EYE MOVEMENT DESENSITIZATION AND REPROCESSING

EMDR SCRIPTED PROTOCOLS

BASICS AND SPECIAL SITUATIONS

MARILYN LUBER
EDITOR

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Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols

About the Editor

Marilyn Luber, PhD, is a licensed clinical psychologist in general private practice in Center City, Philadelphia, Pennsylvania. She was trained in Eye Movement Desensitization and Reprocessing (EMDR) in 1992. She has coordinated trainings in EMDR-related fields in the greater Philadelphia area since 1997. She teaches Facilitator and Supervisory trainings and other EMDR-related subjects both nationally and internationally and was on the EMDR Task Force for Dissociative Disorders. She was on the Founding Board of Directors of the EMDR International Association (EMDRIA) and served as the Chairman of the International Committee until June 1999. In 1997, Dr. Luber was given a Humanitarian Services Award by the EMDR Humanitarian Association, and later, in 2003, she was presented with the EMDR International Association's award "For Outstanding Contribution and Service to EMDRIA." In 2005, she was awarded "The Francine Shapiro Award for Outstanding Contribution and Service to EMDR." In 2001, through EMDR HAP (Humanitarian Assistance Programs), she published *Handbook for EMDR Clients*, which has been translated into eight languages. She has written the "Around the World" and "In the Spotlight" articles for the EMDRIA Newsletter, four times a year since 1997. She has worked as a Primary Consultant for the FBI field division in Philadelphia. Dr. Luber has a general psychology practice, working with adolescents, adults, and couples, especially with Complex Posttraumatic Stress Disorder (C-PTSD), trauma and related issues, and dissociative disorders. She runs Consultation Groups for EMDR practitioners.

Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations

EDITOR Marilyn Luber, PhD

New York

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Dedication

To my colleagues who bring their hearts and souls to their work

To our clients who allow us to participate in their healing journeys

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Epigraph

We shall not cease from exploration
And, the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

T. S. Eliot
“Little Gidding”

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Contributors

Nicté Alcalá, MA, has been working with survivors of traumatic events during her professional life. The clients, with whom she has been working the most, are those who have suffered from complex interpersonal trauma, rape, assault, robbery, kidnapping, and natural or human provoked disasters. She has been involved in humanitarian projects in Latin America since 1998. Her private practice is in Mexico City.

Lucina Artigas, MA, MT, is a Trainer of Trainers, and EMDRIA and EMDR-Ibero-America Approved Consultant. She is cofounder and Executive Director of EMDR-Mexico, AMAMECRISIS, and International Center of Psychotraumatology. In 2000, she received the EMDRIA Creative Innovation Award for the Butterfly Hug, and, in 2007, she received the EMDR-Ibero-America Francine Shapiro Award. She is a trainer for the International Critical Incident Stress Foundation and Green Cross Academy of Traumatology. She is coauthor of the EMD-Integrative Group Treatment Protocol that has been applied successfully with disaster survivors worldwide. She has presented workshops and has published articles on EMDR, Crisis Intervention and Compassion Fatigue. Since 1997, she has been involved in humanitarian projects in Latin America and Europe.

Esti Bar-Sade, MA, is a child psychologist specializing in trauma work with children and adolescents over the past 27 years. She serves as the Director of Psychological Services in Nazareth Ilit. She is an EMDR-Europe Accredited Consultant and Certified Child Trainer and provides training for EMDR practitioners who work with children internationally. She is a consultant in educational settings as well as working in a clinical private practice. She is a member of the Children and Youth at Risk, a faculty member at Oranim College, and is a consultant on the JDC educational programs. She has served as an advisor on the Afula Project during the Eintifada terror attacks and has conducted many supervision groups on trauma-focused therapy with children. Esti has lectured at the European EMDR Conferences in Rome (2003), Stockholm (2005), and gave a keynote presentation on Acute Stress Intervention and EMDR with Children in London (2008). She and Brurit Laub developed the Imma EMDR Group Protocol, and she has used it with many groups of children during the Second Lebanese War.

Sheila Sidney Bender, PhD, is a New Jersey licensed psychologist and retired faculty from the University of Medicine and Dentistry of New Jersey. She is certified as an EMDRIA-Approved Consultant and Approved Provider of Basic Training. She has published or lectured on EMDR in relation to hypnosis, transference and family systems and held two small grants for EMDR, one involving treating PTSD in an MRI scanner. She is coauthor of *Evolving Thought Field Therapy: The Clinician's Handbook* (2004) and *The Energy of Belief: Psychology's Power Tools to Focus Intention and Release Blocking Belief* (2007). She maintains a private practice in Florham Park, New Jersey.

Aiton Birnbaum, PsyD, is a clinical psychologist, college lecturer, Facilitator, and EMDR-Europe Approved Consultant in EMDR. He has gone on EMDR HAP missions to Turkey, Thailand, Sri Lanka, and the Palestinian Authority. He publishes and lectures on psychology, trauma, and the Bible, and maintains a private psychotherapy practice in Kfar Yona, Israel.

David Blore, BSc (Hons), DipBPsych, SRN, RMN, ENBHA, is an EMDR-Europe accredited EMDR Consultant and Facilitator and an accredited cognitive-behavioral therapy (CBT) therapist in York, England. He has been working with victims of psychological trauma for 20 years and using EMDR for 15 years mainly in Occupational Mental Health. He is a Consultant to the United Kingdom railway industry, police forces, the petrochemical industry, and various other organizational groupings. David is cofounder of the Jane Tomlinson special interest group on Post Traumatic Growth at the Centre for Applied Positive Psychology (CAPP). He is the author of 20 peer-reviewed papers and conference presentations, mainly on EMDR, and is currently a PhD student at the University of Birmingham researching the lived experience of Post Traumatic Growth, post-road traffic accident, and post-EMDR.

Teresa López Cano, MA, has worked with survivors of traumatic events throughout her professional career. She treats clients who have suffered from complex interpersonal trauma, rape, assault, robbery, kidnapping, and natural or human provoked disasters. Since 1998, she is actively involved in humanitarian projects in Latin America. Her private practice is in Mexico City.

Esly Regina Carvalho, MS, LPC, is a Licensed Clinical Psychologist in Brazil and is working on her PhD in Psychology. She has been involved in clinical practice for over 25 years in four countries and in three languages. She returned to Brazil 2 years ago and is involved in the start-up of the EMDR movement in Brazil and Ibero-America. She is currently serving as the first President of EMDR-Ibero-America. She is a Facilitator and EMDRIA Approved Consultant and a Trainer of Trainers for practitioners in Spanish- and Portuguese-speaking countries. She has trained psychotherapy professionals to do EMDR in Brazil, Ecuador, and Portugal and, in 1997, trained lay people and mental health professionals about grief and recovery in the aftermath of Hurricane Mitch in Honduras. She is a Fellow of the American Society for Group Psychotherapy and Psychodrama, a Trainer, and Educator Practitioner of Psychodrama by the American Board of Examiners in Psychodrama, Sociometry and Group Psychotherapy. She is the author of many books in Spanish and Portuguese that focus on healing and recovery. Recently, she published an article on EMDR applied to domestic violence.

Neal Daniels, PhD, received his MA in Social Psychology from the New School for Social Research and his PhD from Kansas University and Menninger Clinic. In 1981, he left his long service as a Family Therapist with the Philadelphia Child Guidance Clinic to become Director of the newly formed program for PTSD at the Philadelphia VA Hospital where EMDR became an integral part of the treatment program. An article, "Post Traumatic Stress Disorder and Competence to Stand Trial," was published in the *Journal of Psychiatry and Law,* Spring 1984. His research on the EMDR treatment of triggers remains unfinished due to his retirement and final illness.

Mark Dworkin, LCSW, has practiced EMDR since 1991. His experience in treating traumatized populations started in 1975 when he began working for the Bronx VA Medical Center, just as the war in Viet Nam was ending. He is a Facilitator; an Approved Consultant and Approved Trainer for the EMDR International Association,

and served on its Board of Directors. He is a graduate of The Manhattan Institute for Psychoanalysis, and studied Gestalt Therapy with Laura Perls, PhD. He is published in the *Journal of Psychotherapy Integration* and he taught Consultation Psychiatry on the Faculty of the Mount Sinai School of Medicine. He is currently in full-time private practice in East Meadow, New York, and consults to different professional organizations. He is the author of *EMDR and the Relational Imperative: The Therapeutic Relationship in EMDR Treatment* (2005).

Sandra Foster, PhD, is a performance enhancement psychologist formerly based in San Francisco, California, where she worked both as a peak performance coach and EMDR psychotherapist. Currently, she is a Principal in Korn/Ferry's London-based Leadership and Talent Consulting practice. She served as Acting Assistant Professor and Consulting Associate Professor at Stanford University where she received her doctorate. She attended the first public EMDR training (March 1990) in the United States and was one of three initial facilitators. Dr. Foster founded the Peak Performance SIG, was Founding Chair of the EMDRIA Public Relations Committee, and received the 2000 Francine Shapiro Award for Innovations in EMDR.

Tanos Freiha, DPhil, Dipl Psych, is a psychologist and psychotherapist who holds a German Diploma in Psychology from the University of Tübingen. He is an EMDR therapist, Approved Consultant and a Facilitator for the EMDR-Institut-Deutschland. Since 1994, he has been a practicing psychologist in the Social Pediatrics Unit at the University Children's Hospital in Cologne, Germany. In 1997, he was awarded his PhD in Psychology. Since 1998, his major interest is in working with EMDR-traumatized children; in 2006, he began a project extending his work in EMDR to treating children diagnosed with Diabetes Mellitus Type I concerning their trauma and fears.

Judith S. B. Guedalia, PhD, is Senior Medical Psychologist and a member of the ER (Emergency Room) Trauma Staff in times of Mass Community Events (MCE, or ARAN the Hebrew acronym). She is Director of Shaare Zedek Medical Center's Neuropsychology Unit and among the many symptoms the Neuropsychology Unit has treated are emotional trauma, anxiety, depression, parenting and family issues, stress, children of divorce, self-esteem, patient adjustment to neurological or cognitive problems, adjustment to chronic illness, family adjustment to and coping with a member's illness, and adjustment to developmental disabilities. Dr. Guedalia is an EMDR Therapist and is in the process of completing the requirements to be a supervisor of other EMDR therapists. Dr. Guedalia is the founder and cochair of Nefesh Israel, the Israeli branch of the NEFESH International Organization the Networking Association for Orthodox Mental Health Professionals. She has published in peer review journals in both Neuropsychology and the Judaism and Mental Health. She is also a regular columnist for *The Jewish Press,* the American's largest independent Jewish weekly. She was born in New York City, has studied and worked in New York, New York; London, England; Holyoke, Massachusetts; Los Angeles, California; and Jerusalem, Israel (since 1980).

John Hartung, PhD, is coordinator of the EMDR-Ibero-American Association, an organization that provides humanitarian and for-profit services to Spanish- and Portuguese-speaking countries. As professor with the University of the Rockies, executive coach with the Center for Creative Leadership, and codirector of the Body-Mind Integration Institute of Singapore, he has taught coaching, leadership, EMDR, and energy medicine in 25 countries. He received his doctorate in psychology from the University of Denver. He and his wife, Nikki, live in Colorado Springs near their grandchildren.

Arne Hofmann, MD, is a specialist in Psychosomatic and Internal Medicine. He is a Senior Trainer and is a Trainers' Trainer in Europe. He introduced EMDR into the German-speaking countries of Europe after a 1991 residency at the Mental Research Institute in Palo Alto, California where he learned about EMDR and went on to head the German EMDR Institute. In 1994, he started the first inpatient trauma program in a Psychiatric Hospital near Frankfurt, Germany, where he assisted in developing Aftercare programs subsequent to mass disaster events like the 1998 train catastrophe in Eschede, the 2002 school shooting in Erfurt, and the 2004 Tsunami in Southeast Asia. He is a Founding Board Member of the German-speaking Society of Traumatic Stress Studies (DeGPT) and EMDR-Europe where he currently serves as vice president. He also is a member of a German National Guideline Commission on the treatment of PTSD and Acute Stress Disorder. He has published a number of articles (mostly in German), a book on EMDR, and coedited three other books on trauma and EMDR. He has been teaching at the Universities of Cologne, Witten-Herdecke, and Peking. He lectures internationally and received the Ron Martinez Award from the EMDR International Association in 2005.

Manda Holmshaw, PhD, is a Consultant, Clinical Psychologist, and Clinical Director of Moving Minds, a national rehabilitation organization in the United Kingdom, which treats adults and children after traumatic experiences, especially road traffic accidents, assaults, and accidents at work. She is an EMDR-Europe accredited Trainer and Consultant and divides her time between supervision, clinical work, research, and EMDR training and is based in London.

Ignacio Jarero, PhD, EdD, MT, is a Trainer of Trainers, EMDRIA and EMDR-Ibero-America cofounder and Approved Consultant. He is cofounder and President of EMDR-Mexico, AMAMECRISIS, and International Center of Psychotraumatology. In 2007, he received the EMDR-Ibero-America Francine Shapiro Award and, in 2008, the Argentinian Society of Psychotrauma (ISTSS Affiliate) awarded him the Psychotrauma Trajectory Award. He is a Trainer for the International Critical Incident Stress Foundation and Green Cross Academy of Traumatology. He is coauthor of the EMDR Integrative Group Treatment Protocol that has been applied successfully with disaster survivors worldwide. He has presented workshops and has published articles on EMDR, Crisis Intervention, and Compassion Fatigue. Since 1997, he has been involved in humanitarian projects in Latin America and Europe.

Roy Kiessling, LISW, ACSW, has been an active participant in the EMDR community since he was trained; first as an EMDR Facilitator, and then as a Trainer. He is an EMDRIA Approved Provider and Consultant. In 2000, he became the second worldwide Internet discussion list moderator on EMDR. Since 1998, he has presented annually at the EMDRIA International Conference. In 2001, he began volunteering as a Trainer for EMDR HAP and has helped teach clinicians around the world as well as within the continental United States. In 2007, he received the Liz Snyker Humanitarian Award for his volunteer work with EMDR HAP. He maintains a general private practice for adults, couples, families, and children specializing in brief treatment and EMDR consultation for clinicians seeking to become certified in EMDR in Cincinnati, Ohio.

Brurit Laub, PhD, is a senior Clinical Psychologist, with over 30 years of experience working in community mental health in Israel. She is also a teacher and supervisor at the Machon Magid School of Psychotherapy at Hebrew University in Jerusalem and at different marriage and family counseling centers. She is an accredited hypnotherapist, and a supervisor in psychotherapy and family therapy. She presents workshops concerning models developed independently and together with colleagues on narrative therapy, script changing therapy, coping with monsters,

dialectical cotherapy, trans-generational tools, recent trauma, resource development and work with subpersonalities nationally and internationally. She has published 15 articles on the above topics in International and Israeli journals. In 1998, she became an EMDR Facilitator and she is an EMDR-Europe Accredited Consultant. She has been involved with HAP trainings in Turkey and Sri-Lanka. She developed a Resource Connection Envelope (RCE) for the Standard EMDR Protocol and presented it in workshops and for EMDR conferences in Tel-Aviv, London, Vancouver, Denver, Istanbul, and Norway. With Esti Bar-Sade, she developed the Imma EMDR Group Protocol, which is an adaptation of Artigas, Jarero, Alcalá, and López's IGTP. Together with Elan Shapiro, she presented their Recent Traumatic Episode Protocol (R-TEP) at a workshop for the EMDR-Europe Consultants day at the 2008 EMDR-Europe Annual Conference in London, following the publication of their article in the *Journal of EMDR Practice & Research*. In 1994, she coauthored, with S. Hoffman and S. Gafni, "Co-therapy With Individuals, Families." In 2006, she collaborated again with S. Hoffman on "Innovative Interventions in Psychotherapy." She lives in Rehovot and is in private practice.

Jennifer Lendl, PhD, is a licensed psychologist with a clinical private practice in Silicon Valley, California. She specializes in trauma, performance for sports, business, health, and the arts. She coauthored *EMDR Performance Enhancement for the Workplace: A Practitioners' Manual* (1997). Dr. Lendl was the trauma and performance specialist at the Amen Clinic for 6 years and continues to consult with them. She is the Sports Psychologist with an interdisciplinary training group called Women Involved with Sports Evolution in Ventura, California. She presents at conferences nationally and internationally on EMDR, Performance and Sports Psychology. In 2006, Dr. Lendl was awarded the Francine Shapiro Award by the EMDR International Association for her outstanding contribution to EMDR.

Tessa Prattos, MA, MAAT, is a Certified Traumatologist, Facilitator, EMDR-Europe Consultant, and the Director of the International Trauma Center in Athens, Greece. She has been a professional psychologist for the past 23 years working in prominent psychotherapy centers in Athens and has an ongoing private practice in Athens. Her areas of expertise are in EMDR, systemic psychotherapy, developmental psychology, and art therapy. Founder and director of the International Trauma Center, fully trained and accredited in EMDR, and the organizer of EMDR Hellas Association, her focus is on trauma victims from man-made and natural disasters, PTSD, anxiety disorders, dissociation, grief, and works with groups, individuals, children, and families. She has experience as a trainer to mental health professionals in systemic psychotherapy and art therapy. She has presented at numerous conferences on EMDR and Dissociation topics. She and Frances R. Yoeli have coauthored the published chapter "Terrorism is the Ritual Abuse of the Twenty-first Century" and, currently, they are working on the further development of the Multi-Tiered Trans-Generational Genogram. She has participated in EMDR HAP fieldwork in Asia.

Gary Quinn, MD, is Director of the Jerusalem Stress and Trauma Institute and Clinical Assistant Professor of Psychiatry at Ohio State University. He specializes in Crisis Intervention, the treatment of Anxiety Disorders, and the treatment of Post-Traumatic Stress Disorder following military trauma, terrorist attacks, and motor vehicle accidents. He is the cofounder and cochairman of EMDR-Israel.

Luise Reddemann, MD, is one of the pioneers of trauma therapy in Germany. After 20 years as the Director of a Clinic for Psychosomatic Disorder, she is now a Professor of Psychotraumatology at the University of Klagenfurt, Austria, and is teaching her own seminars in Trauma Therapy throughout the German-speaking world.

Gene Schwartz, LCSW-C, is a Licensed Clinical Social Worker, practicing in Baltimore, Maryland, since 1971. He spent 30 years working at the Veterans Administration Hospital in Baltimore. Since his retirement, in December 2000, he is in private practice in Towson, Maryland.

Elan Shapiro, MA, is a Psychologist in private practice in Israel with over 30 years of experience. He works as a Senior Consulting Psychologist in a Community Psychological Service in Upper Nazareth. Originally specializing in Adlerian psychology, he came to EMDR in 1989 after attending one of the first trainings ever given. After additional training in the United States and Europe, in 1994, he became an EMDR Facilitator. He was among the founding members of EMDR-Europe, EMDR-Israel, and a charter member of EMDRIA. He is an EMDR-Europe Accredited Consultant and was recently re-elected for a second term as Secretary of EMDR-Europe. He has been involved with HAP trainings in Turkey, Sri-Lanka, and Thailand. With Brurit Laub, they presented their Recent Traumatic Episode Protocol (R-TEP) at a workshop for the EMDR-Europe Consultants day at the 2008 EMDR-Europe Annual Conference in London, following the publication of their article on the same topic in the *Journal of EMDR Practice & Research.*

Frances R. Yoeli, MSc, MFT, CAC, LISW, is a Certified Traumatologist, EMDR HAP Facilitator, and Consultant for the Life Energy Center in Israel. Her clinical experience has spanned three continents and 4 decades. She works with PTSD from abuse, wars, mass disasters, terrorism, critical incidents, and traumatic events. Other specialties include anxiety, eating disorders, addictions, new religious movement issues, cults, ritual abuse with trauma victims, couples, families, and clients presenting with depressions, loss, grief, and the full range of psychosomatic and dissociative disorders. She headed the Emergency Mental Health Team in the Emek Bet-Shean Valley for many years. As a HAP Facilitator and Consultant, she faced several Asian challenges in Humanitarian field work, and facilitated EMDR trainings in the region. For 6 years, she worked as coordinator for HAP events in Israel. She has given numerous presentations in professional conferences on EMDR, dissociation, cult and ritual abuse, and terrorism. With her colleague Tessa Prattos, they completed the book chapter "Terrorism Is the Ritual Abuse of the Twenty-First Century" and they are refining their Multi-Tiered Trans-Generational Genogram, cooperating with the International Trauma Center in Athens, Greece, and with other international treatment centers on its clinical application.

Preface

Marilyn Luber

As the practice of Eye Movement Desensitization and Reprocessing (EMDR) approaches its third decade, it is helpful to reflect on the astonishing development of this psychological treatment model. Over these 20 years, EMDR has grown into an approach to psychotherapy that has been extensively researched and proven effective for the treatment of trauma. This is, in part, due to the number of institutions and researchers that are validating the efficacy of EMDR. In the United States, these include the American Psychological Association (APA, 2004; Chambless et al., 1998), the International Society for Traumatic Stress Studies (Chemtob, Tolin, van der Kolk, & Pitman, 2000; Foa, Keane, & Friedman, 2000), the National Institute of Mental Health Web site (Shapiro, 2004–2007), and the Department of Veterans Affairs and Department of Defense (2004). In Europe, EMDR is considered one of the treatments of choice for trauma victims by the Dutch National Steering Committee for Guidelines Mental Health Care (2003); the French National Institute of Health and Medical Research (INSERM, 2004); The Clinical Resource Efficiency Support Team of the Northern Ireland Department of Health, Social Services and Public Safety (CREST, 2003); the National Institute for Clinical Excellence in England (NICE, 2005); and the United Kingdom Department of Health (2001). In the Middle East, the Israeli National Council for Mental Health (Bleich, Kotler, Kutz, & Shalev, 2002); has named EMDR as one of the methods recommended for the treatment of terror victims. EMDR is an important therapy for the treatment of trauma and is taught in many universities. It has also gained a great deal of respect in the therapeutic world for being a modality that is effective.

As a therapeutic approach, EMDR is on the same par as cognitive behavior therapy and psychodynamic therapy. It is composed of a complex methodology applicable to a wide range of disorders. As such, new procedures and protocols have been introduced to address a variety of issues. Whereas the EMDR procedures and original protocol for trauma (Shapiro, 1995, 2001, 2006) have been extensively researched, many of the protocols in this book are not yet validated by research. Information concerning research will be mentioned in the body of the chapter as appropriate. The protocols are included because they have been reported in books and articles and at EMDR conferences worldwide to be of value to practicing clinicians as they work with their clients, and because they can serve as a stimulus and inspiration to other clinicians for research in the future.

Research in other areas of treatment are referenced below and represent a small sample of the ongoing investigations into the applications of this treatment modality, such as addictions (Amundsen & Kårstad, 2006; Besson et al., 2006; Cox & Howard, 2007; Henry, 1996; Popky, 2005; Shapiro & Forrest, 1997; Shapiro, Vogelmann-Sine, & Sine, 1994; Vogelmann-Sine, Sine, Smyth, & Popky, 1998; Zweben & Yeary, 2006), anxiety (Doctor, 1994; Feske & Goldstein, 1997; Goldstein & Feske, 1994; Maxwell, 2003; Nadler, 1996; Shapiro, 1991, 1994, 1999; Shapiro & Forrest, 1997), body dysmorphia (Brown, McGoldrick, & Buchanan, 1997), children and adolescents (Greenwald, 1994, 1998, 1999, 2000, 2002; Hensel, 2006; Maxfield, 2007; Russell & O'Connor, 2002; Tinker & Wilson, 1999), dissociative disorders (Fine, 1994; Fine

& Berkowitz, 2001; Gelinas, 2003; Lazrove, 1994; Lazrove & Fine, 1996; Marquis & Puk, 1994; Paulsen, 1995; Rouanzoin, 1994; Twombly, 2000, 2005; Young, 1994), family, marital, and sexual dysfunction (Capps, 2006; Errebo & Sommers-Flanagan, 2007; Kaslow, Nurse, & Thompson, 2002; Madrid, Skolek, & Shapiro, 2006; Shapiro, Kaslow, & Maxfield, 2007; Talan, 2007; Wernik, 1993), multiply traumatized combat vets (Carlson, Chemtob, Rusnak, Hudlund, & Muraoka, 1998; Errebo & Sommers-Flanagan, 2007; Lipke, 2000; Russell, 2006, 2008; Russell & Silver, 2007; Russell, Silver, Rogers, & Darnell, 2007; Shapiro, 1995; Silver, Brooks, & Obenchain, 1995; Silver & Rogers, 2002), pain (Grant & Threlfo, 2002; Ray & Zbik, 2001), performance enhancement (Crabbe, 1996; Foster & Lendl, 1995, 1996; Graham, 2004), phantom limb pain (Russell, 2008; Schneider, Hofmann, Rost, & Shapiro, 2007; Tinker & Wilson, 2006; Wilensky, 2006; Wilson, Tinker, Becker, Hofmann, & Cole, 2000), previously abused child molesters (Ricci, 2006; Ricci, Clayton, & Shapiro, 2006), stress management (Wilson, Becker, Tinker & Logan, 2001), victims of natural and man-made disasters (Jarero, Artigas, Mauer, López Cano, & Alcalá, 1999; Knipe et al., 2003; Konuk et al., 2006), and so forth, is ongoing (for more information go to the EMDR International Association Web site: http://www.emdria.org or the EMDR Institute Web site: http://www.emdr.com).

EMDR is based on the Adaptive Information Processing Model (AIP; for comprehensive descriptions, see Shapiro, 1995, 2001, 2006; Shapiro et al., 2007). The premise of Adaptive Information Processing is that every person has both an innate tendency to move toward health and wholeness, and the inner capacity to achieve it. When this movement to health is blocked—and not related to organic difficulties or lack of information—it is likely that the experiences related to the block have been stored in a way that does not allow them to connect with any other adaptive information and maladaptive perceptual distortions, images, feelings, and sensations can ensue. When these dysfunctionally stored memories are triggered, this unprocessed material/experience often results in pathological or maladaptive responses to what might be an ordinary event and/or an event that does not warrant the type of response triggered. These dysfunctionally stored memories seem to be frozen in time and they are unable to connect with other memory networks that hold adaptive information. The goal of trauma treatment is to unfreeze these dysfunctionally stored memories so that they can connect with the adaptive information held in other neural networks and resume the normal functioning of memory processing. Over time, this type of maladaptive information processing—when unresolved—can result in a continuum of difficulties leading from maladaptive thoughts and behaviors, to psychological symptoms that can escalate into psychological disorders.

The EMDR approach integrates elements from both psychological theories (e.g., affect, attachment, behavioral, bio-information processing, cognitive, family systems, humanistic, psychodynamic, and somatic) and psychotherapies (e.g., body-based, cognitive-behavioral, interpersonal, personality-centered, and psychodynamic) into a standardized set of procedures and clinical protocols. Research on how the brain processes information and generates consciousness also informs the evolution of EMDR theory and procedure (see EMDR International Association Web site: http://www.emdria.org or the EMDR Institute Web site: http://www.emdr.com). *EMDR is an approach to psychotherapy that is comprised of principles, procedures, and protocols. It is* not*—as often depicted—a simple technique characterized primarily by the use of eye movements.*

Learning EMDR, at first, was considered easy, however, after many years of training over 100,000 mental health practitioners, it has become clear to the trainers, facilitators, and consultants that learning EMDR is not as simple as "a walk in the park" (Shapiro, 1995, 2001). In fact, solid instruction, training, and consultation are essential components in the learning curve of mastering this complex psychotherapy. Shapiro's text, *Eye Movement Desensitization and Reprocessing: Basic*

Principles, Protocols and Procedures (2001) is required reading for a comprehensive understanding of EMDR as a clinical approach.

Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations grew out of a perceived need that mental health practitioners could be served by a place to access both traditional and newly developed protocols in a way that adheres to best clinical practices incorporating the *Standard EMDR Protocol* that includes working on the past, present, and future issues (the 3-Pronged Protocol) related to the problem and the *11-Step Standard Procedure* that includes attention to the following steps: image, negative cognition (NC), positive cognition (PC), validity of cognition (VoC), emotion, subjective units of disturbance (SUD), and location of body sensation, desensitization, installation, body scan, and closure. Often, EMDR texts embed the protocols in a great deal of explanatory material that is essential in the process of learning EMDR. However, sometimes, as a result, practitioners move away from the basic importance of maintaining the integrity of the Standard EMDR Protocol and keeping adaptive information processing in mind when conceptualizing the course of treatment for a patient. It is in this way that the efficacy of this powerful methodology is lost.

"Scripting" becomes a way not only to inform and remind the EMDR practitioner of the component parts, sequence, and language used to create an effective outcome, but it also creates a template for practitioners and researchers to use for reliability and/or a common denominator so that the form of working with EMDR is consistent. The concept that has motivated this work was conceived within the context of assisting EMDR clinicians in accessing the scripts of the full protocols in one place and to profit from the creativity of other EMDR clinicians who have kept the spirit of EMDR but have also taken into consideration the needs of the population with whom they work or the situations that they encounter. *Reading a script is by no means a substitute for adequate training, competence, clinical acumen, and integrity; if you are not a trained EMDR therapist and/or you are not knowledgeable in the field for which you wish to use the script, these scripts are not for you.*

As EMDR is a fairly complicated process, and indeed, has intimidated some from integrating it into their daily approach to therapy, this book provides step-by-step *scripts* that will enable beginning practitioners to enhance their expertise more quickly. It will also appeal to seasoned EMDR clinicians, trainers, and consultants because it brings together the many facets of the eight phases of EMDR and how clinicians are using this framework to work with a variety of therapeutic difficulties and modalities, while maintaining the integrity of the AIP model. Although there are a large number of resources, procedures, and protocols in this book, they do not constitute the universe of protocols that are potentially useful and worthy of further study and use.

These scripted protocols are intended for clinicians who have read Shapiro's text (2001) and received EMDR training from an EMDR-accredited trainer. An EMDR trainer is a licensed mental health practitioner who has been approved by the association active in the clinician's country of practice. The following associations are upholding the standard of EMDR worldwide: EMDRIA in the United States (http://www.emdria.org), EMDR-Canada (http://www.emdrcanada.org), EMDR-Europe (http://www.emdr-europe.org), Ibero-America for Central and South America and Spain (http://www.EMDRiberoamerica.org), EMDR Association of Australia (http://www.emdraa.org), EMDR-Asia is in formation, and EMDR in Africa is evolving. For more in-depth information concerning standards and EMDR practice, it would be judicious to contact these organizations. The names and contact information of EMDR organizations and/or associations are available in Appendix C, the EMDR resources section of this book.

These scripts are not *intended for use by unlicensed practitioners or clinicians who do not understand the complexity of EMDR or the type of problem with which they are working with their client. It is essential that clinicians know their own*

strengths and limitations and seek supervision and/or consultation when needed. Again, access to information concerning clinicians accredited to do supervision and/or consultation is available through the associations.

This book is separated into sections that loosely follow the structure of Francine Shapiro's original texts (1995, 2001): client history, adaptive information processing, preparation, desensitization, and procedures for special situations. Work with special populations is included in a second volume, *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations* (Luber, in press). Both books include chapters that focus on supporting clinicians through clinician self-care as they work with the difficulties of their clients and, in this way, underlining the importance of this subject.

In order to uphold the American Psychological Association's standard of nonbias concerning gender, this editor has chosen to have authors use the personal pronouns opposite to their own gender while referring to a client and the personal pronouns of their own gender while referring to themselves as a way to avoid the awkwardness of using both pronouns together such as *he/she or (s)he,* and so forth.

The Client History section represents the first of the eight phases of EMDR treatment. The ability to gather, formulate, and then use the material in the intake part of treatment is crucial to an optimal outcome in any therapist's work. In Part I, material was chosen to support ways to conceptualize history taking according to the adaptive information processing way of thinking to inform EMDR treatment planning. It also includes several ways to summarize history-taking material after a thorough history has been taken.

Part II includes an important element of the Preparation Phase that addresses ways to introduce and explain EMDR, trauma, and the adaptive information processing (AIP) model. This material by Sheila Bender and Gene Schwartz can also be used during Phase One to explain to clients how their current and past predicaments and distress about the future arose and can be connected.

The importance of teaching clients how to create personal resources is the topic of Part III. Here, an essential element of the Preparation/Second Phase of EMDR work is addressed to ensure clients' abilities to contain their affect and remain stable as they move through the EMDR process. These contributions from Francine Shapiro, Luise Reddemann, Roy Kiessling, Brurit Laub, and Elan Shapiro are a representative sample of the many different ways to create resources during the Preparation Phase. Resources for children and adolescents, and clients who are dealing with difficulties that are in the Dissociative Spectrum are described in *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations* (Luber, in press), as they represent their own unique issues.

Part IV is a section on how to work with clients concerning the targeting of their presenting problems when the usual ways do not work. Esly Carvalho uses drawings as a way to concretize her clients' conceptualization of their issues for targeting while Tanos Freiha gives an alternative, initial targeting method that allows clients more control when issues are overwhelming. Sheila Bender in Part II also addresses this issue with strategies to work in her chapter, "When Words and Pictures Fail."

Although Part V could have been included in other sections, the choice to separate the original protocols that Francine Shapiro introduced in her original texts seemed appropriate as a way to underline the roots from which the rest of the chapters in this book grew and the comprehensiveness of her thinking from the beginning years of EMDR. This section includes protocols that have been scripted based on the material that appears in Francine Shapiro's EMDR textbook (2001) and later written work (2006). The work in these volumes forms the basis of EMDR, including the 11-Step Standard Procedure and the component aspects of the 3-Prong approach of past, present, and future, essential to the effective use of EMDR.

Parts VI and VII address EMDR and Early Intervention Procedures for Manmade and Natural Catastrophes for Individuals and Groups. The core of this work

began as a basic intent by Francine Shapiro to help address and transform the pain and suffering in the world to adaptive functioning and health and enable survivors to move on with their day-to-day lives. The result of this healing was to end the transmission of shame, hate, and retribution that historically has fostered the passing of this legacy into future generations. Although this vision began with individual work and the training of therapists to help the victims of rape, abuse, war, and other issues rampant in mental health centers, the tragedy of Oklahoma City with the bombing of the Alfred P. Murrah Federal Building on April 19, 1995, was the incentive to work with survivors of man-made catastrophes. In response to this tragedy came an outpouring of EMDR-trained clinicians who went to the aid of the victims and their families. Through the dedication and organizational skills of Sandra Wilson, mental health practitioners traveled to train our Oklahoma colleagues to work with EMDR and we assisted them in treating the survivors over a 6-month period. This effort grew into the EMDR Humanitarian Assistance Program (EMDR HAP), a nonprofit organization founded by Francine Shapiro; the first Executive Director was Barbara Korzun followed by Robert Gelbach. The mission of EMDR HAP states that, "We promote recovery from traumatic stress, through direct service and community-based training in EMDR for mental health workers all over the world." Colleagues with expertise in working in disaster situations such as Roger Solomon, Steve Silver, Susan Rogers, Elaine Alvarez, Gerry Puk, Kay Werk, Robert Tinker, and Barbara Parrett were the creators of the foundation from which EMDR HAP spread the importance of working with the psychological aspects of trauma. The work of EMDR HAP has fostered sister organizations in countries and continents around the world.

These were the seeds that grew into the protocols in Parts VI and VII. Elan Shapiro and Brurit Laub's idea on how to think about trauma over its developmental course in their "Recent-Traumatic Episode Protocol" is an important breakthrough and hypothesizes a way to integrate the fragmentation of memory and then how to address it within the EMDR framework to treat clients at different stages of their traumatic experiences. Judi Guedalia's work after seeing hundreds of victims of terrorist attacks in Jerusalem was enhanced by her collaboration with her colleague and EMDR-trained clinician, Frances Yoeli. The work of Lucina Artigas, who created the Butterfly Hug, a form of bilateral stimulation, is possibly one of the most creative and significant contributions of our EMDR community. With her colleagues Ignacio Jarero, Nicté Alcalá, and Teresa López Cano they created the EMDR Integrative Group Treatment (EMDR-IGTP); a treatment that has been used with children and adults around the world after massive man-made and natural disasters and inspired others such as Brurit Laub and Esti Bar-Sade and others to adapt this protocol to their own populations. Gary Quinn works with an Emergency Response Procedure and David Blore adapted the EMDR Standard Protocol to work with the particular issues concerning underground trauma while Aiton Birnbaum's innovative contribution of using EMDR in a workbook format for individuals and groups offers a novel way to approach EMDR for clients whose styles foster a more visual—with the option of a more private—way of working with their traumatic material; this protocol is more comprehensive as it includes the actual workbook that clients can use, as well as the script for therapists.

EMDR and Performance Enhancement featured in Part VIII showcases the work of Jennifer Lendl, Sandra Foster, and John Hartung. Their chapters demonstrate some of the fascinating possibilities when working in this field. Many of their suggestions can be adapted to work with traumatized individuals in the form of resources and addressing issues in the future. Both of these protocols are comprehensive tools as they are more manuals than single protocols.

The idea of clinician self-care is crucial to the welfare of mental health practitioners and their clients. The ability of therapists to tend to themselves and recognize their own triggers, vulnerabilities, and sink holes is an important aspect of training.

In Part IX, Neal Daniels addresses how clinicians can routinely work with their own distress to inoculate themselves against burn out and/or secondary PTSD and Mark Dworkin's work suggests ways to address countertransference issues as they arise.

Appendix A is a pull-out section that includes scripts for the protocols for past, present triggers, and future templates. In fact, the purpose of this book, in general, is to provide the practitioner with a script and/or scripts that can be copied and put in the client's chart to use with his particular issue so that all aspects of the eight phases are incorporated and accessible as a reminder of all of the elements needed for the work to be complete and/or a script to be used and followed specifically. Often, scripts repeat the elements of EMDR to support clarity and ease of using the scripts.

Appendix B addresses an interesting expansion of the 11-Step Standard Procedure by Gene Schwartz. Although this has not been tested, it brings up an interesting question concerning how to address possible changes or expansions in the protocol. The Standard EMDR Protocol is a protocol that has evolved since its inception in 1989 under the auspices of the EMDR Institute and the talented clinicians, facilitators, and trainers that were the foundation of EMDR and represented every psychotherapy tradition. As of 1995, when Francine Shapiro wrote the first comprehensive text on EMDR, *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures,* the standard of how to do EMDR was clearly stated. In 2001, she published the second edition of her original text and updated the standard. The chapters in this book follow the standard that is in this second edition of *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures.*

In Appendix C, worldwide EMDR associations and resources are listed. There are numerous EMDR associations throughout the world as EMDR trained practitioners have come together to share their knowledge, training, and uphold the standard of optimal EMDR practice. Through the interaction of these different groups, much has been learned and shared as clinicians encounter problems that cross cultures and also those that are distinctive and particular to the population and issue being addressed. Included in Appendix C are a number of the known Humanitarian Assistance Programs that have developed as EMDR practitioners have reached out to their peers in other countries in the face of man-made catastrophes and natural disasters. This is followed by resources that catalog information; the most recent is the Francine Shapiro Library, an online repository of all that is written about EMDR. Also included are the *EMDR Journal* and E-Journals and where to find trauma-related information.

In addition, references that are relevant to EMDR and the work of the contributors are included as a compendium of the wealth of information available about EMDR and a way to tap the expertise of those included in this book so that practitioners are able to deepen their own areas of learning. Additional references introduce other resources suggested by the authors or about the authors themselves. Some of these ideas are in the process of being researched while others are presented now for their helpfulness and may serve as the subject of a study in the future. This is a book that is rich in the accumulated knowledge of the clinicians trained in and using EMDR on a regular basis and formatted to support the learning and practice of the reader.

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The genesis of this book took place in 2005 at an EMDR International Association Conference in Philadelphia, Pennsylvania, with an informal conversation with Arne Hofmann. Growing out of an EMDR Supervisory Training Manual that I had created and assembled to conduct Facilitator and Supervisory Trainings in Germany in the late 1990s and then in Israel, Arne asked me to "manualize" Francine Shapiro's protocols from her text, *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures* for the first Trainer's Training that was to occur the following year in Kassel, Germany. I accepted the challenge. I would like to acknowledge Arne for the initial push and his contributions to this project.

In fact, scripting protocols has been my way of helping myself assimilate new material that I have learned from the early days of my professional career. The chapters in this book represent the accumulated knowledge of my many colleagues and friends in the EMDR community and my continuing interest in turning their ideas into scripts that would inspire and assist other therapists to work with their material. I would like to thank them for their contribution, hard work, and continuing interest in using EMDR in their practices to address and resolve the issues of their particular client population. I would particularly like to acknowledge the patience of these authors as they allowed me to engage them in the process of scripting their work. This was no small endeavor and I would like each one of them to know how appreciative I am of their willingness to respond to my numerous e-mails and to my litany of urgent requests with grace as they took time away from their already busy schedules.

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PART I

Client History

In Phase 1 or the Client History Phase of the 8-Phase EMDR protocol, practitioners are responsible for gathering the information that will inform how the treatment of clients will unfold. Acquiring the information that is needed is a crucial step in Case Conceptualization and becomes the organizing foundation for practitioners' thinking. In the training of mental health practitioners, this subject is a standard staple in the art of becoming a professional in the field.

Eliciting a client history from an EMDR-informed approach is a seminal way to insure that the basic components of solid EMDR practice are obtained. It can also be a training ground to teach clients the basics of an Adaptive Information Processing (AIP) approach. The key to history taking is understanding the background of clients in the form of the developmental, familial, interpersonal, medical, work or school, psychological histories, and so forth.

Conceptualizing the best and parsimonious treatment plan entails the following:

- Understanding the ability of the client to contain affect and to achieve stabilization in the face of distressing material in the environment or internally. Sometimes, the client will need to learn stabilization and skill building—because of the nature of the problem—even before Phase 1 is completed.
- Assessing the client's attachment style especially concerning his ability to work in collaboration with the therapist.
- Checking on medical issues that might require special consideration.
- Making sure that the timing for the EMDR session is optimal concerning life events and the availability of the client and therapist for follow-up.

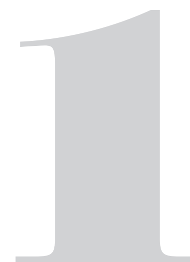
When all of the above criteria are in place, clients are ready to move on to the desensitization and reprocessing phases of EMDR. Crucial to this endeavor is to understand the nature and history of the presenting problem by having an idea about the full measure of the problem as well as the types of associations that might occur. Although by the very nature that maladaptive information is held in the brain, every moment of the client's history will not be known, even with the most detailed history, nor is it necessary. What is needed is a "map" of the territory and this includes the knowledge of the 3-prong approach that addresses the full measure of the problem along the developmental experience of the client. To accomplish this goal it is helpful to elicit the important elements (i.e., images, negative cognitions, positive cognitions, emotions, and sensations) of the presenting problem(s) during the history taking and then connecting them—if possible or appropriate—to the earliest event connected to the problem (Touchstone Event). There are certain populations and situations, however, that call for beginning the desensitization phase with the second or third prong (see below and Luber, in press). The second prong of the 3-prong approach is to recognize and ultimately address the current triggers or conditioned responses that are often the causes for clients to seek counsel in the first place.

This highlights the strength of the EMDR model as it targets the issue clients entrust to us from many different aspects and throughout the time line of their lives. This allows us to be thorough in our ability to access the problem, stimulate the information-processing system and move the information to an adaptive resolution.

In order to be complete concerning the reprocessing of the problem(s), it is important to address the desired treatment goals. EMDR accomplishes this through a future, positive outcome template that enables clinicians to address the possible concerns and anxieties that clients encounter related to how the presenting problem could manifest for them in the future. It also reveals the need for skill building that is often necessary for success.

In this way, a clear, concise, and targeted history taking enables practitioners to capture all aspects of the client's problem(s), teaches the client how to think and conceptualize the issue, and supports the success of the clinical treatment.

In this section, the authors include different ways to gather this data. The first chapter by the editor is a one-page sheet that summarizes basic information salient to EMDR psychotherapy to ensure the therapist a quick way to remember the pertinent facts of a client's history. The time line is another resource to assist both therapists and clients to understand the nature of the positive and negative life events and where they fall along their life's trajectory. The targeting sequence is a helpful way to conceptualize information according to the AIP model and the EMDR-Accelerated Information Resourcing Protocol (EMDR-AIR) assists us in rapidly gaining information about clients, especially concerning familial patterns and legacies.



EMDR Summary Sheet

Marilyn Luber

This author has been interested in the idea of consolidating information in an accessible form throughout her career. The EMDR Summary Sheet was the result of a need on her part to have access to all of the relevant information concerning client information and EMDR interventions at a glance. This EMDR Summary Sheet is a way to consolidate important client information quickly and succinctly.

EMDR Summary Sheet

NAME: ____________ DIAGNOSIS: ____________
MEDICATIONS: ____________
PAPER AND PENCIL TEST RESULTS:
IES-R ________ DES ________ BDI-II ________ Other ________
GOALS
1. ________ 2. ________ 3. ________
PRESENTING PROBLEM-PP #A PP #B PP #C
A. ________ B. ________ C. ________
TOUCHSTONE EVENT
A. ________ B. ________ C. ________

EXPERIENCES		EXPERIENCES	
Birth—12 years of age (Childhood)			
1. ________	1. ________	1. ________	1. ________
2. ________	2. ________	2. ________	2. ________
3. ________	3. ________	3. ________	3. ________
13 years through 19 years (Adolescence)			
4. ________	4. ________	4. ________	4. ________
5. ________	5. ________	5. ________	5. ________
6. ________	6. ________	6. ________	6. ________
20 years and higher (Adulthood)			
7. ________	7. ________	7. ________	7. ________
8. ________	8. ________	8. ________	8. ________
9. ________	9. ________	9. ________	9. ________
10. ________	10. ________	10. ________	10. ________
Present Triggers			
1. ________	1. ________	1. ________	1. ________
2. ________	2. ________	2. ________	2. ________
3. ________	3. ________	3. ________	3. ________
Future Template/Anticipatory Anxiety			
1. ________	1. ________	1. ________	1. ________
2. ________	2. ________	2. ________	2. ________

MAJOR THEMES/COGNITIVE INTERWEAVES

Safety/Survival			
1. ________	1. ________	1. ________	1. ________
2. ________	2. ________	2. ________	2. ________
Self-Judgment/Guilt/Blame (Responsibility)			
1. ________	1. ________	1. ________	1. ________
2. ________	2. ________	2. ________	2. ________
Self-Defective (Responsibility)			
1. ________	1. ________	1. ________	1. ________
2. ________	2. ________	2. ________	2. ________
Choice/Control			
1. ________	1. ________	1. ________	1. ________
2. ________	2. ________	2. ________	2. ________

PRESENT RESOURCES

Safe Place	Mastery
1. ________	1. ________
2. ________	2. ________
Attachment	Symbols
1. ________	1. ________
2. ________	2. ________