August 1991

Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

Vol. 1 Issue 1

This inaugural edition is very exciting for those of us who have watched EMDR grow over the last five years. Thanks to all of you who made it possible, you clinicians and researchers with vision, courage, and a desire to heal.

Worth Repeating

Francine Shapiro, Ph.D.
Mental Research Institute

This column is devoted to statements that were made in the workshop that should be ingrained in the mind of every EMDR practitioner. Since EMDR is still in the "experimental stage" (i.e., replication studies have not yet confirmed its efficacy), the EMDR-trained clinicians are the frontline spokespeople. In order to avoid misunderstandings of untrained clinicians and laypeople, please recall the following:

EMDR is not a "cookie-cutter"

Each client is approached interactively. The needs of the client dictate the initial framing, focus, specific target, type of eye-movement, length of set, cognitive interweave (Intermediate level), final debriefing, log assignment, etc. No two clients are exactly alike--and no two sessions are exactly alike.

Reprocessing a trauma is like removing a quilt from the bed

Only then can you really see the lumps in the mattress. Subsequent to a trauma reprocessing, clients may have to confront a number of dysfunctional relationships, behaviors and attitudes that have been obscured by the rape/molest/accident/war experience. In addition, the reprocessing of dysfunctional information allows the client to adopt new behaviors that may stimulate other dysfunctional beliefs. For instance, when a client is finally able to be assertive and is finally achieving professional success, the neural network that contains the belief "If I am successful, I will be abandoned" may be stimulated for the first time. The purpose of the log is to have the client keep an ongoing record of new anxieties, as they reveal themselves, in vivo, for subsequent reprocessing. One double session may be enough to reprocess a trauma, but follow-up is necessary for the "reverberations."

Using EMDR is like opening a stuck faucet

Once opened, it continues to run. The dysfunctional material starts moving, and the reprocessing is accelerated during the session. However, the processing does not end with the session; it merely progresses at a slower rate. Clearly, debriefing the client to expect further insights, memories, connections, dreams, etc., is crucial. Instructing the client to keep a log of material to be used as targets in subsequent sessions is crucial. Suicidal ideation can occur if the client is not adequately debriefed.

Client safety is paramount

Double sessions are allotted for the treatment of trauma in order to insure that most of the material has been reprocessed before the end of the session. EMDR should never be started without sufficient time for processing and a possible abreactive response. Never let the client leave the office in the middle of an abreaction.

Never attempt EMDR In a non-clinical setting

"Demonstrating over a dinner table" can lead to unforeseen issues and emotional consequences. Likewise, clients should be adequately briefed to allow for the possibility of new connections, memories and possibly repressed material arising in any given session. Clinicians should be comfortable with handling abreactive responses before initiating EMDR with a client.

EMDR is an interface with your clinical skills

While every attempt has been made in the training to prepare you for your clients, there is no substitute for clinical skill, experience, rapport, safety, etc. As a clinician, you must evaluate the ego strength, insight level, openness, support system, stressors, medication needs, etc. of each of your clients, as well as your own availability, level of competence and comfort before attempting EMDR. You have been taught a procedure with many applications. As a clinician, you must evaluate its appropriateness for any particular client. It is an interactive state of affairs and all safeguards must be in place.

At present, only licensed mental health professionals or supervised students are admitted to training. During the first year, a handful of certified hypnotherapists were trained, with the admonition that they use the procedure only within the scope of legal practice. While no problems were encountered, this practice was discontinued; since there are no licensing agency or ethics committee restraints, we could not insure compliance. Since we obviously cannot vouch for the integrity level of all workshop participants, we can only do our best to use official mandates regarding boundaries and limitations to protect clients and the integrity of the procedure.

Clients are at risk if EMDR is attempted by untrained clinicians

Reports nationwide filter in occasionally regarding clients who were harmed by the

attempted use of EMDR by untrained clinicians. Reports include the following:

a) Ocular problems caused by insisting that the client continue with eye movement despite obvious pain.

b) Hospitalization for a near-psychotic break caused by the clinician pushing through the client's defenses.

c) Re-traumatization of clients caused by lack of preparation for the kinds of material that could be revealed, the inability of the therapist to accelerate processing through the material and/or inadequate debriefing.

While reactions to the procedure by untrained clinicians can range from the skeptical to the smug, by far the most dangerous is the latter. This type of clinician disregards caution and, with insufficient information, judges EMDR as "simple finger-waving." Non-results cause the procedure to be denigrated and can deprive others of treatment, or the client can suffer, as described above.

While the Certificate of Completion that you receive does not insure competency, it is proof that you have done your conscientious best to prepare yourself educationally before attempting to discharge your clinical responsibilities. Reading an article, or attending an hour presentation would not prepare a clinician to use hypnosis or any other clinical specialty. EMDR is no exception. The two-day training is a minimal requirement. Make your training known to discourage others from inadequate use of the procedure. The ethics code dictates that untrained clinicians inform their clients of their untrained status.

Clients should not be placed at risk without their informed consent.

Network Study Groups/Special Interest Groups

Coordinator: Cliff Levin, Ph.D. (415) 326-6465

Regional Network Coordinators

California	"Sam" Foster, Ph.D.	(415) 965-8988
Colorado	Andy Sweet, Ph.D.	(303) 377-9588
Illinois	Howard Lipke, Ph.D.	(708) 688-1900 x3312
Pennsylvania	Alan Goldstein, Ph.D.	(215) 667-6490
Washington	Roger Solomon, Ph.D.	(206) 586-8492

Special Interest Group Coordinators

Anxiety Disorders	Dwight Goodwin, Ph.D.	(408) 741-5239
AxisII/Resistance & Transference	Russ Llewellyn, Ph.D.	(415) 595-4500
Children & Adolescents	Alice Ruzicka, Ph.D.	(415) 948-1405
Enhancing Peak Performance	"Sam" Foster, Ph.D.	(415) 965-8988
MPD & Dissociative Disorders	David Fenstermaker, Ph.D.	(408) 257-5032
Psychophysiological	Sally Cappucci, MFCC	(408) 923-3400
PTSD	Mark Russell, MS.	(415) 969-4390

EMDR and Project CAPACITAR in Central America

by Pat Cane

CAPACITAR is a project of healing and enablement connecting North American and Third World Women. In the past two years we have traveled to very poor regions in Nicaragua and Guatemala to work with women suffering from the effects of war, violence, and grinding poverty. We have offered group workshops in stress management, body movement, simple acupressure and massage to help alleviate the physical symptoms of stress and trauma--headaches, insomnia, stomach disorders, neck and shoulder pain.

In September, 1990, we were trained by Francine Shapiro in EMDR with the goal of using the technique with some of these women. During a November trip to Central America, we found that EMDR helped a number of individuals who were suffering from traumas of varying degrees. One woman had survived a Contra attack during which her best friend was killed. Other women had witnessed massacres or had suffered the disappearance of family members. Because of their poverty, many of these women had little access to medical care, let alone therapy, so our work was done on a volunteer basis.

As our project expands, we are planning a summer trip to South Africa and will work with women's groups who have suffered significantly from the on-going violence and racism of the apartheid system. In the fall, we will return to work in Central America (Nicaragua, Guatemala, Honduras, and El Salvador). This summer two therapists are planning to volunteer in Central America with EMDR.

If you would be interested in helping with the work of CAPACITAR, contact:

Pat Cane
3015 Freedom Blvd.,
Watsonville, CA 95076
(408) 724-5526.

Tax-deductible donations (checks made payable to IF-CAPACITAR) help us to expand our work in Third World countries.

Abstract

Chemtob, C., Roitblat, H.L.. Hamada, R.S., Carlson, J.G., Twentyman, C.T. (1988) **A Cognitive Action Theory of Post Traumatic Stress Disorder.** Journal of Anxiety Disorders (2, 253 275)

Abstracted by Andrew Sweet, Psy.D.
Behavior Therapy Institute
Aurora, CO.

The authors of this paper attempt to integrate the existing models of PTSD from associative learning theory, psychodynamic theory, and information processing models of the brain. With the integration they elaborate on a "hierarchical network view of cognition" and specifically detail how it might account for PTSD symptoms.

According to their view, emotion, cognition, action, and memory all flow from the processing of information in the brain, specifically from parallel distributed neural networks. Essentially, this paper weaves the phenomenology of PTSD symptoms into a quite plausible explanation of how a vicious feedback loop is established in the mind/body of the PTSD sufferer. We are led through the role of confirmation bias, physiological arousal and an excitatory-inhibitory model of information processing that sounds quite similar to the **EMDR** theory (i.e., Pavlov).

The model proposes the existence of parallel structures that allow for the multilevel processing of stimuli. These networks and neural 'switch stations' are actually physical structures that are organized around nodes at different levels of abstraction/ meaning. These nodes are purported to interact at different levels and across levels via mutual potentiation and inhibition. It is the summation of these potentiations and inhibitions that determine whether a node is activated or not. (It is tempting to use this balancing act as explanatory of the bipolar shifting that Dr. Shapiro describes in the EMDR training, and which most practioners using EMDR have seen.)

Of major theoretical interest is the proposal that thoughts, images, behaviors, emotions, etc. are all represented in the same sort of networks. Learning, within this model, may occur via pre-existing nodes or in the formation of new ones. The authors attempt to include within this exposition the notions of counterconditioning and lateral inhibition, thus laying the groundwork for explaining why certain therapies work for PTSD (i.e., flooding and desensitzation). They go as far as to say that "... any treatment that reduces the gain of the feedback loop (in PTSD), reduces threat potentiation, or results in the production of strong incompatible competing responses, will be predicted to be effective." (p.271). EMDR may well be promoting this process.

This article does amass an impressive amount of cognitive science research to support its position. Unfortunately, as with most cognitive science, the direct access of these networks, and therefore the testing of these hypotheses awaits significant technological advances. Nevertheless, to this neobehaviorist, it sounds like a fascinating beginning for a map of the brain, and a look into a further explanation of the model for EMDR effects.

EPIC

It is a pleasure to announce the formation of the **EMDR Professional Issues Committee**. The purpose is to provide a forum for the discussion of ethical and professional concerns arising out of the use of EMDR.

For further information, comments, or inquiries contact any one of the following committee members: Ferol Larsen, Ph.D., Virginia Lewis, Ph.D., Marguerite McCorkle, Ph.D., at MRI (415) 321-3055 or Jennifer Lendl, Ph.D. (408) 244-7942. Hope to hear from you.

Virginia

EMDR and MPD

David Fenstermaker, Ph.D.
JFK University

This abstract is one portion of a panel on Eye Movement Desensitization and Reprocessing. It was given on Saturday, February 23, 1991, for the California Psychological Association Conference in San Diego. This paper details a protocol of Eye Movement Desensitization and Reprocessing(**EMDR**) in the treatment of Dissociative Disorders.

The EMDR protocol starts with a list of alters or ego states that are part of a specific memory, and proceeds with hypnotic paralysis, and the reminder that the memory will proceed 2 to 4 times faster than it occurred originally, and a reminder for the signal for pausing. The abreaction is then completed using EMDR. Once the abreaction is completed, the memory is checked to determine if it pushes the patient into reliving. If reliving is demonstrated, EMDR is used to metabolize the remainder of the memory. When the abreaction is completed, hypnotic sleep is induced for the alters involved to promote relaxation and healing, and is used to correct cognitive distortions. After the sleep is started, an agreed upon alter is asked to be present until the end of the session, and finally, the hypnotic stillness is removed.

There have been 371 EMDR abreactions (n = 18 MPDs), two thirds of which have passed the one year anniversary mark. Of these, 98% passed that mark without reliving any portion of an EMDR abreacted memory.

EMDR: A Cautionary Note

Forthcoming in the Behavior Therapist

Francine Shapiro, Ph.D.
Mental Research Institute

The responses to my article, "Eye Movement Desensitization & Reprocessing: From EMD to EMDR -- A New Treatment Model for Anxiety and Related Traumata" in the May 1991 (Vol. 14, No. 5) issue of the Behavior Therapist, have

been both gratifying and, at times, disturbing. After receiving numerous requests for a "description of the revised procedure," and upon rereading the article, I can see that I did not make sufficiently clear the fact that clients are at risk if untrained clinicians attempt to use EMDR.

Since my initial articles were published in 1989, thousands of additional clients and subjects have been treated. Clinical observation, as well as feedback from trained clinicians and clients of untrained clinicians, have clarified the amount of information needed to effectively use the procedure for full therapeutic success. While successful treatment without training may be achieved perhaps 50% of the time, in the other cases, untrained clinicians place the client at risk, (e.g., experiencing ocular problems, re-traumatization, suicidal reactions, etc.).

EMDR is neither a simple technique nor a "cookie-cutter." Rather, it is a specialized approach that requires supervised training for therapeutic effectiveness and client safety.

International Update

Francine Shapiro, Ph.D.
Mental Research Institute

There are now EMDR trained clinicians in the U.S., Israel, Korea, Canada, El Salvador, Germany and Australia.

John Marquis and his daughter **Priscilla** have volunteered to lead two Spanish language EMDR trainings for psychologists and para-professionals in Nicaragua (See CAPACITOR article by Pat Cane). It is gratifying to think of all the suffering that can be eliminated by EMDR in the Third World countries. The trainings are planned for this August.

MRI has submitted an **NIMH grant** proposal to study the effects of EMDR on rape/molestation victims and Vietnam veterans. Principal investigators are myself and **Scott Nelson, Ph.D.**

Research has been launched at **Veterans Administration** facilities at **North Chicago, Augusta, GA,** and **Redding, CA.** Research is also underway at the **University of Pennsylvania, Pennsylvania State University, Harvard University, Temple University, University of Montreal, Stanford University,** and **Rockefelier University.** Requests for reprints have been received from researchers throughout the world.

The research at **Rockefeller University** is being carried out by **Jonathan Winson, Ph.D.,** author of a November 1990 article "The Meaning of Dreams" in Scientific American on memory processing during REM sleep. Dr. Winson attended the EMDR training I gave at Temple University and has since been researching the possible physiological explanation for EMDR treatment effects. He feels that EMDR produces an effect which besides its therapeutic value may allow for a deeper understanding of memory processing and unconscious psychological structure and is consistent with the research he has been doing for the last decade.

The research at **Harvard University** is being conducted by **Roger Pitman, M.D.,** with the assistance of **Howard Lipke, Ph.D.,** the Director of the Stress Disorder Unit of the North Chicago VA Medical Center. Dr. Pitman has an NIMH grant to investigate the treatment effects of EMDR with Vietnam veterans. All research therapists have received EMDR training from me and on-going consultation with Dr. Lipke. The study will take two years to complete.

I co-chaired a clinical round-table with **Joseph Wolpe, M.D.** (developer of Systematic Desensitization) on EMDR at the 1990 annual conference of the Association for the Advancement of Behavior Therapy. Dr. Wolpe announced EMDR as a major new resource in the field. Also on the panel were **Tom Borkevec, Ph.D.,** of Pennsylvania State University, **Tore Nielsen, Ph.D.,** of the Department of Psychiatry, University of Montreal, **John Marquis, Ph.D.,** of Stanford University/ Pacific Graduate School, and **John Patterson, Ph.D.,** of the Catholic Counseling Services.

I gave a symposium presentation and an invited one-day pre-conference institute at the 1990 annual conference of the **International Society for Traumatic Stress Studies.**

I was flown out to Augusta, GA to train the clinical research team led by **Pat Boudewyns, Ph.D.,** at the VA Medical Center. After the two-day training they invited me to write a chapter for a book they are completing on treatments for PTSD. They are presently planning two studies (physiological and long-term outcome) on the procedure.

Joseph Wolpe, M.D., has included EMDR in the fourth edition of the Practice of Behavior Therapy. In addition, I have received requests for information on EMDR for a number of new introductory psychology texts covering the latest advances in the field.

My published articles on EMDR are in the Journal of Traumatic Stress (2, 2, 1989), Journal of Behavior Therapy and Experimental Psychiatry (20, 3, 1989), the California Psychologist (July, 1989), and the Behavior Therapist (May, 1991). The JBTEP article was awarded the journal's prize for the best article submitted during 1988.

A "Cautionary Note" is forthcoming in the September issue of the Behavior Therapist. Many untrained clinicians misconstrue EMDR as a "simple behavioral technique" because some of the publications have been in behavioral journals. This is an attempt to set the record straight. The text of the note is included in this Newsletter. As you know, the EMDR trainings are presently "sole source" to ensure that EMDR is taught correctly until replications studies can be published to substantiate its effectiveness. Until that time EMDR is in an "experimental-limbo" state where special measures seem crucial to ensure client safety and the integrity of the procedure. The goal is to have EMDR taught eventually in universities as a treatment of choice. That cannot be done if the model is diluted prematurely by unqualified trainers and practitioners.

Articles forthcoming this year in the Journal of Behavior Therapy and Experimental Psychiatry are a case study by **Joseph Wolpe, M.D.,** an overview of eighty cases by **John Marquis, Ph.D.,** and a case study by **Gerald Puk, Ph.D.** Members enrolled

in the EMDR Network will receive copies of these articles, my article in the Behavior Therapist and the description published by Dr. Wolpe in the Practice of Behavior Therapy. We expect to receive reprints to distribute some time in the Fall.

I chaired a symposium on EMDR at the 1991 California Psychological Association annual conference. Also presenting were **Karen Anderson, Ph.D., David Fenstermaker, Ph.D., Sandra Foster, Ph.D., John Marquis, Ph.D.**, and **David Wilson, Ph.D.** A summary article is in press in the California Psychologist.

Joseph Wolpe and I co-chaired a symposium at the 1991 Western Psychological Association annual conference. At that time Dr. Wolpe again declared that he considered EMDR a breakthrough in the field, although he disagreed with adding the word "Reprocessing" to the name since it was not syntactically parallel to "Desensitization" (conceptual rather than purely descriptive). Also presenting on the panel were Drs. Fenstermaker, Foster and Wilson.

I was asked to join the Editorial Advisory Group of the Journal of Traumatic Stress. Time constraints have prevented presentations this year at the APA. I hope that other trained clinicians and researchers will start presenting at professional conferences independently.

This year's **Association for the Advancement of Behavior Therapy** will include four presentations on EMDR. I was invited to present a three-hour "workshop" at the conference which will explore the EMDR model. I will present the applications of EMDR in the treatment of psychological trauma on a panel with **Terry Keane, Ph.D.** (flooding) and **Don Levis, Ph.D.** (implosion). I will chair a symposium on latest clinical applications which will include presentations by **Alan Goldstein, Ph.D.** (Temple University), **Howard Lipke, Ph.D.** (North Chicago, VA), **John Marquis, Ph.D.** (Pacific Graduate School) and **Gerald Puk, Ph.D.** (Forensic Psychological Services). In addition, there is a two-hour special interest group (SIG) devoted to EMDR. The behavioral world is extremely receptive to EMDR since it is open to the concept of rapid change. Anyone able to make an inroad in the analytic community should submit a report to the Newsletter immediately. Experience to-date has given new dimensions to the term "cognitive dissonance."

Offering a new treatment to the academic and clinical community has been a very enlightening experience for me. Since the effects of EMDR are so rapid, it is understandable that skepticism often arises when it is initially introduced. However, I find the field divided among those who choose to "see for themselves" and those who refuse to accept even the possibility that substantial change can be rapidly achieved. I greatly appreciate the support of all of you who have written or called either to trouble-shoot or "soothe the waters." Many people of integrity can respond to EMDR as a "narcissistic wound." Many people cannot bear to become "students" again. We just have to do the best we can.

I dedicated the EMDR work of 1990 to Norman Cousins, in the hope that we can continue the work in memory of his loving, humanitarian spirit. I would like to suggest that we establish a scholarship fund for dissertation research in his name. I would like to put this on the September 28 Network meeting agenda. Suggestions for name, amount, practicality and mechanics can be made at that time.

Just as EMDR is a "client-centered" therapy, I consider the EMDR Network to be "clinician-centered." Please give us your thoughts, needs and suggestions. Please have patience as we once again reorganize. These are "birthing pangs," as I am so often reminded, so we need all the help we can get.

Innovative Uses

By
Ron Martinez, Ph.D.

This section will appear in each newsletter and will present innovative uses/variations of the EMDR technique that have been discovered by clinicians trained in the method. I would very much appreciate it if those of you who have found new variations on how to use EMDR would write these up and send them to me at the address below, so they can be included in future newsletters. Although your write-ups can be informal, I would appreciate your including the specific steps of the technique, the number of people on which it has been used, the number of people on which it has been successful, specific outcomes you have consistently noticed, and any further comments. Please include your name, address and phone number, so that I can reach you with any questions. Thank you.

I want to begin this section by discussing the first two variations on the EMDR method that I have used. At first when using EMDR, I found that there were some people who did not get images or thoughts, and who consistently seemed to "circle" through one combination of body sensations after another. Furthermore, although they would sometimes change from anger to fear to other interpretations, I never saw anything approaching a consistent reduction in the intensity of the emotional charge. Therefore, the process, while interesting to the client, did not seem to be producing the rapid improvement that I saw in so many other clients.

I began to wonder if there was any way to develop some awareness either of the image or thought that might help the client connect more completely with the internal representation with which we were working.

On a hunch (having sent a number of clients to body workers over the years), I asked the individuals to pick the most central area in which they felt the body sensation, and then with their fingertips to "gently and gradually increase pressure on the area and notice if an image or thought comes into mind."

I have found that about 70% of the people in this category immediately responded with an image, thought, or awareness that we were then able to use to continue the EMDR procedure. Most of these people stopped "circling" at this point, and I began to see responses more typical of other clients with respect to improvement. I urge you to try this and give me your feedback on what the outcomes are.

The second innovative use I discovered is even more exciting. While EMDR has proven to be extraordinary with respect to reducing emotional charge, developing self-awareness, and installing new beliefs and cognitions that prepare people to develop skills, abilities, and attitudes in which they had previously been severely limited, we often times still get to that point where the question is: "Okay, now that the fear of it is gone, how do I begin to teach this person to be more assertive (or sexually initiating, or more playful, etc.)." The answer is typically a step-by-step teaching/learning paradigm more typical of traditional behavior therapy.

This is an excellent method, but I began to wonder if EMDR could be used to facilitate a faster experience for individuals "learning new skills." I have used the following method with three different clients, and have had excellent results in each case.

First, I asked the client to close his eyes and develop a specific visualization of an individual who has the desired skills and abilities.

The imagined individual must be someone whom the client has seen demonstrating these skills. (This could be a next door neighbor being playful; Clint Eastwood in a movie being assertive; etc.).

Next, I have the client imagine himself, as vividly as possible, "standing behind" that image, then "stepping into the body of the imagined person," and feeling within the client's own body, as vividly as possible, all of the feelings, sensations, awareness and attitudes that would go with "being this new person."

I then have the client open his eyes and do a set of eye movements; this seems to "melt in" the experience more vividly than just imagining it, much like installing a positive cognition. Typically, I have gone through three or four separate sets of eye movements until the person has reached the maximum intensity of experience of that imagined individual.

I have a conversation with the client, and have him describe, in great detail, how differently this feels, what new ways he would handle different situations, and, in fact, give him a full experience of this new internal state.

Finally, I invite him to follow this process on his own, whenever this type of "new behavior" is either called for or can be practiced. Again, my N is only three, but the results so far have been very positive.

I invite you to try variations of this method and please write me about your responses and experiences.

Thanks to Diane Jensen and Cloudia Strohm for their assistance earlier this year. The Redwood Estates office is closed and all inquiries should now be addressed to:

EMDR
555 Middlefield Rd.
Palo Alto, CA 94301
415-328-5821

Elizabeth "Betsy" Slattery has joined the staff of EMDR and is taking over the duties of Administrative Assistant.

EMDR Study Groups

San Francisco: Sylvia Mills, Ph.D. (415) 221-3030
Open for 10 people. Meets Wed 7:30-10:30pm. Case discussions and group process to determine what the meetings will be like.

San Mateo/Burlingame: Ron Martinez, Ph.D. (415) 692-4658
7 people in group, open for more. Meets second Mon of each month 7:00-8:30pm. Case consultation and practice sessions available.

Palo Altos/Los Altos: John Marquis, Ph.D. (415) 965-2422
Dewey Lipe, Ph.D. (415) 851-2855
5 people in group, open for more. Meets ad hoc.

Sonoma/Mendicino: Jean Eastman, MFCC Int. (707) 964-7905
6 people in group, open for more. Meets in Santa Rosa 3rd Tues of each month 12:30-2:00pm at Kay Caldwell's office (707) 525-0911. Primary case discussion, some videos and technique troubleshooting.

Palo Alto: Ferol Larsen, Ph.D. (415) 326-6896
10 people in group. Meets 1st Wed of each month at 10:00am MRI conference room.

East Bay: Edith Ankersmit, LCSW (510) 526-5297
6 in group and presently closed. Meets 3rd Fri of each month at 7:30pm. Case discussion only. Edith has 4 more names and is willing to coordinate another group.

San Jose/Santa Clara: Kent McLaughlin, Ph.D. (408) 244-9317
Open for 8-10 participants. Meeting dates to be decided. Case discussion, role playing.

Los Gatos/Saratoga: Jean Bitter, Ph.D. (408) 354-4048
Liz Mendoza, LCSW
Open for 9 people, agenda to be determined.

Santa Cruz: Linda Neider, MFCC Int. (408) 475-3480
4 people in group, open for more. Meets once a month on a Fri 7:00pm.

Orange County: Karen Anderson, Ph.D. (714) 733-1622
6 people in group, open for more. Meets in Tustin 4th Fri. of month 9:30-11:30am. Case presentations, discussions, videos, exchange sessions.

EMDR Computer Bulletin Board ?

We are considering an EMDR computer Bulletin Board. Some of the information being considered are copies of the newsletter and articles related to EMDR. In addition, questions can be posted regarding problems encountered in clinical practice and other clinicians can reply with solutions and ideas from their personal experiences. Ideas, data, and information exchange on Special Interest Groups or client related topics would be available 24 hours a day, 7 days a week for Network subscribers. If you are interested in such a service or have additional ideas please write and let us know if this would be helpful to you.

Newsletter Staff

Editor: David Fenstermaker, Ph.D.
Co-editor: Ron Martinez, Ph.D.
Staff Coordinator Robbie Dunton
Admin. Assist.: Betsy Slattery
Technical Consultant: A.J. Popky

1991 EMDR Network Schedule

Saturday, Sept. 28th
Saturday, Dec. 7th

The Network meetings have been moved from Ricky's Hyatt to the Palo Alto Hyatt, 4290 El Camino Real, Palo Alto, (415) 493-0800. It is located 1/2 mile north of San Antonio Road.

SCHEDULE

9:30-10:00am - Registration & coffee

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

11:30-12:30 - Lunch [We suggest a second SIG meeting during lunch.]

12:00-12:30 - Coffee & Networking

12:30-3:30pm - General meeting. Presentations by SIGs and Francine.

Sept. 28th presentations: SIG Groups led by Russ Llewellyn and David Fenstermaker.

Submission Information

Our intention is to publish the newsletter quarterly. Submission of general articles can be sent to David Fenstermaker, Ph.D., 4985 Mitty Ave, San Jose, CA 95129-1849. Articles specific to new and innovative use can be sent to Ron Martinez, Ph.D., 1515 Trousdale Drive, Suite 215, Burlingame, CA 94010. If possible, articles need to be submitted on an IBM formatted diskette. The deadline for the next newsletter will be October 15, 1991.

EMDR Network 1991

PLEASE PRINT

Name: _____

Address: _____ Phone (Bus): _____

City: _____ State: _____ Zip: _____ Phone (Res): _____

Special Interest Group: _____

Cost for participating in the Network is $60 for 1991. Membership entitles you to attend the National Network meetings and to receive copies of the EMDR Newsletters and journal articles published in 1991. [If you are interested in only the Newsletters and articles, the cost is $40.]

Make check payable to: EMDR Network, 555 Middlefield Rd., Palo Alto, CA. 94301, (415) 328-5821

TRAINING REGISTRATION FORM

PLEASE PRINT

Name: _____ Phone (Bus): _____

Address: _____ Phone (Res): _____

City: _____ State: _____ Zip: _____ License: _____

COST: $285.00. Make check payable to: EMDR, 555 Middlefield Rd., Palo Alto, CA. 94301, (415) 328-5821

Please circle: **BASIC:** Philadelphia San Francisco **INTERMEDIATE:** Dec. 14-15
Chicago San Jose Aug. 23-24 Oct. 18-19

If INTERMEDIATE: Your date of Basic Training: _____ Specialty: _____

Additional requests for topics in training: _____

For Intermediate training please circle one

Proficient/Very Comfortable [A B C D E] Uncertain/Uncomfortable

BASIC TRAININGS

		Sponsors	
June 8/9	Seattle, WA. Seattle Airport Hilton	Roger Solomon, Ph.D. Washington State Patrol	(206) 586-8492
Sept. 6/7	Philadelphia, PA. Temple Univ. Medical School Dept. of Psychiatry	Alan Goldstein, Ph.D. Agoraphobia & Anxiety Treatment Center Temple University Medical School	(215) 667-6490
Sept. 13/14	San Francisco Bay Area Hotel Sofitel, Redwood City	Francine Shapiro, Ph.D.	(415) 328-5821
Oct. 4/5	Chicago, IL. Holiday Inn Crowne Plaza Northbrook, IL.	Howard Lipke, Ph.D. Director, Stress Disorder Treatment Unit N. Chicago Veterans Admin. Medical Center	(708) 688-1900 x3312
Nov. 2/3	Denver, CO. Doubletree Hotel Aurora, CO.	Andy Sweet, Ph.D. Behavior Therapy Institute of Colorado	(303) 337-9588
Nov. 8/9	San Jose, CA. Sunnyvale Hilton	Francine Shapiro, Ph.D.	(415) 328-5821

INTERMEDIATE TRAININGS

		Sponsors	
Aug 23-24	San Jose, CA. Sunnyvale Hilton	Francine Shapiro, Ph.D.	(415) 328-5821
Oct. 18-19	San Jose, CA. Sunnyvale Hilton	Francine Shapiro, Ph.D.	(415) 328-5821
Dec. 14-15	Chicago, IL. Holiday Inn Crowne Plaza Northbrook, IL.	Howard Lipke, Ph.D. Director, Stress Disorder Treatment Unit N. Chicago Veterans Admin. Medical Center	(708) 688-1900 x3312

EMDR
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Palo Alto, CA 94301

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