EMDRIA™
NEWSLETTER
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In This Issue

Message from the President: Making Strides

Daniel T. Merlis, M.S.W.

Notable Accomplishments

We have made great strides as an organization over the past few months. A network of EMDRIA™ Regional Coordinators is now in place in the United States. These individuals will be working with local members to develop continuing education training programs in EMDR. Many thanks to the hard work of Committee Chair Jocelyne Shiromoto and the other members of the Regional Coordinating Committee who laid the groundwork for what will be an important element of this professional association for many years to come. A listing of approved Regional Coordinators is published in this issue of *The Newsletter*.

Another significant stride forward has been taken by EMDRIA as we launch a certification process for EMDR clinicians. We will soon realize one of our principal objectives in establishing the association—the formulation of standards governing the certification of EMDR clinicians. You have been informed of the details of the application process in a separate letter and information will also be provided in this issue of the *The Newsletter*. Please understand that these are minimum standards designed to protect the interests of the public from exploitation by individuals who have not been trained in EMDR but choose to add "eye movement" to their version of psychotherapy, body work, spiritual growth work, etc. EMDRIA-approved training programs might elect to establish additional requirements for clinicians to be included on program referral lists or for other reasons. Many thanks to Curt Rouanzoin and the members of the Training and Standards Committee, Carol York, our Executive Director, and her staff and the EMDRIA Board of Directors for the hard work which has gone into this. This is a beginning for all of us and is certainly not the end of what will need to be a dynamic process over time involving people from all over the world.

Those individuals who have elected to meet criteria for the *EMDRIA Register* will note that they have qualified for Certification and will also benefit from reduced Certification application fees. There will be a requirement for continuing education in EMDR which can be met by participating in EMDRIA-approved workshops available through the EMDRIA Regional Meetings, the Annual

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From the International Scene

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It is the middle of winter and we on the East Coast of the United States are finally getting some real winter weather. It is cold but the sun has been out giving us the clear, crisp, cold days that are the best of winter.

Since the beginning of EMDRIA™ and my work with members outside of the United States, one of the people I have relied upon most is my friend and colleague, Dr. David Hart. A psychologist from Canada, David has been a vital part of the International Committee and the EMDR community as a whole. His contributions have been many and he brings clarity of thought, critical ability, and heart to every project that he has undertaken.

David spent the majority of his career as a psychologist at Memorial University of Newfoundland, where he was a professor for 34 years. Before retiring three years ago, he spent much of his time directing the M.Sc. Clinical Psychology program as well as teaching undergraduate courses in the psychology of abnormal behavior. During this time, he maintained a clinical practice and worked at a psychiatric hospital one day per week, before working at the psychiatric ward of a general hospital. He also taught at the Teaching Clinic of the University's Psychology Department. David's areas of expertise are with anxiety problems such as trauma, panic, obsessive-compulsive disorders, social anxiety, and weight.

David recounts that his interest in EMDR began when he read Francine Shapiro's 1989 paper and then attended a variety of sessions on EMDR at AABT. He trained with the EMDR Institute and did his Level I and Level II trainings in 1992. While attending the EMDR 1993 Conference the following year, he was an active member in the discussions concerning international membership and was inspired to create a Canadian EMDR Association. He mailed his proposal to the 58 Canadians who had taken EMDR training, resulting in 27 members from the Atlantic to the Pacific coasts of Canada. This group formed an Executive Committee of five from each province and they have led the EMDR Association of Canada, otherwise known as EMDRAC, to its present position as an incorporated organization with more than 200 members. At their first official Annual General Meeting, the Executive Committee was elected as the Board of Directors and David was asked to continue as President and Chairman of the Board.

David has also served as the Editor of the *EMDRAC/EMDRIA Newsletter* for the past two years. He compiled the *EMDRAC Directory*, circulated to its members by floppy disk and, through his expanding wizardry with the computer and the Internet, created an e-mail discussion group for EMDRAC members and a separate forum for the International Committee, thanks to the generosity of his Newfoundland University Department.

David has enjoyed his recent years of retirement by engaging in many of the activities he loves best. He moved from the east to the west, now calling British Columbia home. He has a love of sailing and enjoys racing his Laser, although over the past two decades he has been involved more often officiating as a judge of sailing competitions. He is an avid sportsman and takes great pleasure in cross-country skiing and running.

Music has an important place in David's life and he is a devotee of opera and chamber music. Travel is also important to David and he is often off on an adventure to Europe, China, or elsewhere in Canada with his partner, Linda. A new love in his life since he moved west is learning about the culture of the North American First Nations peoples.

Retirement has given David the time to devote to a new area of interest in psychology concerning the emotional effects of disasters. He believes "there is much to be learned and important lessons for the management of disaster relief, for example, that often the major source of chronic stress problems is the strain caused by the relief management itself, by the bureaucracy."

We are lucky to have David as a member of our International Committee and our EMDR international community. I would like to publicly thank him for all of the time, energy, and effort he has poured into both EMDRAC and EMDRIA.

News from Around the World

- **Argentina:** Dr. Susana Nofal de Tagliavini recently reported on her work with The Argentine Anxiety Disorder Association. Last year, she indicated that she was the only speaker to deliver a presentation about EMDR, while this year five colleagues spoke

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Regional Meeting Coordinating Committee Report

Jocelyne Shiromoto, MSW, LCSW

Approved Regional Meetings

We are pleased to report that, to this point, 28 members have come forward and signed an agreement with EMDRIA™ to coordinate Regional Meetings. In addition, twenty-five to 30 members are still evaluating their ability and/or decision to be Regional Coordinators and thus have not yet submitted signed agreements. As you can see, the process of establishing these meetings continues to evolve. If anyone remains interested in becoming a Coordinator, please notify me as soon as possible.

We would like to officially welcome the six EMDRIA Regional Meetings in Greater Baltimore-Washington, Colorado, Michigan, Southern Nevada, Long Island, and St. Louis. (Information on the six currently approved EMDRIA Regional Meetings is provided below.) At this time, these Coordinators/teams are prepared to activate the meetings under the auspices of EMDRIA. The rest of the 28 members continue to organize themselves and their teams as this report is being written and, by the time this issue of *The Newsletter* is delivered to readers, there will be additional meetings ready to go. We will post new meetings on the EMDRIA web site (www.emdria.org), so a current listing can be available to you without waiting for the next edition of *The Newsletter* to determine whether your area has established a Regional Meeting.

Availability of EMDRIA Credits

Some members have inquired whether EMDRIA Credits will be available at Regional Meetings. Since these meetings will vary in content and size, the availability of credits for a given Regional Meeting will depend on whether the respective Coordinator decides to apply with the EMDRIA office to receive EMDRIA credits and whether the application is approved. Please communicate with the appropriate Contact Person listed below to determine whether EMDRIA Credits are available for your Regional Meeting.

Feedback on Meetings

For those who are already Coordinators or members of teams, we welcome feedback about your meetings. In the future, the *The Newsletter* may include brief information about different speakers, presentations, and activities provided at existing meetings to help new members understand the support services available through Regional Meetings. If you wish to provide this kind of information, please fax or e-mail the information to Jocelyne Shiromoto.

As always, if you have any questions, please contact any EMDRIA Regional Coordinating Committee Member listed below (preferably by e-mail). Until next time . . .

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THE HEALTH CARE COMMITTEE NEEDS YOU!

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

Contacts with the MCO world and Committee Members with experience working in the MCO world have clearly indicated that we must make direct presentations to managed care decision-makers. One of our Committee Members is drafting a protocol to approach, meet, and persuade managed care organizations to accept EMDR as a treatment component.

Anyone who would like to participate in the process is invited to e-mail the Chair of the Health Care Committee:

Mark Dworkin, CSW, LCSW
mdwork5144@aol.com

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

Your Comments about This Project Are Welcomed and Encouraged!

(Regional Coordinating Committee - Continued from page 3)

EMDRIA Regional Meetings

Colorado

Colorado EMDRIA Regional Meeting
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Missouri

St. Louis EMDRIA Regional Meeting
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Nevada

Nevada EMDRIA Regional Meeting
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on different topics related to EMDR: Graciela Rodriguez gave a presentation entitled *EMDR Psychotherapy in Different Cultures*, M. Esther Panizo reported on *Family and EMDR*; Liliana Orsi delivered a talk on *Family and Motor Vehicle Trauma*; Pablo Wizenberg presented *Sex and Performance Anxiety*; and Susana spoke on *EMDR and PTSD*. Susana noted that there were 1,000 participants at the conference and the presentations on EMDR were a great success.

Last March, Susana gave a presentation about EMDR at a Congress for the Argentine Psychiatric Association, with 3,000 in attendance. Susana and Liliana Orsi will be presenting a paper on Trauma and EMDR in October 1999.

- **Bangladesh:** The following is from a letter from Frances R. Yoeli following her trip to Bangladesh: *"I have returned from my trip to Bangladesh and can only say it was a phenomenal experience—I worked with a team of EMDR professionals who not only cooperated with each other, but complimented each other and complemented each other. We worked with people who truly cared about what they were learning in a country suffering the aftermath of an horrendous holocaust in 1971, which over the course of three months cost three million lives. Not only did these people survive their holocaust but they survive year in and year out the pangs and pains of annual floods and other natural disasters accompanied by loss of both worldly goods and life.*

  The city of Dhaka never stops moving, the air is polluted with more grime than Los Angeles and New York combined with London and Tokyo, and yet the people smile, are polite and warm and friendly. They don't know what a green dollar is and aren't interested in it—they want to see the people and become a full partner in the modern world. These are a people who want to live their lives to the fullest and work in that direction. The sincerity of the Bangladeshi professionals can only be described as inspiring.

  As I try to write my experiences up, I am stumped for a way to describe an inner

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ICISF to Hold Fifth World Congress

The International Critical Incident Stress Foundation will hold its Fifth World Congress on Stress, Trauma and Coping in the Emergency Services Professions on April 21-25, 1999 in Baltimore, Maryland at the Omni Inner Harbor Hotel. The theme for this event, which marks the tenth (diamond) anniversary of ICISF, will be "Celebrating the Many Facets of Crisis and Disaster Management." Pre-Congress workshops will be offered on April 21 and April 22, with the Congress officially opening on Friday, April 23, 1999.

The International Critical Incident Stress Foundation is a non-profit membership organization that assists individuals and organizations in mitigating the impact of critical incident stress (traumatic stress). ICISF maintains a worldwide leadership role in developing and disseminating crisis intervention, stress education and recovery programs to all those affected by work-related stress, disasters and other traumatic events.

In addition to mass disasters, topics at the Fifth World Congress will include violence in schools and the workplace, terrorism, crisis and disaster in the airline industry; confidentiality and the law; the Media and CISM, CISM team program development, military trauma, crisis with children and families, innovative therapies for psychological trauma, Chaplain services, grief, and research on traumatic stress, disaster and CISM.

To receive additional information, please contact ICISF at 10176 Baltimore National Pike, Unit 201, Ellicott City, MD 21042, call (410)750-9600, or fax (410)750-9601. You may also visit the ICISF web site at www.icisf.org or send e-mail to Shelley Cohen, Fifth World Congress Coordinator, at wcong5@icisf.org.

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experience with the actual facts—I never left the city of Dhaka, worked all but a day and a half, spent a total of two shopping hours and traveled the same street back and forth to work every morning. So what was it that happened there?. . . a fulfilling, enriching, enhancing EMDR training accompanied by love, trust and deep caring."

- **Brazil:** Graciela Rodriguez will be in Brazil in January and will provide a training in Rio de Janeiro.
- **Europe:** Following in the steps of the European Union, the countries in Europe have joined to form EMDRAE, the EMDR Association of Europe. EMDRAE will be applying to be a member of EMDRIA as soon as possible. They will be developing a center from which they will conduct business and hope to present non-profit workshops like the one in preparation for Istanbul at ESTSS next fall.
- **Germany:** Ute Hofmann has agreed to undertake the administrative aspects of the EMDR-Institute Germany. Under her able care, the German group is updating their data banks for their seminars. EMDR is in demand in Germany. They are conducting a training in February that is full, and they have a waiting list of 35 with new requests daily for applications to be trained in EMDR.
- **Honduras:** Sandra Stevenson reports that she traveled to the Honduras for a period of two weeks this past December to provide direct clinical services to survivors and relief workers after the destruction of Hurricane Mitch. EMDR provided impressive relief to approximately 40 individuals between eight and 58 years old. In addition to working in a shelter, she worked with a medical brigade led by Juan Almendares, M.D., an attendee of Dr. Shapiro's workshops in the United States. Dr. Almendares invited Sandra to lecture informally on EMDR to his team of physicians, psychologists, nurses, and social workers. These professionals work predominantly with torture survivors and prison inmates in Honduras and were excited by the healing potential of EMDR. Sandra noted that Dr. Almendares received the top Honduran honors for his accomplishments in human rights during the 50th Anniversary of the Bill of Human Rights. He has requested EMDR training for his treatment team; EMDRIA and HAP Committee Representatives are helping to make this happen.
- **Poland:** Barbara Anderson, an EMDR Facilitator from Florida, has had a desire to introduce EMDR to Poland from the time she learned to use this methodology. Of Polish descent, Barbara is currently organizing the first Polish training in Warsaw during the month of April 1999.
- **Spain:** Graciela Rodriguez will be in Spain where she will train mental health workers in Barcelona and Santander.

Please continue to send the news of your work and accomplishments to me at marluber@aol.com.

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(Message from the President - Continued from page 1)

EMDRIA Conference, or through commercial training programs. We expect there will be many options available to EMDRIA members.

Your Vote Lends Support

I want to address a matter of enormous importance to us as an organization—the upcoming election of Board Members and Officers. I ask each of you to make the effort to vote. If you do nothing more for the organization than that, you will have helped all of us. We are required by our by-laws to receive votes from at least 51 percent of the membership for the results of an election to be valid. This is higher than most professional associations or societies and has been difficult for us to achieve in the past. Last year, we had to extend the voting an additional two months to secure the needed number of votes. We will be seeking a by-laws amendment which will reduce the percentage number of members required for a valid election but even if this amendment is approved by the membership, we will need your vote each year.

Please be of service to your Association to this degree. We thank each and every one of you for your gracious support.

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Coordinating EMDR and Psychopharmacologic Treatment

Myron D. Brenner. M.D.

Coordinating psychopharmacologic treatment with psychotherapeutic treatment sometimes presents a challenge. Events may arise that the psychotherapist and the prescribing psychiatrist do not expect.

When psychotherapy is successful in resolving the underlying process that are resulting in a patient's symptoms, the need for psychotropic medication is often reduced or eliminated. Since EMDR can bring about resolution of basic problems much earlier in treatment and more suddenly than is common with conventional therapies, both the therapist and the psychiatrist may be surprised by the way in which a rapid change in the in the need for the medication is manifested. Following are cases that illustrate some of the issues that combined EMDR and pscyhopharmacologic treatment may entail.

Case Study: Treatment of PTSD

For some time, my treatment of a Vietnam vet was limited by his work schedule to sporadic supportive psychotherapy sessions and antidepressant medication. He had achieved an impressive degree of recovery without treatment, from a moderately severe PTSD, but still had significant problems even on medication, including occasional rage outbursts while driving, and an inability to give up the ego dystonic role of protective squad leader, for the surviving members of his platoon. He wanted badly to be off his medication, but whenever we reduced it, his depressive symptoms returned.

Eventually, I was able to schedule an EMDR session, and it appeared that it produced some movement. The VoC for the belief that "other people's problems are their own" went from 2 to 5. When I next saw him, he reported a number of positive changes in his functioning. He had been surprisingly open in speaking about the meaning of his war experience at a reunion of high school classmates. But he also reported problems with memory, language, and libido since the EMDR session. I considered the possibility that the session had somehow resulted in a problematic psychological state involving these symptoms. However, I thought it far more likely that as a result of the EMDR, his depression and anxiety had been reduced so much, that the dosage of medication he had previously needed and tolerated had become excessive, and that it was now producing side effects. I dropped the dosage and, as hoped, these side effects resolved.

Though I was familiar with this phenomenon with antidepressant medication, I was completely unprepared for what occurred recently with two patients on medication for ADHD. One was a man who had been severely burned when he was two. A few years ago, we had attempted EMDR, utilizing eye movements within 45-minute sessions, but were unable to achieve results and stopped utilizing EMDR within our sessions.

Recently, I began a series of 90-minute EMDR sessions utilizing the TheraTapper for the patient's persisting dissociative and anxious states. These sessions were productive, with SUD ratings usually dropping to 0 or 1, on issues such as feeling panicky when isolated and going numb when staring intently at something.

After one such EMDR session utilizing tapping, the patient reported a clarity of thought and an ease of speech that were rare for him. He felt that these improvements resulted from a state of calm that seemed to come from the physical experience of the tapping. To help assess what was going on, I had the Test of Variables of Attention, a computerized continuous performance task, administered while the patient was on his usual medication. The T.O.V.A. is a well-normed instrument giving measures of inattention, impulsivity, reaction time, and reaction time variability. A week later the test was administered again, also on medication but after twenty minutes of the use of the tapper in the waiting room, while meditating. The test showed a significant reduction in one of the neurophysiologic measures of ADHD following the period of alternating lateral stimulation, compared with the first testing.

Four days later, the patient reported that he had gone off his Ritalin. In the past, when he felt that he did not have much need for his medication, he found that unless he reduced the dosage or stopped it entirely, the prescribed dosage actually impaired his functioning. These periods in which he reduced or eliminated his dosage were typically less than a day in length. Now, following the EMDR, he was doing fine without the Ritalin, for four entire days. I had him do twenty minutes of tapping in the session, accompanied by informal supportive discussion of these experiences, administered the test a third time, and found that his functioning was better still. Specifically, the standard score for the response time variability, often the T.O.V.A.'s most sensitive indicator of ADHD in adults, went from 105 to 114 to 119, a substantial increase.

Case Study: Treatment of Anxiety Disorder

The following week, another patient whose psychotherapy centered on anxiety disorder, reported

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(Psychopharmacologic Treatment - Continued from page 7)
somewhat similar events. A month previous, EMDR sessions utilizing the TheraTapper had been particularly deep subjectively and effective in bringing about changes in her dealings with family members. Around that time, she noticed that the medication she had been taking for her ADHD seemed to be making her foggy.

She went off her medication for a day, as if by oversight, and was surprised that she did not experience "the crash" she always felt when it was interrupted. She felt better without it, and her functioning in her work had improved somewhat. Previously, her medication had been essential to maintain a high level of functioning. Following the potent EMDR sessions, it was as if the medication had become unnecessary, and was even interfering to some extent.

Without having just seen and objectively measured something similar in my other patient, I would have had a far more difficult time assessing what had happened. Although it has not yet been feasible to administer the T.O.V.A. to this patient, needless to say, I am following developments in these two patients closely.

Conclusions

Improvement in the neurophysiology of ADHD following EMDR would fit well with one of the theoretical models of the disorder that involves dyscoordination of the hemispheres. I am not aware of this phenomenon ever having been observed and would be very interested to hear from EMDR practitioners about similar events.

The sudden reduction in the need for antidepressant medication in the first patient discussed above is easier to relate to familiar clinical experience. When doses are stepping upwards early in the course of the pharmacologic treatment of depression, it is generally understood by psychiatrists that, once a clearly positive response is achieved, increasing the dosage further is more likely to produce side effects than to yield any additional improvement in symptoms. My experience illustrates that side effects can result a dosage becoming higher than that needed to obtain benefits later in the course of treatment as well.

Some psychiatrists, especially those whose faith in psychotherapy tends to be weak, may not be familiar with this end of the same phenomenon. A psychiatrist who does not appreciate how fast EMDR can work may be unable to see that lowering the dose might help. Obviously, it is important for the psychiatrist prescribing for an EMDR patient to be conversant with the way EMDR operates or, at a minimum, to have a good working relationship with the psychotherapist.

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Resource-Focused EMDR: Integration of Ego State Therapy, Alternating Bilateral Stimulation, and Art Therapy

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I conceptualize EMDR as the process of linking the trauma from one part of the brain to a solution in another part of the brain to reach an adaptive resolution. The standard EMDR protocol proposes accomplishing this by focusing heavily on the trauma.

Most of my clients are adult survivors of childhood trauma and their tolerance of a trauma-focused protocol is often low. Consequently, I wondered if the same adaptive resolution could be accomplished by focusing primarily on the part of the brain holding the solution rather than the trauma. In that light, I recently began developing a resource-focused protocol, that borrows from Sandra Paulsen's (1994, 1995, & 1996) suggestions for integrating EMDR with ego state therapy and Andrew Leeds' (1997) protocol for resource development and resource installation (RD/RI).

This new protocol puts significant emphasis on developing and strengthening the felt sense of well-being connected to resource ego states *before* EMDR processing as well as the maintenance of the sense of well-being *during* EMDR processing. It involves using the clients' drawings of resource ego states and traumatized ego states (drawn with the dominant and non-dominant hand) as anchors for ego state processing, and as the focal points in eye movements (EMs).

In this protocol, traumatic material is elicited only when sufficient internal resources, represented by drawings, are displayed in front of the client. The intention of this approach is to minimize the risk of affect overwhelm and maximize the probability that the part of the brain holding the trauma will link to the part of the brain holding the solution.

In my experience, the resource-focused protocol accomplishes everything the trauma-

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EMDR as a Special Form of Ego State Psychotherapy

Part Two of Two Parts

Mark Lawrence, M.D.

EMDR from an Ego State Perspective

[*Note: Part I of this article (in the December 1998 issue of the EMDRIA™ Newsletter) developed an ego state theory of personality, psychopathology, and psychotherapy. In particular, the ego state bridge, ego state shift, and the internal dialogue techniques were described. We shall now review the highlights of the EMDR technique from the perspective of the ego state model described in Part I.*]

The ego state bridge and EMDR

The first step in doing an ego state bridge is to identify and amplify the problematic ego state. In EMDR, the patient is asked the following questions: What is the problem or symptom you want relief from? What image represents the problem to you? What cognition about yourself do you have associated with that image? What affect do you experience when you have that image and cognition? What body sensations do you have when you have that image and cognition?

Clearly, these questions are an attempt to elucidate several, although not all, of the components of an ego state in a very systematic fashion. The patient is asked to focus on each of these components sequentially, which will tend to amplify all of them, both separately and together. When the patient is asked to assign a numerical evaluation to the intensity of affect or cognition, that also tends to amplify those ego state components. When the patient is asked to bring all of these components together, i.e. the image, the cognition, the affect, and the sensation, he is in effect being asked to immerse himself in the ego state that holds all of those components. This is the basis for developing an ego state bridge.

Then the EMDR processing begins, with the patient being invited to let thoughts, images, body sensations, or feelings unfold spontaneously, while simultaneously attending to the left/right alternations (eye movement, sound, or touch) presented to him. Images, thoughts, feelings and memories do unfold, eventually leading, with repeated sets of processing, to uncovering traumatic memories and/or to reduced anxiety or affect associated with the presenting experience. This is the desensitization phase of the EMDR therapy. The unfolding of these associational

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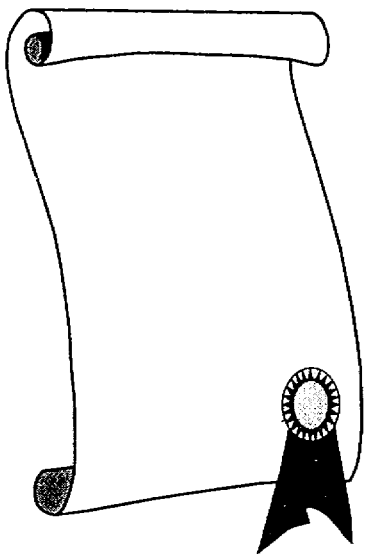

EMDRIA Credit Provider Packets Now Available!

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

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

CALL FOR PAPERS

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Please send your inquiries or submissions to:

Ricky Greenwald, Psy.D.
rickygr@childtrauma.com
(e-mail is preferred)
-or-
P.O. Box 3907, Lihue, HI 96766

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focused protocol does (i.e,. desensitization of traumatic material, decrease in believability of the negative cognition, increase in believability of the positive cognition, and clearing of disturbing body sensations). Clients who have experienced both trauma-focused and resource-focused EMDR report a significant preference for the resource-focused approach. Likewise, feedback from other EMDR therapists who have tried this has been very positive. In this article, I will touch on the component parts of this innovation before briefly describing the four-step method.

The Component Parts:

Each of the key components of the innovation presented here are well known in the field of psychotherapy, including: ego state therapy, alternating bilateral stimulation, imaginal split-screen technique, art therapy, and the significance of expression via the dominant and non-dominant hands.

Ego State Therapy: I am grateful for Mark Lawrence's two-part EMDRIA Newsletter article on "EMDR as a Special Form of Ego State Psychotherapy," which provides detailed historical and theoretical information on ego state therapy. It is highly recommended for readers unfamiliar with ego state therapy. (See Part II in this issue.) In most basic terms, ego states are specialized neural networks that hold specific packages of information related to behavior, affect, sensations, and knowledge of our life experiences (Braun, 1988). For example, an ego state (neural network) specialized for interacting with intimidating authority figures will contain very different information than an ego state specialized for playing with small children. Ego state therapy involves therapist-facilitated integration of needy ego states with resource states and mediation of conflicts between ego states. It promotes communication, cooperation, and mutual appreciation within the family of parts, increasing their ability to work as a democratic team.

Alternating bilateral stimulation (ABS): EMDR therapists are no strangers to ABS. Whether by eye movements (EMs), audio stimulation, or tactile stimulation, ABS appears to play a critical role in the efficacy of EMDR therapy. While it remains unclear how it facilitates changes in the brain, it does seem to accelerate the brain's information processing, and to help facilitate the neural network connections needed for psychological healing.

Imaginal split-screen technique: As early as 1991, Ron Martinez described using this technique with EMDR, which involves having a client hold a mental image of an internal resource alongside a mental image representing the dysfunctional material, like two photos side by side. By adding EMs, he found the positive image strengthened and the negative image became less relevant. This is a helpful technique but some clients have trouble holding the mental images. Expanding on this concept, I began asking clients draw their images (ego states), as a way to make the "split screen" processing more visual and hopefully more powerful.

Art therapy: For years, therapists have been using art to better understand their clients' perspectives and to promote healing (Oster & Gould, 1987). A picture can often convey a wealth of information that cannot easily be obtained verbally. In my experience, when clients face their drawings during EMDR processing, they stay better connected to the associated feelings, and perhaps consequently reach an adaptive resolution faster. (Basic training in art therapy principles is

recommended for therapists planning to use this approach.)

Significance of artistic expression via the dominant and non-dominant hand: According to Carlson (1992), the right hemisphere is important for the recognition and expression of emotion and specializes in global thinking, whereas the left hemisphere of the brain is the language center and specializes in linear thinking. Research by Drake (1984) suggests that the right hemisphere processes information regarding negative affect, whereas the left hemisphere processes positive affect. Capacchione (1988) explains that whether a person is right-handed or left-handed, the dominant hand always connects to the hemisphere with the language center.

She advocates writing and drawing with the non-dominant hand to facilitate therapeutic connection to the right hemisphere and creative expression of inner child ego states. She also encourages resolving internal conflicts by generating dialogue between right and left brain by writing with alternating left and right hands. All of this suggests that unresolved trauma is stored in the right hemisphere, connected to the non-dominant hand, and that resources are stored in the left hemisphere, connected to the dominant hand.

Resource-Focused EMDR: The Four-Step Method

Step One: Ego Strength Assessment and Enhancement:

I'll ask a client to draw a picture that represents for them a positive aspect of self (a resource ego state). For example, I might ask something like: "Draw a picture that represents the part of you that knows you are a worthwhile person" or "draw a picture that represents the part of you that knows how to nurture" or "draw a picture which represents the part of you that is confident." I call this a "resource picture/part," (RP) and I ask clients to draw it with their dominant hand.

I like to ask how their body feels while they are drawing or looking at their picture. If they are connecting to a truly healthy resource ego state, they will enjoy a felt sense of well-being connected to the picture. I will display the RP on a felt board directly in front of the client and discuss the drawing. I'll ask about the meaning and the significance to better understand how this resource can be used to facilitate growth. Some pictures are concrete and logically represent the resource, while some pictures are metaphorical and abstract. Much can be learned about a person's ego strength from their art. Hearing the client's explanation of the picture's meaning is as important as the picture itself.

After it becomes clear that the drawing represents a true resource, I install it. Since the RP represents an ego state, there will be associated memories, positive cognitions (PC), and positive body sensations to focus on during the installation. If I have more than one RP, I may display them at opposite ends of my board and ask for short sets of EMs between the drawings.

As resources strengthen, clients may report that the drawn images need to be modified or changed. For example, a resource drawn lightly at first may need to be reworked with bolder colors; or an ego state depicted as a head only may need the body added. This reworking is encouraged and is seen as evidence of positive ego state enhancement.

If the installation of an RP produces no positive change or makes the client feel worse, then I do not consider it a resource and I will save that drawing for Step Two. When a client demonstrates insufficient ego strength, I will focus considerable session time on building and strengthening ego resources. Andrew Leed's (1997) RD/RI techniques apply here, including investigating and enhancing many aspects of the

(Continued on page 12)

Correction to Conference Brochure

Please note a correction to the *1999 Annual Conference Brochure* on pages 4 and 5 (Course Objectives), as Session 3 and Session 16 were transposed:

- Session 3 should be listed as "EMDR and Sex Therapy" presented by Linda Levine, LCSW
- Session 16 should be "EMDR in the Treatment of Adults Abused as Children" presented by Laurel Parnell, Ph.D.

We apologize for the confusion and any resulting inconvenience.

Look for changes and updates on our website at www.emdria.org.

(Resource-Focused EMDR - Continued from page 11)
client's experience and personality that offer ego strength. As resources are identified and/or developed, I ask the client to put the resource(s) in picture form and install them as described above.

Step Two: Ego State Processing and Integration

I begin this step after a client has drawn and installed one or more RPs and has demonstrated sufficient ego strength in the process to tolerate disturbing affect. At this point, I ask for a "deficiency picture/part" (DP) to represent a deficient or traumatized ego state, drawn with the non-dominant hand. I may ask for drawings tailored to a specific issue, or I may ask for a global DP. For example, for a specific DP I might ask something like: "Draw a picture that represents the part of you that believes you must stay in this abusive job" or "draw a picture that represents the part of you that cannot tolerate work conflict." For a global DP, I might ask something like: "Draw a picture which represents the part of you that believes you are worthless" or "draw a picture which represents the part of you that believes you are inevitably bad." I ask for the SUD level, emotions, and body sensations that the DP evokes.

I then display an RP (from Step One) and the DP at opposite ends of my felt board, in an order preferred by the client (e.g., RP on the right, DP on the left). To process, I will ask the client to move his or her eyes back and forth between the two pictures, pacing EMs to a preferred TheraTapper pulse rate. (I often keep the TheraTapper on constantly, or as long as processing is flowing smoothly, while requesting EMs in sets—set lengths determined by the client's processing.)

The ABS appears to facilitate the gradual integration of the two ego states represented in the pictures. For example, a client drew a DP of a young girl, named "Shame," with stooped posture and head hung. As EMs between the DP the RP (a courageous part) continued, my client reported seeing changes in this picture. She envisioned "Shame" standing up a little taller and, then later, holding her head a little higher. Eventually, she saw Shame standing tall, smiling, feeling strong and confident. At the end of the session, the client renamed the part "Hope" because it beautifully epitomized how she could rise out of deep despair.

Titrating the Disturbance and Unblocking Stalled Processing

If the client feels overwhelmed with affect at any point in the process or, if processing loops, I will remove the DP and have the client look only at the RP. With the TheraTapper providing constant ABS, we go directly into resource installation—which helps restore the feeling of well-being previously experienced with the RP. If necessary, I will ask "What other resources do you need now?" I will display and install all helpful RPs—I'll even return to Step One to get new ones if necessary. Once the client is sufficiently re-grounded, with an appropriate felt sense of the resource ego state(s), I will return to EMs between the RP and DP.

After this type of interweave, the client usually reports the DP is much less disturbing, and processing continues unblocked. Flexibility with displaying the pictures helps me to titrate the client disturbance to keep it within an ideal therapeutic range.

Using Internal Dialogue

I often find it helpful to invite a supportive dialogue between images in the RP and the DP to enhance integration. This supportive dialogue seems to hasten the linking of the deficient/traumatized ego state with resource ego states—as evidenced by gradual calming and releasing reported in the body throughout the process.

Here is an example of how this can work: The DP is a picture of the client as a small, scared boy in a room where he was often violated, dreading his perpetrator's imminent arrival. The RP is a picture of the client as a grown man, able to nurture and protect himself. The pictures are displayed at opposite ends of the felt board to facilitate wide EMs.

Therapist: "What does the adult in this picture most want to tell the child in that picture?"

Client (Adult Part): "One day this nightmare will be over and you'll be safe."

Therapist: "When the child hears this, what's his reaction?"

Client: "It calms him."

Therapist to child in picture: "What would you like to say to the adult in that picture?"

Client (Child Part): "I'm scared and there is no one I can tell about it. Mom and Dad will be mad at me if I tell them I'm scared."

Client (Adult Part to Child Part): "You have a right to be scared, and it's not your fault. It's awful that no one would listen to you then, but I'll listen to you now."

Client (Child Part): "Really? That's good to hear." (Client reports body releases tension.)

Therapist: "Think about that and resume EMs."

Parts sometimes report feeling threatened by each other and are resistant to integration. I have found it

essential to ask each part to consider and acknowledge their common interest of working to establish and preserve safety. I provide validation for each part's point of view, referring to the experiences that brought them into existence. Furthermore, I ask each part to consider the possibility that sharing information with the opposing part may actually increase the probability of each getting the safety they seek. When it is clear that the ice between the parts is melting, I enhance the integration process with ABS and a PC like "We can begin to work together as team, to promote safety." (Schmidt, 1998)

As with the EMDR trauma-focused protocol, the SUD level of the DP and the believability of the irrational belief diminish over time. Abreaction may or may not occur in the process. Curiously, even though traumas are not targeted directly, clients often report a significant drop in the SUD of associated traumas following integration of the DP ego state with RP ego states.

Step Three: Enhancing the Ego State Integration

When the SUD level on the DP is at or near zero, I may ask the client, or the client may volunteer, to draw a new picture to more accurately represent how they feel now. I suggest drawing it with the non-dominate hand to be sure this trauma channel is clear. The new picture should illustrate the degree of integration between the deficient/traumatized ego state and resource ego state. If healthy integration has occurred, I then pair and install the new picture with an appropriate PC of the client's choosing.

Using the above client as an example: The client reported imagining how the grown man part, if he had been the boy's father, would have protected the boy from ongoing violations by the perpetrator by making it safe for the boy to tell. The boy part began to understand that this sane adult is his caretaker now. As the DP SUD dropped, the child volunteered that he wanted to join the adult in his picture. The adult welcomed the boy into his safe home and the client reported feeling a great relief. I asked my client to draw a new picture to represent the ego state changes at this point. He drew a picture of himself as a boy in the room in which he had been violated, but now he was smiling—feeling comfortable and safe. I installed this new picture with the PC "I'm safe now and I can protect myself." The session ended with SUD 0 and wonderful body sensations.

Sometimes there is no need for a new picture because, when the DP SUD drops to 0, the meaning of the picture changes from something negative to something positive. I consider this a good sign and install the picture with the new meaning. For example: A client had drawn a bloody knife to represent her self-loathing part. After this part was integrated with other resource parts, she saw the bloody knife as an arrow pointing her in the direction of healing. The meaning had changed to: "sometimes pain precedes growth." The DP spontaneously became an RP and has been used successfully, as such, in subsequent sessions.

Step Four: Re-evaluation

As with the target trauma in standard EMDR, a single DP may be a node for many different associative channels. At the beginning of a session, I will display the prior

(Continued on page 25)

Deadline for Poster Submissions Extended to April 15, 1999

The deadline for poster submissions for the 1999 Annual EMDRIA Conference has been extended!

Submissions will now be accepted at the EMDRIA office until the April 15th receipt date. To make a poster submission, simply use the standard abstract submission format from the Conference, leaving out the exam questions and the time estimates for your learning objectives. We encourage poster submissions of the following types:

- single case designs
- reports from small (or large) research or evaluation studies
- case studies
- conceptual posters that present new models for thinking about/or using EMDR, and
- innovative assessment models/ instruments for use with EMDR.

Poster sessions are a wonderful way to present your ideas in a non-threatening format, and they promote informal dialogue among colleagues.

Please consider using the poster session format for your Conference proposals!

(Ego State Psychotherapy - Continued from page 9)

linkages is exactly what one would expect from the ego state model—with one exception. No specific effort is made to help the patient dissociate or minimize the anxiety that previously had contributed to the maintenance of the dissociative barriers among the various ego state components. Yet important associational connections do emerge, with or without intense affect.

Shapiro (1995) herself describes this process as accessing the neuro network where the problem resides. It could just as easily be described as accessing the biological infrastructure for the ego state with the presenting problem; *the ego state is the neuro network.* It is remarkable that EMDR appears to transcend the dissociative barriers that hypnotic techniques are sometimes unable to resolve.

The Ego State Shift and EMDR

After the desensitization is completed, *reprocessing* then begins in order to resolve the initial problem. The patient is asked to image the initial problematic scene (which is now anxiety free) and to think about a positive, desirable cognition, again while following the left/right alternations. After repeated sets of processing, the patient experiences the positive cognition as being highly valid *in the context of the original problematic image.*

The positive desired cognition is the cognitive component of a new ego state, which will resolve the initial difficulty that contributed to the maintenance of the dissociative barrier. When the positive cognition feels valid in the context of the original problematic situation, then a therapeutic ego state shift has occurred, and a new ego state with a positive cognition is now linked to the original image. This process is parallel to the ego state shift technique discussed above, except that just the cognitive component is addressed here, and the shift is facilitated through the left/right alternations, rather than through the imagistic process alone.

Inner Dialogue and EMDR

When there is no movement in the EMDR reprocessing (i.e., a therapeutic impasse or resistance), the *cognitive interweave technique* is introduced. In this process, the patient is invited to reflect on cognitions coming from a more adult perspective, i.e., addressing issues of guilt or blame; control and power; or hope and possibilities. While reflecting on one of these cognitions, the left/right processing continues. Several different cognitive interweaves may need to be introduced, but eventually a shift occurs.

The adult perspective from which the cognitive

interweave is introduced is another ego state—one not available to the patient at the time of the initial trauma. This other ego state can help the patient to let go of the traumatic affect. An integrative process occurs, and the previously isolated problematic ego state becomes connected through new neuronal associations to other ego states so that more options are available to the system.

This is the same integrative process which occurs during the internal dialoguing process described earlier. The cognitive interweave can be formulated in the following ego state terms: The therapeutic impasse requiring the cognitive interweave is caused by a covert "resistant" ego state which is opposed to allowing a therapeutic shift. This resistant ego state has a cognition driving its opposition, a blocking belief. The therapist, without directly identifying that covert, resistant ego state or its cognition, attempts to challenge and shift that ego state by systematically offering it cognitions from adult ego states which hold contrary cognitions. In effect, an implicit dialogue is occurring between the resistant ego state with its negative cognition and a more adult ego state with a positive cognition. The EMDR processing diminishes the dissociative barrier between the cognitive components of these two otherwise previously unconnected ego states. Although the dialogue is not explicit, the EMDR left/right alternations facilitates the integration of these previously unconnected ego states.

Although the EMDR cognitive interweave technique is very powerful, the technique can be improved further through this ego state perspective. The EMDR technique focuses solely on the cognitive component of the ego state system, and this component is certainly powerful and salient. But by broadening the concept to include all components of an ego state (an ego state interweave), affective, imagistic, and behavioral internal resources would be used as well. Further, by thinking of the therapeutic impasse as coming from a resistant protector ego state, the therapist could then use EMDR to amplify and explore that particular ego state in a way that is analogous to the processing of the original traumatized ego state. This strategy would open another therapeutic channel, freeing the therapist from having to guess at the appropriate cognitive or ego state interweave.

EMDR Innovations and Ego State Therapy

Many EMDR therapists have in fact developed a variety of techniques and strategies to expand the effectiveness of EMDR, particularly in the face of therapeutic impasses. Many of these techniques can be conceptualized from the ego state perspective, which will make it easier for the EMDR therapist to integrate these techniques into his or her therapeutic repertoire.

The technique of *resource installation* (Leeds and Korn, 1998) can be thought of as an ego state interweave. An integrator or resource ego state is connected with a vulnerable or frightened ego state through the EMDR processing. Even when the patient is apparently using an external resource, he or she is actually accessing an internal imagistic representation of it. These internal representations are also ego states within the patient's system, albeit underdeveloped or not well integrated with the vulnerable ego states.

By conceptualizing the resource as a preexisting ego state, already within the patient, the therapist is freer to invite the patient to discover the most appropriate resource for a specific problematic ego state. The patient is invited to image the problematic/traumatized ego state and is asked, "What needs to happen to give relief to that part?" The patient can usually identify what needs to happen and what ego state resources are necessary to facilitate the process. The patient can then play with the image accordingly, modifying it as necessary to achieve the desired outcome. At this point, EMDR installation can be done without fear of stimulating an adverse reaction. Once the image has unfolded successfully there is no danger of stimulating too much adverse affect with EMDR.

The integration of the resource ego state with the problematic ego state can be further reinforced by inviting the patient to take the ego state back in time (ego state bridge) to its first appearance and then installing the resource ego state after appropriate imaging. This process can be repeated for each of the major historical nodal points for that ego state.

Wildwind's (1998) technique of helping the patient "change" his/her childhood experience by imaging the childhood experiences/traumas as the patient would have liked it to have been can be understood in the same way as resource installation. The problematic/traumatized ego state is identified. That ego state is asked, "What needed to have happened to alleviate the pain?" The patient can then let that unfold imagisticly, and the new image can be installed with EMDR.

Parnell (1998) proposes the use of a variety of interweaves beyond the cognitive—educational, imagistic, affective, a wise being, "power" animals, etc. All of these interweaves can be thought of as resource or integrator ego states. But again, if the therapist understands that these ego states all reside within the patient, then he/she can invite the patient to discover the appropriate ego state as described above.

Grand (1998) uses the dynamic interweave or questioning interweave to elicit covert ego states by asking questions inspired by his understanding of the patient's psychodynamics. He then uses EMDR to install or amplify the response. By amplifying hidden ego states in a complex ego state system, he is then able to do indirect parts work to integrate the system.

(Continued on page 34)

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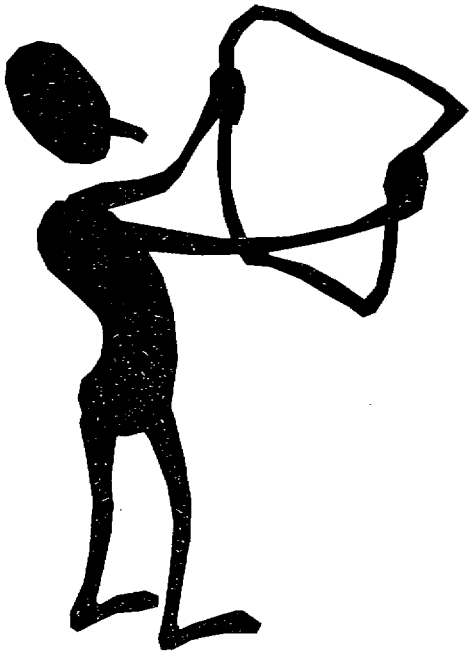
- During the lunch break on Saturday, there will be an opportunity for networking and for Special Interest Groups to meet. You will find more information on this in the Conference Program that you receive upon on-site registration.



Advertising Pullout Section

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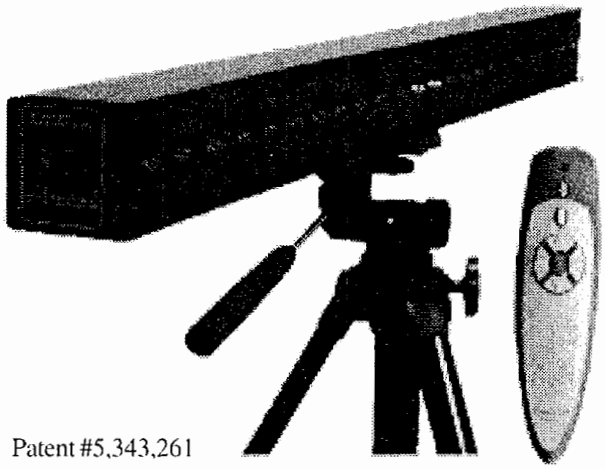

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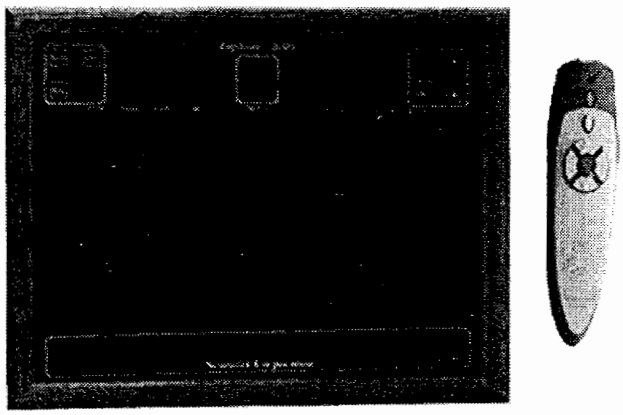

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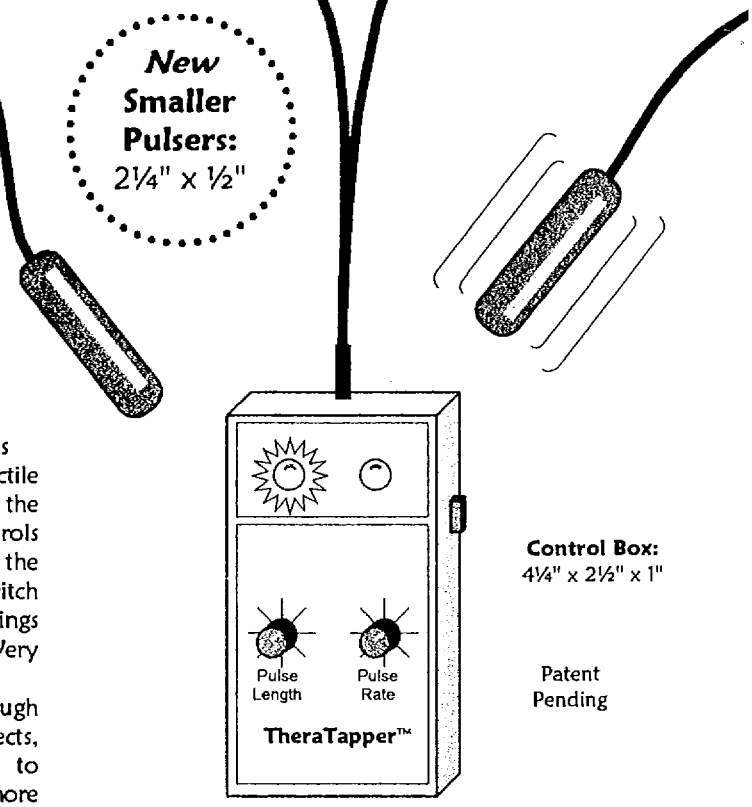

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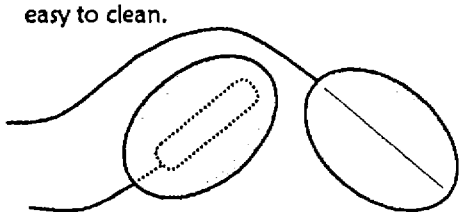

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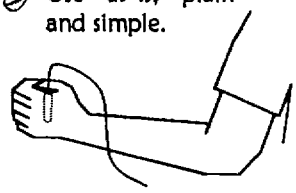
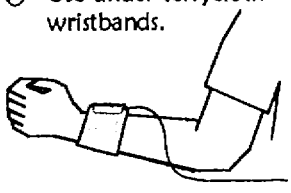
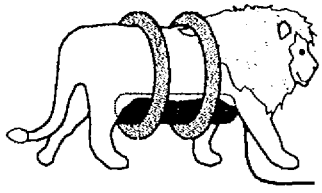


- Use under terrycloth wristbands.





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- **T**he pulsing units of our TheraTapper™ are completely and solidly encased, and cannot be opened by your clients. The imitation version has easily removable caps on both ends.
- **W**e use heavy-duty 6-foot cords to connect the pulsing units to our control box. The imitation version cords are so fragile and thin they come with a list of precautions for use.
- **T**he new TheraTapper™ pulsers are small, but still large enough to comfortably hold in the hands. Alternatively, they can be placed inside the 2 plastic coin purses that come with each purchase, for an excellent soft, cozy grip. The imitation's pulsers are so small they are difficult to use against the palms.

Our TheraTapper™ was the very first EMDR tactile stimulation device - invented in 1997. Since its conception we have had time to make improvements to both quality and features. We believe we have the best alternating bilateral tactile stimulation device you can buy - and we think you will too. We have already sold over 800 TheraTappers™ to satisfied customers around the world – so we must be doing something right! If you want the best for your clients – buy a TheraTapper™!

Upgrade Option

If you already own an *Original* TheraTapper™ and want the new features without buying a new one... consider an upgrade. To upgrade, simply fill out an order form and mail it to us with your *Original* TheraTapper™ and payment. We will replace the larger pulsing units with the small pulsers and return it to you ASAP.

New Carrying Case!

You can now buy an attractive hunter green canvas carrying case for your TheraTapper and accessories. It is 6" x 6" with an easy Velcro closure.

Special Offer: A $30 Value !

Expires 5/31/99

If you buy a New TheraTapper™ for $119 now, we will send you a freebie coupon for David Grand's Bio*Lateral* Sound Recordings. Your freebie coupon will entitle you to your choice of 2 Tapes or 1 CD.

For more information about these products see the BioLateral advertisement in this newsletter.

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TheraTapper™ Order Form

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❑ Facilitator ❑ Other:_____

Sales only to therapists trained by an EMDRIA-approved program.

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2/99 Prices subject to change without notice

BioLATERAL™ SOUND RECORDINGS: AN EFFECTIVE ALTERNATIVE TO EYE MOVEMENTS

Invented and Produced by
David Grand, RCSW, EMDR Facilitator

What Are Bio*Lateral*™ Sound Recordings?

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

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

How Were Bio*Lateral*™ Tapes Developed?

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

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

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

How Is Bio*Lateral*™ Used?

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

How Will My Client's Benefit from Bio*Lateral*™?

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

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

Introducing

Neuro Institute for Advanced Studies In Psychology

- Dedicated to providing quality education and specialized training to enhance professional skills in the practice of psychology.
- Emphasizing *Competence* and *Hands on Experience*
- Creating experiences and opportunities for expanding and improving private and group practices in psychology

The Neuro Institute for Advanced Studies in Psychology is the educational entity of the NeuroSports Lab in Scottsdale, AZ. The NeuroSports Lab is a unique facility focused on providing individuals, families, and organizations with integrative knowledge, desire, and skills necessary to create effective behaviors that produce positive results. The Neuro Institute provides both education and experience in advanced applications of EMDR with:

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Video Workshop

by Landry Wildwind, LCSW

Adapting EMDR with Depressed and Resistant Clients

Treating Depression and Resistance with Essential Experiences

A nurturing interweave protocol based on developmental & psychodynamic theory.
Taped at December, 1996 EMDR Institute Advanced Applications Training.
Includes Handout, Treatment Transcripts, Case Video.

1. Identify developmental gaps from symptoms, beliefs and treatment barriers.
2. Introduce the concept of resistance as an accommodation to an unlivable agreement.
3. Working with ego-states and state-specific learning, note openings for new experiences.
4. Design and install adequate parenting experiences using the most ecological intervention.
5. Adapt EMDR protocols to accommodate the limited affective capacities of depressed clients.
6. Use containers to effectively reduce risks and improve outcomes with ego-impaired clients who need to partialize treatment.

6 hours self-study CEU's available for MFCC, LCSW
This seminar meets the qualifications for continuing education credit for MFCCs and/or LCSWs as required by the California Board of Behavioral Sciences.
Continuing Education Provider # PCE 324

COST: $120, includes shipping and handling

About the Presenter

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

She was trained in EMDR in 1990, 1991 and 1992. She served as a facilitator from 1990 to 1995, and participated in trainer training for three years with the EMDR Institute. She gave her first EMDR International Conference presentation in 1993 on depression and resistance, with further Conference presentations in 1994, 1995 and 1998. The 1996 workshop video represents 6 years of development and experience in this specialty area.

Advanced Workshops in 1999

All-day workshops with practicum elements given in local areas.
March 12, 1999: Kansas City April 10, 1999: Columbus, Ohio
April 24, 1999: Minneapolis

Several workshops will be scheduled for Fall 1999 in the San Francisco Bay Area.
If you interested in these please provide us with your e-mail, fax or mailing information.

Other workshops, telephone consultations and consultation groups available on request.

To order your workshop package, or for more information:

Landry Wildwind, LCSW 510-236-2126, ext.1
109 Bayside Court, Richmond CA 94804
e-mail: landryvicki@earthlink.net

EMDR Institute, Inc

PO Box 51010, Pacific Grove, CA 93950
(831) 372-3900 Fax (831) 647-9881
email: inst@emdr.com http://www.emdr.com

1999 MARCH-JUNE SCHEDULES

Level I Trainings
Earn 17 CEU Credits

St. Paul, MN	March 19-21
Vancouver, BC	March 26-28
Austin, TX	April 23-25
Los Angeles, CA	April 23-25
Detroit, MI	April 30-May 2
Denver, CO	May 21-23
Memphis, TN	May 21-23
San Diego, CA	June 11-13
Chicago, IL	June 25-27

Level II Trainings
Earn 17 CEU Credits

Atlanta, GA	March 26-28
New York, NY	April 16-18
Phoenix, AZ	April 30-May 2
San Francisco, CA	May 14-16
Omaha, NE	May 14-16
Seattle, WA	June 11-13
Detroit, MI	June 25-27

Please contact the EMDR Institute for a complete training schedule.

1999 Advanced Vacation Courses
Designed for the EMDR Level II Trained Clinician

The vacation workshops are scheduled in the mornings. Afternoons and evenings are free to allow time to relax and explore the sights and recreational offerings in the local area.
Register Early!! The vacation courses are space limited!!

Crete, Greece-April 26-30

Case Consultation and Discussion
Francine Shapiro, Ph.D.

Using EMDR for Performance Enhancement in Career, the Creative and Performing Arts, and for test Anxiety
Sandra "Sam" Foster, Ph.D.

Using EMDR in the Treatment of Eating Disorders
Carol York, LMSW-ACP

EMDR Applications in the Treatment of Adult Survivors of Childhood Abuse and Neglect
Debbie Korn, Psy.D.

Cape Cod, MA-Aug. 23-27

Case Consultation and Discussion
Francine Shapiro, Ph.D.

Treating Panic, Phobia and Obsessive Compulsive Disorder with EMDR
Marcia Whisman, LSCW

EMDR with Children and Adolescents in a Family Context
Frances "Frankie" Klaff, Ph.D.

EMDR and Transpersonal Psychotherapy: Cultivating Conscious Contentment
Sheila Krystal, Ph.D.

Sea Ranch, CA-May 24-28 & Oct. 4-8

Personal and Clinical Strategies for Effective Treatment Outcomes
Francine Shapiro, Ph.D.
(space limited to 25 participants)

Visit the EMDR Institute website for information on international trainings, EMDR HAP, current research, study groups, and clinical applications workshops. Go to http:/www.emdr.com

Internet Discussion List

EMDR Institute trained clinicians are invited to join the EMDR Institute Discussion List. Participation in this electronic forum offers opportunities to discuss issues related to: clinical applications, specific protocols, theory and research on EMDR, EMDR Institute and EMDR HAP. Participants in the discussion list include EMDR trained researchers as well as EMDR Institute facilitators and trainers.

Send subscription request to: LISTSERV@MAELSTROM.STJOHNS.EDU
Leave a blank or enter a hyphen (-) in the subject line.
In the text of the message enter: SUBSCRIBE EMDR FIRSTNAME LASTNAME and send.

Call for Nominations

BOARD OF DIRECTORS

Nominations are now being accepted for positions on the Board of Directors of EMDRIA. There are three vacancies on the Board and three offices to be filled: President-Elect, Secretary-Elect, and Treasurer-Elect.

The EMDR International Association is a working board and Directors are responsible for the development of policy, programs and financial matters of the Association. Directors meet by conference call every other month (and the Executive Committee meets monthly and as needed). The act as Chairpersons or Board Liaisons to the committees created by the Board. Terms for Board Members are three years. Officers elect serve one year in the "elect" position until assuming the full office the following year.

The Nomination Committee is currently preparing an election slate. Members are encouraged to contact the Chair of the Nominations Committee is they wish to place a name in for nomination: Curtis C. Rouanzoin, Ph.D., Chair
714-680-0663 or e-mail: ccrounzun@aol.com

AWARDS

The Nominations and Awards Committee are currently accepting nomination for awards to be presented at the 1999 EMDRIA Conference in Las Vegas, NV. Persons may be nominated in the following categories:

- **OUTSTANDING SERVICE**
- **RESEARCH**
- **NEWEST INNOVATIONS**

For more information or to obtain a nomination form, please contact the Administrative office at (512) 451-5200 or by e-mail at emdria@aol.com.

Final decisions will be made by the EMDRIA Nominations and Awards Committee.

EMDRIA NEWSLETTER ADVERTISING RATES

DISPLAY ADVERTISING

	1 ISSUE		2 ISSUES		3 ISSUES	
	Member	Non-Member	Member	Non-Member	Member	Non-Member
¼-Page	$80	$100	$100	$120	$120	$140
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Full-Page	$120	$140	$140	$160	$160	$180
Two Page	$175	$200	$200	$225	$225	$250

INSERTS

	Member	Non-Member
Per Issue/Per Sheet	$100	$125

CLASSIFIED ADS: 3-¾" x 2"

	Member	Non-Member
Per Issue	$30	$60

Please refer to the Newsletter Submission Requirements provided on the inside back cover for specific information on drafting, formatting, and submitting ads.

(Resource-Focused EMDR - Continued from page 13)
session's DPs and RPs and ask for a reaction. I check for incomplete processing from the prior session and for any additional associative channels that may be surfacing. Sometimes it is more therapeutic to process additional channels with new pictures.

Wagon Wheel Metaphor

Clients who understand EMDR as trauma-focused therapy often get confused when I focus on resources and ego strengthening. To explain this approach, I offer the metaphor of a wagon wheel. The hub and the spokes must be well-connected for the wheel to roll smoothly and support weight for long distances. The role of each spoke is important for the wheel to function optimally. I offer the perspective that the hub and the spokes are like parts of self (ego states). Some parts may be well-connected, some loosely-connected, or some may not be connected at all. I explain that we start by strengthening the hub (the core center). We then discern which spokes need (and are ready for) assistance and help connect them to the hub.

Over time, it becomes easier for more spokes to fit securely in the wheel. As more spokes get securely connected to the hub, the wheel performs better and with heavier loads. I have explained that an ability to carry heavy loads is required to do the trauma-focused EMDR.

My clients who are adult survivors of childhood trauma report a significant preference for the resource-focused protocol because (a) seeing the pictures keeps them more present in the processing, and (b) seeing their resources "front and center" helps them to feel safer. Some clients report benefit from thinking about their pictures between sessions, when they need re-grounding. Over time, their file folders fill with RPs, making the therapy easier and easier.

It appears to me that this approach helps my clients to achieve adaptive resolution more efficiently and with less overall disturbance than would occur with the standard trauma-focused protocol. I like using this protocol because I believe I can more accurately see, and safely break through, the dissociative barriers that tend to slow processing. The art provides me a clearer understanding of the clients' ego strengths and

(Continued on page 26)

POST YOUR EMDR STUDY GROUP IN THE NEXT *EMDRIA™ NEWSLETTER*!

If you have an existing Study Group—or will be starting a Study Group—and want it posted in the next *EMDRIA Newsletter*, please submit it to the EMDRIA administration office by April 20, 1999. When submitting your Study Group, please provide the following information (by completing and sending this form or providing the information in another format.)

Contact Name: _____

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

_____

City: _____ State/Province: _____

Phone: _____ Fax: _____ E-mail: _____

(Please see page 36 of this issue for current postings to the Study Group Listing.)

—paid advertisement—

New Mexico Study Group Day Approaching

The next Annual New Mexico Study Group Day will be held on:

April 30, 1999
Indian Pueblo Cultural Center
2104 12th Street NW
Albuquerque, New Mexico
8 a.m. to 4:30 p.m.

Topics this year will include:

- Using EMDR and addictions
- EMDR and seriously ill children
- TFT and EFT overviews
- EMDR research with victims of sexual assault
- EMDR and DID
- Guidelines for working with abuse victims
- Case consultations.

The cost of the Study Group Day is $50.50, which includes lunch.

For more information, please contact:

Peggy Moore at 505-247-8915,

Kathleen Scott or Cathleen Cain at 505-255-8682, or

Donna Bruzzese at 505-246-9096.

(Resource-Focused EMDR - Continued from page 25)

weaknesses—so I am more likely to accurately estimate affect tolerance and provide the safest possible pacing of the healing process.

Over the last three months, I estimate that I have done 50 to 70 sessions of Resource-Focused EMDR with 15 very different clients. Clients are reporting stable gains from these sessions. This of course, is only anecdotal evidence. Rigorous clinical research is needed before any unequivocal claims of efficacy could be made.

I consider this to be work in progress and encourage feedback. I can be contacted at (210) 561-9200 or at sjschmid@netxpress.com.

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INTEGRATING EMDR INTO COUPLES THERAPY

Michael D'Antonio, Ph.D.
PENN Council for Relationships
WWW.PCFR.ORG

This protocol (D'Antonio, 1997) integrates Bowen's (1976) concept of differentiation with a trauma model of relationships. Differentiation refers to a quality of both individuals and relationships: non-defensiveness, responsiveness rather than reactivity, connection without fusion, centeredness without self-absorption, openness with clear boundaries. It might best be thought of as a continuum from extremely undifferentiated to well differentiated. Individuals pair off with others at roughly the same level of differentiation.

Childhood relational trauma might also be thought of as a continuum from benign neglect through non-protection from overwhelming emotion to frank physical, emotional, or sexual abuse. The greater the relational trauma, the less differentiated the relationship and the more reactive the partners. Chronically conflicted, conflict-avoidant, addict-enabler, pursuer-distancer, and dominator-victim couples are all poorly differentiated and highly reactive. The partners experience emotional lability or contagion. They become paralyzed or impulsive in the face of strong emotion. Their blurred boundaries cause them to confuse their thoughts, feelings, and desires with those of the other. They perceive their self-worth as contingent on the feelings or behavior of the other.

This protocol offers EMDR as a potentially valuable component of couples treatment for poorly differentiated, highly reactive couples. It outlines an interview format for the opening treatment sessions, a decision tree for deciding to use EMDR, a rationale for introducing EMDR to the couple (while maintaining therapeutic balance and the focus on the couple), a method of selecting reprocessing targets, and interventions for amplifying EMDR-initiated change in a couples context.

Format for Couples Therapy

This format allows me both to gather all the clinical information I may need to set up EMDR sessions for one or both partners and to prepare them emotionally and conceptually for such work. It is one I use with all couples, whether or not I eventually do EMDR with them. The format includes one conjoint session, followed by one individual session with each partner, followed then by another conjoint session in which I present a conceptual synthesis and treatment plan

My task in these sessions is to:

- identify the couple's interactional pattern
- identify the central struggle of each partner's life, locate its origin in the past, recognize its impact in the present, both in the primary relationship and beyond
- have each client experience me as an empathic witness to that struggle
- formulate a synthesis which connects patterns in partners' families of origin with current couple interactional patterns (e.g,. D'Antonio, 1994) and is consistent with, and suggestive of, the introduction of EMDR, then or later, as indicated.

Introducing EMDR

Because it is individual rather than interactive and still relatively unknown, EMDR violates couples' typical expectations for couples therapy. I have found it best not to introduce it early in treatment unless there is an immediate need to reduce volatility or strong negative affect. I generally introduce it later only when the conjoint sessions do not seem to be moving to the satisfaction of the clients or myself. The clients' level of trust and the compelling the rationale for EMDR must be taken into account in timing the introduction of EMDR. EMDR must be connected conceptually and emotionally with the clients' understanding of the treatment process. Thus, the assessment process and the therapeutic synthesis mentioned above are critically important.

EMDR Treatment

Goal: The desired outcome of EMDR is decreased reactivity and increased differentiation. In other words, the purpose of incorporating EMDR into couples therapy is primarily to have one or both partners experience the generalized effects of EMDR, including clearer focus; greater centeredness; perception of being more of an agent (active ingredient) in one's life; perception of others' thoughts, feelings and actions as separate from one's own; greater ability to identify one's own thoughts, feelings, desires, and wishes; and empathy for others without emotional contagion.

Targets: At the end of the initial conjoint session, each partner is asked to prepare for his/her individual session by creating a list of the ten most negative experiences of his/her life, with five before the age of 18 and five after age 18. Targets are selected from this list as well as from

(Continued on page 28)

(Couples Therapy - Continued from page 27)
among incidents of relational trauma I identify in the early clinical interviews. These targets are chosen for theoretical, clinical, and strategic reasons. Theoretically, the driver for the current reactivity is early relational trauma. Clinically, reprocessing of early targets proceeds more cleanly and does, in fact, impact on current reactivity. Strategically, focus on early targets carries the message that the individual's problems predate the relationship. I move to current triggers, if necessary, only after early experiences have been reprocessed.

Format: One or both partners (in series or in tandem) commit to three consecutive trials of EMDR to assess its effects. At the end of each EMDR session, the client is instructed to notice anything different about himself/herself. In the next session, I use solution-focused interviewing (e.g., O'Hanlon & Weiner-Davis, 1989) to amplify any positive changes the client(s) made. After three EMDR sessions with one or both partners, a conjoint session is held to assess the couple's interaction and amplify any positive changes. Another set of three EMDR sessions may be initiated for one or both. In general, EMDR is used only in support of the couple's work and thus is used less intensively than I might use it in individual treatment.

Balance: In order to prevent an unbalanced or collusive relationship with one of the partners, the EMDR sessions must be highly focused. I stick with EMDR and focus on the individual. During the brief solution-focused debriefing at the beginning of each therapy session following an EMDR session, the individual's reported changes are discussed in terms of his/her responses to events and others, including the partner. This does not become a discussion of the partner or the relationship. For similar reasons, it is often helpful to see that EMDR treatment of only one partner is balanced by some other intervention for the other (e.g., individual Rx, referral for medication evaluation, etc.).

Conclusion

The potential of EMDR to center people in their own lives without making them self-centered; to reduce thoughts, feelings, sensations of personal diminishment; and to render people less defensive and reactive could become a major contribution to couples therapy. It can help couples move beyond the patterns inherited from the past to deal more effectively with one another in the here and now.

To my mind, effective use of EMDR in couples therapy requires both expertise in the use of EMDR and sensitivity to the context and demands of couples work. It places special demands on the therapist to orchestrate a coherent therapeutic experience for clients out of disparate individual and interpersonal-interactive elements. The concepts of differentiation and relational trauma can provide the theoretical basis for this coherence.

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Research Committee Report

Nancy J. Smyth, Ph.D., C.S.W., CASAC
Research Committee Chair

EMDR Research Funded

We've received some wonderful news: the National Institutes of Health has funded two large EMDR research grant proposals: 1) Treatment Outcomes of Fluoxetine vs. EMDR in PTSD (Bessel van der Kolk is the Principal Investigator), and 2) EMDR vs. Prolonged Exposure for PTSD Rape Victims (Barbara Rothbaum is the Principal Investigator). Recall that EMDRIA provided funding for Dr. van der Kolk's pilot work to assist him in obtaining a larger grant; it's gratifying to see that this investment has paid off so richly!

Both studies are only just beginning, so it will be several years before any results are available. However, receiving this funding is an important indication that EMDR has "come of age" despite the seemingly endless controversy in the scientific community. The success of these grant proposals, is due, in large part, to all the research that has come before, so please remember that every study counts!

On other fronts, the Research Committee continues to provide informal consultation on EMDR research proposals and continues to disseminate our Directory of EMDR Researchers and Academics. Please send us information about research projects that you are conducting so we can keep up-to-date on research efforts. You can send information to the Committee Chair, Dr. Nancy Smyth by e-mail to: njsmyth@acsu.buffalo.edu or through postal mail to University at Buffalo School of Social Work, 359 Baldy Hall, Buffalo, NY 14260-1050.

Conference Planning

We've also been organizing research presentations for the June Conference and are hoping to expand poster session offerings at the Conference, as well. The deadline for poster sessions has been extended to April 15, 1999—abstracts should be submitted to the EMDRIA office on the regular conference abstract forms. Posters on pilot studies, single case research, new assessment instruments, and new protocols are all welcome. If you need to see an example of a poster (to help you put yours together) please request a sample from Nancy Smyth (address, phone and e-mail included in this article).

Chemical Dependency Research Underway

Finally, EMDRIA members who have been following the progress of research efforts on the EMDR Chemical Dependency Treatment Protocol will be pleased to know that the multi-site single case research study being conducted by Drs. Nancy Smyth, Silke Vogelmann-Sine, and Larry Sine has received human subjects approval from the University at Buffalo to begin enlisting therapists and clients who would like to participate. If you are interested, please contact Dr. Smyth at njsmyth@acsu.buffalo.edu or 716-645-3381x232.

⇔

Criteria-EMDRIA Certification in EMDR & Approved Consultants

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

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

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

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

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

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

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

		After July1, 1999
• **Certification in EMDR**		
EMDRIA™ member and listed in the Register	$90	$100
EMDRIA™ member and not listed in the Register	$135	$150
Not a member of EMDRIA™	$270	$300
• **Approved Consultants in EMDR**		
EMDRIA™ member and listed in the Register	$180	$200
EMDRIA™ member and not listed in the Register	$225	$250
Not a member of EMDRIA™	$360	$400

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

Application for EMDRIA™ Certification in EMDR

Last Name_____ **First Name**_____ **MI**_____

Address_____

City_____ **State**_____ **Zip**_____ **Country**_____

Tel_____ **Fax**_____ **Email**_____

ADDITIONAL Address_____

City_____ **State**_____ **Zip**_____ **Country**_____

Tel_____ **Fax**_____

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

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

Institution where received_____ Date_____

1) EMDRIA™ APPROVED TRAINING

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

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

2) LICENSE/CERTIFICATION

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

Mental Health Profession_____ ID#_____

State or Country Issued_____

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

☐ Attach notarized documentation supporting this statement.

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

☐ Attach notarized documentation supporting this statement.

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

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

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

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

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

EMDR International Association

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

FEES:

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

☐ VISA ☐ MC ☐ Check #_____(made payable to EMDRIA™)

Card #_____

Exp. Date_____ **Name on card**_____

Signature_____

Application for EMDRIA™ Approved Consultant

Last Name_____ **First Name**_____ **MI**_____

Address_____

City_____ **State**_____ **Zip**_____ **Country**_____

Tel_____ **Fax**_____ **Email**_____

ADDITIONAL Address_____

City_____ **State**_____ **Zip**_____ **Country**_____

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

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

Institution where received_____ Date_____

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

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

2) LICENSE/CERTIFICATION

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

Mental Health Profession_____ ID#_____

State or Country Issued_____

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

☐ Attach notarized documentation supporting this statement.

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

☐ Attach notarized documentation supporting this statement.

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

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

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

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

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

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

☐ VISA ☐ ☐ Check #_____(made payable to EMDRIA™)

Card #_____

Exp. Date_____ **Name on card**_____

Signature_____

OFFICERS, DIRECTORS, & COMMITTEES

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

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(Ego State Psychotherapy - Continued from page 15)

Expanding EMDR by Using the Ego State Therapy Model

In addition to informing the therapeutic process in general, the ego state therapy model offers several specific ways in which the EMDR process can be enhanced. In treating trauma patients, the following variations of the standard EMDR protocol might be considered:

1. If a patient is having difficulty identifying a relevant cognition, other more salient ego state components can be used to identify and amplify the target ego state prior to initiating EMDR.
2. If the clinician is concerned about the possibility of a surprise catharsis during the EMDR processing, a preview of the potential EMDR process can be had by doing an ego state bridge without EMDR.
3. If the patient is not staying adequately focused during the EMDR process, inviting the patient to attend to various ego state components, such as image, somatic sensations, can help amplify the relevant problematic ego state.
4. When the SUDs remains high, and when the therapist suspects that other channels need exploring, they can be accessed quickly and directly through the use of an ego state bridge, which takes the process to the earliest manifestations of the ego state (neuro network).
5. The cognitive interweave may not provide the most relevant resolution for a therapeutic impasse. For example, the traumatized ego state may not need an adult cognitive perspective, but rather the *affective* experience of nurturing, comforting, or safety.
6. The identification of the most appropriate and powerful therapeutic intervention can be accomplished best by asking the patient, "What needs to happen to give you relief?" when the patient is imaging the traumatized ego state in its original context. Formulaic protocols can work, but less precisely.
7. When a therapeutic impasse occurs because of a blocking belief or a protector ego state with a contrary agenda, the "resistant" ego state can be accessed and explored directly through various ego state techniques. Such direct exploration will facilitate identification of what needs to happen to shift the system, rather than requiring the therapist to guess as to what cognition might help the system. Again, a cognitive intervention may be less relevant than an affective one.

In treating non-PTSD patients, including character disordered patients, the ego state model in conjunction with EMDR can be especially useful, because such patients may not present with readily identifiable targets. The therapist can use the ego state model to formulate the ego state conflicts underlying the presenting symptoms or issues. In articulating the ego state system, the therapist can note in particular where there are dissociative breaches within the system. These associative failures can then become the target of the EMDR work, which will facilitate the development of a cooperative, integrated ego state system.

Summary of EMDR as an Ego State Therapeutic Approach

The psychological aspects of all phases of the EMDR process can be understood from the ego state model perspective:

1. Identify and amplify the problematic ego state.
2. Facilitate associational linkages derived from the ego state infrastructure.
3. Facilitate an ego state shift to a more adaptive ego state from the stuck, problematic ego state.
4. Resolve overt or covert conflicts perpetuating an impasse by reducing the dissociative barriers between the conflicted ego states.

The most unique contribution of EMDR appears to be in its impact on the dissociative/associative process, as reflected in the following phenomena:

1. Patients access previously dissociated memories.
2. The affective power of previously overwhelming stimuli becomes diminished, presumably by integrating traumatized ego states with more resourceful and calming ego states.
3. Isolated ego states with negative cognitions become integrated with ego states with more positive cognitions.

[Note: The similarities and differences between Ego State Therapy and EMDR are summarized in the table on the facing page.]

References

Grand, D. (1998). Advanced clinical seminar: innovation and integration in EMDR based diagnosis, technique, teaching, performance enhancement and creativity. EMDR International Association Conference.

Leeds, A. & Korn, D. (1998). Clinical applications of EMDR in the treatment of adult survivors of childhood abuse and neglect. EMDR International Association Conference.

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

Wildwind, L. (1998). It's never too late to have a happy childhood: Using EMDR to create and install essential experiences. EMDR International Association Conference.

COMPARISON OF EGO STATE THERAPY AND EMDR

Similarities

Concepts and Techniques	Ego State Therapy	EMDR
Identify and amplify the problematic ego state by intense focusing on ego state components.	Focuses more on affective, somatic, and imagistic components, but focuses on cognitive when relevant.	Focuses more on cognitions, but uses other ego state components as well.
Facilitate associational linkages derived from the ego state infrastructure by encouraging spontaneous associations.	Therapist looks for subtle shifts and amplifies them.	Associations come spontaneously during EMDR alternations.
Facilitate an ego state shift from the problematic, stuck ego state to a more adaptive ego state.	Therapist asks, "What needs to happen to get relief?"	Associations often come spontaneously during EMDR. Cognitive ego state components are emphasized.
Provide structure directing patient toward new ego state associations when satisfactory spontaneous associations fail to occur.	Therapist uses imagistic content or knowledge of ego state system to direct patient's process. **(Ego State Interweave)**	Primarily cognitive ego state associations are encouraged. **(Cognitive Interweave)**
Resolve overt or covert conflicts perpetuating an impasse by reducing the dissociative barriers between the conflicted ego states.	Uses imagistic internal dialog to reduce dissociation and to facilitate integrative process, among all relevant ego states and using all relevant ego state components.	Uses cognitive interweave supported by alternating hemispheric stimulation to resolve and integrate conflicting ego states without explicitly identifying all parties to the conflict.

Differences

Ego State Therapy	EMDR
Offers a general theory of personality and psychopathology to inform the therapeutic process, particularly during impasses.	Offers a specific technique, modified through accumulative clinical experience to inform therapeutic process, particularly during impasses, without a general theory of personality or psychopathology.
Uses hypnotic techniques to undo dissociative barriers.	EMDR generally spontaneously bypasses dissociative barriers.
Uses imagistic/affective corrective emotional experiences to facilitate development and integration of new neuronal associational pathways.	Alternating hemispheric visual, auditory, or tactile stimulation appear spontaneously to facilitate development and integration of new neuronal associations.

STUDY GROUP DIRECTORY

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

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

UNITED STATES

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California

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E-mail: jwroberts@net-tek.net
3rd Thurs each month, 8-10am

New Jersey

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

New Mexico

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

New York

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

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

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

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

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

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

North Carolina

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

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

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

Ohio

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

Oklahoma

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

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

Oregon

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

Pennsylvania

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

Tennessee

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

Texas

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

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

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

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

Virginia

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

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

Washington

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

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

Wisconsin

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

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

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

OUTSIDE THE UNITED STATES

Canada

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

Germany

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

Israel

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

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

• Please see page 25 for a form to submit Study Group information to the EMDRIA Office. •

1999 - MEMBERSHIP APPLICATION

Please feel free to pass this application onto EMDR Clinicians who have not yet joined EMDRIA

Please print or type.

I would like my information published in the Membership Directory. ❑ **Yes** ❑ **No**

Last Name_____ **First Name**_____ **MI**____ **Degree(s)**_____

Mailing Address_____

City_____ **State**_____ **Zip**_____

Country_____ **E-Mail**_____

(W) Phone_____ **(H) Phone**_____ **Fax**_____

❑ **A) MEMBER:** (Full Voting Privileges) ..... **$100.00 (for those outside the U.S., add $20.00)**

Requirements: 1. Persons or entities (EMDRIA affiliate) licensed, certified, or the equivalent as a mental health professional or per the guidelines of their state, province, or country.

2. Persons or member of EMDRIA affiliate entity who have completed EMDRIA approved training. (i.e. Level I AND Level II from the EMDR Institute or other EMDRIA approved Institutes, or completed a minimum of 18 didactic and 13 supervised hours in an academic institution, etc.)

❑ **B) ASSOCIATE MEMBER:** (No Voting Privileges) ..... **$ 75.00 (for those outside the U.S., add $20.00)**

Requirements: 1. Persons, agencies, or members of EMDRIA affiliate entities who are licensed, certified, or the equivalent as a mental health professional per the guidelines of their state, province, or country OR who are pursuing licensure under supervision and have NOT met the guidelines as outlined above for members OR other interested parties.

-OR-

❑ **B1) Student or Interns:** ..... **$ 50.00 (for those outside the U.S., add $20.00)**

1. Persons who are enrolled FULL TIME (min. of 9 hours per semester) in a University or Academic Institution.

Membership Total $_____ **Donation Total $**_____ **GRAND TOTAL $**_____

❑ **Check (Made payable to EMDR International Association)**

- **A $25 fee will be charged for all returned checks**

❑ VISA ❑ MC

- **If rebilling of a credit card is necessary, a $15 processing fee will be charged.**

❑ I would like to contribute to the support of scientific and educational research of EMDR by donating $_____ to Eye Movement Desensitization and Reprocessing International Association, a 501 (C)(3) non-profit organization. (This contribution is tax deductible)

Card No._____ **Exp. Date**_____

Please check to be sure card will not expire before application has time to be processed (4-6 weeks), as this will delay processing further.

Print name as it appears on card_____

Signature_____

EMDR International Association

PO Box 141925

Austin, TX 78714-1925

Tel (512) 451-5200 Fax (512) 451-5256

- If paying by credit card, you may fax this completed application to the above fax number.
- If paying by check or credit card please enclose this completed application with your payment information in a separate envelope and mail to the above address.

Please allow 4-6 weeks for processing of application.

For Office Use Only: **A**_____ **QB**_____ **CK#**_____ **CC**_____ **M**_____

From the EMDRIA™ Board of Directors

Dear Colleagues:

The EMDRIA Board of Directors and Membership Committee would like to thank you for your support over the past year. As we enter our second year as a professional organization, the EMDRIA Board of Directors would like to take this opportunity to highlight our accomplishments and activities over the past year, as well as projects in their developmental stages. As we continue to expand and grow, we are committed to providing you with greater services to meet your needs as a professional. The Public Relations Committee of EMDRIA, chaired by Sandra Foster, has put together a marvelous professional brochure about EMDR. It looks great and is something you can give to other professionals and even patients. The Committee has also put together a Presenter's Packet for those of you who are in need of assistance for speaking in professional or public forums.

The Membership Committee, chaired by Darlene Wade, MSW, will be combining this year's *Register* with the *Membership Directory* to provide greater distribution and exposure for potential referrals.

We hope to have some very encouraging information regarding managed care and how EMDR is viewed by managed care organizations. There are some very important meetings planned in the near future by our Healthcare Committee Chair, Mark Dworkin. When the outcomes of these meetings are finalized, we will let you know.

The Regional Coordinating Committee, chaired by Jocelyne Shiromoto, has worked diligently to format and facilitate the opportunity for "regional meetings" in areas through out the United States. Regional Meetings will provide opportunities to obtain continuing education (EMDRIA Credits) in EMDR. We hope you will join a Regional Meeting in your area.

EMDRIA publishes a quarterly *Newsletter*. Brad Wasserman, Editor, hopes to publish at least one "Special Edition" in 1999. This special edition will focus on the use of EMDR with children and adolescents. Inquiries and submissions can be made to Ricky Greenwald, P.O. Box 3907, Lihue, HI 96766.

The Annual Conference is shaping up to be another winner! This year, the Conference will be in Las Vegas, June 18-20th. We have taken many excellent suggestions from our attendees and have attempted to incorporate them into the Conference. Look for your brochure to arrive in February.

EMDRIA as a professional organization has striven to develop member services, but we have also been busy working on our mission to set standards and training in the practice and research of EMDR. The Research Committee, chaired by Nancy Smyth, has put together an *EMDRIA Directory of Researchers and Academics*. The Committee is also hoping to set up a database to assist people who are looking to embark on EMDR research projects and need to consult with other EMDR researchers.

The Standards and Training Committee, under the direction of Curt Rouanzoin, has worked on enhancing the standards and practice for EMDR clinicians and training. A process to become an EMDRIA Provider for continuing education in EMDR has been formalized. Persons wishing to become an approved provider for "EMDRIA Credits" can make application for their training or workshop. Please contact Gayla Brown at the Administrative Office for details.

Most importantly, we want to inform you that Certification is here! The Board of Directors has approved a model for certification in EMDR. We have reviewed what other organizations have done before us and adapted criteria to meet the specific needs of EMDRIA. We have two levels of certification. 1) a therapist who is EMDRIA Certified in EMDR and 2) an EMDRIA Approved Consultant in EMDR. EMDRIA will be grandparenting throughout the 1999 calendar year and members of EMDRIA will be eligible for lower fee structures.

There has been some confusion as to the dates of EMDRIA's membership year. Our membership year runs January 1 to December 31. Regardless of the date of joining, members receive all issues of the current year's *Newsletter*, and their names are listed in the on-line *EMDRIA Directory* soon after joining and are included in the printed *EMDRIA Directory* for that year. In addition members are eligible for a discount when making application to be EMDRIA Certified in EMDR as well as an EMDRIA Approved Consultant in EMDR. Late joining members receive virtually all the benefits outlined above. EMDRIA does not pro-rate membership based on the date joined. If you have not submitted an application to renew your membership since January 1, 1999, your membership would not be current.

If you are interested in more information about our programs and services, please contact the Administrative Office for details. We are proud and excited about what is happening with EMDRIA. Because of your support and participation we will continue to prosper. We wanted you to know what we are doing and hope you will join us.

If you have not renewed your membership or have never been a member, take a moment to think about it—then do it!

Sincerely,

The EMDRIA Board Of Directors

EMDR International Association
5806 Mesa Drive
Suite 360
Austin, TX 78731

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Time to Apply?

This issue includes an application for EMDRIA membership as well as applications for EMDRIA certifications for therapists and consultants.

Inside this Issue of *The EMDRIA Newsletter*:

Events and Deadlines

April 15, 1999

Deadline for Poster Submissions for the 1999 EMDRIA International Conference

April 20, 1999

Deadline for Submissions to the next *EMDRIA Newsletter*

April 21-25, 1999

International Critical Incident Stress Foundation Fifth World Congress in Baltimore

April 30, 1999

Annual New Mexico Study Group Day in Albuquerque

June 18-20, 1999

1999 Annual EMDR International Association Conference in Las Vegas