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EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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STRAY THOUGHTS

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The Eight Phases of EMDR Treatment

EMDR consists of eight essential phases and should always be used within a comprehensive treatment plan. It is never to be attempted without appropriate preparation and the opportunity for reevaluation. The following is a quick review of the crucial phases for EMDR treatment.

Phase One: Client History and Treatment Planning

Effective treatment with EMDR demands knowledge of not only how to use it, but when to use it. Therefore, the first phase of EMDR treatment includes an evaluation of the client safety factors that will determine client selection. A major criteria for judging the suitability of clients for EMDR is their ability to deal with the high levels of disturbance that may be precipitated by the processing of dysfunctional information. This involves an evaluation of personal stability and life constraints, such as major deadlines that may be adversely affected if the client is distracted by the ongoing processing of the traumatic material. In addition, the client should be physically able to withstand intense emotion, so the clinician must evaluate potential problems due to age or a preexisting respiratory or cardiac condition.

For clients selected for EMDR treatment, the clinician will then take the information needed to design a treatment plan. This part of the history-taking will evaluate the entire clinical picture including the dysfunctional behaviors, symptoms, and characteristics that need to be addressed. The clinician will then determine the specific targets that will need to be reprocessed. These targets include the initial events that set the pathology in motion, the present triggers that stimulate the dysfunctional information, and the kinds of positive behaviors and attitudes needed for the future. EMDR should only be used to reprocess information after the clinician has completed a full evaluation of the clinical picture and has outlined a detailed treatment plan.

Phase Two: Preparation

It is essential that the clinician give the client enough information about the potential for emotional disturbance during and after EMDR sessions so he or she can give truly informed consent. Not only does this give clients the opportunity to make appropriate choices, but it allows them to prepare their work and social schedules to accommodate any discomfort. Clinicians should also be sure that clients have an audio tape that includes guided relaxation exercises (such as "Letting Go of Stress" by Source Cassette tapes) and that they practice these exercises before beginning the EMDR reprocessing sessions. The goal is for clients to be proficient in the techniques and be able to use the tape with confidence in order to deal with any between-session disturbance.

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Clinicians should also use the guided visualization techniques with the client before reprocessing begins. If the client is unable to successfully eliminate moderate levels of disturbance with these techniques, the clinician should not continue EMDR. Techniques like these may be necessary to help the clinician close down an incomplete session and assist the client in dealing with new memories or unpleasant emotions that may emerge after the session. The effective use of these techniques can give clients the confidence to deal with the high levels of disturbing material that may emerge during the session, while an inability to handle the disturbing feelings can increase the client's level of fear and make processing even more difficult.

The preparation phase also includes briefing the client on the theory of EMDR and the procedures it involves, offering some helpful metaphors to encourage successful processing, and telling the client what he or she can realistically expect in terms of treatment effects.

During the preparation phase, the clinician should also explore with the client any possible secondary gain issues. What does the client have to give up or confront if the pathology is remediated? If there are concerns, these must be addressed first, before any trauma reprocessing begins. This may include the development of an action plan to handle specific situations that may arise, such as needing to find a new job or a new place to live. If the secondary gains are fed by feelings of low self-esteem or irrational fears, they should become the first target of processing. Until these fears are resolved, no other significant therapeutic effects can be expected or maintained.

Phase Three: Assessment

Assessment is the third phase of EMDR treatment. In it, the clinician identifies the components of the target. Once the memory is identified, the client selects the picture that best represents the memory. Then he or she chooses a negative cognition that expresses a dysfunctional, maladaptive self-assessment related to his or her participation in the event. These negative beliefs are actually verbalizations of the disturbing affect and include statements such as, "I am useless, worthless, unlovable, dirty, bad," etc. The client then identifies a positive cognition that will be used as a replacement for the negative cognition during the installation phase of processing (Phase Five). These statements should incorporate an internal locus of control, when possible, such as, "I am worthwhile, lovable, a good person, in control" or "I can succeed." The client then assesses the validity of the positive cognition using the 1-to-7 Validity of Cognition (VoC) scale, where 1 equals "completely false" and 7 equals "completely true."

At this point, the picture and negative cognition are combined to identify the emotion and the level of disturbance using the 0-to-10 Subjective Units of Disturbance (SUD) scale. A rating of 10 means the greatest level of disturbance the client can imagine, and 0 means calm or emotionally neutral. The client is asked to pick a number that indicates the intensity of his or her emotions when the memory is accessed in present time. As reprocessing commences, both the emotions and their intensity will change, with the disturbance often becoming temporarily worse.

Next, the client identifies the location of the physical sensations that are stimulated when he or she concentrates on the event. The assessment stage offers a baseline of response in regards to the target memory, and the specific components necessary to complete processing.

Phase Four: Desensitization

The fourth phase is called "desensitization" because it focuses on the client's negative affect as reflected in the SUDs rating. This phase of treatment encompasses all responses, regardless of whether the client's distress is increasing, decreasing, or "stuck."

During the desensitization phase, the clinician repeats the sets, with appropriate variations and changes of focus, until the client's SUDs levels are reduced to a 0 or 1 (when ecologically valid). This indicates that the primary dysfunction involving the targeted event has been cleared. However, the reprocessing is still incomplete and the information will need to be further addressed in the crucial remaining phases.

Remember that in many cases, the sets of eye movements or alternative forms of stimulation are not sufficient to complete processing. At least half the time, the processing will stop and the clinician will have to employ various additional strategies and advanced EMDR procedures to restimulate the system.

Phase Five: Installation

The overall reprocessing effects of EMDR are manifested by changes in the picture, cognitions, emotions, and body sensations associated with the targeted event. During a simple EMDR treatment session, aspects of the information shift simultaneously to a less disturbing form. Conceptually, the clinician is attempting to "clean out" the dysfunctional information stored in the associative neurophysiological memory network and allow it to be replaced with positive information. The fifth phase of treatment is called installation because the focus is on "installing" and increasing the strength of the positive cognition that the client has identified to replace the original negative cognition. For example, the client might begin with an image of her molestation and the negative cognition, "I am powerless." During this fifth phase of treatment, the positive cognition "I am now in control" might be installed. The caliber of the treatment effects (that is, how strongly the client believes the positive cognition) is then measured using the Validity of Cognition (VoC) scale.

The installation phase starts once the client's level of emotion about the target event has dropped to 1 or 0 on the SUDs scale. At this point, the clinician asks the client to hold the most appropriate positive cognition in mind along with the target memory. Then he or she continues the eye movement sets until the client's rating of the positive cognition reaches a level of 6 or 7 or more on the VoC scale (where 1 is "completely false" and 7 is "completely true"). Keep in mind that the client should rate the cognition based on how he or she feels at a gut level.

Linking the positive cognition with the target memory allows a strengthening of the associative bond so that if the original incident is triggered, its return to consciousness will be accompanied by the new, strongly linked positive cognition, such as, "It's over, I'm safe now." As the client concentrates on the positive cognition, it is infused into the target memory network where it can generalize to the other associated material. As discussed earlier, the positive cognition is chosen so as to generalize and reshape the perspective of the greatest amount of dysfunctional material, as well as to empower the client for present and future occurrences. Metaphorically, if the cognition gives "color" to past and present incidents (as if the client were seeing through rose- or dark-colored glasses), the positive cognition acts as a different color dye that permeates the memory network.

Phase Six: Body Scan

After the positive cognition has been fully installed, the client is asked to hold the target event in mind, along with the positive cognition, and mentally scan his or her body from top to bottom. He or she is asked to identify any residual tension, in the form of body sensation. These body sensations are then targeted for successive sets. Often the tension will simply dissipate, while in other cases, additional dysfunctional information will be revealed. As there appears to be a physical resonance to dysfunctional material, which may be related to the way it is physiologically stored, identifying any residual physical sensation, and targeting it in this sixth phase of EMDR treatment, can help to resolve any remnants of unprocessed information. This is an important phase and can reveal areas of tension or resistance that were previously hidden.

Phase Seven: Closure

The client must be returned to a state of equilibrium at the end of each session, regardless of whether the reprocessing is complete. Techniques to close the session have been reviewed in the Level I and II trainings. In addition, it is vital that the client is given the proper instructions at the end of each session. The clinician must remind the client that the disturbing pictures, thoughts, or emotions that may arise between sessions are simply signs of additional processing. The client is instructed to keep a log or journal of negative thoughts, situations, dreams, memories—anything of that nature that may arise. This allows the client to cognitively distance himself or herself from emotional disturbance through the act of writing. Specifically, the client should take a "snapshot" of any disturbances so that these can be used as targets for the next session. The use of the log and the visualization techniques taught by the clinician or via a relax-

ation tape are extremely important to aid client stability between sessions. Unless the clinician appropriately debriefs his or her EMDR client, there can be a danger of decompensation or suicide, brought on when the client gives his or her disturbing emotions too much significance or views them as indications that he or she is permanently damaged. The clinician should give the client realistic expectations regarding the negative (and positive) responses that may surface both during and after treatment. This increases the likelihood that the client can maintain a sense of equilibrium throughout the possible disturbance engendered by the stimulation of the dysfunctional material. There may be a domino effect that stimulates other negative memories as the information continues to process.

Phase Eight: Reevaluation

The eighth phase of treatment includes the additional targeting, reaccessing, and review necessary to ensure complete treatment effects. After any reprocessing session, a re-evaluation of effects should be made at the beginning of the following session. The clinician should ask how the client feels about the previously targeted material and review the log reports to see if there are any reverberations of the already processed information that need to be targeted or otherwise addressed. The clinician should only proceed with targeting a new event after the previously treated traumas are completely integrated.

Integration is determined in terms of intrapsychic factors, as well as systems concerns. If the reprocessed traumas have resulted in new behaviors on the part of the client, it may be necessary to address problems that arise in the family or social system. The re-evaluation phase guides the clinician through the various EMDR protocols and the full treatment plan. Successful treatment can only be determined after sufficient re-evaluation of reprocessing and behavioral effects.

EMDR AFTER A TERRORIST ATTACK

Liliane Bar, M.D.
Buenos Aires, Argentina

On the 18th of July, 1994, we had a terrorist attack at a Jewish institution, a building of eight floors that was completely destroyed. More than 150 people died and 147 were wounded. The next day, several people with panic attacks were found walking in the streets. They had no memory of what had caused them to be so far away from their homes or work.

This tragedy happened on Monday. On Saturday morning, I received a phone call from a patient in a very excited state who asked me to see her immediately. She was suffering from obsessive ideas, had a fear of new attacks, was feeling "death everywhere," and was terrified that something could happen to her children. On Friday night she had gone to a Jewish temple to pray (she never goes to any temple) and when she came back, the telephone rang and she heard a voice telling her, "We are going to kill you." She said that this was the voice of a man who repeated the menacing statement three times. After that call, she could not sleep.

This 38-year-old woman, who currently is happily married with two children (ages 4 and 6), had been my patient several years ago and I was well aware of her past from our previous work. I believed that although her presenting symptoms were caused by the current situation in our country, I was sure that it had triggered something from her past. I suggested that we try EMDR and she agreed. The initial target was, "I feel death everywhere," which she rated at a 10 SUDs level. The following is an account of the material that emerged.

T:Where do you feel this death?

P:[She put her hand on her stomach.]

T: Stay there.

P: I feel that the death is inside of me, not outside.

[Now I shall describe only her words, with the understanding that after each phrase, there was a set of EMDR.]

P: I think my father wanted to kill me when my mother became pregnant.

P: [She cries.] I know my father was a danger for me, I can now feel the danger.

P: [Abreaction continues.] I know that my mother always protected me from him. She means life for me.

[The patient rates the SUDs as 7.]

P: I have this feeling that I am the danger. I am afraid of myself.

P: I feel that I am my father who wants to kill me. I want my mother to do an abortion.

T: Now, speak to your father and see if you can tell him that you have the right to live.

P: I know that I am able to protect myself.

[Her SUDs is reported to be 3.]

T: I asked if the voice on the telephone still upset her.

P: Yes.

T: So, you are the man who called you?

P: I am full of anger and want to kill. I hate people, I am a terrorist. [She begins to abreact.]

P: I see that I had this hate against my father. I never realized that it was so strong. I have carried this anger all of this time.

[She feels completely calmed and wants to hug me and thank me.]

The session lasted less than one hour.

"INNOVATIVE IDEAS" OR SUCH

Sonya K. "Toni" Binstock, LCSW, BCD

Mrs. O., who had suffered neck and shoulder injuries in an automobile accident several years ago, was referred to me after an incident on her job triggered a post-traumatic stress reaction. Treatment initially consisted of traditional talk therapy, but after having been trained in EMDR, I offered it as an option to deal with the PTSD of the accident itself. We did only 2 sessions of EMDR which were spaced over several months (as there were additional work-related stressors that arose and needed attention). The second and last EMDR session was so remarkable for both of us that I asked her to write her impressions for the Newsletter.

"November, 1993

"During one of my recent visits to see Toni, I had a very different experience, a kind of 'out of body' experience. We were involved in an EMDR session focusing on the automobile accident I had several years ago. This accident has left me with neck and shoulder pain and daily headaches (an average level of pain for these conditions would be 3 or 4 on a 10-point scale).

"While working our way through some negative messages from my past, I suddenly had an image of my inner child, my 'little girl.' As far back as I can remember, the image had always been that of a very sad, scared child and it wasn't any different at that moment. Although I have never thought about it out loud, I have always been ashamed that I am female because females, according to my father, aren't really worth a lot. I have always had to try harder to be perfect so that my father would acknowledge my existence. I had to be prettier, smarter, stronger. Even though I have taken all these 'needs to be' and have done my best, I often feel that I am a failure at much of what I do. It has been very hard not to have my Dad's verbal acknowledgment and acceptance of who I am.

"As we continued our session, one of the statements I made was that, 'I just want my father to love me for who I am' and that, 'I have never been what my father wanted me to be, a boy.' To put a positive message in the negative message's place, I simply said, 'It's over . . . I am who I am and no matter what my father had wanted, I was a good and decent human being, a girl.' All of a sudden I had this very strong 'energy' sensation pulling from the left side of my head and the image of my 'little girl' swinging in the sunshine, smiling and very happy to be a girl! Now, whenever I have self-doubts, I check in with my inner child and I can still see her swinging in the sunshine. This gives me great hope and pleasure."

Ms. O. is now living out of the state of Colorado. I got a note from her last week saying that her child is still "swinging."

EMDR: A PART OF THE WHOLE

Joanne Carnes, M.A.

Since I took the first EMDR training in September, 1993, I have been exploring the outcome of EMDR as compared to more traditional therapy, as well as how EMDR works in conjunction with more traditional techniques. The following two cases include one in which EMDR was all that was needed at that time and one in which EMDR was (and is) but a part of a longer and more complicated process.

First is the case of Terri, whom I first started seeing in 1989, when she came in severely depressed and suicidal. She had been severely sexually abused as a child and had never been in therapy. At that time, she was 35 and in her third marriage. Except for going to work (where she was extremely competent), she stayed home and isolated in her room. Working with a psychiatrist, we put her on Prozac and started the process of working through the sexual abuse.

Over a period of 2-1/2 years, we used various therapeutic modalities. This included psychodynamics as we explored her background and linked it with present patterns and feelings. We also did child within work and cognitive therapy as we looked at healing, self-soothing, and self-esteem. When Terri terminated therapy, she still dealt with major control issues and some depression. She had resolved many of the issues with her stepfather and her mother and was no longer isolating herself from others. She dealt with her husband in a healthier manner and had a best friend for the first time.

In September, 1993, I received a call from her friend who said that Terri was again severely depressed, suicidal, and staying in her room. I called her and she came in almost immediately. Terri was agitated, tearful, and obviously depressed. She stated that she had struggled on and off with memories of other abuse and other abusers, but had used her skills to handle them. However, about three months prior to our session, she had a memory which was unbearable. She had flashed on a scene when she was a young adult. She was lying in bed at night when her 18-year-old brother crept into her room and knelt beside her bed. He fondled her and also placed her hand on his penis. Sobbing, she stated that she was the perpetrator. She was the adult and she did not stop him. That day we could get no further. Her self-disgust and anger toward herself were alarming. She refused any medication. That week I took the basic EMDR training.

When I saw Terri at our next session I discussed this with her, and she was more than willing to be my first EMDR

patient. We thoroughly discussed the procedure and I also gave her an article to read.

I began treatment with the suggested 24 sets of eye movements. Terri was trembling and anxious, but the image was very clear. Her negative cognition was, "I didn't stop him. I am the perpetrator," and her SUDs level was 10. She also saw that she was sleeping in a bed with her mother. The memory and the intensity remained much the same for the next three sets, which I lengthened to 36. We went slowly, allowing her to stop, do some deep breathing, and feel safe enough to continue.

On the fifth set, she suddenly stopped, put her head in her hands, and started crying. She had moved through the memory to the place where she saw herself reaching out quietly and stopping him without awakening her mother. She remembered getting him to leave, getting up and going into the next room to pick up her young daughter, and making sure the child would stay safe.

There was an immediate and major transition in Terri's feelings and cognition. The SUDs went immediately to "0." Her cognition was, "I did stop him. I'm not the perpetrator," and the VoC was 7. We tested the memory and all she could see was that she had stopped him. This all happened in one session. When we tested the situation at our next session, she had remained at a SUDs of 0 and a VoC of 7. She has not been depressed or isolated since then. She is reaching out and doing more new behavior--trying to relax and discover what "fun" is all about. This is a major breakthrough for Terri!

However, since then I have discovered that it is not always that easy. This is demonstrated in the case of Marnie.

Marnie is a 30-year-old, married woman, whom I started seeing in April, 1993. She presented with severe depression and anxiety and stated she was on "an emotional roller coaster" and "always angry inside." She had lost four babies late in pregnancy and she wanted a baby badly. It was discovered that she had cervical cancer very soon after she lost her last baby, leading to the thought, "I didn't even have time to deal with the loss of my baby."

She is from an enmeshed family and grew up with an alcoholic father who is a bright, prominent man in the community and who has been extremely critical and controlling of his two daughters (of whom Marnie is the youngest). Although she hardly remembers what her mother was like, she does like her and is close both to her mother and her sister. The three of them bonded together to protect dad from being upset--to please him in every possible detail. They were constantly worried about what he might say or what others (especially extended family) might say to him. She was often humiliated over her father's behavior. (Her father recently went to treatment and no longer drinks.)

Marnie has many strengths: (a) her intelligence, (b) her sense of humor, (c) her creativity, and (d) her eagerness to work and make changes; all of which helped her deal with her issues. Her goals were: (a) to find a way to deal with her father's control which by this time was so internalized and pervasive, that it dictated most of her waking hours; (b) to deal with her weight (she is a compulsive overeater); (c) to explore her anger; (d) to deal with her inability to say no; and (e) to deal with her growing fear of people and what they would think of her.

We started working with boundaries and self-talk, with choices, and with exploring her own wants and needs. This was all new to Marnie, but she caught on quickly. We also worked with visualization and desensitization using scenarios in which her father acted up or was critical. At the same time, she started working on assertiveness responses. Her father's moods no longer regulated her behavior to the same extent. She was better able to stand up for herself, and her depression had lifted. However, I was quite certain we had only scratched the surface, as evidenced by: (a) her continuing reluctance to be around people, (b) her ongoing anxiety, (c) her despair over both her weight and her inability to carry a child full term, and (d) her continuing hypersensitivity to her father.

In September, after my basic EMDR training, I suggested that we start EMDR and she agreed. To get a starting point, we took the anxiety she felt, which led to eating, and followed back with visualization until we came to a childhood memory where she felt the same way. The memory was pervasive and chained through a whole childhood of: "I'm never good enough." "I'm bad." She could see her father frowning down on her. We finally focused on a specific memory for the purpose of EMDR. The SUDs was a 10.

In the first two series, nothing happened. In the third series, Marnie broke down, sobbing. The SUDs remained the same, but there was also anger for the little girl. We did four more sets and at that time, the cognition was, "I was just a little girl. I did the best I could." The VoC was a 6 and the SUDs was at a 2. It was time for the session to end. The next week, Marnie said that not much had changed. She then proceeded to identify three different times when she dealt with her father's behavior in an entirely different way and did not become anxious or depressed. As we discussed this, she stated, "It seemed like no big deal. I had forgotten how much that kind of thing used to bother me." There were major changes after that, even to the point where Marnie set up a booth in a craft fair without her mother and sister. Dealing with her father was significantly easier which was particularly important since she worked for him. She stopped obsessing on both his behavior and what he would think. She was able to handle his criticism without feeling devastated. She started setting some boundaries and even started making

humorous responses to his comments.

However, the weight problem continued and the dysphoria and anxiety returned. We used hypnosis for the weight which would work for 1 to 2 weeks. The positive was the way things were going with her father, which continued to improve; as did her ability to say "no" to other people.

We started exploring her despair over not being able to ever have what she wanted in life. She got in touch with the feelings and sat with them. We came to the underlying cognition, "It's no use. I can't do anything right." "I'm never going to get there." We then took the feeling and the cognition back in time to the little girl. Marnie again started crying as she saw the picture of the little girl in a situation with her father where she felt utterly shamed and "bad." She was 6 and had written him a note asking him to buy her a dictionary. In the note she spelled "dictionary" wrong. Her father thought it was very funny and talked about it to everyone. He kept the note and showed it to friends in front of her. He never did talk to her about it. This was terribly painful, but toward the end of our time her SUDs had gone from a 10 to a 2. The positive cognition was: "I was only 6. I did pretty well just to ask for a dictionary. I would have felt better if he had talked to me." Another painful memory hit her and we took the time to work it through as well. The ending positive cognition was, "I know I'm going to get there," with a VoC of 7.

The next week she came back showing some real changes. These included making the decision to get pregnant whether she lost weight or not, starting an exercise program (which she has continued since then), and agreeing to a trip to Europe with her husband. (She also had forgotten one of the memories.) Some additional changes noted were: (a) much of her problem with procrastination has been conquered, (b) she has stopped obsessing on what everyone will think of her, (c) she has stopped avoiding public places because of her weight, and (d) she has conquered her fear of her father and is able to set boundaries with him. For the first time, he is making some positive comments to her and she is recognizing these; however, she is still not comfortable with the change.

She continues to be distressed over her weight and recognizes anxiety around the issue. Her statement is, "It's not going to happen." As she sat with this, the memories once again chain back to her father. I suggested more family of origin work. She was uncomfortable, in her new independence, coming this close to enmeshment. We started on child within work around love and nurturing. This again brought sadness and tears.

Marnie's therapy is not over. We would not have gotten this far without EMDR and we may use it again. However, neither would we have come this far with only EMDR

FAMILY INTERVENTIONS TO ENHANCE CHILD EMDR TREATMENT

Ricky Greenwald

Extensive clinical data suggest that EMDR can be quite rapid and effective with children under certain conditions (Greenwald, in press-a, in press-b). Desirable therapist qualities include familiarity with an adequate repertoire of child-oriented EMDR techniques, as well as the ability to develop rapport and enlist the child's cooperation and perseverance. Child qualities conducive to successful, brief treatment include a relatively limited trauma history, as well as parental support for healing. This paper will describe two simple family interventions which can help to mobilize parental support for the child's healing.

"Getting Better Might Be Risky"

The first intervention directly addresses possible secondary gain issues for the child, and should be considered as a routine component of preparation for EMDR. Following a careful assessment of the child and the family, individual child treatment may be deemed appropriate. After introducing EMDR as a potentially helpful activity, the therapist can express concern regarding possible risks of successful treatment. The child may then acknowledge concern that "getting better" might lead to losing parental attention and/or family closeness. Once the child admits to this (sometimes only following specific questioning), the issue can be seriously discussed. Typical outcomes include: contradiction by amazed parents who assert that relationships will actually improve; a discussion of specific ways of tracking possible changes in relationships; and a family commitment to exploring this issue in therapy following individual treatment.

This intervention helps the child to feel permission, support, and safety in attempting to relinquish symptoms. It also may serve to "hype" EMDR, with the therapist's paradoxical worry about success leading to increased motivation. The awareness of family dynamics generated by this discussion may also help the family to reorganize in support of the child's changes.

"What a Good Boy/Girl"

The second intervention addresses the child's underlying sense of "badness," and is used when the child's inner resources have been insufficient for healing with EMDR. For example, a child's memory of an angry, punishing, or upset parent may constitute irrefutable evidence of badness, and limiting progress accordingly. The therapist should introduce corrective information from the most authoritative source available. In a family session, the therapist questions the parents, who must repeatedly insist that

the child is "a good boy/girl" even if he or she sometimes makes mistakes or is punished. (Some parents may need to be prepared for this.) Specific upsetting past events may be brought up, and parents asked if the child was at fault (they should say "no"). After such a session, children tend to integrate this information easily with EMDR, often leading to major behavioral breakthroughs.

This intervention also tends to have multiple effects. Not only does the child acquire a needed healing resource, but the parents may become more able to distinguish their feelings about the child from their feelings about the child's behavior. The parents' inclusion here may also help them to "discover" their child's goodness, and to feel empowered to continue to support their child's healing through praise and positive interaction.

Precautions

Although these interventions are intended to have systemic impact as well as supporting the child's treatment, application is not appropriate with every family. For example, if the family is organized around the child's symptoms as a means of diverting parental conflict, it may be inadvisable to attempt to heal the child prematurely (e.g., Szapocznik et al., 1989). Similarly, if the parents really do blame the child or believe in the child's badness, statements to the contrary will not be credible. Therefore, these interventions should only be attempted when such obstacles are not present, or have been substantially resolved. Of course, the therapist's determination that individual child treatment is appropriate probably means that the family is, indeed, in a position to support it.

References

Greenwald, R. (in press-a). Using EMDR with children: A compendium. Pacific Grove, CA: EMDR.

Greenwald, R. (in press-b). Applying eye movement desensitization and reprocessing (EMDR) to the treatment of traumatized children: Five case studies. Anxiety Disorders Practice Journal.

Szapocznik, J., Rio, A., Murray, E., Cohen, R., Scopetta, M., Rivas-Vasquez, A., Hervis, O., Posada, V., & Kurtines, W. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. Journal of Consulting and Clinical Psychology, 57, 571-578.

INTERNATIONAL UPDATE

Francine Shapiro, Ph.D.
Senior Research Fellow
Mental Research Institute
Palo Alto, CA

Media Coverage

The general consensus is that cheers and sighs of relief went up from EMDR clinicians all over the country at the July 29 airing of 20/20. The episode on EMDR, entitled "When All Else Fails," put the concentration where it belongs, on the clients, and was extremely favorable. Transcripts and videotapes of the show are available from ABC News:

Tapes — 800-913-3434
Transcript — 800-825-5746

Give the show, segment name, and air date as listed above.

Articles have recently appeared in the LA Times Magazine and many daily newspapers around the country. There was also a report on EMDR on National Public Radio, and we have been informed that Longevity and Prevention magazines are planning stories. You might consider sending clippings of the major newspapers to your local media. However, please make sure that no "miracle" claims accompany the coverage. It is important that the discussions are kept to the highest professional standards.

Research Reports

The August 1994 annual conference of the American Psychological Association had three EMDR presentations. Boudewyns, Hyer, Perlame, Touze, and Kiel (1994) presented preliminary findings of research conducted at the Augusta, Georgia VA Medical Center. They found that EMDR with eye movement was superior to EMDR without eye movement. In addition, the full EMDR procedure was significantly better than group therapy (the standard treatment used throughout the VA) which was used as a control condition.

A panel of EMDR papers chaired by Andrew Leeds included a report of the two Hurricane Andrew studies presented by Cliff Levin, the survey of EMDR clinicians treating over 10,000 clients presented by Howard Lipke, and a case report presented by Laurel Parnell. The audience was twice as big as the room allocated and flowed into the hall. The presentations were very well received, and hopefully others will be submitted (and accepted) next year as well.

Sandra Wilson, Bob Tinker, and Lee Becker presented their 1994 study of 80 trauma victims, and APA held a special press conference to announce it. The results are being disseminated through print media throughout the country. As usual, a critic is being asked to dispute it. The following are being cited as problems, which actually do not exist:

1. The study has limited worth because actual diagnoses were not made. Fact: The study did not use diagnoses as a selection criteria, but an internal analysis found that more than 50% met the diagnosis of PTSD.

One of the strengths of the study is the inclusion of clients evincing a full range of post-trauma responses. This self-selecting population would typically be seen by the average therapist.

In addition, a statistical analysis of those subjects meeting the criteria for post-traumatic stress disorder (over 50% of the subjects) show no difference compared to the non-PTSD subjects in the magnitude of change and subsequent indicators of treatment efficacy. There were ten standard measures of trauma sequelae used, and all showed significance at the $p<.001$ level.

2. Results may have been caused by placebo/demand characteristics. Fact: A review of over 300 meta-analyses (Lipsey & Wilson, 1993) appearing in the December, American Psychologist indicated that placebo effects accounted for .19 standard deviations of change, while the Wilson et al. study indicated .50 to 2.35 standard deviations of change. Obviously this is a much greater effect than that caused by placebo alone. Furthermore, a review article by Solomon, Gurrity, and Muff in the 1992 issue of the Journal of the American Medical Association states that PTSD subjects are particularly resistant to placebo effects, indicating that the dysfunction is physiologically mediated.

An additional argument against the possibility of a placebo (or demand characteristic) effect appears in the Wilson, et al. study which states that 64% of the subjects had already received treatment for the disability which had persisted an average of 13.5 years. The positive treatment effects for this group of subjects indicate that the effectiveness of EMDR was not dependent upon the attention of a therapist or his or her demand characteristics. One would assume that paying a therapist weekly for a number of years would have caused a remediation if expectation was a major reason for change.

3. The study does not establish treatment efficacy. Fact: In all of the PTSD research literature, the combined number of flooding subjects in all four non-EMDR studies has been 47, while in the Wilson, et al. study, there were an equal number of diagnosed PTSD subjects assigned to EMDR. While all subjects in the non-EMDR studies show only modest treatment gains, after 9-to-16 sessions, the Wilson, et al. study shows high magnitude gains with EMDR after only 3 sessions. This represents a rather dramatic difference in treatment efficacy.

State of Post-traumatic Disorder Research

In 1992, a review article of controlled clinical treatment outcome research in the field of post-traumatic stress disorder listed a total of eleven studies (Solomon, Gerrity, & Muff, 1992). Five were drug studies and six tested clinical treatments for PTSD. Few of these studies would stand up to intense scrutiny. For instance, one of the controlled studies compared 48 sessions of desensitization to no treatment. Although flooding is used extensively throughout the VA systems as a treatment of choice, the four studies testing the method evaluated only a total of 47 flooding subjects. There are still no studies on natural disaster victims, molestation victims, accident victims, or children.

This paucity of clinical research, the small number of subjects used, and the lack of quality as evinced by the few checks on treatment fidelity indicate the absence of scientific foundation for much of the psychotherapy currently used with PTSD. This situation is particularly disturbing because millions of people suffer from this disorder. In addition, it is often stated within the VA system that more Vietnam veterans have committed suicide since Vietnam than died in the war. A recent manual on PTSD issued by the VA National Centers quotes a lifelong prevalence of symptoms for many veterans, and the need for more research on the methods being used.

State of EMDR Research

At this point, there are more positive controlled studies on EMDR than any other method used in the treatment of trauma. Controlled studies have been done with combat veterans, sexual abuse victims, and natural disaster victims. These seven controlled studies have been presented at major psychological conferences and have been submitted for publication (see "Efficacy of EMDR" report in enclosed packet). Unfortunately, because of the lag time between journal submission and publication, it will be two years before they appear in print.

One study that has received a great deal of media coverage is that of Pitman, Orr, Altman, Longpre, Poire, and Lasko (1993) at the Manchester VA. This study has been erroneously reported as having indicated that placebo effects are responsible for EMDR outcomes. In actuality, Pitman et al. compared EMDR with eye movements to the same EMDR procedure with the eye movements replaced by requiring subjects to fixate a spot on the wall, and handtap rhythmically, while the researcher waved a finger in front of the subject's eyes. In other words, EMDR was compared to itself, with the obvious characteristics of the eye movements (forced fixation, rhythmical stimulation, visual stimulation) used in both conditions. The interpretation of this study can only be that other methods of stimulation can also cause EMDR effects, a fact already known and used clinically for some time. In addition, the checks of treatment fidelity of this study proved to be very low, with a positive correlation between how well the procedure was performed and the magnitude of treatment effects.

Another study, by Wilson, Covi, Foster, and Silver (1993) tested an outpatient PTSD population in conditions comparing EMDR with eye movement, handtapping alone, and no movement. The treatment effects, including physiological measures, revealed a one-session desensitization effect for the eye movement group only. A recent 1993 study by Boudewyns et al. (mentioned earlier in this article) done at the VA in Augusta, Georgia, has also shown a positive treatment effect comparing a condition of EMDR to the group

therapy traditionally used throughout the VA system. In sum, the state of EMDR research far surpasses that of any other method presently used in the treatment of PTSD. (A list of research is included in the Network packet.)

Future of EMDR

I have recently completed an EMDR textbook to be used in the universities. It is due out in March, 1995, and will be published by Guilford. As mentioned in the last Newsletter, we would appreciate input regarding future training practices. The EMDR Network, as a separate professional organization, should begin establishing guidelines for independent trainings and eligibility for membership once the book is released. An EPIC task force has been established, and anyone with experience or background in the professional and ethical guidelines used by comparable organizations please consider giving input. Curt Rouanzoin and Joceyln Shiromoto co-chaired a meeting that took place at the September Northern California Network meeting. Please drop a note to the office indicating interest and you will be contacted.

Please look very carefully at the research articles included with this Newsletter. Once again, it points up the crying need for practical guidelines for publishable research. Two of the studies were conducted by clinicians untrained in EMDR. Another study was conducted by psychology interns who took only the Level I and who did not practice on clients in order to establish any comfort. They tested the method on chronic combat veterans using only two sessions and global psychometrics. They also received a fidelity check and were informed that they were not using EMDR well enough to resolve the problems. The publication of these studies points up the lack of validity and reliability that clinicians have come to expect in clinical outcome research. As a profession, we must start demanding higher caliber investigations. No one study decides the fate of a method, but the principles underlying the selection of publishable research define the scientific bases, or lack of objective standards throughout our profession.

Additional research is presently being conducted, which will almost certainly make EMDR the most highly researched method in the history of psychotherapy. It is to be hoped that researchers and academicians will soon catch up to the widespread and consistent observations of clinicians of the effectiveness of EMDR. Quality research will also assist us in further refining the methodology. We need to be vocal regarding the need for high quality and objective standards. Neither science, nor clients, are served by anything less.

References

Boudewyns, P.A., Hyer, L.A., Perlame, L, Touze, J., & Kiel, A. (1994, August) Eye movement desensitization and reprocessing. Paper presented at the annual conference of the American Psychological Association, Los Angeles, CA..

Grainger, R. L., Levin, C., Allen-Byrd, L. & Fulcher, G. (1994, Aug.). Treatment project to evaluate the efficacy of eye movement desensitization and reprocessing (EMDR) for survivors of a recent disaster. Presented at the 1994 annual conference of the American Psychological Association, Los Angeles, CA.

Lipke, H., (1994, Aug.). A survey of EMDR-trained practitioners. Paper presented at the 1994 annual conference of the American Psychological Association, Los Angeles, CA

Lipsey, M.W. & Wilson, D.B. (1993, Dec.). The efficacy of psychological, educational, and behavioral treatment: Confirmation from meta-analysis. American Psychologist, 48, 12, pp. 1181-1209.

Pitman, R. K., Orr, S. P., Altman, B., Longpre, R. E., Poire, R.E., & Lasko, N. B. (1993, May). A controlled study of EMDR Treatment for Post-Traumatic Stress Disorder. Paper presented at the American Psychiatric Association Annual Meeting, Washington, D.C.

Solomon, S.D., Gerrity, E. T.,& Muff, A. M. (1992). Efficacy of treatments for post traumatic stress disorder. Journal of the American Medical Association, 268, 633-638.

Wilson, D., Covi, W., Foster, S., & Silver, S.M. (1993, April). Eye movement desensitization and reprocessing and ANS correlates in the treatment of PTSD. Paper presented at the California Psychological Association Annual Convention, San Francisco.

Wilson, S. A., Tinker, R. H. and Becker, L.A. (1994, Aug.). Eye movement desensitization and reprocessing (EMDR) method in treatment of traumatic memories. Paper presented at the 1994 annual convention of the American Psychological Association, Los Angeles, CA.

TIDBITS

Jesse Rappaport, LCSW
Eugene, Oregon

I have observed a pattern of mild reluctance or hesitant consent to undergo further EMDR sessions in clients who have had numerous prior sessions which were positive and successful. This hesitancy may stem from association of EMDR with trauma recall.

An approach to mitigating the potential for EMDR becoming a stimulus for negative associations is as follows:

During introduction of EMDR, and intermittently to begin later sessions, I will ask clients for their associational cues (Yvonne Dolan usage) for comfort, safety, and security; i.e., a

beach in Mexico, home in bed with their pillow and teddy bear, etc. I will then "install" these cues using EMDR. This serves to anchor these positive associations and create a linkage of comfort and security with EMDR.

1995 International EMDR Conference
June 3-5, 1995
Santa Monica, CA

Call for Conference Proposals

Proposals are being accepted for the 1995 EMDR International Conference.

Please submit a CV and topic proposal with a 250 word abstract to the EMDR office. Presentations may be 90 minutes or 3 hours. Submit by January 15, 1995.

Call for Conference Research Papers

Dwight Goodwin, Ph.D., will coordinate the selection of research presentations for the 1995 EMDR Conference. Please send a proposal that includes a CV and a 250 word abstract by January 15, 1995, on any of the following:

1. Reports of formal controlled research investigations.
2. Case series with objective assessment suggesting protocols for the treatment of specific disorders.
3. Theoretical papers providing an analysis of recent research.

Send to
EMDR INSTITUTE
P O Box 51010
Pacific Grove, CA 93950-6010

EMDR Network Newsletter 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 MUST 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.

PLEASE NOTE

When advertising in telephone directories, publications, or other media, list yourself as **EMDR TRAINED** not EMDR certified. *Presently there is no EMDR certification.*

EMDR Newsletter Staff

Editor: Lois Allen-Byrd, Ph.D.
Publisher: Arnold J. Popky, M.A.
Data Entry: Sharon Lucas

FROM THE EDITOR

The EMDR Newsletter is in its fourth 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.

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 Research/Training Institute

The EMDR Research/Training Center at MRI is looking for individuals who want to take part in two research projects; (1) Victims of natural disasters. (2) Smoking cessation. Any therapists who have clients interested in participating, please call *Cliff Levin, Ph.D. (415) 326-6465.*

Spiritual Insights

If you have clients who have reported experiencing spiritual openings or insights during or after EMDR sessions and would like to share these vignettes, please write up these cases and send them to: Laurel *Parnel, Ph.D. 22 Von Ct, Fairfax, CA 94930. (4125) 454-2084.*

Donate Time

I am a clinical Ph.D. student at the California School of Professional Psychology in San Diego. I am in need of recruiting EMDR therapists who are willing to donate 4 to 8 hours of their time to assist in running subjects for my research project. The subjects will include a non-clinical population, and the focus of treatment will be anxiety reduction. Therapists in the area of San Diego, Orange County, or City of Claremont can call me, Jonelle Sellers, collect at (714) 631-5514, or (714) 227-5606, if they are interested in the study. The research will begin in September.

Research Project?

If you are currently conducting an EMDR research project, please send information to the EMDR office stating the topic, name of principle investigator, and subject base. *EMDR INSTITUTE, INC., Pacific Grove, CA, 95060-6010.*

Fluent in a 2nd Language?

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

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.*

Addictions, Smoking, Weight

Several therapists have contacted me regarding success in the use of my smoking protocol with other addictions. This has confirmed results I notice with many of my clients with histories of abusing heroin, crack, methamphetamine, marijuana and even food. I would appreciate receiving feedback (success and failures) from those using the protocol. *Arnold J. Popky, MA, 17461 Pleasant View Ave., Monte Sereno, CA 95030.*

Babies

I would like to meet or correspond with others that have used EMDR and/or other body-mind therapies to remove traumatic sequelae in babies in their first year of life (e.g., birth trauma, suctioning, heelsticking [for blood tests] circumcision, etc.). I am also interested in any relevant book titles. *Sheryll Thomson, 1641 Hopkin St., Berkeley, CA 94707, (510) 525-8031.*

Published?

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

CALIFORNIA EMDR STUDY GROUPS

Norva Accornero, LCSW California Network Coordinator (408) 354-4048

CENTURY CITY/SANTA MONICA
Robert Goldblatt (213) 917-2277
Coordinating a new group 90067, 90401 zip area for West L.A.

CERRITOS/CENTRAL CITIES
Pauline Hume (213) 869-0055
Pat Sonnenburg (310) 924-7307
Coordinating a new group. Open

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

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

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

EAST BAY/OAKLAND
Hank Ormond (510) 832-2525
Meets one Friday a month. Call for time & day. Open

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

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

IRVINE
Charles Wilkerson (714) 543-8251
Lois Bregman (714) 262-3266
Meets 2nd Thursday of month. Primarily case discussion. Open. Call for directions.

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
1 Friday per month. 10am - 11:30am. Call for information.

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

NAPA
Marguerite McCorkle (707) 226-5056

NEVADA CITY/GRASS VALLEY
Judith Jones (916) 477-2857
Call for time. Open

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

PALO ALTO
Ferol Larsen (415) 326-6896
1st Wednesday 10am in MRI conference room. Case discussion.

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

RIVERSIDE/SAN BERNARDINO
Byron Perkins (909) 732-2142
Meets 3rd Friday of every month, 9:30am - 11:00am.

SACRAMENTO
Bea Favre, Psy.D. (916) 972-9408
Connie Sears (916) 483-6059
Meets third Friday of every month 1:00 - 3:00pm.
At 2740 Fulton Ave., Sacramento, CA 95821

SAN DIEGO
Jim Fox, MFCC (619) 260-0414
Meets second Friday of Each Month, 9:30am - 11:00am.

Arthur T. Horvath, Ph.D. (619) 445-0042
Call about meeting times and places.

Mary Anderson (619) 434-4422
Meets 2nd Friday of every month from 9:00 - 10:30am. Primarily case discussion. Call regarding availability.

Elizabeth Snyker (619) 942-6347
Meets 3rd Wednesday of every month, 9:00am - 10:30am.
191 Calle Magdelena St., Ste. 230, Encenitas, 92024.

SAN FRANCISCO
Sylvia Mills (415) 221-3030
Meets Friday, call for next date. Potluck dinner and case discussion. New members welcome.

Stan Yantis (415) 241-5601
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 CRUZ AREA
Linda Neider, MA, ATR, MFC-I (408) 475-2849
Meets every month on a Friday (Call for time) Case discussion.

SARATOGA/W. SAN JOSE
Dwight Goodwin (408) 241-0198
Meets alternate Fridays, 9:30am - 11:30am.

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. Case discussion, videos and "troubleshooting." Open

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

UKIAH
Garry A. Flint (707) 468-0418
Meets the last Friday of every month from 10am - 12noon at 101 W. Church St. #10. Open.

VENTURA
Sheila McHenry Worman, MFCC (805) 654-1840
Second Friday of each month, 3 - 5 pm. meetings are held at 2443-A Portola Road, please call for more information.

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

WOODLAND HILLS/NORTHRIDGE/WESTWOOD
Ron Doctor (818) 342-6370
Ginger Gilson (818) 342-6370
Seeking new members. Contact Ginger.

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