This one-stop resource focuses on applying EMDR scripted protocols to medical-related conditions. Edited by a leading EMDR scholar and practitioner, it delivers a wide range of step-by-step protocols that enable beginning clinicians as well as seasoned EMDR clinicians, trainers, and consultants alike to enhance their expertise more quickly when working with clients who present with medical-related issues such as eating and body image dysregulation, relationship distortion, chronic pain, and maladaptive self-care behaviors. The scripts are conveniently outlined in an easy-to-use, manual style template, facilitating a reliable, consistent format for use with EMDR clients.

The scripts distill the essence of the standard EMDR protocols. They reinforce the specific parts, sequence, and language used to create an effective outcome, and illustrate how clinicians are using this framework to work with a variety of medical-related issues while maintaining the integrity of the AIP model. Following a brief outline of the basic elements of EMDR procedures and protocols, the book focuses on applying EMDR scripted protocols to such key medical issues as eating and body image dysregulation, chronic pain experiences such as migraine and fibromyalgia, and maladaptive self-care behaviors. It includes summary sheets for each protocol to facilitate gathering information, client documentation, and quick retrieval of salient information while formulating a treatment plan. Protocols for clinician self-care add further to the book’s value.

Key Features:
- Encompasses a wide range of step-by-step scripts for medical-related issues
- Includes scripted protocols and summary sheets in strict accordance with the AIP model
- Facilitates the rapid development of practitioner expertise
- Outlined in convenient manual-style template
- Includes scripts for EMDR treatment of clients with eating disorders and body image dysregulation, headaches, fibromyalgia, relationship distortion, maladaptive self-care behaviors, and more
Eye Movement Desensitization and Reprocessing

EMDR Therapy

Scripted Protocols and Summary Sheets

TREATING EATING DISORDERS, CHRONIC PAIN, AND MALADAPTIVE SELF-CARE BEHAVIORS
Marilyn Luber, PhD, is a licensed clinical psychologist and has a general private practice in Center City, Philadelphia, Pennsylvania. In 1992, Dr. Francine Shapiro trained her in eye movement desensitization and reprocessing (EMDR). She has coordinated trainings in EMDR-related fields in the greater Philadelphia area since 1997. She teaches facilitator and supervisory trainings and other EMDR-related subjects both nationally and internationally and was on the EMDR Task Force for Dissociative Disorders. She was on the Founding Board of Directors of the EMDR International Association (EMDRIA) and served as the chairman of the International Committee until June 1999.

In 1997, Dr. Luber was given a Humanitarian Services Award by the EMDR Humanitarian Association. 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 the Handbook for EMDR Clients, which has been translated into eight languages; the proceeds from sales of the handbook go to EMDR HAP organizations worldwide. Four times a year, she writes the “Around the World” and “In the Spotlight” articles for the EMDRIA Newsletter, and has done so since 1997. In 2009, she edited Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations and Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations.

She interviewed Francine Shapiro and coauthored the interview with Dr. Shapiro for the Journal of EMDR Practice and Research and later wrote the entry about Dr. Shapiro for E. S. Neukrug’s The SAGE Encyclopedia of Theory in Counseling and Psychotherapy.


In 2014, she edited Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols and Summary Sheets (print and CD-ROM versions) and in 2016 Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols With Summary Sheets: Treating Anxiety, Obsessive-Compulsive, and Mood-Related Conditions (print and CD-ROM versions) and Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols With Summary Sheets Version: Treating Trauma and Stressor-Related Conditions (print and CD-ROM versions).

Currently, there are two new volumes to the EMDR Scripted Protocol Series: Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma in Somatic and Medical-Related Conditions and Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Eating Disorders, Chronic Pain, and Maladaptive Self-Care Behaviors.

In 2014, she was part of the Scientific Committee for the EMDR Europe Edinburgh Conference. Currently, Dr. Luber is a co-facilitator for the EMDR Global Alliance to support upholding the standard of EMDR worldwide. She has worked as a primary consultant for the FBI field division in Philadelphia. She has a general psychology practice, working with adolescents, adults, and couples, especially with complex posttraumatic stress disorder (C-PTSD), trauma and related issues, and dissociative disorders. She runs consultation groups for EMDR practitioners.
Eye Movement Desensitization and Reprocessing
EMDR Therapy
Scripted Protocols and Summary Sheets

TREATING EATING DISORDERS, CHRONIC PAIN, AND MALADAPTIVE SELF-CARE BEHAVIORS

Edited by
Marilyn Luber, PhD
To Bob Raymar

my friend, my husband, my supporter,

for your love for me, your community, your country,

and the world we live in
Trauma is hell on earth. Trauma resolved is a gift from the gods.
—Peter A. Levine
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Paula Baldomir Gago, MS, MC, CP, is a psychologist and psychotherapist. Since 2008, she has worked as an expert in personality disorders, trauma, and dissociation at the Institute for the Research and Treatment of Trauma and Personality Disorders (INTRA-TP). Paula is an expert in childhood and adolescent psychopathology as well as psychosomatic medicine. She is an accredited EMDR practitioner for adults, children, and adolescents. Paula collaborates with the Gender Violence Program in her community, serving both female victims and their children. She has offered different training courses for professionals in the network of educational and youth centers in her community, as well as talks and presentations in different cities on working with children and adolescents with complex trauma.

Renée Beer, MSc, is a clinical psychologist and cognitive behavioral therapist. She is an EMDR Europe-accredited trainer for EMDR with children and adolescents, and has been involved in trainings in the Netherlands since 2000. She participated in the Child & Adolescent Committee of EMDR Europe from the start until 2017. Abroad, she delivered trainings on “EMDR With Children and Adolescents” in Suriname and Australia. She specialized in the treatment of eating disorders at the Department of Child Psychiatry of the University Medical Center in Utrecht from 2000 to 2005. She and Karin Tobias developed a protocol for cognitive behavioral therapy for adolescents, based on the theoretical model of Fairburn (2003), which they published in 2011. She was coordinator of the Center for Trauma and Family in Amsterdam from 2005 to 2013. Together with Carlijn de Roos, she edited the Handbook of EMDR With Children and Adolescents in 2017. Besides her EMDR activities, she is accredited as a trainer in trauma-focused cognitive behavioral therapy (TFCBT). Her major concerns are to establish both EMDR and TFCBT in the Netherlands as the major therapy approaches for the treatment of trauma-related psychopathology in children and adolescents and to promote the implementation of cognitive behavioral therapy (CBT) and EMDR in the treatment of patients (adults and adolescents) with an eating disorder.

Wolfgang Eich, MD, is specialized in internal medicine and rheumatology as well as in psychotherapeutic medicine and psychoanalysis. After studying medicine in Tübingen and Freiburg, Germany, he published his medical dissertation in 1980 on the topic “Medical Semiotics Between 1750 and 1850” (summa cum laude). He continued his studies of internal and psychotherapeutic medicine in Hanover and Heidelberg. In 1994, he completed his postdoctoral qualification at the Medical Faculty of Heidelberg University on “Subjective Illness and Self-Regulatory Control in Ankylosing Spondylitis (M. Bechterew).” In 2002, he was appointed to be medical director of the Acura-Clinic for Psychosomatic Medicine Baden-Baden within the framework of a cooperation agreement between the Medical Faculty,
the Medical University Hospital, and the Center of Rheumatology in Baden-Baden. Since 2004, he is a full professor of integrated psychosomatics and head of the Section of Integrated Medicine at the Medical University of Heidelberg. He is the head of numerous research projects on shared decision making and on chronic pain (most recently, he was the coordinator of the LOGIN (Localized and Generalized Musculoskeletal Pain: Psychobiological Mechanisms and Implications for Treatment) consortium and the principal investigator of LOGIN’s subproject 6: Subgroups characterized by psychological trauma, mental comorbidity, and psychobiological patterns and their specialized treatment funded by the German Ministry of Research and Education. Within this framework, numerous publications on EMDR and chronic pain followed.

Ana Cris Eiriz, MS, MC, LSW, CP, is a psychologist and psychotherapist specializing in trauma, personality disorders, mood disorders, and dissociation. She is an accredited systemic family therapist and an accredited EMDR practitioner. She has been working in the INTRA-TP team since 2004. She is an expert in personality disorders, trauma, and affective disorders. She collaborates with two gender violence programs in her community, one for women who are victims of violence and one for men with anger issues. Ana Cris has published two books on bipolar disorder and several articles on personality disorders and trauma. Ana has presented many psychoeducational workshops on personality disorders at different associations directed at patients and their families. She teaches about personality disorders, trauma, and family interventions to clinicians and regularly supervises the work of other professionals.

Hejan Epözdemir, PhD, is a clinical psychologist and psychotherapist working and living in Istanbul. She studied psychology and later graduated in clinical psychology, receiving her doctoral degree from Hacettepe University Department of Clinical Psychology. Dr. Epözdemir has her own private clinical practice working with adults, couples, and families and also works part-time as faculty and clinical supervisor in both Istanbul Bilgi University and Bahcesehir University. She was a founding member of the Board for EMDR Turkey and is an accredited EMDR consultant and supervisor and an editor of EMDR Turkey Bulletin. She is also interested in research and has had several academic studies, including academic texts, articles, and presentations in both national and international publications, journals, and conferences.

Raquel Fernández Domínguez, LSW, is a social care worker and licensed pedagogue. She has worked as an expert in personality disorders, trauma, and dissociation at the INTRA-TP since 2008. Raquel has specific training in attachment, trauma, and dissociation. She has more than 8 years of experience working with families of severely traumatized children as well as families of people with personality disorders. She has offered different training courses for professionals in the network of educational and youth centers in her community, as well as talks and presentations in different cities on working with children and adolescents with complex trauma. She has also been a speaker at workshops for professionals on the treatment of borderline personality disorder, as well as doing talks and workshops for relatives of people with personality disorders in different cities in Spain.

Carol Forgash, LCSW, BCD, was a president of and on the board of the EMDR HAPs. She has a clinical and consulting practice in Smithtown, New York. She is a facilitator and an EMDR International Association (EMDRIA)-approved consultant. She is a lecturer and consultant on the treatment of dissociation, complex posttraumatic stress disorders, the complex health issues of sexual abuse survivors, and the integration of EMDR with ego state therapy and psychodynamic treatment. She has coauthored and edited Healing the Heart of Trauma and Dissociation With EMDR and Ego State Therapy (Springer Publishing, 2007), the first book to offer an integrative approach to successfully treating clients with the most severe trauma-related disorders.

Önder Kavakçı, MD, is a psychiatrist and psychotherapist specializing in the areas of trauma, anxiety disorders, and pregnancy-related disorders. He is an associate professor at the Medical School of Cumhuriyet University. He is a member of EMDR-Turkey (EMDR-TR). He is president of the Research and Publishing Committees of EMDR Turkey and has been actively working with the Turkish Psychiatry Association Trauma and Disaster Committees. He is the author of the first Turkish EMDR book, EMDR for Psychological Trauma (Ruhsal Trauma Tedavisi İçin EMDR).
Jim Knipe, PhD, has been using EMDR since 1992. He is an EMDR HAP trainer and an EMDRIA-approved consultant and instructor, and was designated a “Master Clinician” by EMDRIA in 2007. He has been an invited speaker at national EMDR conferences in 14 countries in the United States, Canada, Europe, and Asia, and he has been involved since 1995 with the Trauma Recovery/EMDR Humanitarian Assistance organization, coordinating EMDR training programs in developing countries where significant trauma has occurred. He is a coauthor of a published outcome research documenting the effects of EMDR with survivors of the New York 9/11 terrorist attack and with those traumatized by the 1999 Marmara earthquake in Turkey. Dr. Knipe has contributed chapters to EMDR Casebook (2002); EMDR Solutions, Volumes I and II (2005, 2009); Healing the Heart of Trauma and Dissociation (2007); EMDR Scripted Protocols: Special Populations (2009); and EMDR and Dissociation (2012). His book EMDR Toolbox: Theory and Treatment for Complex PTSD and Dissociation was published in August 2014, and he is a coauthor (with Dolores Mosquera) of two recent articles in the Journal of EMDR Practice and Research, entitled “Understanding and Treating Narcissism With EMDR Therapy” (Winter, 2015) and “Idealization and Maladaptive Positive Responses: EMDR Therapy for Women Who Are Ambivalent About Leaving an Abusive Partner” (Winter, 2017). An online streaming video of his two-day training—EMDR-related methods of treating complex PTSD and dissociation—is available through Trauma Recovery/HAP (www.emdrhap.org).

Emre Konuk, MA, is a clinical psychologist. He received his undergraduate degree at Istanbul University, followed by a graduate degree in clinical psychology at Bogazici University. He received his family therapy training at the Mental Research Institute, Brief Therapy Center, Palo Alto. He became a pioneer in Turkey establishing psychotherapy as a profession by founding the Institute for Behavioral Studies (DBE, Davranı¸s Bilimleri Enstitüsü) in 1985, with the vision of providing psychological services to individuals, couples, and families. In 1998, he established the Organizational Development Center in order to contribute to the improvement and growth of organizations and human resources. He is an EMDR Institute and EMDR Europe trainer, president of the Institute for Behavioral Studies—Istanbul, president of EMDR Association and EMDR HAP–Turkey, and general secretary of Couples and Family Therapy Association—Turkey. He was a board member for the Turkish Psychologists Association, Istanbul Branch, between 1990 and 2002, and president and projects coordinator between 1998 and 2002. At present, he is a member of the Ethics Committee for the Turkish Psychologists Association. Since the 1999 Marmara earthquake, he has been responsible for EMDR HAP and EMDR basic trainings in Turkey. More than 600 professionals have been trained during EMDR and several HAP projects. He has participated in EMDR HAP projects in Thailand, Palestine, Kenya, Lebanon, and Iraq. His major concern is to establish EMDR as a major therapy approach in Turkey.

Dolores Mosquera, MS, MC, CP, is a psychologist and psychotherapist specializing in severe and complex trauma, personality disorders, and dissociation. She is an accredited EMDR Europe trainer and supervisor. Dolores is the director of the INTRA-TP in A Coruña, Spain—a three-clinic private institution initially founded in 2000 as LOGPSIC. She collaborates with two different domestic violence (DV) programs, one focused on women victims of DV and another one on males with violent behavior. She belongs to the Spanish National Network for the Assistance of Victims of Terrorism and also collaborates with an organization aiding victims of emergencies, accidents, violent attacks, kidnapping, and other traumatic incidents. Dolores has extensive teaching experience, leading seminars, workshops, and lectures internationally. She has participated as a guest speaker in numerous conferences and workshops throughout Europe, Asia, Australia, and North, Central, and South America. She has published 15 books and numerous articles on personality disorders, complex trauma, and dissociation, and is a recognized expert in this field. She also teaches in several universities and collaborates supervising clinical psychologists in postgraduate training programs in Spain. She is coauthor of the books EMDR and Dissociation, The Progressive Approach, and EMDR Therapy and Borderline Personality Disorder. Dolores received the David Servan-Schreiber award for outstanding contribution to EMDR in 2017 from the EMDR Europe Association.

Marco Pagani, MD, PhD, received his MD in 1985 and his PhD in Brain Neurophysiology and Nuclear Medicine Methodology in 2000 from the Karolinska Institute of Stockholm. He is a Senior Researcher at the Institute of Cognitive Sciences and Technologies of the Italian National Research Council. His work focuses on the pathophysiology of neurological and psychiatric disorders as investigated by...
neuroimaging methodologies. In these fields, he has published more than 130 full papers, more than 30 of which are on PTSD and EDMR. In 2011, he was awarded the Francine Shapiro Award from EMDR-Europe for the best 2010 scientific contribution in EMDR for the paper, *Grey Matter Changes in Posterior Cingulate and Limbic Cortex in PTSD Are Associated with Trauma Load and EMDR Outcome*. He was presented with an Italian award for his work on PTSD and EMDR.

**Livia Sani, MS**, is a clinical psychologist. She graduated from La Sapienza University in Rome, specializing in psychotraumatology and emergency psychology at Lumsa University, Rome. She conducted research on PTSD as a research assistant at Vrije University in Amsterdam and collaborated with the Institute of Cognitive Sciences and Technologies in Rome. She is currently finishing her PhD in clinical psychology at the University of Strasbourg, France. Her work is focused on perinatal death and the long-term psychological consequences of parents.

**Günter H. Seidler, MD**, was head of the Department of Psychotraumatology at the Center for Psychosocial Medicine of the Heidelberg University Hospital from 2002 until his retirement in summer 2015. He began his career as a neurosurgeon and is now working on a freelance basis as an author, coach, consultant, training therapist, and supervisor. He is a medical specialist in neurology and psychiatry as well as in psychosomatic medicine and psychotherapy. Moreover, he is a training analyst, a group training analyst, and a certified EMDR supervisor. The preliminary draft of his first book *In Others’ Eyes: An Analysis of Shame* (Madison: International Universities Press, 2000) was given the sponsorship award of the German Psychoanalytic Society in 1989. The empirical examination of this construct, which he developed and explored in his postdoctoral qualification thesis (“Inpatient Psychotherapy on the Test Bench: Inter-subjectivity and Health Improvement,” 1999), was awarded the “Research Prize for Psychotherapy in Medicine.” His findings led him to a paradigm shift, and he turned to psychotraumatology. He is founder and chief editor of the journal *Trauma & Violence* and of the *Handbook of Psychotraumatology*. He has carried out numerous scientific projects on the consequences of individual violence and large-scale disasters as well as on the development of novel psychotherapeutical approaches. He is internationally regarded as one of the leading psychiatric therapists. In his practical work, he combines a scientific orientation with his own therapeutic approaches based on extensive competence in numerous established therapeutic procedures.

**Natalia Seijo, PhD**, is a psychologist and psychotherapist who specializes in eating disorders, dissociation, and complex trauma. She is the director of an outpatient clinic, which she founded 20 years ago in A Coruña, Spain. She is an EMDR Europe consultant and facilitator for the EMDR Institute. She developed her expertise on eating disorders in one of the most important eating disorders units in Spain. She is currently developing her doctoral thesis on the “Prevalence of Dissociation in Outpatients in Spain” and is also researching eating disorders with several different projects. She teaches EMDR and eating disorders workshops for the Spanish EMDR Association and is a presenter at various international conferences, and also gives workshops on eating disorders. Her publications in the eating disorders field link trauma, attachment, and dissociation. She collaborates with several universities in Spain with programs to train students on the clinical aspects of therapy and is a teacher for the EMDR Master’s Program at UNED University in Spain on eating disorders.

**Jonas Tesarz, MD**, is a specialist in internal medicine and is working as a medical doctor and clinical researcher at the Heidelberg University Hospital, Department of General Internal Medicine and Psychosomatics. After completing his doctor’s degree at the Heidelberg University on the neurobiology of pain processing, he focused his scientific work on the investigation of the role of myofascial tissue in the development and maintenance of low-back pain, before he started working as a medical assistant at the Department of General Internal Medicine and Psychosomatics (Section for Musculoskeletal Pain) at the University of Heidelberg. There, he worked on the relationship between biopsychosocial factors and low-back pain. Since that time, he has focused on the modulation of pain perception by psychosocial factors. In addition to researching the influence of traumatizing life events on pain processing, his particular scientific interest lies in the development and scientific evaluation of EMDR in the treatment of chronic pain syndromes. Tesarz has been researching and publishing internationally in the field of pain research for many years. He is the principal investigator of the first randomized controlled trial on EMDR in chronic back pain patients, writer of the German reference book *Pain Therapies in Chronic Back Pain: A Scientific and Clinical Review*, and a trainer in EMDR and eating disorders workshops for the Spanish EMDR Association.
Treatment With EMDR, and author of numerous scientific publications on EMDR in pain therapy. In 2015, he received the “German Award for Pain Research” for his work on the influence of psychological trauma on pain.

Asena Yurtsever, MA, clinical psychologist and psychodramatist, graduated and completed her master’s degree from Istanbul University. She specializes in EMDR, family therapy, expressive arts therapy, and psychodrama and works with adults and adolescents. Ms. Yurtsever is an EMDR Europe-accredited trainer, consultant, and supervisor. She gives EMDR trainings in Turkey. She supports EMDR Trauma Aid locally and internationally. She worked with Syrian refugees, and at the Atatürk airport explosion, the Beşiktaş explosion, and the Soma mine disaster in Turkey. She is also a part of establishing EMDR basic trainings in Northern Iraq with EMDR Trauma Aid Europe. She gas trained participants in Lebanon (2015) and Germany (2016) with EMDR R-TEP and EMDR G-TEP trainings.

Maria Zaccagnino, PhD, is a clinical psychologist and psychotherapist with a cognitive evolutionary approach. She is co-director of the Center of EMDR Therapy for Eating Disorders in Milan with Dr. Isabel Fernandez. She is an EMDR Europe-approved supervisor and facilitator and she works in the field of attachment theory and eating disorders, where she has achieved remarkable results in both clinical and research contexts. She coordinates much research concerning these areas of EMDR application for the Italian EMDR Association, and she has also presented workshops in Italy and Europe. She has published articles regarding the application of EMDR treatment in the context of parenting problems, attachment dynamics, and eating disorders.

Zeynep Zat, MSc, is a psychologist and psychotherapist specializing in the areas of trauma and anxiety disorders. She had been working for the National Health Service at the Psychodynamic Psychotrauma Institute in London. She is an EMDR practitioner and a member of EMDR-TR. She has been actively working on the Research, Clinical Applications, and Protocol Committees. Her roles in these committees include writing an EMDR-TR newsletter and translating an EMDR book into Turkish. She also gives workshops on using EMDR with different populations. She has recently developed a protocol on the “Treatment of Panic Disorder With EMDR.” A version of the protocol, which is integrated with Strategic Family Therapy, was presented at the last International Family Therapy Association Conference. Currently, she works at the Institute for Behavioral Studies in Istanbul.
Eye movement desensitization and reprocessing (EMDR) came about because of the fortuitous combination of unusual events and an extraordinary person. The discovery of the effects of spontaneous rapid eye movements during the waking state was an unusual event; the extraordinary person was Francine Shapiro. Her books and presentations on EMDR recount that discovery and need not be repeated here. Her extraordinary qualities—an intelligence largely unfettered by preexisting bias and guided by a willingness to explore a largely ignored phenomenon, the quiet grace of an excellent teacher, and a true humanitarian’s willingness to endure rebuffs during the development of a powerful tool for psychological healing—made her exactly the right person at the right place and at the right time.

From the very beginning, Dr. Shapiro believed the psychotherapy of EMDR would be useful to a wide range of conditions and disorders. In the years following EMDR’s introduction in 1989, researchers focused almost entirely on EMDR as a therapy for the treatment of posttraumatic stress disorder (PTSD); so did Dr. Shapiro’s first publication. Her reasoning was straightforward—if PTSD and its symptoms were the result of an experience in life and EMDR successfully treated PTSD, then EMDR might be useful in the treatment of other negatively impacting life experiences.

Conservative in terms of client safety, Dr. Shapiro encouraged clinicians to explore EMDR’s potential usefulness in treating conditions other than PTSD but to do so in an organized fashion allowing research and replication. Her concern was with the problem of clinician enthusiasm for the new without accepting the necessary discipline and organization needed for examination and research of their variations of EMDR’s well-researched protocol for trauma treatment. She felt this so strongly, her first trainings required attendees to promise to not teach EMDR until corroborating research occurred.

Initially, the challenge for EMDR was acceptance. Potential researchers were slow to respond to its steady growth of clinicians. The classic division between academic researchers and therapists in the field seemed to play a role. After a few years the situation gradually changed. Research remained a trickle, but it seemed that a critical mass of therapists was reached. As was the history of other psychotherapies, newly trained individuals started offering their own variations of the EMDR protocol. Some said their changes were needed to serve new populations, while others claimed their changes made EMDR even more effective. To be honest, most of the variations I heard of—they were seldom presented in a juried journal—struck me as ad-libbed procedures whose variations from the original EMDR protocol had little to do with clinical experience and a great deal to do with the ego or financial needs of the presenters.

In counterpoint, individuals and small groups of clinicians treating client populations affected by conditions other than PTSD worked to discover alternative procedures utilizing EMDR for those populations. Probably, the first of these groups were clinicians, led by Gerry Puk, PhD, who were treating dissociative disordered clients. The development of an EMDR approach to dissociative disorders made use of experts in the field of dissociative disorders as well as experts in EMDR (and, as in the case of Dr. Puk, several clinicians who were both). Understanding both the condition and the treatment led to procedural modifications emphasizing client safety as well as therapeutic efficiency.

Now, more than 20 years after the development of an EMDR procedure for the treatment of dissociative disorders, we are at a point where clinicians have taken EMDR into a wide variety of conditions. Dr. Marilyn Luber watched the development of these new approaches over the years and began to build a library of the most promising of them. These variations in the original EMDR protocol have several things in common:

1. First, these variations on the original protocol have built on that protocol—any EMDR clinician would recognize the source of the variants. What we are seeing is not so much a change in the original protocol of Francine Shapiro but an addition to that protocol.
2. Second, the additions allow a clinician to adapt EMDR to the particular needs and presentations of client populations defined by their condition.
• Third, they identify the steps needed to assist the client in selecting the most efficient target for EMDR’s bilateral stimulation.
• Fourth, they note the information and client history particulars needed not only to determine the potential targets for processing but to make the more basic decisions about a client’s readiness and appropriateness for treatment.
• Fifth, the developers have expertise from experience and training with the problem areas as well as EMDR.

Not all of the “variation protocols” in this and the other Scripted Protocol books Dr. Luber has edited are supported by published research. On the other hand, in providing step-by-step instructions for the use of the variation protocol, they clearly establish their procedure. This enables research and replication. I might also add that all of the variation protocols have a clinical case history evidence demonstrating EMDR’s positive effects with the particular treated population.

I first met Dr. Marilyn Luber in the early 1990s. Though we worked in different venues, we both found EMDR fascinating in its efficient effects. I led an inpatient PTSD treatment program open to male and female veterans of wars from Korea to the present. Dr. Luber has a private practice in Center City, Philadelphia, and works with clients, offering a broad range of conditions, including complex PTSD and dissociative disorders. Together, we ran a small group consultation for EMDR clinicians. She began a long effort to network with other EMDR clinicians in the Pennsylvania–New Jersey–Delaware–Maryland area. We continued to work together when I, as an EMDR Institute Senior Trainer, presented workshops that Dr. Luber organized in Philadelphia. I have read almost all of her previous books, particularly those on emergency service workers, clinician self-care, man-made and natural disasters, and treating trauma and stressor-related conditions, and have more than once wished this information had been available earlier in my career.

An examination of the topics covered in her most recent book of Scripted Protocols demonstrates by the details of the subject matter the fifth commonality I noted when describing the most promising of the variation protocols, the expertise of the developers.

Within the broad area of eating disorders, several different protocols are presented. Readers are invited to note similarities and differences where they occur. This area of application is young; it may take a research “horse race” to determine which version is the best or best for which subpopulation. Clinicians with a specialty in eating disorders will find much here for careful consideration.

In other areas, variation protocols appear to have less in the way of competition. Body image distortion, intimate partner violence, and personal health and self-care open new areas for EMDR. A section on chronic pain, one I am particularly interested in, offers three variation protocols for broad-ranging chronic pain as well as the particular forms of migraine and fibromyalgia.

With growing attention on the body–mind connection, it is not surprising to find a discussion on the use of EMDR with complex PTSD and attachment conditions impacting health as well as on the use of EMDR with maladaptive self-care.

Food for thought? Of course. You have in your hands an image, a picture of a psychotherapy still young enough to be in development as clinicians expand its treatment envelope. Nothing here is carved in stone, not yet, but this book, along with its earlier volumes, offers a solid base for taking EMDR to the people who need it. Read, understand, treat, and provide the community with feedback and be a part of the development. And thank Dr. Luber for its organization.

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One of the important themes of this volume is based on the early adverse life experiences and traumas that Felitti et al. (1998) spoke about in their historic adverse childhood experiences (ACE) study that allowed us to begin to understand with real numbers the impact that trauma and stressful experiences have on child development. They include the following:

- Childhood abuse (emotional, physical, and sexual)
- Neglect (emotional and physical)
- Growing up in a seriously dysfunctional household (battered spouse, substance abuse or mental illness in the house, parental separation or divorce, family member in prison)

They found that as the categories of childhood exposures increase, each of the adult health risk behaviors and diseases increased. Participants who had four or more types of childhood exposure, compared to those with none, had 4 to 12 times increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a two to four times increase in smoking; poor self-rated health; or more sexual partners and sexually transmitted disease; and a 1.4 to 1.6 times increase in physical inactivity and severe obesity. They also reported that the number of types of ACEs showed a ranked relationship to the presence of adult diseases, which included ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. More than seven categories were interrelated with persons with multiple health risk factors later in life. They also found that both the number and the severity of ACEs are found to have poor health outcomes across many physical and mental health domains (Anda et al., 2006).

Guillaume et al. (2016) studied the types of associations between ACEs and clinical characteristics of eating disorders. They assessed four clinical characteristics—restraint, eating, shape, and weight concerns—on the Eating Disorder Examination Questionnaire and daily functioning and childhood trauma by the Childhood Traumatism Questionnaire. Their results showed that “emotional abuse independently predicted higher eating, shape and weight concerns and lower daily function whereas sexual and physical abuse independently predicted just higher eating concerns.”

In the Physician’s Guide to Intimate Partner Violence and Abuse, Anda et al. (2006) wrote about their “Insights Into Intimate Partner Violence From the Adverse Childhood Experiences (ACE) Study.” They studied what the relationship of childhood physical/sexual abuse/growing up with a battered mother was to the danger of intimate partner violence and abuse (IPVA) as an adult. They found that each of these three ACEs was connected to the real possibility of IPVA. The more violent ACEs a person has, the increased risk of IPVA. It is in this way that exposure to abuse and domestic violence may turn into revictimization and the perpetuation of a cycle of violence rise.

Concerning pain-related medical conditions, Sachs-Ericsson, Sheffler, Stanley, Piazza, and Preacher (2017) did an interesting study looking at 10-year longitudinal data from the National Comorbidity Surveys (NCS-1 and NCS-2). Through NCS-1, they had reports about ACEs, current health issues, current pain severity, and mood and anxiety disorders, while NCS-2 looked for painful medical conditions such as arthritis/rheumatism, chronic back/neck problems, severe headaches, and other chronic pain. In conclusion, it showed that the retrospective reports of ACEs and lifetime mood and anxiety disorders independently contribute to the occurrence of painful medical conditions. Also, ACEs intensified the chance of mood and anxiety disorders, and these disorders seem to effect the development of painful medical conditions. Even though ACEs added to more painful conditions irrespective of the level of mood and anxiety disorders, interestingly lower levels of mood and anxiety disorders showed a stronger result than those with higher levels. If these results are looked at together, they show that
ACEs have potent effects on the growth of pain-related medical conditions, and mood and anxiety disorders may, in part, explain this connection.

A large number of patients present with eating disorders, chronic pain, intimate personal violence and abuse, and/or maladaptive self-care habits, so there was never a more important time for the EMDR practitioner to learn to address these ubiquitous problems.

Shapiro highlights the importance of this study in the third edition of her text Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures. It supports the Adaptive Information Processing (AIP) model that underlies EMDR therapy. The AIP model hypothesizes that inadequately processed dysfunctionally stored memories establish the basis for psychopathology and that these memories can impact our psychological and physical well-being throughout our lives. The ACE study enlarges our understanding to include not only trauma but also the adverse life experiences of everyday life, and illuminates working with medical and somatic issues in our patients.

Following this line of thinking, Hase et al. (2015) and Hase, Balmaceda, Ostacoli, Liebermann, and Hofmann (2017) discuss the idea of “pathogenic memory” (Centonze, Siracusane, Calabresi, & Bernardi, 2005). It broadens the “origin of many mental disorders to the formation and consolidation of implicit dysfunctional memory that leads to the formation of the theory of pathogenic memories (Hase et al., 2017, “Abstract”). They connect this to EMDR and the AIP model:

Research proposes to extend the range of disorders that are linked with pathogenic memories beyond PTSD and other trauma-based disorders. This is in line with the EMDR literature, where the AIP model of EMDR has predicted that PTSD is not the only memory-based disorder and has linked many other disorders to “dysfunctionally stored memories.” (Hase et al., 2017, “Discussion”)

This is an important expansion of the use of EMDR therapy to include working with adverse life experiences. Many clinicians have already expanded this concept into their work with patients and research is beginning to confirm this as well in the areas of affective disorders (Hase et al. 2015; Hofmann et al., 2014; Landin-Romero et al., 2013; Novo et al., 2014), chronic pain (de Roos et al., 2010; Gerhardt et al., 2016; Schneider, Hofmann, Rost, & Shapiro, 2008; Wilensky, 2006), addiction (Abel & O’Brien, 2010; Hase, Schallmayer, & Sack, 2008), and obsessive compulsive disorders (Marsden, Lovell, Blore, Ali, & Delgadillo, 2018).

This volume is the seventh in a series of books that support the principles, protocols, and procedures of EMDR therapy. In the very first book, Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations (Luber, 2009a), the purpose was to build on the foundation of Francine Shapiro’s (1995, 2001, 2018), the originator of EMDR therapy, by scripting her basic six protocols and including other EMDR-related work to basic knowledge for an EMDR practitioner. The second book, Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations (Luber, 2009b), broadened the base of the original book to include special populations that included children and adolescents, couples, dissociative disorders and complex posttraumatic stress disorder, addictive behaviors, pain, specific fears, and clinician self-care. Some changes occurred with the order of the books as there seemed to be a need for Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters (2014), in book, CD, and ebook formats, before publishing Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Depression and Medical-Related Issues. In 2011, there were more than 300 man-made and natural disasters, including the Japanese earthquake and tsunami, tropical storm Washi in the Philippines, flooding in Thailand and Brazil, the earthquake in Turkey, and severe drought and famine in the Horn of Africa (Swissre, 2012). In discussion with Springer Publishing and colleagues in EMDR-related humanitarian work around the globe, we decided to move up the publication of the disaster-focused book. It was published in 2014 and included the most up-to-date information of the collected wisdom of the EMDR community concerning early EMDR intervention for individuals, groups, first responders, law enforcement, the military, mineworkers, self-care, and resources for patients as well as practitioners. There was a large section on how to respond with early mental interventions in Israel, Turkey, Spain, Mexico, the United States, and India.

By the time this author was ready to start working on Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Depression and Medical-Related Issues, the American Psychiatric Association had released the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which resulted in a need to update some of the chapters. In fact, the reorganization resulted in four books so the material was more
Easily accessed. *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Obsessive-Compulsive, and Mood-Related Conditions* and *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma and Stressor-Related Conditions*, with the choice of print, CD, and/or ebook formats for both volumes, were the first two books. They were published in 2016. The next book should have been *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols and Summary Sheets: Medical-Related Issues*; however, the wealth of material resulted in *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma in Somatic and Medical-Related Conditions* and this book, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Eating Disorders, Chronic Pain, and Maladaptive Self-Care Behaviors*, to be released at nearly the same time.

These volumes hold a unique place and use a distinctive design for the EMDR library of books. 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 AIP 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 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: 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 four parts with 10 chapters, including material on eating disorders and body image dysregulation from different perspectives, transforming relationship distortion such as physical violence injury, shifting chronic pain experience, and treating maladaptive self-care behaviors. The editor asked each author to write the chapter from an EMDR therapist’s viewpoint that includes the principles, protocols, and procedures that form EMDR therapy and the AIP model. The authors shaped their eight-phase protocol to tailor their history-taking phase to their specific population’s requirements and a clear treatment plan. They included the resources that they often adapted to their patients’ needs and added the types of cognitions and interweaves through the next phases. They were all asked to include pertinent research that is relevant for their work.

After the Preface, there is a short commentary by Marco Pagani and Livia Sani on “Neurobiological Foundations of EMDR Therapy.” Pagani holds posts at the Institute of Cognitive Sciences and Technologies in Rome and the Department of Nuclear Medicine in Karolinska Hospital in Stockholm. Sani is his trainee from the institute. They discuss how traumatic events affect us and how neuroimaging techniques such as positron emission tomography, single photon emission tomography, electroencephalography, and functional and structural magnetic resonance imaging have helped us to identify what is happening concerning the pathophysiology of PTSD and how EMDR therapy affects it.

In Part I, the focus is on “Treating Eating and Body Image Dysregulation With EMDR Therapy.” This section begins with Renée Beer’s work “Protocol for EMDR Therapy in the Treatment of Eating Disorders.” Beer is an EMDR Europe–accredited trainer for EMDR with Children and Adolescents from the Netherlands. Recently, she and Beer and de Roos (2017) edited the *Handbook of EMDR With Children and Youth*. She specialized in the treatment of eating disorders at the Department of Child Psychiatry of the University Medical Center in Utrecht from 2000 to 2005 and brings her updated Dutch perspective to treating patients with eating disorders. Maria Zaccagnino represents her Italian perspective in her chapter, “EMDR Therapy Protocol for the Management of Dysfunctional Eating Behaviors in Anorexia Nervosa.” Zaccagnino is a co-director with Isabel Fernandez of the Center of EMDR Therapy for Eating Disorders in Milan, where she coordinates research as well. Natalia Seijo contributes two chapters to this section: “EMDR Therapy Protocol for Eating Disorders” and “The Rejected Self EMDR Therapy Protocol for Body Image Distortion.” Seijo brings a Spanish viewpoint to the treatment of eating disorders. She developed her expertise in one of the most influential eating disorders units in Spain, and she is involved in teaching and clinical work in a number of different places nationally and internationally.
There is one chapter in the section on “Transforming Relationship Distortion With EMDR Therapy.” Dolores Mosquera and Jim Knipe integrate their expertise to write about “EMDR Therapy and Physical Violence Injury: ‘Best Moments’ Protocol.” Mosquera has a wide range of interests, and among them she collaborates with the Women Victims and Domestic Violence Program and the Males and Violent Behavior Program. Knipe has been presenting on dysfunctional positive affect for many years and has written about this extensively.

The third section addresses “Shifting Chronic Pain Experiences Using EMDR Therapy.” Chronic pain is ubiquitous, and these chapters contribute to provide us with some answers to use with our patients. “EMDR Therapy and Chronic Pain Conditions” features work by Tesarz, Seidler, and Eich. These three medical doctors are connected to the Medical University of Heidelberg. Each of these men has dedicated himself to research and clinical work on chronic pain and has been recognized by his peers. They write about three different protocols to use with chronic pain. The second chapter is “EMDR Therapy Treatment for Migraine” by Emre Konuk, Hejan Epözdemir, Zeynep Zat, Sirin Hacıomeroğlu Atceken, and Asena Yurtsever. This team from Davranış Bilimleri Enstitüsü (DBE; Institute for Behavioral Studies) has focused their interest on headaches over a number of years. “Fibromyalgia Syndrome Treatment With EMDR Therapy” is the eighth chapter, written by Konuk, Zat, and Kavakçı. Emre Konuk brings his wealth of experience as a pioneer in Turkey who established psychotherapy as a profession by founding DBE. Zeynep Zat is an active member of the Research, Clinical Applications, and Protocol Committees for EMDR-Turkey, and Onder Kavakçı is an associate professor at the Medical School of Cumhuriyet University and involved with research and publishing for EMDR-Turkey.

The last section is focused on “Treating Maladaptive Self-Care Behaviors Using EMDR Therapy” and features two important chapters devoted to teaching patients better self-care behaviors. Carol Forgash’s chapter on “The Impact of Complex PTSD and Attachment Issues on Personal Health: An EMDR Therapy Approach” is an important subject for all therapists dealing with patients suffering with dissociative disorders and complex PTSD. She has been writing and presenting on the subject and has been particularly devoted to helping abuse survivors deal with their complex health issues. Dolores Mosquera, Paula Baldomir Gago, Ana Cris Eiriz, and Raquel Fernández Domínguez write about the “EMDR Therapy Self-Care Protocol.” They work at the Institute for the Study of Trauma and Personality Disorders (INTRA-TP). Together, they have developed seven self-care protocols: understanding self-care, learning how to take care of ourselves, preventing relapse, developing resources, learning about and managing self-harm and self-destructive behaviors, developing and installing positive alternative behaviors, and working with the inner child.

Each chapter is accompanied by summary sheets that serve as checklists and memory support to highlight the distinctive parts in each of these protocols.

There are updated versions of Appendix A’s Worksheets for the Past Memory Worksheet Script, the Present Trigger Worksheet Script, and the Future Template Worksheet. These were updated to include material from Shapiro’s updated text, *Eye Movement Desensitization and Reprocessing—Basic Principles, Protocols, and Procedures*, third edition (2018). To ensure fidelity to the model, the past, present, and future worksheets in Appendix A show the important elements of the Standard EMDR Protocol. These worksheets can be copied and put into patients’ charts. In Appendix B, there are updated versions of Luber “EMDR Summary Sheet” (2009a, 2009b, 20016b) and the EMDR Session Form (2016a, 2016b) as a way to summarize and quickly see important patient information. In Appendix C, there is a list of EMDR Worldwide Regional Associations who support EMDR therapy standards around the world and their contact information.

Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Eating Disorders, Chronic Pain, and Maladaptive Self-Care Behaviors is accessible in print and electronic formats. This book follows the structure of the previous six books in this series. Experts in their fields show how they work with their patients with EMDR therapy. Again, this book is not a comprehensive look at eating disorders and body dysregulation, physical violence injury, chronic pain conditions, and maladaptive self-care behaviors. However, the goal is to assist us to use what we have observed and gathered data on to enrich our effectiveness as EMDR therapy practitioners.

**REFERENCES**


Neurobiological Foundations of EMDR Therapy

Marco Pagani and Livia Sani

Traumatic events damage the mental and emotional processes and affect brain physiology. According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013), people with posttraumatic stress disorder (PTSD) may present with the following:

- Negative alterations in cognitions and mood
- Symptoms of irritability and outbursts of anger
- Reexperiencing of the traumatic event
- Self-destructive behavior
- Hypervigilance
- Alarm response exaggerated
- Trouble concentrating
- Trouble falling asleep or staying awake

In recent years, many researchers have focused on trauma and its symptoms, obtaining important results concerning the understanding of traumatic memory and how it affects the brain and human behavior.

Through neuroimaging techniques such as positron emission tomography, single photon emission tomography, electroencephalography (EEG), and functional and structural magnetic resonance imaging, it has been possible to identify the brain circuits involved in the pathophysiology of PTSD. Changes in metabolism, brain morphology, and networking have been found in the amygdala, the medial prefrontal cortex (mPFC), and the hippocampus (Martin, Ressler, Binder, & Nemeroff, 2009; Shin, Rauch, & Pitman, 2006; Wager, Lindquist, & Kaplan, 2007; Yehuda & LeDoux, 2007), which together form the so-called neural model of PTSD (Shin et al., 2006).

These are the types of changes that occur in the different areas of the brain in PTSD patients:

- **Amygdala**: At the amygdala level, psychological traumas give rise to excessive arousal, resulting in a reaction of exaggerated alarm in response to external stimuli (Herry et al., 2007; Sander, Grafman, & Zalla, 2003).
- **Dorsolateral frontal cortex (DLFC)**: In PTSD, DLFC does not exert its inhibitory effect on the amygdala, resulting in hyper-activation of the latter following traumatic stimuli.
- **Medial prefrontal cortex (mPFC)**: The increased responsiveness of the amygdala interferes with the functioning of the mPFC regions, which include the rostral anterior cingulate cortex, the ventral medial frontal gyrus, and the orbitofrontal cortex (Etkin & Wager, 2007). This region is pivotal in executive functions and in mediating the transfer of traumatic memories from subcortical structures.
- **Hippocampus**: A reduction in the volume of the hippocampus has been repeatedly found in PTSD patients. In patients, this would cause a functional inhibition of the ability to cognitively evaluate their experiences, resulting in explicit memory disorders and unelaborated memories (Liberzon & Sripada, 2008).
• **Limbic and paralimbic cortical regions**: Differences in the density of gray matter were also recorded in the limbic and paralimbic cortical regions (Bremner et al., 1997; Chen et al., 2006), eliciting emotional distress and parasympathetic symptoms.

• **Broca’s area**: Broca’s area is partially disabled, and this could explain the difficulty that patients with PTSD have in describing, verbalizing, and cognitively restructuring their traumatic experience (Hull, 2002).

A few functional studies on traumatized patients have disclosed the impact of various psychotherapies, such as cognitive behavioral therapy (CBT), brief eclectic therapy, and mindfulness, on the neurobiology of PTSD as investigated before and after therapy. In this respect, research on the efficacy of EMDR therapy in psychological trauma has identified that postintervention, there is a significant normalization of blood flow, mainly in the limbic and in the frontal cortex areas, thus determining a higher control over the amygdala. In turn, this normalization decreases the pathological cortical hyper-activation, resulting in the disappearance of PTSD symptoms, including a reduction in anxiety, somatosensory symptoms, flashbacks, intrusive memories, and the feeling of reliving the trauma with persistent sensations even at somatic level (Lansing, Amen, Hanks, & Rudy, 2005; Oh & Choi, 2007; Pagani et al., 2007).

In a study where traumatized subjects suffering with PTSD were compared to traumatized subjects not developing PTSD, Nardo et al. (2010) found a decrease in gray matter density in several limbic regions, such as the posterior cingulate, para-hippocampal, and insular cortex in those subjects with PTSD. These regions are implicated in processes such as integration, encoding, and retrieval of autobiographical and episodic memories, self-referential conscious experience, emotional processing (i.e., classical conditioning, cognitive appraisal, experience of feeling states), and interoceptive awareness (Pagani, Högborg, Fernandez, & Siracusano, 2013), and are the typical target regions of EMDR therapy. The same investigation highlighted that the subjects not responding to EMDR therapy showed significantly lower neuronal density in the same areas, suggesting that the therapeutic failure might be due to a previous atrophic state not allowing for any neurobiological effect of EMDR therapy.

Most recently, EEG investigations, performed during the bilateral stimulation phase of EMDR sessions, have deepened the knowledge about the neurobiological processes occurring during the therapy. The comparison between the prevalent cortical activation during the first and last EMDR therapy sessions showed a significant deactivation of the orbitofrontal and subcortical limbic structures and an increased activation of the temporo-occipital cortex, mainly on the left side (see Figure 1).

**Table 1.** Prevalent cortical activation comparing first and last EMDR therapy sessions.

<table>
<thead>
<tr>
<th>Before First EMDR Therapy Session</th>
<th>After Last EMDR Therapy Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activation of the orbitofrontal structures</td>
<td>Deactivation of the orbitofrontal structures</td>
</tr>
<tr>
<td>Activation of the subcortical limbic structures</td>
<td>Deactivation of the subcortical limbic structures</td>
</tr>
<tr>
<td>Normal activity of temporo-occipital cortex</td>
<td>Increased activation of temporo-occipital cortex</td>
</tr>
</tbody>
</table>

**Figure 1.** Prevalent cortical activation comparing first and last EMDR therapy sessions.

As a result, traumatic experiences and memories move from an implicit subcortical state to an explicit cortical state and are properly processed, reeleraborted, and adapted into patients’ semantic memory (Pagani et al., 2011, 2012, 2015; Trentini et al., 2015).

The following are some of the models to explain the mechanisms of action used to elucidate EMDR therapy:

- **Psychological** (e.g., orienting and working memory account)
- **Psychophysiological** (e.g., REM sleep model)
- **Neurobiological** (e.g., changes in inter-hemispheric connectivity, neural integration and thalamic binding model, structural and functional brain changes associated with EMDR therapy)

The neurobiological model provides solid foundations in how to unravel the functional and structural correlates of effective treatments. Taking also into account the rapid eye movement (REM) sleep model, a further possible mechanism has been hypothesized (Carletto, Borsato, & Pagani, 2017; Pagani, Amann, Landin-Romero, & Carletto, 2017). During bilateral stimulation in EMDR therapy, the cortical activity as recorded by EEG resembles that of slow wave sleep (SWS), in which fragmented episodic and traumatic memories move from the amygdalar–hippocampus complex to the neocortex, in which they will be further integrated and encoded during REM sleep. Since during EMDR therapy the frequency of bilateral stimulation matches that of SWS (0.5–4 cycles per second, delta waves), the repetition of such stimulation during several sessions might be its “added value,” mimicking the natural physiological memory processes and favoring the traumatic traces to be contextualized in the neocortex. This would make EMDR faster and more effective in treating PTSD than other psychotherapies.

In conclusion, all changes found in EMDR therapy research confirm at various levels a solid neurobiological basis for the psychotherapy, resulting in improved symptoms and quality of life in patients with a PTSD diagnosis.

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The idea for the EMDR Scripted Protocols series originally grew out of supervisory/consultant trainings that I was doing for EMDR practitioners in Germany and Israel in the late 1990s. At the time, clinicians at that level did not have a firm grasp of the EMDR protocols and procedures, so, after consulting with Arne Hofmann, I created a manual that incorporated Shapiro’s six basic protocols from her text (Shapiro, 1995) and others that I thought would be helpful. In 2007, Bob Gelbach, the director of the EMDR HAP (now Trauma Aid) at that time, and I were at the EMDR International Association’s annual conference in Dallas, Texas, and we were talking about doing something with the manual I had put together for HAP. He suggested that I go speak to the representative at the Springer Publishing booth. With some prodding, I went over and spoke to Sheri Sussman. She took a copy of my manual from my thumb drive on the spot and 5 days later offered me a contract. I was very surprised and excited and asked my very talented colleagues if they were interested in contributing to this project, and they did. Their additions became *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations* (2009a) and *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations* (2009b), which basically followed the structure of Shapiro’s 1995 text. I found interacting with my colleagues exhilarating as we worked together to put their chapters into the scripted protocol format to help fellow clinicians learn EMDR therapy.

I found the work so compelling that I started to formulate a book that would address major issues in the psychotherapeutic world: anxiety, depression, and medical-related issues. However, before I got too far with this idea, I felt that it would be more important to address the increase in man-made and natural disasters that were occurring worldwide in 2011, such as the Tohoku earthquake and tsunami in Japan; the East African drought; Tropical Storm Washi in the Philippines; the April 27th tornado in the U.S. southeast; the Joplin, Missouri, tornado; and many wildfires, snowstorms, and wind storms. I discussed the idea with my colleagues who were actively involved in responding to many of these disasters—such as Elan Shapiro, Brurit Laub, Nacho Jarero, Sushma Mehrotra, Derek Farrell (director of HAP Europe), and Carol Martin (director of EMDR HAP/Trauma Aid)—using the work that they had crafted or the organizations with which they responded. *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols and Summary Sheets* (2014) was born.

I had already begun the book mentioned earlier on anxiety, depression, and medical issues before I started *Implementing*, so when it was done I was ready to move forward with this project that I had been thinking about for a while. The one book became four books because of the wealth of material I had collected from EMDR experts in these areas. Two were published in 2016: *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma- and Stressor-Related Conditions* (Luber, 2016a) and *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Obsessive-Compulsive, and Mood-Related Conditions* (Luber, 2016b).

Recently, the medical-related book turned into *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Somatic and Medical-Related Conditions*, and into this volume, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Eating Disorders, Chronic Pain, and Maladaptive Self-Care Behaviors*.

The EMDR Scripted Protocol books are now a series of seven volumes with 143 chapters (11 are updated chapters), 145 authors coming from 15 different countries (Australia, Brazil, Canada, Germany, Greece, India, Israel, Italy, Lebanon, Mexico, The Netherlands, Spain, Turkey, the United Kingdom and Scotland, and the United States).

I would like to thank all of my contributors to this book. It is through the joint efforts of all 18 of them that *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Eating Disorders, Chronic Pain, and Maladaptive Self-Care Behaviors* are now available.
Summary Sheets: Treating Eating Disorders, Chronic Pain, and Maladaptive Self-Care Behaviors (Luber, 2019) is in your hands. I want them to know how much I appreciated their patience as different personal issues and another book got in the way of the timely publishing of this volume. The authors are my colleagues and, for this volume, they come from Germany, Italy, the Netherlands, Spain, Turkey, and the United States. It has been an honor and a privilege to work with them and to learn from their expertise and passion for their work. I have grown more sensitive in so many ways from working on these chapters and rediscovered working with the body as a focus of attention. I hope that the clinicians who read and use this book will be inspired to think of their patients within the context and structure of EMDR therapy.

I am indebted to Springer Publishing for the support and the faith they have put in me, and the work of experts in the field of EMDR therapy, in these sixth and seventh books in the EMDR Scripted Protocols series. The past year was the first time I visited the physical space of Springer Publishing in the Salmon Tower Building in New York City across the street from Bryant Park. It was a great treat to meet professionals such as Mindy Chen and Joanne Jay, with whom I had only shared emails over the past 11 years. I cannot thank Sheri Sussman enough for the amount of encouragement, work, and patience she has demonstrated over these past years. She has been dedicated to this series and has always supported me through difficulties with deadlines and the wealth of great material!

Whenever you write seriously, especially when it is not your regular job, it is hard to do it without friends and colleagues who are supportive and caring. Thank you Elaine Alvarez, Renee Beer, Michael Broder, Valentina Chiorino, Herb Diamond, Robbie Dunton, Elisa Faretta, Isabel Fernandez, Catherine Fine, Carol Forgash, Irene Geissl, Richard Goldberg, Arlene Goldman, Barbara Grinnell, Barbara Hensley, Phyllis Klaus, Brurit Laub, Tali Perlman, Zona Scheiner, Bonnie Simon, Cynthia Thompson, Howard Wainer, Stuart Wolfe, and Bennet Wolper.

I would like to thank Andrew Leeds for faithfully writing about EMDR-related research in the EMDR International Association’s newsletter over many years.

I would like to mention my appreciation to Barbara J. Hensley. Through her focus and tenacity, she built the Francine Shapiro Library—a gift to all of us who are interested in EMDR therapy.

Thank you to Francine Shapiro for always upholding the standard of EMDR and her gift of EMDR therapy to me personally and the world in general.

I would like to acknowledge the death of my friend and mentor Donald Nathanson. After a long illness, he left us. The world is a lot dimmer without his wit and his enormous intelligence.

My appreciation as always goes to the people involved in my daily life and how they help me in so many ways, allowing me to work as a clinician, an editor, and an author. They are Harry Cook, Jorge Alicea, Dennis Wright, and Rose Turner. Without Lew Rossi, my chosen way of writing would not happen. Thank you for keeping my computers up-to-date and always going out of your way—even at inconvenient times—to assist me in the latest catastrophe.

The pets in our lives are our hearts. My dear Emmy, who kept me company during the writing of all my previous books, left us 2 years ago, but she remains with us in spirit. We have a new 1-year-old schnauzer, Henry, who has sometimes made writing a challenge, but he is always a joy and ready to play when I take a break.

Thank you to my mother, Shirley Luber, who continues to give me support, friendship, and love even as she goes through the trial of her own chronic disease.

This book I am dedicating to Bob Raymar. Bob came back into my life after we originally met on July 4, 1968, at the Fourth of July Celebration in Geneva, Switzerland, where I was living and Bob was at an internship for the summer. We got to know each other there and when I returned to attend college in the United States later that year. Then, we lost touch for 45 years. About 4 years ago, LinkedIn reached out and we reconnected. In January 2018, Bob asked me to marry him when we were at the extraordinary Mamounia Hotel in Marrakech, where his parents were married. I said yes.

Since we reconnected, Bob, you have been my friend, my confidante, and my love. Throughout the writing of these last four volumes, you have been there every step of the way supporting me as a second reader and catching my missed commas, helping me pick the right phrase, and being a sounding board to help me think through all of the difficult issues that come up while writing a book. You have also been gracious about the missed concerts, movies, family and friend get-togethers, and taking care of Henry. You are a kind, wise, and knowledgeable man who has enriched my life in so many ways. This book is in honor of you, Bob.
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Eye Movement Desensitization and Reprocessing EMDR Therapy Scripted Protocols and Summary Sheets: Treating Eating Disorders, Chronic Pain, and Maladaptive Self-Care Behaviors
INTRODUCTION

Everything we have been told about who we are is connected to our physical appearance. Body image refers to the image we have created in our minds regarding our own body, that is to say, the way in which we see ourselves (Schilder, 1935). The lives of people with eating disorders (EDs) end up revolving around the meaning that lies behind this image.

The person’s dissatisfaction is the result of a discrepancy between the perceived self and the ideal self (i.e., who the person would like to become). However, concern over the perception of the body begins when a rejected self is generated. This rejected self is the image of the self from the past that the person rejected, to which she compares herself and does not want to return ever again. When this point is reached, we start talking about body image distortion.

The author has observed that there are other defenses that are helpful with which to work other than the classical ones such as denial, regression, acting out, dissociation, compartmentalization, projection, reaction formation, repression, displacement, intellectualization, rationalization, undoing, sublimation, compensation, and assertiveness. Defenses can also be “the experiences from inside that block the therapeutic process at an emotional or cognitive level” (Seijo, 2015b). These are defenses because they do not allow the client to work in therapy. It is in this way that emotions can be seen as defenses.

The application of the rejected self protocol for body image distortion in EDs (Seijo, 2016) is quite straightforward. The protocol involves neutralizing the three main emotional defenses of rejection, shame, and worry and the body image distortion defense (also of a dissociative nature) that are blocking full awareness of the body and lie between the actual body image and the rejected self. This body image distortion is one of the most resistant defenses in treating clients with EDs. Through the application of this protocol in the treatment of EDs with EMDR therapy, the client learns to identify and process the part of the inner world that represents the rejected self. By doing this, two of the primary goals in regard to the actual body are achieved: first, developing awareness, and second, reaching the point of acceptance.

DIAGNOSES

The concept of body image implies a continuum. Depending on the degree of rejection toward the body, the person may shift from simply having a realistic self-image to having a negative self-image.

This is the continuum of body image:

Realistic body image >>>> Negative body image >>>> Body image disorder >>>> Body dysmorphic disorder

The following are the definitions of these concepts:

- **Body image** (Schilder, 1935): The image we create in our minds regardless of our bodies
- **Negative body image** (Bell & Rushforth, 2008): The dissatisfaction regarding the body or parts of it
Body image distortion (Thompson, 1990): A persistent state of dissatisfaction and worry related to some aspect of physical appearance that can lead to obsession.

Body dysmorphic disorder (BDD), DSM-5: A mental disorder characterized by an obsessive preoccupation that some aspect of one’s own appearance is severely flawed and warrants exceptional measures to hide or fix it. In BDD’s delusional variant, the flaw is imagined.

MEASURES

We know that clients have a distorted body image when their real image does not match the description of their self-image. There are different degrees of body image distortion, which will be described later. Using clinical judgment during history gathering, assess how far this described self-image is from reality and how often this has happened in the past.

Some questionnaires assess body image distortion, such as the body shape questionnaire, which measures:

- Alterations in proportions regarding body image and concept
- Alterations in perceptual accuracy
- Paralyzing feeling of ineffectiveness

It includes 34 items and is scored on a Likert scale from 1 to 6. The items are divided into four subscales:

- Body dissatisfaction
- Fear of gaining weight
- Low self-esteem due to appearance
- Desire to lose weight

THE REJECTED SELF EMDR THERAPY PROTOCOL FOR BODY IMAGE DISTORTION SCRIPT NOTES

Phase 1: History Taking and Case Conceptualization

History of Body Image Distortion

The body image distortion phenomenon is based on day-to-day life experiences. It is as if the representation of the body from the past remains static, impermeable to the effect of the passage of time and bodily experiences; it is as if there was a distorted cognitive filter that does not allow the person to see how he or she truly is.

In order to assess body image, how the person perceives the shape of his or her body (i.e., the image that has been created in his or her mind) must be taken into account. Thus, it is important to check how the person evaluates his or her body size and to gather information regarding the emotional aspects involved, such as the attitudes toward this self-image. This is the aspect we normally focus on when we speak of negative body image, also using the terms dissatisfaction or rejection of the body.

In order to gather information regarding body dissatisfaction, ask questions that will provide all the necessary data about how body dissatisfaction has developed and how it might have derived into body image distortion or BDD, if that is the case. Among other issues, at this stage inquire about the following:

- Information on how the body image was experienced in the family of origin
- Information on how parents related to their own bodies, which may have developed into implicit procedural learning
- Comments that the client may have received at home about his or her body
- Whether the client was compared to other people in relation to his or her body
- Through whose eyes the client may have learned to look at himself or herself (often, we see ourselves as other people saw us or as who we were told we were)
Identification and History of the Rejected Self

After exploring body dissatisfaction, move on to gathering the history about the rejected self. In order to do this, the first thing will be to define this concept. One way of doing it is using simple words that can automatically connect the clients with that part, which tends to appear rapidly. They are told to try and identify their rejected self, the part that they reject, the part of themselves they would never want to be again, and the part with whom they currently compare themselves. It is the part that the person is ashamed of. In order to begin working on this protocol, the clinician must know that processing the rejected self reaches directly into the most profound layers of trauma, be it of traumatic or attachment origins.

In the Body Image Distortion Protocol, two types of images can represent the rejected self:

- **Past body image distortion**: The rejected self part is like an image imprinted on the brain through which the current body image is seen, generating a great deal of distortion. Most of the time, the person sees that image of the past instead of seeing the present image of the true body. Hence, in disorders such as anorexia nervosa, when a woman looks in the mirror, she sees the parts of the body she rejects, and sometimes, it does not correspond to the actual image.

- **Present body image distortion**: It may be that when asked for the image of the rejected self, the image clients get is the image of the present and not of the past. When this occurs (e.g., after a pregnancy in which the person has great weight gain and becomes overweight, obesity provoked by a complication of an organic or psychological kind, or a car accident in which the body can find itself affected at the level of physical appearance), work will be done with the rejected self of the present in the same way as with the rejected self from the past.

The common difference between the image from the rejected self from the past and the rejected self of the present is that in the former, the work tends to be associated with attachment traumas. On the contrary, the latter tends to be associated with a traumatic event. Although in these cases we can find both types of trauma, it will be interesting to differentiate them in order to guide ourselves when conceptualizing and establishing a clear treatment plan.

In the phenomenon of body image distortion, daily experience does not change the person’s idea about his or her body. The representation of the body from the past remains static—unaffected by the passage of time and bodily experiences—as the image of that “rejected self” from the past to which the person does not want to return ever again. The body image distortion goes along with a distorted cognitive filter, which may be seen in examples such as, “When I look at myself in the mirror, I don’t see my lips as full as I would like them to be; so that’s when I cut them so they swell up and I can have them as I wish them to be” or “I sleep each night wrapped up in plastic, so I can sweat and get rid of my abdominal fat; I won’t stop until my hipbones are prominent.”

The “rejected self” and the body image distortion manifest when the strongly rejected image from the past stands between the image he or she sees in the mirror and his or her current real image. Not wanting to be that person again generates intense concern. The mental representation of the “rejected self” could be, for example, her “15-year-old self” with the same flaws that he or she had at the time.

Toward this part of herself, the person feels rejection, shame, or concern. These emotions are the emotional defenses that maintain dissociation. Since she sees herself through the lens of this rejected self from the past, she is unable to see her body image objectively when the person looks in the mirror and does not see the reflection in the mirror; instead, she sees the body of the past, from when she was a teenager, that is not real and will never be real again.

When a client was asked about her rejected self, she described her 16-year-old self, with fat legs, flabby belly, and a big butt, even though she was in treatment for anorexia nervosa and her weight was 38 kilograms (183 pounds). She continues to feel ashamed and concerned, because she still sees her fat legs and flabby belly, just like that rejected image from the past, even though she is now 20 years old and nothing of what she sees in her body is real anymore. Due to her image distortion, what she sees in the mirror is the dissociated image from her rejected self of the past.

The appropriate time to start working with the rejected self is when the person is stabilized, when general defenses have been neutralized, and when judgments and critical comments from inside have been channeled and turned into more healthy and constructive comments. Once this step has been taken, frame the work with the rejected self and the body image distortion and follow the steps of the protocol that are described in the following sections.
Phase 2: Preparation

Resources

The resource work helps clients to connect better with the rejected self’s vulnerability and to provide strength and empowerment. The results are that clients increase their sense of internal security, trust more in the process, and are assisted in neutralizing their defenses.

It is important for clients to have previously worked on the necessary resources. In this way, the client will be prepared to face difficult situations that may arise from this work.

Ironically, the most appropriate resources for this phase will be those based on exceptions in clients’ lives, the situations that clients barely recognize and often need a great deal of help to recover from.

The clinician may ask questions about the following experiences:

- Positive comments/affect: Situations or moments—however brief—in the clients’ history where they were able to see themselves without their habitual critical gaze. If they cannot find any exceptions, ask for times when others said something positive about their physique at any time throughout their lives. Aside from comments about the body, the exceptions can extend to positive affect about physical, cognitive, or emotional qualities that they can appreciate about themselves.
- Loving eyes: Resources related to the person who looked at the client with loving eyes without paying attention to his or her physical appearance
- Ideal figure: Resources that refer to an ideal figure that makes the client feel that it is okay to be just the way he or she is

In some cases, these qualities will probably compensate for shortcomings clients believe they have and will help us as clinicians. By working on them as resources, they give a solid and supportive foundation to neutralize and process the part of the rejected self.

Psychoeducation and Self-Care

Psychoeducation is offered in order to help the client create an internal locus of control and sense of self. This is done by promoting healthy and appropriate self-care through healthy eating and drinking habits, hygiene, sleeping habits, medical checkups, appropriate hydration, and so on.

These concepts must be recovered and developed once the rejected self is neutralized and integrated.

- Self-concept: The image each person has of his or her self, as well as the ability to self-recognize. Self-concept includes the evaluation of all parameters relevant to the person: from physical appearance to skills. Self-concept is not innate; it develops with experience and the image projected and perceived by others. It is dynamic, which means that it can be modified by new data.
- Self-esteem: Set of perceptions, thoughts, feelings, and behaviors directed toward ourselves, toward our way of being and behaving, toward the features of our bodies and our character. Ultimately, it is how we assess ourselves. The importance of self-esteem lies in that it affects our worth and our way of being. Respect becomes a fundamental construct because self-esteem is related to how we have been respected and how we learn to respect ourselves.

It is important to know that when working with the rejected self, the mother figure is the main issue that emerges as part of the processing. It is the reference figure, probably because it is the physical model from which to learn and model the self. When we work with the rejected self, we also process and repair the relationship with the attachment figure of the mother (Seijo, 2012).

Psychoeducation on the Three Defenses: Rejection, Shame, and Worry

Defenses are the mechanisms through which the internal system protects itself so the person can be “functional.”

The body, or a part of the body, is often not felt as one’s own; it feels strange. It is important to highlight dissociation as one of the defenses that tends to appear in body image distortion through the rejected self. It is usually a dissociative experience of the psychoform type (i.e., mental in nature), through which the clients perceive their bodies in unrealistic proportions.
During our work with body image distortion, the defenses to be processed first are the emotional ones described later in text, since they are the main ones that block the processing and acceptance of the rejected part.

- **Rejection**: Nonacceptance, confrontation, or opposition. It is the internal experience that causes avoidance toward the part.
- **Shame**: Not to show oneself in order to conceal that which is perceived as negative. This defense helps enable the avoidance of implicit memories associated with the rejected self.
- **Worry**: Protects from going back to being what was. It is an internal process that maintains the distortion, thus maintaining the nonacceptance and blocking the emotions and beliefs that may come up. The person feels worry that he or she could become the rejected self again.

**Psychoeducation on EMDR**

The Rejected Self Protocol, like the Standard EMDR Protocol, is based on the Three-Pronged Protocol: past, present, and future. The EMDR Three-Pronged Protocol is used to reprocess past adverse/traumatic experiences, work with present triggers, and address future concerns in order to bring the client to the highest level of adaptive response.

The Standard Three-Pronged Protocol developed by Francine Shapiro (1995, 2001, 2018) recommends that all traumatic incidents be sequentially reprocessed from the earliest to the present. The author has made some modifications to the Standard EMDR Protocol to better address the work with this dissociative part.

Bear in mind that despite working with the image of the past and the present, both of them will take us first to the past. Processing the traumas associated with the distortion will result in the neutralization of the imprinted image of the rejected self and will help attain a realistic body image in the future. Thus, self-concept and self-esteem are restructured at the same time and acceptance of the real body is achieved.

People with body image disorders usually present a rich constellation of attachment and trauma events throughout their lives associated with their bodies. Therefore, it is often necessary to start the therapeutic treatment from the perspective of working with defenses. When speaking of defenses, we are referring to blockage points that prevent the natural flow of the EMDR processing. Defense work begins in Phase 2 through psychoeducation, helping the person understand the process.

Defenses in EDs are one of the key points to insist upon, since they can be the cause of therapeutic failure and/or possible dropout from treatment.

In order to graphically explain how defenses are distributed in the inner world of these clients, use the “artichoke metaphor” (Seijo, 2015b). Each layer contains the part and the defenses whose function is to protect it when something is being triggered inside. The leaf, in turn, covers another leaf and all of them form a structure that protects the core, where the most vulnerable part resides. The metaphor describes the therapeutic development as a spiral moving from the outside in, from the outermost layers inward, to finally reach the heart of the “artichoke,” where the pain of the wounded child remains. The process is similar to “weaving.” The final result is the integration of the inner world and the normalization of body image.

This metaphor helps clients understand that when the rejected self is activated, defenses are triggered. When these defenses are neutralized, they allow access to the trauma, which is then reprocessed with the Standard EMDR Protocol. The clinician’s understanding of this structure will help the work that will later be developed in detail during the protocol.

In summary, the process would be described as follows:

A layer is accessed. >>> The rejected self is activated. >>> The defense appears. >>> Work on the defense with the Rejected Self Protocol for body image distortion. >>> The defense is neutralized. >>> Access to trauma. >>> Standard processing with EMDR.

**Phase 3: Assessment**

*Using the “Rejected Self” as an Established Treatment Plan Target*

The rejected self is a dissociative part, and the body image distortion is the defense used by the rejected self. By processing the rejected self directly, it is possible to process both at the same time. After the rejected self and body image distortion—which is the person’s dissociation from his or her own
body in an attempt to avoid what the body is and what it conveys, feels, or expresses (Seijo, 2016)—
have been identified, confirm the rejected self image.

Figure 4.1 describes how the rejected self and the body image distortion are organized in the inner
system. The far left end of the diagram shows the true/real image of the client, who looks at his or
her body in the mirror through the rejected self and, at the same time, is influenced by the ideal self
the client has. When the client sees himself or herself in the mirror, what the client sees is the rejected
self (the part that is rejected from the past). The client does not see the real body; what the client sees
is the rejected self. This perception of the rejected self is influenced by the discrepancy between the
real image of the self and the ideal self. The whole time the client is comparing the real body with the
ideal body, because the real body is not the body the client wants. As a result of the comparison of
the rejected self with the ideal self-image, a discrepancy between both images arises, the perceived one
and the ideal one described in Figure 4.2. The rejected self image has the effect of reflecting back a
distorted image of the body. This distortion is strongly influenced by the idea of an ideal self to which
people constantly compare themselves in a negative way.

By applying this protocol, clients integrate the rejected self into the accepted self and become free
to finally see the actual image of their own body that can be seen without distortion.

Figure 4.2 illustrates how body dissatisfaction appears when there is a discrepancy between the
perceived self and the ideal self the person would like to be (Seijo, 2016). For example, it happens
when clients look at themselves in the mirror and there is a discrepancy (i.e., an illogical or surpris-
ing lack of compatibility or similarity) between the perceived self (the body that clients see) and the
ideal self (the unrealistic self concerning size and weight). As a result, body dissatisfaction can occur.

![Figure 4.1 The rejected self image.](image1)

![Figure 4.2 Body dissatisfaction.](image2)
Phase 4: Desensitization

Reprocessing Specific Features

When reprocessing begins, the target of the rejected self identified in Phase 2, clients will make associations to traumatic and adverse life experiences throughout their lives. The memories of these traumas are maintaining the dissociation of the rejected self in the inner world, and this protocol becomes a great way to identify them.

Use the Standard EMDR Protocol when the traumas that appear during reprocessing block and interrupt the flow of the Rejected Self Protocol. Then, reprocess these targets independently with the Standard EMDR Protocol and later continue with the Rejected Self Protocol to check if the image distortion continues and to assess if the rejected self seems more integrated and the processing is flowing again on its own. It is possible that even more processing of memories is needed because this protocol can open the window to adverse life experience related to this rejected part and the body. Sometimes, it will not always be necessary to work with the Standard EMDR Protocol, and the Rejected Self Protocol will be all that is needed to help integrate the rejected self.

Usually, after the defenses and the traumatic and adverse life experiences have been successfully reprocessed, clients will no longer feel rejection, shame, or worry. Instead, they will feel sorrow for the part of themselves they once rejected. This is a way to know that processing is taking place. Little by little, the defenses start weakening, making room for the other emotions that were always underneath.

When asking clients to connect with the rejected self, they often feel rejection, shame, and worry toward that past self. However, in certain disorders such as EDs—in which the person is overweight, for example—the rejected self may be the self of the present. In these cases, it is important to work in the present in order to get to the past.

Information to Consider During This Phase

It is common for the information that starts to come up to be related to the maternal figure. Maternal representations play a fundamental role in the construction of body image. The maternal attachment figure fulfills the functions of validation and acceptance of the self, which are the foundation of the construct of the self. Without recognition and validation, especially from the maternal figure, the concept of the self is built upon a base of insecurity and will seek external confirmation in order to be internally validated.

Criteria for target selection will follow the standard clustering method, which includes the first, worst, and most recent memories related to the present symptom with which the therapist and client work. In the case of multiple targets, choose those related to the symptoms that keep the rejected self dissociated in the inner world and facilitate the distortion of body image.

Just as is done in the Standard EMDR Protocol, in which we return to the original memory, in this protocol, go back to the image representing the rejected self and ask about the defenses. As the rejected self is processed, the adverse experiences that maintain the dissociation of this part are reprocessed and desensitized. Once the part becomes integrated, the distortion of the body image is neutralized and the client is then able to begin to see himself or herself in a more realistic way. In the next phase, install the new image of the client that begins to develop from that moment.

Phase 5: Installation

Strengthening Reprocessing With Knipe’s “Loving Eyes” Protocol

During this phase, once defenses have been neutralized and the client has processed the sorrow for the part of the rejected self, apply Jim Knipe’s Loving Eyes Protocol (Knipe, 2015) in order to promote increased acceptance of this part and enhance integration. It must be very clearly conveyed that the client and the part are the same person. Once this point in the protocol has been reached, the client has gone through an important transformation and is on the way to integration.

Phase 6: Body Scan

The body scan is performed exactly as in the Standard EMDR Protocol. The only difference is that, as it has been done throughout this protocol, the client returns to the image of the rejected self and pays attention to whether there is discomfort in any part of the body. The goal is to do reprocessing until the client feels fine with it and the SUD equals zero.
Phase 7: Closure

Ask the client if it is okay to leave it like this or if there is anything else he or she feels the part needs to hear or the client has to do. If all is well, close the session by instructing the client to write down what comes up in the days ahead and that the work will continue next session.

Phase 8: Reevaluation

When the client comes back to the next session, check again to see if he or she feels the rejected self part, if there is any rejection left, and if she or he feels that the part is integrated and the rejection processed.

It is possible that there will be work with the protocol needed over the course of a few sessions until the integration of the rejected self is achieved.

THE REJECTED SELF EMDR THERAPY PROTOCOL FOR BODY IMAGE DISTORTION SCRIPT

Phase 1: History Taking and Case Conceptualization

Please ask the client the following questions:

Body Image Distortion Questions

Say, “How would you define your body?”

Say, “What emotions, feelings, or sensations are generated by your body?”

Say, “Have you ever dieted or changed the amount of food you eat in order to change the size of your body?”

Say, “How much satisfaction do you feel in relation to your body?”

Say, “What defects do you perceive in your body?”

Say, “How much time do you spend observing, judging, or covering the features of your body you dislike?”
Note: Say “features” to avoid using the word “part” and prevent confusion with the rejected self part.

Say, “How much have you been influenced by your body whenever you have had to relate to others or attend different social events throughout your life?”

Say, “Is there anyone in your family with the same problem?”

Say, “How was body image valued in your family of origin?”

Say, “How did your parents relate to their own bodies?”

Say, “Who used to look at you in the way you look at yourself nowadays?”

Say, “What comments have you received about your body throughout your life, both from your family and from other people?”

Say, “Did you ever compare your body to that of others, looking for the flaws in your own?”

Say, “How much does what you see in your body have to do with how other people see you?”
Say, “Which life experiences have been crucial for you in regard to your body?”

Say, “How old were you when you started paying attention to your body or to the possible defects you find in it, in a negative way?”

Say, “What was happening in your life the first time you were aware of your body dissatisfaction?”

Identification of the “Rejected Self Questions”

Identify the rejected self. Most of the time, the image of the rejected self comes up immediately, since it always accompanies the client.

Say, “I want to talk to you about the idea of ‘the rejected self.’ The rejected self is a part from the past or the present that you reject and of which you are ashamed. Take the time you need to allow this image of yourself to come to mind. This part may hold feelings of disgust or contempt, and it may have been there throughout the years as an imprinted image of what you never want to be again, and through which you see yourself when looking in the mirror.”

When the rejected self comes up, ask for detailed information.

Say, “Can you identify your rejected self, the part you don’t want to be anymore?”

If the person answers that the rejected self is the body in the present, say the following: “Can you identify the image of yourself you reject in the present?”

Say, “Can you tell me about the part that you would never like to be again?”
Say, “Floating back and focusing on this rejected self, what is the oldest or most significant memory in which you have felt or seen yourself rejected?”

Phase 2: Preparation

**Resources**

Say, “What are some of your resources?”

**TIMES WHEN CLIENTS SEE THEMSELVES IN A POSITIVE LIGHT**

Say, “Please tell me what resources you have that show you in a positive light, without criticism.”

Say, “What are some of the positive things people have said about your body?”

Notice which traits or qualities were highlighted, validate them, and offer bilateral stimulation (BLS) to integrate them.

Say, “_________ (state highlighted traits and qualities) are very helpful and important. Let’s do some bilateral stimulation to integrate that. Go with that.”

Do BLS.

**ATTACHMENT FIGURE WHO OFFERED THE MOST LOVE OR SECURITY**

Say, “Who was the person who made you feel the most loved and secure?”

Say, “Please describe who it was and how it was done.”
Say, “What are the feelings that come up when you think about this?”

Say, “What traits in yourself do you think you may be able to learn to love like he or she does?”

Ask how receiving love and security makes the client feel as a person; it generally helps to increase feelings of being worthy of love and often adds self-worth.

Say, “What does having received love and security say to you about yourself as a person?”

Offer BLS so the client can integrate it.

Say, “Go with that.”

Do BLS.

IDEAL FIGURE

Say, “Please look for someone in your life you admire or who stands out because of his or her excellent self-concept or sense of self-esteem. Who might that be?”

Underline the characteristics that show that these ideal figures love or respect themselves, so you can work on those same traits for the client.

Say, “Observe what proves to you that this person has an excellent self-concept or sense of self-esteem. What do you notice?”

Say, “Imagine being able to see yourself having these same traits, fully accepting that these traits have been embodied and internalized, and are now yours. Notice how you see yourself.”

Offer BLS so it can be integrated.

Say, “Go with that.”

Psychoeducation and Self-Care

Offer a clear explanation of the ideas of self-concept and self-esteem.

Say, “I would like to talk to you about self-concept. Self-concept is the image each person has of himself or herself, as well as the ability to self-recognize. Self-concept includes an evaluation of all parameters relevant to the person: from physical appearance to skills. Self-concept is not innate; it develops with experience and the image projected
and perceived by others. It is dynamic, which means that it can be modified by new data. After this work, the person changes the old information for the new information and feels better.”

Say, “Let’s go on to the idea of self-esteem. Self-esteem is a set of perceptions, thoughts, feelings, and behaviors directed toward ourselves, toward our way of being and behaving, toward the features of our bodies and our character. Ultimately, it is how we assess ourselves. The importance of self-esteem lies in that it affects our worth and our way of being. Respect becomes a fundamental construct because self-esteem is related to how we have been respected and how we learn to respect ourselves.”

We will obtain information about the client’s self-esteem and self-concept with the following question:

Say, “Where did you learn to see yourself in that way?”

This question is crucial because it provides information that will help us to better understand the rejected self and will likely bring up memories from the past that will have to be processed later on with the Standard EMDR Protocol.

Psychoeducation on the Three Defenses: Rejection, Shame, and Worry

First offer a brief explanation about the three most common defenses in this work.

Say, “There are three common defenses that usually appear when you imagine placing the rejected self in front of you: rejection, shame, or worry, or perhaps all three at once. These three defenses encompass the different emotions, feelings, and sensations you may feel toward your rejected self. These will be the defenses that we will neutralize in order to reach the compassion and acceptance of this part of you, a part that you have been rejecting all these years.”

REJECTION

Identify the rejection that the person is feeling and where it is felt in the body in regard to the part from the past identified as the rejected self.

Note: One of the three defenses prevents clients from accepting themselves. Since the image perceived is the rejected self of the past, it gets in the way of being able to see the actual body image. This is where the blockage appears.

Say, “Imagine placing the part of you that represents your rejected self in front of you and tell me if and how you notice a sense of rejection.”
Say, “Where do you feel it in the body?”

______________________________

Say, “How would you describe the sensations?”

______________________________

SHAME

Identify the shame that is felt toward the rejected self.

Say, “Can you identify the shame that you feel toward your rejected self?”

______________________________

Say, “Where do you feel it in the body?”

______________________________

Say, “Can you tolerate the feeling of shame?”

______________________________

WORRY

Do the same with the worry that the person feels while focusing on the rejected self. Clients are concerned that once again they could become who they were in the past, and this activates an alarm that can be used as feedback for the distortion.

Say, “When you focus on your rejected self, are you worried that you may once again become that person with that body?”

______________________________

If the answer is “yes,” say the following:

Say, “Which emotions and/or sensations are generated by this worry about becoming that rejected self again?”

______________________________

Say, “Where do you feel them in the body?”

______________________________
After identifying the defenses and seeing how they maintain the rejected self, focus again on resources to enable the client to process the rejected self—and everything that is connected to it—back in time.

**Psychoeducation on EMDR**

Before stepping into Phase 3, we will offer a brief explanation of EMDR.

Say, “*When a trauma occurs it seems to get locked in the nervous system with the original picture, sounds, thoughts, and feelings. The eye movements we use in EMDR seem to unlock the nervous system and allow the brain to process the experience. That may be what is happening in REM or dream sleep—the eye movements may help to process the unconscious material. It is important to note that it is your own brain that will be doing the healing and that you are the one in control. When we process using the Three-Pronged Protocol, we are talking about the experiences of the past that affect your present life. After these past experiences are processed, they will stop affecting you negatively in the present and will not disturb you in the future.*"

**The Artichoke Metaphor**

Say, “*The inner world could be represented through an artichoke metaphor, which helps us see all the leaves/layers covering up the inner world in order to protect its most vulnerable part. When working with EMDR therapy, each of these leaves/layers contains the traumas, adverse experiences, and defenses that may arise. We will gradually process each one of these leaves/layers, until we reach the artichoke heart and repair what needs to be repaired. This is always done with great care, respecting the inner world and, above all, trusting in the process.*"

**Phase 3: Assessment**

First, ask the client to focus on the rejected self and confirm the image that comes up.

Say, “*We have identified __________ (describe what the client says about the rejected self) about the rejected self.*"

__________________________

Say, “*Is this accurate?*"

__________________________

Say, “*We have identified __________ (describe what the client says about the distortion of the body image) about the distortion of your body image.*"

__________________________

Say, “*Is this accurate?*"

__________________________

Then, ask the client to feel/experience the defenses. Give clients enough time to check inside and answer if they feel one, two, or all three of the defenses, as well as their location in the body.
Say, “When you put your rejected self in front of you, do you feel rejection, shame, or worry?”

Once the person has identified the defenses, ask where they are felt in the body, and the level of disturbance when looking at the rejected self. Assess each of them on a scale from 0 to 10, 0 being no rejection, shame, or worry at all to 10 being complete rejection, shame, or worry.

Say, “If you feel rejection, where do you feel it in your body?”

Say, “On a scale of 0 to 10, where 0 is no rejected feelings or neutral and 10 is the most rejection you can imagine, how disturbing does your rejection feel now?”

0 1 2 3 4 5 6 7 8 9 10
(no rejected feelings/neutral) (most rejection)

Say, “If you feel shame, where do you feel the shame in your body?”

Say, “On a scale of 0 to 10, where 0 is no shameful feelings or neutral and 10 is the most shame you can imagine, how disturbing does your rejection feel now?”

0 1 2 3 4 5 6 7 8 9 10
(no shameful feelings/neutral) (most shame)

Say, “If you feel worry, where do you feel the worry in your body?”

Say, “On a scale of 0 to 10, where 0 is no worry or neutral and 10 is the most worry you can imagine, how disturbing does your rejection feel now?”

0 1 2 3 4 5 6 7 8 9 10
(no worry/neutral) (most worry)

Say, “If you feel all of them, tell me where you feel each one of them in your body.”

Say, “On a scale of 0 to 10, where 0 is no rejection, worry, or shame, or neutral and 10 is the most rejection, shame, or worry you can imagine, how disturbing does your rejection, shame, or worry feel now?”

0 1 2 3 4 5 6 7 8 9 10
(no rejection, worry, or shame/neutral) (most rejection, worry, or shame)
Phase 4: Desensitization

Once the client tells us which defense he or she is feeling and its intensity, ask the client to focus on the image of the rejected self; connect with the one, two, or all three defenses; locate them in the body; and notice their intensity. You may process all the defenses at once here.

Say, “Please focus on the image of your rejected self and connect with __________ (state the defense/s) and where you notice it in your body as well as its intensity.”

Say, “Go with that.”

Do BLS.

Write down every big “T” or small “t” trauma associated with the rejected self. If these traumas seem to be interrupting the flow of the Body Image Distortion Protocol, we must stop and reprocess them using the Standard EMDR Protocol.

Say, “What comes up now?”

Process using sets of BLS, letting the information flow until nothing is coming up or the information that arises has nothing to do with the matter in question. Then ask the client to go back to connecting with the rejected self and check once again on the defenses: rejection, shame, or worry. Wait for the answer and ask the client to focus on the rejected self and the defenses.

Say, “Please connect with the rejected self again and tell me which of the defenses comes up: rejection, shame, or worry.”

Say, “Okay. Please focus on your rejected self and __________ (state the defense’s name). Go with that.”

Do BLS.

Process until nothing comes up.

Say, “Now, let’s return to thinking about the rejected self and check each of the three defenses. Do you notice any of the defenses of rejection, shame, or worry? Aside from these three defenses, are there any other emotions or feelings that we have not yet named?”
Often when the client no longer feels rejection, shame, or worry, the underlying emotion that comes up is sorrow. Once defenses have been neutralized and the client can start to feel sorrow or compassion for the part of the rejected self, we can process this sadness by simply focusing on it and then having the person allow himself or herself to just feel it.

Say, “Let yourself feel that sadness. Where are you feeling it in the body?”

“Go with that.”
Do BLS.
Process until nothing comes up or the client starts making positive associations.

**Phase 5: Installation**

*Strengthening Reprocessing With Knipe’s “Loving Eyes” Protocol*

Once the sadness is processed, apply Knipe’s Loving Eyes Protocol in order to integrate this part. This helps increase compassion toward this part, and compassion leads to integration.

Say, “Imagine that you can look the rejected part in the eyes and imagine that the part looks back at you. Please allow yourself to see that this part’s eyes are your eyes, because you and this part are the same person. It is the part of you that you have been rejecting for so long.”

Say, “Go with that.”
Do BLS.

**Phase 6: Body Scan**

Say, “Go back to the rejected self and scan your body from head to toe. Check if there is any uncomfortable sensation still remaining, or if everything is fine.”

If the body is clear, the procedure is complete. If it is not, process the point of disturbance, just focusing on that point.

**FUTURE TEMPLATE**

In order to work with the future template, check for the part that represented the rejected self in the past. Clients use the most adaptive information learned from experiences in the past and present with the goal of integrating this part into their life in the future once the rejected self is accepted and integrated.

Have the client imagine a future anticipated situation.
Install the Future Template.
Say, “Okay, we have reprocessed all of the targets that we needed to do. Now, let’s anticipate what will happen when you are faced with the picture of your body. What comes up?”

Say, “I would like you to imagine yourself coping effectively with (the picture of your body) in the future. Bring up this picture and say to yourself, ‘I can handle it,’ and feel the sensations. Okay, have you got it? Follow my fingers (or any other forms of BLS).”

Say, “Bring up the picture again, on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true. To what extent do you think you can manage to really do it?”

1 2 3 4 5 6 7
(completely false) (completely true)

Install with sets of eye movements until a maximum level of validity of cognition (VOC) has been achieved. If there is a block, meaning that even after 10 or more installations, the VOC is still below 7, there are more targets that need to be identified and addressed. The therapist should use the Standard EMDR Protocol to address these targets before proceeding with the template (see worksheets in Appendix A). Also, evaluate whether the client needs any new information, resources, or skills to be able to comfortably visualize the future coping scene. Introduce this needed information or skill.

Say, “What would you need to feel confident in handling the situation?”

Or say, “What is missing from your handling of your body?”

Use BLS; if blocks are not resolved, identify unprocessed material and process with the Standard EMDR Protocol.

Video Check (Future Template as Movie)

Say, “This time, I’d like you to imagine yourself stepping into the scene of a future confrontation with your body for which the future template was meant. Close your eyes and play a movie of this happening, from the beginning until the end. Imagine yourself coping with any challenges that come your way. Notice what you are seeing, thinking, feeling, and experiencing in your body. While playing this movie, let me know if you hit any blocks. If you do, just open your eyes and let me know. If you don’t hit any blocks, let me know when you have viewed the whole movie.”
If the client encounters a block and opens her eyes, this is a sign for the therapist to instruct the client to say the following:

“Say to yourself ‘I can handle it’ and follow my fingers (introduce a set of eye movements).”

To provide the clinician with an indication regarding the client’s self-efficacy, ask her to rate her response on a VOC scale from 1 to 7. This procedural step may give the clinician feedback on the extent to which the goals are met.

Say, “As you think of your body, how do the words feel from 1 being completely false to 7 being completely true?”

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>(completely false)</td>
<td>(completely true)</td>
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</table>

If the client is able to play the movie from start to finish with a sense of confidence and satisfaction, the client is asked to play the movie once more from the beginning to the end, BLS is introduced, and the positive cognition (PC) “I can handle it” is installed. In a sense, this movie is installed as a future template.

Say, “Okay, play the movie one more time from beginning to end and say to yourself, ‘I can handle it.’ Go with that.”

Phase 7: Closure

Say, “Is it okay to leave it like this or is there anything you feel the part needs to hear or that you need to do?”

Say, “Things may come up or they may not. If they do, great. Write it down and it can be a target for the next time. You can use a log to write down triggers, images, thoughts, cognitions, emotions, and sensations; you can rate them on our 0-to-10 scale, where 0 is no disturbance or neutral and 10 is the worst disturbance. Please write down the positive experiences, too.”

Say, “If you get any new memories, dreams, or situations that disturb you, just take a good snapshot. It isn’t necessary to give a lot of detail. Just put down enough to remind you so we can target it the next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it’s still just the old stuff. Just write it down for the next time.”

Phase 8: Reevaluation

Say, “When you think about the rejected self, what comes up for you now?”

Say, “Does it feel like there is any rejection left?”
Say, “Do you feel that this part of you is integrated and the rejection is processed?”

If yes, say, “Feel it,” and do BLS.
If no, repeat the Rejected Self Protocol until the rejected self is accepted.

**SUMMARY**

Our body image develops from a process of implicit learning, meaning that we learn to see ourselves based on who we were told we were and how we see that others perceive themselves in our family environment. This shapes the way in which we end up seeing ourselves in the future, our body image, and our acceptance of it.

Once we develop this learning about our own image, the negative beliefs and ideas about it become resistant to change, given that what we learn early in life becomes more resistant to change (van der Kolk, 1986).

Through the Rejected Self Protocol, change becomes easier because defenses are neutralized and the memories that maintain the fixed image are reprocessed. By doing this, the body image becomes integrated into the whole person and it improves, based on the reality that clients will learn to accept with compassion and understanding that it is okay to be who they are.

Overall, the goals that lead to the therapeutic success are the following: identifying the body as one’s own; accepting the body as one’s own; processing the trauma contained in the rejected self, at both cognitive and emotional levels; substituting body image distortion for acceptance; learning to respectfully feel and take care of the body; and integrating this dissociative part that represents the rejected self and its defense (body image distortion).

**REFERENCES**


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.

PHASE 1: HISTORY TAKING

Body Image Distortion Questions

Identification of the “Rejected Self” Questions

Definition of body: ____________________________________________________________

Emotions, feelings, sensations generated by your body: ______________________________________

Have you dieted/changed the amount of food you eat to change body size:    ☐ Yes ☐ No
Comment: _______________________________________________________________________

Satisfaction you feel in relation to your body: ____________________________________________

Defects perceived in your body: ______________________________________________________

Amount of time spent observing, judging, or covering features of your body you dislike: _________

How much influenced by your body when relating to others/attending different social events in your life: ________________
Anyone in family with same problem: ________________________________

How body image valued in family of origin: ________________________________

How parents related to own bodies: ________________________________

Who looked at you the way you do now: ________________________________

Comments received about your body from family and friends throughout life: ________________________________

You compared your body to others looking for your flaws: □ Yes □ No
Comment: ________________________________

How much of what you see has to do with how others view you: ________________________________

Life experiences crucial for you concerning your body: ________________________________

Age when paid attention to body/defects in negative way: ________________________________

What was happening in your life when first aware of body dissatisfaction: ________________________________

Identification of the “Rejected Self” Questions

“I want to talk to you about the idea of “the rejected self.” The rejected self is a part from the past or the present that you reject and of which you are ashamed. Take the time you need to allow this image of yourself to come to mind. This part may hold feelings of disgust or contempt, and it may have been there throughout the years as an imprinted image of what you never want to be again, and through which you see yourself when looking in the mirror.

Can you identify the rejected self? □ Yes □ No
Comment: ________________________________

If person identifies it in the present?

Can you identify the rejected self in the present? □ Yes □ No
Comment: ________________________________

Can you tell me about the part you would never want to be again? □ Yes □ No
Comment: ________________________________

Floating back and focusing on this rejected self, what is the oldest or most significant memory in which you have felt or seen yourself rejected: ________________________________
PHASE 2: PREPARATION

Resources: ____________________________________________________________

________________________________________________________________________

TIMES WHEN CLIENTS SEE THEMSELVES IN A POSITIVE LIGHT

Resources you have when you see yourself in a positive light: __________________________________

________________________________________________________________________

Positive things people said about your body: __________________________________________

________________________________________________________________________

________________________________________________________________________

_________ (state highlighted traits/qualities) + BLS

ATTACHMENT FIGURE WHO OFFERED THE MOST LOVE OR SECURITY

Person who made you feel most loved and secure: _________________________________________

________________________________________________________________________

Describe who it was and how it was done: ______________________________________________

________________________________________________________________________

________________________________________________________________________

Feelings that come up when you think about this: _______________________________________

________________________________________________________________________

Traits in yourself you think you may be able to learn to love like she or he does: _____________

________________________________________________________________________

What does having received love and security say to you about yourself as a person: ___________

________________________________________________________________________

_________ (state what it says about you) + BLS

IDEAL FIGURE

Someone in your life you admire because of his or her excellent self-concept/self-esteem: ______

________________________________________________________________________

Observe proofs that this person has excellent self-concept/self-esteem: _______________________

________________________________________________________________________

Traits in yourself you think you may be able to learn to love like she or he does: _______________

________________________________________________________________________
See yourself having these same traits, fully accepting that these traits have been embodied and internalized and are now yours. Notice how you see yourself: ____________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

_________ (state what you noticed) + BLS

Psychoeducation and Self-Care

“I would like to talk to you about self-concept. Self-concept is the image each person has of himself or herself, as well as the ability to self-recognize. Self-concept includes the evaluation of all parameters relevant to the person: from physical appearance to skills. Self-concept is not innate; it develops with experience and the image projected and perceived by others. It is dynamic, which means that it can be modified by new data. After this work, the person changes the old information for the new information and feels better.

Let’s go on to the idea of self-esteem. Self-esteem is a set of perceptions, thoughts, feelings, and behaviors directed toward ourselves, toward our way of being and behaving, toward the features of our bodies and our character. Ultimately, it is how we assess ourselves. The importance of self-esteem lies in that it affects our worth and our way of being. Respect becomes a fundamental construct because self-esteem is related to how we have been respected and how we learn to respect ourselves.”

Where did you learn to see yourself in that way? ____________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

This question is crucial because it provides information that will help us to better understand the rejected self and will likely bring up memories from the past that will have to be processed later on with the Standard EMDR Protocol.

Psychoeducation on the Three Defenses: Rejection, Shame, and Worry

“There are three common defenses that usually appear when you imagine placing the rejected self in front of you: rejection, shame, or worry, or perhaps all three at once. These three defenses encompass the different emotions, feelings, and sensations you may feel toward your rejected self. These will be the defenses that we will neutralize in order to reach the compassion and acceptance of this part of you, a part that you have been rejecting all these years.”

REJECTION

Identify the rejection that the person is feeling and where it is felt in the body in regard to the part from the past identified as the rejected self.

Note: One of the three defenses prevents clients from accepting themselves. Since the image perceived is the rejected self of the past, it gets in the way of being able to see the actual body image. This is where the blockage appears.

Someone in your life you admire because of his or her excellent self-concept/self-esteem: ________

Imagine placing the part of you that represents your rejected self in front of you; tell me if and how you notice a sense of rejection: ____________________________________________________________

Location in body: __________________________________________________________

Describe sensations: __________________________________________________________

SHAME

Identify shame you feel toward rejected self: __________________________________________________________

________________________
Can you tolerate shame feelings: □ Yes □ No

**WORRY**

Do the same with the worry that the person feels while focusing on the rejected self. Clients are concerned that once again they could become who they were in the past, and this activates an alarm that can be used as feedback for the distortion.

Focus on the rejected self; are you worried you will become that person with that body: □ Yes □ No

Comment: ________________________________________________________________

If yes, identify emotions/sensations generated by the worry about becoming the rejected self again:

________________________________________________________________________

________________________________________________________________________

Location in body: ________________________________

Can you tolerate shame feelings: □ Yes □ No

Comment: ________________________________________________________________

After identifying the defenses and seeing how they maintain the rejected self, focus again on resources to enable the client to process the rejected self—and everything that is connected to it—back in time.

**Psychoeducation on EMDR** □ Yes □ No

Before stepping into Phase 3, we will offer a brief explanation of EMDR.

“When a trauma occurs, it seems to get locked in the nervous system with the original picture, sounds, thoughts, and feelings. The eye movements we use in EMDR seem to unlock the nervous system and allow the brain to process the experience. That may be what is happening in REM or dream sleep—the eye movements may help to process the unconscious material. It is important to note that it is your own brain that will be doing the healing and that you are the one in control. When we process using the Three-Pronged Protocol, we are talking about the experiences of the past that affect your present life. After these past experiences are processed, they will stop affecting you negatively in the present and will not disturb you in the future.”

**The Artichoke Metaphor** □ Yes □ No

“The inner world could be represented through an artichoke metaphor, which helps us see all the layers covering up the inner world in order to protect its most vulnerable part. When working with EMDR therapy, each of these layers contains the traumas, adverse experiences, and defenses that may arise. We will gradually process each one of these layers, until we reach the artichoke heart and repair what needs to be repaired. This is always done with great care, respecting the inner world and, above all, trusting in process.

**PHASE 3: ASSESSMENT**

Identify rejected self: ____________________________________________________

_____________________________________________________________________

□ Accurate □ Inaccurate

Identify distortion of body image: __________________________________________

_____________________________________________________________________

□ Accurate □ Inaccurate
Feel or experience the defenses

Rejection: ☐ Yes ☐ No  Location of rejection in body: ______ SUD: __/10
Shame: ☐ Yes ☐ No  Location of rejection in body: ______ SUD: __/10
Worry: ☐ Yes ☐ No  Location of rejection in body: ______ SUD: __/10

**PHASE 4: DESENSITIZATION**

Focus on the image of rejected self + (state defense/s) + location in body + intensity of feeling + BLS

List of big “T” and small “t” traumas associated with the rejected self:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Focus on rejected self: Which defenses come up? ☐ Rejection ☐ Shame ☐ Worry

Focus on rejected self + ___ (state defense) + BLS until nothing comes up

________________________________________________________________________________________
________________________________________________________________________________________

Check if any defenses come up: ☐ Rejection ☐ Shame ☐ Worry

________________________________________________________________________________________

Other emotions noticed (often sadness): ____________________________________________________

Focus on ___ (state emotion) + Location in body + BLS until client makes positive associations.

________________________________________________________________________________________

**PHASE 5: INSTALLATION**

Strengthening Reprocessing With Knipe’s “Loving Eyes” Protocol

Imagine that you can look the rejected part in the eyes and imagine that the part looks back at you. Please allow yourself to see that this part’s eyes are your eyes, because you and this part are the same person. It is the part of you that you have been rejecting for so long + BLS.
PHASE 6: BODY SCAN

Rejected self + Scan your body from head to toe

Unresolved tension/tightness/unusual sensation: ____________________________________________

Unresolved tension/tightness/unusual sensation + BLS

Strengthen positive sensation using BLS.

If there is more discomfort, reprocess until discomfort subsides + BLS. Then repeat body scan.

PHASE 7: CLOSURE

Anything the part needs to hear/you need to do: ☐ Yes ☐ No

Comment: ________________________________________________________________

“Things may come up or they may not. If they do, great. Write it down and it can be a target for the next time. You can use a log to write down triggers, images, thoughts, cognitions, emotions, and sensations; you can rate them on our 0-to-10 scale, where 0 is no disturbance or neutral and 10 is the worst disturbance. Please write down the positive experiences, too.”

“If you get any new memories, dreams, or situations that disturb you, just take a good snapshot. It isn’t necessary to give a lot of detail. Just put down enough to remind you so we can target it the next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it’s still just the old stuff. Just write it down for the next time.”

PHASE 8: REEVALUATION

Rejected self + What comes up for you now: ____________________________________________

Any rejection left: ☐ Yes ☐ No

Comment: ________________________________________________________________

Is this part integrated and the rejection processed: ☐ Yes ☐ No

Comment: ________________________________________________________________
INTRODUCTION

Complex trauma is prevalent in the general therapy population and is rooted in early neglect and traumas of long duration, resulting in posttraumatic stress disorder (PTSD), dissociative disorders, attachment problems, and personality disorders. When these clients present themselves to the medical community by way of their family doctor or specialist, their psychological and physical symptoms are often misdiagnosed. They are seeking help for the severe symptoms of dissociation, PTSD, depression, and anxiety, as well as illnesses and pain. Articles on the correlation between poor health and sexual and physical abuse survivors focus on issues such as anxiety, phobias, loss of control, and powerlessness. The topic of dissociation, generally thought to be a typical symptom for complex trauma clients and clearly significantly related to healthcare treatment avoidance, has been absent from the literature concerning this population until recently. Attachment issues are now thought to be related to health problems as well. These issues are a legacy of adverse childhood experiences (ACE) in the life of the survivor. ACEs such as abuse, neglect, attachment deficits, and ruptures have a serious, negative effect on clients’ health. These early experiences often lead to the adoption of behaviors that put the person at an additional risk for health problems, that is, substance abuse, eating disorders, smoking, and other compulsive behaviors. These ACEs also increase dissociative symptoms and vulnerability to PTSD. This will subsequently have negative effects on the immune system.

Additionally, ACE survivors (many with complex/chronic PTSD) frequently have no consistent experience in the management of affective and dissociative symptoms. Addressing this set of problems becomes an important emphasis of the work during the stabilization phase of EMDR therapy. The author wants to help her clients develop more stability, not merely to get to the “processing” phase quickly, but to increase self-efficacy, trust in the therapy relationship, and ensure that self-development is taking place.

Issues for the complex trauma/ACE survivor client, which can be targeted with EMDR therapy, include the following:

- Serious illness
- Chronic conditions such as migraines
- Untreated medical or dental symptoms
- Untreated substance abuse
- Lack of skills related to hygiene and healthcare
- Other health risk behaviors
- Avoidance of health treatment
- Lack of follow through

Finally, current accidents, illnesses, hospitalizations, and so on, may be related to and may trigger flashbacks to earlier traumatic events. These current symptoms and conditions, even with medical care, may not resolve without EMDR treatment of first the early trauma, and then the current issues.

These clients often are characterized by a chaotic/unstable family of origin, which can result in insecure, avoidant, and/or disorganized attachment styles. There may have been early losses and breaks in attachment. As a result of the neglect that they experience, these clients may lack skills in a number
of basic areas, especially in regard to healthcare and hygiene. This cycle of abuse, neglect, attachment deficits, and ruptures has a negative effect on clients’ health and often put them at an additional risk for health problems such as substance abuse, eating disorders, smoking, and other compulsive behaviors. They may present with issues concerning trust, self-hatred, and a fear of abandonment, in addition to the posttraumatic symptomatology. As a result, they have no consistent experience in receiving comfort from significant others that results in a lack of capacity for self-soothing. They often have no skill or training in managing affect. Furthermore, these clients often suffer from flashbacks with no one to witness and provide support. On a practical level, it is easy to understand that hygiene practices may never have been modeled—if practiced at all. Additionally, medical care may have been inconsistent during their abusive and neglectful childhoods.

If this were not enough, it is important to note that PTSD depresses the immune system. PTSD may be a result of health and iatrogenic events, such as untreated illnesses or procedures that might have been very painful. If the parent or physician did not explain to the child how the medical problem was going to be treated, the child may have been traumatized or there may have been malpractice issues. Another issue involves hospitalizations, where parents could not stay overnight with the child, leading to feelings of abandonment.

Another set of problems for complex trauma clients involves difficult-to-diagnose illnesses or conditions. They are typically called medically unexplained symptoms (MUS), such as the following:

- Respiratory illness
- Musculoskeletal complaints
- Chronic pain
- Fibromyalgia
- Chronic fatigue
- Eating disorders
- Headaches
- Irritable bowel syndrome (IBS)
- Gynecological problems, including pregnancy
- Regional pain syndromes
- Pseudo-neurological symptoms
- Sleep disorders

They are also prevalent among ACE survivors and can be treated with EMDR therapy.

For treatment planning, it is necessary to explore the roots of the CPTSD clients’ health problems that emanate from their early neglect and/or abuse. Often, specific injuries, accidents, and illnesses occur, and their family either overreacts, underreacts, or ignores the symptoms. Often, when the child victims present in the physician’s office or at the emergency room, there is no linking of their symptoms with the probable cause of abuse. By the time they reach adulthood, their reactions to their bodies and health needs have become more complex. ACE/complex trauma survivors may not have “normal” reactions to pain: either under- or overreacting or misinterpreting the pain. They may not notice symptoms of illness or tooth decay. They use dissociation to detach from their body and may have different thresholds of pain tolerance while dissociated. This creates problems when they try to explain medical/dental issues to a health practitioner who has no knowledge about PTSD and dissociation.

Felitti et al. (1998) note in the ACE study that there is a relationship between adult health status and childhood abuse and neglect. Childhood stressors are strongly related to development and the prevalence of risk factors for disease, health, and social well-being throughout the life span. Acute or prolonged stress increases cortisol production; this is adaptive for acute trauma, but over time becomes maladaptive and impairs the immune system, which, in turn, impairs healing. Cortisol levels become chronically decreased, resulting in illnesses such as rheumatoid arthritis (RA), fibromyalgia, chronic fatigue syndrome, thyroid diseases, Crohn’s disease, and IBS (Bergmann, 2012). Furthermore, new research exploring neurotransmitters and hormones such as oxytocin show that these may be dysregulated by early human relational trauma and maltreatment, resulting in the development of dissociative, somatoform, and interpersonal disorders.

CPTSD clients rarely link their current difficulties with their treatment for prior trauma. This often results in increased traumatization in medical settings. Often, their level of anxiety mystifies them when they think about dealing with the healthcare profession. They may dissociate and/or have flashbacks in the medical/dental/therapy office; they have many issues about authority figures that may impact their relationships with physicians and dentists. This is complicated by their not being able to ask for help and experiencing confusion and/or disorientation if they try to focus on the problem.
Many CPTSD survivors do not believe they deserve good health and are ridden with shame and guilt. In fact, healthcare treatment can be so triggering that they avoid it for years, resulting in serious health problems.

Dissociation is a way that the CPTSD client copes with triggers and perceived threat or danger (Chefetz, 2015). Symptoms include the following:

- Hyper- or hypo-arousal/numbing
- “Out of body” experiences
- Not being present in the body
- Losing time
- “Going away” when stressed
- Depersonalization/derealization
- Looking “different” in the session
- Presenting with a childish voice
- Speaking about themselves in the third person
- Becoming disoriented
- Hearing “voices”

Depending on the degree of the continuum of dissociative symptoms, a CPTSD client may be diagnosed with a dissociative disorder. Somatic dissociation is not often talked about, but is not infrequent. According to Scaer (2007), clients using somatic dissociation may experience perceptual alterations and somatic symptoms such as shape, color, size, pain, functioning postural changes, sensations, and/or numbing. Often, they experience depersonalization of a body part and have fragmented images of the experiences of the traumatic event that produced the pain or injury. Their current injury may be in the same areas as an earlier accident or traumatic event such as abuse, but they may have amnesia for that earlier event.

These clients have complex problems and are difficult to treat. During the history-taking phase, it is essential to take a complete health history. It is important when taking the history to get the history of treatment, traumatic events, medications, and surgeries, as many current problems are based on earlier traumas (including medical issues and accidents). The site of the current medical problem is often the site of the earlier problem. It is important to treat earlier trauma, or treatment will be ineffective (Scaer, 2005). Of necessity, this history-taking phase may be lengthy, and must be paced carefully, due to the chance of overwhelming the client.

COMPLEX PTSD, PERSONAL HEALTH, AND EMDR THERAPY SCRIPT NOTES

CASE Conceptualization Overview

The treatment plan for EMDR therapy with CPTSD clients who are presenting with complex health issues includes the use of a phased treatment approach to provide stabilization/reduce symptoms of dissociation and deal with affect management problems. Phase 1 requires a good history taking, and having the client discuss current problems with a focus on health issues and trauma history, and then completing a Dissociative Experiences Scale and ACE questionnaire. In Phase 2, any needed stabilization work will be taught. After teaching and practicing many individualized interventions and skills, clinicians can safely desensitize and reprocess trauma memories and eliminate the dissociative and PTSD symptoms that impede these clients from dealing with health issues (Forgash, 2009).

In Phases 3 to 6, when making these treatment-planning decisions, remember it is a cooperative process. Phases 7 and 8 continue throughout the work.

In Phase 1, please note that it is necessary to obtain a complete history that includes many realms. At the same time, this has to be carefully timed as the CPTSD client may easily be triggered during history taking, or even casual conversation. Some of this important material may emerge over a long time as a trusting relationship develops. The therapist needs to be attuned to make sure that the pacing fits the client’s needs. Therefore, expect historical material to come up in later phases of work. Determine if health issues are related to the following:

- Developmental/attachment trauma
- ACE trauma

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• Shock trauma: actual abuse, injury, environmental incidents (this could also include medical treatment with negative results [iatrogenic])
• Normal health issues that the client is lacking skills to deal with
• History of family illnesses/self-destructive patterns (substance abuse, etc.)
• Chronic health problems
• Pain issues

It is important that decisions between therapist and client are jointly determined; giving back as much control as possible to the client is essential.

During Phases 1 to 3, the focus is on normalization of symptoms and the repair of attachment deficits while building client/internal system/therapist rapport and exploring historical material. Remember, during the history-taking phase, clients can become easily triggered. Therapists need to use their attunement skills to make sure of the pace of history taking.

It is often necessary to use an ego state (or parts) approach with complex trauma clients due to earlier dissociation and fragmentation of parts (Forgash, 2017; Knipe, 2008). There needs to be a system agreement among parts or ego states for the client to work on their problems. Part/s of the system may need to be “present” at the sessions (see Forgash & Copley [2008] for more information on how to work with dissociated parts of the personality or ego states, and Forgash [2009a], pp. 204–215, for a well-formulated explanation of working with dissociative clients and their part systems). With CPTSD clients, be sure to assess for readiness prior to proceeding with processing phase work. Then, select the appropriate targets by determining the past traumatic events, current issues, the main touchstone memories, negative cognitions (NCs), blocking beliefs, and needs of the client (and the ego state system) regarding attachment issues, trauma, health, illness, and pain.

Which targets take precedence? There may be several discussions to come to consensus:

• Adverse life experiences/small “t” trauma clusters concerning health and losses from earlier times
• Current life issues and illnesses
• Large “T” trauma, current and past
• Recent incidents/illnesses/injuries
• Health problems related to similar/earlier incidents

Certain types of NC and positive cognition (PC) come up frequently in this population:

• Avoidance of treatment due to prior interactions with healthcare providers
  NC: “I am not safe. I am not worth it.”
  PC: “I am safe now. I’m worth it.”
• History of being labeled and misinterpreted
  NC: “It is all in my head.”
  PC: “My medical problems are real. I’m worth listening to.”
• History of abandonment
  NC: “I am always going to be alone. I will die alone.”
  PC: “I deserve support. I can start to connect with people.”
• Fear of exams/procedures provoking flashbacks/dissociation
  NC: “I am crazy. No one will understand me.”
  PC: “I can advocate for myself and be understood.”
• Chronic illness/pain
  NC: “It will never get any better. I am going to die.”
  PC: “I can cope with my situation.”
• Losses, including identity
  NC: “I have lost too much.”
  PC: “I can find a way to still be myself. I’m still able to have a life.”

Introduce dissociative and affect management strategies to help clients stay in the optimum window of arousal:

• Resource development and installation
• Ego-building activities (see Phillips M. in Forgash & Copley, 2008)
Mindfulness activities
Learning to control stressful feelings and pain (Grant, 2009)
Healing imagery (Siegel, 1988; Simonton, 1978)
Positive body resource exercise (Levine, 2010)
Cocoon of light healing exercise; meditation practices (Borysenko, 1988)
Safety/distancing work (containers, affect dial/screen work; Back-of-the-Head scale; journaling, drawing, mapping [Forgash, 2009a; Forgash & Copley, 2008])
Heart coherence exercise (Servan-Schreiber, 2004)

With current health problems, link up with any past trauma memories, similar feelings, thoughts, and beliefs. Treatment of current injuries/illnesses is more effective if old related traumas are desensitized and reprocessed; otherwise, many symptoms may not resolve after medical treatment.

Make sure to look for earlier traumas that are behind current beliefs as many serious life events emerge when the person has to deal with life-threatening illness. Always work with the medical team. Always be attentive to the client’s physical condition and pace the work accordingly. Always end the session with debriefing and self-soothing work.

Always use the Standard EMDR Protocol except for the following variations: For complex trauma/dissociative clients, dissociated ego states may need to work together on a target, or several ego states with the same issue may work together to promote internal connection and cohesion. For example, the client may have had painful, traumatic medical procedures at different ages in childhood. Those child states may decide to process one of those events (first, worst, most recent) together. After that one has been processed, explore if some of the other events still need processing. Sometimes, processing one event generalizes to the others. If not, process each event (Forgash & Copley, 2008).

Other targets of importance include mourning past losses, missed opportunities, and regrets, as well as remorse about poor health. Remember that complex trauma clients may need to frequently return to stabilization phase work during Phases 4 to 8. This is typical and not client “failure.” It should be normalized. Additionally, therapists need to take responsibility and work on pacing and readiness with the client. Remind them of skills they now have. Remind them of the stop sign, that they can determine how long they can process in any given session. This respectful treatment will often ease the path through the processing phases.

As you proceed through the processing phases, some of the most important work with a physically ill person concerns the present and future. There may be concerns, anxiety, and fear about life changes, re-occurrences, financial issues, and so on. Work is complete when the client can tackle once-feared problems, possible procedures, new tasks, and goals.

In this phase, clients work to regain realistic control of their lives, achieve healthy functioning, and enjoy as much efficacy in life domains as is possible. They work on gaining positive self-worth and identity and a sense of empowerment even if full recovery is not possible. They may try on new healthy behaviors and activities. The client often reports seeing old events and relationships from more of an adult perspective. Additionally, they express feelings of competence and can attend to their healthcare needs as an adult.

Future Template Work

What skills need to be learned and practiced? Rehearsals of any projected future situation (physical therapy, other rehabilitation, diagnostic testing, family occasions, returning to work, becoming well again, etc.) can be the focus of sessions. Work is not complete until clients can tackle once-feared problems, possible procedures, new tasks, and goals. Clients can imagine behaviors such as speaking up and asking questions assertively, going for diagnostic procedures, attending an annual checkup or having an OB/GYN exam, learning how to use “aids” or prostheses, taking on new roles, and so on. Note any distress, and process until no distress is noted.

**COMPLEX PTSD, PERSONAL HEALTH, AND EMDR THERAPY SCRIPT**

**Phase 1: History Taking**

*Health and Trauma History*

Always explain the need for a health and trauma history for client and family members, such as a health genogram.
Say, “I am interested in knowing about your health history. Is it OK to ask you some questions about this area? Remember, I want to go at your pace. Please stop me at any time.”

Say, “I’d like to ask you, first, some questions on childhood experiences, which may be linked to your present issues, including health problems. These are the questions that appear on the ACE questionnaire. ACE stands for adverse childhood experiences. I think that your responses will help us clarify some of your issues. There is only one score per question, even if the events occurred more than once.”
ADVERSE CHILDHOOD EXPERIENCE (ACE) QUESTIONNAIRE

Say, “Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch his or her body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Did you often or very often feel that no one in your family loved you or thought you were important or special? Or your family didn’t look out for each other, feel close to each other, or support each other?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Did you often or very often feel that you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Was a biological parent ever lost to you through divorce or abandonment or for another reason?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Was your mother or stepmother often or very often pushed, grabbed, slapped, or had something thrown at her or kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Was a household member depressed or mentally ill, or did a household member attempt suicide?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Did a household member go to prison?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Since the ACE report was written almost 20 years ago, other researchers have come to see that questions on poverty and community violence and bullying may also affect health.

Say, “Did you grow up in poverty?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Did anyone outside your home bully you?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Say, “Was there violence in your community?”

☐ If Yes, enter 1 ☐ If No, there is no score ______ Score

Total Score: ______
To obtain your ACE score, add up your “Yes” answers. The ACE score gives information to help you develop goals for your treatment, and for specific targets to process.

**Note:** You may use your own questions instead of what follows. You will certainly work to match your language to your client. Also, much of this information will be revealed as the relationship develops. However, it may be easier for a new therapist, or one who has not focused on health issues before, to utilize the questions. Like all other history taking with these clients, pacing is critical. Speed is irrelevant! Additionally, many clients will not be comfortable sharing material that may be shaming or guilt producing. They also may have dissociated much of their early history. You can assure them that speed is not of the essence here—their comfort is most important. Teach them the stop sign in the early phase work. It is very empowering and helps trust develop.

Say, “I am going to ask you some questions and I would like us to go at a pace that is comfortable for you. Please hold your hand up if you want to stop, like this (demonstrate). Do you have any questions or concerns?”

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During the next sessions, or when comfortable for the client:

Say, “Tell me about any health issues in your childhood. Were you ill in your early years?”

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Say, “Did you have many fevers growing up?”

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Say, “Did you have any serious falls?”

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Say, “When you fell, did they result in fractures?”

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Say, “Were you ever hospitalized?”

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If so, say, “Please describe what happened.”
The definition of iatrogenic is “physician induced or caused.” This may have to be carefully explained.

Say, “Did you have any recurrent illnesses and/or situations that were iatrogenic (which means that the physician induced or caused problems?)”

Say, “Did you have any painful conditions?”

Say, “What are your current problems including pain and disability?”

Say, “Have you had any serious illnesses or surgeries?”

Say, “How has your mental health been?”

Say, “Have you ever been in therapy before?”

Say, “Have you had any problems with drugs, alcohol, or eating disorders?”

If yes, “Please tell me about it.”

Say, “Can you tell me about the health of close family members? Have any of them had serious illnesses, substance abuse, eating disorders, mental health issues, and medical and dental problems?”
Say, “Were there any deaths in your family, especially when you were a child?”

If so, say, “Please tell me about them.”

Say, “Were there ever people with whom you were close in your immediate family who went away or came and went frequently?”

Health Practices

Say, “Were you taught regular basic hygienic routines such as brushing your teeth, washing your hands, and so on?”

Say, “Did you go regularly to the doctor and dentist when you were young?”

If yes, ask the following:
Say, “What were those visits like for you?”

If no, ask the following:
Say, “Why do you think that you didn’t go regularly or at all?”

Say, “When did you have your last dental and medical exams?”

Reinforce that your work together will help them to make changes.
Say, “I am asking these questions today so that our work together can help you make the changes that you have said you want.”
Tell the client that you will be asking questions about some difficult areas.
Say, “I will be asking questions about some difficult areas.”
Tell the client that you understand that many of these issues were attempts to solve problems stemming from early trauma.

Say, “It is important to know that many of the issues you have were attempts to solve problems stemming from early trauma.”

**Other Health Risk Behaviors**

Say, “Sometimes people go through periods where they had some risky health habits like using drugs or alcohol, having unprotected sex, having an eating disorder, or cutting. Have you had some of these problems?”

**AVOIDANCE OF HEALTH TREATMENT**

Say, “Do you have a history of avoiding medical care?”

**LACK OF FOLLOW THROUGH**

Say, “Has it been a problem following up on the doctor’s suggestions or taking medications?”

Use your own words and ask about the following:

**CURRENT ACCIDENTS**

Say, “Have you had any accidents recently?”

**ILLNESSES**

Say, “Have you had any illnesses recently?”

**HOSPITALIZATIONS**

Say, “Have you been hospitalized recently?”

**Note:** ACE clients may present with issues concerning trust, self-hatred, and a fear of abandonment, in addition to the posttraumatic symptomatology. As a result of these, they have no consistent experience in receiving comfort from significant others that results in a lack of capacity for self-soothing. They often have no skill or training in managing affect. Pay attention to pacing, and normalize their responses.
Say, “There are categories of problems that are called medically unexplained symptoms (MUS). Please let me know if you have any of the following conditions. If so, we can explore how they have impacted you and determine how we can work on the issues that result from these problems.”

**Note:** This discussion may take place in segments depending on client willingness, fatigue, and so on.

Say, “Have you ever been ill with any of the following?”

- [ ] Respiratory illness
- [ ] Musculoskeletal and joint complaints
- [ ] Chronic pain
- [ ] Fibromyalgia
- [ ] Chronic fatigue
- [ ] Eating disorders
- [ ] Headaches
- [ ] Irritable bowel syndrome
- [ ] Gynecological problems including pregnancy
- [ ] Regional pain syndromes
- [ ] Pseudo-neurological symptoms
- [ ] Sleep disorders
- [ ] Rheumatoid arthritis
- [ ] Thyroid diseases
- [ ] Crohn’s disease

**Note:** These are some symptoms of dissociation. Over time, explore these symptoms. Normalize them as being common results of being traumatized as a child.

Say, “The symptoms I am going to ask you about next are common results of being traumatized as a child. Adults, when faced with danger, can often utilize ‘fight’ or ‘flight.’ Unfortunately, a child can do neither and what is left is the ‘freeze’ position and then dissociation. Have you experienced any of the following symptoms?”

- [ ] Hyper- or hypo-arousal/numbing
- [ ] “Out of body” experiences or not being present in the body
- [ ] Losing time
- [ ] “Going away” when stressed
- [ ] Depersonalization/observing yourself from outside your body
- [ ] Derealization/having a sense that things aren’t real inside or outside your body
- [ ] Looking “different” in session
- [ ] Hearing “voices”

Say, “Sometimes, you may use something we call somatic dissociation to help you. Do you experience the following?”

- [ ] Perceptual alterations such as unusual pain in certain parts of your body; experiencing sensations in parts of the body that were injured, abused, or painful at other times in your life
- [ ] Somatic symptoms such as shape, color, size, pain, change in functioning of an extremity, and postural changes, sensations, and/numbing

**Client’s Supports, Skills, and Strengths**

Say, “Who are the supports in your life currently?”

Say, “Who were the supports in your life in the past? I’d like to learn about your relationships with family and friends.”
Note: Some clients cannot acknowledge their skills and strengths early in treatment. They find it difficult to maintain positive affect. This can be a normal reaction to childhood trauma.

Say, “Tell me about your skills and strengths.”

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Phase 2: Preparation

**Psychoeducation on Trauma-Informed Psychotherapy**

This work will take several sessions or longer to communicate these very important concepts or information with clients. Some of it could be “triggering” or upsetting. Slow is best. People who have physical illness tire easily and have less energy, focus, and retention.

Clients need basic information about their conditions, the psychosomatic issues, and their rights. Convey that you are well informed about trauma/health issues and know why some people are reluctant health consumers.

Say, “Lots of times when people have had difficult childhoods, illnesses, injuries, and abusive experiences, they have a lot of trouble trusting others, and that can include health practitioners. You may have had painful procedures and illnesses and, also, you may have worked with doctors who have not listened to you. If you have discomfort dealing with your health problems because of any of these issues, I hope that you will share them with me and I can help you overcome them.”

**Psychoeducation About Patient Rights**

Discuss client rights.

Say, “Clients have rights as health consumers. Every one of your health providers should give you and discuss with you the Client Bill of Rights. You need to read it and ask questions about anything you don’t understand.”

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**Psychoeducation About Becoming a Proactive Health Consumer**

Teach the client how to become a proactive health consumer.

Say, “One of the things you can do is bring a friend or family member with you to the doctor’s office. When you are not feeling well, it’s easier to misunderstand or be confused. You can make up a list of questions and concerns to discuss at the visit. Or we can do that as well.”

---

Give information about resources that help deal with illness/problems and trauma issues.

Say, “In our community you will find associations such as the ________ (state the one that is appropriate: American Cancer Society, AA, the American Heart Association, etc.). They offer many kinds of services and education. It might be helpful for you to contact them. Would you be interested in speaking with them?”
Psychoeducation About General Health, Stress and Pain, Normalizing Trauma Symptoms, and Their Effects on Health and Stress Reduction Work

Introduce general concepts about improving health, stress, and pain, and normalizing trauma symptoms and their effects on health and stress reduction work.

Say, “We know that trauma, stress, and pain all have an effect on health. What do you do in your life now to help yourself be healthy? Have you tried exercise, meditation, relaxing imagery? We can work on some of these strategies in the office.”

Psychoeducation About Psychosomatic Symptoms

Say, “Psychosomatic problems or conditions are generally affected by stress. Do you think that stress is a factor in your situation?” □ Yes □ No

“If so, how does it affect you?”

Psychoeducation About Goal Setting, Hopes, and Plans

Explore goal setting, hopes, and plans.

Note: This can be a very informal discussion. As you talk, be aware of possible negative core beliefs and possible targets for EMDR processing.

Say, “Having health issues can make you fatigued, so we will make sure to go at your pace. Always let me know when you want to take a break. Let’s explore some goals for us to work on.”

Explanation of EMDR as in the Standard EMDR Protocol

Introduce EMDR therapy and explain the AIP concepts, function, and types of bilateral stimulation in your usual style, when appropriate.

Say, “When a trauma occurs, it seems to be locked in the nervous system with the original picture, sounds, thoughts, and feelings. The eye movements we use in EMDR seem to unlock the nervous system and allow the brain to process the experience. That may be what is happening in REM or dream sleep—the eye movements may help to process the unconscious material. It is important to remember that it is your own brain that will be doing the healing and you are the one in control.”

Say, “BLS, or bilateral stimulation, is a component of EMDR therapy. It consists of eye movements, auditory tones, or tactile tapping. I’ll show them all to you. We generally start with eye movements.”

Say, “EMDR therapy is an evidence-based therapy that is rated as highly effective in the treatment of trauma. As physical illnesses take a toll on the mind and body, they can be conceptualized as traumatic. Therefore, they are appropriate for EMDR treatment.”

Positive Healing Resources

Teach positive healing resources such as progressive muscle relaxation, slow deep breathing, and yoga breathing.
Say, “These are strategies that will help you be calm and relaxed. You’ll find a couple that you like and can practice at home in-between sessions. I will teach them to you now.”

PROGRESSIVE MUSCLE RELAXATION

Say, “This is a gentle way to achieve relaxation. Just imagine the muscles in your head, scalp, and face feeling calm and relaxed, soft and loose. Now do the same with the muscles in your neck, shoulders, chest, arms, and back. Notice how that feels. Keep going slow until you reach your toes. Can you describe what that feels like? What are you noticing?”

Note: If it seems safe and timely, introduce the idea of resourcing with BLS.

Say, “Let’s do a few sets of BLS to enhance your response.”

SLOW DEEP BREATHING

Say, “Often when we are ill, stressed, and sleep deprived, we take shallow breaths and it’s hard to relax. Here’s another way to relax. Put one hand on your belly and notice what it feels like when you take a nice slow deep breath. As you inhale, notice your belly filling up with that breath and getting flat when you exhale. Try it a few times and see what you notice.”

YOGA BREATHING

Say, “Here is another easy breathing exercise. Watch me, and then you can try it. I’ll breathe in and count to 4. Then I’ll hold my breath to the count of 4 and breathe out to the count of 4.

Now you try it. If 4 is too long, try counting to 3. Do that three times.

What did you notice when you tried that?”

COCOON OF LIGHT MEDITATION

Say, “Find a comfortable position. With this exercise, we work with light as well as the breath. Take some slow gentle breaths. As you inhale, imagine a healing light of any color you like coming from the universe above, a spiritual place, or any source. Imagine the light forming a cocoon surrounding your entire body. Notice how that feels. If you like, you can imagine the cocoon of light entering your body and filling it with the same healing light. You can keep this light around you and keep gently breathing as long as you like.”

CALM SPACE

Teach the Calm Space exercise to your clients.

Say, “Think about being in a place that feels calm and relaxing. Just notice what you see, feel, and even hear. You may notice emotions and physical sensations that feel comfortable. Let yourself enjoy them, and ______ (state BLS)”
Do slow BLS.

Say, “What do you notice now?”

Say, “Think of a word that represents your calm place. Focus on that and _____ (state BLS).”

Do slow BLS.

**Crisis Work: Immediate Need for Health Treatment in Any Phase**

Teach how to deal with an upcoming visit to the medical/healthcare provider office, with medical and dental procedures, and so on. You are still working in Phases 1 to 3 and processing work has not begun. Remember, many CPTSD clients are avoidant of medical treatment.

Say, “We’ve talked a little about going to the _______ (whatever health situation is upcoming). You’ve been feeling anxiety about keeping the appointment, and have described avoiding and not following up on healthcare before. Do you have a sense of why this happens?” (Explore for future EMDR processing.)

Say, “What do you think will help you get through this more easily? Please share your needs and concerns.”

Utilize imaginal rehearsal of an office visit if appropriate (may be repeated as future template work). Introduce and use BLS if safe.

Say, “Imagine the steps of making an appointment, asking questions of the doctor, telling the doctor your needs and concerns, having the work done, and seeing it go well. If there are problems, we’ll try again.”

Say, “How did you do?”

If the client is still avoidant, introduce the “Constructive Avoidance of Present-Day Situations” exercise. This is an opportunity to introduce the concept of parts, ego states, and so on. The goal is to teach parts to stay safe when the client or “adult” has to do “adult tasks” such as visit a healthcare provider. This technique can be taught to all clients who become overly stressed in these situations.

Say, “All of us have different parts of our personality. When we have a discussion in our heads, or are aware of two sides of a conflict, we can say that our parts are talking, or arguing. The argument could be about keeping the appointment. It might have to do with an old trauma. Later on, when the time is right, we can process these with EMDR. For now, the goal is to help you get through this _______ (state what client is preparing for) with more comfort.”

For dissociative clients:

Say, “Due to the many traumatic events in your early life, many of your parts may not feel safe in a medical/dental setting and you are feeling their desire to avoid the situation. We can help them feel more comfortable.”
CONSTRUCTIVE AVOIDANCE OF PRESENT-DAY SITUATIONS SCRIPT

Note: This protocol assumes that clients have already established a home base (Forgash, 2009b) and workplace (Forgash, 2009c).

Say, “Okay, now that you have been working with your calm place for a while, let us put it to use in this situation of ____________ (state the current situation that the client is concerned about). Bring up the calm place and just spend a little time there. We can teach your parts about a calm place that they can have for themselves. Can you suggest a place that they might like for their calm place? It could be a house in the country or on the beach. Imagine showing your parts that place and have them visit the ____ (state the place). Show them the family room and kitchen. Ask them what they would like in the place. Tell them that you can use it for meetings, for fun, whatever they would like.”

Option:
If a real event is going to occur relatively soon, use the real event.

Say, “If no real event is going to occur soon, you can make one up just for practice. What would you like to use for a practice situation?”

Say, “Chances are some of your parts or ego states are not ready to deal with this situation. How about this? The day of the appointment, they will remain at their calm place while you deal with the present situation and go to ____________ (state the current situation that the client is concerned about).”

Let’s invite them to listen in as we work on this.

Say, “I would like to tell you about a new way to work with ____________ (state the upcoming situation).”

Say, “This is just an imaginary practice session. You can remind parts that they don’t have to listen if they don’t want to. Is that all right with everyone?”

If appropriate, say the following:

Say, “Tell them that they have the choice of watching what will happen on a screen or not watching. Or you could ask them what would they like to do while they are at their calm place and you are at ____________ (state where you will be, such as doctor, dentist, etc.).”
Say, “Okay, tell the parts that you will always, when possible, tell them when you are going to have a situation that you have to deal with but for which they don’t need to be present. They can stay at the calm place.”

Say, “Remind them that they are always with you, but by staying ‘at the calm place,’ they don’t have to ‘be’ at the __________________ (state the kinds of situations that they might have to encounter) or even pay attention to the situation while it is happening.”

Say, “Also, you might tell them that you will always let them know when the situation or event has been completed. If you would like, you can ask them what they think about this idea.”

Say, “Another choice is to let the parts know that sometimes they might want one part to take care of everyone while you are at the __________________ (state where you will be). Who could that be? Does anyone want to volunteer?”

Say, “Tell the parts in words they can understand what is going to occur. For example, if you are going for a dental checkup and you know that in the past you have felt some anxiety but not too much, let them know this is what usually happens. Otherwise, use a practice situation.”

Say, “Let’s practice by imagining together that _________________ (‘I am going to the dentist in 2 weeks’ or use as an example any appropriate task that needs to be done). It’s only for _________________ (a checkup or state the purpose). _________________ (‘The dentist will just look at my teeth and take an x-ray’ or state the appropriate task.) What would you like to do at home while I’m getting my _________________ (checkup or state the activity)?”

Say, “Tell them, if they like, that they can watch the TV screen now and you can show them what the _________________ (checkup or state the activity) will look like.”
Say, “Anyone who doesn’t want to watch doesn’t have to. Remind them that they can say, ‘Stop!’ at any time. Play a short movie (of going to the dentist, sitting in the waiting room, or state the appropriate task). Going into the (office or other relevant area). Telling the (dentist or relevant person) that you want them to ‘Stop!’ when you put your hand up and to always tell you what will be happening. (show the dentist looking at your teeth and the hygienist taking an x-ray or whatever relevant action). Let them see you are leaving (the office or the relevant area). Ask them what they noticed about how things went. You can go ahead and do that now.”

Say, “Do you have any questions before you start?”

Say, “Is there anything else they need to help them be okay that day?”

Say, “If all is well, ask them what feels good about what they did today.”

This can be enhanced with a few short sets of BLS.

Say, “When the day of the appointment arrives, tell the parts, ‘I’ll tell you when I’m leaving to go there and I’ll let you know when I leave the (dentist’s office or wherever they are going). Is that okay with all of you?’”

Say, “Remind them that there will be opportunities to practice at the next session and at home. Ask if there are any more questions, and if there are, go ahead and discuss them.”

Debrief with a relaxation exercise and reminder to practice at home.

Say, “Is there anything else that happened today that you feel is important and we should address, or are there any parts who have something to say or have questions?”

Say, “Okay, let’s end with a relaxation exercise. You can choose from the ones that we have worked on before such as your safe or comfortable space, progressive muscle relaxation, slow deep breathing, yoga breathing (breathe in to the count of 4, hold to the count of 4,
breathe out to the count of 4), finding the relaxed place in the body and gently focusing on that place or another one that you would find helpful, or any other relaxation exercises. Which one would you like to do today?”

When the client chooses one, go through the closing exercise. Always use this as a time to check in with the system to make sure that everyone is okay before leaving the session. This is a good safety measure and models for everyone how to take care of themselves.

After doing the closing exercise, say the following:

“Okay, I would like to check in with everyone to make sure that all of you are okay before you leave the session. How are you doing?”

Say, “I would like to remind you before you leave that you can practice this exercise at home this week.”

Phase 3: Assessment

Note: For complex trauma/dissociative clients, dissociated ego states may need to work together on a target. Or several ego states with the same issue may work together to promote internal connection and cohesion.

Say, “From what you have told me, you were traumatized by ______________ (state if it was abuse, rape, abandonment, etc.) several times. Let’s talk with the parts and see if it would be helpful if those parts who were traumatized in the same ways would like to work.”

Say, “Let’s talk about the traumas we need to reprocess concerning your personal health. We can talk about current health issues and old childhood traumas and decide the sequence of processing.”

List of Traumas to Reprocess

Choose the target with which to begin and do the assessment.

Example:

Say, “We’ve been talking about your current medical problems and how that affects you. With which concern would you like to begin?”
Say, “What happens when you think of ________ (state the issue)?”

_______________________________________________________

Say, “Or you may want to bring up the earliest time you had this ________ (state the issue).”

_______________________________________________________

Or say, “When you think of ________ (state the issue), what do you get?”

_______________________________________________________

**Picture**

Say, “What picture represents the entire ________ (state the issue)?”

_______________________________________________________

Say, “What picture represents the most traumatic part of ________ (state the issue)?”

_______________________________________________________

**Negative Cognition**

Say, “What words best go with the picture that express your negative belief about yourself now?”

_______________________________________________________

**Positive Cognition**

Say, “When you bring up that picture or ________ (state the issue), what would you like to believe about yourself, now?”

_______________________________________________________

**Validity of Cognition (VOC)**

Say, “When you think of ________ (state the issue or picture), how true do those words ________ (clinician repeats the PC) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”

1 2 3 4 5 6 7
(completely false) (completely true)
Sometimes, it is necessary to explain further.

Say, “Remember, sometimes we know something with our head, but it feels differently in our gut. In this case, what is the gut-level feeling of the truth of __________ (clinician states the PC), from 1 (completely false) to 7 (completely true)?”

1 2 3 4 5 6 7
(completely false) (completely true)

**Emotions**

Say, “When you bring up the picture or __________ (state the issue) and those words __________ (clinician states the NC), what emotion do you feel now?”

**Subjective Units of Disturbance (SUD)**

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)

**Location of Body Sensation**

Say, “Where do you feel it (the disturbance) in your body?”

Say, “Please list the adverse life experiences/small ‘t’ traumas we need to reprocess.”

**List of Adverse Life Experiences/Small “t” Traumas to Reprocess**

Choose the target with which to begin and do the assessment as earlier.

Say, “Please list the important losses we need to reprocess.”

**List of Important Losses**
Choose the target with which to begin and do the assessment as earlier.

Say, “Please list the missed opportunities, regrets, and remorse about poor health we need to reprocess.”

**List of Missed Opportunities, Regrets, and Remorse About Poor Health**

Choose the target with which to begin and do the assessment as earlier.

Say, “Please list the harmful habits we need to reprocess.”

**List of Harmful Habits**

Choose the target with which to begin and do the assessment as earlier.

**Phase 4: Desensitization**

**Note:** Due to fatigue, confusion, and disorientation due to illness, plus the possibility of dissociation, it’s often necessary to work in small segments and to let the client know that it is perfectly normal for him or her to ask to stop. Go over the stop sign. It may take many sessions to complete a target. This is common and needs to be normalized, as well.

Say, “Now, remember, it is your own brain that is doing the healing and you are the one in control. I will ask you to mentally focus on the target and to follow my fingers (or any other BLS you are using). Just let whatever happens, happen, and we will talk at the end of the set. Just tell me what comes up, and don’t discard anything as unimportant. Any new information that comes to mind is connected in some way. If you want to stop, just raise your hand. Often, it is helpful to work in small segments. We can decide that as we go.”

Then say, “Bring up the picture and the words __________ (clinician repeats the NC) and notice where you feel it in your body. Now follow my fingers with your eyes (or other BLS).”

Additionally and equally important is to look for signs of dissociation such as looking away, shutting down, being unable to communicate, and so on. This will necessitate using stabilization interventions to bring the person back to present orientation. When this occurs in a processing session, these are the types of phrases you can use to support the processing with your client. Say any of these phrases as you will learn which work best with each client:

- “What are you feeling in your body?”
- “Where are you right now?”
- “Let’s use the Back-of-the-Head scale.”*
- “Is there a part who needs to talk right now?”

Or use physically based strategies as the following:

- “Tap your feet.”
- “Here, catch this ball.”
- “Listen to the clock ticking.”

Then, if possible, return to processing and say any of the following:

Say, “Do you feel present in your body now?”

________________________________________________________________________

Or, say, “What did you notice when we worked on helping you come back to the present?”

________________________________________________________________________

Or, say, “What are you noticing now?”

________________________________________________________________________

Say, “Let’s go back to the target or the processing.”

________________________________________________________________________

If necessary, close down the session with a relaxation exercise that can include the ego states.

Say, “You have worked very hard today. Why don’t you go back to a calm place and help the parts who were here today go back to their calm place? Remind them that this is a private place for them totally unknown to anyone but you and them. Let them know that you will check in occasionally and that we’ll continue working together at the next session.”

________________________________________________________________________

Phase 5: Installation

Say, “How does ________ (repeat the PC) sound?”

________________________________________________________________________

Say, “Do the words ________ (repeat the PC) still fit, or is there another positive statement that feels better?”

________________________________________________________________________

If the client accepts the original PC, the clinician should ask for a VOC rating to see if it has improved:
Say, “As you think of the incident, how do the words feel, from 1 (completely false) to 7 (completely true)?”

1 2 3 4 5 6 7
(completely false) (completely true)

Say, “Think of the event and hold it together with the words __________ (repeat the PC).”

Do a long set of BLS to see if there is more processing to be done.

Phase 6: Body Scan

Say, “Close your eyes and keep in mind the original memory and the PC. Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness, or unusual sensation, tell me.”

Phase 7: Closure

Say, “Things may come up or they may not. If they do, great. Write it down and it can be a target for the next time. You can use a notebook or journal to write down triggers, images, thoughts or cognitions, emotions, and sensations; you can rate them on our 0-to-10 scale, where 0 is no disturbance or neutral and 10 is the worst disturbance. Please write down the positive experiences, too.”

Say, “If you get any new memories, dreams, or situations that disturb you, just take a good snapshot. It isn’t necessary to give a lot of detail. Just put down enough to remind you so we can target it the next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it’s still just the old stuff. Just write it down for the next time. Then use the tape or the Safe Place exercise to let as much of the disturbance go as possible. Even if nothing comes up, make sure to use the tape every day and give me a call if you need to.”

Phase 8: Reevaluation

Present Stimuli That Trigger the Disturbing Memory or Reaction

List the situations that elicit the symptom(s). Examples of situations, events, or stimuli that trigger clients could be the following: another trauma, the sound of a car backfiring, or being touched in a certain way.

Say, “What are the situations, events, or stimuli that trigger your trauma __________ (state the trauma)? Let’s process these situations, events, or stimuli triggers one by one.”

Fears About Present and Future Due to Permanent Physical Damage Trigger List

Say, “What are the fears you have about the present and future due to permanent physical damage?”
Say, “What are the problems that trigger you?”

Problems Trigger List

Target or Memory
Say, “What situation, event, or stimulus that triggers you would you like to use as a target today?”

Picture
Say, “What picture represents the _________ (state the situation, event, or stimulus) that triggers you?”

If there are many choices or if the client becomes confused, the clinician assists by asking the following:
Say, “What picture represents the most traumatic part of the _________ (state the situation, event, or stimulus) that triggers you?”

When a picture is unavailable, the clinician merely invites the client to do the following:
Say, “Think of the _________ (state the situation, event, or stimulus) that triggers you.”

Negative Cognition
Say, “What words best go with the picture that express your negative belief about yourself now?”

Positive Cognition
Say, “When you bring up that picture or the _________ (state the situation, event, or stimulus) that triggers you, what would you like to believe about yourself now?”

Validity of Cognition
Say, “When you think of the _________ (state the situation, event, stimulus, or picture that triggers you), how true do those words _________ (clinician repeats the positive cognition) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”

1  2  3  4  5  6  7
(completely false)  (completely true)
Sometimes, it is necessary to explain further.

Say, “Remember, sometimes we know something with our head, but it feels differently in our gut. In this case, what is the gut-level feeling of the truth of ________ (clinician states the PC), from 1 (completely false) to 7 (completely true)?”

1 2 3 4 5 6 7
(completely false) (completely true)

**Emotions**

Say, “When you bring up the picture (or state the situation, event, or stimulus) that triggers you and those words ________ (clinician states the NC), what emotion do you feel now?”

**Subjective Units of Disturbance**

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)

**Location of Body Sensation**

Say, “Where do you feel it (the disturbance) in your body?”

Continue to process the triggers according to the Standard EMDR Protocol.

**FUTURE TEMPLATE SCRIPT**

**Fears of Being Alone and Unsupported List**

Say, “Please note any fears you have of your illness or medical condition reoccurring.”

**Fears of Recurrence of the Illness or Medical Condition**

Say, “Please note any fears you have of your illness or medical condition reoccurring.”

**Check the Significant People and Situations of the Presenting Issues for Any Type of Distress**

It is helpful to check to see if all the material concerning the issue upon which the client has worked is resolved or if there is more material that has escaped detection so far. The future template is another place to find if there is more material that needs reprocessing.
**Significant People**

When the client’s work has focused on a significant person, ask the following:

Say, “Imagine yourself encountering that person in the future __________ (suggest a place where the client might see this person). What do you notice?”

Watch the client’s reaction to see if more work is necessary. If a client describes a negative feeling in connection with this person, check to see if it is reality based.

Say, “Is __________ (state the person’s name) likely to act __________ (state the client’s concern)?”

If the negative feeling is not matching the current reality, say the following:

“What do you think makes you have negative feelings toward __________ (state the person in question)?”

If the client is unsure, use the floatback technique or affect scan to see what other earlier material may still be active.

Say, “Please bring up that picture of ____ (state image) and those negative words______, ____ (repeat client’s disturbing image and NC); notice what feelings are coming up for you, where you are feeling them in your body; and just let your mind float back to an earlier time in your life—don’t search for anything—just let your mind float back and tell me the first scene that comes to mind where you had similar:

Thoughts of ___ (repeat NC)
Feelings of ___ (repeat emotions stated previously)
In your ____ (repeat places in the body where the client reported feelings).”

If the negative feelings are appropriate, it is important to reevaluate the clusters of events concerning this person and access and reprocess any remaining maladaptive memories. (See Past Memory Worksheet.)

**Significant Situations**

Say, “Please list the skills needed to be learned and practiced.”

**SKILLS NEEDED TO BE LEARNED AND PRACTICED LIST**
Say, “Please list any projected future situations of concern such as physical therapy, other rehabilitation, diagnosis, testing, family occasions, returning to work, becoming well again, and so on.”

**PROJECTED FUTURE SITUATION LIST**

(Physical therapy, other rehabilitation, diagnosis, testing, family occasions, returning to work, becoming well again, etc.)

It is important to have the client imagine being in significant situations in the future; this is another way of accessing material that may not have been processed.

Say, “Imagine a videotape or film of how ________ (state the current situation client is working on) and how it would evolve ________ (state the appropriate time frame) in the future. When you have done that, let me know what you have noticed.”

If there is no disturbance, reinforce the positive experience.

Say, “Go with that.”

Do BLS.

Reinforce the PC with the future situation with BLS as it continues the positive associations. For further work in the future, see later in the text.

If there is a disturbance, assess what the client needs: more education, modeling of appropriate behavior, or more past memories for reprocessing.

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?”

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**Anticipatory Anxiety**

When the SUD is above 4, or when the desensitization phase is not brief, the clinician should look for a present trigger and its associated symptom and develop another targeting sequence plan using the Three-Pronged Protocol. (See worksheets on Past Memories and Present Triggers.)

When there is anticipatory anxiety at an SUD level of no more than 3 to 4 maximum, it is possible to proceed with reprocessing using the future template. The desensitization phase should be quite brief.

Say, “What happens when you think of ________ (state the client’s anticipatory anxiety or issue)?”

Or say, “When you think of ________ (state the client’s anticipatory anxiety or issue), what do you get?”
Picture
Say, “What picture represents the entire _________ (state the client’s anticipatory anxiety or issue)?”

If there are many choices or if the client becomes confused, the clinician assists by asking the following:
Say, “What picture represents the most traumatic part of _________ (state the client’s anticipatory anxiety or issue)?”

Negative Cognition
Say, “What words best go with the picture that express your negative belief about yourself now?”

Positive Cognition
Say, “When you bring up that picture or _________ (state the client’s anticipatory anxiety or issue), what would you like to believe about yourself now?”

Validity of Cognition
Say, “When you think of _________ (state the client’s anticipatory anxiety or issue) or picture, how true do those words _________ (clinician repeats the PC) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”

1 2 3 4 5 6 7
(completely false) (completely true)

Emotions
Say, “When you bring up the picture or _________ (state the client’s anticipatory anxiety or issue) and those words _________ (clinician states the NC), what emotion do you feel now?”

Subjective Units of Disturbance
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)
Location of Body Sensation

Say, “Where do you feel it (the disturbance) in your body?”

Use the Standard EMDR Protocol.

Video Check (Future Template as Movie)

Say, “This time, I’d like you to imagine yourself stepping into the scene of a future confrontation with the object or the situation for which the future template was meant (e.g., to focus on illness/future challenges). Close your eyes and play a movie of this happening, from the beginning until the end. Imagine yourself coping with any challenges that come your way. Notice what you are seeing, thinking, feeling, and experiencing in your body. While playing this movie, let me know if you hit any blocks. If you do, just open your eyes and let me know. If you don’t hit any blocks, let me know when you have viewed the whole movie.”

If the client encounters a block and opens her eyes, this is a sign for the therapist to instruct the client to say the following:

“Say to yourself ‘I can handle it’ and follow my fingers (introduce a set of eye movements).”

To provide the clinician with an indication regarding the client’s self-efficacy, ask her to rate her response on a VOC scale from 1 to 7. This procedural step may give the clinician feedback on the extent to which the goals are met.

Say, “As you think of the incident, how do the words feel from 1 being completely false to 7 being completely true?”

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<td>(completely true)</td>
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If the client is able to play the movie from start to finish with a sense of confidence and satisfaction, the client is asked to play the movie once more from the beginning to the end, BLS is introduced, and the PC, “I can handle it,” is installed. In a sense, this movie is installed as a future template.

Say, “Okay, play the movie one more time from beginning to end and say to yourself, ‘I can handle it.’ Go with that.”

SUMMARY

The intent of this chapter is to provide information that will help EMDR therapists enhance their ability to provide effective EMDR treatment for clients diagnosed with complex trauma who are also dealing with current health problems. The use of the ACE questionnaire, which provides much needed information on childhood abuse, neglect, attachment disorders, PTSD, and dissociation, is highlighted. This questionnaire, when combined with a broad developmental and health history, will be very helpful in case conceptualization and development of targets for work in Phases 4 to 7. Additionally, the author describes the links between the ACE issues and later health risks and problems that make these clients difficult to treat. Add to these issues with trust and relationship problems, and it is easy to recognize why these clients have had historical problems with accessing good healthcare. They deserve the best that we can give them.
Working with complex trauma clients who are also dealing with illness can be stressful, frustrating, and exhausting. It is important for us to be supported as we do this important, but difficult work. It is vital to seek consultation, peer support, and other aids (i.e., attending conferences, reading) to help us thrive in our work.

REFERENCES


INTRODUCTION

Issues for the complex trauma/ACE survivor client, which can be targeted with EMDR therapy, include the following:

- Serious illness
- Untreated medical or dental symptoms
- Untreated substance abuse
- Lack of skills related to hygiene and healthcare
- Other health risk behaviors
- Avoidance of health treatment
- Lack of follow through
- Current accidents
- Illnesses
- Hospitalizations

Another set of problems for complex trauma patients involves difficult-to-diagnose illnesses or conditions. They are typically called medically unexplained symptoms (MUS) such as the following:

- Respiratory illness
- Musculoskeletal complaints
- Chronic pain
- Fibromyalgia
- Chronic fatigue
- Eating disorders
- Headaches
- Irritable bowel syndrome
- Gynecological problems including pregnancy
Dissociation is a way that the CPTSD client copes. Symptoms include the following (Forgash, 2009a):

- Hyper- or hypo-arousal/numbing
- “Out of body” experiences
- Not being present in the body
- Losing time
- “Going away” when stressed
- Depersonalization/derealization
- Looking “different” in session
- Hearing “voices”

Somatic Dissociation

- Perceptual alterations
- Somatic symptoms
- Depersonalization of body part
- Fragmented images of the traumatic event that produced the pain or injury
- Current injury may be in same areas as earlier accident/traumatic event but may have amnesia

CPTSD, PERSONAL HEALTH, AND EMDR THERAPY SCRIPT NOTES

When making treatment-planning decisions, remember it is a cooperative process. Determine if health issues are related to the following:

- Developmental/attachment trauma
- Shock trauma (including iatrogenic shock treatment)
- Normal health issues that the client is lacking skills to deal with
- Family illnesses/patterns
- Chronic health problems
- Pain issues

Which targets take precedence?

- Adverse life experiences/small “t” trauma clusters concerning health and losses from earlier times
- Current life issues and illnesses
- Large “T” trauma, current and past
- Recent incidents/illnesses/injuries
- Health problems related to similar/earlier incidents

Certain types of negative and positive cognitions come up frequently in this population:

- Avoidance of treatment due to prior interactions with healthcare providers
  - NC: “I am not safe. I am not worth it.”
  - PC: “I am safe now. I’m worth it.”
- History of being labeled and misinterpreted
  - NC: “It is all in my head.”
  - PC: “My medical problems are real. I’m worth listening to.”
- History of abandonment
  - NC: “I am always going to be alone. I will die alone.”
  - PC: “I deserve support. I can start to connect with people.”
- Fear of exams/procedures provoking flashbacks/dissociation
  - NC: “I am crazy. No one will understand me.”
  - PC: “I can advocate for myself and be understood.”
- Chronic illness/pain
  - NC: “It will never get any better. I am going to die.”
  - PC: “I can cope with my situation.”
Losses, including identity
NC: “I have lost too much.”
PC: “I can find a way to still be myself. I’m still able to have a life.”

Introduce dissociative and affect management strategies to help the client stay in the optimum window of arousal.

- Resource development and installation
- Ego-building activities
- Mindfulness activities
- Learning to control stressful feelings and pain (Grant, 2009)
- Healing imagery (Siegel, 1988; Simonton, 1978)
- Positive body resource exercise (Levine, 2010)
- Cocoon of light healing exercise; meditation practices
- Safety/distancing work (containers, affect dial/screen work); Back-of-the-Head scale; journaling, drawing, mapping [Forgash & Copley, 2008]
- Heart coherence exercise (Servan-Schreiber, 2004)

CPTSD, PERSONAL HEALTH, AND EMDR THERAPY SCRIPT

Adverse Childhood Experience (ACE) Questionnaire Score = ______

See the questionnaire in the chapter for questions.

General Medical Questions:
Health issues in early childhood: ____________________________

<table>
<thead>
<tr>
<th>Fevers:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comment:</td>
<td>____________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Serious falls:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comment:</td>
<td>____________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe if yes:</td>
<td>____________________</td>
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</tbody>
</table>

Recurrent illnesses and/or situations that the physician induced or that cause problems:

<table>
<thead>
<tr>
<th>□ Yes □ No</th>
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<tbody>
<tr>
<td>Comment:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Painful conditions:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comment:</td>
<td>____________________</td>
</tr>
</tbody>
</table>

Current problems including pain and disability: ____________________________

<table>
<thead>
<tr>
<th>Serious illnesses or surgeries:</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe mental health:</td>
<td>____________________</td>
</tr>
</tbody>
</table>

Been in therapy:

<table>
<thead>
<tr>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comment:</td>
</tr>
</tbody>
</table>

Drugs, alcohol, or eating disorders:

<table>
<thead>
<tr>
<th>□ Yes □ No</th>
</tr>
</thead>
</table>
Comment: ________________________________________________________________

Health of close family members (serious illness, substance abuse, eating disorder, mental health issue, medical or dental problems): ________________________________________________________________

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Deaths in family, especially when child: ____________________________________________ □ Yes □ No
Comment: ______________________________________________________________________

Close friends or family went away or came and went frequently: □ Yes □ No
Comment: ______________________________________________________________________

**HEALTH PRACTICES QUESTIONS**

Taught regular basic hygienic routines: □ Yes □ No
Comment: ______________________________________________________________________

Went regularly to doctor and dentist when young: □ Yes □ No
Comment: ______________________________________________________________________

Last dental and medical exams: ____________________________________________________
______________________________________________________________________________

**OTHER HEALTH RISK BEHAVIORS**

“Some risky health habits include using drugs or alcohol, having unprotected sex, any eating disorders, or cutting. Have you had some of these problems?”: □ Yes □ No
Comment: ______________________________________________________________________

**AVOIDANCE OF HEALTH TREATMENT**

History of avoiding medical care?: □ Yes □ No
Comment: ______________________________________________________________________

**LACK OF FOLLOW THROUGH**

Problem following doctor’s suggestions or taking medications?: □ Yes □ No
Comment: ______________________________________________________________________

**CURRENT ACCIDENTS**

Recent accidents?: □ Yes □ No
Comment: ______________________________________________________________________

**ILLNESSES**

Recent illnesses?: □ Yes □ No
Comment: ______________________________________________________________________

**HOSPITALIZATIONS**

Recent hospitalizations?: □ Yes □ No
Comment: ______________________________________________________________________
“Have you ever been ill with any of the following?”

☐ Respiratory illness
☐ Musculoskeletal and joint complaints
☐ Chronic pain
☐ Fibromyalgia
☐ Chronic fatigue
☐ Eating disorders
☐ Headaches
☐ Irritable bowel syndrome
☐ Gynecological problems including pregnancy
☐ Regional pain syndromes
☐ Pseudo-neurological symptoms
☐ Sleep disorders
☐ Rheumatoid arthritis
☐ Thyroid diseases
☐ Crohn’s disease

Check if you have these symptoms:

Hyper/hypo-arousal/numbing: □ Yes □ No
Describe: ____________________________________________________________

“Out of Body” experiences: □ Yes □ No
Describe: ____________________________________________________________

Not being present in the body: □ Yes □ No
Describe: ____________________________________________________________

Losing time: □ Yes □ No
Describe: ____________________________________________________________

“Going away” when stressed: □ Yes □ No
Describe: ____________________________________________________________

Depersonalization/derealization: □ Yes □ No
Describe: ____________________________________________________________

Looking “different” in session: □ Yes □ No
Describe: ____________________________________________________________

Hearing “voices”: □ Yes □ No
Describe: ____________________________________________________________

Perceptual alterations: □ Yes □ No

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Describe: 

Somatic Symptoms:  □ Yes □ No

Describe: 

Client's Supports, Skills, and Strengths

Current supports in life: 

Past supports in life: 

Describe your skills and strengths: 

Phase 2: Preparation

Psychoeducation

“This work will take several sessions or longer to communicate these very important concepts or information with patients. Some of it could be ‘triggering’ or upsetting. Slow is best. People who have physical illness tire easily and have less energy, focus, and retention.”

Psychoeducation About Patient Rights:  □ Yes □ No

“Clients have rights as health consumers. Every one of your health providers should give you and discuss the Client Bill of Rights. You need to read it and ask questions about anything you don’t understand.”

Psychoeducation About Becoming a Proactive Health Consumer:  □ Yes □ No

“One of the things you can do is bring a friend or family member with you to the doctor’s office. When you are not feeling well, it’s easier to misunderstand or be confused. You can make up a list of questions and concerns to discuss at the visit. Or we can do that as well.

In our community you will find associations such as the (state the one that is appropriate: American Cancer Society, AA, the American Heart Association, etc.). They offer many kinds of services and education. It might be helpful for you to contact them. Would you be interested in speaking with them?”

Psychoeducation About General Health, Stress and Pain, Normalizing Trauma Symptoms, and Their Effects on Health and Stress Reduction Work:  □ Yes □ No

“We know that trauma, stress, and pain all have an effect on health. What do you do in your life now to help yourself be healthy? Have you tried exercise, meditation, or relaxing imagery? We can work on some of these strategies in the office.

Psychoeducation About Psychosomatic Symptoms:  □ Yes □ No

Psychosomatic problems or conditions are generally affected by stress. Do you think that stress is a factor in your situation?  □ Yes □ No

If so, how does it affect you? 

Psychoeducation About Goal Setting, Hopes, and Plans:  □ Yes □ No

“Having health issues can make you fatigued, so we will make sure to go at your pace. Always let me know when you want to take a break. Let’s explore some goals for us to work on.”

Explanation of EMDR as in the Standard EMDR Protocol:  □ Yes □ No

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“When a trauma occurs, it seems to be locked in the nervous system with the original picture, sounds, thoughts, and feelings. The eye movements we use in EMDR seem to unlock the nervous system and allow the brain to process the experience. That may be what is happening in REM or dream sleep—the eye movements may help to process the unconscious material. It is important to remember that it is your own brain that will be doing the healing and you are the one in control.

BLS, or bilateral stimulation, is a component of EMDR therapy. It consists of eye movements, auditory tones, or tactile tapping. I’ll show them all to you. We generally start with eye movements.

EMDR therapy is an evidence-based therapy that is rated as highly effective in the treatment of trauma. As physical illnesses take a toll on the mind and body, they can be conceptualized as traumatic. Therefore, they are appropriate for EMDR treatment.”

Positive Healing Resources

PROGRESSIVE MUSCLE RELAXATION

“This is a gentle way to achieve relaxation. Just imagine the muscles in your head, scalp, and face feeling calm and relaxed, soft, and loose. Now do the same with the muscles in your neck, shoulders, chest, arms, and back. Notice how that feels. Keep going slow until you reach your toes. Can you describe what that feels like? What are you noticing? + BLS.”

SLOW DEEP BREATHING

“Often when we are ill, stressed, and sleep deprived, we take shallow breaths and it’s hard to relax. Here’s another way to relax. Put one hand on your belly and notice what it feels like when you take a nice slow deep breath. As you inhale, notice your belly filling up with that breath and getting flat when you exhale. Try it a few times and see what you notice.”

YOGA BREATHING

“Here is another easy breathing exercise. Watch me, and then you can try it. I’ll breathe in and count to 4. Then I’ll hold my breath to the count of 4 and breathe out to the count of 4. Now you try it. If 4 is too long, try counting to 3. Do that three times. What did you notice when you tried that?”

COCON OF LIGHT MEDITATION

“Find a comfortable position. With this exercise, we work with light as well as the breath. Take some slow gentle breaths. As you inhale, imagine a healing light of any color you like coming from the universe above, a spiritual place, or any source. Imagine the light forming a cocoon surrounding your entire body. Notice how that feels. If you like, you can imagine the cocoon of light entering your body and filling it with the same healing light. You can keep this light around you and keep gently breathing as long as you like.”

CALM SPACE

Teach the Calm Space exercise to your clients.

“Think about being in a place that feels calm and relaxing. Just notice what you see, feel, and even hear. You may notice emotions and physical sensations that feel comfortable. Let yourself enjoy them, and follow my fingers. (Slow BLS) What do you notice now?”

“Think of a word that represents your calm place.”

Focus on that + BLS

Crisis Work: Immediate Need for Health Treatment in Any Phase

☐ Visit to medical/healthcare provider office
☐ Imaginal rehearsal of an office visit, if appropriate
Note: This protocol assumes that clients have already established a home base (Forgash, 2009b) and workplace (Forgash, 2009c).

**Constructive Avoidance of Present-Day Situations Accomplished:** □ Yes □ No

Real/practice situation: ____________________________________________________________

Let clients know whether it is a real/practice situation: □ Real □ Practice

Ego states not ready to go will remain at calm place: □ Yes □ No

Invite all to the calm place to learn about a new way to deal with present-day situations.

Choice of watching on screen/what would they like to do while client is at ___ (state). ___________

Tell parts when a situation will be coming up and they can stay home: □ Yes □ No

Tell parts always with you, but can stay at “home”: □ Yes □ No

Tell parts will let them know when the situation is over: □ Yes □ No

Thinking: ____________________________________________________________

Or there might be one part who takes care of everyone while you are at the ___ (state): □ Yes □ No

Who would the parts want to take care of them while you are at the __ (state)? _________________

Tell them what to expect when ___ (state). __________________________________________________________

**Practice**

Imagine going to ___ (state the appointment you are going to) + What you would like to do at home while I am ___ (state)

State the activity: ________________________________________________________________

Imagine it: ________________________________________________________________

**Movie** of activity going to do:

Parts participating: ________________________________________________________________

Parts not participating: ________________________________________________________________

Imagine ___ (state activity) + ___ (state what will happen) + What would you like to do when I am ___ (state activity)?

Practice activity and saying, “Stop!” (to relevant person) when they need to: □ Yes □ No

Let them see you leaving: □ Yes □ No

**Questions**

Anything else that needs to be okay: □ Yes □ No

What feels good about what they did: ________________________________________________________________

Use BLS.

**Day of activity/appointment**

Tell when leaving to go: □ Yes □ No
Tell when leaving the ___ (state where went):          □ Yes □ No
Agreement to do this:                                □ Yes □ No
Opportunities to practice at the next session and at home.

**Debrief**

Anything else to address or parts with questions/something to say: ________________________________
________________________________________________________________________________________
________________________________________________________________________________________

**Relaxation Exercise**

___ Calm place ___ Progressive muscle relaxation ___ Slow deep breathing ___ Yoga breathing ___
Finding the relaxed place in the body ____ Other
Check in with everyone to make sure okay:                 □ Okay □ Not okay
________________________________________________________________________________________

Practice this exercise at home this week.

**Phase 3: Assessment**

*List of Traumas to Reprocess*

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Target/Memory/Image: ________________________________
________________________________________________________________________________________
NC: _____________________________________________
PC: _____________________________________________
VOC: ___/7
Emotions: ________________________________________
SUD: ___/10
Sensation: _______________________________________

*List of Adverse Life Experiences/Small “t” Traumas to Reprocess*

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Target/Memory/Image: ________________________________
________________________________________________________________________________________
NC: _____________________________________________
PC: _____________________________________________
VOC: ___/7
Emotions: ________________________________________
SUD: ___/10
Sensation: _______________________________________

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List of Important Losses

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Target/Memory/Image: ________________________________________________________________

NC: ______________________________________________________________________________
PC: ________________________________________________________________________________
VOC: ___/7
Emotions: __________________________________________________________________________
SUD: ___/10
Sensation: _________________________________________________________________________

List of Missed Opportunities, Regrets, and Remorse About Poor Health

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Target/Memory/Image: ________________________________________________________________

NC: ______________________________________________________________________________
PC: ________________________________________________________________________________
VOC: ___/7
Emotions: __________________________________________________________________________
SUD: ___/10
Sensation: _________________________________________________________________________

List of Harmful Habits

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Target/Memory/Image: ________________________________________________________________

NC: ______________________________________________________________________________
PC: ________________________________________________________________________________
VOC: ___/7
Emotions: __________________________________________________________________________
SUD: ___/10
Sensation: _________________________________________________________________________
Phrases to bring the client into present orientation:

- “What are you feeling in your body?”
- “Where are you right now?”
- “Let’s use the Back-of-the-Head scale.”
- “Is there a part who needs to talk right now?”

Or use physically based strategies as the following:

- “Tap your feet.”
- “Here, catch this ball.”
- “Listen to the clock ticking.”

**Phase 4: Desensitization**

Apply the Standard EMDR Protocol for all targets.

**Phase 5: Installation**

*Install the PC.*

Original PC: □ Use original PC □ Use new PC

New PC (if new one is better): __________________________________________________________

VOC: ___/7

Incident + PC + BLS

**Phase 6: Body Scan**

Unresolved tension/tightness/unusual sensation: ____________________________________________

Unresolved tension/tightness/unusual sensation + BLS

Strengthen positive sensation using BLS.

If there is more discomfort, reprocess until discomfort subsides + BLS. Then repeat body scan.

VOC: ___/7

**Phase 7: Closure**

“Things may come up or they may not. If they do, great. Write it down and it can be a target for next time. You can use a log to write down triggers, images, thoughts or cognitions, emotions, and sensations; you can rate them on our 0-to-10 scale, where 0 is no disturbance or neutral and 10 is the worst disturbance. Please write down the positive experiences, too.

*If you get any new memories, dreams, or situations that disturb you, just take a good snapshot. It isn’t necessary to give a lot of detail. Just put down enough to remind you so we can target it next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it’s still just the old stuff. Just write it down for the next time. Then use the tape or the Safe Place exercise to let as much of the disturbance go as possible. Even if nothing comes up, make sure to use the tape every day and give me a call if you need to.*

**Phase 8: Reevaluation**

Noticed since last session: ______________________________________________________________________________________________________________________

Current symptoms: _________________________________________________________________________________________________

New material: ________________________________________________________________

SUD: ____/10

**PRESENT TRIGGERS**

Situations, Events, or Stimuli Triggers

- □ Trigger 1:
  Most disturbing part: _______________________________________________________

- □ Trigger 2:
  Most disturbing part: _______________________________________________________

- □ Trigger 3:
  Most disturbing part: _______________________________________________________

- □ Trigger 4:
  Most disturbing part: _______________________________________________________

Target: ______________________________________________________________________

Picture/Image: __________________________________________________________________

Negative cognition (NC): __________________________________________________________________

**Note:** If difficulty: “In your worst moments, when you are remembering some aspect of the event, what thoughts or negative beliefs do you have about yourself?” ____________________________________________

Positive cognition (PC): __________________________________________________________________

Validity of cognition (VOC): ____/7

Emotions: _______________________________________________________________________

Subjective units of disturbance (SUD): ____/10

Location of body sensation: __________________________________________________________________

**Fears About Present and Future Due to Permanent Physical Damage Trigger List**

- □ Trigger 1:
  Most disturbing part: _______________________________________________________

- □ Trigger 2:
  Most disturbing part: _______________________________________________________

- □ Trigger 3:
  Most disturbing part: _______________________________________________________

- □ Trigger 4:
  Most disturbing part: _______________________________________________________

Target: ______________________________________________________________________

Picture/Image: __________________________________________________________________

Negative cognition (NC): __________________________________________________________________

**Note:** If difficulty: “In your worst moments, when you are remembering some aspect of the event, what thoughts or negative beliefs do you have about yourself?” ____________________________________________
Positive cognition (PC): ________________________________

Validity of cognition (VOC): _____/7

Emotions: ____________________________________________

Subjective units of disturbance (SUD): ____/10

Location of body sensation: _____________________________

Problems Trigger List

☐ Trigger 1:
Most disturbing part: __________________________________

☐ Trigger 2:
Most disturbing part: __________________________________

☐ Trigger 3:
Most disturbing part: __________________________________

☐ Trigger 4:
Most disturbing part: __________________________________

FUTURE TEMPLATE

Fears of Being Alone and Unsupported List

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Fears of Recurrence of the Illness or Medical Condition List

________________________________________________________________________________________

________________________________________________________________________________________

Significant People and Situations of the Presenting Issues for Any Type of Distress List

________________________________________________________________________________________

________________________________________________________________________________________

Use floatback as needed:

Floatback: “Please bring up that picture of ____ (state image), and those negative words______, _______ (repeat client’s disturbing image and NC); notice what feelings are coming up for you, where you are feeling them in your body, and just let your mind float back to an earlier time in your life—don’t search for anything—just let your mind float back and tell me the first scene that comes to mind where you had similar:

Thoughts of ___ (repeat NC)

Feelings of ___ (repeat emotions stated earlier)

In your ____ (repeat places in the body where the client reported feelings).”

Skills Needed to Be Learned and Practiced List

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Projected Future Situation List

Do the installation for whatever is needed from these lists.

**Installation of the Future Template (Image)**

Image of coping effectively with or in the fear trigger in the future: ____________________________

PC: (I can handle it) ____________________________

Sensations: ____________________________

+ BLS

VOC (able to handle the situation): ___/7

Install until VOC = 7

If continuing to be greater than 7, there are more targets to be identified, addressed, and used with the Standard EMDR Protocol.

Blocks/Anxieties/Fears in future scene: ____________________________

1. ____________________________
2. ____________________________
3. ____________________________

Do BLS. If they do not resolve, ask for other qualities needed to handle the situation or what is missing.

1. ____________________________
2. ____________________________
3. ____________________________

Use BLS. If blocks are not resolved, identify unprocessed material and process with the Standard EMDR Protocol.

1. ____________________________
2. ____________________________
3. ____________________________

Target/Memory/Image: ____________________________

NC: ____________________________

PC: ____________________________

VOC: ___/7

Emotions: ____________________________

SUD: ___/10

Sensation: ____________________________
Video Check (Future Template as Movie)

“This time, I’d like you to imagine yourself stepping into the future. Close your eyes, and play a movie from the beginning until the end. Imagine yourself coping with any challenges that come your way. Notice what you are seeing, thinking, feeling, and experiencing in your body. While playing this movie, let me know if you hit any blocks. If you do, just open your eyes and let me know. If you don’t hit any blocks, let me know when you have viewed the whole movie.”

If block/s, say, "I can handle it,” and BLS. Repeat until the client can go through the whole movie entirely without distress.

VOC: ___/7

If the client can play the movie from beginning to end with confidence and satisfaction, play the movie one more time from the beginning to end + BLS:

☐ Yes ☐ No

REFERENCES