon as the NC is selected, request the PC. Whenever possible, select and confirm an appropriate PC before asking the client to access the feelings and body sensations that go with his/her imaginal memories. A VoC may be elicited once the PC is selected. (Note: a VoC on the NC is generally <u>not</u> requested.)

Phrases Helpful in Eliciting the NC and PC

After the client describes the memory selected as the target for processing, ask for the NC with a phrase appropriate to the client's description. The most general phrase would be: "As you think about that incident (or memory), what thoughts do you have about yourself?"

If the client uses visual metaphors in describing the target memory, you may ask about "the words that go with that picture." However, with clients who

refer to their memory with primarily auditory or kinesthetic metaphors, avoid phrases like "when you see that picture." If the person refers to auditory impressions, use the auditory cue as part of your eliciting question: "When you hear that child cry out, what do you say to yourself about yourself?" Similarly with a client who describes a kinesthetic cue: "When you feel the weight of his body on you, what do you sense yourself thinking about yourself?"

Avoid asking: "What feelings do you have about yourself in that picture?" At this time we are seeking a belief not an emotion.

To elicit the PC ask: "How would you rather think about yourself when you think of that memory (or incident)?" For the same reason, do not ask: "How would you rather feel about yourself?"

Selection Criteria for Negative Cognitions

The first criterion of a NC is that it be an irrationally negative, self-referencing belief. This self-critical, self-blaming assessment is often based in guilt ("It was my fault") or shame ("I am disgusting").

Note that the NC is a continuing, presently held belief. The NC is derived from prominent or prototypical memories, but it is also actively influencing the client in the present.

A common clinician error is accepting a description of circumstances, events, or the attributes of others that have a negative tone as a substitute for a negative self-referencing belief. Another common error is accepting a NC that is localized only in the past and does not relate to the client's presenting issues.

An example is the initial NC elicited from an adult client who as a child was restrained and abused by a much larger, stronger adult: "I couldn't stop him." This is an accurate depiction of a negative circumstance. It is not an appropriate NC because it fails the first test. It is not a self-referencing belief. It is a self-referencing observation. Note, it is also set in the past and, thus, is not a current belief.

When the client offers a description, the simplest way to develop the NC is for the clinician to incorporate the description into the eliciting question. In this case it might be: "As you remember not being able to stop him, what thoughts do you have about yourself?" Depending on what the eliciting question evokes, a more appropriate NC might be: "I am defenseless," or "I am to blame."

The second criterion of a NC is that it should accurately focus the client's presenting issue. As evidence of this focus, clients should indicate they accept the NC as appropriate when the therapist restates it.

A preliminary NC that fails this test may describe a client issue, but not in a focused way. It may be too wordy or elaborate. It may fail to reflect the core schema linked to the event.

In order to develop a NC that meets this second criterion, the clinician often must listen carefully and then go through several steps to determine what the core issue is for the client. For example, one client, a survivor of childhood sexual abuse, offered the following as a preliminary NC: "I can never forget what happened because it was just too terrible, too shameful. The memory of what happened will always be there in the back of my mind as a terrible reminder of how I went along with what they wanted from me."

At first it might seem that the NC revolves around the intrusive quality of the memory. This might lead to a NC of: "I can never forget what happened." However, we must remember the goal of EMDR processing is to help the client shift the dysfunctional process (belief) linked to the memory, rather than to try to erase memories.

Upon further reflection and inquiry of the client, it emerged that the "most painful part of the memory" was the shame. This led to the development of a NC focused on the way that the memory was being held: "I am a terrible person for doing what they asked me to do."

Note that the even shorter NC, "It was shameful," which might be adequate for some clients, was not appropriate in this case. For this client the presenting issue was inappropriate shame and withdrawal stimulated when the client's spouse verbalized specific sexual requests. Both the client and therapist believed these requests were reasonable and the client often enjoyed these behaviors when initiating them. Since the problem occurred in response to the spouse's request, the longer NC which referenced responsive behavior was essential.

The third criterion of a NC is that it should have an affective resonance. Evidence of affective resonance is that when saying or hearing the NC, the client shows or feels (more) shame, fear, anger, or other emotional arousal. Careful observation will generally give the clinician evidence of this affective resonance. Sometimes, direct questioning is needed to confirm the appropriateness or choice of one NC over another.

Some clients will neither show nor feel significant affect until EMDR processing begins. However, most clients do reveal affective resonance when describing the presenting material or target memory. In these cases, the NC should only be considered appropriate when it elicits affects that the client has previously demonstrated feeling.

The fourth criterion of a NC is that it is generalizable to other, possibly related, loci of concern. Belief in this NC would have affected the client in various ways at different settings or times up to and including the present.

The most common error related to this criterion is a NC too specific to the incident. This may involve detailed references to the past situation. As in: "I should have locked the door." Clearer is: "I didn't do everything I could have." This latter formulation is much more likely to be linked to a variety of analogous situations. These other situations may not involve failure to lock doors, but could still lead to anxiety and self-criticism or unnecessary checking behavior.

Selection Criteria for Positive Cognitions

The first criterion of the PC is a statement of a positive, self-referencing belief. The PC is a self-validating belief generally reflecting self-confidence or self-worth. However, not all PCs are self-referencing. A PC also may reflect safety ("It's over") or the attribution of responsibility ("She/he had a problem giving love") without being self-referencing.

A common error in selecting the PC is allowing a negation of a negative belief (double negative). This often arises after identifying the NC when the clinician asks, "What would you rather think?" The client responds by reversing his/her NC with a negation. Starting with a NC of "I'm helpless," this could easily lead to a PC of: "I don't have to feel helpless anymore."

In EMDR, we do not accept this "denial" form of a PC. Instead we look for a PC that can be the basis for organizing thinking, feeling, and behavior in new ways. In this case the PC might be: "I'm safe," or "I can protect myself now."

Another common error is permitting a PC that contains magical thinking about changing actual past events or the attributes of someone else. For example, the incest survivor whose NC was: "I am not loveable," stated she would rather think, "My father really did love me." When the magical element was pointed out to her, she instead chose: "I am loveable."

The second criterion of the PC is that it accurately focuses the client's desired direction of change. The most positive PC may not be acceptable to the client. Thus, a diluted version in the desired direction may be selected initially.

A common error is pushing for a PC that is too big a step for the client's present frame of reference. Many clinicians find that after reprocessing, the stronger form of the PC may be accepted. Initially selecting a diluted PC still orients the positive direction.

A client began with the NC: "She never loved me." The revised NC was "I am not loveable." The client was unable to generate a PC. The clinician initially suggested the PC: "I love myself." The client did not find this acceptable, so the clinician offered the diluted PC: "I can learn to love myself now."

The third criterion of the PC is that it is generalizable to other, possibly related loci of concern. Shorter PCs of three to eight words are often best. However, length per se is not the central factor in generalizability.

The challenge in formulating the PC is to identify the core issue or schema in the client's presenting problem. A weak or peripheral PC fails to focus or does not generalize well to other salient issues of concern. A client with performance anxiety linked to family expectations began with the NC: "I don't know if I can live up to their expectations." The clinician responded: "And when you don't know if you can live up to their expectations, what do you think about yourself?" The revised NC selected was: "I'm unlovable if I fail." When the client was asked for the PC ("And what would you rather think?") The response was: "I can show them how much I can achieve." This magical thinking PC was still oriented to the initial NC that is part of a schema in which being loveable was linked to performance. When this was pointed out, the client selected the revised PC: "I'm loveable as I am."

The fourth criterion of the PC is that it have a positive, affective resonance. Initially, this may be hope, embarrassment, or an awkward, but skeptical, acknowledgement of the PC's desirability. After reprocessing, the PC usually will resonate with a much stronger, positive affect.

A common challenge in selecting the PC is that it may be positive, focused, and generalizable, yet still fail to evoke any affective resonance. One possibility when the PC fails to evoke an affective resonance is that the NC may not have been appropriately selected. Clinicians may want to check to be sure the NC evokes increased affective response.

Usually, properly selected PCs will evoke some affective response, if only due to cognitive dissonance. On the other hand, some clients (such as those with chronic depression or borderline features) may have precious few positive resources on which to draw for an affective response to the PC. Others, such as clients who over-defend with intellectualization, may block nearly all affective responses including those to the PC. Normally, there will be some evidence of feelings evoked by the PC.

Conclusion

I have described several, broad principles and four specific criteria that may be helpful to clinicians in eliciting and selecting appropriate negative and positive cognitions. My aim was to focus on the problems most frequently observed among clinicians when they first apply the EMDR model to clinical practice. This list is not meant to be exhaustive or absolute. Clinicians who formulate additional principles or exceptions to those I have described are invited to share them with the author or the editor.

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International Update

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Palo Alto, CA

The Association for the Advancement of Behavior Therapy (AABT) 1992 Annual Conference hosted six hours of special interest group meetings on EMDR to a standing room only audience. The presentations were well received and the subsequent discussions indicated that the fitness of AABT as one of the homes of EMDR seems assured. There were many trained clinicians in attendance who expressed support for the continued efforts and on-going policies. A number expressed displeasure that no official EMDR proposals had been accepted for presentation. However, it was observed that the attendance was just as large at these meetings as at the other ones on the official bill. Further, because of the host-city, we could now say we had been "banned in Boston." Two past presidents of AABT who were in the room expressed specific intention to support on-going efforts. One of these clinicians stated , "If I had to do it over again, I'd do it the way you are. People should be trained before doing research." Out of that discussion came the intention to write guidelines for publication regarding research ethics, which would also be presented to the appropriate AABT committee. Ron Kleinknecht, Ph.D., Chairman of the Psychology Department of Western Washington University will chair the committee. Clearly treatment outcome research is largely useless if researchers are either untrained in the method, or deliberately restrict it from being done the way it works successfully in clinical practice. While this seems to have been decried in certain circles for years, it has not stopped the practice. It seems that more attention should be given to clinical needs than to the expansion of academic curriculum vitae. The prospect seems hopeful for the advent of EMDR to make an impact not only on clinical circles, but on research as well.

The invited presentations at the Milton H. Erickson Foundation 1992 Annual Conference this December appeared to go very well. I appeared on a panel on PTSD with three others, including D. Corydon Hammond, Ph.D., who is the President of the American Society for Clinical Hypnosis (ASCH). As you know, from the articles we have sent you, Dr. Hammond has been an extremely vocal opponent of EMDR. He attacked EMDR while on the panel, so I had an opportunity to respond to him. When he reiterated what he had stated in writing, that he had used EMDR on the basis of the 1989 article, I stated my belief that clinicians should be trained in a method before attempting to evaluate it. I then addressed as many of his consequent stated misconceptions as I could in the time allotted (e.g., only anxiety is targeted, clinicians are trained to tell patients, "The memory will go away for good," etc.). Many members of the audience were quite vocal in their disapproval of his arguments and manner, while a number of trained clinicians commented on their client successes with EMDR. When Don Wright, M.A., chided him for his lack of openness and encouraged him to attend an EMDR training, Dr. Hammond replied that "despite the contract," he had been instructed by someone trained by me. This appeared rather ironic to me since ASCH is presently sponsoring authorized certification programs in hypnosis as a prerequisite for practice.

In the memory of Ron Martinez, Ph.D., we would like to offer scholarships to EMDR trainings (guidelines for these scholarships will be annnounced in the next Newsletter) for clinicians who specialize in treating the following populations: handicapped, cancer, terminally ill, as well as HIV/AIDs and the homeless. I consider Ron to have been the "Heart of EMDR" and would like him to be remembered above all as one who made a difference. In addition, we will offer scholarships for all legitimate published researchers and dissertation students with accepted proposals who are committed to doing quality treatment outcome research. Please send all applications to the EMDR office in Pacific Grove.

Invited presentations for 1993 include the Family Therapy Networker Annual Conference in March, the California Association of Marriage and Family Therapists Conference in April, and the Brief Therapy Conference sponsored by the Ericksonian Foundation in December. I would like to encourage all of you to

make independent submissions to local meetings and regional conferences. If you would like to connect with other presenters on given topics, please use the Help Wanted column of the Newsletter or contact the coordinator of the appropriate special interest group listed in past issues. Without your journal articles, as well as the continued presentations, EMDR may become a one generation phenomenon. If you truly believe in its efficacy, then your voice can make a valuable contribution.

EMDR RESEARCH NEWS

Sandra "Sam" Foster, Ph.D.
Mt. View, CA

Francine continues to encourage thoughtful investigations of EMDR and invites clinicians, dissertation students, and others in research settings to explore the efficacy of EMDR. To assist those of you who are interested in conducting research, there are several mechanisms being established.

Research Data Base

By calling the EMDR office in Pacific Grove (408) 372-3900, you can access the growing list of researchers and their areas as well as the NAME OF INVESTIGATOR, SUBJECT POPULATION, and SUBJECT DIAGNOSIS. When investigators have made them available to us, we can provide a summary of results and a copy of any measures used. Investigators' addresses and work telephone numbers will also be made available.

Currently, we are collecting this information for your use and will be continuously updating this growing list. By summer 1993, we should have an impressive compilation of work in EMDR. If you have conducted a study and wish us to include your results, please send me a summary of the investigation. If you have a research question, you can write or fax your inquiry to me. I can be most helpful with already formulated research proposals or ideas based on the reading of existing EMDR research articles.

Norman Cousins Research Fund

The Network has established a research fund in the memory of Norman Cousins. One thousand dollars will be available each calendar year in the form of two five hundred dollar awards. This funding is intended primarily (although not exclusively) for dissertation students pursuing a study of EMDR.
To apply for one of the $500 grants, please mail a copy of your research proposal (preferably the summary submitted to your dissertation committee) to me. I will be screening the proposals and will be forwarding the best formulated and most promising proposals to Francine for final selection. The deadline for submission is July 1, 1993, for this year's awards. The selection will be announced to the recipients by August 15, 1993, and the funds dispersed soon after that date.

Scholarships Available to Dissertation Students

If you are pursuing a Ph.D. and wish to conduct research in the efficacy of EMDR and have not yet received both levels of training, you may be interested in this announcement. **Scholarships are available to doctoral students whose EMDR research proposals have been accepted by their committees and appear to appropriately test EMDR.**

Please submit your proposal to me at the address below. I will be screening them and passing them along to Francine who will make a final decision about the acceptability of the proposal to qualify the student for the EMDR training at no charge. Suggestions for procedural changes in methodology may be made.
All students submitting a proposal will be notified as soon as possible by letter.

At this time, scholarships are available for clinical outcome research or physiological research only. No scholarships will be offered for component analysis.

Dissertation Students or Researchers Needing Assistance with Methodological Questions for EMDR Research Proposals

I am available to assist dissertation students and other investigators with methodological questions. Mail of fax your questions to me. Please read the published articles first (available for a small fee by calling the EMDR office in Pacific Grove) and then put your questions or research plans in writing.

Send to: *Sandra Foster, Ph.D.*
1503 Grant Rd., Ste. 503
Mt. View, CA 94040
fax: (415) 321-8151

EMDR Newsletter Staff
Editor: **Lois Allen-Byrd, Ph.D**
Co-editor: **Andrew Leeds, Ph.D.**
Publisher: **A. J. Popky, CHT**

EMDR HELP WANTED

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

EPIC (EMDR Professional Issues Committee)

The EMDR Professional Issues Committee (EPIC) is recruiting new members that have either experience or interest in professional and ethical issues. We meet on the third Wednesday of each month from 10:00 A.M. to 11:00 A.M. in Palo Alto. Contact one of the following:
Lois Allen-Byrd, Ph.D. (415) 326-6465
Virginia Lewis, Ph.D. (415) 326-8752
M. McCorkle, Ph.D. (415) 322-4884

Native/Non-native Research

Assistance desired for research project. A comparative outcome study between native and non-native people with short (3-9 month onset) versus long (years past/childhood) term trauma using EMDR. Contact: *Theodore Phillip Cadman, P.O. Box 1597, Rocky Mountain House, Alberta, Canada TOM 1TO*

Head Injuries

Clinicians who are using EMDR with this population are invited to network with other clinicians to explore indications, contraindications, evaluation, and research possibilities. For more information, contact:
Robert J. Peters, LCSW, CEAP
1720 S. Bellaire Street, Ste. 805
Denver, Colorado 80222
(303) 790-5762

Disaster Research Tools

Ruth Grainger, Ph.D., requests copies of disaster research tools. If you would like to consult on a longitudinal disaster study to determine the efficacy of EMDR as a post-disaster treatment, contact: *Ruth Grainger, Ph.D., 8585 Sunset Drive, Ste. 65, Miami, FL 33143 (305) 595-3399 eve.*

EMDR In Employee Assistance Program (EAP)

EAP professionals who are using EMDR are invited to network with other EAP professionals to explore selection criteria, contraindications, evaluation, and research possibilities. Contact: *Robert J. Peters, LCSW, CEAP, Mgr, Employee Assistance Program, Rocky Mountain Adventist Healthcare, 2465 S. Downing Street, Ste. 200 A, Denver, CO 80210, (303) 778-5272, FAX (303) 778-5769*

EMDR Surveys

Howard Lipke, Ph.D., Director of the Stress Disorder Treatment Unit of the N.Chicago VAMC, sent out surveys to all EMDR clinicians trained before Feb., 1992. Your input is important for the validation of EMDR, so please return them as soon as possible. It will be invaluable for an independent assessment of EMDR treatment effects and pitfalls. Results will be published in 1993. Contact: *Howard Lipke, Ph.D. (708) 688-1900 x4673*

Fighting Prejudice

I am asking for ideas or collaboration in developing interventions for modification of prejudice. During my work in the Mississippi Delta at a community mental health center, it has often seemed that individual patterns of intense prejudice could be viewed as schema driven clusters of intense negative affect, irrational thinking, and behavior which result in both avoidance of cue exposure and maintenance/support of core cognitions. Many victims have also experienced related traumas or long series of "mini traumas." EMDR could be part of a schema-focused, cognitive-behavioral intervention. Contact: *Richard Sayner, PhD, Life Help, PO Box 1505, Greenwood, MS, 38930.*

Low Fee EMDR Services Needed for Referral

I frequently have referrals for women therapists in the San Jose area (perhaps as far north as Palo Alto) who have completed Level II EMDR training. Background in chemical dependency and relapse prevention will be very helpful. If you are willing to see one or two low fee clients, please call me as soon as possible. Eirin Gould, LMFCC (408) 985-6858

Available for Critical Incident/Disaster Relief

I am interested in doing EMDR with critical incident and disaster relief victims for a period of 1-2 weeks. I am available 4/19/93 to 7/9/93. I expect to be licensed 6/93 as a clinical psychologist. *Jill Greenwald, 12 Newcastle Rd., Brighton, MA 02135, (617) 787-9076.*

Success with Schizophrenics?

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

1993 EMDR Network Newsletter Publication Dates

Deadline for Submissions

Apr. 15, 1993 for May 20, 1993
Jul. 15, 1993 for Aug. 20, 1993
Oct. 15, 1993 for Nov. 20, 1993

1993 LEVEL II TRAININGS

Francine Shapiro, PhD, Presenter

Date	Location
June 12/13, 1993 Sat./Sun.	**Denver, CO** Sheraton Denver Tech. Center
July 10/11, 1993 Sat./Sun.	**Chicago, IL** Holiday Inn Crowne Plaza
July 23/24, 1993 Fri./Sat.	**San Jose, CA** Sunnyvale Hilton
Nov. 14-15, 1993 Sun./Mon.	**Portland, OR** Sheraton Portland Airport Hotel
Dec. 3-4, 1993 Fri./Sat.	**San Jose, CA** Sunnyvale Hilton
Dec. 11-12, 1993 Sat./Sun.	**Philadelphia, PA** Embassy Suites

***History-taking and specified questioning for focused identification of problem areas**

***Closing down "incomplete" sessions**

***Axis II applications**

***Integration of EMDR with cognitive therapy**

***Dissociative & other major disorders**

***Abreactive responses and alternative strategies**

***Working with difficult/resistant clients**

***Integrating "self-control" techniques**

***Treatment of Process Phobias**

Based on suggestions and requests from past Level II participants, future Level II trainings have been reformatted to include an ***optional* question and answer period from 9:00am to 9:30am the first day of the training. The intended purpose of this debriefing session will be to provide participants with an opportunity to ask questions regarding Level I material, such as: (1) Proper selection of negative and positive cognitions; (2) the basic EMDR model; and (3) closing incomplete sessions. If you would like to attend this pretraining session, please check the space provided on the registration coupon. ***[Please note: Registration will begin at 8:30am to accommodate those participants attending the early session.]***

As a service to members, an audio tape of RonMartinez's keynote address is included in this Network packet. If you feel that copies of this tape would be beneficial to friends or clients, please order directly from the memorial fund. A man's legacy should be honored. It can make a difference.

The Alchemy of Success
TURNING LOSSES INTO WINS
by Ronald A. Martinez, Ph.D.

I wish to order copies of Ron's inspiring tape:

Quantity	Quantity	Cost
1 - 9 tapes @ $10.00each tape	______	______
10 - 29 tapes @ $9.00each tape	______	______
30 - 50 tapes @ $8.00each tape	______	______
	Sub-total	______
	Please add appropriate sales tax	______
	Shipping 1-9 tapes add $3.00 10-29 tapes add $5.00 30-50 tapes add $7.00	______
	TOTAL DUE	______

____Enclosed is my check or money order payable to:
Ronald A. Martinez, Ph.D., Memorial Fund, 762 Gull Av., Foster City, CA 94404
or please charge my____Master Card _____Visa
Card No.____________________Exp. Date_________ Signed____________________________

Please SHIP TO: Name:___________________________________
Address:__________________________________
City__________________State_____Zip_______

Mail orders to: **Ronald A. Martinez Memorial Fund, 762 Gull Av., Foster City, CA 94404**

CALIFORNIA EMDR STUDY GROUPS

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

[Listed alphabetically by region]

CENTURY CITY/SANTA MONICA

Robert Goldblatt (213)917-2277
Coordinating a new group in the 90067, 90401 zip area for West L.A.

CUPERTINO

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

DOWNEY

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

EAST BAY

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

EAST BAY/ALBANY

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

EAST BAY/OAKLAND

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

FRESNO

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

HUNTINGTON BEACH

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

LOS ALTOS/PALO ALTO

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

LOS GATOS/SARATOGA/CAMPBELL

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

MANHATTAN/REDONDO BEACH

Randall Jost (213) 539-3682
Coordinating a new group.

MARIN COUNTY

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

ORANGE COUNTY/FULLERTON

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

PALMDALE/LANCASTER

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

PALO ALTO

Ferol Larsen (415) 326-6896
Meets1st Wed. 10:00am in MRI conference room. Case discussion. Limited to 10 participants.

REDDING

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

SACRAMENTO

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

SAN DIEGO

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

SAN FRANCISCO

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

Stan Yantis, MD Open (415) 241-5601

SAN MATEO/BURLINGAME/REDWOOD CITY

Pat Grabinsky (415) 692-4658
Florence Radin (415) 593-7175
Coordinating a new group. Contact Florence.

SANTA CRUZ

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

SARATOGA/W. SAN JOSE

Dwight Goodwin (408) 241-0198
Meets Fri. 10am-12:30. Open

SOLANO/ NAPA COUNTY

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

SONOMA COUNTY

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

TORRANCE

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

WEST LOS ANGELES

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

WOODLAND HILLS/NORTHRIDGE/WESTWOOD

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

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

Submission Information

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

To this end, the following represent the guidelines for submissions to the Newsletter: Send articles to Lois Allen-Byrd, Ph.D., Editor, EMDR Newsletter, 555 Middlefield Road, Palo Alto, CA, 94301. Please include home and business telephone numbers, professional degree, location of practice (city and state only), professional affiliation (if applicable—university, if a lecturer or teacher, and/or institute, if an associate). Example: John Smith, Ph.D., John Doe University, Johnson, WA. If possible, please submit articles on a diskette, IBM format. Typed articles should be double spaced with wide margins. APA standard and style--both text and references should be in accordance with APA standards. All submissions are subject to editorial revisions. Proofreading of material is suggested before submission. Authors submitting a manuscript do so with the understanding that, if it is selected for publication, copyright of the article is assigned to the Newsletter.

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

1993 Network Registration Form

(Print following information as you want it to appear in Directory. *DEADLINE APRIL 15, 1993*) ___$50 ___$70 (Includes CA Meetings)

Last name:______________________First name:______________________

Professional Degree:_________City where practicing:________________State:_____Zip:________

[Mailing address will not appear in directory.]

Mailing Address:_____________________City:________________State:____Zip:______

Phone (Bus):_______________________________________

Professional Licensing:__________________Willing to take referrals:_____yes____no

Specialty Areas:_______________________________________

Membership: _____ISTSS_____AABT_______APA_______Other:__________________

Academic Affiliation:__________________Research Interests:__________________

SIGs or special interest areas:_______________________________________

EMDR Level: [ ] Level I - Year trained:_____ [ ] Level II - Year:______ [ ] Facilitator

Comments:_______________________________________

Cost for participating in the National Network is $50 for 1993 [$70 includes National Network meetings in CA Bay Area.] National membership entitles you to receive copies of the newsletters, journal articles, directory, selected audiotapes and discounts on the EMDR Conference and specialty trainings.

Check payable to:

EMDR Network ✉ P.O. Box 51010, Pacific Grove, CA 93950-6010 ☎(408) 372-3900 fax: (408) 647-9881 Newsletter

Training Registration Form

Please print name as you want it to appear on certificate

Name:_______________________________________Phone (Bus): ________________

Address:_______________________________________Phone (Res): ________________

City: ______________________State: ______Zip: _________Prof. Lic. #:________________

COST: $285.00 [$315 if postmarked within 30 days prior to seminar date, $345 if postmarked within 14 prior to seminar date, CE Credits $10].

Make check payable to: **EMDR**, P.O. Box 51010, Pacific Grove, CA 93950-6010, (408) 372-3900, fax (408) 647-9881

Please circle: **LEVEL I** Location:______________Date:__________

LEVEL II Location:______________Date:__________

If LEVEL II: Your date of Level I Basic Training:______________Specialty:______________________

Level II participants only: Yes, I would like to attend the Optional Debriefing Session______

Additional requests for topics in training:_______________________________________ Newsletter

[For Office use Only: Amt_________Ck__________Confrm__________]