INTERNATIONAL EMDRIA ASSOCIATION ™

EMDRIA NEWSLETTER

Issue 1 June 1996

CHAIR'S REPORT

by David L. Wilson, Ph.D.

First: Who is Dave Wilson and how did he become Chair of the EMDRIA Board?

I am a clinical psychologist in full–time private practice in Redding (in Far Northern California) since 1972. I started training in EMDR in 1990 and have been a Facilitator since 1991. I think I was asked to serve on the EMDRIA Board because of my extensive experience with organizations. Over the years, I have served on the board of Directors for 25 community, social service, and professional associations, and as Chair/President for a dozen. After Ron Doctor developed a serious health problem, which required surgery and an extended convalescence, the Board asked me to act as Chair. Although all of us on the Board have contributed, it has become obvious to me that Ron did the lion's share of the work. As I review what we have put together, it is also clear we all owe a deep gratitude to Ron. Please join me in wishing Ron a full recovery.

Second: What has EMDRIA done for you this past year?

Like housework, a lot of what we have done is not obvious. We enrolled enough members to be able to fund basic services for our membership, without subsidy by the EMDR Institute or Network, and in that connection, we owe a special debt to the generosity of our Charter Members. We created a formal structure for EMDRIA, crafted Bylaws, and successfully completed our applications with the state and federal government as a non–profit, educational corporation, which means your dues are fully tax deductible. EMDRIA will be able to receive and award grants for research and other projects. Thanks largely to the work of Conference Chair, Carol York, we put together an Annual Conference, co–sponsored by the EMDR Institute during this year of transition. We managed to handle all the details to create a Newsletter, and to start providing the services previously provided by the Network: a Membership Directory, a system for providing reprints of the literature, and continuation of the Regional Network Meetings. If all goes well, we will have the elected Officers in place by the Annual Conference.

Third: What is next in terms of goals?

1. To expand participation in our committees and shift the Board of Directors from completing tasks to creating policy. In this connection, there are openings on almost all our committees: Membership, Publications, Professional Issues (Ethics), Professional Standards and Training, Conference, Finance, Personnel, Structure Function and Bylaws, Awards, and Research. If you are interested in serving on a committee, call The Administrators at 602– 912–5300 and ask for Ruth Helein.

2. To establish a structure on the Board of Directors for representation from the international community; something we plan to work out at the Conference.

3. To forward the action on our many projects, e.g., promoting research, establishing standards for education and training, and publicizing and forwarding the contribution of EMDR. If you are reading this, you are one of those stalwarts who is committed to what is inherent in EMDR: to relieve human suffering and promote the common good. For taking this stand, I thank you on behalf of the EMDRIA Board.

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STRAY THOUGHTS

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As we move into the era of managed care, we can only hope that science will weigh more heavily in evaluation and guidance of clinical methods. Unfortunately, regardless of rhetoric to the contrary, this has not previously been the case. For instance, although the diagnosis of PTSD was officially recognized in 1980 (DSM–III), a full 13 years later, only six controlled PTSD treatment studies, excluding those involving drugs, had been published (Solomon, Gerrity, & Muff, 1992). While a number of methods showed promise, the Solomon, Gerrity, and Muff (1992) review indicated that the studies evaluated "suffer from methodological limitations" and "further research is needed before any of these approaches can be pronounced effective as lasting treatments of PTSD" (p. 637). The studies reviewed by Solomon, Gerrity, and Muff (1992) included: (1) a comparison of 45 sessions of desensitization and a no–treatment control (Peniston, 1986); (2) three studies of the effectiveness of flooding on traumatized, compensated, combat veterans (Boudewyns & Hyer, 1990; Cooper & Clum, 1989; Keane, Fairbank, Cadell, & Zimering, 1989); (3) a comparison of flooding, stress inoculation therapy, and supportive counseling with rape victims (Foa, Olasov Rothbaum, Riggs, & Murdock, 1991); and (4) a comparison of desensitization, hypnosis, and psychodynamic therapy for a variety of traumata (Brom, Kleber, & Defaresk, 1989). The paucity of controlled research on the treatment of PTSD is obviously of great concern, given the millions of people estimated to be suffering from it.

Recently, the APA Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1996) indicated that no methods are presently considered "well–established treatments" for PTSD. Two methods, exposure (flooding) and stress inoculation therapy, are termed "probably efficacious." In a recent interview with a reporter from the Science News, a spokesperson of the Task Force was quoted as saying that only published studies were considered for validation and one more supportive published EMDR study would be needed to place it on the list. However, this information was not mentioned in their published APA report. Consequently, in order to prepare clinicians for the inevitable questions that will arise following the publication of the Task Force list, this article will place the completed controlled studies of EMDR within the context of extant PTSD controlled research.

The original controlled study of EMDR by Shapiro (1989) found substantial treatment effects for its 22 subjects (victims of a variety of traumata). In this experiment, EMDR was compared to a placebo condition which controlled for both exposure to the memory and therapist attention. Treatment efficacy was assessed by means of the SUD scale and the quantification of a self–report of PTSD symptoms (e.g., number of flashbacks, nightmares, intrusive thoughts). Corroboration of the change in the latter self–report measures was provided by the subject's spouse, parent, or primary therapist. Nevertheless, the apparent positive outcome of this study should be interpreted with caution because of the lack of standardized assessments (e.g., PTSD diagnoses were made by referring therapists using DSM–III criteria) and the fact that the investigator and the therapist were the same. Nevertheless, the results of these preliminary data were very encouraging and led to a series of more rigorously controlled studies.

To date, the results of the original study (Shapiro, 1989) have been replicated by four controlled studies, all demonstrating EMDR's superiority to one or more alternative treatments (Boudewyns, Hyer, Peralme, Touze, & Kiel, 1995; Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1995; Levin, Grainger, Allen–Byrd, & Fulcher, 1994). Furthermore, two controlled studies have found EMDR to be superior to wait–list controls (Rothbaum, 1995; S. Wilson, Becker, & Tinker, 1995a). Substantial alleviation of PTSD symptoms has also been documented in two controlled component analyses (Renfrey & Spates, 1994; D. Wilson, Silver, Covi, & Foster, in press), as well as in the case studies listed earlier.

To make the most precise comparison of EMDR's efficacy to other modes of treatment, it is necessary to place these studies in context. In the Keane et al. (1989) experiment on exposure, cited in a previous section, 11 flooding participants revealed a statistically significant, albeit small, clinical improvement in comparison to a group of wait–list controls. A wait–list control was also used in one study of EMDR (Rothbaum, 1995), while delayed treatment controls were used in three others (Shapiro, 1989; D. Wilson, Silver, Covi, & Foster, 1996; S. Wilson, Becker, & Tinker, 1995a). In all four studies, EMDR produced clinical effects that were reliably greater than those found for the control groups. Furthermore, all of them found that only 1 to 3 sessions of EMDR were necessary to produce substantial clinical improvement, in comparison to the 14 to 15 sessions required to obtain the comparatively small effects reported by Keane et al. (1989) with flooding.

The studies of Cooper and Clum (1989) and Boudewyns and Hyer (1990), which contrasted flooding to a control group that received standard VA treatment, are comparable to the studies of Boudewyns, Stwertka, Hyer, Albrecht, and Sperr (1993) and Boudewyns, Hyer, Peralme, Touse, and Kiel (1995), who also compared EMDR to standard VA care. Boudewyns and his colleagues found EMDR to be superior in terms of patient and therapist evaluations (Boudewyns et al., 1993), as well as on standard PTSD measures and patient reports (Boudewyns et al., 1995). Similarly, Carlson et al. (1995) reported that EMDR was superior to biofeedback–assisted relaxation and to VA routine care on the basis of interview measures of PTSD symptoms, on the Mississippi Scale, the Spielberger measures of anxiety, and the Beck Depression Scale.

One often mentioned study is by Foa et al. (1991) in which flooding, stress inoculation training, and supportive counseling were compared in the treatment of rape victims. However, only small clinical differences were found among the three treatment conditions at a follow–up test (e.g., 10% difference in those still diagnosed with PTSD). Similarly small differences were reported in a study by Vaughan et al. (1994) who found the benefits of EMDR to be equal or superior to those of exposure and relaxation controls. However, simply taking the similarity of treatment effects at face value, the Vaughan et al. study could be misleading because of the fact that the two control groups (but not the EMDR group) received 60 and 40 minutes, respectively, of additional daily homework over a 2–to–3–week period. Moreover, the trend in favor of EMDR reported between groups did not reach significance, according to Vaughan et al. (1994), perhaps because of limited power due to the small sample sizes.

In another comparative study, Levin, Grainger, Allen–Byrd, and Fulcher (1994) found EMDR to be superior to supportive counseling in the treatment of Hurricane Andrew victims. However, considerable caution is needed in interpreting these results because of the primitive field conditions (an unmitigated disaster) under which they were obtained. Finally, in a comparative design by Carlson, Chemtob, Rusnak, Hedlund, & Muraoka (1995), EMDR proved superior to a biofeedback relaxation control group and to a group receiving routine VA clinical care. Large treatment effects characterize the latter study.

The effectiveness of a therapeutic procedure can also be evaluated on the basis of: (1) the size of the treatment effects, (2) the number of subjects meeting a therapeutic goal, (3) the number of sessions required to obtain that goal, (4) the total number of subjects tested, and (5) the subject attrition rate. For example, while only 49 flooding participants and 9 stress inoculation participants have been examined in all the controlled PTSD studies combined, approximately 250 EMDR participants have been assessed under similar controlled conditions.

The attrition rate for groups receiving EMDR appears less than for groups receiving other forms of therapy. For instance, out of the 66 participants with which the Foa et al. (1991) study began, only 27 remained for the statistical analysis. In contrast, the later studies of EMDR by Rothbaum (1995) and Wilson, Becker, and Tinker (1995a) experienced only a 10% attrition rate, together with much more substantial treatment outcomes than the Foa et al. (1991) study. In a combat veteran study, Carlson et al. reported a similar 10% attrition rate in the EMDR group at a nine months follow–up. This rate should be compared to a range of 25% (with inpatients) to 45% in other treatment studies of combat–related PTSD (Solomon, Gerrity, & Muff, 1992).

In non–EMDR studies, only two reported symptom improvement of greater than 30%. Brom et al. (1989) reported an improvement in 60% of the participants, although no differences in outcomes were found for desensitization, hypnosis, and psychodynamic procedures, and the treatment effects that were described required a total of 15 treatment sessions. Foa et al.

(1991) reported that at the follow–up of a previous set of seven treatment sessions, 55% (n=5) of participants who had received stress inoculation training or flooding no longer met full PTSD criteria, while 45% (n=4) who had received supportive counseling met this standard. Once again, however, these results should be interpreted with caution because of the high attrition rate (over 50%).

In contrast, Rothbaum (1995) found that after three EMDR treatment sessions, 90% (n=9) of the participants no longer met the full criteria for PTSD. In a test of subjects whose responses to EMDR were reported by Wilson, Becker, & Tinker (1995a), it was found that 83% (n=25) of the participants initially diagnosed with PTSD still failed to meet criteria at 15–month follow–up (Wilson, Becker, & Tinker, 1995b). Similar data were reported by Lazrove (1995) in a recent, systematically evaluated case series. While one subject dropped out very early in the study, of the seven subjects who completed treatment (including mothers who had lost their children to drunken drivers), none met PTSD criteria at follow– up. The latter study should be interpreted with caution, however, because of the lack of control conditions. Nonetheless, it is important to note that each of these studies used only three EMDR treatment sessions and employed both standardized PTSD measures and independent assessors.

It appears that the only other controlled study of exposure techniques with a PTSD population published since the Solomon et al. (1992) survey was by Richards, Lovell, and Marks (1994). They found symptom improvement of 65 to 80% after 50 hours of combined imaginal and live exposure (therapist sessions plus daily homework). The number of treatment sessions required to achieve somewhat more limited treatment effects strongly suggests that the effects of EMDR are not due to simply its exposure component. That is, while exposure is undoubtedly part of the mechanism contributing to the treatment efficacy, any evaluation of the clinical effects of EMDR must take into consideration all of the procedural elements of this relatively complex therapeutic intervention (see Shapiro, 1995).

In summary, within the context of extant PTSD research, the converging evidence seems to justify recognizing EMDR as an empirically validated treatment for PTSD. The more recent, well controlled EMDR studies documenting large effects have used blind interviews (which evaluate behavioral response), self–report, standard psychometrics, and physiological measures in the same proportion as the studies evaluating flooding and stress inoculation therapy. Those EMDR studies reporting only small effects for the procedure must be evaluated in the light of: (1) their use of chronic, multiply–traumatized veterans, most of whom are receiving disability compensation (i.e., experiencing secondary gains); (2) the lack of adequate treatment fidelity; and/or (3) the use of insufficient treatment time or number of sessions (Boudewyns, 1994, 1995; Jensen, 1994; Pitman, 1993; see Shapiro, 1995). Nevertheless, the results of even three of these EMDR studies, which are sometimes considered to be evidence that EMDR is not effective, in fact compare favorably to those from studies that have tested flooding with comparable clinical populations. Indeed, Pitman et al. (1993, 1995) noted decreases in PTSD symptomatology equivalent to those reported by Keane et al. (1989), but with fewer complications and drop–outs than with flooding. The remaining eight controlled EMDR studies have documented large, long–lasting treatment effects that are comparable to, or better than, the best results from the controlled studies of all other PTSD treatments.

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FURTHER THOUGHTS ON THE NEUROPHYSIOLOGY OF *EMDR*

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The following speculations considered in this paper are submitted to stimulate further discussion and research about the primary neurophysiological processes that are involved in EMDR. These speculations are meant to expand on the ideas previously posited by Francine Shapiro (1994) and Steven Henry (1994) in the first issue of the EMDR Newsletter.

Shapiro posits that one of the simplest ways of describing integrative EMDR effects is to say that the target event has remained unprocessed because the immediate biological responses to the trauma have left it isolated in neurobiological stasis. The processing mechanism of EMDR is physiologically configured to take misprocessed information to an adaptive level (Shapiro, 1994, 1995). To comprehend how this takes place at a neurobiological level, I believe that it is imperative to understand the relationship between the amygdala and

the following: the other limbic structures, the neocortex, specific neurotransmitters, as well as the physiological aspects of dream sleep.

The concept of the limbic system is, today, an issue of controversy in the fields of neuroanatomy and neuroscience. Those who object to viewing the limbic structures as a system cite the lack of objective structural and functional criteria that are needed to define it as an anatomical entity (Brodal, 1980; Brodal, 1992; LeDoux, 1992; Walsh, 1987). However, it is beyond the scope of this paper to discuss this issue in detail. For the purposes of this presentation, the term limbic system will be used to indicate a group of limbic structures and will be defined as composed of, collectively, portions of the thalamus, hypothalamus, hippocampus, amygdala, caudate nucleus, septum, and mesencephalon. This paper will address the particular limbic structures essential to this current discussion.

The amygdala is an almond–shaped cluster of interconnected structures perched above the brainstem, near the bottom of the limbic ring. The amygdala is composed of two structures (the corticomedial and basolateral nuclear groups), one on each side of the brain, nestled in the temporal lobe, underneath the uncus. The corticomedial nuclei are connected primarily with the olfactory bulb, the hypothalamus, and the visceral nuclei of the brain stem. The basolateral nuclei are connected with thalamus and parts of the cerebral cortex. The hippocampus is also located in the temporal lobe. It forms an elongated bulge in the temporal horn of the lateral ventricle. The thalamus, the largest part of the diencephalon, is situated on each side of the third ventricle. The thalamus is composed of many smaller nuclei and is a relay station for almost all information transmitted from the lower parts of the central nervous system to the cerebral cortex. Below the thalamus lies the hypothalamus, the smaller part of the diencephalon, which is primarily involved with the central control of the autonomic nervous system (Brodal, 1992). The septum, also located in the temporal lobe, receives neural input from the hippocampus and sends neural input to the hypothalamus (Bloom & Lazerson, 1988; Brodal, 1992).

The hippocampus and the amygdala were the two key parts of the primitive "nose brain" (rhinencephalon) that evolved and gave rise to the cortex and then to the neocortex (Brodal, 1992; Goleman, 1995). These limbic structures do much of the brain's learning and remembering (Brodal, 1980; Brodal, 1992; Goleman, 1995; LeDoux, 1986, 1992, 1994; Walsh, 1987). The amygdala provides the central crossroads junction where information from all senses is finally tied together and endowed with emotional meaning. It is here that the sights, sounds, smells, tastes, proprioceptive, and touch sensations of an experience are brought together and remembered (Reiser, 1994). The hippocampus has been referred to as the "gateway" to the limbic system (Winson, 1985). It is here that information from the neocortex is processed and then transmitted to the limbic system, where memory and emotion are integrated (Reiser, 1994). This is accomplished through: 1) extensive, two–way connections with various cortical association areas and 2) the direct and indirect connections with other limbic structures such as the septal nuclei and the hypothalamus (Brodal, 1992). This complex strucure is known to play a central role in memory, particularly the retrieval of memories for approximately three years following the registration of the experience (Brodal, 1992; Reiser, 1994). Observations indicate that the hippocampus is particularly important for the memory of events, objects, words, and other types of information. The observations of patients in whom the hippocampus has been destroyed by disease or trauma indicate that they suffer from global amnesia. They cannot remember anything that happened to them during the three years preceding the onset of the disorder (retrograde amnesia), although they can remember things that happened prior to it. Moreover, they cannot lay down any new memories at all (anterograde amnesia). Anything that happens to them now cannot, without rehearsal, be remembered for more than a few minutes (Bloom & Lazerson, 1988; Brodal, 1992; Reiser, 1994; Walsh, 1987). While the amygdala retains the emotional flavor of memory, the hippocampus retains the dry facts and it appears to process memory in terms of perceptual patterns and contexts (LeDoux, 1992; van der Kolk, 1994). It is the hippocampus that recognizes the different significance of a bear in the zoo versus one in your backyard (Goleman,1995).

The brain's damper switch for the amygdala appears to lie at the other end of a major circuit to the neocortex, in the left prefrontal lobe, just behind the forehead. Some of this circuitry is also found in the temporal lobe. This neocortical part of the brain brings a more analytic and appropriate response to our emotional impulses, modulating the amygdala and other limbic areas (Goleman, 1995; LeDoux, 1986).

The connections between the amygdala (and related limbic structures) and the neocortex are at the hub of adaptive adjustment, maladaptive dysfunction, and trauma (chronic and acute). The prefrontal cortex is the brain region responsible for working memory. The presence of circuits connecting the limbic brain to the prefrontal lobes implies that the signals of strong emotion, anxiety, anger, and terror generated in the amygdala, can create neural static, sabotaging the ability of the prefrontal lobe to maintain working memory and homeostasis (Selemon et al., 1995). Beside the structural bridge between these areas, there is also a biochemical one. Both contain areas that have a high concentration of receptor sites for the neurotransmitter seratonin. Our capacity for happiness, sadness, and terror are housed in this architecture and its circuitry.

Recent studies of the amygdala have discovered a role that is pivotal in the understanding of trauma, as well as in shedding new light on maturation and development (Goleman, 1995; LeDoux, 1986, 1992, 1994). In the brain's architecture, the amygdala is poised like an alarm. Incomplete or confusing signals from the senses let the amygdala scan every experience for danger. Sensory signals from the eyes, nose, mouth, skin, and ears travel first in the brain to the thalamus, and then across a single synapse, to the amygdala. A second signal from the thalamus is then routed to the neocortex--the thinking brain. This branching allows the amygdala to respond before the neocortex, which mulls the information through several layers of brain circuits before it fully perceives and initiates a response (LeDoux, 1986).

Prior to LeDoux's observations, it was thought that the limbic system had to wait for the neocortex to give its permission for the amygdala to react. LeDoux's studies (1986, 1992, 1994) have shown that anatomically, the "emotional" amygdala can act independently of the neocortex. He posits that some emotional reactions and memories can be formed with no cognitive conscious participation. The amygdala can store memories and initiate response repertoires that we enact without consciousness, because the shortcut from the thalamus to the amygdala bypasses the neocortex. As the amygdala becomes aroused, either from external stress or internal anxiety, a nerve running from the brain to the adrenal gland triggers a secretion of epinepharine and norepinepharine, which then surge through the body, eliciting alertness. These neurotransmitters also activate the receptors on the vagus nerve which stimulates more rapid cardiac functioning. The memories become imprinted by the neurotransmitters resulting in an emotional charge. The more intense amygdaloid arousal, the stronger the imprint (LeDoux, 1986). Similar observations have been made by van der Kolk (1994) where he cites that when people are under severe stress, they secrete endogenous stress hormones that effect the strength of memory consolidation. He posits that "massive secretion of neurohormones at the time of the trauma plays a role in the long–term potentiation (and thus the overconsolidation) of traumatic memories" (p.259). He cites LeDoux's work in noting that this phenomenon is largely mediated by the input of norepinepharine to the amygdala. This excessive stimulation of the amygdala interferes with hippocampal functioning, inhibiting cognitive evaluation of experience and semantic representation. Memories are then stored in sensorimotor modalities, somatic sensations, and visual images (van der Kolk & van der Hart, 1989). From an evolutionary perspective, this is adaptive and allows animals to react quickly and protect themselves. Overreacting is, obviously, more adaptive for survival than underreacting (LeDoux, 1994). For humans, this method of allowing past, highly charged emotionally imprinted memories to control our present day functioning and relations is maladaptive. This notion has a profound implication on the way we understand and treat trauma and other nosological conditions; particularly vis–a–vis EMDR.

Turning, now, to dream (also known as D and REM) sleep, it has been posited that its presence suggests some sort of internal information processing (Aston– Jones & Bloom, 1981; Henry, 1994; Winson, 1993). Another hypothesis states that a necessary aspect of mammalian memory processing is the integration of individual experience into a strategy for future use (Winson, 1985, 1993). Experience gained during species–specific waking behavior is reaccessed and integrated into an animal's behavior strategy during D–sleep. The integrative memory process that occurs in humans is the same as in lower species, with one modification. In humans, the information integrated is no longer confined to specific behaviors, but consists of all waking experiences that pertain to psychological survival (Winson, 1993). Winson's (1985) studies of a variety of mammalian species found certain behavioral states (important for survival) and physiological conditions in which a particular rhythm of brain electrical activity (theta rhythm) can be regularly observed in parts of the hippocampus. He also noted that theta rhythm always appears in one other state in all the species studied, namely REM sleep. Since theta rhythm (during REM) occurs when there is no sensory input from the outside world, Winson posits that "it is as if certain information gathered during the day, information associated with survival behavior, was being dealt with again by structures in which theta rhythm is generated: the entorrhinal cortex and the hippocampus" (pp.190–91).

During sleep, a number of mid and hind brain structures and mechanisms become involved--the ascending reticular activating system (ARAS), the pons, and the locus coeruleus (LC). The ARAS can be activated by any sensory stimulus and subsequently, diffusely activates the entire cerebral cortex. The LC is extremely important to REM sleep. A major contribution of the LC to REM sleep is the activation of another set of neurons, the Gigantocellular Tegmental Field (GTF) neurons. These are very large cells located in the LC and in the reticular formations of the pons. They are thought to provide executive control of dream sleep (Henry, 1994; Reiser, 1994).

An important mechanism during REM sleep involves a distinct pattern of high amplitude electrical potentials in three areas: the reticular formations of the pons (P), the lateral geniculate (G) in the nucleus of the thalamus, and the occipital cortex (O); collectively known as PGO waves (Henry, 1994; Reiser, 1994). They appear to originate in the GTF neurons of the pons, occur just before the start of REM, and continue during the REM period. Observations have shown that a relationship exists between PGO spikes and rapid eye movement (REM)

(Reiser, 1994). The conclusion that PGO spikes represent a primary triggering process for phasic ocular movements is supported by the findings that in cats, the first derivative of the electrooculargram, during episodes of REM, is perfectly corrolated with PGO spike activity (Kelly, 1991). The conclusion is that the GTF cells drive the PGO waves and generate REM sleep (Henry, 1994; Hobson, 1989; Hobson & McCarley, 1977; Reiser, 1994). In order for GTF cells to become activated and for REM sleep to ensue, the noradronergic cells of the locus coeruleus must be quiescent. Put another way, there must be a suppression of the neurotransmitter norepinepharine (NE), also known as noradrenalin (Henry, 1994; Winson, 1993). Henry posits that GTF cells are activated at two times. First, they are highly active during D–sleep. Second, they are also activated when there are muscle and eye movements during wakefulness.

With the above discussion in mind, a good way to try to understand how EMDR appears to work is to outline the process of trauma, its sequalae in the brain, and then how EMDR appears to return the brain to homeostasis.

A traumatic event ensues. The amygdala sounds the alarm and sends urgent messages to every major part of the brain: it triggers the secretion of the body's fight or flight hormones and the hypothalamus is signaled to order the pituitary gland to produce corticotropin (CRF). It mobilizes the cerebellum for movement and signals the medulla to activate the cardiovascular system, the muscles, and other systems. Other circuits signal the locus coeruleus (LC) for the secretion of norepinepharine (NE) to heighten the reactivity of the brain centers, as well as suffusing the brainstem, limbic system, and the neocortex; in other words, setting the brain on edge. The hippocampus is signaled for the release of dopamine to allow for the riveting of attention (Goleman, 1995; van der Kolk, 1994). In most cases, the traumatic event wanes and the systems return to baseline.

If the trauma continues without abating, a feeling of loss of control and helplessness begins. The brain becomes overwhelmed, brain changes ensue, and the brain enters a state that we know as post–traumatic stress disorder (Goleman, 1995, Kolb, 1987). The LC becomes hyperactive, secreting extra large doses of NE in situations that hold no danger, but are, somehow, reminiscent of the trauma. The hypothalamus becomes hyperactive, continuing to signal the pituitary gland to secrete CRF, thus alerting the body to an emergency that is not there. The aroused amygdala signals opioid centers in the cortex to release endorphins which triggers numbing and anhedonia (van der Kolk, 1994). In effect, the neocortex is taken out of the loop. The left prefrontal cortex is unable to shut down the emergency systems.

Since NE levels are extremely high, GTF and PGO activities decrease or fail. REM sleep is disturbed or fully inhibited. The information that should be processed for a more adaptive tomorrow is misprocessed. As this continues for days, REM deprivation ensues. The emotional and cognitive interpretations of the event are distorted. The event is locked in the amygdala, and the neocortex is unavailable to mediate.

Shapiro (1994) noted that the examination of EMDR clients by qualitative analysis of electroencephalography (QEEG) has shown a normalization in the slower brain wave activity in the two cortical hemispheres. She cited Nicosia's position that the phase relationship of the two hemispheres is disrupted by the failure of NE suppression. This asynchrony prevents integrative memory processing. Nicosia (1994) suggested that EMDR resynchronizes the activity of the two hemispheres because the repetitive alternating stimulation mimics the activity of the pacemaker mechanism within the cortex that exists for this purpose and which was suppressed. The observations by Winson (1993) of pacemaker cells, in the septum, and their function appear to corroborate Nicosia's position. Kelly (1991) posits that pontine generated phasic activity is thought to be the pacemaker that drives many of the phasic events of REM sleep, including middle ear muscle activity, muscle twitches, changes in respiration, heart rate, and coronary flow, in addition to eye movements.

It may be that EMDR stimulates or emulates the pacemaker cells in the septum and/or the pontine saccade generator in the midbrain and resynchronizes the hemispheres. It is my opinion, that if true, this would seem to facilitate an integration of neocortical and amygdaloid activity. Stated more specifically, EMDR processing gradually shifts the brain activity from amygdaloid hyperactivity to activation of greater neocortical functioning. In other situations, where no cognitions are available, a predominant focus on body sensations leads to the amelioration of symptoms by apparently facilitating amygdaloid inhibition. Is it possible that attending to the negative cognition (NC), negative affect, SUDS, and body sensations brings the amygdala on line for EMDR stimulation and processing? This is probably most profoundly relevant to body sensations since so much response is observed when processing them. Can we view the reprocessing of the positive cognition (PC) as a stimulation of cells in the left prefrontal lobe of the neocortex?

If the above is accurate, it has great implications for our understanding and treatment of trauma, both chronic and acute, as well as other clinical conditions. It has long been known that many potent emotional memories date from the first few years of life. During this early period, other brain structures, like the hippocampus (crucial for forming consciously accessible memories and therefore, narrative memory, as well as the neocortex, the seat of rational thought)

have yet to fully develop. The amygdala, by contrast, matures very early in the infant's brain development (LeDoux, 1994; van der Kolk, 1994). LeDoux posits this as support for the position that psychodynamic psychology has taken: that the experience of life's earliest years lays down a set of emotional lessons based on the level of atunement between infant and caretaker. This sheds light on the difficulty traditional psychotherapy has had in ameliorating neuroses and character disorders. These early interactions are so potent and difficult to understand and work through from the vantage point of adult life because they are stored in the amygdala as rough, wordless blueprints for emotional life (LeDoux, 1992, 1994).

To state it differently, the target event has remained unprocessed because the immediate biological responses to the trauma have left it isolated in neurobiological stasis (Shapiro, 1994, 1995).

A multitude of questions remains to be answered. The hypotheses contained in this discussion need to be verified and operationalized. The neurophysiological meaning of the chronicity of these brain changes versus their acuteness remains to be understood. The neurophysiological understanding of the brain and of EMDR is not just for those who are so inclined or curious. It is crucial because it informs practice. If EMDR is used to treat chronic neuroses and personality disorders, and we understand that we are dealing with preverbal material, the above information may direct us to focus more on processing body sensations; using them as a language. What appears to be evident is that EMDR may be the first clinical tool that interfaces with the amygdala and the other limbic structures.

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CHILDREN AND OCD: EXTENDING THE TREATMENT PARADIGM

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Tammy, a vivacious 6–year–old, was brought to my office by her parents who had observed the development of ritualistic behaviors soon after Tammy started to walk. These rituals consisted of arranging her toys to such a precise degree that she was unable to leave her room until each toy was exactly in its place. As she grew older, cleaning became another compulsive behavior that paralyzed her. Tammy's ritualistic behavior was affecting the whole family to such an extent that her parents were blaming and fighting with each other, and her younger siblings were becoming "difficult" and "uncooperative."

Tammy became so compulsive that she fought constantly with her siblings because they could never keep the house clean enough to meet her standards. A great deal of Tammy's young life was spent "checking" for messes and dirt. Other children were not able to visit her home because they would alter her world and create chaos with her toys, which Tammy would then need to rearrange endlessly. Unless she completed these checking and arranging rituals, she felt nauseous and physically uncomfortable.

Tammy's parents were understandably frustrated with her behavior and considered therapy with me as their last available resource before they would resort to medication. My evaluation of Tammy supported a previous diagnosis of Obsessive–Compulsive Disorder (OCD), and I referred Tammy and her family to a major hospital–based treatment center here on the West Coast so that her parents could explore and evaluate other treatment possibilities. The treatment center supported my diagnosis of OCD, and medication was prescribed along with a behaviorally–based treatment plan. Because of the significant travel and time commitment involved in pursuing this recommended treatment, her parents felt they were unable to follow through with it.

I had been trained in Eye Movement Desensitization and Reprocessing (EMDR) and had applied it, with excellent results, to children in my practice who had been traumatized in auto accidents. In working with these children, I observed that the anxiety related to avoiding the initial stimulus dissipated after using EMDR. I considered the benefits of using EMDR to manage Tammy's OCD, and after discussing the current research regarding EMDR with her parents, obtained informed consent to treat Tammy.

I established a strong therapeutic relationship with Tammy. Using concepts from narrative therapy, I began talking with Tammy about her obsessions and compulsions and together we created an identity called "Mr. Clean," who compelled her to engage in these behaviors. She identified "Mr. Clean" as a bully who came to visit her at different times and forced her to clean her room and arrange her toys. This identity helped her to externalize and personalize her OCD. She stated that she knew her behavior was "silly," yet she could not help herself because "Mr. Clean" was very strong. He was so strong that when she tried to fight him, her stomach felt "funny," and this served as a reminder that she needed to do his bidding to avoid the nausea and physical discomfort she experienced. By listening to "him," and doing what he demanded, she was able to relax until he "visited" her again.

After establishing the identity of "Mr. Clean," I began using EMDR with Tammy. With very young children, I have found that it is important to give them the visualizations of the "trigger," or the initial constellation of associated experiences surrounding the presenting problem. In this case, it was the anxiety related to the OCD. Additionally, I gave Tammy the visualizations that helped her continue the process of desensitization and reprocessing from beginning to end.

For example, I gave Tammy the visual cue of "Mr. Clean" whispering in her ear, telling her to clean her room and to arrange her toys. Additionally, I asked her to feel the "funny" feeling in her stomach when he "visited" her. I asked her to follow my hand movements until I observed her taking a deep breath. Taking a deep breath after a series of hand–eye movements was a physiological cue which meant that she had completed her initial desensitization and was ready to move on to the next visualization.

The next image I utilized was of "Mr. Clean," or Mr. OCD, becoming a bully and being mean to her in a way that was familiar to her. Again, I used eye movements to help her release the emotional blockage, desensitize, and reprocess this visualization. I then asked her to see herself telling "Mr. Clean" that she was not ready to listen to him and that he had to come back later. The next visualization, with subsequent eye movements, consisted of her becoming bigger than the bully and in a powerful tone, telling him to come back later.

In order to give Tammy an opportunity to utilize her parents effectively, another visualization with accompanying eye movements, was developed. This consisted of her asking her par-

ents to hold her hands and help her with deep breathing exercises when "Mr. Clean" became a bully. The final visualization I suggested was of a very small "Mr. Clean." Each time that Tammy said "later" to him, he would become smaller until he became insignificant. She then described him as being like an itch and if she scratched the itch, he went away.

To deal with family system issues, I included the parents by helping them devise a reward system for Tammy. To prevent sibling rivalry and to depathologize her behavior, her siblings were rewarded for positive behaviors as was Tammy. She was rewarded every time she asked her mother to hold her hands and count her deep breaths until her anxiety diminished. Her siblings were rewarded for positive interaction with each other without any ensuing fights.

All of this was accomplished in just three sessions. At Tammy's last session, her mother noted that after each round of eye movements, Tammy appeared physically tired, as if she had spent a great deal of energy. At this last session, Tammy's mother also reported that Tammy had significantly reduced her compulsive behaviors and no longer needed to clean house or arrange her toys. As her mother stated, "She is becoming a normal 6–year–old." At this point, a new visualization was added to treatment. This consisted of Tammy being in different scenarios of her life, and as "Mr. Clean" would come to visit her, she would say to him in an emphatic and commanding voice: "Later, Mr. Clean! I am not ready to listen to you now!"

Tammy's mother stated that Tammy was indeed coming to her for help in doing the breathing exercises and was rewarded as previously arranged. She noted that the sibling rivalry had decreased considerably since the other children were included in the reward system, and I encouraged her and her husband to continue the reward system with all three children to strengthen the sibling subsystem.

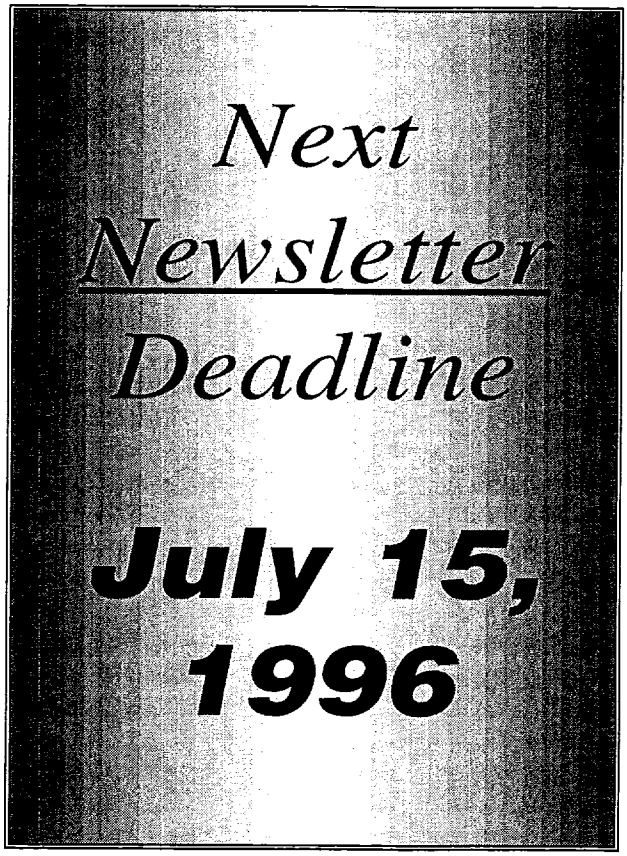
After the third and last session, Tammy's mother reported that Tammy did not exhibit any compulsive behavior and that the family had normalized their interactions. Both of Tammy's parents were pleased that medication would not be necessary. We agreed that should additional sessions be needed, they would not hesitate to call me. Six months later, her mother reported to me that her compulsive behavior had not returned.

At a follow–up appointment a few months later, Tammy's mother reported conversations in which Tammy said that "Mr. Clean" was getting stronger. Furthermore, Tammy's mother believed that Tammy was experiencing physical and emotional discomfort. Tammy was asked by her mother if she needed to return to see me. Tammy stated that she was not ready to do that and that she wanted to work this out with "Mr. Clean" herself. Her mother reported a few weeks later that Tammy had indeed worked it out and that her visible discomfort had diminished considerably.

Summary

Children with OCD present a unique challenge to clinicians. Though medication has been proven to help many children with OCD, there are still some side effects to these drugs which may be undesirable. Because of the creative imagination of children, visualization can be presented by the clinician in a way which makes sense to the child. By externalizing the OCD, the child can create a relationship with the problem and begin to contextualize it in a manner in which he or she can effectively deal with it.

EMDR has been shown to be effective with some children when dealing with trauma and anxiety, and its use appears to provide an efficacious treatment approach for some children with OCD. It appears that in certain instances, children can be quickly treated and given a lengthy period of respite from the physical and emotional disturbances caused by the OCD without the need for medication. Additionally, this method appears to be gentle in nature and readily accepted by both children and parents. It is important to study this approach further through standardized clinical studies to determine its long–term efficacy.



Visualization for Survivors of Molest

Carol Anderson, MS
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In my work with survivors, I have been noticing some interesting patterns developing in those who make particularly rapid progress.

This pattern consists of five basic steps which occur, more or less consistently, during the EMDR process. For clients who progress rapidly, this pattern occurs both spontaneously and visually. When progress is slower, the pattern is absent, unless clients are prompted to think about scenes using cognitive interweave. The pattern is more effective when clients are allowed to creatively build the scenes in a manner that fits their own needs and experience.

The five steps include:

1. **Distancing** – Usually by the third set of eye movements, clients remark that they see the target incident at a distance, rather than it happening to them. This appears to be necessary for objectivity and to allow the adult survivor to begin to gain control in the scene.

2. **The Rescue** – The adult survivor in some way intervenes in the abuse and rescues the victim child from the hands of the perpetrator. Often it includes taking the child out of the place of abuse (perhaps to the identified "safe place" with the survivor adult). This results in an amazing sense of control and empowerment for the adult and a sense of never before experienced protection for the child.

3. **Reassurance** – Once the child is safe, the adult reassures the child that she is indeed safe, it is over, and it was not her fault. It may also include expressing love for the child and other such positive feelings as appropriate. This allows the child to receive validation and results in the adult being able to esteem and accept herself.

4. **Integration** – At this point, clients usually need to be prompted to put their arms around the child, give her a hug, and draw her into the adult's heart, where she remains safe, protected, and valued.

5. **Closure** – Clients are asked to construct a scene whereby they can come to some kind of closure with the perpetrator. They are encouraged to let their imagination "run wild," to do anything they want. (Clients who are more repressed may need to be given some ideas.) Sometimes this involves merely an angry conversation, but often these scenes may become quite violent. (If the perpetrator is still alive, it may be a good idea to remind the client that while anything goes in the imagination, it would obviously not be appropriate to act out her fantasy.)

In summary, it is my observation that these steps appear necessary to complete a full resolution and integration of the abuse. If the client does not have the resources to spontaneously create these scenes, more help and guidance may be provided through the cognitive interweave process. I have had success in guiding clients through these steps by providing general ideas and then having clients create their own personal scenes during the eye movements.

I have not attempted to research this pattern, but if you have had similar experiences or have other ideas, I would appreciate your writing to me and letting me know.

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The Humanitarian Assistance Program, Inc.

Steve Silver, Ph.D.

One of the things that attracts many of us to EMDR is its ability to alleviate human suffering. We have seen how such suffering can be visited upon following generations who, in turn, become links in a chain of pain and despair which continue seemingly without limits.

EMDR offers an opportunity to break such chains, in addition to its immediate benefit of resolving and ending the immediate suffering of survivors and victims. In order to provide more opportunities to bring EMDR where it is needed, Dr. Shapiro formed the EMDR Humanitarian Assistance Program (EMDR–HAP).

Background

The need for such a program was identified early. EMDR clinicians, equipped with a new and powerful therapeutic tool, began to offer themselves for assistance in a variety of settings. For example, following the devastation of Hurricane Andrew in Florida, a group of EMDR clinicians responded to the survivors. This was the first large scale response by the EMDR community to a disaster.

As a result of her original research study, Dr. Shapiro recognized that EMDR could provide American war veterans relief from their suffering. She offered to train Department of Veterans Administration (DVA) clinicians at no cost, but the DVA was reluctant to make use of what appeared to be a relatively unproven treatment methodology. Eventually, however, this changed. After repeated successes with EMDR by clinicians within the DVA, a program for training DVA clinicians was developed. Since then, over 220 clinicians have been trained at DVA Medical Centers from Maryland to Pennsylvania to New York to Arizona. (DVA clinicians are still offered discounted training where they are unable to make use of the DVA–EMDR training.)

Current Programming

It is a tremendous logistical challenge to develop the organization and procedures of the Humanitarian Assistance Program, Inc. while simultaneously delivering services. In spite of this, since EMDR–HAP formed last year:

* We sent a volunteer training team to Sarajevo, which resulted from our successful training in Zagreb, Croattia earlier in the year.

* We completed our volunteer effort in Oklahoma City.

* We are developing teams for Belgrade, the Navajo Nation, Northern Ireland, Rwanda, and Hungary.

* We are examining the possibility of a Level II Training for the Balkans, as well as considering a project for providing EMDR in prison settings.

The range of what has been done and what is in the planning stage suggests the possibilities for the future. EMDR–HAP is oriented towards providing three kinds of services:

* Training in the EMDR method for mental health professionals.

* Treatment with EMDR for individuals surviving recent traumatic events.

* Assisting in developing EMDR applications for new populations.

Tapping into EMDR–HAP

The procedure for engaging EMDR–HAP is relatively straight forward. A request for EMDR–HAP is received by the Programs Chairperson of the EMDR–HAP Board of Directors. If the request is appropriate, the Programs Chairperson will designate a Project Coordinator to oversee the assistance provided. If the assistance will involve a training, the Programs Chairperson will identify an EMDR Senior Trainer to serve as the Training Team Leader.

The Project Coordinator has the responsibility of determining the nature of the need in detail, liaisoning with other agencies as needed, and ensuring the appropriate level of logistical support for the services to be provided.

The Training Team Leader is responsible for organizing the training team. In high stress situations, a second Senior Trainer may be assigned and will be the Team Leader's immediate assistant. Volunteer, designated Facilitators will be assigned to the team as needed, with numbers being determined by the amount of people to be trained and resources available to transport them.

All training will involve ongoing follow–up with the Senior Trainer. If appropriate, the Project Coordinator will be available to the trained group for consultative purposes by FAX, e–mail, or other means.

From the above, it is hopefully clear that EMDR–HAP may become involved either as a result of a request generated from the "grassroots"--that is, from people involved immediately in a situation--or the result of efforts from an EMDR clinician recognizing a need and seeking to gain support in providing EMDR services for that need. What this translates into is an opportunity for EMDR clinicians to provide help where they believe it is needed.

For example, an EMDR clinician might be aware of a mental health program that has clients who may benefit from EMDR, and the clinicians are without funds to obtain the training in a commercial setting. The EMDR clinician does the leg work: makes contact with the mental health program, provides information on EMDR, perhaps does presentations on it, and then, after ascertaining that there is interest in training, contacts EMDR–HAP.

EMDR–HAP might provide scholarships for the clinicians to attend a regularly scheduled training or, if the number is large enough, might see about arranging a training specifically for the clinicians by asking for a Senior Trainer to volunteer. The Trainer and the Project Coordinator would set about getting the training to the clinicians. Particular areas might be emphasized to

reflect the special needs of the clinicians, such as, for example, children or recent disasters.

It might be that the EMDR clinician is not in a position to serve as the Project Coordinator. If so, EMDR–HAP would seek out another person to do that job.

The big job of EMDR–HAP, once a project is initiated, is to serve as a resource for the individuals actually doing the job. Hopefully, at some time we will be at a point where we will be able to provide financial assistance. In any case, we will be able to provide information to team members and serve as a central clearing house for requests.

How You Can Help

Many individuals have expressed an interest in volunteering for EMDR–HAP activities. If interested, please contact Mary Ann Gutoff to see about being entered on our database. We are particularly interested in identifying EMDR clinicians with special skills such as foreign language abilities, a willingness to do logistics work, ability to assist with research, and so forth.

While reading this, you may have noticed that none of the names of the EMDR clinicians who have worked in these projects have been mentioned. The reason is simple. At the first meeting of clinicians interested in forming HAP one of us said that for this to work, we would have to leave our egos at the door. What is important is the mission and the people we seek to help.

Although we have nearly 300 volunteer therapists ready to donate their time and expertise to service, EMDR–HAP currently has no money to support its programs. As we struggle to obtain grants and develop creative fund–raising approaches, we are utterly dependent upon contributions. All contributions are tax deductible. Please send contributions to:

MaryAnn Gutoff, EMDR–HAP
P. O. Box 1542
El Granada, CA 94018
415–728–5440 FAX 415–728–2246

The current Chairperson of EMDR–HAP is Steve Silver, Ph.D. If you are interested in developing an HAP project, please feel free to contact him:

Director, PTSD Program
VA Medical Center
Coatsville, PA 19320

Steve Silver, Ph.D.

INSURANCE COMMITTEE

Under the leadership of Chair Mark Dworkin, the EMDRIA Insurance Committee is working to establish EMDR as a CPT Code for third party payors, including Medicare, Medicaid, managed care, and indemnified insurance companies.

INTEGRATING EMDR INTO THE PSYCHODYNAMIC TREATMENT PROCESS

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EMDR was originally developed utilizing cognitive therapy theories and constructs (i.e., cognitive/behavior restructuring, information processing, rating scales) (Shapiro, 1995). Accordingly, the relevance and potential application of psychodynamic concepts to EMDR went largely unnoticed. However, Dr. Shapiro formed the concept 'synclectic' (synthesis of the eclectic) as she recognized the analytic contributions to EMDR such as the significance of early childhood memories, the unconscious, free association, insight, catharsis, abreaction, and symbolism (Shapiro, 1995). In fact, a psychodynamic therapist incorporating EMDR into his or her technique cannot help but learn and recognize the value of many cognitive ideas and practices. The same holds true for cognitive practitioners who can discover that the use of EMDR opens to them the shadowy world so familiar to the analyst. Accordingly, EMDR lies at the confluence of two great rivers of thought which is further evidence of its profound nature.

For the sake of clarity, it is important that I define terms as they are used here as they often have multiple usages and meanings. In this article, psychodynamic and psychoanalytic or analytic are used interchangeably. It is essential to note that word psychoanalysis not only connotes the method of treatment Freud devised, which is for the most part outmoded, but refers to the body of knowledge developed and redeveloped by Freud throughout his life in addition to the more modern theories of developmental (ego psychology and separation/individuation) and self psychology.

Throughout his life, Freud faced the limitations of the treatment method he developed and refined over many decades. He admitted the need to, "Alloy the pure gold of analysis," by modifying his treatment model (Freud, 1919). He even wrote of imposing time–limits in his 1937 monograph, Analysis Terminable and Interminable. Although EMDR is at its most effective when utilizing the complete protocol, I have also experimented on occasion with modifications of technique which alloy the pure gold of the protocol.

With a portion of clients in my practice with whom I work in a more long–term, insight oriented modality, I integrate EMDR into the treatment in two ways. The first is used with trauma material, when the patient is blocked

or stuck and for which I use a fully developed protocol. The second approach, employed at moments when I hear material that is clearly EMDR responsive, such as distorted negative beliefs and self–statements ("I can't do anything right," "My life has no value") or positive cognitions that can be installed ("I'm not responsible," "I am valuable"), I might say, "Would you like to process this?" This becomes a coded communication the client understands for immediately utilizing the method.

A striking parallel between EMDR and the analytic approach is the use of free association. The client is instructed during EMDR to observe and report back, if he or she chooses, any thoughts, feelings, bodily sensations, or memories which may occur during each set of eye movements. In EMDR, however, any immediate discussion of these associations is discouraged as it interferes with the need to continue processing. In analytic therapy, free association is used as a tool to plumb the deeper hidden meanings of symbolism expressed through dreams, screen memories, and parapraxes (slips of the tongue, mislaying of objects, etc.). When material of this kind surfaces in session, instead of asking the client to associate to it, I ask if he or she wants to process it. I have found this to be a more reliable and efficient method of helping the client understand the workings of his or her unconscious mind. I have also found that EMDR dramatically speeds up the associative process, almost like putting a tape into fast forward. I refer to this as "accelerated associating."

A vexing problem we encounter in our clinical work is that insight often leads to intellectual understanding which does not translate easily, if at all, into emotional integration. With remarkable effectiveness, EMDR often bridges the gap between the cognitive and affective spheres. This raises the following questions: What is the ego's involvement with the EMDR process? and Does EMDR bypass or activate the ego? These queries deserve much thought and investigation. My preliminary impression is that EMDR processing, despite apparently operating out the conscious volitional control of the client, activates a variety of ego functions. A typical byproduct of EMDR is enhanced perspective, insight, and self–understanding. This is consonant with the ego functions of perception of external reality, self–perception, and the synthesis of external and internal reality.

There are interesting parallels between the analytic technique of interpretation and the EMDR strategy of cognitive interweave. Both are aimed at helping the client when he or she is unable to make use on his or her own of the natural treatment flow. In EMDR, the interweave is used with patients who may present with, among other things, complicated pathologies and who tend to loop, block, or be limited by inhibiting belief systems. This strategy can be used with any client when the processing becomes blocked. Analytic interpretation is used to facilitate the process of making the unconscious conscious. Proper timing is essential for successful interpretation and is determined by addressing preconscious material that is close to breaking through to awareness. The melding of the EMDR and analytic techniques has been coined the "dynamic interweave" by my colleague, Uri Bergmann. It is accomplished by utilizing analytic listening to material being processed with EMDR with particular sensitivity to emerging preconscious ideation which is then interpreted and interwoven into the processing. This is a powerful technique which can deepen and speed the resolution of the conflict or trauma. It is often best employed socratically by a pertinent, leading inquiry which will likely be responded to in the affirmative. The positive retort can then be immediately installed with great effectiveness. For example, a well timed, "You seem angry, are you?" may be answered with an emphatic, undistorted "yes." In this procedure, the client is induced to explore his or her own thinking and arrive at his or her own answer. This accomplishes a stimulation of the client's neurophysiological system leading to the installation of the material as genuinely emanating from him or herself, not artificially forced in from an outside source.

When introducing EMDR into an ongoing analytic therapy process, many issues must be considered, e.g., the effect of EMDR on resistance and transference. My experience has been that resistance emerges to EMDR as it does to the analytic treatment process. The greater anxiety appears to be in giving up the the secondary gains of passivity and internalized aggression in the form of self–punishment. However, the making conscious of unconscious material appears to occur with less resistance, perhaps because of the concurrent desensitization and gained perspective that so often accompanies it with EMDR treatment. Transference responses to EMDR usually relate to the relative speed and ease that movement is accomplished, as contrasted with the painstaking and incremental changes which come with more traditional treatment. In the short term, EMDR may alter thinking patterns, awareness, and symptoms; however, character is not easily effected. It is fascinating to observe the conflict in clients who symptomatically no longer need treatment, yet find their attachment to the therapist and the holding environment remaining undiminished. I have also observed occasional, subtle transference reactions regarding the "magical quality," implied power, and intrusion of the therapist performing EMDR.

The issue of the effectiveness of EMDR in the treatment of personality disorders, some of the most difficult individuals to treat from any orientation including analytic, is controversial. There are experienced EMDR practitioners who report having little success in treating individuals with rigid, ego–syntonic, maladaptive character structures. My experience has been otherwise,

although one's treatment approach needs to be modified to address the special needs of this population. No treatment can proceed unless rapport has been established and there is sufficient trust in the therapist. One must be cognizant that this takes time and cannot be rushed. I have found that EMDR is far and away the most effective clinical tool in modifying character structure. Uniformly, this population has experienced repeated early traumas and accurate EMDR targeting of these events results in softening of the rigidity, and in increased internal and external relatedness. It is crucial to stay with one protocol until full desensitization and reprocessing has occurred. Significant movement on the SUDS and the VoC will often times require many weeks and at times months and accordingly, there are therapists who erroneously believe the work is ineffective and give up. Of course, active use of the cognitive interweave is necessary to bridge the many gaps found with this population. Additionally, a combination and variation of different techniques is required. I have found that high repetitions of eye sweeps (100 to 400) can accomplish movement that briefer repetitions would not accomplish with concretized material and deeply distorted beliefs. I have also found that repeated returns to target, even if processing is still occurring, seems to jar lose rigidly entrenched beliefs and perceptions. Active targeting of ego–syntonic pathology can initiate a slow emergence of more healthy and appropriate ego–dystonic mentation.

Obtaining EMDR training and integrating it into one's practice is not an emotionally simple venture for the analytic therapist, especially one who is institute trained. He or she can struggle with the internal guilt of violating allegiances or the fear of being exposed, cast in a negative light, and ostracized by teachers, supervisors, and colleagues. A dramatic shift away from the way one has practiced successfully and comfortably for years raises a therapist's anxiety level as he or she is knocked out of his or her comfort zone. I have personal knowledge of many "EMDR dropouts" who despite attending EMDR trainings, cease using the method. We all have struggled in doing treatment with the ubiquity of our countertransference reactions to our clients. In employing EMDR, the analytic therapist has to consider countertransference issues such as whether he or she is using it out of frustration or to control or distance him or herself from the client, whether he or she is using it too much or too little, and to face the fear of the repressed traumas that may emerge.

The EMDR process has much in common with the analytic approach. It focuses deeply on the individual's intrapsychic mechanisms: affect, cognition, dream work, fantasies, repressed memories, somatization, unconscious defenses, conflict, self–perceptions, and early object relations. With the aid of EMDR, we can more effectively treat patients who are stuck, who change at a snail's pace, or who are unable to translate intellectual into emotional understanding. As the analytic clinician must be caring, sensitive, thoughtful, and respectful, the same demands apply to the EMDR practitioner. The psychodynamic therapist untrained in EMDR can refer ongoing clients for consultations with an EMDR clinician to address issues of post–traumatic stress disorder or childhood trauma in order to expedite the client's treatment process. Individuals who have completed analysis, often clinicians, can receive EMDR to address unresolved issues, especially before considering a second analysis. I have found that people who have been analyzed are usually highly responsive to EMDR.

In conclusion, I have presented my observations and experiences in integrating EMDR into analytic, dynamic, insight oriented treatment. This is a work in progress in its early stages. I am aware of only a handful of other practitioners in the field who also pursuing this pioneering work. It is important to be at least informed as to these advances in practice. For those of you with interest in this area I encourage you to join me in further exploring the variety of ways that EMDR can be creatively be melded with the in–depth approach.

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REGIONAL NETWORK

The old EMDR Network Meetings are being reorganized to EMDRIA Regional Network Meetings by National Coordinator, Liz Snyker.

Liz is in the process of contacting all EMDR Network Coordinators and seeking their help. We will provide a list of all Regional Coordinators in the next Newsletter.

Contact Liz at (619) 942-6347
Her address: 191 Calle Magdalena #230
Encinitas CA 92024

International Update

Francine Shapiro, Ph.D.
Senior Research Fellow
Mental Research Institute

This year has been a very impressive one for the new non–profit organization we have called EMDR Humanitarian Assistance Programs (EMDR–HAP). As of April 1996, we marked the first year existence, with the first mobilization of resources going towards efforts following the Oklahoma

City bombing. As a result, almost 300 people were treated by clinical cohorts who rotated in on a weekly basis, and almost 300 clinicians received pro bono EMDR trainings. The full details have been given in previous Newsletters.

In addition, EMDR–HAP has also sponsored a number of pro bono trainings throughout the world. There were trainings in Zagreb in March of 1995 and in Sarajevo in December 1995. The training team included Steven Silver, Gerald Puk, Geoffrey White, and Susan Rogers. Additional trainings are being planned for that region this year as well, including the possibility of one in Belgrade. This would mean that there would be the possibility of opening lines of communications among the three sides of the war through the EMDR trained clinicians. We have also done a pro bono training in Kiev with Roger Solomon as the trainer, and Ad de Jong and Dan Merlis as the facilitators.

I presented a training in Bogota, Columbia with an organization called "Forjar" which works with abandoned children who have AIDS or cancer. It was one of the most touching experiences in my life. With me as facilitators were Pablo Solvey, Graciela Rodriquez, John Hartung, and Linda Vanderlaan. We had the joy of teaching EMDR to clinicians who really appreciated its possibility not only for their clients, but for the country as a whole. In addition, we were able to work with some of the children at the site. The results were heart– warming, starting with the first night when Linda Vanderlaan helped a little girl who had just had her leg amputated get rid of the phantom limb pain with EMDR. Other trainings are planned for that region in the near future.

Another recent EMDR workshop was done as a joint sponsorship with UNICEF. It took place in Rwanda with Roger Solomon as the trainer, and Bob Tinker as both facilitator and the trainer for a special workshop on children. The primary reason for going was to work with clinicians who would be treating refugees, especially the children traumatized from the war. The need was great and a great deal of flexibility was needed to work under difficult conditions. A heavily subsidized training is taking place for the second time in Israel this month. The goal is to have other trainings in the region as soon as possible. Anyone with contacts in other countries, please let us know. There cannot be peace until some of the pain is healed on all sides.

Another training is tentatively scheduled for August of this year for the Navajo Nation. The training will be open to Native American clinicians and will be led by Steven Silver who has previously worked with this population and published on the use of Native American rituals in the treatment of PTSD. Volunteer facilitators will come from all over that region. Other trainings in the planning stage include one for Budapest and one for Northern Ireland. Please let us know of any other sites you would like to see included and how much responsibility you can take for making the contact to allow it to happen. As much as we may want to go and give, we cannot do it unless someone is willing to receive.

With this activity, there is an obvious need for funds. Please support HAP with a contribution so we can continue to make things happen.

In the last Newsletter, I voiced a desire for feedback regarding how to structure the different EMDR organizations and settle on a relationship among them. The feedback I have received has led me to suggest that EMDR–HAP stand independently, receiving contributions directly from clinicians, organizations, and the public. As you know, EMDRIA has from its inception stood independently as the professional organization. It has now taken over the functions of handling the conference, Newsletter, and directory and is the liaison to managed care and other professional organizations. The EMDR Institute continues to be an independent training organization, and will shortly begin a program for proficiency assessment to begin a preferred providers list that will be used for referrals.

The feedback I have received has mostly been directed at the function of the Network. Since all of its functions have been taken over, there appears to be no present need for the organization. Therefore, it will be my recommendation that the EMDR Network be inactivated for at least one year--and possibly for good. The confusion among many people about the different organizations seems very great and this seems like the best way to handle it. We will take suggestions regarding any role you might want to see the Network have, if any. For now, if the conference participants endorse this idea, it will be retired to avoid needless confusion.

I want to thank all of you who are reading this for supporting EMDRIA. The birthing of a new organization is difficult and needs the patience and participation of all involved. This is a time of transition when the future of EMDR is being forged by those who are practicing it in the trenches. Although I have no role in the organization, I can say as an onlooker, that it needs, and deserves, your support. Please vote in the upcoming elections and please consider becoming an even more active participant. You have countless talents that are needed to allow EMDR to make the contribution to the globe that it is capable of doing. There are many committees to choose from, many roles you can fill. Please offer your guidance where, and in the way, it can do the most good. As I have said before, the overall vision is to contribute to global harmony as best we can. For us to help to accomplish that, it must first begin with us.

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FROM THE EDITOR

Lois Allen-Byrd, Ph.D.

I want to take this opportunity to acknowledge those individuals who are the founding members of the Board of Directors of EMDRIA. It is because of their diligence, dedication, hard work, and belief in EMDR and its potential, that EMDRIA is a reality. Without their contributions--individually and collectively--the transition to EMDRIA would not have been a smooth one, and EMDRIA would not be the viable organization that it is today.

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I also want to acknowledge those individuals who chaired the various committees. They too have been instrumental in the transition.

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I know that all of you join me in thanking each of these people for their tireless efforts in establishing EMDRIA and making the transition a smooth one.

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