Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols

Special Populations

EDITOR Marilyn Luber, PhD

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Marilyn Luber, PhD, is a licensed clinical psychologist in general private practice in Center City, Philadelphia, Pennsylvania. Dr. Luber has a general psychology practice, working with adolescents, adults, and couples, especially addressing the resolution of complex post-traumatic stress disorder (C-PTSD), trauma and related issues, and dissociative disorders. She has worked as a Primary Consultant for the FBI field division in Philadelphia. She was trained in eye movement desensitization and reprocessing (EMDR) in 1992. She consults with individuals and runs consultation groups for EMDR practitioners. She is an EMDR International Association certified practitioner and consultant. 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. In 2009, she edited Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations (Springer Publishing).
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Robbie Adler-Tapia, PhD, is a licensed psychologist who has worked with traumatized children and their families for 23 years. She is certified in EMDR, an EMDRIA Approved Consultant, a Facilitator, an EMDR/HAP (Humanitarian Assistance Program) Trainer and works with the EMDR HAPKIDS Project. Along with her coauthor, Carolyn Settle, Dr. Adler-Tapia is coauthor of the new book *EMDR and the Art of Psychotherapy With Children* and accompanying treatment manual for clinicians (Springer Publishing, 2008).

Lucina Artigas, MA, MT, is a Trainer of Trainers, 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 EMDR-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.

Don Beere, PhD, ABPP, has Bachelor degrees in Physics and Philosophy, an MA in Experimental Psychology and a doctorate in Clinical Psychology. He is currently in full-time private practice in the Greater Cincinnati, Ohio area, and specializes in the treatment of severe trauma and the dissociative disorders. Dr. Beere is a Certified Therapist and Consultant in EMDR, a Facilitator, and a Specialty Presenter on the dissociative disorders. He was one of the original faculty selected by the International Society for the Study of Trauma and Dissociation (ISST-D) to teach in the Dissociative Disorders Psychotherapy Treatment Program. The chapters in this volume summarize his research and present Beere’s theory of the dissociative disorders.

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.

Michael D’Antonio, PhD, is a licensed psychologist, EMDRIA-certified EMDR Therapist, and Consultant and AAMFT-Approved Supervisor. He is a Senior Clinician

Ad de Jongh, PhD, DDS, is both a Clinical Psychologist and Dentist. He is Professor of Anxiety and Behavior Disorders at the University of Amsterdam. He is an expert in the field of dental phobia, and author of more than 150 scientific articles and book chapters as well as the author of four books on the treatment of anxiety disorders. He is Director of the Centre for Psychotherapy and Psychotrauma in Bilthoven and of the Trauma Treatment Unit of D.O.E.N. in Druten. Ad de Jongh is an approved trainer for the EMDR Europe Association.

Carlijn De Roos, MA, is a clinical psychologist and psychotherapist working with traumatized children, adolescents, and adults as well as with patients suffering from chronic pain. In her present post, she coordinates a specialized Trauma Centre for children and adolescents, which is part of the Mental Health Centre (GGZ) Rivierduinen in Leiden, the Netherlands. She is an EMDR-Europe approved child and adolescent trainer and consultant, president of the Dutch EMDR Association, and a member of the EMDR Europe Child Board.

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 Vietnam 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).

Dagmar Eckers, Dipl.-Psychologin, is a psychotherapist in private practice, who works with children, adolescents, and adults in Berlin, Germany. She uses Behavior Therapy, Hypnotherapy, Family Therapy, and EMDR. She is a Facilitator and an Approved European Child and Adolescent Trainer in EMDR.

Catherine G. Fine, PhD, is a clinical psychologist specializing in trauma, dissociative disorders, anxiety, and depression as well as women’s issues. She teaches nationally and internationally focusing on outpatient management of overwhelming traumata, affect management, and structured interventions using formal or informal hypnosis. She has served as President of ISSMPD and ASCH.

Carol Forgash, LCSW, BCD, is the Board President of the EMDR-Humanitarian Assistance Programs and has a clinical and consulting practice in Smithtown, New York. She is a Facilitator, and an EMDRIA Approved Consultant. She is a lecturer and consultant on the treatment of dissociation, complex post-traumatic stress disorders, the complex health issues of sexual abuse survivors, and the integration of EMDR with Ego State therapy and psychodynamic treatment. She has coauthored and edited Healing the Heart of Trauma and Dissociation With EMDR and Ego State Therapy (Springer Publishing, 2007), the first book to offer an integrative approach to successfully treating clients with the most severe trauma-related disorders.
**Denise Gelinas, PhD,** is an EMDRIA Approved Consultant, a Facilitator and is a Specialty Presenter on Dissociation. She conducts her private practice of psychotherapy and consultation in Northampton, Massachusetts, and is a member of the Associate Professional Staff, Department of Psychiatry, Baystate Medical Center. She is the author of *Integrating EMDR Into Phase-Oriented Treatment for Trauma* (2003) and coauthor as part of the International Society for the Study of Dissociation Task Force on Revision of *Guidelines for Treating Dissociative Identity Disorder in Adults* (2005).

**Ana Gomez, LPC,** is a psychotherapist in private practice in Phoenix, Arizona. She works with children and families affected by trauma. She has served as a practicum supervisor at the Educational Psychology Department at Northern Arizona University. She is the author of *Dark, Bad Day . . . Go Away,* a book for children about trauma and EMDR. She has been a presenter at the EMDRIA conference and she was a preconference guest speaker at the 2008 EMDRIA conference. She is an EMDRIA Training Provider and an Approved Consultant. She is a Facilitator, a specialty presenter on EMDR with children, and an EMDR-HAP trainer-in-training.

**Mark Grant, MA,** is a psychologist who treats sufferers of pain and stress in Sydney, Australia. He has published several papers including a case study design research article regarding EMDR in the treatment of chronic pain. He has also presented at numerous conferences and workshops around the world. His work has been cited in the *New York Times* (“Living With Pain That Just Won’t Go Away”). His self-help CDs have been published in English and Spanish and attracted an award for didactic material from the University Education Distancia (UNED), Madrid, Spain. He maintains a Web site for chronic pain sufferers (www.overcomingpain.com).

**Michael Hase, MD,** is a Psychiatrist and Psychotherapist, EMDR Senior Trainer and head of the Department of Psychosomatic Medicine and Psychotherapy at the Reha-Centrum Hamburg (former Reha-Zentrum Berliner Tor). His specialties include treatment of psychosomatic disorders, addiction, and acute stress disorders.

**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.

**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.

**Jim Knipe, PhD,** has been a Licensed Psychologist in private practice in Colorado and uses EMDR in his practice. He has written about how to extend EMDR to clients who present with self-defeating psychological defenses or dissociative symptoms. He is an EMDR-HAP Trainer, an EMDRIA Approved Consultant and Instructor, and was designated a Master Clinician by EMDRIA in 2007. In 2006 and 2007, he was the guest speaker at the EMDRIA Annual Conferences, and in 2008 he was the guest speaker in the EMDR-Europe Annual Conferences and national EMDR conferences. He has been involved with the EMDR Humanitarian Assistance Programs, serving on the Board of Directors and as Research and Training Director. In addition, he is a coauthor of published outcome research documenting the effects of EMDR with survivors of 9/11 and with those traumatized by the 1999 Marmara earthquake in Turkey.

**Ulrich Lanius, PhD,** is a Clinical Psychologist and Neuropsychologist who specializes in the treatment of traumatic stress. He is a Facilitator and EMDRIA Approved Consultant. He has presented at conferences nationally and internationally. He is in the forefront of integrating recent neuroscience research into the treatment of traumatic stress syndromes and has been instrumental in adapting EMDR for clients with significant dissociative symptoms.

**Brurit Laub, MA,** 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 a 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.

**Barry K. Litt, MFT,** received his Master’s degree in family therapy at Hahnemann University in Philadelphia where he studied contextual therapy with its founder,
Ivan Boszormenyi-Nagy. His continuing fascination with contextual therapy’s integration of psychodynamic thinking and systems theory was brought to a whole new level when he began using EMDR and studying dissociation in the early 1990s. His professional activities have included in-home family therapy, outpatient substance abuse treatment, consultation and training for Head Start programs and group homes, and investigating misconduct complaints for the New Hampshire Board of Examiners. In addition, Litt has taught MFT students at two graduate schools and given numerous workshops to international audiences on contextual theory, couples therapy, dissociation, and EMDR. He is a regular presenter at ISST-D and EMDRIA annual conferences. He is author of a chapter entitled “The Child as Identified Patient: Integrating Contextual Therapy and EMDR” in F. Shapiro, F. Kaslow, & L. Maxfield (Eds.), Handbook of EMDR and Family Therapy Processes (2007). He has also written a chapter entitled “The Marriage of EMDR and Ego State Theory in Couples Therapy: A Contextual Integration” in C. Forgash & M. Copeley (Eds.), Healing the Heart of Trauma and Dissociation With EMDR and Ego State Therapy (Springer Publishing, 2008). Litt is an AAMFT Approved Supervisor and an EMDRIA Approved Consultant and is currently in private practice in Concord, New Hampshire.

Marina Lombardo, LCSW, is a licensed psychotherapist and personal coach in private practice in Orlando, Florida. For over 20 years, she has worked with adults and couples in addressing a full range of issues, including marriage and relationships, life transitions, and the emotional aspects of infertility. She writes the column “Emotionally Speaking” for Conceive Magazine, and serves on their advisory board. She is the author of the book I Am More Than My Infertility: 7 Proven Tools for Turning a Life Crisis Into a Personal Breakthrough (2007). She has presented, in seminars and on radio, on a range of subjects, including general and fertility lifestyle issues, always building on the premise that within life’s challenges are opportunities for growth. She has developed an IVF education series for couples, served as a fertility consultant, and facilitated fertility support groups. In addition, she has served on the adjunct faculty staff of Valencia College, in Orlando, Florida, designing and teaching continuing education classes in body-centered psychotherapy. She is a Certified Therapist in EMDR, and is a member of EMDRIA and the Mental Health Professional Group of the American Society of Reproductive Medicine.

Regina Morrow, EdS, LMFT, LMHC, NCC, is an EMDR HAP Trainer, Facilitator, EMDRIA Approved Consultant and Orlando, Florida, EMDRIA Regional Coordinator. She owns a private practice in Windermere, Florida, specializing in marital therapy, trauma, and EMDR consultation. She is a member of EMDRIA, ISTSS, AAMFT, and ACA.

Sandra Paulsen, PhD, has spoken internationally, written, and consulted on the power, benefits, and risks of EMDR and ego state therapy since 1992. She was an invited Master Series Lecturer for EMDRIA in Montreal and invited faculty for the First World Congress of Ego State Therapy in Bad Orb, Germany. She teaches advanced specialty trainings in dissociation and ego state therapy through EMDRIA. She moderates a forum on EMDR at www.behavior.net and cofounded the Bainbridge Institute for Integrative Psychology in Bainbridge Island, Washington. Her illustrated book will be published in early 2009.

Sabitha Pillai-Friedman, PhD, received her degree in Social Work from Graduate School of Social Work and Social Research at Bryn Mawr College. She is a licensed social worker and an AASECT–certified sex therapist. She is also trained in the use of EMDR and has been using the technique in creative ways to enhance her treatment
of individuals and couples. She practices individual, couple, and sex therapy at the Institute for Sex Therapy at the Council for Relationships in Philadelphia. She is also the adjunct assistant professor and the director of supervision in the Couple and Family Therapy Program at Thomas Jefferson University in Philadelphia. She has been practicing psychotherapy for over 18 years.

Arnold J. (AJ) Popky, PhD, is a former Marine and has been involved in EMDR from its beginning. He has over 25 years experience in sales and marketing with high-technology Silicon Valley start-ups. He is a Master Practitioner of NLP and is a Senior Facilitator with over 19 years EMDR experience. He is certified in Ericksonian Hypnosis and was on the teaching staff of the Los Gatos Institute of Medical Hypnosis. He specializes in addictions and core traumatic issues and has developed DeTUR: an urge protocol for the treatment of addictions and dysfunctional behaviors. He consults with therapists worldwide and presents at EMDR training sessions and international conferences. He has interned at the Santa Clara County Drug and Alcohol Agency, Catholic Charities, Mental Research Institute, and the Haight-Ashbury Free Drug Clinic. He is a lifetime charter member and Certified Consultant of EMDRIA and has a private practice in Los Angeles, California.

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.

Carolyn Settle, MSW, LCSW, is a Facilitator, Specialty Presenter, EMDRIA Approved Consultant, as well as an EMDR Humanitarian Assistance Program (HAP) Trainer-in-Training and a regular HAP volunteer. Ms. Settle has presented several times at the EMDR International Association Annual Conferences and at the EMDR Europe Conference on using EMDR with children. She provides advanced training workshops on using the 8 Phases of EMDR with children. Her areas of specialization are in post-traumatic stress disorder, depression, anxiety, phobias, ADHD, and gifted counseling for children, adolescents, and adults. Ms. Settle’s experience working in community mental health centers, psychiatric hospitals, and with managed care insurance companies gives her practical knowledge that helps in her private practice in Scottsdale, Arizona. Ms. Settle is coinvestigator on a research study focused on the efficacy of using EMDR with children 2 to 10 years of age. Along with Robbie Adler-Tapia, Ms. Settle is coauthor of the new book EMDR and the Art of Psychotherapy With Children and the accompanying treatment manual for clinicians (Springer Publishing, 2008).

Robert Tinker, PhD, PC, a licensed Clinical Psychologist in private practice for more than 30 years, and specializes in EMDR treatment for adults and children. He is senior author of Through the Eyes of a Child: EMDR With Children (1999). Dr. Tinker is coauthor of several published EMDR research articles (Journal of Consulting and Clinical Psychology, 1995, 1997; International Journal of Stress Management, 2001). He has been keynote speaker with EMDR Europe in Paris, 2007 and with EMDRIA in Phoenix, Arizona in 2008, both to standing ovations. With Dr. Wilson, he has trained other therapists in using EMDR with adults and children, most recently in China in October 2008.

Joanne H. Twombly, LICSW, MSW, is in private practice in Waltham, Massachusetts, specializing in complex trauma and dissociative disorders. She also provides consultation in EMDR, hypnosis, and Internal Family Systems (IFS). She has given many workshops and written articles and chapters on diagnosis and treatment of
dissociative disorders, the use of EMDR in treating dissociative disorders, EMDR, IFS (with Richard Schwartz), and hypnotic language. She is a Director on the International Society for the Study of Trauma and Dissociation’s Executive Council and a Facilitator for the EMDR Humanitarian Assistance Program. She is an EMDRIA Certified Consultant and an American Society of Clinical Hypnosis Certified Consultant.

**Sandra Veenstra, MA,** is a clinical psychologist, psychotherapist, and child psychologist working in a private practice in Tilburg, the Netherlands. Before that she worked 18 years in a general hospital in which she developed her neuropsychological knowledge. In 2002 she was level I trained in EMDR, in 2003 she completed her level II training for adults, and in 2004 she completed her EMDR training for children. Mrs. Veenstra specializes in working with patients with medical complaints, especially chronic pain and chronic fatigue. She has written several articles about pain and the brain. Besides her private practice, she is visiting lecturer at the University of Tilburg and at the Dutch postgraduate training for health psychologists (RINO). She is also a cognitive behavioral therapist and supervisor.

**Sandra A. Wilson, PhD,** is Executive Director and founder of the Spencer Curtis Foundation in Colorado Springs, which conducts humanitarian projects and treatment outcome studies of EMDR. She has published research on EMDR in the *Journal of Consulting and Clinical Psychology*, a tier-one peer-reviewed journal (Wilson, Becker, & Tinker, 1995, 1997) and in the *International Journal of Stress Management*. Dr. Wilson has directed EMDR relief programs, including the programs in Oklahoma City after the bombing of the Murrah Building and with ethnic Albanian children after the war in Kosovo. More recently, she has initiated training of all therapists at Pikes Peak MHC in EMDR to treat returning military at Fort Carson, Colorado. She is coauthor with Dr. Tinker of *Through the Eyes of a Child: EMDR With Children* (1999).

**Barbara Wizansky, MA,** is a senior clinical psychologist, trauma specialist, associated with the Child and Adolescent Outpatient Psychiatric Unit of the Sheba Medical Center, Tel Hashomer, Israel. She is a Facilitator and EMDR Europe Child Trainer. At the present time, she works in private practice, teaches, and supervises both individuals and groups.
Foreword

Catherine Fine

Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations, a companion volume to Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations, will forever be embedded in our memory because of its landmark impact in the field of EMDR as well as the field of psychotherapy (unlike the 1958 song from Gigi, “I Remember It Well,” performed by Maurice Chevalier and Hermione Gingold, which cautions us about the vicissitudes of memory in highly emotionally charged situations). Yes, this book we will remember very well. Dr. Marilyn Luber’s edited book concretizes for novice as well as experienced therapists the intentionality, creativity, and focus of EMDR-trained specialists working to ameliorate the treatment of human suffering, to facilitate the successful processing of overwhelming experiences, and to more rapidly achieve successful outcome. From the beginning of her involvement in the field of EMDR, Dr. Luber has been dedicated first as a student of EMDR, then as a user, and eventually as a facilitator and trainer of facilitators and consultants to the correct utilization of the protocol devised by Dr. Francine Shapiro.

This second volume was made possible not only through Dr. Luber’s unending efforts but also from the thoughtful, innovative, and groundbreaking efforts of many clinicians, each working in their separate area of expertise. Each contributor introduced EMDR to their patients and their practice slowly and progressively, monitoring their improvements and cautiously avoiding pitfalls. The one case study became the many case observations, soon to result in clinical investigations with larger sample sizes. We are now positioned to promote and implement evidence-based multisite clinical research.

The EMDR arenas explored in this book presuppose knowledge and mastery over the concepts discussed in Dr. Luber’s first book and familiarity with the protocols therein. This second book addresses very specialized groups of patients each with their own separate dilemmas, struggles, and clinical battles; these special patient populations require an adaptation of the Standard EMDR Protocol to accommodate their particular clinical circumstances. The scripted protocols in this second volume are derived from the Standard EMDR Protocol that they often rejoin; however, the scripts also consider the distinct characteristics and predicaments commanded by certain diagnostic categories and patient types.

Part I is devoted to the scripted EMDR protocols used to develop resources for children and adolescents who may have suffered traumatic events in their life. The protocols take into account the particular difficulties of this developmental group and help minimize common difficulties and major hurdles. Part II describes scripted EMDR protocols designed by couples therapists and sex therapists to further the progress of their patients precisely targeting templates of relational interaction, anxiety, or sexual dysfunction.

Part III of the scripted protocols is the closest to my heart and to my soul. These protocols represent the structured scripted efforts of many trauma therapists over a considerable number of years. This journey I know to have been long and painful but ultimately productive. Dr. Luber’s introduction to Part III captures effectively
the multitude of efforts, starts, fits, and stalls in the field of Complex Posttrauma Stress Disorder (CPSD) and Dissociative Disorders (DD). She effectively elaborates on the journey of EMDR and the Standard EMDR Protocol in these much traumatized populations. She rightly honors the gargantuan efforts of Francine Shapiro in assuring the appropriate usage of EMDR in these easily destabilized patient populations.

Francine Shapiro was committed to ensuring that only qualified therapists take EMDR training. Before training onset, they had to be licensed in their respective fields. She went to great effort to secure that the Standard EMDR Protocol was well elaborated, understood, and practiced by the trainees. Patient safety was always at the forefront of Francine Shapiro’s mind and very rapidly after realizing the power of EMDR and the vulnerability of the patients, she set up a task force to tackle some of the basic concerns about DD and C-PTSD and she included them in her 1995 book *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*. Since then, her efforts have continued in bringing to therapists and patients alike the most thorough understanding and the most successful EMDR interventions in the service of the wounded. Part III is the glorious fruit of those labors.

Parts IV and V of this volume address the concretization of much needed scripts for the EMDR treatment of addictions and pain—two interconnected public health worries. Part VI has us travel into the world of people’s adaptation to fears and tackles the usage of scripted protocols to detoxify the impact of specific phobias. Part VII demonstrates the usage of scripted EMDR protocols in clinician care and in the management of secondary PTSD and vicarious traumatization, respectfully healing the healers so that they may continue to alleviate the distress of their fellow men and women.

The meticulous scripting of the EMDR protocols presented in this book is essential. The scripted protocols establish a common platform of communication between therapists and patients, clinicians and researchers, and teachers and students of EMDR. These scripted protocols are the next step in refining our thinking on trauma and trauma cure. The sequellae of tangible and scripted EMDR interventions can be measured and documented on brain scans and fMRIs. These scripted concretized protocols can serve as independent variables in both experimental and quasi-experimental studies; they are foundational for a common language in evidence-based investigations and multisite analyses. Their time has come—we will remember them well.

All this is true. For me, personally, however, these protocols mean much more. They are a journey well travelled in terms of thinking, air mileage, and friendships. It was in 1985 that Dr. Luber and I met surrounding a clinical consultation on a Dissociative Identity Disorder patient. Yes, we spoke of the patient, but we came to discover that our paths, although separate, had been quite overlapping—taking us both from educational institutions abroad to practically crossing as we travelled the same streets in Paris during the very same years! All of this was out of our awareness. We decided to be more mindful and very consciously decided to remain in touch and we have—both professionally and personally. In the late 1980s we worked with complex PTSD and DD exploring the various strategies for talk therapy and hypnosis; we also discovered together EMDR.

In the early 1990s another “radical” treatment methodology emerged from California called EMD. There were trainings on the West Coast—actually, only an extended workshop. Having befriended David Fenstermaker, an EMD trainer in California, I somehow convinced him to come to the East Coast to do training for a select group of therapists in Philadelphia—the group was taken from study groups that I participated in and was select in that they did not mind doing a training in my basement. Marilyn Luber was part of that group. Dr. Fenstermaker’s presentation was appealing and tweaked the interest of a few of us. He encouraged us to
train in California with Dr. Shapiro as well. The trip was planned and only one of us (Dr. Luber) embarked (I ran into some unexpected hindrance that prevented me from going). Dr. Luber and I both plowed on upon Dr. Luber’s return, supporting one another in the use of EMD (now R) in our practices. Eventually, as two levels of EMDR training evolved, we, of course, signed up. Ultimately, Dr. Luber continued on to become a facilitator and trainer of facilitators, supervisors, and consultants and to travel to Europe, the Middle East, and other countries to spread the good word and good works of EMDR. She has become a beloved contributor to the field of EMDR and trauma and clearly a tireless collector of EMDR protocol scripts.

Dr. Luber’s scripted protocol books are timely and welcomed not only for those clinicians who have “trained in basements” but also for those who have more recently joined the field. They promise to be a resource for research as well as for the next generation of therapists. It would behoove us all to tip our hats and bow to Dr. Luber’s involvement, productivity, and contribution through these protocols—but if we did so, we would run the risk of being asked to script it.
One day in 1987, Francine Shapiro took a walk in the park that resulted in a major change. By noticing a naturally occurring phenomenon, Dr. Shapiro was continuing her lifelong journey of “using her mind and body as a laboratory to see what worked” to heal. She had cultivated her “ability to carefully self-monitor” and so, on that day, she attended to her observation that eye movement in a certain manner changed her experience of her disturbing thoughts with great interest (Luber & Shapiro, 2009). Her capacity to self-monitor and then act on that experience would ultimately result in strongly effecting the special populations that are included in this book. Her observation was that when she noticed her eyes moving rapidly, her thoughts changed and her negative affect decreased. Combining this idea, with her understanding of psychology and human behavior, Dr. Shapiro created a treatment that she first called Eye Movement and Desensitization (EMD) and then later expanded it to Eye Movement Desensitization and Reprocessing (EMDR) when she realized that EMDR not only resulted in a relaxation response but also metabolized or reprocessed the trauma. This book is about EMDR and the special populations it serves.

Since that day, EMDR has grown into a therapeutic methodology recognized by associations such as the American Psychological Association (APA, 2004; Chambless et al., 1998) and the International Society for Traumatic Stress (Cromtof, Tolin, van der Kolk, & Pitman, 2000; Foa, Keane, Friedman, & Cohen, 2008). Governmental organizations in many different countries have advocated the use of EMDR in the treatment of trauma such as the United Kingdom Department of Health (2001), Israel (Bleich, Kotler, Kutz, & Shalev, 2002), The Netherlands (Dutch National Steering Committee for Guidelines Mental Health Care, 2003), Northern Ireland (Clinical Resource Efficiency Support Team [CREST], 2003), France (French National Institute for Health and Medical Research [INSERM], 2004), the United States (Department of Veterans Affairs and Department of Defense, 2004; National Institute of Mental Health, 2004–2007), United Kingdom (National Institute for Clinical Excellence, 2005), and Australia (Australian Centre for Posttraumatic Mental Health, 2007). In August 2009, Dr. Francine Shapiro herself was recognized by APA Division 56 with an Award for Outstanding Contributions to Practice in Trauma Psychology. This award recognizes distinguished contributions to psychological practice. It may be given for the development of a highly effective intervention, for contributions to practice theory, or for a sustained body of work in the field of trauma psychology practice. It is clear that the efficacy of EMDR is in the process of being recognized worldwide.

Ongoing research has been gathered on different populations: abuse (Maxwell, 2003); addictions (Amundsen & Kårstad, 2006; Besson et al., 2006; Cox & Howard, 2007; Hase, Schallmayer, & Sack, 2008; Henry, 1996; Popky, 2005; Shapiro, Vogelmann-Sine, & Sine, 1994; Vogelmann-Sine, Sine, Smyth, & Popky, 1998; Zweben & Yeary, 2006), anxiety (Doctor, 1994; Feske & Goldstein, 1997; Goldstein & Feske, 1994; Nadler, 1996; Shapiro, 1994, 1999; Shapiro & Forrest, 1997), body dysmorpia (Brown, McGoldrick, & Buchanan, 1997), children and adolescents
(Greenwald, 1994, 1998, 1999, 2000, 2002; Hensel, 2006; Maxfield, 2007; Russell & O’Connor, 2002; Shapiro, 1991; Tinker & Wilson, 1999), dissociative disorders (Beere, 2009a, 2009b; Fine, 1994; Fine & Berkowitz, 2001; Gelinas, 2003; Lazrove, 1994; Lazrove & Fine, 1996; Marquis & Puk, 1994; Paulsen, 1995; Rouanzoin, 1994; Talan, 2007; Twombly, 2000, 2005), family, marital, and sexual dysfunction (Capps, 2006; Errebo & Sommers-Flanagan, 2007; Kaslow, Nurse, & Thompson, 2002; Madrid, Skolek, & Shapiro, 2006; Shapiro, Kaslow, & Maxfield, 2007; Wernik, 1993), multiply traumatized combat vets (Carlson, Chemtob, Rusnak, Hedlund, & Murakoa, 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; Roos de & Veenstra, 2008; Schneider, Hofmann, Rost, & Shapiro, 2007; Tinker & Wilson, 2005; Wilensky, 2006; Wilson, Tinker, Becker, Hofmann, & Cole, 2000), performance enhancement (Crabbe, 1996; Foster & Lendl, 1995, 1996; Graham, 2004), phantom limb pain (Roos de et al., 2008; Russell, 2008; Schneider et al., 2007; Tinker & Wilson, 2005), previously abused child molesters (Ricci, 2006; Ricci, Clayton, & Shapiro, 2006), stress (Wilson, Becker, Tinker, & Logan, 2001), victims of natural and manmade disasters (Jarero, Artigas, Mauer, Lopez Cano, & Alcala, 1999; Knipe et al., 2003; Konuk et al., 2006), and so forth. The referenced here are a small sample of the research that has been done in this area.

In fact, former past president of the EMDR International Association (EMDRIA) and EMDR consultant, Barbara J. Hensley’s collection of scholarly articles and other writing about EMDR grew so large that—in conjunction with Northern Kentucky University—she turned it into the Francine Shapiro Library, an electronic library available online at http://library.nku.edu/emdr/emdr_data.php. As stated on the Web site, “The intent of the FSL is twofold: (1) to electronically house documents related to EMDR or AIP and (2) to maintain a comprehensive, accurate, and up-to-date list of citations related to AIP and EMDR.” As of July 2009, the Library listed 4472 writings that include material written in 20 different languages (Bosnian, Chinese, Danish, Dutch, English, French, German, Hebrew, Italian, Japanese, Korean, Norwegian, Portuguese, Russian, Serbian, Slovak, Slovenian, Spanish, Swedish, and Turkish). Other sources of information and research about EMDR are listed in Appendix C.

Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations—as with Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations (Springer Publishing, 2009)—evolved from my own learning process. Routinely, after an interesting workshop, I would script the relevant material that I wanted to incorporate into my practice—essentially my own study guide so that I could remember the different steps of whatever I had learned. Later, as I trained Facilitators, then Supervisors and Consultants nationally and internationally, I grew concerned at the lack of understanding of the basic elements of the 11-Step Standard Procedure (Shapiro, 2001) and the Standard 3-Pronged EMDR Protocol and started including the essentials of the protocols into my Supervisory–Consultant manual. After a conversation and request by my colleague, Arne Hofmann, at the 2006 EMDR International Association Conference in Philadelphia, I operationalized this work further by putting together all of the different elements of the protocols, including the specific language used in the form of a script for each of Dr. Shapiro’s six basic protocols: Protocol for a Single Traumatic Event, Protocol for Current Anxiety and Behavior, Protocol for Recent Traumatic Events, Protocol for Phobias, Protocol for Excessive Grief, and Protocol for Illness and Somatic Disorders (Luber, 2009). His request was to have these protocols ready for the first European Trainers’ Training in March 2007 so that the Trainers could have a clear script that would ensure a standard and these Trainers—who were from a variety of countries—would literally and figuratively be on the same page. The other concern
was that there be a standard to inform researchers of all the elements of Shapiro’s six basic protocols.

As a result of my personal interaction with many EMDR-trained clinicians and researchers from all over the world, as I attended conferences, regional meetings, study groups and trainings, and participated in listservs about EMDR, I became fascinated by the wealth of creativity alive in the EMDR community. For many, the Standard EMDR formulations worked well; however, we found that many of us who were using EMDR consistently were applying the protocols to our clients and bumping up against similar difficulties and issues depending on the population with which we were working. We had taken our excitement about EMDR into our offices and were coming up with educated ways of working with the protocol within our areas of expertise. Many began to present and write about these areas of specialty, sparking others to think about these unique situations. After I completed scripts for Dr. Shapiro’s protocols, I began to look at the work of my colleagues who were using EMDR with different populations and difficult situations and to revisit the work that I had already scripted. In this way, the concept for two books, *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations* and *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations*, was born and then evolved.

These books of scripted protocols have no official sanction; however, they are informed by my own years of work. I was trained in 1992 and benefited from the years of teaching I had done from 1994 to 1996 working with EMDR-trained practitioners as a Co-Consultant with Steve Silver, later—1998 to the present—as a Facilitator, Supervisor and Consultant Trainer nationally and internationally, and from 2000 to the present as a Certified Consultant for Consultants and Certified Therapist in EMDR through the EMDR International Association since the certification program’s inception. The contributors in this volume represent many years of accumulated practice in EMDR in their specialty areas; most are Facilitators, certified Consultants, and/or Trainers. Some of these protocols are in the process of being researched and the others reflect the observation and innovations of skilled clinicians using EMDR within areas of their expertise.

The goals of *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations* are twofold: to provide a standard that reflects the basic elements of the 11-Step Standard Procedure (Shapiro, 2001); and the Standard 3-Pronged EMDR Protocol (Shapiro, 2001, 2006) as they are applied to different populations such as children and adolescents; couples; clients suffering with complex post-traumatic stress disorder and dissociative disorders; clients with anxiety; clients who demonstrate addictive behaviors; clients who deal with pain; clinicians themselves; and to serve as a basis to encourage research into these various applications for EMDR. I have used this structure as much as possible in the chapters that follow.

Many of the chapters reflect the particular needs of their population through a detailed and specific client history. Chapters that reflect resources are part of the Preparation Phase of the 8 phases of the 11-Step Standard Procedure. Most authors have used the 8 phases as the template around which they have structured their material. Some notable places where authors have departed from this format are those related to the section on complex post-traumatic stress disorders and dissociative disorders; the treatment reflected in these chapters uses the Standard EMDR Protocol where possible and incorporates adaptations that reflect the needs of their clients. The reader will notice that different populations may follow the 3-pronged protocol but in a different order than the standard; these, too, reflect the needs of the population with whom they are working as is explained below. There are a few clinical examples; however, this is not uniform throughout the volume.
Even though a script may give the illusion that it need only be read, in fact, that is not accurate. Although these protocols are scripted to encourage the accurate use of the EMDR methodology, they have not been written down for nontrained clinicians to use or for practitioners operating outside their area of expertise to follow. These protocols are only for EMDR-trained clinicians and for those trained to work in their areas of specialty as they have the skill to tailor these protocols to the unique needs of the particular client with whom they are working.

Clinicians are encouraged to seek training in EMDR from recognized trainers who have demonstrated their knowledge, understanding, and success as an EMDR trainer through documentation by the associations that give accreditation for expertise in EMDR. These associations are listed in Appendix C of this volume. 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: Special Populations* is divided into seven sections to address the variety of special populations served in the EMDR community. For the sake of clarity, pronouns are used for the same sex as the author to refer to the therapist and the pronouns for the opposite sex of the author are used to refer to the client. For example, if the author is female, any reference to the therapist would be as “she” while any reference to the client would be referred to as “he.” Part I addresses the special needs of children and adolescents while using EMDR. The section begins with a foundational chapter on a special way of doing bilateral stimulation (BLS) created by Luci Artigas and Ignacio Jarero that has been essential in working with large groups of children originally as survivors of natural disasters and then expanded and used with individual children and also adults. Innovative resource work developed by Ana Gomez using olfactory stimulation is applied to the standard safe place and resource development and installation. Barbara Wizansky and Dagmar Eckers sensitively translate resources that were developed for adults originally into solid and important work with children and adolescents. Ms. Wizansky goes on to use bilateral stimulation in the form of footsteps to support problem solving and Robbie Adler-Tapia and Carolyn Settle help therapists understand the importance of framing EMDR assessment specifically for children.

Work with EMDR and couples presents its own unique issues that are clearly illuminated in Michael D’Antonio’s and Barry Litt’s work on integrating EMDR into couples work. Sabitha Pillai-Friedman offers us a way to work with sexual dysfunction that highlights the particular issues that are important to address this population while Marina Lombardo and Regina Morrow educate us about infertility and how EMDR can be used effectively with this group.

The section on EMDR, Dissociative Disorders, and Complex Post-Traumatic Stress Disorder is a rich part of the book that addresses the particular issues working with this complicated and challenging population. An interesting trend began to appear while studying the way that various practitioners addressed this complex population; all noted the importance of a more extended preparation phase to ascertain that the clients are able to modulate and contain their affect even in the face of talking about or reexperiencing their trauma before proceeding with EMDR. For most, instead of floating back into the past connected issues of the trauma, clinicians stressed the importance of starting by working with clients in the here and now. Carol Forgash introduces us to a number of concepts to help orient clients through her use of working with ego states, “Home Base,” “Workplace or Conference Room,” and “Orienting the Ego State System to Present Reality.” Jim Knipe includes several important chapters that empower clients and help keep practitioners in the loop concerning clients’ ability to stay in the present or not, and teaching
clients how to be more aware of what usually had been an involuntary process of dissociating. Joanne Twombly—also understanding the necessity of assisting clients to be present—has a number of chapters teaching a variety of ways to support clients in this critical skill. Arne Hofmann and Don Beere have created several ways to work with resources that particularly target the special needs of this population. Carol Forgash includes a chapter that helps clients manage critical life issues while Joanne Twombly has a chapter that addresses how to target traumatic material with this population.

Arne Hofmann’s chapter on the Inverted EMDR Standard Protocol for Unstable Complex Post-Traumatic Stress Disorder is an invaluable work that describes how to know when to begin EMDR processing and what skills must be in place before proceeding. Catherine Fine shows us how to imbricate hypnosis and EMDR while working with dissociative patients. In Ulrich Lanius’s work on the Bottom Up-Processing Protocol, he integrates his understanding of the importance of somatic work and how that structures his work with this population. Sandra Paulsen takes us through the steps in an EMDR session that inform her work and some of the choice points that are involved while making decisions in this complicated and nuanced work. Don Beere shows us how a basic hypnotic technique can be integrated into EMDR work and allow for clients to fully process a trauma using the Protocol for Recent Traumatic Events. This section ends with Denise Gelinas’s important understanding of how to work with the characteristic types of negative cognitions that get stuck when working with patients suffering with complex trauma.

Part IV addresses a particularly important problem in our societies—dealing with addictive behaviors. Jim Knipe provides us with an innovative contribution as he accesses addictive behavior by addressing dysfunctional positive affect to clear the pain of unrequited love, to deal with codependence or obsession with self-defeating behavior, to assist clients with unwanted avoidance defenses, and the difficult problem of procrastination. When Michael Hase works with substance abuse clients, he uses a particularly interesting way to address addictive memories, while A. J. Popky reveals a way to reduce the urges connected with addictions.

Pain patients are an exacting sector of the population that demand different ways of addressing their issues. Mark Grant, along with Carlijn de Roos and Sandra Veenstra, shows us how to work with pain patients while the chapter by Sandra Wilson and Robert Tinker helps us understand the specific needs of working with phantom pain and EMDR.

In Part VI, dentist and psychologist Ad de Jongh addresses the particular difficulty of working with clients who have specific fear phobias and the unique issues that apply when working with this population.

The last section is a part that is also found in Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations, although there are some helpful changes in the introduction to that section. The chapters in this section appear in both books as a way to underline and promote the importance of self-care by clinicians while they work with human suffering. Neal Daniels’s way to process traumatic residue after a session is essential and would be helpful for any practitioner. Mark Dworkin’s chapter helps clinicians become aware of their own internal reactions to client material and how this can impact both therapists and clients.

Appendices A, B, and C also appear in both volumes. Appendix A includes Worksheets for Past, Present Triggers, and Future Template. In Appendix B, Gene Schwartz introduces an addition to the Desensitization Phase that assists clinicians in being thorough while processing through the traumatic material by addressing unconsolidated sensory triggers. There are many resources in the EMDR community and they are included in Appendix C. References, Further Readings and Presentations include more information about EMDR that will support the practitioner.
Eye Movement Desensitisation and Reprocessing (EMDR): Special Populations is a book designed to support the reader’s proficiency in EMDR through the scripted protocols written by the skillful EMDR practitioners represented in this volume and informed by the Standard EMDR Protocol of Francine Shapiro (2001).

References


When we are in a community active in the art and science of healing, it is an opportunity to learn and grow. The process of editing this volume and *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations* has resulted in much more than I would have ever dreamed when I began this journey. As in the words of Sheenagh Pugh’s poem “Sometimes” (1990), “Sometimes our best efforts do not go amiss; sometimes we do as we meant to”; the authors of these volumes—my peers—and I have done more than I dared possible. Our collective work has brought to light how much better we are for the work that we are and have been doing. I would like to acknowledge these authors and the growth and depth of understanding I have experienced in the course of absorbing and clarifying their work in an active exchange of ideas with each of them so that I could pass these ideas on in scripted form to other clinicians. To each one of you, I would like to say, “Thank-you.” We are all truly able to benefit from their knowledge. I hope in using this book, you will have the same experience.

This book is dedicated to Francine Shapiro and Robbie Dunton. They are two of the most community-oriented people that I have met. They are passionate in their pursuit of teaching EMDR and creating a healing community worldwide. Through watching, listening, and learning from Robbie, I learned how to create community. From Francine, I learned what it takes to germinate an idea, plant it, and watch it grow into an effective healing community. This book is a tribute to the seeding that you, Francine and Robbie, have done since the beginning of the EMDR journey.

I would also like to acknowledge the international community at the International School of Geneva that I joined at the impressionable age of 11 years. Through the day-to-day rubbing elbows and ideas with people from diverse cultures, belief systems, religions, and teaching styles, I learned a great deal about the importance of the boundaries of my own ways and the transformation that occurred by learning early that there are many more ways to think about a problem than my own.

To my colleagues in the greater EMDR community, I would like to acknowledge the many gifts I have received through the experience of knowing each one of you. It is the friendships, small and large kindnesses, and reaching out at times of happiness and sorrows that has made this experience in my life a rich and profound one. I have learned from the lessons of interpersonal conflict, friendship, and leadership and have been truly impacted by the exchange. Most of all, I have been deeply touched by the consistent changes that we have begun to make as we work with clients on their inappropriately stored life experiences to their large “T” traumas. I am awed by the work that our community has done throughout the world in the face of man-made and natural disasters. The world is a more compassionate and healthy place as a result of our EMDR community.

I also recognize the importance of the staff of Springer Publishing, especially Sheri W. Sussman and Deborah Gissinger and Julia Rosen of Apex CoVantage. Thank you for your help and guidance during these two projects. In particular, I would like to thank Sheri for barely blinking when she was presented with much more material than she expected.
Again, without Lew Rossi and his ability to handle any of the major issues that have come about concerning the software and hardware of my computer, this project would never have even approached completion; thank you for all of your hard work. The Internet is also a source of great gratitude as without the benefit of this medium, this book would have taken much longer and possibly resulted in less diversity.

I would like to thank my kind colleagues and recognize them as they took time away from their busy schedules to read over some of the text and/or provide support and guidance: they are Elaine Alvarez, Sheila Bender, Michael Broder, Catherine Fine, Irene Giessl, Richard Goldberg, Barbara Hensley, Jennifer Lendl, Donald Nathanson, Udi Oren, Sandra Paulsen, Zona Scheiner, Elan Shapiro, Howard Wainer, Stuart Wolfe, and Bennet Wolper. To Emmy, my inimitable therapy dog, I would like to acknowledge the trials and tribulations that she has gone through mirroring my intensity and focus while working with these scripts and her ability to always make me smile during the course of the day. Although I have neglected my friends during this time of concentrated and solitary work, I want them to know how much I have appreciated all their support from the wings and airways. I would like to acknowledge and remember my cousin, Steven Waxman, who was friend and counsel until his passing away this year. I would like to thank Shirley Luber always for her support and loving kindness.
Understanding child development is the foundation upon which to build our clinical skills. It enriches our thinking and helps us understand the types of clinical interventions to choose as we work with our clients—child, adolescent or adult. The chapters in this section can be used not only for working with children and adolescents but with our adult clients as well.

The integration of EMDR and working with this population began as soon as Francine Shapiro taught Robbie Dunton how to do Eye Movement Desensitization (EMD) and later EMDR. Ms. Dunton could not believe the power of EMDR when she worked with the behavioral issues of school-aged children as it helped her uncover the histories of early trauma in her students. By understanding the presenting learning problem, she began to see the connection between the problem and a trauma or issue that precipitated the learning issue. If a child came in with a fraction problem, as this skill was taught in fourth grade, Ms. Dunton would ask, “What happened in fourth grade?” Often, there was a trauma that became the target for reprocessing; frequently resulting in the decrease or disappearance of the presenting learning issue (Luber, 2007). Ms. Dunton presented her work on the “Treatment of Learning Disabilities” in Australia in 1992 at the EMDR Symposium at the Fourth World Congress of Behavior Therapy and in 1993 at the Second Annual EMDR Conference in Sunnyvale, California, setting a high bar for all of the child and adolescent therapists who followed her.

In August 1991, the EMDR Institute published Volume 1, Issue 1 of the Network Newsletter. The EMDR Institute communicated with those who participated in EMDR Institute trainings through the Network Newsletter. The newsletter was filled with information and concerns from Dr. Shapiro, reviews of relevant professional papers and books, information from the EMDR Professional Issues Committee
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Eye Movement Desensitization and Reprocessing (EMDR), the *International Update*, and a column by Ron Martinez called “Innovative Uses.” It is in here that practitioners such as Liz Mendoza-Weitman (1992), Ricky Greenwald (1993b), and Joan Lovett (1994) broached such issues as depression in a 10-year-old boy whose father abandoned him at age 5, treating a child’s nightmares with EMDR, and a case report on treating a toddler with EMDR. It became an excellent way to find out what people were doing in EMDR. In June 1996, the *Network Newsletter* turned into the *EMDRIA Newsletter* when the EMDR International Association was formed.

One of the first articles published about EMDR was in the *Journal of Behavior Therapy and Experimental Psychiatry* (Pellicer, 1993) on EMDR and the treatment of a child’s nightmare. Meanwhile, through the EMDR Institute Conferences that began in 1991, child therapists began to present their work. During the second annual EMDR Conference, topics such as working with school behaviors and learning issues (Dunton, 1993), EMDR and a sexually abused child (Sutton, 1993), and children and critical incidents (Greenwald, 1993a) were explored. By the 1994 EMDR Conference, Robert Tinker was presenting on attention deficit/hyperactivity disorder (ADHD; 1994), Michael Abruzzese was addressing the use of Tourette’s disorder with EMDR (1994), and Jean Sutton continued to present on traumatized children and EMDR (1994). In 1995, the EMDR Institute hosted a joint conference with the newly formed EMDR International Association in Santa Monica. There were five presentations addressing child and adolescent issues concerning case presentations (Greenwald, 1995), disruptive behaviors (Abruzzese, 1995), fears (Klaff, 1995), darkness phobias (Cocco, 1995), and with toddlers (Lovett, 1995). An all-day workshop for child and adolescent therapists was widely attended and included “Using EMDR to Treat Children” (Tinker, 1995), “Treating Severely Traumatized Children—Assessment and Treatment Strategies for Using EMDR” (York, 1995), and “Using EMDR With Adolescents” (Thompson, 1995). The interest in child and adolescent work with EMDR was clear.

In 1996, the baton was passed formally to the EMDR International Association and this group began to host the EMDR Conference with the mission to uphold the standard of EMDR practice. In this spirit, a meeting to promote the development of EMDR for children and adolescents was called by Ricky Greenwald (Chair) along with his panel members; Michael Abruzzese, Ann Godwin, Joan Lovett, Robert Tinker, and Carol York. Some of their goals included working on research and publications for the efficacy of EMDR for children and adolescents, maintaining an updated literature review, offering support for research projects, promoting EMDR training for mental health professionals in schools, understanding child trauma and EMDR internationally and with the medical community, developing diagnostic and screening tools for EMDR appropriateness, increasing the focus on child EMDR skills in the standard trainings, and establishing standards of training for a specialty with children and adolescents. In the following years, presentations and research on EMDR with children and adolescents increased.

The year 1999 was a banner one for EMDR and the treatment of children and adolescents. Four of the early pioneers working with EMDR in this field turned their knowledge into the following books: *Eye Movement Desensitization and Reprocessing (EMDR) in Child and Adolescent Psychotherapy* (Greenwald, 1999a), *Small Wonders: Healing Childhood Trauma With EMDR* (Lovett, 1999), and *Through the Eyes of a Child: EMDR With Children* (Tinker & Wilson, 1999). Each book added knowledge to the already growing ways to treat children and adolescents with EMDR. In the same year, mirroring the interest of practitioners in this area, the EMDRIA Newsletter had a special edition on “Children, Adolescents, & EMDR: A Closer Look” with articles on “EMDR With Children: The First Ten Years” (Greenwald, 1999b); “Developmental Considerations in Using EMDR With Adolescents” (Geller, 1999); “Slaying the Monsters” (Spindler-Ranta, 1999); “The Butterfly Hug:
Some History and Updates on Its Use With Children” (Boel, 1999); “After Zero: Further Processing with Teens” (Greenwald, 1999e); “Book Reviews: Three EMDR Book About Children and Adolescents” (Dutton, 1999); “Group EMDR Therapy in Young Children” (Forte, 1999); “A Crisis Response Approach for Suicidal Teens” (Greenwald, 1999d), and “Breaking the Cycle of Violence: EMDR Treatment of a Traumatized Violent Teen Girl” (Van Winkle, 1999).

Child and adolescent therapists in Europe trained with Robert Tinker and Sandra Wilson in the late 1990s. Many of these clinicians went on to become accredited Child Trainers. The accredited Child Trainers in Europe—at this writing—are the following: Joanne Morris-Smith (Great Britain), Kamala Müller (Great Britain), Renee Beer (Netherlands), Carlijn de Roos (Netherlands), Barbara Wizansky (Israel), Esti Bar-Sade (Israel), Dagmar Eckers (Germany), Beatrix Musaeus-Schürmann (Germany), Lutz-Ulrich Besser (Germany), Edeltraud Toddy Sochaczewsky (Germany), Thomas Hensel (Germany), Margareta Friberg (Sweden), Reet Oras (Sweden), Lene Jacobson (Denmark), Michel Silvestre (France). Currently, there is a Child Committee in the EMDR European Association that decides on the rules for training child and adolescent therapists in coordination with the Standard Committee of EMDR Europe.

In the United States, the EMDR for Children and Adolescents Special Interest Group continued to flourish. They sponsor conferences annually and work on special projects such as creating a resource packet for EMDR clinicians that contain information on helpful resources for children and EMDR. Marsha Heiman, an EMDR practitioner living in northern New Jersey, helped create a brochure to explain trauma to professionals in other related fields. The brochure (Child and Adolescent Special Interest Group, 2007), “EMDR & Children: A Guide for Parents, Professionals, and Others Who Care About Children” is available for purchase through the EMDR International Association (www.emdria.org). Anyone who is a member of EMDRIA can join this special interest group (SIG) and the Child SIG Clinical Listserv.

The new millennium has brought many more presentations, chapters in books, articles and books concerning this area; in fact, as of June 2009, the Francine Shapiro Library reported 318 abstracts about children. EMDR is being used with children and adolescents for a wide range of issues all over the world. A short sample of work includes art therapy (Cohn & Chapman, 2002); attachment (Wesselman, 2007); family (Klaff, 2002); grief (Donovan, 2005); hospital trauma (Lovett, 2002); juvenile sex offenders (Gates, 2002); joy (Morris-Smith, 2003); learning disabilities (Bacon, 2001); man-made and natural disasters (Artigas, Jarero, Alcalá & Lopez, 2009); phobias (Nofal, 2008); and PTSD (Maxfield et al., 2004).

Clearly, there is a great interest in EMDR and the treatment of children and adolescents. Part I of this book is aimed at the community of child and adolescent specialists, as well as those clinicians who work only with adult populations, who are always looking for new and creative ways to work with their adult clients—especially those with early trauma—both large “T” and small “t” traumas. The first part of this section addresses how to develop resources for children and adolescents. In the first chapter, Lucina Artigas and Ignacio Jarero show us how to use the “Butterfly Hug.” This way to help children learn bilateral stimulation in the face of natural disaster was an innovation that was heard around the world. Practitioners have taught their child and adult clients this helpful intervention during man-made catastrophes and natural disasters (see Part VI, Artigas, Jarero, Alcalá, & López, 2009) to help them work through their terrible experiences.

Ana Gomez has been presenting at the EMDRIA Conferences for a number of years and is so inventive that her work is shown as a demonstration during the current EMDR Institute Basic Trainings. Using olfactory stimulation may be more effective in reaching different parts of the brain if the thalamic activity is decreased;
Dr. Gomez has turned this information into an original way of pairing olfactory stimulation with the Resource Development and Installation and Safe Place Protocols for optimal results with her clients.

Barbara Wizansky and Dagmar Eckers have modified adult techniques so that they may be used with children. Ms. Wizansky has taken Brurit Laub’s Resource Connection and added her own modification to support children in reinforcing their resources and using them as needed. Dr. Eckers’s work with the Absorption Technique for Children is an adaptation of Arne Hofmann’s adaptation (chapter 23) of Roy Kiessling’s “The Wedging Technique” (Kiessling, 2009) and is used for present challenges and future concerns. Ms. Eckers also has adapted Jim Knipe’s “Method of Constant Installation of Present Orientation and Safety” (CIPOS; chapter 18) for children. She incorporates drawing into this method to help the child have a sense of their current security and stability and the establishing of a safe place while using CIPOS.

Barbara Wizansky’s Footsteps Through the Maze Protocol (chapter 7) has created a problem-solving tool that uses bilateral stimulation (BLS) to create resources that eventually lead to the introduction of the Standard EMDR Protocol.

Robbie Adler-Tapia and Carolyn Settle, as many clinicians who become serious about EMDR, joined a study group that included other practitioners interested in working with EMDR and children. They began a research study on using EMDR with young children with the goal of helping therapists adhere to the EMDR protocol. The result is a state of the art text, *EMDR and the Art of Psychotherapy With Children* (2008a) and the accompanying manual, *EMDR and the Art of Psychotherapy With Children Treatment Manual* (2008b). This book and manual can be consulted for a more in-depth treatment of work with children. In their chapter on EMDR Assessment and Desensitization Phases with children, they give step-by-step directions on how to move through these phases.

These scripts can be used to help expand your treatment skills and learn important ways to build resources and work with children and adolescents with EMDR. It is important to note here that those clinicians who use these protocols with children and adolescents should have extensive knowledge of how to work with EMDR and with children and adolescents before they begin work with their clients.
The Butterfly Hug was originated and developed by Lucina Artigas during her work performed with the survivors of Hurricane Pauline in Acapulco, Mexico, 1997 (Artigas, Jarero, Mauer, López Cano, & Alcalá, 2000; Jarero, Artigas, & Montero, 2008).

For the origination and development of this method, Lucina Artigas was honored in 2000 with the Creative Innovation Award by the EMDR International Association. In Francine Shapiro’s 2001 EMDR text, she wrote that “The Butterfly Hug has been successfully used to treat groups of traumatized children in Mexico, Nicaragua and Kosovar refugee camps” (Shapiro, 2001, p. 284). By 2009, The Butterfly Hug had become standard practice for clinicians in the field while working with survivors of man-made and natural catastrophes.
The Butterfly Hug Script

The “Butterfly Hug” provides a way to self-administer dual attention stimulation (DAS) for an individual or for group work.

Say, “Would you like to learn an exercise that will help you to feel better?”

Say, “Please watch me and do what I am doing. Cross your arms over your chest, so that with the tip of your fingers from each hand, you can touch the area that is located under the connection between the clavicle and the shoulder. Your eyes can be closed or partially closed looking toward the tip of your nose. Next, you alternate the movement of your hands, like the flapping wings of a butterfly. You breathe slowly and deeply (abdominal breathing), while you observe what is going through your mind and body such as thoughts, images, sounds, odors, feelings, and physical sensation without changing, pushing your thoughts away, or judging. You can pretend as though what you are observing are like clouds passing by.”

This exercise can be done for as long as the person(s) wishes to continue. Watch to make sure that the children are following along with you. If not, check to find out what is going on and then return to teaching The Butterfly Hug.

Uses for This Method

To install the Safe Place:

Say, “Now, please close your eyes and use your imagination to go to a place where you feel safe or calm. What images, colors, sounds, and so forth do you see in your safe place?”

When in groups, the Emotional Protection Team moves among the children listening to them as they answer out loud. The goal here is to make sure that each child has found a Safe/Calm Place they imagined.

The following is optional:

Say, “Now, please take out your paper and draw the Safe/Calm Place that you imagined. When you are finished, please do the Butterfly Hug while looking at your drawing.”

Say, “You are welcome to take your picture home and you can use it with the Butterfly Hug whenever you need to feel better.”

Make sure to notice the children’s responses. There is no talking during this time so that the children are not taken out of their process.

Once the patients or clients (children or adults) have learned the Butterfly Hug, they can be instructed to take this method with them to use between sessions,
whether to modulate any disturbing effect that arises, to reground with their Safe Place or simply to help them get to sleep more easily.

Say, “Now that you have learned the Butterfly Hug you can use it anytime that you are having disturbing feelings, or you want to go back to your Safe Place. You can also use it to get to sleep more easily. Do you have any questions before we stop for today?”

There are many uses for the Butterfly Hug such as the following:

- To anchor positive affect, cognitions, and physical sensations associated with images produced by the technique of “guided imagination.”
- During the EMDR Standard Protocol, some clinicians have also used it with adults and children to facilitate primary processing of a fundamental traumatic memory or memories. Instead of the clinicians being in charge of the bilateral stimulation, the client is asked to do the Butterfly Hug during the Phases 4, 5, and 6. It is thought that the control obtained by the client over their contralateral stimulation may be an empowering factor that aids their retention of sense of safety while processing traumatic memories.
- During in vivo exposure to process the experience. For example, in the Quiche’s region of Guatemala the persons that are witnessing the burial of their relatives use the Butterfly Hug to be self-comforted and to cope with the experience.
- In the EMDR Integrative Group Treatment Protocol (EMDR-IGTP) used to work with children and adults who have survived traumatic events, to process primary traumatic memory or memories including the death of family members. During this process, the children and adults are under the close supervision of mental health professionals who form the Emotional Protection Team. (Jarero et al., 2008).
- Use of the Butterfly Hug in session with the therapist can be a self-soothing experience for many trauma-therapy clients. For instance, the therapist might say, “Would you like to use the Butterfly Hug while you are telling me what happened?”
- Some professionals use the Butterfly Hug simultaneously with their client as an aid to prevent secondary traumatization.
- Other professionals have used this method as a substitute for touching clients and they might say, “Please give yourself a Butterfly Hug for me.”
- Professionals report that they have used the Butterfly Hug with clients with debilitated egos because it produces less abreaction than other bilateral stimulation techniques.
- Teachers in a Guatemalan school for child victims of parental violence tell the children that they can feel Father God’s love through the Butterfly Hug.
- During the Pasta de Conchos mine tragedy in Mexico in 2006, a paramedic stabilized and saved the life of a mine engineer who was having a heart attack using the Butterfly Hug.
Using Olfactory Stimulation With Children to Cue the Safe or Happy Place
Ana Gomez

The standard Safe Place Protocol uses a word for cuing and self-cuing (Shapiro, 2001). For many clients, using a cue word to elicit the Safe Place and its positive associations may be effective, however, this author has hypothesized that other forms of cuing may be more effective, depending on the severity of their trauma and patterns of neurobiological responses. For the last 3 years, this author has used olfactory stimulation with more than 30 children and adolescents to cue the Safe Place and resources installed with the Resource Development and Installation (RDI) Protocol (Korn & Leeds, 2002). These children have shown positive responses with increased self-regulation to self-cuing with olfactory stimulation using simple scents and scented lotions. The effectiveness of olfactory cues to assist traumatized children in accessing previously installed resources for self-regulation may be associated with the relationship between trauma and thalamic activity. The thalamus is the sensory gateway to the cortex and the limbic system. This means that all incoming sensory information is routed through the thalamus with the exception of olfactory stimulation (Bergmann, 2008a). Several studies conducted by Ruth Lanius and her colleagues (R. Lanius et al., 2004; R. Lanius, Bluhm, Lanius, & Pain, 2006; R. Lanius, Lanius, Fisher, & Ogden, 2006), suggest that thalamic response patterns may be different depending on the type of trauma. Individuals with simple post-traumatic stress disorder (PTSD) might show an increase in thalamic activity and those with complex PTSD, a decrease in thalamic activity. According to Ulrich Lanius (2006), if thalamic activity decreases as a result of trauma and PTSD, then incoming information will not be efficiently sent to other parts of the brain. Ulrich Lanius has hypothesized that this might be the case in complex PTSD and dissociative individuals. With this information in mind, when using the Safe Place and RDI Protocols, olfactory stimulation may be more effective in reaching different regions of the brain even if thalamic activity is decreased.

For many years, aromatherapy has been used as an adjunctive form of therapy in mental health. Some research studies even suggest that the use of scents and aromas may be effective as a tool for crisis management in adolescents and adults (Fowler, 2006).
Initially, the use of olfactory stimulation with Safe Place and RDI resources was limited to youngsters with symptoms of dissociation and complex PTSD, but, later on, it was extended to young clients with simple PTSD and other trauma-related disorders. These children reported that using scents and lotions for self-cuing facilitated the effective use of resources when they were experiencing negative emotions, resulting in an increased ability for self-regulation. In addition, children, and especially the younger ones, reported that self-cuing with lotions and scents made the use of the Safe Place and other resources very motivating. However, at this point, this is an anecdotal report with objective measures and no controls. The effectiveness of using olfactory stimulation to cue Safe Place and RDI has not been established.

As described in earlier reports (Korn & Leeds, 2002; Shapiro, 2001), if at any point while you are using the Safe Place or RDI resource protocol the child reports negative emotions, reevaluate the resource and assist the child in identifying a different Safe Place or a new resource that has only positive associations. A child who is unable to identify any Safe Place or any positive resources shows you the magnitude of the child’s deficits. If this is the case, do a more thorough assessment of the child’s support system and environment, since a chaotic environment may be maintaining the child in the alarm state. More work might be necessary with the caregivers and support system to stabilize the environment.

The following is the adapted Safe Place Protocol for children using olfactory stimulation. This protocol can be used with children and adolescents from 4 to 12 years of age. Some young children might not understand the word “safe” so referring to the Safe Place as the Happy Place might be more appropriate. Before using this protocol, assess the presence of allergies or skin conditions that can be worsened by the use of lotions and scents. This applies to the child, the parents, and the clinician as well. Even though this author has yet to have any child report negative associations to the selected scent, any stimulus can potentially become negative. If this is the case, you can encourage the child to choose another lotion or scent at any point during the administration of this protocol.

**Safe Place Protocol Script Notes**

Before establishing the Safe Place, it is important that you explain to the child and the caregivers what EMDR is and how it works, especially the different forms of bilateral stimulation (BLS). Based on research, Dr. Francine Shapiro has suggested that eye movement might have a stronger effect than other forms of BLS for adults that can tolerate them. On the other hand, it has been suggested that tactile and auditory stimulation seem to create a less concentrated, more diffused and evidently gentler signal to the brain in comparison to eye movement (Bergmann, 2008b). When working with highly dissociative individuals, less activation to the brain during trauma reprocessing might be more appropriate (Bergmann, 2008c; Lanius, 2008). Therefore, using tactile or auditory BLS might be more suitable. It has yet to be established whether one form of BLS is more effective with children, but if we follow adult research, eye movements should be offered first unless the child cannot tolerate them or reports discomfort. However, when working with highly dissociative children using tactile and auditory stimulation might be more appropriate.

In order to make eye movements more appealing for children, this author has created a set of finger puppets that are part of a team called the “EMDR Helpers.” This team consists of a group of finger puppets that are introduced to the child when EMDR is explained for the first time so the child can develop a relationship with the helpers. The names of these finger puppets form the acronym EMDR: Elizabeth, Mario, David, and Robbie are always available to assist the child by providing the BLS. Through clinical observation, it has been noted that children
are usually more motivated to do EMDR and use eye movement when they have
developed a relationship with a puppet. Every time the clinician needs to provide
BLS, it is important to ask the child for the name of the helper puppet.

The following Safe Place Protocol has been adapted from the adult Safe Place
Protocol developed by Neal Daniels in his work with veterans at the Veterans Ad-
ministration Hospital in Philadelphia and formalized in Shapiro (1995). Depending
on the child’s age and preference, use your clinical judgment to determine the ap-
propriateness of having the caregiver present during the session.
Safe or Happy Place Script

Say, “I want you to meet my EMDR helpers. They help kids do EMDR.”

Say the name of each puppet and have the puppets introduce themselves.

Say, “Hi, my name is Elizabeth. Hi, my name is Mario. Hi, my name is David, and my name is Robbie and we are THE EMDR HELPERS! We help kids move their eyes from side to side, please follow us.”

Have children follow the puppets with their eyes while you move the finger puppets back and forth. If the child cannot tolerate eye movement, have the puppets tap the child’s hands or knees. Demonstrate the other forms of BLS.

Say, “Okay, how about if I have the puppets tap your hands? Would that be okay to try?”

If the child can tolerate eye movement say, the following:

Say, “Good job, now pick your favorite one, which EMDR helper would you like to have today?”

Say, “We are going to practice EMDR with good stuff and you are going to move your eyes from side to side (if the child cannot tolerate eye movement, mention the BLS selected by the child). Which EMDR helper would you like to have today?”

Image

Say, “Can you think of a place where you have been or that is in your imagination, where you feel good, happy, and safe? This is a place where you remember good things happening and where nothing bad has ever happened. What place do you have in mind? What colors, sounds, and smells do you remember in this place?”

Emotions and Sensations

Say, “When you think about this place, how do you feel?”

Say, “Where do you feel that inside your body?”
Enhancement (Optional)

Ask the child to draw a picture of the Safe Place.

Say, “I would like you to draw a picture of this place that you created in your mind. Think about this place and all the colors, the sounds, the smells, and everything that you see around it that make you feel ________ (repeat the emotions identified by the child previously). You can use paper and pencils, crayons, or paint to draw your Safe or Happy Place.”

Or create the Safe or Happy Place using the sandbox.

Say, “I would like you to use the sandbox to make this place that you have created in your mind. Think about this place and all the colors, the sounds, the smells, and everything that you see around it that make you feel ________ (repeat the emotions identified by the child previously). You can use any figures to create your Safe or Happy Place (have different sandbox figures the child can choose from to create the safe place).”

Bilateral Stimulation (BLS)

Say, “Now I would like you to bring up your Safe or Happy Place and those ________ (repeat the emotions reported by the child) feelings that you feel in your body and follow ________ (say the name of the EMDR helper selected by the child).”

Do 4 to 6 slow passes of BLS.

Say, “What do you feel now?”

Repeat several times if the emotions and positive associations to the Safe Place continue to be enhanced.

Say, “Go with that” or “Think of that.”

Do 4 to 6 slow passes of BLS.

If negative feelings and associations occur, assist the child in identifying a different Safe Place.

Say, “Okay, it looks like when you think about this place you are getting some mixed-up feelings. How about if we find another place where you don’t have any mixed-up feelings and you only feel good, happy, and safe. Can you think of another place?”

You could also ask the child for a safe or happy place they have had in their dreams.

If the child cannot identify such a place, more intensive stabilization work with the child and caregivers might be necessary.
Cue Scent

Have different lotions, scents, or essential oils available for the child. (Hand lotions and essential oils can be found at any department store.) Allow the child to explore and experiment with different scents and lotions. Have a small container ready and give it to the child.

Say, “I would like you to try the lotions and scents that are here so that you can pick one that will help you remember your Safe or Happy Place and the good feelings that you have when you think about this place. It can be any lotion or smell you want. Make sure it is a scent that does not remind you of anything bad or yucky.”

_____________________________________________________________
_____________________________________________________________

Say, “That's a great choice. Here is your own special container to put it in. What would you like to call this lotion?”

_____________________________________________________________
_____________________________________________________________

Most children call it the “good feelings lotion” or my “safe place lotion” or my “happy feelings lotion.” If the child does not come up with a name you can say the following:

Say, “Some children like to call their lotion the ‘good feelings lotion’ or my ‘safe place lotion’ or ‘my happy feelings lotion.’ You can use these names or any other name that you might think of that makes you think about your lotion.”

_____________________________________________________________
_____________________________________________________________

Say, “Now, I would like you to think about your Safe or Happy Place and the ________ (repeat the emotions identified by the child) feelings. Now, smell the ________ (state the name of the lotion the child chose) and continue to hold the container to your nose and follow __________ (state the EMDR helper’s name).”

Do 4 to 6 slow passes of BLS with the finger puppet.

Say, “What happened? How do you feel?”

_____________________________________________________________
_____________________________________________________________

Say, “Great, go with that.”

_____________________________________________________________
_____________________________________________________________

Repeat several times as long as the experience continues to be enhanced.

Say, “You can put the container down now. How do you feel?”

_____________________________________________________________
_____________________________________________________________
Self-Cuing

Say, “Now, I would like you to smell the lotion again and ask your mind to think about your Safe or Happy Place and see what happens.”

Allow the child to stay in their Safe Place for about 60 seconds.
Say, “How do you feel now?”

If the child reports positive emotions, then say the following:
Say, “Okay, just notice or think about those _______ (repeat the positive emotions reported by the child) feelings and follow _______ (state the EMDR helper’s name).”

Do 4 to 6 slow BLS with the finger puppet.

Cuing With Disturbance

Say, “I would like you to think about something from your life that might be happening now that is a bit upsetting for you or that makes you have mixed-up feelings just a little bit. Let me know when you have it.”

When the child has identified the situation, say the following:
Say, “Now, tell me where you feel the mixed-up or upsetting feelings in your body.”

Say, “Okay, now I would like to put the _______ (state the name of the lotion the child chose) next to your nose or you can put some lotion on your hands and smell the lotion from your hands and see what happens.”

Allow the child to stay in their Safe Place for about 60 seconds.
Say, “How do you feel now?”
If the child reports a positive difference then say the following:

Say, “Okay, just notice or think about those (repeat the positive emotions reported by the child) _______ feelings and follow _______ (the EMDR helper’s name).”

Do 4 to 6 slow BLS with the finger puppet.

Self-Cuing With Disturbance

Say, “Now, we are going to do this again but this time you are going to smell the lotion yourself and you are going to take your mind to your Safe or Happy Place by yourself. Ready?”

Say, “I would like you to think once again about that thing from your life that is a bit upsetting for you or that makes you have mixed-up feelings just a little bit. Let me know when you are thinking about it.”

Wait until the child tells you he is thinking about it.

Say, “Now tell me where you feel the mixed-up or upsetting feelings in your body?”

Say, “Now, whenever you want, smell and use your ___________ (state the name of the lotion the child chose) and see what happens.”

Allow enough time for the child to do it.

Say, “How do you feel now?”

If the child reports a positive difference then say the following:

Say, “Okay, just notice or think about those _______ (repeat the positive emotions reported by the child) feelings and follow _______ (the EMDR helper’s name).”

Do 4 to 6 slow BLS with the finger puppet.
If the child reports negative emotions, check if the negative associations come from the Safe Place or the scent. Check for the appropriateness of the Safe Place. Also check if the child wants to pick a different scent.

Say, “Do these mixed-up feelings come from the Safe Place or from _______ (state the name of the lotion or scent)?”

If the scent is changed, go back to the Cue Scent step.

Practice

Say, “Okay, if you want, you can decorate your container with any of the stickers that you like.”

Let the child decorate the container.

Say, “You can take your _____ (state the name of the lotion). Whenever you feel down or bad or you have mixed-up feelings, you can use your _____ (state the name of the lotion) so it can help you remember your Safe or Happy Place and get the good feelings back.”

If the parents were not present in the session, invite the parents before the session ends.

Say, “We can share this with mom and dad (or the caregiver) so they can help you remember to use your _______ (state the name of the lotion) and think about your Safe or Happy Place. Is that okay with you?”

If the child does not want the parents to know about their Safe Place, gently explore the reason behind it. This could be diagnostic of problematic parent–child dynamics that need to be addressed in therapy.

If the child is in agreement about the parents’ involvement, proceed to invite the parents into the session.

Say, “_____ (name of child) would you like to tell your parents about your Safe or Happy Place and the lotion? Or, would you like me to tell them?”

If the child wants you to talk to the parents:

Say, “Today ______ (name of child) did such a great job. We did EMDR with good stuff for the first time. ______ (name of child) created a Safe or Happy Place. When ____ (name of child) thinks about this place, ___ (he or she) has really good feelings. ______ (name of child) also picked a special lotion with a very special name ___ (say the name
of the lotion). When ______ (name of child) smells the lotion, it helps ____ (him or her) remember ____ (his or her) Safe or Happy Place and all the good feelings. So, whenever ____ (name of child) feels down or bad or has mixed-up feelings ____ (name of child) can use ____ (his or her) _______ (state the name of the lotion) so it can help ____ (him or her) remember the Safe or Happy Place and get the good feelings back. So if __________ (name of child) forgets to use the ____ (state the name of the lotion), you can help ____ (him or her) remember by saying: ____ (name of child) I can see that you are having some mixed-up feelings now, let’s use your special lotion together. Let’s get your special container and put some lotion on your hands and let’s think about your Safe or Happy Place so you can get your good feelings back.”

Say to the caregivers, “You continue to encourage ____ (name of child) to stay in ___ (his or her) Safe or Happy Place until ____ (name of child) calms down or reports having positive feelings.”

Make sure that you have the scent chosen by the child available or ask the child to bring the lotion to every session. You can use the lotion if the child uses the stop signal during reprocessing or at the end of an incomplete session to cue to child to go to the Safe or Happy Place.