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Network Newsletter

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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STRAY THOUGHTS

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ISSUES OF COMPLIANCE IN EMDR

1) THE BOUNDARIES OF THE THERAPIST'S ABILITY SHOULD NOT BE DESIGNATED AS LIMITATIONS OF THE CLIENT

Too often the limitations of the therapist's model, repertoire of interventions, or ability to interact with the client are dismissed as due to client "resistance." While client resistance and non-compliance may certainly be issues that need to be overcome, the interaction between the client and the clinician should not be discounted as possibly contributing to the lack of the therapeutic effect.

In EMDR, the therapist variables that impact upon the treatment effect include the ability to target the appropriate part of the pathology, order of targeting, and comfort with a multimodal approach. For full therapeutic effect of EMDR. the therapist must be able to: (1) establish a level of rapport that allows the client to comfortably experience revivification of trauma, (2) accurately identify the appropriate targets, (3) use insight and sensitivity to assist in the completion of processing, (4) interweave a variety of coping skills, and system's information, and (5) offer appropriate modeling when necessary. Fortunately, it is a client-centered approach that allows most of the work to be done in the office. Therefore, non-compliance is often (of course, not always) based on inflexibility of the clinical approach and indicates the need for more appropriate targeting.

2) NON-COMPLIANCE IS PART OF THE PATHOLOGY

In EMDR, pathology is the target of therapy. Non-compliance is not under the client's conscious control and is therefore not considered an ancillary issue. With this understanding, consequences of non-compliance become part of the debriefing of the client on an on-going basis. This allows the lack of compliance to be viewed as part of the pathology that needs adjusting. We do not tell our clients to return for help when they are not so depressed—telling them to come back when they are more compliant often amounts to the same thing.

3) CO-PARTICIPATION IN DETERMINING GOALS

The therapist/client relationship is an interaction which should incorporate the specific goals of the client. The actual effects of non-compliance should be assessed.

The positive or negative effects of any therapy will be based upon an interaction of client, clinician, and method. Part of this interaction is the appropriate selection of goals that are agreed upon by both client and clinician. If the client is being asked to re-experience disturbing aspects of the targeted traumas, the reasons should be acceptable to the client. While there can be no guarantees, clearly the reasons for choosing to experience the discomfort of reprocessing will include the possibility of liberation from the on-going debilitating effects of the trauma. The client must recognize these potential effects in order for the discomfort generated by the processing to be acceptable.

The clinician's goals should be approved of by the client, and the client's goals evaluated by the clinician as appropriate. For instance, never feeling angry while driving may be impossible to achieve and may be part of an inappropriate self-assessment that underlies the reason for non-compliance (e.g., inability to succeed). Non-compliance should be coached as preventing the achievement of specific goals initiated by the client, not ones foisted upon him or her by the therapist. This increases the likelihood of managing the areas of resistance.

4) SECONDARY GAIN ISSUES

Issues underlying non-compliance include fear of success, fear of terminating therapy, fear of failure, etc. Appropriate assessment can be made by asking the client to respond to the question, "What would happen if you are successful?" After any appropri-

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ate fears are adequately addressed, any residual feeling of tension or resistance can then be targeted with EMDR in order to reprocess any inappropriate fears. Fears of losing benefits should be addressed as a realistic fear before investigating the possible pathogenic basis (e.g., I cannot succeed if I try). Unless secondary gains are appropriately identified and addressed, little therapeutic progress can be made.

5) PRIORITIZING OF TARGETS

Therapeutically, fears must be addressed in terms of appropriateness and in the sequence of pathological blocks.

Specifically, the EMDR model calls for the sequential targeting of appropriate memories that impact upon the pathology. The order in which these targets is accessed and processed is significant (e.g., memories having to do with lack of worth should be targeted before memories having to do with fear of failure). If blocking beliefs are not appropriately addressed, the therapeutic effect will be questionable.

As previously stated, EMDR calls for directly addressing the appropriateness of fears. When the fear appears to be based on "consensus reality" issues such as the loss of a disability check if the PTSD is handled, an action plan for substituting an appropriate source of livelihood should be inaugurated before targeting the actual dysfunction. When appropriate fears are addressed through the inclusion of new information, coping skills, etc., then the residual fears are viewed as appropriate targets for reprocessing. After these have been addressed, the trauma targets may be approached more effectively.

6) GENESIS OF FEARS

Non-compliance should be evaluated in terms of spiritual beliefs (e.g., life is suffering), parental injunctions or need to remain loyal to parents through parallel suffering, manipulation and power needs. Appropriate memories underlying these factors may be targeted before processing the targets that underlay the primary presenting complaint. As with other EMDR protocols, after the memories have been reprocessed, the present stimuli that elicit the negative affect or behavior should be targeted and processed. In addition, a positive template for appropriate action should be installed. With issues of non-compliance, the client should be asked to imagine doing the task easily and comfortably. Targeting with EMDR allows the behavioral possibilities to become more enhanced and allows any residual feelings of discomfort to be reprocessed

7) FLEXIBILITY OF TREATMENT

The experiences and actual behavior of non-compliance can often be targeted by EMDR. Many rehearsals can be accomplished in the office.

In EMDR, a feedback Log is useful for reprocessing stimuli. After a trauma is addressed, the client is asked to report back on any disruptive feelings or experiences for further targeting. Ironically, excluding the refusal to engage in the treatment itself, this Log is the major source of non-compliance in EMDR treatment and can be used as an appropriate reprocessing target. Specifically, the feelings of resistance to the task, along with any negative cognition and salient memories, should be addressed as they arise within the office. Results are then reported back in vivo.

In sum, in attending to issues of non-compliance, the choice of treatment should be flexible enough to work around the client resistance until it is resolved. This can often be accomplished with EMDR, since most of the work is done during the treatment session.

EMDR Network Newsletter

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NATIONAL NETWORK MEETINGS

Norva Accornero, LCSW, California Network Coordinator
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1994 EMDR Network Schedule

Saturday, Mar. 5th	**12:00 to 2:00pm (at the 94 Conference)**
Saturday, May 21st	**9:30am to 4:00pm**
Saturday, Sept. 17th	**9:30am to 4:00pm**

The Network meetings are held at the Sunnyvale Hilton, 1250 Lakeside Drive, Sunnyvale, California (408) 738-4888.

SCHEDULE *for May, and Sept.*

9:30-10:00am Registration & coffee

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

11:30-1:00pm Lunch [We suggest a second SIG meeting during lunch.]

1:00-4:00pm General meeting. Presentations by SIGs and Francine.

The quarterly Network meetings have been a success as a forum for sharing new applications of **EMDR**, learning about the latest research results, and observing talented colleagues demonstrate innovative twists with **EMDR**.

EMDR AND THE ATROCITIES IN BOSNIA

Geoffry White, Ph.D.

By now, everyone who reads the front page of the newspaper realizes that for the past 2 years, there has been a war in Bosnia (part of the former Yugoslavia). Most people probably do not really know where Bosnia-Herzegovina is, cannot pronounce it, and are even less familiar with the reasons for the war. Whatever the purported reasons for the conflict (civil war, age-old ethnic hatred, lingering issues from World War II, etc.), it is clear that the stronger, better armed group (the Serbians, primarily Christians) are conducting not only a war, but a campaign of genocide (called "ethnic cleansing") against the weaker, poorly armed Bosnians (who are primarily Muslim).

My first real introduction to the unbelievable atrocities being committed against the innocent, helpless, noncombatant population was a Newsweek article ("A Pattern of Rape," January 4, 1993). What I found most disturbing is this: The article estimated that from 30,000 to 50,000 women and children, most of them Muslim, have been raped since the war began less than 18 months ago. Scores of first-person testimonials "tell of repeated rapes of girls as young as 6 or 7, gang rapes so brutal their victims die; rape camps where Serbs routinely abuse and murder Muslim women; rapes of young girls performed in front of fathers, mothers, siblings and children; rapes committed explicitly to impregnate Muslim women and hold them captive until they give birth to unwanted Serbian babies." In short, the Serbians are using systematic, mass rape as part of their genocidal ambitions.

For the last year, I have been trying to do something about this tragic situation. Most of my effort has gone toward informing the major relief organizations about EMDR. It is my hope that EMDR could be integrated into the relief effort. It is hard to imagine the consequences for present and future generations of Bosnian war victims. The term "post-traumatic stress disorder" cannot do justice to what these people must be experiencing. Since EMDR has been used successfully in other widespread national disasters, perhaps it could be helpful in Bosnia as well. So, I set about to contact those organizations doing the major relief work.

I was able to meet the mental health professional, Diane Paul, who heads the Red Cross' effort in the area of conflict. She has become very interested in EMDR through the material I continue to send her and she hopes to attend the training programs as soon as possible.

Marlene Young, Ph.D., J.D., Executive Director of NOVA (National Organization for Victim Assistance, Washington DC [202]232-6882), has also shown strong interest in learning more about EMDR. In February, 1993, Dr. Young was requested by the Bosnian Government to travel to the former Yugoslavia to visit refugee camps and assess the need for victim assistance in response to the trauma suffered by the war victims. Among other activities, NOVA has set up "War Trauma" training programs for the relief workers. One of their goals is to prevent the well-meaning workers from inadvertently "re-traumatizing" the war victims.

The American Jewish Congress in Los Angeles helped set up a multiethnic group known as the "Womens Coalition Against Ethnic Cleansing." This group has sent several delegations to the areas of conflict where they made contacts with the local relief groups. I have attended several meetings of the relief committee of the Womens Coalition and made several presentations about EMDR. Again, there was strong interest in learning about EMDR.

I have also informed numerous groups about my activities (described above). These other groups and individuals include, but are not limited to:

1. Gail Abarbanel, LCSW: founder and director of the well-known "Rape Treatment Center" at Santa Monica Hospital.

2. Paul Kimmel, Ph.D.: President of the Division of Peace Psychology (Division 48) of the American Psychological Association. Paul invited me to be the Division 48 delegate to a conference in Wisconsin in May, 1994, on Nonviolent Large Systems Change that will focus on Bosnia.

I have been involved in other political (non-EMDR) activities concerning Bosnia, but that is beyond the scope of this report.

The purpose of this report is to inform Network Newsletter readers of my activities, in the hopes of inspiring others to get involved. If you have suggestions, comments, ideas, know of people doing similar things, or want to get involved, please contact me: Geoffry White, Ph.D., 2566 Overland Ave., Suite 780, Los Angeles, CA 90064; phone (310) 202-7445; fax (310) 202-7615.

EMDR FOR CHRONIC PAIN

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There are two widely accepted assumptions about personality and psychopathology that influence the success or failure of our use of EMDR with patients. While the following notions have been restated in different ways by various schools of personality, the reader is referred to the work of George Kelly (1955) for the most complete elaboration of these assumptions.

The first assumption is that the unconscious being **literal** does not distinguish between reality and imagination. Both are processed literally as experiences. Hypnosis practitioners and psychoanalytic clinicians operate on this belief in their use of techniques such as hypnotherapeutic suggestion, guided imagery, free associations, and dream analysis.

The second assumption is that a person will resist giving up any behavior, belief, or sensation (even pain) that is experienced on some level in the psychological system as being the best choice for the organism at that moment in time. A related corollary is that a person will only accept an alternative idea or behavior if it is perceived as offering a greater possibility of maintaining and elaborating the psychological system than does the currently operative idea or behavior.

These two working assumptions create both opportunities and limitations for the EMDR clinician. The main opportunity is that we need not be concerned with "what really happened" in our work with patients. We deal with our patient's personal stories. Given the working assumption that "reality" is constructed and not copied, no two persons' views of the same event can be expected to be identical. Of course, this means that all pain is real to the person who has it and the notion of mind and body as being separate is not useful for our purposes. (It may be for a surgeon, but if you read people like Bernie Siegel, surgeon-psychologist-philosopher, this notion is rapidly dispelled even in this operating arena!)

The main limitation (although we probably should reconstrue it as an opportunity since it can protect us from doing harm) is that EMDR will not remove or install anything that the patient is not yet ready to relinquish or accept.

EMDR and Chronic Pain

So how is all this epistemology relevant to EMDR and chronic pain? If the patient psychologically is ready to be rid of his or her chronic pain, then referring to the second assumption, when you target the pain sensations with EMDR reprocessing, the pain sensations should diminish. If, on the other hand, the patient is not psychologically ready, then the pain will either increase, stay the same, or EMDR will bring up other issues that will then need to be reprocessed.

Additionally, referring to the first assumption above, if the patient is ready to move on from the pain, we should be able to install positive coping behaviors, antidote images, and positive, rational cognitions with EMDR. This is because the ready or "prepaid" patient is likely to experience unconsciously the new coping material as "literally real" and psychologically palpable to his or her system.

Types of Pain Patients

My evolving work with chronic pain patients has led me to construct a diagnostic typology which seems to help in treatment planning. I first discussed this typology in the Spring 1993 EMDR Network Newsletter. I have been finding (and this needs to be borne out by more systematic research) that EMDR is most useful with the post-traumatic stress disordered pain patient. These patients do not respond to other methods as well as they respond to EMDR because of the levels of affectively loaded material underlying their pain that need to be reprocessed before the pain can be alleviated, altered, or avoided.

EMDR so far seems least useful with secondary gain patients (such as those currently in litigation).

With patients whose pain is fed by chronically contained intense hostility and rage, I have found that the rage and hostility first have to be resolved before they are ready to work on the post-traumatic stress or the pain. To this point, I have not been successful in using EMDR for reprocessing the rage and hostility.

Hypochondriacal patients, if they have histrionic personality traits, seem to respond well. However, watch out for these patients if they have very narcissistic personalities (in the DSM-IIIR sense)! In such cases, I have had poor results with EMDR as the patient is prone to challenge me to prove

the validity of EMDR. Such patients are also likely to be poor candidates for hypnosis or, in fact, for any therapeutic modality where they are prone to feeling like they are in a "one-down" position.

Lastly, the objective pain patient who copes relatively well despite his or her unremitting pain is likely to respond well to an integrated application of EMDR and hypnosis.

Targets for EMDR Reprocessing

The "COMPISS" notion that I discussed in my article in the Spring 1993 EMDR Newsletter provides a useful model for conceptualizing the complex of variables that can maintain chronic pain. Please refer to the work of Cheek and LeCron (1968), the originators of this model, for a thoroughly detailed discussion. To briefly recapitulate, **"COMPISS"** is a convenient acronym that stands for Conflict, Organ language, Motivation, Past experiences, Identification, Suggestion, and Self-punishment.

EMDR is proving useful for reprocessing the **"PISS"** part of the **"COMPISS"**. This comprises the pain patient's Past experiences; Identifications with persons from the past; Suggestions, beliefs, or negative cognitions (i.e., the VoCs); and Self-punishment maintaining beliefs and negative cognitions.

Starting Psychotherapy with the Pain Patient

The initial target for EMDR reprocessing should be the pain sensations. This validates the existence and reality of the pain patient's pain. Starting prematurely with psychodynamic material will alienate the patient who is in your office to learn how to achieve physical pain relief. The nice thing about EMDR is that it follows the course of natural uncovering. We begin doing EMDR by targeting the pain sensations and then proceeding to reprocess whatever is brought up. Thus, we go to deeper and deeper levels. As stated by Shapiro (1993), doing EMDR is like lifting a quilt off a bed so the bed can be remade. How can we be sure what is underneath the patchwork quilt before we lift it up?

With all of the categories of pain patients for whom EMDR is indicated described above, the reprocessing will naturally lead to whatever levels are uncovered which are relevant and "hot." The one exception is the "objective pain patient" with little to no psychodynamic material underneath the pain. To be honest, I have seen few such patients, but my limited sample has led me to hypothesize that this type of pain patient can benefit most from direct **training** in **controlled imagination** and **self-hypnosis**.

Controlled Imagination

Here, we want to teach the patient techniques to **alter** and **imaginatively transform** the subjective pain experience, **alleviate** the suffering (by filtering out the hurt from the pain sensations), and **self-distract** from the pain sensations.

A Standardized EMDR Pain Protocol

With all of the foregoing in mind, I have evolved an EMDR pain protocol with which I am getting excellent results. Much research needs to be done with this protocol and for this reason, it is provided below. I think that it should be applied in a standardized way for research and development purposes. Up to this point, I have been using EMDR in a more intuitive manner, drawing on my unconscious as I conduct the EMDR sessions. However, we all agree that the model is in need of rigorous studies that should employ standardized testing of specific EMDR protocols with specific populations and specific disorders. With this in mind, I invite the reader to apply this protocol with your chronic pain patients. However, let me underscore an essential reminder. That is, you should not attempt to do this work with chronic pain patients unless you are very knowledgeable about working with this population. Otherwise, you are bound to run into trouble. Abreactions in strange territories and foreign lands can be dangerous.

EMDR-Vipassana Protocol for Pain Relief

The protocol draws on Shapiro's (1992) adaptation of the Vipassana meditation which she teaches in the Level I training. Please also refer to the work of Edstrom (1993) and Shinzen Young. Here are the steps:

Step 1 - Identify and Rate Your Pain Stress Point

Concentrate for 10 to 30 seconds on the pain locked up in your body that you now want to work on. This is your current pain stress point. We are going to **desensitize** you to it and **reprocess** it. First, rate your **pain intensity level (on a "O" to "10" scale).** Hopefully, by the end of the exercise, your pain will begin to **dissolve**.

Pain Rating = _____

Step 2 - Visualize and Describe Your Pain Stress Point

Ask yourself and answer these questions about the **physical attributes** of your **pain stress point**:

* How **big** or **small** is it?
* What are its **boundaries**?
* What **shape** does it take?
* How **deeply** does it penetrate?
* If it had a **color**, what would it be?
* How **warm** or **cool** does it feel?
* If it made a **sound**, what would it sound like and would it be high or low?
* Does it have a **texture**? If so, would it be soft, smooth, even, hard, rough, or what?

Please rate again now how **intense** it is on your **"O" to "10" scale**.

Pain Rating = _____

Step 3 - Identify Your Negative Cognitions

Identify any **negative thoughts**

you may now be having that **limit you, block you, or impede your potential or ability to heal this pain and get better.** Record Patient's **Automatic Negative Thoughts** below:

1. _____
2. _____
3. _____

If Patient cannot bring to mind any **negative thoughts**, you may suggest any of the following and check for **"goodness of fit"**:

Feeding negative cognitions:

___ "What's the use."
___ "Nothing has worked up until now so nothing will work including this."
___ "I need somebody to kill my pain or take my pain out of me."
___ "My therapist thinks I can do it with my mind and this I don't believe!"
___ "This is not going to work! We still don't know what is causing my pain."
___ "I'm 'helpless' to do anything to ease my pain."
___ "I'm a born victim and/or a sufferer. I'm born to suffer."
___ "I have to learn to live with this pain or else I will die."
___ "I'm going to die with this pain."
___ "My pain has a mind of its own."
___ "I'm out of control."
___ "This is hopeless."
___ "Nothing is going to work. This will prove it."
___ "I'm a mess, an invalid, a mass of degenerating, disintegrating flesh and bone."
___ "My spine is disintegrating by the minute."
___ "The scar tissue will remain and rub and hurt no matter what I do with my mind."
___ "This pain is awful or horrible."
___ "The pain is purely a physical problem. My mind cannot effect it."
___ "I can't stand to live this way anymore."
___ "I am weak and/or worthless because of the condition I'm in."
___ "I cannot afford to relax or I cannot learn how to relax."
___ "I cannot function anymore at all."
___ "I must be always on guard lest I reinjure myself and get even worse!"
___ "I can't stand the pain. It is unbearable!"

Step 4 - Get a "VoC" on the Central Negative Thought

Rate your degree of belief (VoC) in the most central of these negative thoughts.
This is your current VoC and it is rated from **"1" (it feels totally untrue) to "7" (it feels completely believable).**
VoC=__
The thought is:_____.

Step 5 - Identify Desirable Alternative Positive Cognitions
Elicit positive, healthier thoughts to replace the negative ones. Come up with a **central positive thought to heal yourself**. If necessary, read the list of **positive cognitions** below and **circle Yes or No** for each one to note if Patient feels that it applies or does not apply.

Feeding desirable alternative positive cognitions:

Y N "I now have faith in my ability to heal myself."
Y N "I can trust again."
Y N "My pain is part of me. I am learning to relate to it and understand it."
Y N "I am going to enjoy my life once again or for the first time in my life."
Y N "I can enjoy living with comfort as well as occasional pain."
Y N "This is really going to work!"
Y N "My body is learning to be more receptive to my own thoughts."
Y N "Easy does it. A little bit at a time, I am mastering my pain and my comfort level."
Y N "I am a lot more than my pain."
Y N "I can choose to look at this objectively or to feel it at a deeper level."
Y N "I can stand pain."
Y N "I deserve to be comfortable."
Y N "I accept my pain."
Y N "I accept relief and comfort."
Y N "I can feel the relief."
Y N "I have a mind of my own or my own mind."
Y N "Every day I can do a little bit more, more and more."
Y N "Every day it gets better and better."
Y N "I accept myself with my pain."
Y N "I accept myself without my pain."
Y N "I have my own life to live."
Y N "I can manage my pain."
Y N "I have control over my pain. I can control my pain."
Y N "My pain changes. The sensa tions go up and down."
Y N "I can filter the hurt out of the pain."
Y N "I am a curious person."
Y N "My life is interesting."
Y N "I can manage my pain by con trolling my thoughts and behavior."
Y N "I can do things to ease how much I hurt."
Y N "I can control my behavior for my own good."
Y N "I can get rid of unwanted thoughts and keep positive thoughts."
Y N "I can make pleasant and com forting pictures in my mind that ease my pain."
Y N "I can share and spread the com fort from one part of my body with any other that needs it."

My central positive thought is:
_____.

Step 6 - EMDR Desensitization

Concentrate on your pain stress point and **visualize its physical attributes** you imagined before. Mentally hold in mind your **central negative thought**, which is:
_____.
While holding this material in mind, do standard EMDR sets, taking it to whatever levels of material it leads. When the process reaches some natural point of resolution, go on to Step 7.
What comes up?_____.

Step 7 - Reevaluate Pain Stress Point

Now, take notice to what happens to your pain stress point—to its shape, its color, its size, its temperature. its texture... Notice how it feels... What else changes?
Pain intensity level: _____.
Thoughts? _____.

Step 8 - EMDR Desensitization

Continue doing EMDR taking **what comes up** in your visualization of your **pain stress point** as the focus of the eye movement sets. Rate your **pain intensity level** *every other set.*
What comes up?_____.
Pain Rating = _____.

NOTE: THE NEXT STEP IN THE PROCESS (STEP 9) IS OPTIONAL

Step 9 - Imagery Interweave and Further EMDR Reprocessing (Optional)

Identify your favorite color associated with healing. Imagine your favorite color. Imagine a beam of light of your favorite color is radiating down through your head into your **pain stress point** in your body. Pretend the source of the light is the cosmos and an unlimited supply is available. (This is taken from Shapiro's adaptation of the Vipassana Meditation Exercise). As you imagine this, continue imagining that the light is continuing to direct itself at your **pain stress point** and that it is permeating it, resonating with it, and also vibrating and massaging it, as well as around it and through it, easily and gently, more and more (Shapiro, 1993).

Now, while holding this in mind, do EMDR sets. Repeat **Step 7** with the material that comes up. That is, continue doing EMDR taking **what comes up** in your visualization of the **healing light** permeating your **pain stress point** as the focus of the eye movement sets. Rate your **pain intensity level** every other set. (Following further from Shapiro's adaptation of the Vipassana meditation.) Keep imagining the light directing itself there, penetrating and absorbing until your **pain stress point** is diminished and dissipated to a more comfortable level.

Notice the light permeate, penetrate, and direct itself, filling your head and coming down your neck, into your shoulders, down your arms, into your hands, and out your fingertips. Easily and gently filling the trunk of your body. Gently flowing down into your buttocks, legs, and into your feet. Filling your entire body easily and gently.

Step 10 - Cognitive Interweave

Say to yourself the words (i.e., the positive cognitions) you most need and want to hear right now, **whatever comes up for you**, easily and gently, to **bring comfortable, soothing pain relief,** and listen to your tone of voice. Do EMDR sets linking these positive soothing thoughts with the pain stress point. If patient cannot self-generate, **feed** positive healing thoughts selected before from list.
Words are: _____.

Step 11 - Reevaluate Your VoC

Reevaluate your VoC for your **central negative thought** and your **pain intensity level**. Now, scan your body. Check your former **pain stress point** and compare to how you felt before.
Central Negative Thought is:___.
VoC = _____.
Pain Rating = _____.
Record here any Spontaneous Positive Thoughts and do EMDR sets to install:
1._____.
2._____.
3._____.

Step 12 - Once Again, Install Your Positive Cognitions

Out loud **and** mentally, state your **central positive thought and** link it with your current image of your pain stress point. Do EMDR set. Then rate the **VoC for your new central positive thought**.
Central Positive Thought is:_____.
Positive VoC ("1 - 7") =_____.

Step 13 - Debrief and Assign Therapeutic Homework (HW)

Assign appropriate HW healing exercise or ask patient to listen to a (INSERT NAME OF SPECIALLY PREPARED TAPE ASSIGNED TO PATIENT) taped exercise for relaxation and comfort for homework. You might consider teaching Patient a simple form of the Vipassana exercise for HW **without** EMDR.
HW is: _____.

Also, keep a **pain log** and please also **log** thoughts, images, dreams, feelings, associated sensations, and all other symptoms in this log.

THERAPIST NOTES

Summary
That is the protocol. Again, you are cautioned to refrain from using it with chronic pain patients if you do not have experience and training in working with this population. My brief introduction on types of pain patients and their characteristics will not suffice.

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PREPARATION FOR CARDIAC CATHETERIZATION

Dean Funabiki, Ph.D.

This article describes a treatment protocol that I used to prepare a client for a stressful medical treatment. The case study will illustrate how experiences with stressful medical interventions can be viewed as psychological traumas.

Clinical Case Description

Mr. M. is a 48-year-old, married, Caucasian male, who was referred by his internist for evaluation and treatment of his "psychologic background . . . with an associated diagnosis of coronary heart disease." The physician went on to describe Mr. M.'s unfortunate history of three open-heart surgeries, the first at age 24, the second at age 34, and the most recent at age 44. Recurrent angina developed three years after the last surgery and he was a "very poor, if not limited, surgical candidate and he has been relegated to a medical trial to help control symptoms of chest pain."

He was first seen by this clinical psychologist in April, 1993. He presented as a very personable and intelligent individual. He was well-educated and employed as an educational administrator. His presenting problem was that he experienced an anxiety reaction whenever he thought about his heart condition. This anxiety reaction occurred almost daily, with the following symptoms in varying degrees: flushed feelings with a very uncomfortable tightness that would rush to his head, vertigo, nausea, gastric upset with diarrhea, and increased heart rate. Mr. M. stated that the flushed feeling and dizziness were especially severe and uncomfortable for him. These feelings would come on, typically in the morning, last three to four days, and recur three to four weeks later. Sometimes, sleep would seem to improve the vertigo. Mr. M. reported no significant sleep difficulties and his alcohol and caffeine consumption was negligible.

Many different kinds of medically-related stimuli would trigger Mr. M.'s anxiety reaction. For example, while browsing television channels, brief visual scenes of hospitals or surgeries, and even the beeping sound of heart monitors and pagers, would bring on the flushed feeling, tension, and increased heart rate. As Mr. M. aptly described it, "I am frightened to death of hospitals and medical gadgets."

Three weeks prior to our first session, Mr. M. had resumed a walking regimen for exercise after a 6-month hiatus due to angina. Unfortunately, the angina returned as an exercise-related problem. If the angina continued for another few weeks, he was to see his cardiologist, with the likely outcome being a cardiac catheterization and with possible angioplasty. Just contemplating these possibilities was very uncomfortable for Mr. M., and he experienced a number of his anxiety symptoms, including feeling flushed and tense, in our first session.

Conceptualizations and Case Considerations

It was useful to conceptualize this case in two ways. First, from the standpoint of post-traumatic stress disorder, it seemed reasonable that the memories associated with the first surgery experience would be a viable target for EMDR treatment. Second was the need to help Mr. M. develop effective coping strategies.

As an EMDR target, Mr. M.'s history of cardiac surgeries was both extensive and traumatic. His first surgery was in a Veterans Administration Hospital in 1969 and he spent five months there in inpatient recovery. He had a collage of uncomfortable and intrusive memories—the long recovery period in a stark hospital room; the sound of the heart monitoring equipment; the needles; lying in bed with tubes down his throat; being unable to talk with visitors; and, naturally, fears about dying.

Given Mr. M.'s likelihood of undergoing additional medical treatments so soon, another important goal was to develop effective coping strategies. Both cognitive-behavioral and guided imagery strategies came to mind. Philip Kendall and his colleagues (Kendall, Williams, Pechacek, Graham, Shisslak, & Herzoff, 1979) have conceptualized cardiac catheterization as an invasive medical procedure constituting a crisis. In a well-controlled study, they found that patients benefited from two kinds of preoperative interventions: a) a patient education program designed to inform about heart disease and the catheterization procedure and b) a cognitive-behavioral skills program which focused on identifying stress and stress-related cues, developing cognitive self-statements that emphasized coping, therapist modeling of coping skills, and patient rehearsal of these skills. Similarly, Gerald Piaget (1989) described preparation of cancer surgery patients by helping them reframe the feared medical intervention as a more positive process. For example, the surgical scalpel was metaphorically reframed as a therapeutic agent that helps the surgeon heal the body.

EMDR Treatment

Mr. M. could readily bring on symptoms of anxiety by thinking of his first surgery, some 24 years ago. He mostly thought about his post-surgical recovery, citing the months in the hospital, the continuous sound of the heart monitor, the needles, the tubes, and the inability to speak due to the placement of the tubes. He reported feelings of tightness in the head, a flushed feeling, and increased respiration. On the 11-point scale of subjective units of discomfort (SUDs), he rated a 6 to 7 (0 = "very comfortable" and 10 = "very uncomfortable") when thinking of this EMDR target. The standard EMDR treatment protocol was used. The Validity of Cognition (VoC) scale ratings (1 = "completely untrue" to 7 = "completely true") were as follows for the

following pre-treatment statements: "I can be calm thinking of these memories" (3-4); "I can easily tolerate the memories" (3-4); "It's in the past" (3-4); "I can let go of it" (3-4); and "I can more effectively deal with my medical problems" (5-6). Groups of 20 to 25 horizontal, bidirectional saccadic eye-movements were produced with the visual tracking method.

During the course of treating the primary target, two new memory nodes emerged. One included memories of his first myocardial infarction and the ambulance ride to the hospital, while the other was a memory of a previous catheterization procedure in which the dye infused into his blood stream caused him concern about passing out from the burning sensations. These memories were SUDs-rated in the 4 to 7 range. Both of these memory constellations were also treated with the visual tracking method. EMDR treatment continued until the SUDs level was 0 for the target and the memory nodes. At the conclusion of the treatment session, the memories were reportedly much more tolerable, with post-treatment SUDs ratings ranging from 0 to 3 for the memories. The client stated that he had "a better feeling about the whole thing."

In the third session, one week after the first EMDR treatment, Mr. M. reported that he was to see his cardiologist in about one week. (A specific date had been set for the catheterization procedure.) Since the EMDR session, Mr. M. had, coincidentally, viewed two different TV medical scenes while "channel surfing." Both scenes were graphic depictions—one of a bypass surgery and the other of the catheterization procedure. He reported surprise at how calm he was during both segments. Though he did not linger on either image, he noted that he did not have the usual anxiety reaction to them.

Coping Strategies: The Benevolent Catheter

Mr. M. developed some anticipatory anxiety when the date for the cardiac catheterization procedure was set (some five weeks away). While the memories that we had worked on with EMDR in the second session were no longer causing discomfort, Mr. M. was still very uncomfortable anticipating the upcoming procedure.

In this case, it was important to empower the client with a greater sense of control over what he would be experiencing. He already knew what to expect, a decided advantage. However, in my view, he needed a sense of working together with the medical staff, rather than feeling that an "intervention" was being done to him.

Guided imagery techniques were used in two ways. First, Mr. M. learned to develop his own "personal place," which was an imagined experience of being in a relaxing outdoor location. This was accomplished using David Bressler's materials for creating a "personal place" (Bressler & Rossman, 1984). Second, Mr. M. was encouraged to imagine that his "personal place" and the corridor leading to the hospital prep room were physically connected. Consistent with Gerald Piaget's work, the hospital setting and staff were depicted as creating a warm, caring atmosphere that was working with him to improve his cardiac condition. The operating room, for example, was imagined as a clean, friendly room containing an operating table personified as therapeutic arms gently cradling him. The catheter, catheterization sleeve, and angioplastic balloon were similarly construed as benevolent creatures. Even the dye was given good intentions, as a "pulsating entity" on a gentle "search and repair mission," helping to locate any blockages with the least possible amount of discomfort. These guided imagery exercises were practiced in each of the next five sessions leading up to the catheterization.

Outcome

Mr. M. was seen 8 days following the surgery. Physically, he was feeling well after undergoing what he estimated were six to eight dye infusions and four angioplastic "grafts." The client stated that it went well, "as we visualized it, to the wire." The only unexpected experience was that, unlike his previous five catheterizations, a flat, comfortable table was used instead of a V-shaped "trench" table which suited him fine. He emphasized to me that he was able to stay calm throughout the procedures. On two occasions, he put himself in his imaginary "personal place." Once, he just did a breathing exercise that he had learned in conjunction with the personal place image. He found the dye infusions "quite tolerable." Finally, much to his surprise, he was even comfortable watching the surgical procedures on the video monitor. By mutual agreement, we terminated treatment, which totaled nine sessions, including both the intake and follow-up sessions.

Discussion

This case study illustrates the combined application of EMDR and guided imagery in successfully preparing a client for a stressful medical intervention. It was useful to conceptualize the client's past surgical experiences as traumatic and therefore, amenable to EMDR treatment. Additionally, conceptualizing the impending surgery as an acutely stressful event led to the identification of guided imagery as a strategy for stress reduction. Since this was a case study, it is unclear to what extent the EMDR, the guided imagery, or other factors contributed to the treatment effect. Only a well-controlled group outcome study could definitively determine the effects of the various treatment components. Nonetheless, the value of EMDR in addressing stressful reactions to medical procedures was demonstrated and warrants further investigation. Adding guided imagery shows promise in helping individuals cope with cardiac catheterization.

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USING THE SUDS AND VOC TO MAP THE MEMORY NETWORK

Eirin Gould, LMFT

Generally, there appears to be a relationship between the variables we call the SUDs and the VoC. When the client does not reduce the SUDs level to 0, usually the VoC does not rise to 7. For example, I have observed that a 2 or 3 SUDs is often paired with a VoC of about 5, a SUDs of 1 is often accompanied by a VoC of 6.

Frequently, particularly with multiple trauma survivors, the trauma memory networks are more complex, and the numbers may not seem to make sense. For example, a client may report a SUDs of 2 or 1 that will not go to 0, and when trying to install the positive cognition, the VoC is reported as a 7. Or, conversely, clients sometimes report a 0 SUDs and a 5 or 6 VoC. I have observed these results many times in my practice and as a facilitator at Level I and Level II trainings. The clinicians often abandon the measures at this point in favor of verbal descriptions and explanations of the client's present state. The incongruent SUDs and VoC are viewed as evidence of incongruence of cognition and affect. This is not necessarily true.

Many clinicians tell me that they no longer "use the numbers." I would like to encourage those of you who have not found the numbers useful to reconsider these measures and the valuable clinical information they provide. If you go back to the model, the numbers will help you to begin to see the network map (the organization of the components of the memory network) early in treatment and to gain knowledge of each individual's unique information processing system (as described below).

When the reprocessing stalls and you help the client to get it moving again, you may discover that the client usually stops reprocessing at the same level of intensity each time. Simply observing this for the client may help the client to normalize and move through it. It may be that the reprocessing stalls at an uncomfortable SUDs level when targeting certain historical features of the client's childhood (e.g., the perpetrator, certain locations in the childhood home, certain acts of abuse, etc.). Try thinking of that target as the node of a network of memories organized around that particular feature.

As the Information Processing System is catalyzed with the eye movements, the information seems to emerge in the order in which items need to be targeted, again suggesting a natural, logical organization to the memory networks. It appears that the numbers can assist in visualizing the memory network map and in locating the present process on that map. For example, the seemingly incongruent results of a 0 SUDs paired with a 5 or 6 VoC or a 1 to 3 SUDs paired with a 7 VoC reveals the network structure much like coordinates on a graph. When the positive cognition is fully believable and the client is still experiencing discomfort when the original target is stimulated, you may be seeing an event/target that has other negative cognitions associated with it that did not emerge during the process and were not resolved by the generalization effect. This is an example of a target around which a number of cognitions are organized; however, it can be much more complex with two or more networks linked by shared cognitions. In the simpler case, targeting the body sensations represented by the SUDs will usually reveal the work that remains while in the more complex case, the reprocessing appears to be stalled there.

Additional investigation by discussing and history-taking usually provides enough information to set up another EMDR session. Generally, when additional information is required, you will need to identify new cognitions, affect, and body sensations, complete with measurements, then reprocess and install a new positive cognition. The positive cognition will be different from the previous one because it will have to be meaningfully related to the new negative cognition.

In cases of very early trauma where cognitions are not well developed, you may only have affect and body sensation reported at first, with the cognitions developing during the reprocessing. This may occur for each of the sessions until all of the associated cognitions emerge and develop to a positive result. In the other situation, where the SUDs is 0 and the VoC will not move higher than 5 or 6 (6.7375 for those scientific clients), look for the possibility that there are other experiences that support the negative cognition. Thus, while the original target memory is no longer disturbing, perhaps there are others that were not fully resolved by generalization. This is a cluster of events that is organized around a cognition, and at its more complex, a clustering of networks linked together by a single cognition.

Before making this assumption, test it

by having the client think only of the target while holding the positive cognition. It may be that the client is measuring the Voc as it relates to life in the present, in all situations, or as he or she anticipates the future. While that is the goal, until all past experiences supporting that belief are resolved, it is premature to expect an overall VoC of 7. So be certain your client is clear about what you are asking him or her to measure. If the reading is still a SUDs of 0 and VoC below 7, this is a strong indicator that other events and experiences need to be reprocessed that are associated with that cognition. Usually, additional discussion and history-taking and careful review of earlier sessions will provide the information you need to access a new target. Again, you will need to identify and clarify the picture, cognitions, affect, sensations, measurements, and install the positive cognition for each node that you target.

Remember that the information will emerge according to what must be resolved first. In other words, the process is informed by the networks. You do not need to be able to visualize or literally map these complexities. Simply thinking of stalls or obstacles to the reprocessing as a naturally ordered system encourages the client (and the therapist) to keep moving, to begin to investigate where to focus next. In other words, the obstacle is the path. So if the process stops moving, you know you are on the right track.

NEWS FROM THE EMDR CENTER

Clifford Levin, Ph.D.

Hello out there. Is anybody listening? The EMDR Research/Training Center at the MRI in Palo Alto is interested in hearing from you. In the last Newsletter I gave a description of the proposed activities for the Center and asked for feedback. To date, I have received only one call, which was from Nevada City, California. The world of psychotherapy delivery services is changing quickly and either: (1) all of you are already expert in conducting research in your private or public practices and have begun to gather data and calculate statistics to submit to managed health care organizations to justify your existence, or (2) well . . . I had lunch with Jim Walt, president of CAMFT, the other day. He was adamant that MFCCs are underestimating the importance of research in assuring their place in the future of mental health delivery systems. Instead of my speaking for him, take a look at his commentary in the next CAMFT magazine.

At this point, there usually comes a sales pitch, but alas, I have nothing to sell you at this time. We would like to hear about your questions and concerns regarding these matters so that we may develop programs for the future. At present, the Center is open for low fee referrals (the fee scale will range from a high of $50 to as low as we have to go to provide services to a needy person). Services are also available in Spanish. We would particularly like to receive referrals of PTSD survivors of natural disasters (e.g., earthquakes, fire storms, mud slides, etc.) that have occurred more than six months ago. I look forward to hearing from you. Please address your correspondence to Clifford Levin, Ph.D., 555 Middlefield Road, Palo Alto, CA 94301.

DISSOCIATIVE DISORDERS AND THE "SPATIAL MAP"

Curtis C. Rouanzoin, Ph.D.

Individuals with dissociative disorders present unique therapeutic difficulties for most therapists. These clients have developed an intricate and often creative defense structure to protect themselves from painful emotions and traumatic memories. Subjectively, extensive dissociation can occur when something so terrible happens that to defend against it, a person divides or splits his or her awareness into two levels or streams of consciousness. One stream of consciousness belongs to the participant in the event, while the other belongs to a detached observer who was distanced from the event. This may be described as floating about the event and seeing the event as unreal and happening to someone else. Colin Ross, M.D. (1989), defined the dissociative aspects of MPD as ". . . a little girl imagining that the abuse is happening to someone else. This is the core of the disorder to which all other features are secondary. The imagining is so intense, subjectively compelling, and adaptive that the abused child experiences dissociative aspects of herself as other people" (p. 56).

As a defense, dissociation can allow an individual to split off the awareness of painful emotions and memories and to function fairly well in the world at large. However, extensive dissociation often prevents an individual from connecting thoughts and events with the corresponding emotions. As a result, individuals with dissociative disorders do not experience life as a continuum of moments in time, but as separate, discontinuous blocks of time. The normal integrative function of identity, memory, or consciousness is therefore altered. Individuals experience this alteration on a continuum from simple to complex dissociation. Simple dissociation can be felt as a "not me," depersonalized experience, while complex dissociation results in the diagnosis of Multiple Personality Disorder. Amnesia, fugue, and DDNOS (Ego States Disorders) fall between these two extremes on the dissociation continuum.

Therapists often report frustration in working with individuals who dissociate extensively. Clients with dissociative disorders report that it is very difficult or impossible for them to stay in touch with painful emotions. One client stated, "The moment I get in touch with the hurt, it just goes away

and I can't get it back." This can be particularly true with the use of EMDR which facilitates the processing of traumatic memories and painful affect. While doing eye movements, clients who dissociate may find themselves suddenly "losing" the feeling. They describe it at times as "going numb," "feeling nothing," "going into a fog," "getting stuck," or "looping." This is the subjective experience of dissociation. This is the defense that has allowed them to function in the world, but it has also prevented them from dealing with and resolving the trauma.

There are different procedures that can be utilized with EMDR to continue movement when clients dissociate. Some of these procedures are: (1) change the direction of the eye movements; (2) increase the length of the eye movement sequence; (3) focus on any cognitive distortions ("if I remember I'll die") and use eye movements; and (4) use cognitive interweave for safety, responsibility, and choice. There is a fifth option that I learned about while working with a very bright and creative client who extensively dissociated. I call this option the "Spatial Map." While doing eye movements on a particularly intense, negatively charged event, I noticed that halfway through the sequence, the client suddenly looked up and to her right without breaking the rhythm of the eye movements. Upon completion of the sequence, the client stated she "felt nothing." My assumption at this time was that she had split off her painful feelings. I asked the client to imagine that there was an 8-1/2" by 11" piece of paper before her face. I then said, "This may be the dumbest question anyone has ever asked you, but when you feel 'nothing' where do you go?" The client said, "That's not stupid. No one's ever asked me that before. I go here." The client then pointed to her upper right, above her right eye—exactly where her gaze had shifted so suddenly during the EMDR sequence. I asked her to "stay with that" and began another sequence of eye movements that incorporated the upper right portion in a diagonal movement. Immediately the client was once again in touch with the painful emotions from which she had split off moments before.

Since this experience, I have been able to use the concept of the "Spatial Map" hundreds of times. Frequently, it has allowed the clients to get in touch with dissociated emotion. When it does not, one of the other four procedures is utilized to continue the processing. I have found that different clients have different "Spatial Maps" which represent the dissociative aspects of themselves. Working with clients to identify their particular "map" seems to speed the processing of information and reduce client, as well as therapist, frustration when feelings get "lost" or "stuck."

I would be very interested in getting feedback from anyone who has had similar findings.

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EMDR WITH CLIENTS IN RECOVERY FROM CHEMICAL DEPENDENCY

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We have found that the treatment protocol outlined below has been very helpful in our work with clients suffering from substance abuse or dependence.

Step 1: Arriving at an Accurate Diagnosis

Initially, we need to obtain a careful substance use history including types of substances used, patterns of use, relapse patterns, symptoms associated with substance use and withdrawal, and periods of successful abstinence. We need to know to what extent substance use has impaired the person's life in terms of relationships, vocational adjustment, etc. We also need to evaluate why the person is seeking treatment now. Is the person serious about treatment, or is the person simply complying with external pressure and unmotivated to commit to work on himself or herself? As we all know, clients with substance use frequently have hidden agendas and are not honest about their underlying motivations.

In order to utilize EMDR, we need to assess how trauma-related symptoms (e.g., numbing or avoidance, arousal dysregulation, or flashbacks and intrusive sensory experiences) relate to substance abuse. Is the person using drugs in order to numb overwhelming feelings of guilt and low self-esteem? A current client, a 19-year-old young man, indicated that he has been overwhelmed by unpredictable and chaotic relationships all his life and that marijuana offered him stable support by always providing him with a sense of calmness when he felt internally overwhelmed or out of control. **The connection between trauma-based symptoms and drug use is important in the development of a treatment approach aimed at preventing relapse.**

In order to utilize EMDR, it is necessary to screen for the presence of a dissociative disorder. According to Watkins (1992), dissociations occur across a continuum. He indicates that in normal individuals, the dissociative barriers are fluid, whereas in Multiple Personality Disorder (MPD), they are very rigid and impenetrable. It is of utmost importance to determine whether a client suffers from MPD or DDNOS (ego state disorders) because the treatment strategy is significantly different in such cases. We have discovered several clients with an undiagnosed dissociative disorder who had longstanding histories of treatment failures and had gone through a number of drug rehabilitation programs without success. They

only improved when they were correctly diagnosed with MPD or DDNOS and efforts were made to work in conjunction with various alters to enter a recovery program. We have also found it helpful to determine if a person has distinct ego states (Watkins, 1992) which are at cross purposes. For example, a person may have a part of himself or herself that is an addict and another part that wants to get clean and both are constantly at war with each other. In such cases, it is helpful to work with these ego states using EMDR in order to achieve more internal harmony and cooperation. When a client is diagnosed with MPD or DDNOS, the client needs to be treated by someone who is trained to work with dissociative disorders.

It is also important to determine the presence of other psychiatric disorders (comorbidity) in order to develop a comprehensive treatment plan.

Step 2: Developing a Treatment Program

This step includes determining the appropriate level of care for an individual, such as outpatient, residential treatment, inpatient treatment, etc. The individual needs to have a stable environment in which support is provided to aid the individual in his or her recovery. Clients who are uncomfortable with a 12 step recovery program are encouraged to develop alternative support systems to aid in their recovery. Clients with a diagnosis of substance abuse/dependence and DDNOS or MPD are informed that treatment will involve understanding different alters and working with the system as a whole. The general emphasis is to assist individuals in developing alternative ways of coping with life rather than using drugs.

Step 3: Educating Clients about EMDR

Clients are informed that EMDR is helpful in neutralizing painful emotional states and in acquiring more positive attitudes about oneself and the world. They are fully briefed about the method and told that painful experiences from the past, which are related to the current issue, may be accessed. It is helpful if the clinician can give specific examples as to how EMDR can be utilized with a particular client in order to improve functioning. It is also immensely useful if a client has a present situation which is bothersome, but not highly charged, so that a trial demonstration can be given.

Step 4: Timing the Use of EMDR

Clients in recovery from chemical dependency may have several typical reactions to EMDR. Many clients get scared and frightened of facing their feelings and do not want anything to do with EMDR. Frequently, such clients are unwilling to change, are invested in their symptoms, and derive satisfaction from acting out. They also frequently do not trust and are not honest. **It is not wise to use EMDR with such individuals until an honest therapeutic relationship has been established and they have made the commitment to treatment. Furthermore, in general, presenting symptoms cannot be evaluated accurately until a client has been abstaining from substances for some time, making it possible to determine whether presenting symptoms are related to past trauma**. In our work with this population, we have found it helpful to find a balance. Clients need to learn to tolerate negative feelings and work through them. For example, some of the clients we have worked with who were suffering from hyperarousal were willing to utilize EMDR in order to decrease negative feelings. However, they began to rely on EMDR excessively and utilized it like a new drug.

Clients also should be assisted in the removal of serious emotional blocks jeopardizing treatment. As a rule of thumb, we first assist clients in working through denial and to face serious issues. Once they get in touch with feelings and begin to **experience** the impact of their circumstances, and are ready to do something about it, EMDR is helpful in neutralizing overwhelming feelings, such as fear, that are blocking progress (e.g., a person has selected a sponsor, but feels too scared to communicate feelings). If this fear is more deeply rooted, EMDR might be helpful. If it is a normal fear associated with doing something new, the client is encouraged to face the discomfort and work through it since it is important for the client to begin tolerating normal levels of feelings.

In addition, all the cautions usually utilized with EMDR are necessary (Shapiro, 1993). For substance abusers, a stable environment is particularly important, as is the honest commitment to treatment. We feel that EMDR is a powerful tool which will help motivated clients to work through significant emotional pain. Rather than offering EMDR prematurely, we feel that clients have to demonstrate to us that they are ready to use the method.

Step 5: Increasing Client's Readiness to Benefit from EMDR

In the following, we have compiled a list of problems and solutions that are commonly encountered with individuals in recovery. This is only a preliminary list and we would greatly appreciate input from other professionals through this Newsletter about similar issues.

Clients Have Difficulties Giving Up Control and Tolerating Feelings

Often these clients have a history of growing up in a family where emotions were poorly tolerated and they learned to suppress their feelings in order to cope. Some have difficulty in accepting certain types of feelings, such as anger, sadness, vulnerability. Clients are made aware of such a learning history and are trained to accept their feelings without making value

judgments. (They frequently need to be motivated to change.) We have found it useful to have clients alternate between staying with their feelings, escaping briefly from their feelings by distracting themselves, and then returning to their feelings while moving their eyes (a desensitization approach). Within a few sets, clients usually report that they are better able to stay with their feelings.

Clients are Unable to Name Feelings (Alexithymia) and Sensations

We use a feeling chart in order to educate clients as to the different types of feelings and encourage them to connect these feelings to body sensations. It has been helpful to talk with clients between sets as to what body sensations they have experienced and what feelings connect with them. Sometimes it is helpful to teach clients to label feelings first as pleasant or unpleasant before refining their awareness of specific feelings.

Clients are Dissociative

When clients have different sensations and feelings that come "out of nowhere," the BASK model of dissociation (Braun, 1988) is explained to them in detail, i.e., that only some aspects of the memory (the behavior, affect, sensation, or knowledge) may be available. With clients who have separate ego states, it may be more helpful to access the ego states with EMDR. In such cases, we ask the individual to give the addict a voice and then focus on the material that comes up. Later, the part who wants to do recovery is given a voice, and subsequently both are asked to mediate solutions. This approach has been used by Robbie Dunton (1994), as well as Sandra Paulsen (1993).

Transference Issues

Clients are encouraged throughout to share feelings and thoughts that come up with regard to the method or therapist that are blocking progress. At times, such issues become EMDR targets (e.g., the client does not feel safe opening up or sharing with anyone).

Keeping a Log of Restimulation and Other Significant Experiences

Clients are asked to document significant emotional and cognitive reactions to ongoing events, as well as memories from the past, between sessions. This is helpful in order to establish a collaborative relationship with the client in which the client assumes more responsibility for his or her own treatment. Furthermore, it helps clients to learn to recognize how trauma-based symptoms affect their lives today so that appropriate EMDR targets can be identified.

Unresolved Issues and Questions

Should one utilize EMDR with individuals who are still using drugs? Generally, we feel that EMDR should not be utilized when people are still using substances. We feel that generally, clients using substances are not motivated to face issues in their lives and, therefore, would not benefit from EMDR. However, we have seen clients with a primary diagnosis of PTSD, or serious trauma-related symptoms, and a secondary diagnosis of substance abuse. We have found that if such individuals are motivated to neutralize the particular trauma, are able to abstain from substances for a specified length of time, and do not exhibit serious withdrawal symptoms, EMDR has been effective. Depending on the severity, pattern of use, potential for withdrawal symptoms, ego strength, and available social support, the clinician needs to determine the appropriate length of abstinence necessary for the client to benefit from EMDR treatment. Caution and judicious clinical judgment are necessary. We have had two clients on Workers' Compensation who were referred because they experienced serious industrial accidents. Although both continued to use alcohol, both were able to benefit from EMDR in that the traumatic experience was neutralized in both cases and each person was able to assume work responsibilities. Neither individual was willing to abstain from alcohol: however, alcohol did not seriously impair their functioning and both agreed to be sober for some time prior to EMDR treatment sessions.

What EMDR targets should be utilized with individuals who are in recovery? In order to select appropriate targets, the therapist needs to have a good understanding with regard to significant emotional blocks that interfere with the client's functioning and the types of feelings the client needs to learn to tolerate. **We feel that EMDR is useful at all stages of recovery**. This includes crisis intervention, decreasing urges to use, relapse prevention, fears associated with working a recovery program, skills training, and, ultimately, working through significant traumatic issues associated with family-of-origin issues or past relationships/traumas. EMDR is invaluable in installing positive attitudes and beliefs about oneself and the recovery process. It has been helpful to even install relevant steps from the AA program to strengthen recovery.

When clients have extensive trauma histories, it has been useful to utilize EMDR to reprocess painful material associated with each significant person in the client's past (e.g., mother, father, siblings, etc.). When such work is done systematically, dramatic improvements have been noted in a variety of long-term serious cognitive, emotional, interpersonal, and behavioral disturbances. We have also found that several people who were molested as children were able to neutralize traumas within several sessions and felt so comfortable that they did not need to attend additional support groups, such as Adults Molested as Children (AMAC). It is important to recognize, however, that such individuals were already stable in their recovery before the incest was targeted.

EMDR has also been very helpful in addressing codependency issues. We have found that compulsive caretaking and controlling of others, sexual acting out, and workaholism were amenable to EMDR once clients began to experience **negative feelings** associated with their compulsive behaviors, such as feeling used by a significant other, being angry at the boss for making unreasonable demands, being hurt and angry when a lover promised to call but did not, and feeling completely overwhelmed and powerless/inadequate to cope with current demands.

How can we work with compulsive behavior? Clients in recovery frequently have a number of compulsive behaviors such as sexual addictions, food addictions, etc., which are aimed at avoiding negative feelings. It seems that it is necessary that clients acknowledge that such behaviors are destructive and that they are experiencing pain associated with such compulsive behaviors **before implementing EMDR**. It appears that as long as a client derives a great deal of satisfaction from acting out, it is virtually impossible to access (even with EMDR) underlying painful feelings. When clients begin to experience negative consequences associated with compulsive behaviors, a **window of opportunity** opens up to utilize EMDR. It seems that once painful feelings can be accessed, defenses are weakened and the process of recovery in these areas is facilitated. We hope that, over time, we gain more experience from other clinicians working in this area in order to arrive at a better understanding with regard to utilizing EMDR with compulsive behaviors.

Note

Recovery from chemical dependency is a specialty area requiring training in chemical dependency treatment. Caution and judicious clinical judgment are necessary to utilize EMDR with this population.

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EYE MOVEMENT "GLITCHES" AND SLOWER PASSES: THE IMPORTANCE OF OBSERVING HOW THE EYES MOVE DURING EMDR

Sheryll Stuart Thomson, MFCC

This is a note on the relationship between the resolution, in EMDR, of a problem or target issue and the degree of freedom, or smoothness, of eye movements. It is my observation that when the eyes can move freely and steadily, on a path without "glitches" (without stops and starts, roughness, blinking or jerkiness), it is likely, if the client has been attending to the target issue and not dissociating, that the issue is resolved. Eye "glitches" are usually related to the experience of an uncomfortable memory or part of a memory or idea which is still being held. Therefore, it behooves the therapist to observe closely the ways the eyes move. The way the eyes move can be seen as a metaphor for the style and amount of holding on to a negative pattern, belief, or memory that the brain is doing. Typically, we have worked with the beliefs, feelings, and memories a client reports to us verbally. I would suggest that we can also go in to those states nonverbally and change them by working sometimes only with the eyes, without words. I will outline some ways the eyes may be worked with to free them up and thus, to free up and resolve the negative internal state or pattern.

When you notice these glitches during negative cognitions, this is natural and they may smooth out automatically with more passes. However, when you notice them during positive installations, it may indicate there is something left—some doubts, an unprocessed part—which will impede the full installation of the positive cognition. In this case, the client cannot quite let the disturbing pattern go which is reflected in the way the eyes seem to "hold on," to not move freely, and appear to want to do something else besides follow the hand easily. This is a useful indication, in addition to the VoC rating, that the positive statement is not yet fully believed. When you observe a glitch you may remark on it, ask the client if there is something unresolved that wants to be reported, and go back to work on the unresolved issue before coming back again to the positive installation.

Or, nonverbally, you may slow down the back and forth movement of your fingers, "dancing with the glitch" in an aikido-like way, back and forth at the place where it occurred, and then continue in longer passes (or a circle, see below) until the glitches are smoothed out. I slowly move my hand back and forth two or three times on the particular place on the path where the glitch is occurring before moving on. (As in verbal psychotherapy, it is of course important to convey being nonjudgmental and connected with the client in the way the hand moves and leads the eyes—it is not a power struggle.) This change in hand movement conveys acknowledgment to the client that I know there is something disturbing still there; it is likely something which holds on to the old pattern and corresponds to a negative belief, discomfort, or memory. Briefly moving my hand back and forth, slowly,

near the point of the observed glitch, also conveys both acceptance of that fact and my patience with it. Acceptance evokes change. The client senses what is happening within, and that the repeated passes at the point of the glitch are changing something. (The therapist does not have to know what it is; indeed, more may come up in the client's consciousness if he or she knows he or she does not have to report on it.) This acknowledgment may itself be experienced by the client as so deeply affirming that he or she lets go—toward a smooth, free movement of the eyes and a corresponding shift in the internal pattern. I continue this, stopping and leading the eyes back and forth in short movements at each glitch, until the movement of the eyes along a line, in both directions, is smooth and without glitches.

Of course, if the client develops an abreaction during one of the slow, back and forth passes, the eyes should be kept moving, as taught in the trainings, or the client may become retraumatized.

On "controlling" eye behavior and slowness of passes: During the installation of a positive cognition with one client, her eyes became "controlling"; that is, the movement had a quality of "holding on" or holding back, though the phenomenon was subtle. Thus, when I moved my hand forward, the eyes did not come with it, rather they held back, seeming to want to go slower; they also jerked forward and back along the trajectory my hand was following. I guessed it was because she could not fully believe the new positive statement on which she was focusing (she corroborated my guess afterwards). I then moved my hand more and more slowly, matching my speed to hers, moving even slower, and continued until the movement of her eyes seemed freer. I also made a comment of encouragement and this seemed to help free up her eyes. We ended when her eyes moved freely. This corresponded to a look of pleasure on her face which was in contrast to the fear or worry I had seen in the earlier part of the positive installation. She also reported feeling "good." This was without speaking about or going back to process any of the conscious connections she would have made to the "resistance" of her eyes to moving freely. Again, the dialogue here during the installation was, on the whole, a wordless "movement" dialogue, the therapist conveying acknowledgment, acceptance, and "staying with" the client by how she directs the eyes with her hand.

Observations on the use of the circular movement: The smoothness of the eyes in a circular pattern may be diagnostic when used at the beginning, and evaluative when used at the end, of the session if the therapist pays attention to the glitches: blinking, jerking, roughness of movement, and holding on, as the eyes attempt to follow the hand in a circle. The glitch typically corresponds to an internal negative pattern, idea, or feeling. If the circle is used at the beginning of the session, the therapist can, having commented on a glitch, say, "Focus on what you are experiencing now," then lead the eyes, more rapidly, side to side or in a diagonal, returning to the circular to check for smoothness or glitches. If a glitch is repeated, you may find it will be reflected again and again in exactly the same spot on the circle; you can repeat your brief back-and-forth passes each time you encounter it. You can check with the client on this for content. However, using this procedure without commenting on it is especially useful when the client does not particularly want to tell you what is going on; she or he may have been surprised by what comes up and embarrassed. (Again, I think when it is agreed beforehand that clients do not have to tell you all of what is going on unless they want to, more may, in fact, come to consciousness and become available to be worked on.)

When you use the circular movement at the end of a session to tie things up and integrate the work, watch for the glitches. Move slowly. Make a brief, slow, backward pass whenever you see a glitch in the circle, then continue onward in a circular trajectory in the direction you were going. I recommend starting at the top, going around and stopping when you reach the top again; then reversing direction, rather than moving round and round in the same direction. Note: The circle should have a wider diameter, to the degree that the eyes need to stretch a bit in order to follow, and the eyes should be in the center of it.

Summary: When you observe glitches on the smooth path of hand-eye movements you, as therapist, see where, and that, a left-over issue is occurring. By noticing the glitches, using slower hand movements, and aikido-like "dancing" back and forth at the point of the glitches, you can alert the client that some discomfort is still there, convey your patience, acknowledgment, and acceptance, and affirm that you as therapist "get it" or receive (are a witness to) the message the eyes are trying to convey—to the point where the eyes let go, resulting in a smoother movement path and a seeming corresponding release in the brain's thinking/feeling patterns. Therefore, in the context of a good, established, therapeutic setting, the dialogue between the therapist's hand and the client's eyes may at times be a changing and therapeutic activity by itself, without words.

EMDR: WHEN MIRACLES BECOME COMMONPLACE

Donald Weston, Ph.D.

Since I was trained two years ago, I have been using EMDR with persons who are HIV+, have AIDS, and/or are surviving the loss of a partner. As I sat in a recent lecture, I was thinking about the work being done with persons who are HIV+ or have AIDS. I thought about men who are feeling "ashamed and dirty" because they are HIV infected. I thought about men who said, "I was feeling so badly about myself, I opened myself to this disease." I thought about men who were

overwhelmed with guilt because they had infected a life partner with this disease. I thought about men who were saying, within weeks of their death, "Yes, the quality of my life is high. I wouldn't change it."

EMDR has been very helpful in reducing the guilt, pain, and fear about the future in the HIV disease process. Clients talking about symptoms of HIV disease, about their lives being changed through illness and death, state that they can "handle it" with ease because of their EMDR work. Miracles were happening in my office every day. With EMDR, they had become so commonplace that I had not noticed and was not affirming the result of this work. Once I became aware of this, I asked myself what is it that we need to do to keep our EMDR work from becoming commonplace. I came up with four suggestions that are presented below.

First, we need to take time to recognize and affirm the impact of our work with clients. This, of course, is a main goal of EMDR, and it is critical that we be aware of and acknowledge it.

Second, we need to share our experiences with colleagues—preferably people who are trained in EMDR. They will understand EMDR and how it works in "miraculous" ways. This is one function of study groups and one of the reasons that when EMDR practitioners gather, there is so much excitement. You can share the results of EMDR work with your "dyed-in-the-wool" psychodynamic colleagues, but do not anticipate a great deal of acceptance of the rapidity with which EMDR achieves change. They will tell you that EMDR does not allow development of the transference on which, they contend, all healing is based. One woman, who developed an intense transference with her therapist, saw the therapist, through EMDR work, as a "helpful father" which was in contrast to the emotionally abusive father she experienced.

Third, try and find colleagues who are working in the same area with EMDR! With HIV/AIDS, there are an increasing number of therapists aware of the benefits of EMDR. My experience is that we tend to gather together at trainings and at the Annual Conference. This is an excellent time to share experiences, learn from each other, and recognize that the miracles happening in our offices are not unique.

Finally, recognize that miracles happen through the EMDR process. When using EMDR with persons with HIV/AIDS, we are involved in searching for the boundaries of the impact of the emotional/mental life on the illness process. This is an exciting frontier to be exploring.

When a client says, "I can keep the HIV virus in my peripheral vision, feel the breezes, smell the flowers, and live every day," miracles are happening.

INTERNATIONAL UPDATE

Francine Shapiro, Ph.D.
Mental Research Institute

This year marks the beginning of the fifth year of trainings in EMDR in the United States. The workshops have changed dramatically since the early days, with special trainings for facilitators, and much greater awareness on my part of the complexity of the method and the parameters of client selection. The breadth of information now included is not only based on my own experience, but on the accumulated information of Level II participants and Network members who have been willing to share both negative and positive clinical experiences. I would like to thank all of you who have contributed to the information base, as well as all of you who have been willing to share your experiences with your colleagues.

By mid-1994 we will have trained over 7,000 clinicians world-wide and the clinical anecdotal evidence continues to grow. Hopefully, the research will catch up so that EMDR can enter into the universities.

Along these lines, I am happy to announce that the study in Colorado, with Sandra Wilson as the principal investigator, has been completed. 80 PTSD subjects were randomly assigned to either treatment or delayed treatment conditions and to one of five EMDR trained clinicians. Significant differences were found 30 days post-treatment at $p<.001$ on SAS, IES, SCL-90-R, SUDs, and VOC. A ninety day follow-up indicates maintenance of treatment effects. The controlled study has been accepted for presentation at the 1994 annual conference of the American Psychological Association (Division 12, Clinical Psychology) in Los Angeles this August and is a major contribution to the field. It is presently being prepared for publication.

An EMDR presentation on the treatment of sexual molestation survivors was given by Eirin Gould, MFCC, as part of a sexual abuse treatment panel at the 1993 International Society for Traumatic Stress Studies. More proposals are necessary for next year's conference which will take place this coming November in Chicago. EMDR presentations were given at the 1993 International Conference on Multiple Personality Dissociative States. Sandra Paulsen, Ph.D. chaired a symposium with Silke Vogelmann-Sine, Ph.D. and Steven Lazrove, MD with Walter Young, MD as the discussant. The symposium was very well-attended and received, resulting in an invitation to Dr. Lazrove to present at the Harvard Medical School 1994 symposium on trauma chaired by Bessel van der Kolk, MD In addition, a symposium presented at the Hawaii Psychological Association was also chaired by Sandra Paulsen, Ph.D. with Chalsa Loo, Ph.D., Byron Eilashof, MD, Silke Vogelmann-Sine, Ph.D., Terence Wade, Ph.D., and Darlene Wade, Ph.D.

These kinds of presentations make a tremendous impact on the field, and I

would like to encourage all Level II participants to consider offering talks at local, regional, and international conferences. There is a presentation packet available from the EMDR Institute office for anyone who is interested. If everyone waits for someone else to do it, we end up with no presentations at important conferences. For instance, although the California Psychological Association 1994 conference will be in San Francisco this year, no EMDR presentations were submitted.

At the 1994 EMDR Conference, the first Ron A. Martinez, Ph.D. Memorial Award will be presented to Joseph Wolpe, MD for his contribution to EMDR. Dr. Wolpe is the originator of systematic desensitization, which is one of the most widespread methods in behavior therapy. His willingness to support EMDR when he became aware of its potential, and becoming the first person with an established reputation to speak in its favor, indicates his humanitarianism and desire to help in the alleviation of suffering. The award will be presented annually to individuals who have made a major, selfless contribution aiding in the dissemination of EMDR.

Geoffrey White, Ph.D. of Los Angeles has been doing his best to have EMDR treatment available to victims of the Bosnian conflict.(See article on page 3). Anyone with ideas or connections, please contact him through the membership directory. Anyone else with projects or requests, please remember to use the "Help Wanted" section of the Newsletter. There is a vast range of interests and expertise among the Network members that may prove to be of assistance.

EMDR workshops are presently being conducted by 10 clinicians, who are trained facilitators, I have trained in the standard format. These trainings are going on all over the country. However, please make sure your colleagues check for the EMDR Institute logo and the Pacific Grove address to assure the quality of the information. We will also be conducting EMDR workshops in England, France, and the Netherlands this fall. If you have colleagues you would like us to contact, please inform the office.

The continued success of the Network and the Newsletter is based on your willingness to share information. Please look at the suggested formats for submissions and take the time to share your expertise. All new innovations, interpretations, cases, research, book reviews, etc. are welcome additions. Please don't just wait for someone else to do it. Your contribution is valuable and desired.

THE USE OF EMDR WITH COMBAT VETERANS

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In discussing the use of Eye Movement Desensitization and Reprocessing (EMDR) with veterans with military-related Post-Traumatic Stress Disorder (PTSD), an overview of the disorder will be provided. Additionally, salient aspects of PTSD will be reviewed; considerations for dissociative clients will be delineated; case examples illustrating applications of EMDR will be provided; issues with respect to client preparation will be discussed; and special needs, such as treating outpatients, will be explored.

PTSD Overview

In order to have a diagnosis of PTSD, one has to have experienced an event, a trauma, that is outside of the range of normal human experience. It is an event that causes a person to feel helpless and powerless, and would be distressing to almost anyone (American Psychiatric Association [APA], 1987). The result is that traumas involve a loss on some level, be it an actual loss of a buddy or loved one, the loss of a belief or view of the self, loss of an ideal, or view of the world. Thus, frequently an essential part of therapy is to assist the client in grieving and emotional processing of the loss, while processing the impact of the trauma on the client's belief system.

Additionally, guilt issues such as survivor's guilt seem to be at the heart of the traumatic incident. Social psychologists talk about how others often "blame the victim," and it is to be noted that trauma victims also blame themselves for what happened. It is not unusual for combat veterans to say that they did not do enough, they should not have been afraid, they should have known what was going to happen, etc. Guilt and grief often get confused: how one wishes that the situation would have turned out in his or her heart seems easily transposed into what one thinks should have been done to make the situation turn out differently (S. Hardin, personal communication, January 26, 1994). Perhaps, rather than face the reality that one is never fully in control of the situation, one would rather assume responsibility for it; this may be a way to avoid a type of emotional anniversary, i.e., feeling powerless.

In addition to the aforementioned issues or aspects of PTSD, symptoms are usually divided into three clusters, or groups. The first is the reexperiencing phenomena, which includes nightmares, flashbacks, and intrusive memories of the trauma (APA, 1987). Calendar and/or emotional anniversaries are accompanied by distress, and often by an increase in intensity of symptomatology. In addition, it is not unusual to see an increase in the frequency and intensity of reexperiencing symptoms when the veteran suffers a loss (job, marriage, loved one).

The second cluster involves the avoidance/numbing symptoms. This in-

cludes emotional numbing, avoidance of stimuli resembling the trauma, social isolation, psychogenic amnesia, feeling disconnected and estranged from others, and a sense of a foreshortened future (APA, 1987). It is not unusual to hear: "The only thing that I feel is anger" or "When I'm with other people I feel like I'm in the twilight zone—I don't connect with anyone."

The third cluster of symptoms involves symptoms which reflect a hyperaroused nervous system—hypervigilance, hyperstartle, rage, anger, irritability, physiologic reactivity, initial insomnia, and difficulty staying asleep (APA, 1987). Symptoms need to have been present for at least one month.

It can be helpful to frame EMDR trauma work in terms of Lang's (1985) explanation of how memories of emotional experiences are encoded in highly organized, semantic networks that contain the following types of information: (a) information about stimulus cues that elicit emotion; (b) information about cognitive, motor, and psychophysiological responses; and (c) information about the meaning of the stimulus cues and responses for the individual ("I am going to die"). Because of the way in which these three related types of information are encoded, integrated cognitive, motor, and physiological responding is facilitated. In accessing a part of the trauma network, one accesses the memory of the trauma and associations related to it. Therefore, EMDR can be used with combat veterans for any of the aforementioned symptom clusters. Any of the symptoms delineated in the DSM III-R (APA, 1987) can be the entry point for EMDR, as they are entry points for the trauma network or target issue.

It is recommended that EMDR therapists have the Level II training, in addition to already having a specialization in treating PTSD, before using EMDR with this population. There are two reasons for this: (1) frequent encounters of blocks and (2) dissociative phenomena. Freud (1939), Horowitz (1976), and Brett and Ostroff (1985) emphasized the two-fold, or biphasic, aspects of PTSD: intrusion and avoidance of the trauma. Thus, a block can be viewed as a manifestation of one of the facets of PTSD: defensive reactions or avoidance of remembering and repeating the trauma. Emotional avoidance and numbing is also commonly seen. It is therefore not unusual to encounter these defenses when using EMDR with combat veterans; it is important to know how to handle these situations as they develop.

With respect to dissociation, research indicates that there is a difference between veterans with severe PTSD and those who have moderate PTSD. Stutman and Bliss (1985) noted that severe cases of PTSD had high hypnotizability susceptibility scores and above average imagery ability. Those with low PTSD scores had normal hypnotizability scores and high imagery scores. Thus, the authors speculated that humans may use a spontaneous form of self-hypnosis as a coping tactic. Charles Marmar (1988), as part of the National Vietnam Veterans Readjustment Study, reported similar findings. When working with a veteran population, it is important to be prepared to deal with severe PTSD and dissociation. With clients who are highly dissociative or are dissociative disordered, one needs to re-target, reassess, and reprocess as appropriate, as well as check to see if the material has been processed, or if it has been further dissociated. It is essential to have the abilities to use cognitive interweaves and fractionated abreactions.

Veterans with chronic PTSD often meet the criteria for personality disorders. There are several applications if this is the case. Specific aspects of the disorder can be worked on, such as impulsivity, splitting, dependency, etc. Symptoms, thoughts, and feelings may be able to be traced to an original activating incident (or the worst incident, or the most recent situation), which then becomes the target for EMDR.

EMDR has also been used with this population with chronic pain. Although this is an application in and of itself, some veterans who are reluctant to work on a trauma issue may be more willing to work on a chronic pain issue. While this can be helpful as a less-threatening way to help the veteran to gain an understanding of EMDR, careful exploration of the client's history needs to be done in order to ensure that the pain is not connected to a trauma. However, even a thorough history does not rule out the possibility of repressed memories emerging in the session.

Another area of application of EMDR with the veteran population is substance abuse relapse prevention. PTSD and substance abuse quite frequently go hand-in-hand. Trauma victims often self-medicate or misuse prescription medications in an attempt to manage their PTSD symptoms—for example, to feel less anxious, to socialize, to "numb out." A thorough history can be helpful in identifying targets for treatment: first time, most recent, situations in which a person is vulnerable to relapse, etc.

Providing Information/ Preparation for EMDR

With this population, it is very important to have established rapport and to have a solid therapeutic relationship with the client. Trust issues are also very important and therefore, it is imperative that in addition to a solid therapeutic alliance, one explain the EMDR method, along with its possible risks and benefits, to the potential client. (For example, a "risk" for clients who are emotionally numb is that they might get in touch with some powerful emotions. Clients also sometimes report a temporary increase in distress, an increase in memories, or an exacerbation of PTSD symptoms.) It is helpful to prepare them for this possibility ahead of time,

and to examine the support system and methods they have at hand to deal with these things.

Common questions are: **"Can I do it to myself?"** It might be helpful to explain that with emotional material, many people stop moving their eyes. The client might need someone to guide his or her eyes to help him or her to get "unstuck" and to assist when emotional material emerges.

"Is this hypnosis?" Howard Lipke (personal communication, 1992) answers this by saying that EMDR is "unhypnosis." One could also explain that hypnosis involves special communication between the hypnotherapist and the client, and that the hypnotherapist gives the person suggestions. EMDR is different in that the client comes up with the suggestions, the solutions. Much of the concern about hypnosis appears to be connected to control issues, and wondering if they could be forced to do things against their will.

"Will I be able to come out of it—if I have a flashback I may not come out?!" This question touches on issues regarding safety. An explanation of why you are considering using the method with the client may be helpful (that he or she has ego strength, etc.). A brief discussion of how dissociative experiences will be handled may also be instructive: if the client gets intensely into the experience, the therapist may become more active in getting him or her to keep moving his or her eyes, and as long as the eyes are moving, the client will be partially grounded in the present. Remind clients that they can choose to stop at any time. You might also review possible methods to close down a session.

"I have multiple tours, how can I even begin to deal with my trauma?" Explain how memories are organized, and that they sometimes are clustered or grouped based on where the trauma occurred, specific aspects of the trauma, who the client was with at the time, feelings he or she had, his or her beliefs about the situation and himself or herself, etc. Work on one trauma can affect the rest; the results can be generalizable.

At the end of the preparatory session, the client can be reminded to be a good consumer and get the information he or she needs to make an informed decision. For those vets who are interested in reading, general information articles which do not go into detail about how to do EMDR may be provided. Ask if he or she knows anyone who has had EMDR, if so, encourage him or her to talk with the person about his or her experience. Support the asking of questions about the method, and indicate in chart notes that the EMDR method has been explained to the client. When informed consent is given, note it in the chart.

Additional Groundwork

With this population, it is extremely important to do a thorough history which should include: (1) physical or psychological trauma, periods of memory loss, any dissociative episodes; (2) medication and drug history; and (3) what recovery support programs are being utilized. Shapiro (1993) delineates a fairly comprehensive list of client safety concerns for the use of EMDR.

It is also important to ask about medical problems. This includes a history of seizures, eye problems, pregnancy, brain damage, neurological problems, diabetes, headaches, and heart conditions. For some clients, getting permission to do cathartic or abreactive work is recommended. Other clients require medical support (either nearby or even inside the room).

Also check for eye problems or injury: blindness, astigmatism, fungus on retina, detached retina, etc. With conditions such as fungus on the retina, detached retina, or sutures in the eye, other forms of bilateral stimulation (other than eye movements) need to be used. Whenever the client reports eye pain of any kind during the procedure, stop.

PTSD measures such as the PTSD Checklist, Penn Inventory, Mississippi Scale for Combat Related PTSD, SCID, MMPI PTSD Scale, PTSD Stroop, and Impact of Events Scale can be used to assess PTSD. It is important to investigate whether or not the veteran has talked about his or her trauma(s) before and whether or not he or she has been able to get in touch with emotions around the traumatic event. This may indicate how much has already been processed and also may alert you to possible blocks or defenses against doing the work.

Appropriate screening for dissociative disorders should be done before you do EMDR. If the client does have a dissociative disorder, a good background in dissociative disorders as a specialty, in addition to the Level II training, is recommended. To screen for dissociation, the Dissociative Experience Scale (DES), which is a 28-item, self-administered device, can be used. High scores (above 30) indicate further evaluation for dissociative disorder is needed. Low scores do not necessarily rule out a dissociative disorder. For more confirmation, the Dissociative Disorders Interview Schedule (DDIS) can be administered. It is a structured interview, takes about 90 minutes to administer, and is approximately 95% reliable. The SCID-D by Marlene Steinberg is another interview schedule, and is a good source of information. However, this test takes some training and is longer to administer.

One of the handouts given at the Level I training discusses various screening devices, and also talks about the clinical features which suggest the presence of Multiple Personality Disorder: (1) history of childhood sexual and/or physical abuse; (2) client in treatment for years with little, if any, improvement; (3) client having several different diagnoses over the years; (4) multiple psychiatric hospitalizations with varying diagnoses; (5) frequent headaches and somatic complaints; (6) Schneiderian first-rank symptoms

(e.g., inner voices, thought broadcasting, etc.); (7) self-destructive behavior; (8) gaps in relating personal history; memory lapses; and (9) high hypnotizability.

People with dissociative disorders demonstrate behavior that involves sudden, temporary alterations of consciousness that serve to blot out painful experiences. It involves feelings of unreality, estrangement, and depersonalization ("I'm watching myself experience this"), and sometimes a loss or shift of self-identity. One of the dissociative disorders is psychogenic amnesia, which involves extensive, but selective, memory losses (like taking the licensing exam!). These memory losses can be for specific events, people, places, or objects while memory for other, simultaneously experienced events, remains intact (Sarason & Sarason, 1989).

Another type of dissociative disorder is psychogenic fugue, which involves losing a sense of identity, giving up customary life and habits, and characteristically wandering far from home. Sometimes this involves setting up a life in a new town as a new person. This can be precipitated by intolerable stresses such as marital quarrels, personal rejection, military conflict, and natural disasters. With depersonalization, there is no memory disturbance. Instead, what changes is the person's self-perception and his or her sense of reality is temporarily lost or changed. Exploring the aforementioned areas is essential when working with severe PTSD.

Other Considerations

Being on an inpatient unit has its advantages in that observation of the veteran following a session can easily be facilitated. However, EMDR has also been used successfully with veterans with PTSD on an outpatient basis. Some therapists schedule outpatients earlier in the day and encourage them to take time following the session to rest and to be observed. Outpatients can also be told to have a friend accompany them to the session or to have someone drive them. In some cases, clients may check into an acute inpatient unit before or after a session in order to give them time and a place to stabilize. Although it may appear that these considerations are overcautious, in one case, an outpatient therapist used EMDR with a veteran and felt that some desensitization had been obtained. When the client left the session, he found himself in rush hour traffic and a flashback was triggered (he had been a truck driver in Vietnam).

Considerations of the impact of EMDR on court testimony and emotional presentation have been mentioned in the Level I training. The veteran population has similar considerations for disability hearings. This is a complex issue and it is beyond the scope of this article to discuss it here.

This article is not intended to be all-encompassing, nor a substitute for proper training and experience with this population. If you have further questions, or would like consultation, please refer to the list of names at the end of this article. Additional names can be obtained by contacting Robbie Dunton at the EMDR office.

Case Study #1

At the time of treatment, the client was a 42-year-old Caucasian male who was beginning the third week of inpatient treatment on a specialized unit for Post-Traumatic Stress Disorder. This was the second inpatient admission on this unit; the first was a year earlier, in 1989. He presented with symptoms of PTSD, chronic, severe; history of partial complex seizures; and alcohol dependence (in remission). Previous diagnoses included major depression and bipolar disorder. The client was on Tegretol, 100 mg 5 times a day. The unit psychiatrist and another EMDR clinician were consulted regarding whether or not there needed to be any special considerations due to the history of seizures. The veteran reported being alcohol- and drug-free for at least two months.

The incident which the veteran identified as the target for the EMDR session occurred during his third combat tour in Vietnam. He had recurrent nightmares of the first part of the incident. The transmission on his helicopter was hit by a rocket-propelled grenade, the engine cowling was smoking and the instruments were out, and the pilot was forced to land in a rice paddy near the source of the grenade. When he initially saw the smoke, he asked the pilot, "Are we in the clouds?" The veteran was a new crew chief on this flight and described feeling tense and scared because he was helpless. He gave an initial SUDs rating of 7 to "feeling scared" and later added that he hated to admit that he was scared. He described the physical sensations of tenseness in his stomach and clammy arms. The negative self-statement for this veteran was "I am helpless." (This was one of my first EMDR sessions. Now I might have explored this more.) When asked how he would like or prefer to think about himself or his involvement in the incident, he stated, "I was in control . . . I did everything I could."

After the first set of diagonal saccades, the veteran reported his SUDs level was 3. He stated: "I feel calm about it . . . I still feel—my arms feel the same, but my stomach doesn't feel as tight." Following the second set of eye movements, he reported a SUDs level of 2. "I think I feel more upset, but I think it's because I can't bring the picture back into my mind." The therapist asked if he ever previously had difficulty recalling the scene when he tried to bring it to mind; he noted that he had never had difficulty remembering the scene prior to this. He then related: "This shouldn't be upsetting, but it is . . . You cured me, Doc. Maybe this worked or maybe it's the distractions like that coat hanger there, but I don't feel the tightness in my stomach. I still feel, felt, the clamminess. Now I'm feeling more depressed (sic, than scared). I'm thinking you're taking something away from me . . . I had a

gun capable of firing 600 rounds a minute, but I was helpless."

During the third set of saccades, there was a small break in the client's tracking. He rated his SUDs level as 5, and noted a change in the scene: "After we touched down . . . after we're sitting in the rice paddy . . . I feel depression in my chest and tightness in my face and eyes and forehead." (This tightness in the face was also observed by the therapist.) When asked about the break in tracking ("What just happened?"), he stated that he felt ". . . a rush of adrenaline. My arms feel the same, I have tightness in my chest, but I feel like I got a rush of adrenaline. Maybe it's the same feeling I had on the ground—I was going to have to fight. I think I got scared."

The client noted another change in the scene following the fourth set of saccades and rated his SUDs level at 5. "What I'm seeing is the treeline. I think all the time when we got on the ground I was expecting to take fire from the tree line, but we never did . . . wanted to be sure the battery was on (or the mini-gun wouldn't fire); otherwise, it would be helpless upon helpless upon helpless." After the fifth set of saccades, he again reported a SUDs level of 5. He reported that his mouth was feeling "tingly." "I think about the way I feel now and when I first saw the smoke. I feel the same . . . danger. We were really vulnerable because of the chase ship. Timewise it was less than a minute before I was carrying the minigun to the other ship." He was told to "go with that."

There was a noticeable change in the client's appearance following the sixth set: The tension which had previously been so apparent in his face had disappeared. He gave a SUDs level of 2, and stated: "I feel safe. I felt a little lightheaded this time. There's some tightness in the back of my head." Following the seventh set, he rated his distress at .5. "I don't feel upset. There's a slight burning in here (points to his abdomen), but it's not real tight like someone's about to punch me in the stomach." Regarding the SUDs rating, he chuckled and said, "I gotta be a little resistant." After the eighth set, veteran gave a SUDs rating of .001. He then stated: "Calm. I still got a little ache right here, but I feel okay. I feel happier than .5. I feel a lot happier on that one." He later elaborated that he recalled an aspect of the scene that he had not previously remembered, that the chase ship had .50 caliber guns on it and that they were covering him. "I don't feel so helpless."

At the time of treatment, the veteran and the therapist had a therapeutic alliance of only about 2 weeks duration (although I knew him from a previous hospital stay). Results were obtained in less than an hour. Although the client alluded several times to fears of "having something taken away" from him and to being "resistant," the treatment was still significantly effective in reducing self-reported distress. (If there had been a lack of movement at the point when the client said that he felt like something was being taken away, that could have become the starting point for the next set of eye movements.)

Reprocessing aspects of the EMDR are also demonstrated by the client's remembering details such as being covered by the chase ship which provided him with some security. Prior to the session, when the client had had the nightmare, he did not recall the entire incident, only getting hit and falling. Concomitant with the changing image or scene and the changing sensations that the client reported experiencing during the EMDR process, was a change in the negative self-statement to the awareness of being safe.

Case Study #2

This was a Vietnam veteran who was nearing the end of his stay on the inpatient unit. We had used EMDR to treat several traumatic memories and during some of this work (these sessions were done in 1991), I also learned that EMDR could impact chronic pain. During one of the sessions, this client reported pain in his neck like "a pinched nerve." I had him focus on the pain, which was just one part of the entry material, and did eye movements. We then continued to work through the trauma to some resolution. The next day, he came in and said, "That pain is still gone, just wanted to tell you." When I gave him a quizzical look, he said, "That pain I had yesterday, in my back and neck. I've had it all the time since my motorcycle accident 2 years ago. It's gone."

As the client neared his discharge date, he began to get anxious and worry about relapse. He had dreams of drinking and seeing himself in a gutter. He came into this session reporting that he kept thinking about his last 30 days in country (in Vietnam). He recalled being on stand-down, and remembered being real anxious to go home in one piece. "I put in commo bunkers for the last month. I was all shut in, locked up inside for 8 hours, but it was pretty secure. I didn't want to go out of country for R & R. I knew something was going on in my head . . . wanted to look my best . . . I had 1-1/2 years left in the service—I was depressed. It's similar to what's going on now." He added: "I was trying to be real careful," and recalled one of the traumas in which a helicopter crashed. "I was coming off of drugs: benoctals, m-benoctals, week, drinking rum and coke to try to get it out of my system. I stayed away from the guys."

When asked to think about the waiting and what it was like, he began to get emotionally intense and said he felt anxiety and depression. The scene he envisioned was pacing in the commo bunker. ". . . Calling each tower to make sure everything is okay . . . rocket attacks, .122 mm . . . Am I gonna make it? Am I gonna make it? . . . I can see it . . . I feel anxiety and my head rushing." I asked him to give me a SUDs rating, he rated his distress at a "6." Because of the emotional intensity he was demonstrating and past successful experiences using EMDR

with him, I decided to go ahead with the eye movements rather than question him further.

After the first set, he said that he saw a bit of the airport runway and felt some tightness in his chest. He felt "about the same, 3 or 4 (men) watching." He was told to go with that, and after the second set, he said that what came up was "the same thing." He rated his SUDs at a 6 level. When asked about the original material, he said: "I can still see the airfield . . . can't see on the right side . . . can still see the airfield and hangars. I feel uneasy." I asked, "Where do you feel that?" He replied that he felt it in his head and back. "Three guys—just watching and shaking heads . . . not believing what's going on . . . not going for cover."

After the fourth set, he noticed that the picture was getting "bigger, moving closer." He was told to go with that, and after the fifth set of eye movements said: "It's bigger, up and this way." He gestured with his arm. The sixth set of eye movements was done, and he reported that "I don't see it too much, my head feels clearer." I had him go back to the original material, and he said "I barely see it." When asked what he was feeling, he said "real hard." He rated his SUDs as a "2," and said "It didn't bother us." (One might notice the change in tense of this last statement to past tense.)

After the next set, he noted that "My head feels a lot better . . . lightness." "It's opening up?" I asked. "Yeah, looseness, less depressed." "I see a little part of the picture. The end of it, a little bit of the picture. I'm feeling good now. Looseness." "And are any thoughts about yourself coming up?" I queried. "That thing I said . . . I put it behind me. It's over now." He rated "It's over now" as a 6 on the Validity of Cognition Scale and "I put it behind me" as a 7. I had the client "think about that," and did another set of eye movements.

He then said, "I can't see it, I'm feeling good." SUDs were rated as "O." "I put it behind me" he rated as a 7 on the VoC scale. Because this statement went down since the last set, I thought I should do another set of eye movements to see what came up. After this set (the ninth), he began to refer to his present situation. "I'm anxious to go there. My whole body was depressed, my head . . . but cleared up now. I'm thinking about saying goodbye here." I asked him if there was a particular image that came to mind when he thought about that and he said "sitting in my room not talking to nobody." When asked what thoughts about himself came up with respect to that situation he said, "I'll go back into my shell. Gonna go back to old ways." When asked how he would like to or prefer to think about himself in the situation or about his involvement in the situation, he said "I like to learn new things. I can get help." I neglected to get a VoC rating at this time, but instead asked what he was feeling. He said he felt depressed and rated it as a 10, then added, "I don't think I'm going to get that way."

After the 10th set, he said that he felt anxious, but that it was not overwhelming. "I just drank coffee. The depression seems to have gone away. I'm doing a lot of paperwork . . . I can take care of things." The 11th set was completed and he reported that he was anxious at a 4 or 5 level, there was no depression, and he rated "I can take care of things" as a 6 on the VoC. After set 12, he said he felt anxious and that it was still as intense. Following the 13th set, he felt his "head starting to close up. Anxiety is higher, a point higher." After the next set, his experience was that "my body feels cold and warm at the same time. Eyes are tired. Head feels heavy. Anxiety . . . cold and sweaty on back of neck."

Following the 15th set, he said, "The picture of the drunk came up again . . . cold feeling . . . scary." I had him go with that, did another set, and he replied, "The thought of that drunk keeps coming up. Anxiety is down, depression down, head opened up. I don't want to be like that again." The question "What's coming up now?" following the 17th set was responded to with: " . . . opened up a little more . . . the thought is there but the picture is gone." I wasn't sure exactly which "thought" was his referent, the positive or negative self-statement or the thought of the drunk, but since he was continuing to "move" or process, I decided to do more eye movements. He then said, "I don't feel cold right now. Don't feel that anxious." SUDs were at a 1 level. "There's just a little bit of the picture, part of him. A part of the picture like an arm or part of a shoulder." Another set of eye movements, and he said, with confidence, "I am different than that."

The last set (number 20) was done, and he said, "I feel better already. I feel warm. Anxiety is down a whole lot." I asked him to go back to the original, and he reported that he could see "very little . . . gray stuff . . . I can't make out what it is." He reported his SUDs level was a 0 and rated the self-statement "I am different than that" as a 7.

He did do some things to reinforce his being "different than that" by arranging for his aftercare, setting up outpatient therapy for himself, and reconnecting with several people who had had a therapeutic effect on him. He was able to say good-bye and left the unit with a degree of confidence and self-commitment.

Case Study #3

This was a 61-year-old Korean vet. He came back six months after this treatment session to tell me that he was not having "that dream" anymore, but "I don't want you to think it was that EMDR stuff." I told him that I did not care what the cause was, but I was glad he was not having the dream.

He began the session by telling me that he was having intrusive memories that were "always there." He described an incident which occurred in combat in which he was lying in a

ditch, watching the enemy coming across a rice paddy. "I was lying there, still, cold, 40-50 below. Small arms fire off in the distance. I'm hoping the enemy won't come . . . knowing they are. The senior officers are holding us back. We are hearing sounds like horses coming. There's a thousand things running through my mind. We hear the toots of tin horns, screaming, and yelling."

"What are you feeling as you are thinking of this right now?" He replied: "Scared, frightened, cold." "On a scale from 0 to 10, 0 being calm or neutral and 10 being the most distressed you have ever felt or could ever imagine experiencing, how would you rate how you feel right now?" "A 10," he said, and noted that he felt it in his head and across his forehead. "What negative thoughts . . . " I started to ask, when he interrupted me: "It didn't feel negative. I couldn't believe it was real. I had to pinch myself. As a boy, I dreamed about going to war . . . This is for keeps, this is for real. I felt like I did something bad and that's why I was there. I was being punished."

"Okay, how would you like to or prefer to think about yourself or your involvement in the incident?" He stated, "I did what I had to do. Everything was gonna be all right. Now I wish I had, have been a John Wayne and had a chestful of medals, but yet I'm realistic. I'm proud of what I did." I then asked, "On a scale from 1 to 7, with 1 being completely false and 7 being completely true for you, right now, how do you feel about the statement, 'I'm proud of what I did'?" "7," he replied, without hesitation. Now that I look back on this session, I might have spent more time having him rate the other self-statements. At the time, I decided to go ahead and begin the eye movements.

Following the first set, he said he got dizzy following my fingers. "The picture is the same . . . no special feeling." After the instructions to go with that and another set of eye movements, he replied that "it seems like the overall scene is fading away . . . (the original) comes up, but after I do this a couple times, especially after a stop, the scene is no longer there. It's not as vivid." SUDs were a 5, ". . . but that's based on not having as intense a scene as when the memory started. If I concentrate, I'd feel more concerned about it." "Bring it up, concentrate on it, and how would you rate it now?" I queried. "Still about 5," he said.

Another set of eye movements and he said, "There again it seems like—I don't want to say erased, but I don't feel as distressed as I felt originally." "On a scale from 0 to 10 . . . " I started to ask. "Mild, very mild," he replied, and added, "I don't feel the feeling across my forehead, that feeling is gone." He gave a SUDs of 2 or 3 and a VoC of 7.

After the fourth set, he said that he saw the scene, but that it was not "as intense, not distressing." He reported his SUDs was at a 2 level. When asked what it would take to make it a 0, he said, "I don't believe it could ever get to 0, but this has proved that it can be less distressing." After the fifth set, the client stated, "It's over now, it happened in the past. When I think about the scene it's barely visible. I don't feel distressed, very slight, like a remembrance. No hurt or pain." SUDs were a "2, 1, somewhere in there." When asked to rate "It's over now, it happened in the past" on the VoC scale, he said, "I know that's a realistic statement. At this point it's history." Eye movements were done to continue to install these beliefs. He then said, "It's still barely visible." When asked for a SUDs rating, he said there was "none . . . no distress at this point." He rated the VoC as 2, adding, "The impression I have been left with is it bothers me less. I need to see what happens . . . 2 . . . I feel more relieved, don't feel as frightened, as much hurt." Therapist was confused about the rating, and so asked, "What would it take to make it a 7?" The client said, "You mean a 1. I'd like to have it completely erased from memory, but that can't happen. I'd like to see what happens in the future."

[VOC=6 with realistic consideration].

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Resources

Combat Veterans/Military-Related PTSD

Jamie Zabukovec, Psy.D.
PTSD Residential Rehabilitation Program
Portland, Oregon
(206) 696-4061, extension 3983

Howard Lipke, Ph.D.
Stress Disorder Treatment Unit
North Chicago, Illinois
(708) 688-1900, extension 4673

Dissociative Disorders

Curt Rouanzoin, Ph.D.
California (714) 680-0663

Gerald Puk, Ph.D.
New York (916) 635-1300

Marilyn Luber, Ph.D., (215) 925-9982, may also be called for additional consultation on the use of fractionated abreactions with dissociative disorder clients.

DEADLINES FOR 1994 SUBMISSIONS
APRIL 18
JULY 18
OCTOBER 18

Remember, submissions should be in APA format.

EMDR HELP WANTED

"Help Wanted" is 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 of specific populations or problems, etc., submit them to the Newsletter and include your name, address, telephone, and fax numbers.

EMDR trained clinicians who are interested in Peak Performance, please contact me so we can exchange ideas. *Dr. Mark Huthaite, 27 North Cottages, Napsbury Hospital, London Colony, St. Albans, AL2 1AW UK..*

If you are interested in sponsoring a training for small groups in your area, please contact *Robbie Dunton at (408) 372-3900.*

Fighting Predjuce

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, Ph.D., Life Help, P.O. Box 1505, Greenwood, MS, 38930.*

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

If you are an EMDR trained clinician and have had any books published, please contact the EMDR office at *(408) 372-3900.*

The EMDR Research/Training Center at MRI is looking for individuals who want to take part in a research project on addictions especially smoking, eating, and substance abuse. Anyone who has clients interested in participating, please call *Cliff Levin, Ph.D. or A. J. Popky, MA at (415) 326-6465.*

If any EMDR trained therapists are fluent in a second language, please contact the EMDR office at *(408) 372-3900.*

I would appreciate receiving feedback (success and failures) from any therapist using my smoking protocol. *A. J. Popky, MA, 17461 Pleasant View Ave, Monte Sereno, CA 95030, (408) 395-8541*

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*

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*

The following is a list of published articles and selected presentations that may be helpful for citation purposes. I have excluded from this list all of my panels and presentations as being both too numerous and redundant.

Please send all panels and presentations, upon acceptance, to the Newsletter for future publication. In addition to new articles, we can include those topics not already covered in the bibliography, and mention the others in a separate section.

I want to thank all of you who have taken the time and energy to help in the dissemination of EMDR. It cannot continue to flourish in mainstream psychology and eventually in the universities without your efforts. *FS*

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CALIFORNIA EMDR STUDY GROUPS

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CENTURY CITY/SANTA MONICA
Robert Goldblatt (213) 917-2277
Coordinating a new group 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

MONTEREY
Glenn Leonoff (408) 373-6042
Robbie Dunton (408) 372-3900
Coordinating a new group. Open

NAPA
Marguerite McCorkle (707) 226-5056
Open.

NEVADA CITY/GRASS VALLEY
Stephanie Zack (916) 272-6738
Call for time. Open

ORANGE COUNTY/FULLERTON
Curtis Rouanzoin (714) 680-0663
Jocelyne Shiromoto (714) 764-3419
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
Meets 1st Wed. 10am in MRI conference room. Case discussion.

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

SACRAMENTO
Barbara Parrett (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
Stan Yantis (415) 241-5601
Sylvia Mills (415) 221-3030
Meets 1st Wed. 8-10pm., 180 Beaumont St. Please call to confirm. Case discussion and group process. Open.

SAN MATEO/BURLINGAME/REDWOOD CITY
Pat Grabinsky (415) 692-4658
Florence Radin (415) 593-7175
Coordinating a new group. Contact Florence.

SANTA ANA
Charles Wilkerson (714) 543-8251
Judy L. Albert (714) 841-2296
Meets 2nd and 4th Thurs. of mo. 8:30-10:30am at 1633 E. 4th St. #206. Primarily case discussion. Open

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

UKIAH
Garry A. Flint (707) 468-0418
Meets the last Fri. of mo. from 10am to 12 noon at 101 W. Church St. #10. 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.
PO Box 51010, Pacific Grove, CA 93950-6010 (408) 372-3900 Fax (408) 647-9881

FROM THE EDITOR

The EMDR Newsletter is in its third year of publication and is a wonderful forum to use to impart EMDR-related information. The primary purpose of the Newsletter is to provide EMDR-trained clinicians with the opportunity to share with, and learn from, the experiences of others.

The following is a brief list of general topics that have generated interest among readers.

Innovations: EMDR continues to evolve in order to meet the demands of client needs. Always welcome are suggestions of new and different ways to apply EMDR.

Red Flags: This includes cautions regarding certain clinical populations, suggested safeguards, contraindications, etc.

Book Reviews: This includes any books that may be relevant to neurophysiology, learning theory, memory theory, PTSD, etc., or any books that you think would be of interest to practitioners of EMDR.

Protocols: If you have designed a protocol for a specific population or issue, please let us know.

International Update: Let us know what is happening with EMDR internationally (e.g., conferences, publications, awards, etc.).

Help Wanted: This is a column that can be used to advertise research projects, groups, etc.

Tidbits: This column is for brief (one page or less) comments, ideas, suggestions, etc, about EMDR.

Case Study: This is a description of a case in which EMDR was used either as the sole treatment method, or in conjunction with another modality.

Theory: Francine Shapiro, Ph.D., has developed a model based on information processing and neuropsychological activity. If you have other ideas on why/how EMDR works, please let us know.

Research Reports: Results from research studies are vital to the continued growth and understanding of EMDR and are welcome contributions to the Newsletter.

Controversy: EMDR has generated some controversy since its inception. Bringing it to the attention of our readers encourages debates which, in turn, stimulate thinking.

This list is by no means exhaustive and other ideas and suggestions are welcome.

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 method. 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. **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.

1994 LEVEL I BASIC TRAININGS

Shaded areas indicate seminars presented by Francine Shapiro, Ph.D. Other trainings listed are conducted by presenters who have been selected and trained by Dr. Shapiro.

Date	Location
Mar. 19/20 Sat./Sun.	New York, NY Loews NY Hotel
Apr. 8/9 Fri./Sat.	San Jose, CA Red Lion Inn
Apr. 8/9 Fri./Sat.	Boise, ID Holiday Inn
Apr. 16/17 Sat./Sun.	Fayetteville,AR Fayattevill Hilton
Apr. 23/24 Sat./Sun.	Denver, CO Sheraton Denver Tech Cntr.
May 13/14 Fri./Sat.	Tallahasse, FL Ramada Inn Tallahasse
May 14/15 Sat./Sun.	Hartford, CT Sheraton Hartford Hotel
May14/15 Sat./Sun.	Syracuse, NY Sheraton University
May 15/16 Sun./Mon.	Honolulu, HI Kahala Hilton
May 21/22 Sat./Sun.	Seattle, WA Seattle Airport Hilton
June 3/4 Fri./Sat.	Los Angeles, CA Sheraton Airport Hotel
June 3/4 Fri./Sat.	Albuquerque, NM Ramada Hotel Classic
Jun. 4/5 Sat./Sun.	Chicago, IL Marriott Oakbrook
June 4/5 Sat./Sun.	Salt Lake City, UT University Park Hotel
June 10/11 Fri./Sat.	Columbus, OH Fawcett Center
Jun 17/18 Fri./Sat.	Philadelphia, PA Radisson Hotel Airport
July 4/5 Mon./Tues.	Brisbane, Australia Brisbane Hilton Hotel
July 7/8 Thurs./Fri.	Perth, West Australia Sheraton
July 15/16 Fri./Sat.	Sacramento, CA Sacramento Hilton
Aug. 6/7 Sat./Sun.	Portland, OR Sheraton Portland Airport Hotel
Aug. 29/30 Mon./Tues.	Sydney, NSW. Australia Ritz Carlton, Double Bay
August TBA	Melbourne, Victoria, Australia TBA
Sept. 9/10 Fri./Sat.	San Francisco, CA Clarion Hotel
Sept. 10/11 Sat./Sun.	Washington, DC Embassy Row Hotel
Sept. 10/11 Sat./Sun.	Minneapolis, MN Radisson Hotel & Conf.Cntr.
Sept. 16/17 Fri./Sat.	Mt. Pleasant, MI Holiday Inn
Sept. 23/24 Fri./Sat.	London, England London Regents Park Hilton
Sept. 23/24 Fri./Sat.	Phoenix, AZ Sunburst Hotel
Sept. 24/25 Sat./Sun.	Aix-en-Provence, France Hotel Pullman Roi Rene
Sept. 30/Oct. 1 Fri./Sat.	Amsterdam, The Netherlands Grand Hotel Krasnapolsky
Sept. 30/Oct.1 Fri./Sat.	Atlanta, GA Holiday Inn Dunwoody
Oct. 7/8 Fri./Sat.	San Antonio, TX TBA
Oct. 21/22 Fri./Sat.	San Jose, CA Sunnyvale Hilton

1994 LEVEL II TRAININGS

Apr. 15/16 Fri./Sat.	San Jose, CA Sunnyvale Hilton
Jun. 24/25 Fri./Sat.	San Francisco, CA Doubletree SF Airport
Jul. 30/31 Sat./Sun.	Denver, CO Hyatt Regency Tech. Ctr.
Aug. 27/28 Sat./Sun	Sydney, NSW, Australia Ritz Carlton, Double Bay
Aug. 5/6 Fri./Sat.	Los Angeles, CA Sheraton, LA Airport
Oct. 15/16 Sat./Sun.	Seattle, WA Seattle Hilton Airport
Nov. 5/6 Sat./Sun.	New York Loews New York
Nov. 12/13 Sat./Sun.	Chicago, IL Marriott Oakbrook
Dec. 2/3 Fri./Sat.	San Jose, CA Sunnyvale Hilton

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