



EYE MOVEMENT DESENSITIZATION AND REPROCESSING

EMDR

SCRIPTED PROTOCOLS

BASICS AND SPECIAL SITUATIONS

 SPRINGER PUBLISHING COMPANY

MARILYN LUBER
EDITOR

Eye Movement

Desensitization and

Reprocessing (EMDR)

Scripted Protocols:

Basics and Special

Situations

EDITOR

Marilyn Luber, PhD

 **SPRINGER PUBLISHING COMPANY**

New York

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Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Sheri W. Sussman
Project Manager: Julia Rosen
Cover design: Steve Pisano
Composition: Apex CoVantage, LLC

Ebook ISBN: 978-0-8261-2238-4

09 10 11 12 / 5 4 3 2 1

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Library of Congress Cataloging-in-Publication Data

Eye movement desensitization and reprocessing (EMDR) scripted protocols : basics and special situations / Marilyn Luber, editor.

p. cm.

Includes bibliographical references.

ISBN 978-0-8261-2237-7 (alk. paper)

1. Eye movement desensitization and reprocessing.
 2. Medical protocols.
- I. Luber, Marilyn.

[DNLM: 1. Desensitization, Psychologic—methods. 2. Eye Movements—physiology. 3. Mental Disorders—therapy. 4. Psychotherapy—methods. WM 425.5.D4 E97 2009] RC489.E98E94 2009
617.7—dc22 2009006157

Printed in the United States of America by Bang Printing.

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Preface

Marilyn Luber

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Acknowledgments

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

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

Beyond this, one of the greatest joys for me has been to get to know so many of my colleagues more fully during the course of this work.

I would also like to acknowledge those members of this vast community of EMDR practitioners who use EMDR on a regular basis with their clients.

Special thanks goes to Robert Gelbach, the Executive Director of EMDR HAP, who suggested that I find a publisher for the book and pushed me in the direction of the Springer booth at the 2007 EMDR International Association Conference in Dallas, Texas; Victoria Britt, who helped me write my book proposal; Howard Wainer, who guided me in the mysterious ways of book publishing; Sheila Bender, Zona Scheiner, and Bennet Wolper, who engaged in helping me think about how to organize the content of the book; Louise Maxfield, who helped me think about critical points concerning EMDR; Francine Shapiro, Roger Solomon, Barbara Hensley, Nancy Errebo, and Bennet Wolper, who read and critiqued portions of this manuscript; Donald Nathanson, who has been a stalwart supporter of my writing; Catherine Fine and Richard Goldberg, who have been friends, colleagues, and supporters of my evolution as a clinician and writer; A. J. Popky, who introduced me into the EMDR community; and Shirley Luber, my mother, for her support and understanding.

With a great deal of irony, I would like to acknowledge my computer and the Internet. Despite countless crashes, blue screens, and runaway cursors, without the use of the computer and the Internet, this book would have taken much longer and resulted in the destruction of many more trees than necessary. In fact, contact

with my contributors who came from all over the United States, Canada, South and Central America, Europe, Australia, and the Middle East was facilitated by the possibility of sending drafts through the international access of the Internet computer-to-computer. To my computer savior, Lew Rossi, I would like to acknowledge his coming out on a Friday night—without knowing me—to find my draft that had disappeared and continuing to tirelessly tackle the unique difficulties of my computer so that I could finish this book.

I would like to thank the Springer staff, especially my editor, Sheri Sussman, for her help and support.

I would particularly like to thank Robbie Dunton for her never-ending support and heart-felt compassion throughout my EMDR career.

To Francine Shapiro, I am forever grateful that she shared her dream with me by creating a way of addressing the trauma in the world, and asking me to support and nurture the learning of EMDR internationally. It has truly been a spectacular journey, way beyond that first walk in the park.

Client History

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

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

Conceptualizing the best and parsimonious treatment plan entails the following:

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

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

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

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

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

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



EMDR Summary Sheet

Marilyn Luber

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

EMDR Summary Sheet

NAME: _____ DIAGNOSIS: _____

MEDICATIONS: _____

PAPER AND PENCIL TEST RESULTS:

IES-R _____ DES _____ BDI-II _____ Other _____

GOALS

1. _____ 2. _____ 3. _____

PRESENTING PROBLEM-PP #A PP #B PP #C

A. _____ B. _____ C. _____

TOUCHSTONE EVENT

A. _____ B. _____ C. _____

EXPERIENCES

EXPERIENCES

Birth—12 years of age (Childhood)

1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____

13 years through 19 years (Adolescence)

4. _____	4. _____	4. _____	4. _____
5. _____	5. _____	5. _____	5. _____
6. _____	6. _____	6. _____	6. _____

20 years and higher (Adulthood)

7. _____	7. _____	7. _____	7. _____
8. _____	8. _____	8. _____	8. _____
9. _____	9. _____	9. _____	9. _____
10. _____	10. _____	10. _____	10. _____

Present Triggers

1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____

Future Template/Anticipatory Anxiety

1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____

MAJOR THEMES/COGNITIVE INTERWEAVES

Safety/Survival

1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____

Self-Judgment/Guilt/Blame (Responsibility)

1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____

Self-Defective (Responsibility)

1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____

Choice/Control

1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____

PRESENT RESOURCES

Safe Place

1. _____	1. _____
2. _____	2. _____

Mastery

Attachment

1. _____	1. _____
2. _____	2. _____

Symbols



History Taking: The Time Line

Arne Hofmann and Marilyn Luber

Client history taking is an important part of well-prepared clinicians' understanding of their clients. The Time Line Script (Hofmann, 2004) is based on a number of personal communications with other EMDR clinicians. The forms are a way of eliciting the material crucial to preparing for future work in EMDR.

The Time Line Script Notes

Start with the best events and ask for the negative events in the session. This is especially important when working with unstable clients.

Continue to gather this information and put it into the form so that you can put it in your client's chart and see the important memories and resources easily. Also, when you complete processing, there is a place to put that (new) SUD score.

You can use the questions below to gather the rest of the information. When all of the memories are gathered, it is helpful to plot them onto a "Positive and Negative Memories Map" (Beere, 1997; Shapiro, 2006). This Map allows for a visual presentation along the time line of the client's life and offers a window into what the important landmarks of the client's life were for the clinician and client to see together. Often, just seeing the events in a visual chronological pattern helps both of you to see the gestalt of the client's life experience, the themes, the clusters, the gaps in memory, and the positives—or lack of positives—along the way.

You can use the form below or create your own time line on a larger piece of paper so that there is more room.

Part of the EMDR clinician's understanding of the client is to understand the future concerns and anticipated triggers that are connected to the presenting problem(s) or any other issues of concern that the client has revealed during the history-taking process. These future concerns or anticipated triggers can be added to the form throughout the course of treatment.

The Time Line Script

Say, *“Today, I am going to ask you to remember the best and the worst memories that you have had and we will put it into this chart. We can start with about five and if there are more or less, that is fine. Where would you like to start?”*

Okay, *“What is the first _____ (worst or best) memory that you can remember throughout the whole time line of your life? You do not have to go into all of the details because we will do that later.”*

Say, *“How old were you when you had that _____ (worst or best) experience?”*

Only ask for the subjective units of disturbance (SUD) scale for the worst memories.

Say, *“On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?”*

0	1	2	3	4	5	6	7	8	9	10
(no disturbance)						(highest disturbance)				

Create the “Positive and Negative Memories Map” with the client.

Say, *“Now that we have talked about the memories that are the most important to you in your life, let’s create a Map. We can put the positive or best ones on top of the ‘Age’ line and we can put the negative or worst ones under the Age line. I have found it very helpful to see the important events in a person’s life along the time line. Where would you like to start?”*

Say, *“Do you have any thoughts about the time line of your life now that we can see it? What do you think about what has happened in your life?”*

Say, "Are there any particular themes that are clearer to you now that you can 'see' the important memories of your life in front of you. Or, does anything jump out to you of importance?"

Elicit the current situations/events/stimuli that trigger the client and enter them on the form.

Say, "Memories from the past are important, but, it is also important to think about what situations/events/stimuli trigger or bother you in the present. What have you noticed really gets you upset when it happens in your day-to-day life? Sometimes, it is the way your boss talks to you, or how your spouse gives you 'that look' _____ (state examples pertinent to your client). Other times, it is a certain song or smell. What have you noticed that triggers you recently?"

Identify the client's future concerns, anticipated problems or other situations/ events/stimuli that you think might trigger you in the future and enter into them into the chart.

Say, "Now that we know about your positive and negative memories and some of the situations/events/stimuli that trigger you have in your daily life, it is helpful for us to identify the kinds of future concerns or anticipated problems or situations/events/stimuli that might trigger you and that you have been thinking about. What comes to mind for you, especially the ones connected to the problem(s) we have been talking about?"

Say, "Now that we have these memories and concerns mapped out, we can talk about how we want to proceed in our work together. With all of this in mind, what are your current thoughts about our objectives and goals for treatment?"

Best or Positive and Worst or Negative Memories

List the best or positive memories and the worst or negative memories.

Best/Positive Memories

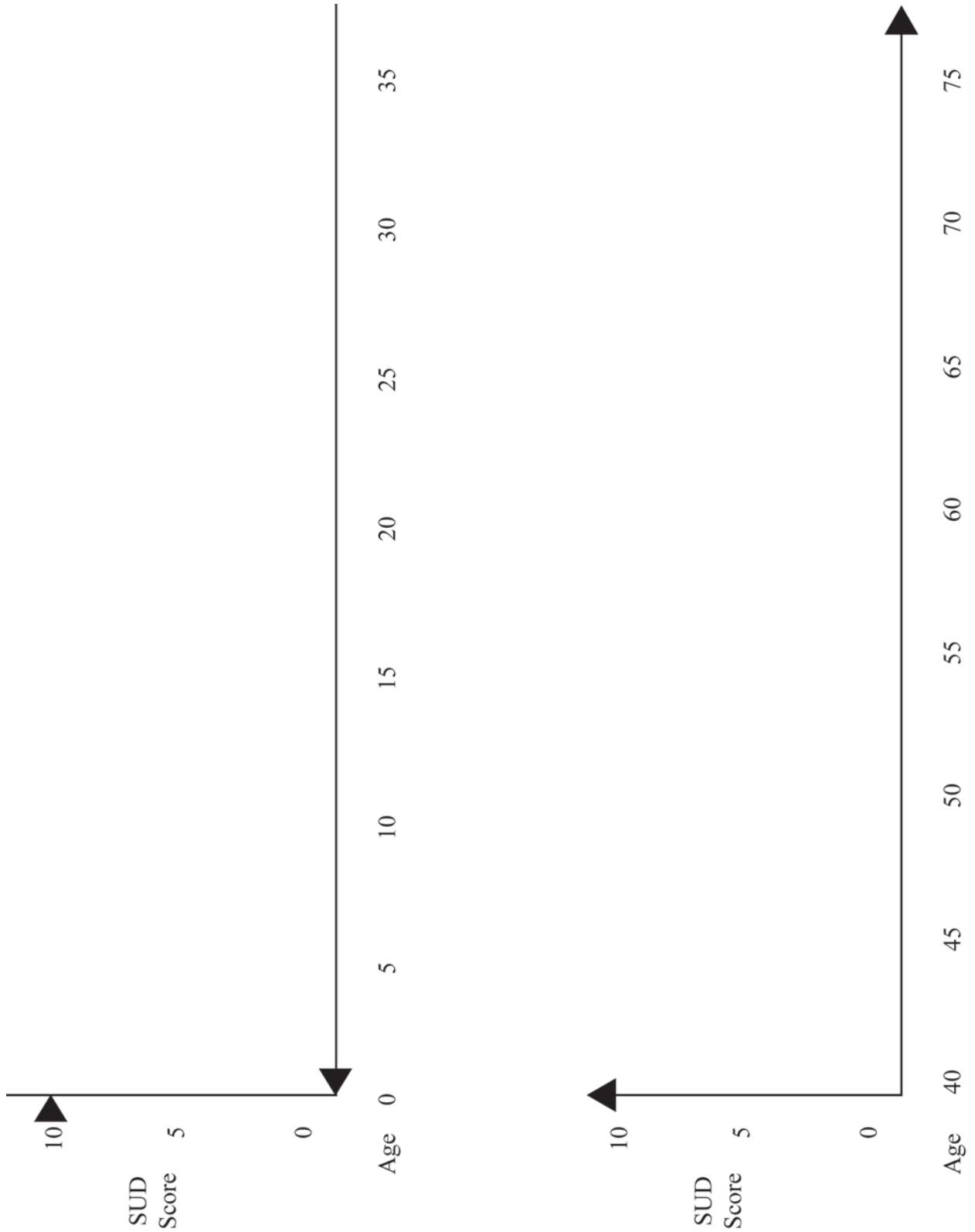
	Memories	Age
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Worst/Negative Memories

	Memories	Age	SUD	SUD Post Processing
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Positive and Negative Memory Map

Fill in the positive/best memories above the Age line and the negative/worst memories below the Age line:



Positive and Negative Memory

Present and Future Situations/Events/Stimuli That Are Triggers or Concerns

List the present situations/events/stimuli that are triggers and the future situations/events/stimuli that are triggers or concerns.

	Present Trigger List	SUD	SUD Post Processing
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

	Future Triggers or Concerns List	SUD	SUD Post Processing
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			