EMDRAA Newsletter April 2017

A belated welcome to 2017. It doesn't seem that long ago that we were enjoying a marvellous conference in Melbourne. That was five months ago, so what have we been doing since.

We welcome three new members to the board, and I'm pleased to report that they have all taken on significant responsibilities, spreading the load on what was an overworked executive team.

Carolyn Burrows takes care of brochure orders, and has bravely taken on the task of coordinating the maintenance of our website, which has fallen a little behind.

Zineta Dedovic is heading the team planning our 2017 conference. Further details will be announced shortly, but you can put aside the dates of 16-17 September when in Sydney we will be hosting Dr Robert Miller for a two day training on the Feeling-State Addiction Protocol. We had many requests after the November 2016 conference for specialised training in this area, and this comprehensive protocol has attracted much interest. Zineta is also coordinating our ongoing webinar program.

Larissa Meysner has taken in the task of producing our Newsletter. We will also be communication more regularly with the membership, with emailed EMDRAA Newflashes. We are mindful of how much email everyone gets, but there sometimes is a need to communicate more often than a Newsletter.

The application to Medicare to have EMDR recognised as a treatment has taken another big step forward. We employed Sarah Dominguez, who is doing an EMDR-related PhD, to produce a detailed report as required by the Medicare people. We await the next step. As is detailed elsewhere in this newsletter, the whole procedure requires several steps, and we don't anticipate any final result in 2017, but we are making progress.

Members in New South Wales will know of the restrictions that the state Victims of Crime body places on EMDR in the treatment of people suffering crime related trauma. Our initial approach to have this reviewed did not go anywhere, so we are taking a more informal approach, attempting to get the key people on side, and to fully understand the official position so we can better challenge it in an appropriate manner.

Many of our Accredited Consultants are nearing the end of their five year accreditation, and we are exploring the question of reaccreditation standards. This is something we have not had to face until now. EMDRIA is looking to move towards competency based standards, and that is something that we too are keen to explore. A subcommittee of the board will be preparing a draft of ideas, which we will then share and discuss with consultants and trainers.

The association enjoyed a huge growth of membership in 2015 and 2016. This was without any formal efforts on our part to promote the Association to practitioners and trainees. This is

something that we wish to move on. A strong association has the resources to provide more for its members, and in turn these resources are an attraction to join the association. Already we have 19 hours of quality professional development available on the member's area of the website.

Last year the Association made its first ever research grant to an Australian researcher. I'm pleased to announce that for 2017 the board has set aside $15,000 to support EMDR research in Australia and New Zealand. Guidelines for applicants will be announced shortly, and will be actively promoting this research fund to universities and other health organisations throughout the country. This endeavor highlights EMDR as a serious area for research in arenas where it has not had a presence. The vast majority of university training programs either completely ignore or EMDR or promulgate fallacious and misleading information about it. Hopefully our initiative will help change this.

As I write this I am preparing to leave for the EMDR Asia conference in Shanghai where the board of EMDR Asia, of which EMDR Australia is a member, will deliberate on matters pertaining to the governance of EMDR associations in our area. It appears that EMDR Australia is far more advanced in the establishment of standards and procedures than other countries in EMDR Asia.

All the best for 2017.

Graham Taylor

Graham Taylor

EMDRAA President

Springer Journal Update

Those who took to optional EMDR journal subscription when joining or renewing should have received their login details from Springer. This enables you to access the very latest editions as they are produced.

For those who did not take the subscription, you can still access all issues apart from the last 12 months by going to the open access page. The URL is

http://www.ingentaconnect.com/content/springer/emdr

Medicare Submission

An application has been drafted to the Australian Government Department of Health to propose that EMDR Therapy be listed as an additional, individual Focused Psychological Strategy under the Medicare Better Access to Mental Healthcare Scheme.

Much time and care have gone into describing the detailed information required by the department, in order for them to determine whether a proposed medical service is suitable or appropriate for addition. Dr Chris Lee's research assistant, Sarah Dominguez has done a very comprehensive and thorough job of attaching a summary of research evidence to demonstrate the effectiveness of EMDR therapy. The board is in the process of refining this application and ensuring that all allied health practitioners who provide services under the Better Access Scheme are included in the proposal.

This will likely be a long process as once this draft is submitted to the department it will then be sent to a committee who will determine if the application is worth further investigation. Further requests for information might be made or other refinements or amendments necessary. From there EMDR will be judged on its treatment and cost effectiveness before being added as a Focused Psychological Strategy. So it might be a long road in the end, but this is definitely a worthwhile goals; to give EMDR the recognition it deserves and increase clients' accessibility to this treatment under Medicare.

Zineta Dedovic

Brainspotting was developed by David Grand, as an evolution from EMDR. This brief note appears as an advertisement.

Brainspotting

Brainspotting is a powerful, focused treatment method that works by identifying, processing and releasing core neurophysiological sources of emotional/body pain, trauma, dissociation and a variety of challenging symptoms. Brainspotting is a simultaneous form of diagnosis and treatment, enhanced with BioLateral sound, which is deep, direct, powerful yet focused and containing.

"Brainspotting is based on the profound attunement of the therapist with the patient, finding a somatic cue and extinguishing it by down-regulating the amygdala. It isn't just PNS (Parasympathetic Nervous System) activation that is facilitated, it is homeostasis." -- Robert Scaer, MD, "The Trauma Spectrum

Brain-based therapies are the fastest growing field of psychological health because of their proven ability to address issues that talk therapy can take years to heal.

Dr David Grand has combined the strengths of both brain-based therapy with the importance of a highly attuned relationship between the client and the therapist from talk therapy into a powerful technique he calls Brainspotting® which is a brain-based relational therapy.
Trauma can overwhelm the brain's processing capacity, leaving behind pieces of the trauma, frozen in an unprocessed state.

Brainspotting® uses your field of vision to find where you are holding pieces of the trauma in your brain. Your eyes can actually scan inside your brain as well as outside! Brainspotting® uses this inner scanning ability of your eyes and brain to identify an external spot in your field of vision and while you focus on it, your brain begins to naturally release and resolve the frozen pieces of your unprocessed trauma. The motto of Brainspotting® is, "Where you look affects how you feel."

2017 Training Dates		
Brainspotting Phase One	28-30 April	Melbourne
	19-21 May	Sydney
	21-23 September	Christchurch, NZ
Brainspotting Phase Two	24-25 June	Melbourne

www.brainspottingaustraliapacific.com.au

BRAINSPOTTING
AUSTRALIA PACIFIC
WHERE YOU LOOK AFFECTS HOW YOU FEEL

Book Review

EMDR Scripted Protocols "Basics and Special Situations"

Editor: Marilyn Luber

This book is the first of a pair produced by Luber, the second bearing a similar main title, with a subtitle which addresses "Special Populations". They were typically bought as a pair and complement each other. While I have reviewed "Basics and Special Situations" on its own merits, it only presents half of the story as presented by Luber. I should note at this stage that I have both copies and have used them extensively.

The book is written in easy to understand English and divided into nine parts, each with its own theme and contributions from several authors. It is easy to find the information in the contents section but does not have a subject index at the back. The book is written for EMDR trained clinicians of all levels of experience. Hence "Basics and Special Situations" may appeal to lesser experienced clinicians with topics covering history taking and explaining EMDR therapy to clients, while "Special Populations" may appeal to more experienced clinicians with topics including dissociation, addictive behaviours and pain management.

Part 1 covers history taking and there is a caveat in the Preface which states, "it also includes several ways to summarise history taking material after a thorough history has been taken". Part 1 fails to provide the reader with information on what should be included in taking a client history that will facilitate the clinician to develop a necessary and clear "clinical landscape" of the client. This is most disappointing as the title implies that "basics" will be covered in the book. There is nothing more basic than knowing your client. I suggest readers will do better to familiarise themselves with the work of Arnold Lazarus and his Multimodal therapy assessment.
Part 2 focusses on explaining the AIP model to clients. Again this section leaves much to be desired and includes only two contributions. Neither entry does much to convey to clients the message that memories created from adverse life events in childhood, impact on them in the present.

Part 3 is where the book begins to shine with a section on creating resources. There is some good work presented here and Roy Kiesling's work is acknowledged with four entries. Sadly, the work of Korn and Leeds has not been included.

Part 4 introduces the client to drawing protocols. There are two articles presented. Interestingly Carvalho deviates from the standard protocol in desensitisation phase by omitting reference to the body (page 109). Freiha also varies the protocol in desensitisation phase with a self contradiction (page114) by introducing emotion into the protocol having omitted it in the sentence immediately before.

Herein lies perhaps the greatest flaw of the book. It would appear that Luber has accepted at face value the validity of the work of presented by contributors, some of whom do not follow the procedures as suggested by Shapiro.

Part 5 presents Shapiro's protocols as provided in her seminal text. It is pleasing to note that Luber has not varied from Shapiro's text and continues to use the following statement when establishing the positive cognition "When you bring up that picture or incident, what would you like to believe about yourself now ". The point being made here is that there have been shifts from this statement that have used words such as … " what would you prefer to believe about yourself " and the "now" has been omitted. I think Shapiro's original text got it right.

Part 6 introduces the concept of early intervention procedures. Two protocols worthy of mention are "Blind to the Therapist" protocol which facilitates processing of humiliating memories without having to provide explicit information to the therapist and the "RTEP" protocol which has recently been used as a group protocol with female Syrian refugees in Turkey.

Part 7 introduces the reader to group protocols for adults and children. Generally speaking, I do not think enough consideration is given to group work so the presence of this section is very much appreciated. The work of Artigas and Jarero is well respected worldwide.

Part 8 includes two contributions on performance enhancement and its presence in the "Basics" manual is thought provoking. Part 9, is about clinician selfcare and is well placed in this book.

One final point I wish to make regarding this book is that many of the protocols have not been validated by any reputable research. This caveat is provided in the Preface. However, the question does arise as to how many practitioners will have taken the time to read the Preface? I suspect that many clinicians, particularly the lesser experienced ones, may accept the protocols as "EMDR therapy truths" which is not the case. To this end, I think the books presentation may have been enhanced if at the

beginning of each contribution information was provided on the research that supported it, the specific context in which it had been used and author information for further contact.

Summary

I have found this book to be a useful addition to my EMDR library and I recommend it and its pair to readers. I think the second book offers more for the experienced clinician, but the first book certainly has a place. Its shortcomings presented in this review may be addressed with the reader maintaining an enquiring perspective and proceeding cautiously when examining the information provided.

Book Reviewed by: Sigmund Burzynski

EMDR Institute Senior Trainer

App Review

Provider Resilience

Creator: National Center for Telehealth and Technology

This app, available from the iTunes store, is designed for health care providers working with trauma clients – predominantly from a military background although the principles are the same.

It focuses on recording and tracking the provider's general wellbeing across key domains. The Dashboard is the app's most useful and valuable component and is very easy to use. It includes a vacation clock that records the time since your last holiday, and a quick check in around key resilience 'killers' and 'builders'. These include things like skipping lunch, working on weekends, taking a short work, laughing, performing stretches and so forth. There is also a Burnout survey with an easy to use rating scale focused on key emotions like feeling connected, satisfied, worn out, valuable, traumatized etc.

The dashboard also has a link to the Professional Quality of Life scale (ProQOL). After completing it allows a visual representation of the provider's scores on the subscales of Compassion Fatigue, Burnout and Secondary Traumatic Stress.

A tools section contains additional resources such as Physical Exercise (prompts for at-work stretches), I need a laugh (daily Dilbert Cartoon) and client stories to Remind me why I do this. There is also a section with values cards based on the Virtues Project, although their relevance to resilience or application is not well explained.

The user can modify the settings including the option to set daily reminders and the time for these.

Summary

Overall, the app is a useful and portable tool for keeping oneself accountable for the self-care and compassion fatigue we are all aware of but may not deliberately record. The tools section does not feel especially continuous or well thought-out, and some users may not find a Dilbert cartoon helpful nor funny.

I find the app's most appealing function is the ability to graph ProQOL and Burnout scores over time, and in particular the visual representation of key ideas including the vacation clock on the Dashboard (pictured).

App Reviewed by: Larissa Meysner

Research

PTSD and Sleep
Gehrman, Harb & Ross (2016) in

PTSD Research Quarterly

For those of you interested in PTSD Research, this quarterly publication by the US National Centre for PTSD provides comprehensive yet easily digestible updates on current research. A summary of the literature and key ideas on each topic is followed by clear and concise summaries of relevant research paper.

In Volume 27, the sleep problems inherent in so many cases of PTSD are reviewed in further detail, including treatment approaches such as pharmacotherapy, cognitive behavioural treatments and group treatments specifically targeting trauma-related insomnia. Figures cited by the authors suggest that 92% of active duty personnel with PTSD report clinically significant insomnia, compared with 28% of active duty personnel without PTSD. The authors also suggest that sleep difficulties often shift from being a symptom of PTSD to become disorders in their own right, and recommend that sleep problems and their treatment should form part of standard care for military personnel with PTSD.

You can subscribe to PTSD Research Quarterly at no charge. Go to www.ptsd.va.gov

Compiled by Larissa Meysner.