Eye Movement Desensitization and Reprocessing

EMDR Therapy

Scripted Protocols and Summary Sheets

TREATING TRAUMA-AND STRESSOR-RELATED CONDITIONS
Marilyn Luber, PhD, is a licensed clinical psychologist and has a general private practice in Center City, Philadelphia, Pennsylvania, working with adolescents, adults, and couples, especially with complex posttraumatic 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.

In 1992, Dr. Francine Shapiro trained her in Eye Movement Desensitization and Reprocessing (EMDR). 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. Also, she was a member of the EMDR Task Force for Dissociative Disorders. She conducts facilitator and consultation trainings and teaches other EMDR-related subjects both nationally and internationally. Since 1997, she has coordinated trainings in EMDR-related fields in the greater Philadelphia area. In 2014, she was a member of the Scientific Committee for the EMDR Europe Edinburgh Conference. Currently, she is a facilitator for the EMDR Global Alliance to support upholding the standard of EMDR Therapy worldwide.

In 1997, Dr. Luber was given a Humanitarian Services Award by the EMDR Humanitarian Association. Later, in 2003, she was presented with the EMDR International Association’s award “For Outstanding Contribution and Service to EMDRIA” and 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; the proceeds from sales of the handbook go to EMDR HAP organizations worldwide. 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) and Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations (Springer). She interviewed Francine Shapiro and co-authored the interview with Dr. Shapiro for the Journal of EMDR Practice and Research (Luber & Shapiro, 2009) and later wrote the entry about Dr. Shapiro for E. S. Neukrug’s, The SAGE Encyclopedia of Theory in Counseling and Psychotherapy (2015). Several years later, in 2012, she edited Springer’s first CD-ROM books: Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols With Summary Sheets CD-ROM Version: Basics and Special Situations and Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols With Summary Sheets CD-ROM Version: Special Populations. In 2014, she edited, Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets. In 2015, three ebooks were published that supplied protocols taken from Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets: EMDR Therapy With First Responders (ebook only), EMDR Therapy and Emergency Response (ebook only), and EMDR Therapy for Clinician Self-Care (ebook only). The text, Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Obsessive-Compulsive and Mood-Related Conditions will be released in 2015. Currently, she is working on Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Medical-Related Conditions.
Eye Movement Desensitization and Reprocessing

EMDR Therapy

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TREATING TRAUMA- AND STRESSOR-RELATED CONDITIONS

Edited by
Marilyn Luber, PhD
To my extraordinary companion and therapy dog, Emmy Luber,
a true wonder of nature and
sweet loving presence,
my heart.
The wound is the place where the Light enters you.

—Rumi
PART I
EMDR Therapy and Trauma- and Stressor-Related Conditions

Reactive Attachment Disorders

Chapter 1  Child Attachment Trauma Protocol  
Debra Wesselmann, Cathy Schweitzer, and Stefanie Armstrong  
Summary Sheet: Child Attachment Trauma Protocol  
Marilyn Luber

Chapter 2  Working on Attachment Issues With EMDR Therapy: The Attachment Protocol  
Anna Rita Verardo and Maria Zaccagnino  
Summary Sheet: Working on Attachment Issues With EMDR Therapy: The Attachment Protocol  
Marilyn Luber

Posttraumatic Stress Disorder

Chapter 3  EMDR Therapy for Traumatized Patients With Psychosis  
Berber van der Vleugel, David van den Berg, Paul de Bont, Tonnie Staring, and Ad de Jongh  
Summary Sheet: EMDR Therapy for Traumatized Patients With Psychosis

Chapter 4  EMDR Integrative Group Treatment Protocol® Adapted for Adolescents (14–17 Years) and Adults Living With Ongoing Traumatic Stress
Ignacio Jarero and Lucina Artigas  
Summary Sheet: EMDR Integrative Group Treatment Protocol® Adapted for Adolescents (14–17 Years) and Adults Living With Ongoing Traumatic Stress
Marilyn Luber
## Contents

**Acute Stress Disorder**

**Chapter 5**  
**Reaching the Unseen First Responder With EMDR Therapy:**  
**Treating 911 Trauma in Emergency Telecommunicators**  
Jim Marshall and Sara G. Gilman  

**Summary Sheet: Reaching the Unseen First Responder With EMDR Therapy:**  
**Treating 911 Trauma in Emergency Telecommunicators**  
Marilyn Luber  

**PART II**  
**EMDR Therapy and Grief and Mourning**

**Grief and Mourning**

**Chapter 6**  
**EMDR Therapy and Grief and Mourning**  
Roger M. Solomon and Therese A. Rando  

**Summary Sheet: EMDR Therapy and Grief and Mourning**  
Marilyn Luber  

**PART III**  
**Self-Care for Clinicians**

**Chapter 7**  
**Healer, Heal Thyself: A Commonsense Look at the Prevention of Compassion Fatigue**  
Catherine M. Butler  

**Summary Sheet: Healer, Heal Thyself: A Commonsense Look at the Prevention of Compassion Fatigue**  
Marilyn Luber  

Appendix A: Worksheets  

Appendix B: EMDR Therapy Summary Sheet and EMDR Therapy Session Form

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Stefanie Armstrong, MS, LIMHP, specializes in treating trauma resolution and attachment problems in children and adolescents. Before she cofounded The Attachment and Trauma Center of Nebraska, she spent 10 years working in the public school system as a school counselor. She is EMDR certified and is an EMDR consultant providing training and consultation as part of The Attachment and Trauma Center Institute consultation team. Ms. Armstrong is part of the team that created the EMDR and Family Therapy Integrative Protocol for the treatment of attachment trauma in children. She is a coauthor of a book on EMDR treatment for attachment trauma in children and a parenting book related to attachment trauma. She has presented her expertise nationally to numerous parent and professional groups. Ms. Armstrong is a trainer for The Attachment and Trauma Center Institute, training clinicians in the Family Therapy and EMDR Integrative Team Treatment and training parents in the Integrative Parenting Approach. Ms. Armstrong has been invited to present at numerous professional conferences and workshops around the country and has also trained public school personnel in the area of trauma and attachment.

Lucina Artigas, MA, MT, who specialized in Humanitarian Programs for early EMDR Therapy intervention with children and adolescents, has provided field services in Latin America, the Caribbean, and Spain to natural or human-provoked disaster victims, family members of those deceased, and first responders. She is an EMDR Institute and EMDR-Iberoamerica Senior Trainer of Trainees for Latin America and the Caribbean and has received the EMDRIA Creative Innovation Award for the Butterfly Hug method for bilateral stimulation and the EMDR-Iberoamerica Francine Shapiro Award. Lucina is a coauthor of The EMDR Protocol for Recent Critical Incidents (EMDR-PRECI), The EMDR Individual Protocol for Paraprofessionals Use in Acute Trauma Situations (EMDR-PROPARA), and The EMDR Integrative Group Treatment Protocol, which have been applied worldwide for natural or human-provoked disaster survivors. She has conducted trainings, seminars, and workshops around the world and coauthored articles on topics of EMDR Therapy, trauma, resilience, crisis intervention, and cancer-related posttraumatic stress disorder (PTSD) treated with EMDR Therapy in group format. She is the cofounder of EMDR Mexico; cofounder and executive director of International Center of Psychotraumatology; and cofounder and executive director of the Mexican Association for Mental Health Support in Crisis (AMAMECRISIS, NGO). She has presented workshops in United States, Latin America, and Europe, and has published articles on EMDR, crisis intervention, and compassion fatigue.

Catherine M. Butler, EdD, LMFT, is a clinician in private practice in San Diego, California. Her practice focuses on the impact of PTSD on first responders and veterans. The area of compassion fatigue and burnout has been of interest for several years and she trains extensively in the San Diego area for agencies, volunteer groups, and organizations that face increasing demands for their services and dwindling resources. She is a member of the San Diego EMDR Trauma Recovery Network (TRN) and works to assist the community after critical incidents, as well as supporting the first responder network as they meet emergent needs. Promoting strength, resilience, and compassion within the treatment and first-responder community is the focus of her work and passion.
Contributors

Paul A. J. M. de Bont, MSc, is a clinical psychologist. He is a member of the Dutch EMDR Association (Vereniging EMDR Nederland) and scientist–practitioner at the Mental Health Organization GGZ Oost Brabant, the Netherlands. He works with severely mentally ill psychiatric patients in an outpatient setting for assertive community services. He is a researcher and PhD student in the RCT Treating Trauma in Psychosis (TTIP). He is author and coauthor on several TTIP-related studies and protocols concerning the application of guidelines of psychological treatment (EMDR and prolonged exposure) for PTSD in patients with psychosis. He received the European EMDR Francine Shapiro Award in 2014.

Ad de Jongh, PhD, is both a clinical psychologist and dentist. He is professor of anxiety and behavior disorders at the Behavioural Science department of the Academic Centre for Dentistry (ACTA) in Amsterdam, the Netherlands, a collaboration of the University of Amsterdam and Vrije University. He is also an honorary professor at the School of Health Sciences of Salford University in Manchester, UK. He is involved in research investigating the efficacy of evidence-based treatments for the consequences of traumatic events in a variety of target populations, including children, people with intellectual disabilities, and people with complex psychiatric conditions, including psychosis and schizophrenia. He (co)authored more than 250 scientific articles–book chapters on anxiety disorders, and their treatment (including five books), and provides lectures and courses in his field of expertise, both in the Netherlands and abroad. He is an EMDR Europe–accredited trainer. In 2011, he received the outstanding EMDR Research Award from the EMDR International Association.

Sara G. Gilman, MS, LMFT, is the founder and president of Coherence Associates, Inc., a professional individual and family counseling corporation. Coherence Associates is dedicated to expanding human potential through the coherence of mind, body, and spirit, and is located in Encinitas, California. Ms. Gilman is a licensed marriage and family therapist, and specializes in the areas of performance enhancement, trauma, and addictions. She graduated in 1983 from California State University, Fullerton, with a masters of science degree in clinical psychology. She is a diplomate in forensic traumatology and holds a fellowship status with the American Academy of Experts in Traumatic Stress. She is certified in NLP, hypnotherapy, and HeartMath; is an EMDR consultant; and is the past president of the EMDR International Association. As a former firefighter/EMT, she has a passion for working with first responders, is CISM certified, and supports agencies with their peer support teams. She has brought EMDR to first responders of all kinds, speaks nationally on this topic, and serves on the 911 Wellness Foundation (911WF) board of directors.

Ignacio Jarero, PhD, EdD, specializes in humanitarian programs for early EMDR Therapy intervention and has provided field services in Latin America, the Caribbean, Spain, and South Asia to natural or human-provoked disasters victims, family members of those deceased, and first responders. Dr. Jarero is an EMDR Institute & EMDR-Iberoamerica Senior Trainer of Trainers for Latin America and the Caribbean and has received the EMDR-Iberoamerica Francine Shapiro Award; the International Critical Incident Stress Foundation International Crisis Response Leadership Award; the EMDR Colombia Jaibaná Award for Humanitarian Work; and the Argentinean Society of Psychotrauma (ISTSS affiliate) Psychotrauma Trajectory Award. He is a coauthor of The EMDR Protocol for Recent Critical Incidents (EMDR-PRECI), The EMDR Individual Protocol for Paraprofessionals Use in Acute Trauma Situations (EMDR-PROPARA), and The EMDR Integrative Group Treatment Protocol, which have been applied worldwide for natural or human-provoked disaster survivors. He is a mental health adviser for the Mexican Department of Defense and Air Force, Navy, National Human Rights Commission, and World Vision International. He has conducted trainings, seminars, and workshops around the world and authored articles on topics of EMDR Therapy, trauma, resilience, crisis intervention, and cancer-related PTSD treated with EMDR Therapy in a group format. Dr. Jarero is the cofounder of EMDR Mexico; founder and president of Latin American and Caribbean Foundation for Psychological Trauma Research (Francine Shapiro Award Winner); cofounder and president of the International Center of Psychotraumatology; cofounder and editor in chief of Iberoamerican Journal of

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Psychotraumatology and Dissociation; and cofounder and president of the Mexican Association for Mental Health Support in Crisis (AMAMECRISIS, NGO).

Jim Marshall, MA, is the president of MasterCare Institute and a certified EMDR Therapist, specializing in treatment of traumatic stress and its impact on relationships. The brother of a 911 telecommunicator, he recognized emergency telecommunicators to be an underserved population at high risk of PTSD and became embedded in the 911 community as an emergency mental health educator and policy advocate. As director of the 911 Training Institute, he has created and delivers curricula preparing 911 professionals to prevent stress-related illnesses and boost peak performance through personal resilience and mastery of emergency calls involving mental illness and suicidality. He is a regular contributor to 911 industry journals and conferences and is founding chief executive officer (CEO) and chair of the 911WF, a nonprofit organization devoted to fostering optimal health and performance of public safety telecommunicators through research, education, policy, and intervention. He served as a cochair of the National Emergency Number Association Working Group and coauthored the industry's first Standard on 911 Acute, Traumatic, and Chronic Stress Management. With past EMDRIA president Sara Gilman, he is developing the National Registry of EMDR Therapists for 911, assuring access to this evidence-based treatment for all emergency telecommunicators.

Therese A. Rando, PhD, BCETS, BCBT, is a clinical psychologist in Warwick, Rhode Island, USA. She founded The Institute for the Study and Treatment of Loss, which provides mental health services through psychotherapy, training, supervision, and consultation, and specializes in loss and grief; traumatic stress; and the psychosocial care of persons impacted by chronic, life-threatening, or terminal illness. A recipient of numerous awards for her accomplishments in thanatology, she has consulted; conducted research; provided therapy; written; provided expert witness legal testimony; and lectured internationally in areas related to loss, grief, illness, dying, and trauma. Current professional foci include treatment of complicated mourning, loss of a child, the interface between posttraumatic stress and grief, anticipatory mourning, and specialized intervention techniques for traumatic bereavement. Dr. Rando has written more than 80 works pertaining to the clinical aspects of thanatology and is a national media resource expert in dying, death, loss, and trauma for the American Psychological Association.

Cathy Schweitzer, MS, LMHP, specializes in treating trauma resolution and attachment problems in children and adolescents. She is a cofounder of the Attachment and Trauma Center of Nebraska in Omaha, Nebraska. She is part of the treatment team that created the EMDR and Family Integrative Protocol for the treatment of attachment trauma in children and the coauthor of a book on EMDR treatment for attachment trauma and children and a parenting book related to trauma-informed parenting. Ms. Schweitzer is also the cofounder of the Attachment and Trauma Training Center Institute, an organization dedicated to training clinicians in the EMDR and Family Therapy Integrative Team Treatment, as well as training parents in the Integrative Parenting Approach. She is a certified EMDR Therapist and consultant and provides consultation to professionals across the country. Ms. Schweitzer has also been invited to present at numerous professional conferences and workshops around the country and has participated in training public school personnel in the area of trauma and attachment. Ms. Schweitzer spent 15 years in both private and public school settings as a school counselor.

Roger M. Solomon, PhD, is a psychologist and psychotherapist specializing in the areas of trauma and grief. He is on the senior faculty of the EMDR (Eye Movement Desensitization and Reprocessing) Institute and provides basic and advanced EMDR training internationally. He also provides advanced specialty trainings in the areas of grief, emergency psychology, and complex trauma. He currently consults with the U.S. Senate, the National Aeronautics and Space Administration (NASA), and several law enforcement agencies. As a police psychologist with the South Carolina Department of Public Safety, he is the clinical
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Contributors

director of the Post Critical Incident Seminar (PCIS), a 3-day posttrauma program that draws on psychological first aid, peer support, and EMDR Therapy. Working with the South Carolina Army National Guard, he is the clinical director of the Post Deployment Seminar, a 3-day program for war veterans. He has provided clinical services and training to the FBI; Secret Service; U.S. State Department, Diplomatic Security; Bureau of Alcohol, Tobacco, and Firearms; U.S. Department of Justice (U.S. attorneys); and numerous state and local law enforcement organizations. Internationally, he consults with the Polizia di Stato in Italy and also provides a posttrauma program for the police in Finland. Dr. Solomon has planned critical incident programs, provided training for peer support teams, and has provided direct services following tragedies, such as Hurricane Katrina, the September 11 terrorist attacks, the loss of the space shuttle Columbia, and the Oklahoma City bombing. He has authored or coauthored 34 articles and book chapters pertaining to EMDR, trauma, grief, and law enforcement stress.

Tonnie Staring, PhD, is a clinical psychologist, psychotherapist, CBT supervisor, and EMDR Therapist. He works at Altrecht Psychiatric Institute for young people with psychosis, and the Early Detection and Intervention (EDI) team. He got his PhD at the Erasmus Medical Center in the area of psychological interventions for psychosis. He worked as a guest teacher and supervisor for various Dutch institutes, and occasionally for the WHO and the NIMH. He is a board member of the psychosis section of the Dutch Association for Behavioural and Cognitive Therapy, as well as the Cognition and Psychosis Foundation. He participates in various research projects in the treatment of psychosis and anxiety. He has published various books, and more than 40 national and international articles and chapters.

David van den Berg, MSc, is a clinical psychologist at Parnassia Psychiatric Institute, the Hague, the Netherlands. He has specialized in CBT for psychosis, PTSD, and ultra-high risk for psychosis patients and has coauthored treatment protocols, books, and scientific articles on these topics. He is conducting a PhD study into the feasibility and safety of EMDR and prolonged exposure on patients with psychotic disorders and chronic PTSD (www.ttip.nl). He is a member of the Dutch Association for Behavioural and Cognitive Therapy and the Dutch Association for EMDR. David leads several innovative projects, in which he collaborates with industrial design engineers and service users. In 2013, he received the outstanding EMDR Research award from the EMDR International Association and, in 2014, he won the Rotterdam Designers Award for an app for people who hear voices.

Berber van der Vleugel, MSc, is employed at the Community Mental Health Service GGZ Noord-Holland Noord in the Netherlands. She works as a therapist in a Flexible Assertive Community Treatment (FACT) team, offering treatment to patients with severe mental illnesses, and is the coordinator of scientific research in this population. She is a PhD candidate on agents of change in the Dutch multisite randomized clinical trial TTIP. She is a member of the board of the Psychosis Section and trainer and supervisor of the Dutch Association for Behavioural and Cognitive Therapy. She is a registered member of the Dutch Association for EMDR and, in 2013, she received the first Research Award that was given out by the VEN. She has coauthored several articles and book chapters on treatment for psychosis and assertive outreach.

Anna Rita Verardo, PsyD, is a psychologist and psychotherapist and an EMDR Europe-approved trainer and supervisor. She is a member of the Italian EMDR Association board and coordinator of the EMDR Child and Adolescents Committee. She is also a member of the European EMDR Child Board. Her main area of intervention is childhood and adolescence, and she has conducted numerous workshops on the use of EMDR in children, in particular regarding loss and mourning and adopted children. She has published a number of articles and books on EMDR and she coordinates research, in collaboration with CNR and Tor Vergata University, in Italy. Since 2001, she has been involved in humanitarian projects in Italy.
Debra Wesselmann, MS, LIMHP, has specialized in treating trauma resolution and attachment problems in adults, children, and families for the past 25 years. She is cofounder and member of the treatment team at The Attachment and Trauma Center of Nebraska in Omaha, Nebraska. She is part of the team that developed the EMDR and Family Therapy Integrative Protocol for the treatment of attachment trauma in children and the Integrative Parenting method for raising traumatized children. She is a co-trainer for professionals and parents associated with The Attachment and Trauma Center Institute. Ms. Wesselmann has been on the faculty at the University of Nebraska at Omaha and collaborates with faculty at the University of Nebraska at Lincoln for research and development of effective trauma treatment methods. She is an EMDR consultant and has been on the faculty of the EMDR Institute since 1998. She is a coauthor of a book on EMDR treatment for attachment trauma in children, two books related to parenting, and a number of chapters and articles related to trauma and attachment. Ms. Wesselmann has been invited to present or deliver keynote addresses for numerous professional conferences and workshops nationally and internationally, including invited presentations at the Menninger Clinic, EMDRIA, and conferences in Rome, Amsterdam, Hamburg, Cologne, Madrid, the Netherlands, Hong Kong, and Costa Rica.

Maria Zaccagnino, PhD, is a clinical psychologist and psychotherapist with a cognitive evolutionary approach. She is an EMDR Europe–approved supervisor and she works in particular in the field of attachment theory and eating disorders, where she has achieved remarkable results in both clinical and research contexts. She coordinates several studies concerning these areas of EMDR application for the Italian EMDR association and she has also presented workshops. She has published articles regarding the application of EMDR treatment in the context of parenting problems.
It was the 25th anniversary celebration of EMDR Therapy in Edinburgh, Scotland, at the 15th EMDR European Conference. The EMDR Europe Research Network had convened a very special meeting for a very important guest: Dr. Francine Shapiro. Derek Farrell, head of the Scientific Committee for the Conference; France Haour, head of the EMDR Europe Research Committee; and Udi Oren, EMDR Europe president, hosted a group of invited guests, presenters, and researchers. For EMDR Therapy’s 25th birthday, Dr. Shapiro’s European colleagues gave her the best gift possible: the gift of research on EMDR Therapy. The ongoing and prospective research ranged from randomly controlled trials to case series; from working with specific diagnoses with EMDR, such as psychosis, intellectual disabilities, obsessive-compulsive disorder, to bipolar disorders and more; from recent trauma, ongoing trauma, to past trauma; from medical issues, such as headaches, chronic pain, and cancer, to multiple sclerosis, and so on; and many, many, more. In 1.5 hours, 10 presenters, representing 10 European countries, presented the research that was being done or about to begin in their countries, at approximately 8-minute intervals! It was breathtaking.

Approximately 25 years ago, Francine Shapiro took her “walk in the park,” making the discovery that a naturally occurring phenomenon could change the nature of the experience she was having. Dr. Shapiro built that experience into a treatment she first called Eye Movement Desensitization (EMD; Shapiro, 1989a, 1989b). As she came from a behavioral tradition, she conceptualized what was happening as desensitization, because she thought that she was seeing the removal of fear and anxiety, and the behavioral symptoms. However, after further study, she read Pavlov’s (1927) work about an “excitatory-inhibitory balance in the brain” and understood that when it was disrupted, processing would cease (Luber & Shapiro, 2009, p. 220). This correlated with what she was seeing in her own work with patients, so she shifted to thinking in terms of information processing and incorporated the notion of memory networks (Lang, 1977, 1979). She changed the way she implemented EMD by not returning to the same image, allowing cognitive and emotional shifts to occur, dropping the repeated cognition, and letting the process move more freely. As a result of shifting to the reprocessing perspective, she changed the name from EMD to Eye Movement Desensitization and Reprocessing (EMDR).

She considered EMDR Therapy experimental until it was validated. To encourage more research, she published her controlled study, presented her work to colleagues, and conducted trainings for veterans and research groups; she wanted the effects of EMDR to be validated and taught with the safety of the client and the clinician as paramount. At the time, she often heard about untrained people using EMDR with negative results and hoped that the swift replication of her work would allow for EMDR as a clinical intervention for professional use only. Sadly, this was not the case.

The first randomized EMDR study was conducted 4 years later within the Veterans Administration (VA). In her initial study, Dr. Shapiro used one session and noticed the decrease in anxiety and fear. The authors of the VA studies thought that they could treat their subjects in a short period of time using only one incident of many—often unspeakable—traumas that veterans presented. It was no surprise that they did not see global changes in posttraumatic stress disorder (PTSD) measures with one incident as their treatment intervention. The authors concluded that EMDR was not validated as highly effective, although researchers like Boudewyns and Hyer (1996) mentioned that they preferred EMDR as a
treatment for the veterans when compared to exposure therapy. Other controlled studies in that era had a variety of methodological problems, such as treatment integrity issues (Jensen, 1994; Pitman et al., 1993; Sanderson & Carpenter, 1992); limited or unusual populations (Boudewyns et al., 1993; Jensen, 1994; Pitman et al., 1993; Sanderson & Carpenter, 1992); or small sample sizes (Boudewyns et al., 1993; Jensen, 1994; Pitman et al., 1993). Although the progress of EMDR Therapy research has been slow and hampered by many difficulties, over the years, the studies are increasing. See the EMDR Institute’s website (www.emdr.com) or EMDR International Association’s (EMDRIA) website (www.emdria.org) for the current status of randomized controlled trials.

The work with EMDR and clinical applications, as seen in the chapters in this text, is based on the adaptive information-processing model (AIP) as explained by Dr. Shapiro (2001, 2002, 2006, 2007). This model is used to guide our clinical practice and show EMDR Therapy’s clinical effects. The idea is that the direct reprocessing of the stored memories of the first and other events connected with the problem—as well as any other experiential contributors—has a positive effect on clients’ presenting problems. The results of case studies and open trials with various diagnostic categories give support to this prediction. In fact, many experts have taken the basic standard EMDR protocols reported by Shapiro in Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols and Procedures (1995, 2001) and adapted them to meet the particular needs of their clients while maintaining the integrity of EMDR Therapy.

Furthermore, the AIP model is in keeping with the important findings of Vincent J. Felitti and Robert F. Anda in the Adverse Childhood Experiences (ACE) Study. The ACE study was conducted with more than 17,000 Kaiser Permanente members, who voluntarily participated in a study with the purpose of finding out the effects of stressful and traumatic experiences during childhood on adult health (acestudy.org website, 2015). They learned that 63% of the participants in the study had at least one childhood trauma, while 20% experienced at least three or more categories of trauma, which were labeled adverse childhood experiences, such as emotional abuse (11%), physical abuse (28%), sexual abuse (21%), emotional neglect (15%), physical neglect (10%), witnessing their mothers treated violently (13%), growing up with someone in the household using alcohol and/or drugs (27%), growing up with a mentally ill person in the household (19%), losing a parent due to separation or divorce (23%), and/or growing up with a household member in jail or prison (5%). They found that the more categories of trauma a person experienced in childhood, the greater the likelihood of experiencing the following: alcoholism and alcohol abuse, chronic obstructive pulmonary disease (COPD), depression, fetal death, hallucinations, illicit drug use, ischemic heart disease (IHD), liver disease, risk of intimate partner violence, multiple sexual partners, obesity, poor health-related quality of life, PTSD, sexually transmitted diseases (STDs), smoking, suicide attempts, and/or unintended pregnancies. These are important findings that inform our work as EMDR practitioners.

Felitti and Anda (2009, pp. 77–87) in their chapter, “The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders, and Sexual Behavior: Implications for Healthcare,” concluded the following concerning adverse childhood experiences:

The influence of childhood experience, including often-unrecognized traumatic events, is as powerful as Freud and his colleagues originally described it to be. These influences are long lasting, and neuroscientists are now describing the intermediary mechanisms that develop as a result of these stressors. Unfortunately, and in spite of these findings, the biopsychosocial model and the biomed model of psychiatry remain at odds rather than taking advantage of the new discoveries to reinforce each other.

Many of our most intractable public health problems are the result of compensatory behaviors like smoking, overeating, and alcohol and drug use which provide immediate partial relief from the emotional problems caused by traumatic childhood experiences. The chronic life stress of these developmental experiences is generally unrecognized and hence unappreciated as a second etiologic mechanism. These experiences are lost in time and concealed by shame, secrecy, and social taboo against the exploration of certain topics of human experience.
The findings of the Adverse Childhood Experiences (ACE) Study provide a credible basis for a new paradigm of medical, public health, and social service practice that would start with comprehensive biopsychosocial evaluation of all patients at the outset of ongoing medical care.

A number of EMDR clinical applications are mainly case studies or open trials that show promise; however, they are in need of further investigation. To see examples of EMDR clinical applications, go to the EMDR International Association website: www.emdria.org, or the EMDR Institute website: www.emdr.com.

As a result of the growing research, many organizations have recognized the efficacy of EMDR Therapy as a treatment for PTSD by including it in their treatment guidelines beginning with the Clinical Division of the American Psychological Association (Chambliss et al., 1998) and most recently the WHO Guidelines for the management of conditions specifically related to stress (WHO, 2013). For the complete list, check the EMDR Institute website (www.emdr.com).

With the understanding of the importance of randomized controlled studies, several groups have made it their mission to support EMDR research. Since 2011, the EMDR Research Committee of the EMDR Europe Association has been granting monetary rewards for research to further the understanding of the mechanisms involved during the various steps of EMDR Therapy, the application to many psychological disorders related to stress and anxiety, and the efficacy of the standard protocol as well as adapted protocols. Our European colleagues have truly set a high bar for the work that they are doing through their encouragement of the gold standard in research. For further information, see EMDR Europe’s website: www.emdr-europe.org.

From the United States, a group of concerned EMDR practitioners (Wendy Freitag, Jim Gach, and Rosalie Thomas) founded the EMDR Research Foundation (ERF; www.emdresearchfoundation.org) in 2006 as a 501(c)(3) nonprofit organization dedicated to the promotion of quality, unbiased research in EMDR Therapy, and the only funding agency dedicated solely to support EMDR Therapy research worldwide. Its mission is to “promote health and growth of human beings through the support of quality research, evidence-based practice and compassionate, well-informed clinicians.” Since 2010, ERF has offered research grants, dissertation grants, consultation awards, and research dissemination travel awards. ERF also offers nonfinancial support to both researchers and clinicians via the two monthly clinical newsletters, the “Translating Research Into Practice” article published in the Journal of EMDR Research and Practice, and the Researcher’s Resource Directory. Currently, it is possible to sign up for the EMDR Early Intervention Researcher’s Toolkit on their website.

This is the fifth in a series of texts dedicated to the better understanding of EMDR Therapy and how the Standard EMDR principles, protocols, and procedures form the basis for the work that we do as EMDR Therapy clinicians. To understand any subject matter deeply, the rule of thumb is to know the basics, so that if a departure from the structure is needed, it is done in an informed manner. The purpose of Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations (Luber, 2009a) was to support the structure in Dr. Shapiro’s (1995, 2001) earlier texts by showing each step in detail. Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations (Luber, 2009b) was built on that structure and showcased how many experts use the EMDR principles, protocols, and procedures to adapt to their specific populations, such as children; couples; and patients with dissociative disorders, complex PTSD, addictive behaviors, pain, and specific fears. The next book would have been: Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols and Summary Sheets: Anxiety, Depression and Medical-Related Issues to continue to show how expert clinicians are working with EMDR Therapy clients with anxiety disorders, depression, and medical-related issues. However, in 2011, man-made and natural disasters were impacting our colleagues experiencing the Tōhoku earthquake and tsunami in Japan; floods in China, the Philippines, Thailand, Pakistan, Cambodia, India, and Brazil; earthquakes in Turkey and New Zealand; droughts and consecutive famines affecting Ethiopia, Kenya, and Somalia; storms in the United States; and so on. In consultation with Springer and EMDR colleagues in the EMDR Humanitarian Assistance Programs worldwide, the decision was made to move up the publication of
Preface

Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters, in book, CD, and e-book formats. It was published in 2014 as an up-to-date collection of the current EMDR Therapy–related responses and protocols for recent trauma events.

In 2012, Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols and Summary Sheets: Anxiety, Depression and Medical-Related Issues was slated to appear and was originally conceptualized with the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-4-TR; American Psychiatric Association, 2000) in mind; however, as the publication time approached, DSM-5 had become the standard. This entailed some reorganization, resulting in Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma, Anxiety and Mood-Related Conditions. However, there was so much material involved that it was decided to create three books instead of one. This is the second of this trio—Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma- and Stressor-Related Conditions—with the choice of book, CD, and/or e-book formats. Anxiety-, obsessive–compulsive-, and mood-related issues were separated from this current text and will appear as Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Obsessive–Compulsive, and Mood-Related Conditions (Luber, in press [b]) in 2016. Medical-related issues, as well, were separated from this current text and will appear as Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Medical-Related Conditions (Luber, in press [a]) in 2016.

The following description from Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations gives a clear understanding of the evolution and importance of this format:

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

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

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

These scripted protocols are intended for clinicians who have read Shapiro’s text (2001) and received EMDR training from an EMDR-accredited trainer. An EMDR trainer is a licensed mental
health practitioner who has been approved by the association active in the clinician’s country of practice. (Luber, 2009a, p. xxi)

In 2012, the CD-ROM versions of the original 2009 books were published in a different format. Included in the CD-ROM were just the protocols and summary sheets (the notes were not included and are available in the 2009 texts in book form). As explained in the preface of Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols With Summary Sheets (CD-ROM Version): Basics and Special Situations (Luber, 2012a):

The idea for Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Summary Sheets for Basics and Special Situations grew out of the day-to-day work with the protocols that allowed for a deeper understanding of case conceptualization from an EMDR perspective. While using the scripted protocols and acquiring a greater familiarity with the use of the content, the idea of placing the information in a summarized format grew. This book of scripted protocols and summary sheets was undertaken so that clinicians could easily use the material in Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations. While working on the summary sheets, the interest in brevity collided with the thought that clinicians could also use these summary sheets to remind themselves of the steps in the process clarified in the scripted protocols. The original goal to be a summary of the necessary data gathered from the protocol was transformed into this new creation of data summary and memory tickler for the protocol itself! Alas, the summary sheets have become a bit longer than originally anticipated. Nonetheless, they are shorter—for the most part—than the protocols themselves and do summarize the data in an easily readable format...

The format for this book is also innovative. The scripts and summary sheets are available in an expandable, downloadable format for easy digital access. Because EMDR is a fairly complicated process, and often intimidating, these scripted protocols with their accompanying summary sheets can be helpful in a number of ways. To begin with, by facilitating the gathering of important data from the protocol about the client, the scripted protocol and/or summary sheet then can be inserted into the client’s chart as documentation. The summary sheet can assist the clinician in formulating a concise and clear treatment plan with clients and can be used to support quick retrieval of the essential issues and experiences during the course of treatment. Practitioners can enhance their expertise more quickly by having a place that instructs and reminds them of the essential parts of EMDR practice. By having these fill-in PDF forms, clinicians can easily tailor the scripted protocols and summary sheets to the needs of their clients, their consultees/supervisees and themselves by editing and saving the protocol scripts and summary sheets. The script and summary sheet forms are available as a digital download or on a CD-ROM, and will work with any computer or device that supports a PDF format.

Consultants/supervisors will find these scripted protocols and summary sheets useful while working with consultees/supervisees in their consultation/supervision groups. These works bring together many ways of handling current, important issues in psychotherapy and EMDR treatment. They also include a helpful way to organize the data collected that is key to case consultation and the incorporation of EMDR into newly-trained practitioners’ practices. (Luber, 2012a, p. iv)

This book is divided into three parts with seven chapters that comprise Trauma- and Stressor-Related Conditions, including Reactive Attachment Disorders, Posttraumatic Stress Disorder, and Acute Stress Disorder; Grief and Mourning; and Self-Care for Clinicians. To address the specific needs of their populations or issues, authors were asked to include the types of questions relevant for history taking, helpful resources and explanations needed in the preparation phase, particular negative and positive cognitions that were frequent in the assessment phase and for cognitive interweaves, other concerns during phases 4 (desensitization) through 8 (reevaluation), a section on case conceptualization and treatment planning, and any pertinent research on their work.

Part I is devoted to “Trauma- and Stressor-Related Disorders,” with chapters on how EMDR Therapy is used for a range of these disorders. In the area of “Reactive Attachment Disorders,” Debra Wesselman, Cathy Schweitzer, and Stefanie Armstrong present some of their innovative work at The Attachment and Trauma Center of Nebraska in their “Child Attachment Trauma Protocol.” Anna Rita Verardo and Maria Zaccagnino’s (from Italy) “Working on Attachment Issues With EMDR Therapy: The Attachment Protocol,” uses
their wide range of knowledge concerning children, adolescents, parenting, and attachment theory to craft their own way to address attachment trauma for adults. Both chapters have research showing that the processing of attachment-related memories with EMDR Therapy results in a positive effect on participants’ attachment status. The groundbreaking work on “EMDR for Traumatized Patients With Psychosis” by the Dutch team of Berber van der Vleugel, David van den Berg, Paul de Bont, Tonnie Staring, and Ad de Jongh, is one of a series of articles and chapters this team has brought to our community to address this population’s many traumas. Ignacio Jarero and Lucina Artigas extend their idea of working in a group with the Integrative Group Treatment Protocol to its use with ongoing traumatic stress, in the chapter, “EMDR Integrative Group Treatment Protocol Adapted for Adolescents (14–17 Years) and Adults Living With Ongoing Traumatic Stress.” In the section on “Acute Stress Disorder,” Jim Marshall’s knowledge of 911 telecommunicators intrigued Sara Gilman with her expertise in working with other groups of first responders and EMDR, and, together, they crafted “Reaching the Unseen First Responder With EMDR: Treating 911 Trauma in Emergency Telecommunicators,” “a true gift to our community and the underserved 911 Telecommunicators.”

In the section on Grief and Mourning, Therese Rando paired her extensive knowledge about complicated mourning with Roger Solomon’s EMDR expertise and working in the field with grief-related issues to put together an excellent approach to this subject, “EMDR Therapy and Grief and Mourning.”

The idea of “Self-Care for Clinicians” has been underlined in all of the Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocol books (Luber, 2009a, 2009b, 2012, 2014) and should be at the core of all of our work. Too often we focus on our clients at the expense of ourselves. Catherine Butler’s chapter, “Healer, Heal Thyself: A Common-sense Look at the Prevention of Compassion Fatigue,” is an important reminder about how essential it is for us to practice the self-modulating techniques that we teach to our clients and look out for the signs and signals that let us know we are in need of help ourselves.

Appendix A includes the scripts for the 3-Pronged Protocol that includes past memories, present triggers, and future templates. This section helps clinicians remember the important components of the Standard EMDR Protocol to ensure fidelity to the model. Furthermore, it allows practitioners to copy the protocols and put personalized copies in clients’ charts. Appendix B contains an updated version of this author’s “EMDR Summary Sheet” (Luber, 2009a) and the “EMDR Session Form” to assist in easy retrieval of important client information and the important components of EMDR sessions. A summary sheet for each of these chapters serves as a checklist showing the important steps needed in these protocols, with a CD-version format also available to provide mobile access.

Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma- and Stressor-Related Conditions, with the choice of book, CD, and/or e-book formats, in the manner of its predecessors, offers EMDR practitioners and researchers a window into the treatment rooms of experts in the fields of trauma- and stress-related conditions. This book is in no way a compendium of all that is being done with EMDR in this field, but points us to the possibilities of EMDR Therapy. It is designed to apply what we are learning through research and to support the increasing knowledge and capabilities of clinicians in the method of EMDR Therapy.

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The idea for this new text began in 2010 after editing two books on EMDR Scripted Protocols. I was thinking about all of the clinical creativity of my colleagues and how important it is to support their work. Ad de Jongh and I were sitting together at an EMDR Europe conference and talking about how to include some of the fascinating research that colleagues have been doing in Europe, especially in the Netherlands. We decided that addressing anxiety-, depression-, and medical-related issues would be most illuminating and helpful to our EMDR community. I began developing this project and, in due course, signed a contract with Springer Publishing in November 2010.

On March 11, 2011, the world stepped in by way of the Tohoku earthquake and tsunami in Japan and our EMDR community mobilized to help our Japanese colleagues. I pulled together the recent event protocols we had worked on in Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations to send to the members of EMDR Japan. An international group of concerned EMDR practitioners rallied to support them through webinars, including Ignacio Jarero and his team to teach his EMDR-Integrative Group Treatment Protocol (EMDR-IGTP), Elan Shapiro to teach his and Brurit Laub’s Recent-Traumatic Episode Protocol (R-TEP), and Carol Martin, who facilitated donations through EMDR HAP’s website. As a result of this process and other catastrophes, I thought that it would be helpful to have a place where all of the updated EMDR work on recent traumatic response would be available, and proposed this to my editor, Sheri W. Sussman. Ever resourceful, pragmatic, and cognizant of the importance of helping our colleagues respond to recent events, she was enthusiastic about my idea and convinced Springer management to switch the deadlines so that Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets preempted the earlier contracted book.

By the time Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets was delivered in 2013 and published in 2014, Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000) had transitioned to DSM-5 (5th ed.; American Psychiatric Association, 2013); so I had to reorganize the current project. Sheri and I also decided to separate this book into three volumes: treating anxiety, obsessive-compulsive, and mood-related conditions; treating trauma and stress-related conditions; and treating medical-related conditions in a later book. I want to acknowledge the help of Ad de Jongh and Arne Hofmann in this process. These supportive and knowledgeable friends and colleagues assisted me in setting up a new structure for the project and suggested some of the content.

I want to recognize the joint efforts of the 17 authors of these seven chapters from four countries (Italy, Mexico, the Netherlands, and the United States). I owe a great debt to each one of them for the amount of time and energy that they devoted to this project. However, in many cases, our efforts went beyond that. The joy of interaction with my intelligent and creative colleagues is the essence of this effort and is one of the reasons that I continue to edit and work on these chapters. Experiencing their perspectives widened my own as I learned how they cope with the dilemmas of working with their particular population. I hope this text will inspire the clinicians who read it and help them to think about their clinical challenges within the context and structure of EMDR Therapy.
Acknowledgments

I would like to thank Springer Publishing for the faith that they have demonstrated by publishing this body of work. I would like to acknowledge Sheri W. Sussman—always—for the amount of support she provides, her dedication to these projects, and for always finding a way to help me as I work within my own time limitations dealing with my practice, my life, and the inevitable book deadlines. She never fails to meet my requests with thoughtfulness and usually a smile—even in some of the more challenging circumstances. Thank you, Sheri, this book would have been impossible without you.

My consultation groups have always been a point of inspiration and feedback for some of the questions I have had with concept and content. I would like to acknowledge Bernie Epstein, Jane Hart, Dave Kannerstein, Diane Koury Alessi, Stephanie Lunt, Kathy Miller, Maria Manzo, Bobby Posmontier, and Sarah Trotta for their feedback on my updated summary sheets, and for sharing their wisdom as clinicians in the consultation groups.

I would like to thank and acknowledge the Western Massachusetts EMDR Regional Group for choosing me as their keynote speaker in May 2014. Their invitation was for me to speak about these four books (now six) of scripted protocols. I had not had the occasion to step back and review this body of work in which I had been engaged for nearly a decade, and they gave me a reason to do so. As I did, I looked at the basic statistics for the five books and found that there are approximately 135 authors, 126 chapters (including some updates of the same chapter), from 14 countries on six continents! My keynote was titled, thanks to Jim Helling, “EMDR Protocols and EMDR Practice: A Clinician’s Journey Toward Mastery.” It was a challenge to prepare something on this amount of work; however, I focused on recent trauma, the importance of self-care for practitioners, and an overview of the books themselves. In summary, I came up with eight important take-home messages I learned in the process of my work that I shared with my Western Massachusetts audience:

- **Know the basics**: EMDR Therapy is a psychotherapy approach and how you conceptualize your client’s issue is critical. Know the AIP, the EMDR 3-Pronged Protocol, the EMDR 11-step procedure, and the eight EMDR phases.
- **Pay attention**: Make sure you are paying attention to all aspects of your clients’ presentation, such as their body language, facial expressions, tone of voice, how they interact with you, and how you feel in their presence.
- **Keep your eye on the ball**: Know the client’s goals, create the treatment plan together, and reevaluate at intervals.
- **Keep it simple**: The Standard EMDR Protocol is robust. Use it as your standard as well as the eight phases. Use other EMDR protocols when the Standard EMDR Protocol is not the best option, as in special situations and/or special populations.
- **Consult to grow**: Work within your area of expertise, talk to your colleagues, check the Journal of EMDR Practice and Research and the Francine Shapiro Library to see what others are doing, get supervision to learn about a new area of expertise, and consult when you are triggered and it persists.
- **Remember where you come from**: You bring your unique self to the art and science of your therapeutic work, so learn EMDR and the basics. Always remember yourself and your own unique style. EMDR becomes yours when you integrate your style with the basic tenets of EMDR.
- **Take care of yourself**: Take a personal, professional, and spiritual life review at intervals. Notice what you do to take care of yourself and notice if you are not taking care of yourself so that you can ask for help. Keep a list of symptoms of vicarious trauma/burnout and check to see if you are showing signs or symptoms. Have a buddy and check in with each other at intervals.
- **Connect with the EMDR community**: EMDR is prevalent worldwide. Connect with your EMDR Association Nationally and your EMDR community group locally. Volunteer for Trauma Recovery: EMDR Humanitarian Assistance Program (HAP) and create a Trauma Recovery Network (TRN) in your region. WE NEED YOU!
I would like to add two more take home messages in keeping with the importance of adding research into our clinical work:

- **Use Assessment Measures**: Utilize assessment measures to follow your clients’ progress and outcome.
- **Contribute to Research**: Individually or in conjunction with a larger group set up your study. Reach out to the EMDR Research Foundation for help with your project.

Throughout the process of writing these books, a group of friends and colleagues have been a consistent source of encouragement and inspiration. Thank you Elaine Alvarez, Michael Broder, Robbie Dunton, Catherine Fine, Irene Geissl, Richard Goldberg, Arlene Goldman, Barbara Grinnell, Barbara Hensley, Donald Nathanson, Mark Nickerson, Zona Scheiner, Stuart Wolfe, and Bennet Wolper.

I would like to recognize Barbara J. Hensley for her enormous contribution of the Francis Shapiro Library (FSL). The FSL has been a constant resource for me from the moment of its inception, especially while writing these books.

As always, I would like to thank Francine Shapiro. Her gift of EMDR Therapy to the world and to me has been incomparable.

I would like to remember my “Aunt” Sis Eisman and “Uncle” Henry Rosenfeld, both of whom passed away early in 2015. They would have loved to see this new book come to fruition.

I would like to acknowledge and thank the people who are involved in my daily life, helping me in so many invaluable ways that allow me both to have a “day” job and to indulge my interest in writing. They are Harry Cook, Rose Turner, and Dennis Wright. My overwhelming thanks to Lew Rossi, who has kept my computers working even in the shadow of disasters and major catastrophes; and Howard Wainer, who has helped me learn the ways of the publishing world. Thank you to Shirley Luber, my mother, who has been my primary audience for all I have written from kindergarten to my dissertation and into the present.

I would also like to acknowledge Bob Raymar, who has recently come back into my life after 45 years and changed it in so many ways that I could not even begin to write them all down. Thank you, Bob, for your assistance over these many months, listening to my very long keynote, for your infinite patience, and for always finding time to comment on what I have written and lending me your insightful and discerning perspective.

To my sweet dog Emmy, therapy dog extraordinaire: I have had you since you were 14 weeks old and now you are 14 years old. You are my office mate and clients have come to expect you to be their co-therapist and part of their treatment and you are and have been remarkable. You are with me through the ups and downs of our lives and by my side as I write. You have had illnesses and experienced your own personal trauma in the form of being attacked by a pit bull, yet you survived with your usual aplomb and a bit of bilateral stimulation! You have taught me to take joy not only in writing but in the basic functions of life: drinking some water, taking breaks, strolling along, having a treat, and delighting in a belly rub. You have even inspired me to write photo books about you and your friends’ escapades, including the “Miniature Schnauzer Picture Book Series” of four picture books! You are my heart and you have brought such joy and happiness into my life. Emmy, this book is dedicated to you.
When Dr. Shapiro was looking for a population to work with Eye Movement Desensitization (EMD) for her dissertation research in 1987, she recognized that the people most troubled by old memories were trauma victims, rape victims, and so on. At the time, she did not know if EMD would work with a diagnosed population and so she contacted a veterans’ outreach. She was allowed to demonstrate EMD with a counselor who was also a Vietnam vet with a troubling memory from the war that still bothered him. After several moments of EMD, the memory changed, faded, and was resolved. EMD worked and Dr. Shapiro did the first controlled study with a group mainly consisting of sexual assault victims and veterans still troubled by old memories; it was published in the Journal of Traumatic Stress (JTS; 1989).

In 1980, the diagnosis of posttraumatic stress disorder (PTSD) was accepted into the Diagnostic and Statistical Manual of Mental Disorders (Third Edition [DSM-III], American Psychiatric Association, 1980); however, there were no validated treatments for trauma then. Peniston (1986) was the first to publish a randomized study (N = 8) with combat veterans evaluating biofeedback-assisted desensitization. By the year 1989, when Dr. Shapiro’s study appeared in JTS, several other studies have been published and probably began the field of trauma treatment. According to Dr. Shapiro (Luber & Shapiro, 2009), there were very few treatment outcome studies then (Brom, Kleber, & Defares, 1989; Keane et al., 1989; Kinzie, 1989; Lindy, 1989). One of the 1989 studies used exposure therapy with in-patient combat veterans. Even though there was only a 30% success rate and a 30% dropout rate, clinicians appreciated anything that could help with this difficult-to-treat population. In spring 1990, the PTSD Research Quarterly was published by the National Center for Post-Traumatic Stress Disorder. Matthew J. Friedman’s article “1989: The Year’s Work in PTSD” appeared in it, and he gave an overview of 18 papers demonstrating the breadth and diversity of the PTSD publications (e.g., articles on assessment and diagnosis of PTSD; biological research and treatment; the importance of trauma itself versus pretraumatic factors for predicting subsequent psychiatric symptoms in military cohorts; risk factors for developing posttraumatic symptomatology following disasters; treatment of PTSD; an article on “Janet” that offered the first systematic understanding of how the mind can dissociate in the face of overwhelming threat); and an additional 27 citations in an annotated bibliography. The diagnosis of PTSD and the need for treatment were becoming more familiar.

By 1998, the APA Division 12 Task Force (Chambless et al.) looked at the field in order to figure out what treatments had been validated for different disorders. They gave two distinctions: “fully validated” and “probably efficacious.” A treatment was fully validated when it had two comparative studies from different research teams. Although there
were hundreds of treatments for the various disorders, they identified only 12 treatments that were on the empirically validated list, such as exposure therapy for specific phobias and another for headaches. For the treatment of PTSD, eye movement desensitization and reprocessing (EMDR) and exposure therapy appeared on the list of “probably efficacious.” At this time, the field was not working with validated procedures and there was little funding for treatment outcome studies, mainly because these studies were hard to conduct. In the same year, Carlson et al. did a randomized study investigating the effectiveness of two psychotherapeutic interventions for PTSD that were compared in a randomized controlled outcome group design. Treatment comprised 12 sessions of biofeedback-assisted relaxation, 12 sessions of EMDR or routine clinical care as a control with a combat veteran population; on completion, EMDR showed significant treatment effects when posttreatment results on measures were compared. In contrast to the other treatment group, effects were generally maintained at a 3-month follow-up.

Since then, meta-analyses comparing EMDR Therapy to numerous exposure therapies with and without cognitive therapy techniques have found that both methods are equally efficacious (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Bradley, Greene, Russ, Dutra, & Westen, 2005; Davidson & Parker, 2001; Lee & Cuijpers, 2013; Maxfield & Hyer, 2002; Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009; Seidler & Wagner, 2006). It is important to note that in EMDR’s favor, exposure therapy uses 1 to 2 hours of daily homework and EMDR uses none (retrieved from the EMDR Institute website: www.emdr.com, 2015).

After Dr. Shapiro’s pivotal study in 1989, randomized clinical trials have been slowly appearing in the literature: 1994 (Vaughan et al.); 1995 (Wilson, Becker, & Tinker); 1997 (Marcus, Marquis, & Sakai; Rothbaum; Wilson, Becker, & Tinker); 1998 (Carlson, Chemtob, Rusnak, Hedly, & Muraoka; Scheck, Scheck, & Gillette); 1999 (Edmond, Rubin, & Wambach); 2002 (Chemtob, Nakashima, Hamada, & Carlson; Ironson, Freund, Strauss, & Williams; Lee, Gabriel, Drummond, Richards, & Greenwald; Power et al.); 2003 (Taylor et al.); 2004 (Jabergaheri, Greenwald, Rubin, Dolatabadim, & Zand; Marcus, Marquis, & Sakai); 2007 (Abbasnejad, Mahani, & Zamyad; Ahmad, Larsson, & Sundelin-Wahlsten; Höberg et al.; van der Kolk et al.); 2008 (Cvetek; Högberg et al.; Wanders, Serra, & de Jongh); 2010 (Kemp, Drummond, & McDermott); 2011 (Arabia, Manca, & Solomon; de Roos; Jarero, Artigas, & Luber; Ter Heide et al.); 2012 (Nijdam, Gersons, Reitsma, de Jongh, & Olff); 2013 (Capezzani et al.; Doering, Olhmeier, de Jongh, Hofmann, & Bisping); 2014 (Diesel, Opmeer, Boer, Mannarino, & Lindauer) and 2015 (van den Berg et al.). However, more research is needed to guarantee acceptance of EMDR Therapy throughout the world.

Since the 1998 APA Division Task Force’s classifying EMDR Therapy as one of the “probably efficacious treatments” for the treatment of PTSD (Chambless et al., 1998), the following countries and organizations have mandated EMDR as a recommended treatment for patients suffering from trauma:

- **Cities and Countries:** Australia, Australian Centre for Posttraumatic Mental Health, 2007; France, INSERM, 2004; Israel, Bleich, Kotler, Kutz, & Shalev, 2002; London, England, National Collaborating Centre for Mental Health, 2005; The Netherlands, Dutch National Steering Committee Guidelines Mental Health Care, 2003; Northern Ireland, CREST, 2003; Stockholm, Sweden, Sjöblom et al., 2003; United Kingdom, Department of Health, 2001

In 2013, the World Health Organization (WHO) published its Guidelines for the Management of Conditions Specifically Related to Stress and stated: “Trauma-focused CBT and EMDR are the only psychotherapies recommended for children, adolescents and adults with PTSD.”
The chapters in this section on “EMDR and Trauma- and Stressor-Related Disorders” are divided into three categories: Reactive Attachment Disorder, Posttraumatic Stress Disorder, and Acute Stress Disorder.

**Reactive Attachment Disorder**

In 2002, reactive attachment was first discussed in the EMDR Therapy literature when R. J. Taylor published an article on the treatment of a family with an 8-year-old child with reactive attachment disorder and the qualitative evaluation observed by the parents concerning the child’s instant change of attitude. There have also been case studies to support the positive effect of EMDR with children who have attachment trauma (Madrid, Skolek, & Shapiro, 2006; Robredo, 2011). Since 2007, Wesselmann (2007, 2009, 2010, 2013a, 2013b) has been writing and presenting on the innovative work that she and her colleagues, Cathy Schweitzer and Stefanie Armstrong, are doing at The Attachment and Trauma Center of Nebraska to make sure that children affected by attachment trauma and their families can work through these difficulties. Their approach includes an integrative treatment team that highlights the importance of the incorporation of parents into treatment with their child (Wesselmann et al., 2014a, 2014b). The authors’ research showed that there is distinct improvement in behavioral and attachment measures after using EMDR and conjoint therapy (Attachment and Trauma Center of Nebraska, 2011; Wesselmann, 2013a, 2013b; Wesselmann & Shapiro, 2013a, 2013b; Wesselmann et al., 2012). In the section on Reactive Attachment Disorder, “Child Attachment Trauma Protocol” is Wesselmann, Schweitzer, and Armstrong’s contribution to support EMDR clinicians in furthering their understanding and treatment of this important topic.

The authors Anna Rita Verardo and Maria Zaccagnino, from Italy, wrote the chapter, “Working on Attachment Issues with EMDR Therapy: The Attachment Protocol.” They used John Bowlby’s theoretical framework (1969, 1973, 1980) to guide their work and were interested in helping clients change their internal representation, or Internal Working Models, that they were unworthy of care to one where they felt worthy and worthwhile to be cared for. These clinicians used the Adult Attachment Interview (George, Kaplan, & Main, 1985) to understand the client’s early experience and state of mind regarding attachment relationships and Grice’s conversational maxims (1989) to evaluate and understand the attachment style further. In their preliminary study, they saw significant changes in attachment patterns using the EMDR Attachment Protocol during treatment. Their innovative “Parent as Child” exercise at the end of the protocol is particularly helpful.

**Posttraumatic Stress Disorder**

The next section, on posttraumatic stress disorder (PTSD), is but a small representation of the many ways in which EMDR Therapy is used with a wide range of populations and situations. One of Dr. Shapiro’s six basic protocols, “Single Traumatic Event Protocol,” which shows the basic structure for working on single traumatic events with the Standard EMDR Protocol and the 3-Pronged Protocol (Luber, 2009, 2012).

Berber van der Vleugel, David van den Berg, Paul de Bont, Tonnie Staring, and Ad de Jongh broke new ground when they began working with traumatized patients with psychosis. Their chapter, “EMDR Therapy for Traumatized Patients with Psychosis,” introduces us to their innovative ways of working with patients diagnosed with psychosis and opens up a whole new possibility of work with this population. They create a comprehensive treatment program that includes a multidisciplinary team, and EMDR Therapy is part of this program. They have stepped carefully into this treatment by doing an open study (van den Berg & van der Gaag, 2012) from which they found significant improvements; another group did a within-subjects controlled case study model (de Bont, van Minnen, & de Jongh, 2013), with both EMDR Therapy and Prolonged Exposure, showing positive results for both modalities. Then, they did a randomized clinical trial applying EMDR Therapy and Prolonged Exposure...
for PTSD for patients with psychosis in addition to treatment as usual (de Bont, van den Berg, et al., 2013) and again the eight-session treatment was shown to be “feasible, effective and safe” (van den Berg et al., 2015). The effects for both treatments were maintained 6 months later. What they are finding is that using standardized treatment protocols is possible with minor adaptations and is effective in treating comorbid PTSD with this population. Their approach is the Dutch Two Method Approach (de Jongh, ten Broeke, & Meijer, 2010), a structured approach in Phase 2 to select target memories that need to be processed for symptom relief. They include a Third Method (also called flashforwards) to deal with the unrealistic expectations or negative imagery related to psychosis.

Note: Only well-trained clinicians who are familiar with psychosis and part of a multidisciplinary team should use this protocol.

Ignacio Jarero and Lucina Artigas’s chapter, “EMDR Integrative Group Treatment Protocol for Adolescents (14–17 years) and Adults Living With Ongoing Traumatic Stress,” is an adaptation of their EMDR Integrative Group Treatment Protocol (EMDR-IGTP; Artigas, Jarero, Alcalá, & López Cano, 2009, 2014). The EMDR-IGTP was originally used in response to the need to address the large numbers of victims of Hurricane Pauline in 1997. The addition here is to take into consideration patients who have been traumatized and then lack a posttrauma safety period for memory consolidation. They observed that six applications of this protocol were necessary in an intensive treatment format (twice a day for 3 consecutive days) to resolve the traumas.

Acute Stress Disorder

For the Acute Stress Disorder section, Jim Marshall and Sara Gilman introduce us to the world of 911 emergency telecommunicators (911 TCs) through their chapter “Reaching the Unseen First Responder with EMDR Therapy: Treating 911 Trauma in Emergency Telecommunicators.” Through Marshall’s access to his brother—a 911 TC—and his brother’s 911 TC colleagues, he recognized the vulnerability of these “very first responders” who are often not seen as being in the line of fire. He took on the responsibility of serving this underserved group by creating the 911 Institute and establishing a nonprofit organization, 911 Wellness Foundation, devoted to the health and safety of this population through research, education, policy, and intervention. Gilman brings her expertise in EMDR Therapy and knowledge as a first responder herself. They introduce us to the 911 TCs and educate us about what we need to do to treat them competently, effectively, and respectfully.

References


Part One: EMDR Therapy and Trauma- and Stressor-Related Conditions

Summary Sheets: Treating Trauma- and Stressor-Related Conditions

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Introduction

Children who have experienced neglect, abuse, attachment losses, or some other form of attachment trauma frequently exhibit severe behaviors, even when they are placed in a stable environment (Wesselmann, Schweitzer, & Armstrong, 2014a). The stored, unprocessed attachment trauma drives reactivity and mistrust of caregivers and other adults (Ide & Paez, 2000; van der Kolk, 2005; van der Kolk et al., 1996). Behaviors may include aggression, stealing, lying, defiance, food and elimination problems, and sexualized behaviors.

Team Collaboration for Challenging Cases

In order to address the traumatic roots related to their inability to trust and be close, children need the support of parents or other caregivers. Yet, the parent–child relationship may be fraught with conflict due to the parents’ feelings of frustration and anger regarding the children’s behaviors. In the most challenging cases, we recommend that the Eye Movement Desensitization and Reprocessing (EMDR) therapist collaborate with a family therapist to address the parent–child relationship and lay the groundwork for the EMDR Therapy session each week, increasing the efficiency with which the EMDR Therapy is conducted.

The EMDR therapist treating a complex child case can develop a two-person team by approaching another therapist who is like-minded regarding the etiology of the child’s behaviors and who is willing to collaborate and work with the family. Although, logistically, it is helpful to work with someone who has an office in the same physical location, it is not a prerequisite. Therapists working in different nearby settings can communicate via phone or email between sessions. Prior to the EMDR session, the family therapist communicates discoveries to the EMDR therapist regarding the child’s recent triggers, identified memories, or future template needs.

If there is no opportunity for a two-person collaboration, one therapist can perform both the family therapist and the EMDR therapist roles by designating one session as the family therapy session and the next as the EMDR Therapy session, and so on. The intent should be made clear to the child and family so expectations for the respective sessions are clear.

The Family Therapist

The family therapist strengthens attachment security by helping the parents understand the traumatic roots of the children’s behaviors and respond to their children’s emotions...
Early attachment trauma interferes with the typical developmental trajectory, leaving children with immature social, emotional, and cognitive skills. The family therapist coaches the child in identifying, managing, and expressing feelings, listening, following directions, and improving peer and sibling relationships. The family therapist addresses current crises and identifies related triggers, cognitions, and memories, and subsequently provides the information to the EMDR therapist, who follows up with EMDR Therapy as soon as possible. The work of the family therapist allows the EMDR therapist to implement EMDR Therapy every week, accelerating the rate of healing and recovery for suffering children and their families.

The EMDR Therapist

The EMDR therapist implements EMDR Therapy resource development exercises to strengthen attachment security and self-regulation (see later) and addresses memories, triggers, and future templates, depending on the insights discovered and communicated by the family therapist. Because the family therapist devotes an hour to the time-consuming work of identifying triggers, emotions, cognitions, touchstone events, and future templates with the child and parents, the EMDR therapist is able to implement EMDR Therapy weekly. The EMDR therapist typically begins processing current triggers and developing future templates prior to memory work. As the child develops skills for self-regulation and the parent–child relationship is strengthened, past events are targeted and reprocessed.

Research

Case studies have shown EMDR Therapy to improve symptomology and attachment in adults with complex trauma (Potter, Davidson, & Wesselmann, 2013; Wesselmann & Potter, 2009). Case studies have demonstrated that EMDR has a positive effect on symptoms and parent–child attachment in children with a history of attachment trauma (Madrid, Skolek, & Shapiro, 2006; Robredo, 2011; Taylor, 2002). In our ongoing research with children with a history of attachment trauma, children have shown marked improvement on behavioral and attachment measures following EMDR and conjoint family therapy (Attachment and Trauma Center of Nebraska, 2011; Wesselmann, 2013; Wesselmann & Shapiro, 2013; Wesselmann et al., 2012).

Randomized treatment control studies are needed to further appraise the impact of integrative EMDR and family therapy on attachment security and other disorders in children related to early relational traumas.

Treating Attachment Trauma in Children Protocol Script Notes

Phase One: History Taking

The history taking helps the therapist identify likely past, present, and future targets for EMDR Therapy and helps increase parental attunement and compassion related to the child’s challenging behaviors. History taking begins initially with an interview with the parents and can be conducted by the EMDR therapist or the family therapist when using the collaborative approach. The psychosocial history should include identification of the following:

- **Past symptoms, behaviors, and traumatic events**: Identify the child’s problem symptoms and behaviors and all traumatic events in the child’s past.
- **Current and recent triggers**: The therapist asks the parents to consider the child’s symptoms/behaviors and identify the present-day situations (current and recent triggers) that tend to precede the child’s symptoms.
- **Negative thoughts/cognitions**: Finally, the therapist asks the parents to assist in brainstorming and hypothesizing the negative thoughts/cognitions (NCs) that might be
driving the child’s behaviors, taking into consideration the child’s traumatic experiences and current triggers. Common NCs related to attachment trauma are as follows:
- Defectiveness (e.g., I am not good enough)
- Responsibility (e.g., I deserved to be abandoned/abused)
- Safety (e.g., I am not safe)
- Control (e.g., I must be in charge of getting what I want and need)
- Parents/others (e.g., Parents are mean)
- Love/belongingness (e.g., I do not belong).

Case Conceptualization

When using a team approach, the EMDR therapist and family therapist look at the child’s history together and write down the following:

- Potential EMDR Therapy targets
- Current triggers that seem to precipitate aggression, defiance, or other symptoms or behaviors; hypothesized NCs associated with the child’s traumas and triggers
- Needed skills related to self-awareness, self-regulation, socialization, and communication. The skills list is a working plan for psychoeducation and skills work that can be conducted by the family therapist and reinforced by the EMDR therapist through future templates.

Phase 2: Preparation

Attachment Resource Development

These are the exercises used to develop attachment resources:

1. “Playing Baby” Exercise
2. “Lollipop” Game
3. “Magical Cord of Love” Exercise
4. “Circle of Caring” Exercise
5. “Safe Place for the Little One” Exercise
6. Songs for younger children

Children who do not trust or feel close to their attachment figures naturally dissociate or use other defenses to protect themselves from vulnerable emotions. Parents are integral to attachment resource development (ARD), as the therapist facilitates experiences of emotional and physical closeness between the parent and child and then reinforces the child’s positive affect with bilateral stimulation (BLS; Wesselmann et al., 2014a). Therapists can prepare parents by explaining the process in advance. The therapist disarms the child initially by pointing out that his parent(s) will be doing all the work during this exercise, while he gets to sit back and take it easy. The therapist should use clinical judgment in order to avoid pressuring the child or parent to move into a position that involves more physical touch than one or both can tolerate with a reasonable level of comfort.

Note: Although ARD is part of the Preparation Phase, it is helpful to repeat ARD exercises regularly throughout the course of treatment to help maintain the positive feelings of connection.

BLS During Resource Development

Children should be introduced to the various forms of BLS prior to commencing the exercises. During the resource work, it is helpful to use tactile BLS, at a relatively slow speed, because it reinforces positive affect and enhances feelings of relaxation. Many children seem to enjoy the bilateral tactile pulsars, as a form of BLS. These can be conveniently placed in the children’s hands, shoes, socks, or pockets, allowing children the freedom to position themselves in any way they feel comfortable. The therapist holds the control and can easily keep one hand free to take notes.
It is recommended to continue the tactile BLS while the therapist or parent is guiding the child’s thoughts through the positive messages or imagery and to discontinue the BLS when the dialogue stops. This helps ensure that the child’s thoughts and affect remain positive throughout the exercises.

**Note:** Scripts for the following exercises can be found in the next section.

**MESSAGES OF LOVE EXERCISE**

During this exercise, the therapist creates an experience of closeness and connection between the child and the parent(s). Through a series of questions, the therapist encourages the parent to talk about traits the parent loves about the child, positive early memories with the child, activities the parent enjoys doing with the child, and the parent’s hopes and dreams for the child. BLS is implemented to reinforce the child’s feelings of closeness, warmth, and security created through the physical closeness and the parent’s loving words. The exercise is conducted with one parent at a time.

**PLAYING BABY EXERCISE**

This exercise is very applicable to children 7 and younger, although some older children may also enjoy the exercise. The therapist should use clinical judgment regarding its appropriateness and then implement the exercise in a playful manner. The therapist reinforces the child’s feelings of shared pleasure and closeness with the parent(s) using BLS. The exercise is conducted with one parent at a time.

**“LOLLIPOP” GAME**

This adaptation to the authors’ Playing Baby Exercise was developed by Lovett (2009). The “Lollipop” Game is another playful exercise designed to help the child experience feelings of closeness and to view the parent(s) as safe, attuned, and responsive to his needs. BLS reinforces the child’s feelings of trust and comfort. The exercise is conducted with one parent at a time.

**MAGICAL CORD OF LOVE EXERCISE**

Children with insecure attachment do not trust love to be continuous. They are often concrete thinkers, and from their perspective, they are unloved and alone when a parent is not present and interacting with them. Children who are unable to hold onto a feeling of the parent’s love commonly develop maladaptive methods for seeking attention. The positive image of connection through the cord of love is reinforced with BLS to assist the child with insecure attachment in trusting that the parent’s love is always present.

**CIRCLE OF CARING EXERCISE**

Attachment trauma, changes in caregivers, and moves to new homes teach children that they are outsiders who do not really belong anywhere. The Circle of Caring Exercise heightens the child’s awareness of the people who love and care about him in his present-day life, and BLS reinforces associated feelings of safety, security, and belonging. This exercise can be conducted easily with children and adolescents who are residing in nonpermanent foster care or residential placements.

**SAFE PLACE FOR THE INNER CHILD EXERCISE**

Children with a history of attachment trauma often exhibit quick changes in affect state, especially when traumatic material is consciously or subconsciously triggered. One way to help parents understand this is by explaining the sudden fearful or aggressive behaviors as stemming from feelings associated with a younger age at which the child was traumatized. Parents and children of all ages and developmental levels seem to intuitively understand the concept of the “smaller child within.”

The exercise for working with “the smaller child within” involves creating a safe or comfortable place for the inner child and prompting parents to describe how they imagine
caring for the inner child there in the safe place. The exercise helps create inner feelings of safety and helps stabilize children with varying degrees of dissociation. The therapist normalizes the concept by bringing out a set of nesting dolls and allowing the child to take them apart, while explaining that everyone carries the thoughts and feelings they experienced as a young child somewhere inside themselves. After completing the exercise, the imagery can be accessed whenever needed to reinforce feelings of safety and nurturance for the inner child.

**SONGS FOR YOUNGER CHILDREN**

Younger children are soothed by music, rhythm, and rocking with their parents. Music and rhythm can be combined with bilateral movement to reinforce feelings of pleasure, safety, and security between children and their parents. Parents and therapists can make up lyrics that provide the positive messages children need to hear.

**Self-Regulation Development and Installation**

Whereas ARD reinforces the child’s sense of connection with parents, Self-Regulation Development and Installation (S-RDI) is resource work specifically intended to reinforce the child’s experience of self-efficacy in moving from a dysregulated state to a regulated state (Wesselmann et al., 2014a). A good time to implement this protocol is when a child becomes anxious for the session to be over, irritated over some small annoyance, or compelled to pick at his skin or bite his nails. The therapist reinforces the parents’ role as expert and coach by asking for parents’ opinions and encouraging them to join the therapist in demonstrating skills.

**Phase 3: Assessment**

When a past trauma has been identified and the child has been adequately prepared for EMDR, the therapist takes the child through the assessment phase, using child-friendly language and assisting the child as needed. It is often easier for the child to identify the emotion associated with the image prior to identification of the NC. The identified emotion can then be used to lead the child to the associated negative thoughts. Parents can be prompted to talk about the feelings and thoughts they might have experienced as children in order to encourage openness and to assist their child with self-awareness.

**Phases 4 to 8: Desensitization, Installation, Body Scan, Closure, and Reevaluation**

**Keeping Parents Present**

Keeping the parent present for the child during EMDR processing naturally increases the parent’s level of empathy and compassion for all the difficulties and traumas the child has endured. Additionally, the presence of a supportive parent or trusted adult can provide the vulnerable child with a sense of protection and safety, giving the child courage to feel his feelings and address his traumatic past with EMDR. The presence of attuned parents can help the child stay present and regulated as memories, thoughts, emotions, and sensations are accessed during reprocessing.

Adult clients can find empowerment through the integration of the child and adult perspective regarding childhood traumas, while the child client lacks a store of adult adaptive information. Interactive interweaves involve feedback from parents, prompted by the therapist, that help provide adult perspective as well as newfound awareness of parents’ empathy and support. Parents can be utilized for assistance during any of the eight phases of EMDR, reinforcing parents’ role as expert and caregiver in the eyes of the child.

**BLS During Desensitization and Reprocessing**

There are many ways in which BLS can be implemented with children during desensitization and reprocessing. The therapist may move the child’s eyes bilaterally by simply asking
the child to watch her hand or fingers move from side to side. To help keep the child’s attention, the therapist may hold a wand, puppet, or other toy or use an electronic eye scan machine. During reprocessing, the stimulation should be applied as rapidly as the child can comfortably manage. Attune to the child’s preferences for modality and speed. Bilateral tactile stimulation through tapping on the child’s hands or knees, use of tactile pulsars, or use of headphones that provide bilateral tones are alternative methods of BLS. The therapist should be prepared to change direction, speed, or modality of stimulation as a possible means of accessing new associations when processing seems stuck.

**The Rescue Interweave**

The rescue interweave is an interactive interweave, utilizing the parent to describe an imaginary rescue of the child from an earlier traumatic event. The parent may describe removing the child from the scene and taking the child to a safe place, protecting the child in some other way, or removing or intervening with the perpetrator figure. The therapist can implement BLS throughout the parent’s dialogue. This type of interweave provides the parent with an opportunity to demonstrate his or her dedication to protection of the child (Wesselmann et al., 2014a). The child develops a feeling of empowerment through envisioning the scenario in which he is protected.

**Separating Present-Day Triggers From the Past Through Inner Child Interweaves**

The child often lacks adequate adaptive information for spontaneous reprocessing, and it is frequently helpful to utilize interweaves to help him separate the present triggers from the past traumas. Interweaves prompting both the parent and the child to dialogue with the inner, smaller child part help the child step into the more mature affect state and establish the difference between past and present. By utilizing the parents as a resource during the interweave, the therapist helps the child see the parent as an expert and a supporter (Wesselmann et al., 2014a).

**Future Template**

The future template should always follow EMDR processing of current triggers, and may be conducted at any time a skills deficit becomes apparent. Due to the effects of attachment trauma on emotional and cognitive development, children with a history of attachment trauma typically are lacking many behavioral and coping skills, such as assertiveness and communication skills, friendship skills, responding to directions or redirection, and coping with frustration. The family therapist gives specific behavioral instructions and demonstrations, freeing the EMDR therapist to reinforce the new skill with an EMDR future template. The EMDR future template can be effectively reinforced by a more hands-on method of role-play versus an imagined rehearsal.
Treating Attachment Trauma in Children Protocol Script

Phase 1: Client History

Say to the parent, “Let’s make a list of your child’s behaviors and symptoms that are problematic.”

“To the best of your ability, please tell me everything you can about your child. I would like to know about _______ (his/her) strengths as well as ________ (his/her) problems and symptoms. Include any behavioral problems at home or school, academic functioning, social functioning, fears, sleep, food, and bathroom issues. I’m going to take extensive notes, because it is all going to be important to understanding what is going on.”

Say, “Tell me what you know about your child’s ‘story.’ I especially need to know about any distressing or traumatic events that your child has experienced, even if those events took place when _______ (he/she) was a baby. You may or may not know everything that has happened to your child, but please try to identify the events that are known to you. This would include any physical, sexual, or emotional abuse; neglect, losses, and major changes; witnessing of domestic abuse or drug or alcohol abuse by parents; accidents, medical interventions; changes in caregivers.”

Say, “Were there any prenatal or postnatal issues such as prenatal drug exposure, domestic violence during pregnancy, or postpartum depression?”

Together with the parent, make a list of hypothesized NCs. Themes include defectiveness, responsibility, safety, control, parents/other, and love/belongingness.

Say, “Your child experienced multiple traumatic events during the period of _______ (his/her) development in which ________ (he/she) was formulating foundational beliefs about self and others. Instead of learning that _______ (he/she) was loved and lovable, that _______ (he/she) could trust and depend upon ________ (his/her) caregivers to love and care for _______ (him/her), your child was learning to believe the opposite. Look again at this list of your child’s problems and triggers. Let’s brainstorm together and see if we can come up with a list of negative beliefs about self and others that might be clouding ________ (his/her)
judgment and impacting (his/her) ability to accept love and guidance from you.”

Say, “Tell me about any previous therapeutic or psychiatric treatment and the outcome.”

Say, “Does your child have any health concerns or have there been health concerns in the past?”

Say, “Please list your child’s current medications, including any over-the-counter medications.”

Say, “Raising children who exhibit these kinds of problems can be very stressful. How are you coping in the face of all of this?”

Say, “Tell me about your child’s strengths, and the traits you most enjoy about your child.”

Say, “What are the positive attitudes and behaviors you hope your child will be able to adopt in the future?”

Phase Two: Preparation Phase: ARD

If either the child or parent becomes significantly uncomfortable during these exercises, gently move out of the exercises by introducing a game or another playful activity. In this case, ARD can be conducted for a very short time each session until the child and parent become more comfortable.

“Messages of Love” Script

Although both parents may be in the room, this exercise is conducted with one parent at a time. The therapist first meets with the parent(s) without the child in the room.
Chapter One: Child Attachment Trauma Protocol

Explain the exercise to the parent(s) by saying the following:

Note: Alternative wording, depending on the presence of one or both parents, is provided.

Say to the parent(s), “We are going to do an exercise today that will help create and reinforce feelings of closeness and connection between you and your child. Remember that increasing your child’s sense of security and connection with you will help calm ________ (his/her) nervous system and increase ________ (his/her) capacity to listen and cooperate at home and school.”

“When your child joins us, if you don’t mind, I will suggest that your child sit physically close to ________ (you/one of you), or as close as possible while remaining relatively comfortable.”

If both parents are in the room say the following:

Say, “We will conduct the exercise with one of you and then the other. I will then prompt you to talk about things that will help your child experience positive feelings of closeness and connection with you. For example, I will invite you to talk about things you enjoy about your child, times you have felt proud of your child, and positive early memories with your child. Let’s brainstorm and make sure ________ (you/each of you) feel prepared with some positive thoughts and memories. I will make notes to which you can refer, if needed, during the exercise.”

Note: Many parents identify positive thoughts and memories with little assistance, while other parents welcome ideas and suggestions from the therapist.

Say to the parent(s), “If there is anything during the ARD exercise that begins creating a high level of distress for ________ (you/either one of you), give me a small signal (show parent how to lift a finger to give a signal) and I will find a way to comfortably close it down for today.”

Invite the child to join you and the parent(s) in your office.

Say to the child, “Today, you get to sit back and relax. Your ________ (mom/dad) will be doing all of the work! But first, I would like to invite you and your ________ (mom/dad) to sit close to each other today. Perhaps your ________ (mom/dad) can put an arm around you, if you are comfortable.

Say to the child, “During this exercise, if it is OK, I would like you to hold the buzzers (tactile pulsars) or place them in your pockets, whichever you prefer. Is it OK?”

If the tactile pulsars are not an option, say the following:

Say to the child, “During this exercise, if it is OK, I would like to tap lightly on your hands or knees, whichever you prefer. Which would you prefer?”
Ask the parent to talk about the things he or she enjoys about the child.

Say to the parent, “I would like to know about all of the things you enjoy about [state child’s name]. First, what are the strengths and positive traits that you appreciate about [state child’s name]?”

Implement slow, tactile BLS for the duration of the parent’s dialogue.

Say to the parent, “Tell me about the activities you enjoy doing with your child.”

Implement slow, tactile BLS for the duration of the parent’s dialogue.

Say to the parent, “Describe the ways in which the two of you are alike. For instance, do you like any of the same foods or have any of the same habits?”

Implement slow, tactile BLS for the duration of the parent’s dialogue.

Say to the parent, “Tell me about some times that you felt proud of [state child’s name], recently, or in the past.”

Implement slow, tactile BLS for the duration of the parent’s dialogue.

Say to the parent, “Describe your memory of when you first set eyes on [state child’s name] or even when you first learned about [state child’s name] and how you felt.”

Implement slow, tactile BLS for the duration of the parent’s dialogue.

Say to the parent, “Tell me about some of your favorite early memories of [state child’s name].”

Implement slow, tactile BLS for the duration of the parent’s dialogue.

Say to the parent, “Please talk about your positive hopes and dreams for [state child’s name] and for your relationship.”

Implement slow, tactile BLS for the duration of the parent’s dialogue.
Implement slow, tactile BLS as you direct the child to notice the positive feelings.

If the parent(s) and child appear to be enjoying feeling close and relaxed, give them some quiet time together. In the case of a younger child, the therapist can turn on lullaby music or play a heartbeat sound and offer a soft blanket.

Say to the child, “Just notice the feelings of closeness between you and your ________ (mom/dad) right now, and notice the feelings of calm and comfort in your body. Notice the feelings of warmth and connection.”

Repeat the above for the other parent.

“Playing Baby” Script

This exercise is best conducted with one parent at a time.

Meet with the parent(s) first and say, “If you are comfortable with it, I would like to do a fun activity today that allows your child to pretend ________ (he/she) is a baby on your lap. I’ll conduct the exercise with one of you and then the other. It provides an opportunity for your child to get some of ________ (his/her) earlier unmet needs met through imagination and play, and we will use bilateral stimulation to reinforce feelings of trust and closeness. Does this feel do-able for ________ (you/both of you) if your child is also receptive?”

Invite the child to join you and the parent(s) in your office.

Say to the parent, “__________ (Mom/Dad), if __________ (child’s name) were a baby again, just for a day, what would that be like for you?”

Say to the child, “Let’s just pretend for a few minutes that you are a baby again. Maybe you could get right up on __________ (mom’s/dad’s) lap!”

Say to the parent, “__________ (Mom/Dad), what position would feel most comfortable for you?” Help the child and parent arrange pillows and create a comfortable position for both of them.

If using tactile pulsars, say, “May I place these tappers in your shoes or pockets?”

If tactile pulsars are not an option, say, “Is it all right if I sit near you and do a little tapping on your legs once in awhile?”

Say to the parent, “__________ (Mom/Dad), what do you think about this little baby __________ (child’s name) on your lap?”
Add bilateral stimulation by tapping slowly on the child’s legs or running the tactile pulsars at a relatively slow speed throughout the parent’s discourse.

Say to the parent, “I’ll bet you would be stroking __________ (his/her) hair, looking at __________ (his/her) little fingers, tracing with your fingers around __________ (his/her) face, mouth, and eyes, and feeling __________ (his/her) soft baby skin.”

Say to the child, “Notice how comfy you feel right now.”

Tap slowly on the child’s legs or run the tactile pulsars at a relatively slow speed for a short time.

Say to the parent, “__________ (Mom/Dad), what other things would you be doing with this lovable little baby?”

Tap on the child’s legs slowly or run the tactile pulsars slowly throughout the parent’s discourse.

If the other parent is present, do the above exercise again with this parent.

**The “Lollipop Game” Script**

This exercise is best conducted with one parent at a time.

Meet with the parent(s) first and say, “I would like to do another fun activity designed to help children learn that it can be safe and even enjoyable to allow the parent/s to be in charge. The parent holds a lollipop during the activity and the child signals to the parent when __________ (he/she) wants the lollipop or doesn’t want the lollipop. We will want to stay positive and playful and just have fun with it. I’ll handle the logistics. Which one of you would like to do the activity with your child today? Does this activity feel relatively comfortable for you?”

Say to the child, “We’re going to do a fun activity today that involves a lollipop. First, you get to show me which flavor you want.”

The therapist offers two or three flavors and allows the child to pick one.

Say to the child, “Now, your __________ (mom/dad) is going to hold the lollipop, but don’t worry. __________ (He/She) will make sure you get to suck on the lollipop just as much as you want. Your job will be to signal your __________ (mom/dad) with your mouth and eyes when you want the lollipop in your mouth and when you want it out. Your __________ (mom/s/ dad’s) job is to watch carefully and read your signals. Now, let’s help you get situated, right on your __________ (mom/s/dad’s) lap, nice and comfy.”
Help the child get situated with pillows and a comfortable position.

Say, “Can we place these tappers inside your pockets or shoes?” (Or if tactile pulsars are not an option, say, “Is it OK if I sit nearby and tap a little sometimes on your feet or knees?”)

Say to the child, “OK, you can signal your _________ (mom/dad) with your mouth and your eyes when you want to suck on that lollipop! You can signal, too, when you don’t want to take a break from the lollipop. _________ (Mom/Dad) is going to pay close attention.”

Sit silently for a minute or two while the parent and child play the game.

Then say to the child, “Notice how comfortable it is to let your _________ (mom/dad) be in charge of the lollipop. You can trust _________ (him/her) to know what you need. If you were a baby, you could trust your _________ (mom/dad) to read your signals and take good care of you. _________ (She/He) would give you a bottle as soon as you needed one. _________ (She/He) would rock you, hold you, change you, and provide whatever you needed to feel safe and comfortable.”

Tap slowly or run the tactile pulsars slowly as you say these words. Allow the parent and child to continue with the game until the lollipop is gone or the child tires of the game.

If the other parent is present, do the above exercise again with this parent.

The “Magical Cord of Love” Script

This exercise can be conducted with one or both parents at the same time. Alternate wording for two parents is provided in parentheses.

Say to the child, “None of us can see love, but we all know it exists. If you could see love, what color would it be? There is no right or wrong answer, it is whatever color you choose.”

Say to the child, “So if we could see the love that is streaming from your _________ (mom’s/dad’s/parents’) heart/s into your heart, we would see a beautiful, shimmery, _________ (child’s chosen color) cord of light—a “magical cord of love.”

Say to the child and parent(s), “This would be a good time to sit close or snuggle.” Help arrange pillows as needed so both child and parent(s) will be comfortable.

Say to the child, “If it’s OK, I’m going to ask you to place the buzzers (tactile pulsars) in your shoes or pockets, and I will be turning them on a little and then off a little. Is it OK?”

Alternatively, say, “If it’s OK, I’m going to tap on your legs a little now and a little more later. Is it OK?”
Say to the child and parent(s), “Let’s all close our eyes and picture this magical cord of love together. See the beautiful, shimmery, __________ (child’s chosen color) cord of light, pouring from __________ (mom’s/dad’s/parents’) heart/s into your heart. This cord is magical because it stretches and stretches, so you are always connected, and the love never stops. Even if __________ (mom/dad/mom and dad) are on the moon or in Australia, the love can stretch and stretch and you are still connected, heart-to-heart, every second, every minute, every hour, everyday.”

Reinforce with slow BLS as you guide the child’s thoughts with the mental imagery.

Say to the parent(s), “__________ (Mom/Dad/Mom and dad), when you can’t see __________ (child’s name) because you are at work and __________ (he/she) is at school, is __________ (he/she) gone from your heart and from your mind? Or is __________ (he/she) still in your mind and heart? Do you love __________ (him/her) just the same?”

Tap on the child’s legs slowly or run the tactile pulsars slowly throughout the parent’s (each parent’s) discourse.

Say to the parent(s), __________ (Mom/Dad/Mom and dad), “What happens if you get busy? For example, what happens to the cord of love if you are tending to another child’s needs, or if you are on the phone talking with someone else? When you are not paying attention to __________ (child’s name), does your love for him/her still exist?”

Tap on the child’s legs slowly or run the tactile pulsars slowly throughout the parent’s discourse.

Say to the parent, “__________ (Mom/Dad/Mom and dad), what about if you are frustrated or angry with __________ (child’s name)? Can you be angry and love _________ (him/her) at the same time? Do you stop loving _________ (him/her) when you are upset with _________ (him/her)?”

Tap on the child’s legs slowly or run the tactile pulsars slowly throughout the parent’s discourse.

Say to the child, “The magical cord of love stretches and still connects you with your __________ (mom/dad/mom and dad) all of the time, no matter what. If your __________ (mom/dad/parents) can’t see you, or if your __________ (mom/dad/parents) __________ (is/are) busy, paying attention to another child, or paying attention to someone else, the magical cord of love stretches and stretches so that you and your __________ (mom/dad/parents) __________ (is/are) still connected, heart to heart. Even when __________ (mom/dad/mom and dad) is upset, __________ (mom/dad/mom and dad) still love/s you, and you are still connected, heart-to-heart.”

Tap on the child’s legs slowly or run the tactile pulsars slowly throughout the guided imagery.
“Circle of Caring” Script

Say to the child, “I am going to make a list of all of the people in your life who care about you. This list includes adults and children, relatives, nonrelatives, neighbors, and professional helpers. Your list may also include pets. I will write down all of the names on this piece of paper.”

Say to the parent, “You may contribute names that come to you, as well. Please tell me the list.”

Write down the list of names.

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Say to the child, “Now, I am going to read through your list, and I want you to picture all of these people here in this room, surrounding you with their love. You can see how much they care about you by the beautiful, shimmery, _______ (child’s chosen color for love) light, all around you, like sparkly floating glitter in the air.”

Tap on the child’s legs slowly or run the tactile pulsars slowly throughout the guided imagery.

“Safe Place for the Inner Child” Script

Bring out a set of nesting dolls.

Say to the child, “We are all a little like these nesting dolls. Each one of us still holds feelings deep inside from when we were much younger. We call this the ‘inner child’ or the ‘smaller child inside.’ I have an inner child, your ________ (mom/dad/parents) ________ (has/have) an inner child, and you have an inner child. You have feelings and thoughts you carry inside from when you were just a preschooler, a toddler, and even from when you were a baby. Let’s look at these nesting dolls again. If this bigger one is your bigger self, see if you can pick ages for the smaller dolls.”

---

Say to the child, “Pick one doll that you think is your most hurt little one.”

---

Say to the child, “What do grown-ups need to do to help little children feel safe and loved?”

The therapist writes down any ideas offered by the child. All ideas should be accepted unless they are unsafe or unhealthy.
Say to the child, “We want to begin helping this littler one inside your heart to feel safe and loved.”

Say to the parent(s), “____________(Mom/Dad/Mom and dad), you will have an important role in helping to make the smaller child inside feel safe and loved today.”

Say to the child, “The smaller you needs a nice, comfortable, safe place. What kind of place do you think this should be? What kind of items should be in this place to help the little you feel happy and safe?”

Say to the parent(s), “Do you have any suggestions about what might make this little one feel happy and safe?”

Say to the child, “Do I have permission to add your __________ (mom’s/dad’s/parents’) suggestions to the list?”

Say, “Would you like to draw a picture of this safe place for the little one?”

If the child agrees, offer paper and crayons or any other preferred medium.
Say, “Here are some __________ (state the preferred medium).”
If the child asks for help, the parent and therapist and child can all work together to draw the picture.
Say, “If you like, we can all work together to draw the picture.”

Alternatively, a picture can be made in a sand tray.
Say, “If you like, you can make your picture in the sand tray.”
Say, “All little ones need parents to take care of them. __________ (Mom/Dad/Mom and dad) will need to take care of this little one inside the safe place.”
Allow time for the child to draw his or her parent(s) into the picture. If the child has made a visual representation, say the following:
Say, “Where could you add __________ (mom/dad/mom and dad) to the picture, taking care of the little one?”
Encourage the parent and child to be physically close, if it is comfortable for both of them. Sometimes younger children will sit on their parent’s lap.

Say to the child, “I would like you to relax now with your __________ (mom/dad/parents).”

Say to the child, “You may place the buzzers in your hands, socks, or pockets. What would you prefer?”

Alternatively, say to the child, “Is it OK if I tap on your hands or on your knees? Which would you prefer?”

Say to the child, “Picture the smaller you in this wonderful safe, calm, enjoyable place and __________ (describe the details of the created safe place).”

Implement slow, tactile BLS through the duration of your verbal description.

Say to the parent(s), “__________ (Mom/Dad/Mom and dad), can you picture yourself, there, with the littler __________ (state child’s name) in the safe place today? Tell us what you are doing there, for the little __________ (state child’s name) today.”

Implement slow, tactile BLS throughout the parent’s description of his or her nurturing actions in the inner child’s safe place.

If the parent(s) give(s) a short answer, continue to probe and ask questions to elicit more description.

Say to the parent(s), “What will you do if the littler __________ (state child’s name) feels uncomfortable or distressed?”

Implement slow, tactile BLS throughout the parent’s description.

Say to the parent(s), “What will you do to have fun with the smaller __________ (state child’s name)?”

Implement slow, tactile BLS throughout the parent’s description.

Say to the parent(s), “What will you do when the littler __________ (state child’s name) gets tired?”
Implement slow, tactile BLS throughout the parent’s description.

Say to the child, “Notice the feelings of closeness and the feelings of calm inside your body right now. Notice the feelings of connection, warmth, and safety.”

Implement slow, tactile BLS as the therapist guides the child’s thoughts.

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**Songs for Younger Children Script**

Initially talk with the parent(s) individually while the young child plays or draws on the floor.

Say, “Song, rhythm, and movement are soothing and regulating for the developing nervous system of young children. When children are soothed by their parents, their sense of security and connection with their parents grows. Furthermore, right–left stimulation, an important component of EMDR Therapy, assists with integration of the emotional and cognitive regions of the brain. We are going to combine both today to help your child. An easy and fun way to do this is through simple tunes that we all know and love along with simple lyrics that will help your child feel loved. A good way for you to engage your child in the song and provide bilateral stimulation is to place your child on your lap facing me, swaying side-to-side with him in rhythm with the song. I’ll lead the song and you can join in. Often children will catch on and join in as well.”

Say to the child, “________ (child’s name), we’re going to sing a fun song today. Feel free to bring the _________ (stuffed animal or other toy) to hold while we sing. Come up on your _________ (mom’s/dad’s) lap. OK, here we go!”

Sample lyrics to the tune of “Wheels on the Bus”:

Say,

> “Mommy and Daddy love you so, love you so, love you so,
> Mommy and Daddy love you so, each and every day.
> Mommy and Daddy keep you safe, keep you safe, keep you safe,
> Mommy and Daddy keep you safe, each and every day.
> Mommy and Daddy give you hugs, give you hugs, give you hugs,
> Mommy and Daddy give you hugs, each and every day.”

Say to the parent, “You can sing and sway with your child at home as much as you like. Feel free to make up a variety of lyrics with your own favorite tunes. Young children need repeated experiences of soothing and closeness over time to develop a calm and regulated nervous system and feelings of security and connection with parents.”

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**Self-Regulation Development and Installation**

**S-RDI Script**

The EMDR therapist or family therapist can best prepare the child for S-RDI by teaching “belly breath” when the child is calm.
Say, “I’m going to teach you and your parents a way to calm your body and your brain. We call this method ‘belly breath.’ The more any of us practices belly breath, the easier it is to keep our bodies and our brains calm. Let’s all lie back comfortably together and put a hand on our bellies like this. As you take a breath, let your belly fill up with air. You can feel it with your hand. Let it go, and now feel the air leave your belly. Continue breathing in this way, and let your body relax.”

Therapist, parent, and child all begin taking slow breaths, filling the diaphragm with air on the inhale and blowing it out slowly on the exhale.

The EMDR therapist implements S-RDI when children become irritable or fidgety.

Say, “I notice that you are getting fidgety/irritable. Can you tell me what is going on?”

Say, “OK, this gives us an opportunity to help you practice finding your calm feelings.”

Hand the child the tactile pulsars or get positioned to tap on the child’s legs or feet.

Say, “The tapping will help your body learn and remember the feeling of going from fidgety/irritable to calm. One of the first things I do when I get fidgety/irritable is take big belly breaths.”

Say to the parent(s), “Do belly breaths help you when you get fidgety?”

Say, “Let’s all take five big belly breaths together. Notice what happens in your body with five big belly breaths. Remember, breathe in and fill your belly with air like a big balloon.”

Implement BLS throughout your discourse while you say the following:

Say, “I can see your body is relaxing. Pay attention to how it feels in your body as you continue taking big breaths. You are helping your body go from an upset/fidgety feeling to a more relaxed feeling. That’s right, continue to breathe nice and slow with me, in, and out.”

Stop the BLS.

Say, “Are you completely relaxed, or is there still some upset/wiggly feeling there?”

If the child remains slightly dysregulated, say the following:

Say, “Another important way for you to relax is by talking to your brain. This is sometimes called self-talk. For instance, when I get the ‘I can’t wait’ feelings and get fidgety, I tell my brain, ‘It’s OK, this will be done soon. I can handle it.’”
Say to the parent/s, “________ (Mom/Dad/Mom and dad), what do you say to your brain to help when you get fidgety?”

Say to the child, “What can you say to your brain right now that might help?”

Implement the BLS throughout while you say the following:

Say, “Excellent. Talk to your brain right now and notice what happens. Tell your brain __________ (remind the child what he/she can say to his/her brain). Notice how it feels in your body and your brain, as your brain slows down, your body slows down, and you feel more relaxed. That’s right, keep breathing, all the way into your belly. Talk to your brain. Notice how good it feels as your body relaxes.”

Phase Three: Assessment

Say, “When you remember what happened, what is the most upsetting part?”

Say, “What is the picture that is stuck in your brain?”

It is sometimes easier for children to identify their emotions before identifying the NC. Show the child a list of feelings or pictures of feelings faces.

Say, “Look at these faces and point to any faces that match the way you feel when you see that picture in your brain.”

If the child still has difficulty, say the following:

Say to the parent(s), “________ (Mom/Dad/Mom and dad), what would you feel if this had happened to you when you were a child?”

Say to the child, “Could this be a feeling you have inside?”
Identify the NC.

Say, “What is the ________ (state the sad/mad/scared/confused, etc.)
 thought that goes with that feeling?”

If the child still has difficulty,

Say to the parent(s), “________ (Mom/Dad/Mom and Dad), what would you think if you were a child and you had gone through something like this?”

Say, “Do you have a thought like that?”

Identify the PC:

Say, “Let’s come up with a thought that would be more helpful. Can you think of one? Even though it might not feel very true to you right now, see if you can come up with something that is opposite to your upset thought.”

If the child needs some extra assistance, say the following:

Say to the parent, “________ (Mom/Dad/Mom and Dad), what thought would you want ________ (state child’s name) to have instead of the upset thought?”

Say to the child, “Would that be a helpful thought? Remember, it’s OK if it doesn’t feel true to you, right now.”

Say, “Let’s check how true it feels right now. When you see that picture in your brain, how true does it seem to you, down inside, to say ________, (repeat PC)?”

“Completely true?” (Therapist spreads hands wide.)

“Pretty true?” (Therapist moves hands closer together.)

“Just a little true?” (Therapist holds hands close together.)
Say, “Right now when you think of the picture and the upset thought _________ (repeat the NC), how big is the upset feeling?”

“The biggest upset feeling ever?” (Therapist spreads hands wide.)

“Pretty big?” (Therapist moves hands closer together.)

“Just a little upset feeling?” (Therapist holds hands closer together.)

Say, “Where do you notice the upset in your body? Let’s look for it together. Pay attention to how it feels in your head, face, jaw, neck, and gradually notice all the way down your body.”

If the child is not aware of any feelings in his body and he is sitting near the parent, say the following:

Say to the parent(s), “If it’s OK with you both, I would like you to put your arm around your child. As you do so, notice if there is any tension in _________ (his/her) back, shoulders, or neck. What do you notice?”

Phase 4: Desensitization

Say, “Remember, you are safe here with your _________ (mom/dad/parents) and me, and you can have any feelings or thoughts today and be OK. It’s normal to want to push those feelings and thoughts away, but then they stay stuck inside. If you can just let your feelings and thoughts pop up without pushing them away, as you watch my fingers, we can help those feelings and thoughts get better so they aren’t stuck anymore. Bring up the picture and your upset thought _________ (repeat the NC). Also notice that place in your body. Now follow my fingers.”

Alternatively, say, “I am going to run the buzzers/tap.”

Add BLS.

“Take a breath, now let it go. What is there? Is there anything in your brain or in your body?”

Desensitizing Early Traumatic Memories: The Rescue Interweave

An appropriate time to implement the rescue interweave is during the Desensitization Phase when the child is experiencing sudden intense feelings of helplessness or fear that does not shift with further eye movements or changes in direction or speed.
Say to the parent(s), “If right this minute, you could jump into a time machine that would take you back in time, and you could land right in the middle of this situation, what would you do? You have permission to help in any way you wish.”

**Note:** Typically, the parent describes rescuing the child and taking the child to a safe place, protecting the child in some other way, or removing or intervening with the perpetrator figure. Implement BLS as the parent describes the rescue.

Say to the child, “Take a breath and let it go. What is there now? Is there something in your brain or in your body?”

Say, “Go with that.”

Resume BLS and continue reprocessing. When the child’s SUD is 0 or 1, or slightly higher, if deemed ecological, begin installation. See Phase 5: Installation.

**Desensitizing Present Triggers: Interweaves to Separate the Present From the Past**

An appropriate time to implement this interweave is when a child is stuck and looping in the feelings and negative beliefs associated with a present-day trigger during EMDR desensitization.

After another set of BLS, say the following:

Say to the child, “Do you think this feeling __________ (repeat child’s feeling) and this upset thought __________ (repeat the NC) might be stuck in your brain from those earlier experiences we talked about?”

If the child agrees, say the following:

Say to the child, “The little you inside may not understand that the past is over, even though the bigger you does understand. How is your __________ (life/parent/home) today different from your __________ (life/parent/home) in the past?”

Say, “What could you say to the smaller child inside to help __________ (him/her) understand?”

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Say, ”Go with that.” Resume eye movements.

Turn to the parent(s) and say, “What do you want the littler __________ (state child’s name) to know?”

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Say, ”Go with that.” Continue the Standard EMDR Protocol to desensitize the current trigger.

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Phase 5: Installation

To begin installation, the EMDR therapist checks on the appropriateness of the PC, using child-friendly language.

Say, ”Remember the helpful thought, __________ (repeat the PC). Is that still the best thought, or do you think there might be a better thought?”

---

If the child indicates that he might prefer a different thought, say the following:

Say, ”What would be a more helpful thought? It might be a thought you had during our work today.”

---

Say, ”When you think of what happened, how true does __________ (repeat the PC) feel right now?”

”Completely true?” (Therapist spreads hands wide.)

”Pretty true?” (Therapist moves hands closer together.)

”Just a little true?” (Therapist holds hands close together.)

---

Say, ”Hold the thought with the memory and watch my fi ngers.”

---

Continue with installation until the PC feels completely true to the child.

Phase 6: Body Scan

Say, ”Keep the helpful thought in your mind with the memory, and let’s check your body for any uncomfortable feelings. Let’s start with your head, move
down into your face, your jaw, and your neck. Notice your shoulders, your chest, your stomach, your arms, and your hands. Did you find anything?”

If the child notices any disturbing residual body sensations, resume eye movements until the sensations are eliminated.

If the child notices any pleasant sensations, repeat a set of BLS to reinforce the positive sensation.

**Phase 7: Closure**

If the session is incomplete, say the following:

Say, “What is the most helpful idea that you have had about this memory so far?”

Say, “Just hold that thought in mind while you watch my fingers one more time.” Implement one set of slow eye movements to reinforce the helpful idea.

If the session is complete or incomplete, say the following:

Say, “You worked hard today. Remember that there is no need to continue to think about today’s session. You are free to go home and play and learn and have a good week. Leave this and any upsetting past memories here in the __________ (use any container image that is useful for the child, such as a file cabinet). But let your parent/s know if anything bothers you this week.”

Additionally, the child can be asked to bring up a safe place or other resource, or the therapist can invite the child and parent to play a short game to help reinforce feelings of safety and connection.

Say, “If you would like, bring up __________ (remind child of safe place or other resource).”

**Phase 8: Reevaluation**

In the follow-up session, begin without the child in the room.

Say to the parent, “Was there any indication from your child’s behaviors this last week that __________ (he/she) was experiencing any thoughts or feelings related to the last session?”

If the session from the previous week was left incomplete, or the parent’s observations indicate the child may have continued processing the material, the EMDR therapist says the following:

Say, “I would like you to think back on the memory we worked on last week. Today, when you think about what happened, what feelings do you notice?”
Say, “How big are your feelings today? Show me with your hands—big (hands held wide), medium, or small (moving hands closer together).”

Say, “Do you notice any upset inside your body? Start at the top of your head, then check your face, neck, shoulders, chest, stomach, arms, hands.”

Say to the parent(s), “If it’s OK with you both, I’d like you to put your arm around your child and see if you observe any tension in ________ (his/her) back, shoulders, or neck.”

Say to the child, “Bring up the picture, notice the feelings and that place in your body, and follow my fingers.” Resume reprocessing from desensitization through closure.

**Future Template**

**Future Template Role-Play**

Say to the child, “Let’s think back on the incident that triggered those big feelings. I think you might need the skill of __________ (name a skill such as cooperation, following directions, assertiveness, staying calm, saying no, asking for what you need) to better handle that situation the next time. I am going to pretend to be you, and I will demonstrate how I would have handled the situation, using this skill.”

Say to the parent(s), “_________ (Mom/Dad/Mom and dad), would you help me role-play so I can demonstrate?”

Act out the incident with the help of the child’s parent, demonstrating an appropriate skill for handling the situation.

Say to the child, “Now it’s your turn to try it. See if you can respond to ______ (Mom/Dad/Mom and dad) the way I just did. The tappers (handing child the tactile pulsars) will help your brain remember how to do this.”

Alternatively, say, “If it’s OK, I would like to tap on your ____ (knees/shoulders) to help your brain remember how to do this.”

Add relatively slow, bilateral, tactile stimulation throughout the child’s demonstration of the skill.

Say, “You acted so grown-up just now. How do you feel inside right now?”
Say, “Just notice those great feelings.”

Repeat the slow bilateral tactile stimulation.

Summary

Children who have suffered attachment trauma due to maltreatment, neglect, separations, losses, and caregiver changes have difficulty trusting adults, accepting comfort, recognizing and managing their feelings, and managing their behaviors. They carry deep-seated negative beliefs about themselves, others, and their world. Relationships are natural triggers for mistrust and fear. Parents are frequently overwhelmed by the child’s behaviors, and they may resort to punitive disciplinary tactics, which only escalate the child’s emotional and behavioral dysregulation. Families are frequently desperate for help.

The Integrative Team Treatment approach is designed to improve the child’s behaviors and relationship in the most efficient way possible. Creating a two-therapist team allows the EMDR therapist to implement EMDR Therapy weekly, while a family therapist coaches parents and children in new skills and patterns of interaction. ARD and S-RDI with parent involvement during the preparation stage increase the child’s sense of security and capacity for self-regulation. Involving parents during work with memories, triggers, and templates helps children move from feelings of loneliness, mistrust, and fear to feelings of connection, security, and safety.

References


Lovett, J. (2009, October). Using EMDR to treat trauma and attachment in children and adults. Paper presented at the Attachment and Trauma Center of Nebraska, EMDR Specialty Workshop by Joan Lovett and Debra Wesselmann, Omaha, NE.


SUMMARY SHEET:
Child Attachment Trauma Protocol

Debra Wesselmann, Cathy Schweitzer, and Stefanie Armstrong
SUMMARY SHEET BY MARILYN LUBER

Name: ___________________________ Diagnosis: ________________
Medications: ___________________________
Test Results: ___________________________
☑ Check when task is completed, response has changed, or to indicate symptoms.

Note: This material is meant as a checklist for your response. Please keep in mind that it is only a reminder of different tasks that may or may not apply to your incident.

Treating Attachment Trauma in Children Protocol Script

Phase 1: Client History

Child’s problematic behaviors and symptoms: __________________________

__________________________

__________________________

__________________________

__________________________

Child’s strengths: __________________________

__________________________

__________________________

__________________________
Child’s distressing or traumatic events (physical, sexual, or emotional abuse; neglect, losses, and major changes; witnessing of domestic abuse or drug or alcohol abuse by parents; accidents, medical interventions, or changes in caregivers):

Prenatal/postnatal issues (drug exposure, domestic violence during pregnancy/postpartum depression):

List of hypothesized NCs (defectiveness, responsibility, safety, control, parents/other, and love/belongingness):

Previous therapeutic/psychiatric treatment and outcome:

Health concerns now or in past:

Current medications including OTC meds:

How parent(s) is coping:
Traits parent(s) enjoy about child: __________________________

_____________________________________________________

_____________________________________________________

Positive attitudes and behaviors parent(s) want for child: __________________________

_____________________________________________________

_____________________________________________________

Case Conceptualization

The EMDR therapist and family therapist write down the following from the child’s history:

- Potential EMDR targets
- Current triggers that seem to precipitate aggression, defiance, or other symptoms or behaviors. Hypothesized NCs associated with the child’s traumas and triggers
- Identify needed skills related to self-awareness, self-regulation, socializing, and communicating. The skills list is a working plan for psycho-education and skills work that can be conducted by the family therapist and reinforced by the EMDR therapist through future templates

Phase 2: Preparation Phase: Attachment Resource Development

- Messages of Love Script—to create an experience of closeness and connection between child and parents
  
  Note the positive messages: __________________________

  __________________________________________________________

  __________________________________________________________

- Playing Baby Exercise—(usually 7 and younger) therapist reinforces child’s feelings of shared pleasure and closeness with parents using BLS.
  
  Note child’s and parents’ responses to the exercise: __________________________

  __________________________________________________________

  __________________________________________________________

- Magical Cord of Love Exercise—positive image of connection through the cord of love is reinforced with BLS to assist the child with insecure attachment in trusting that the parent’s love is always present.
  
  Note child’s description of the cord: __________________________

  __________________________________________________________

  __________________________________________________________

- Circle of Caring Exercise—heightens the child’s awareness of the people who love and care about him in his present-day life, and BLS reinforces associated feelings of safety, security, and belonging. Can be conducted easily with children and adolescents who are residing in nonpermanent foster care or residential placements.
  
  Note names of individuals in the child’s circle: __________________________

  __________________________________________________________

  __________________________________________________________
Safe Place for the Inner Child Script—for working with “the smaller child within.” Involves creating a safe or comfortable place for the inner child and prompting parents to describe how they imagine caring for the inner child there in the safe place. The exercise helps create inner feelings of safety and helps stabilize children with varying degrees of dissociation. Show nesting dolls while explaining that everyone carries the thoughts and feelings they experienced as a young child somewhere inside themselves. Later access imagery whenever needed to reinforce feelings of safety and nurturance for the inner child.

Note the child’s description of the place: __________________________________________

Songs for Younger Children—combine music and rhythm with BLS to reinforce feelings of pleasure, safety, and security between children and their parents. Make up lyrics that provide the positive messages children need to hear.

Note tunes or words: __________________________________________________________

Self-Regulation Development and Installation—resource work specifically intended to reinforce the child’s experience of self-efficacy in moving from a dysregulated state to a regulated state. Helpful when a child becomes anxious for the session to be over, irritated over some small annoyance, or compelled to pick at his skin or bite his nails.

Note child’s response: __________________________________________________________

Phase 3 Assessment

Note: Get emotion before cognition

Target: ____________________________

Picture/Image: ____________________________

Emotions: “Look at these faces and point to any faces that match the way you feel when you see that picture in your brain”

If there is difficulty, ask parent(s) how they would feel if this happened to him/her when a child.

Negative Cognition: ____________________________

If there is difficulty, ask parent(s) how they would think if this happened to him/her when a child.

Positive Cognition: ____________________________

Validity of Cognition:

- Completely true? (Spread hands wide)
- Pretty true? (Hands closer)
- Just a little true? (Hands close together)

Subjective Units of Disturbance:

- The biggest feeling ever? (Spread hands wide)
- Pretty big? (Hands closer)
- Just a little upset feeling? (Hands close together)

Location of Body Sensation: ____________________________
If there is difficulty, ask parent(s) to put arm around child and notice if tension is in back, shoulders, or neck.

**Phase 4: Desensitization**

To child: “Remember, you are safe here with your ____________ (mom/dad/parents) and me, and you can have any feelings or thoughts today and be OK. It’s normal to want to push those feelings and thoughts away, but then they stay stuck inside. If you can just let your feelings and thoughts pop up without pushing them away, as you watch my fingers, we can help those feelings and thoughts get better so they aren’t stuck anymore. Bring up the picture and your upset thought ____________ (repeat the NC). Also notice that place in your body. Now follow my fingers.”

**Desensitizing Early Traumatic Memories: The Rescue Interweave**

Use when child is experiencing sudden intense feelings of helplessness or fear that do not shift with further eye movements or changes in direction or speed.

To parent(s): “If right this minute, you could jump into a time machine that would take you back in time, and you could land right in the middle of this situation, what would you do? You have permission to help in any way you wish.”

Parent describes rescuing the child and taking the child to a safe place, protecting the child in some other way, or removing or intervening with the perpetrator figure. Implement BLS as the parent describes the rescue.

**Desensitizing Present Triggers: Interweaves to Separate the Present From the Past**

Use when a child is stuck and looping in the feelings and negative beliefs associated with a present-day trigger

“Do you think this feeling ____________ (repeat child’s feeling) and this upset thought ____________ (repeat the NC) might be stuck in your brain from those earlier experiences we talked about?”

If child agrees: “The little you inside may not understand that the past is over, even though the bigger you does understand. How is your ____________ (life/parent/home) today different from your ____________ (life/parent/home) in the past?”

To child: “What could you say to the smaller child inside to help ____________ (him/her) understand?” Add BLS.

To parent(s): “What do you want the littler ____________ (state child’s name) to know?” Add BLS.

**Phase 5: Installation**

PC: □ Completed

New PC (if new one is better): __________________________________________________________________________

Validity of Cognition:

□ Completely true? (Spread hands wide)
□ Pretty true? (Hands closer)
□ Just a little true? (Hands close together)
Phase 6: Body Scan

“Keep the helpful thought in your mind with the memory, and let’s check your body for any uncomfortable feelings. Let’s start with your head, move down into your face, your jaw, and your neck. Notice your shoulders, your chest, your stomach, your arms, and your hands. Did you find anything?

Note: If child reports any disturbing body sensations, resume BLS. If notices pleasant sensations, repeat a set of BLS.

Phase 7: Closure

Most helpful idea about this memory: ________________________________

+ BLS

“You worked hard today. Remember that there is no need to continue to think about today’s session. You are free to go home and play and learn and have a good week. Leave this and any upsetting past memories here in my _______________ (use any container image that is useful for the child, such as a file cabinet). But let your parent(s) know if anything bothers you this week.

Bring up Safe Place or other resource as needed.

Phase 8: Reevaluation

Parent’s report of child’s behaviors related to last session: ________________________________

If incomplete session, ask what is noticed: ________________________________

Subjective Units of Disturbance:

☐ The biggest feeling ever? (Spread hands wide)

☐ Pretty big? (Hands closer)

☐ Just a little upset feeling? (Hands close together)

Location of Body Sensation: ________________________________

If there is difficulty, ask parent(s) to put arm around child and notice if tension is in back, shoulders, or neck.
Future Template

Future Template Role Play

Script: “Let's think back on the incident that triggered those big feelings. I think you might need the skill of __________ (name a skill such as cooperation, following directions, assertiveness, staying calm, saying no, asking for what you need) to better handle that situation the next time. I am going to pretend to be you, and I will demonstrate how I would have handled the situation, using this skill.”

To parent(s) __________ (mom/dad/mom and dad), “would you help me role-play so I can demonstrate?”

Act out the incident with the help of the child’s parent, demonstrating an appropriate skill for handling the situation

To the child, “Now it’s your turn to try it. See if you can respond to __________ (mom/dad/mom and dad) the way I just did. The taps (handing child the tactile pulsars) will help your brain remember how to do this.”

Alternatively, say, “If it’s OK, I would like to tap on your __________ (knees/shoulders) to help your brain remember how to do this.”

Use slow BLS.

To child: “You acted so grown-up just now. How do you feel inside right now?”

Then: “Just notice those great feelings.”

Repeat BLS