TREATING ANXIETY, OBSESSIVE-COMPULSIVE, AND MOOD-RELATED CONDITIONS

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

EMDR THERAPY

SCRIPTED PROTOCOLS AND SUMMARY SHEETS

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EDITOR
Eye Movement Desensitization and Reprocessing

EMDR Therapy

Scripted Protocols and Summary Sheets

TREATING ANXIETY,
OBSESSIVE-COMPULSIVE,
AND MOOD-RELATED
CONDITIONS
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In 2001, through EMDR HAP (Humanitarian Assistance Programs), she published, *Handbook for EMDR Clients*, which has been translated into eight languages; the proceeds from sales of the handbook go to EMDR HAP organizations worldwide. She has written the “Around the World” and “In the Spotlight” articles for the EMDRIA Newsletter, four times a year since 1997. In 2009, she edited *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations* (Springer) and *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations* (Springer). She interviewed Francine Shapiro and co-authored the interview with Dr. Shapiro for the *Journal of EMDR Practice and Research* (Luber & Shapiro, 2009) and later wrote the entry about Dr. Shapiro for E. S. Neukrug’s, *The SAGE Encyclopedia of Theory in Counseling and Psychotherapy* (2015). Several years later, in 2012, she edited Springer’s first CD-ROM books: *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols With Summary Sheets CD-ROM Version: Basics and Special Situations* and *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols With Summary Sheets CD-ROM Version: Special Populations*. In 2014, she edited, *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets*. In 2015, three ebooks were published that supplied protocols taken from *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets: EMDR Therapy With First Responders* (ebook only), *EMDR Therapy and Emergency Response* (ebook only), and *EMDR Therapy for Clinician Self-Care* (ebook only). The text, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma- and Stressor-Related Conditions* will be released in 2015. Currently, she is working on *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Medical-Related Conditions*. 

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Eye Movement Desensitization and Reprocessing

EMDR Therapy

Scripted Protocols and Summary Sheets

TREATING ANXIETY, OBSESSIVE-COMPULSIVE, AND MOOD-RELATED CONDITIONS

Edited by

Marilyn Luber, PhD
To Ad de Jongh,
my friend and colleague,
for his insight, guidance, humor, and
for his dedication to EMDR Therapy and the EMDR community
All the evidence that we have indicates that it is reasonable to assume in practically every human being, and certainly in almost every newborn baby, that there is an active will toward health, an impulse toward growth.

—Abraham Maslow, PhD
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Contributors

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**Ad de Jongh, PhD**, is both a clinical psychologist and a dentist. He is a professor of anxiety and behavior disorders at the Behavioural Science Department of the Academic Centre for Dentistry (ACTA) in Amsterdam, the Netherlands, a collaboration of the University of Amsterdam and Vrije University. He is also an honorary professor at the School of Health Sciences of Salford University in Manchester, UK. He is involved in research investigating the efficacy of evidence-based treatments for the consequences of traumatic events in a variety of target populations, including children, people with intellectual disabilities, and people with complex psychiatric conditions, including psychosis and schizophrenia. He has (co-)authored more than 250 scientific articles and book chapters on anxiety disorders, and their treatment, as well as 5 books, and provides lectures and courses in his field of expertise, both in the Netherlands and abroad. He is an EMDR Europe–accredited trainer. In 2011, he received the outstanding EMDR Research Award from the EMDR International Association.

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In 2013, Dr. Vincent John Felitti presented Dr. Robert F. Anda and his groundbreaking work on “The Adverse Childhood Experiences Study” (ACE Study) at the EMDR International Association’s annual conference in Austin, Texas. The ACE Study is a research study conducted by Kaiser Permanente Health Maintenance Organization and the Centers for Disease Control and Prevention with the purpose of finding out the effects of stressful and traumatic experiences during childhood on adult health (acestudy.org website, 2015). Between 1995 and 1997, more than 17,000 volunteers were recruited into a long-term study to follow up on their health outcomes from a Kaiser HMO. In this cohort, 50% were female, 74.8% were Caucasian, 75.2% had attended college, all had jobs and health care, and the average age was 57 years. What they learned revolutionized our basic understanding of the etiology of mental and physical illness. From the reports of the participants in the survey, they discovered that 63% had at least one childhood trauma, whereas 20% had experienced at least three or more categories of trauma, which were labeled adverse childhood experiences (ACE). ACE included experiences of abuse as in emotional (11%), physical (28%), and sexual (21%); neglect comprising emotional (15%), and physical (10%); growing up in households where a member was mentally ill (19%), in jail or prison (5%); used alcohol and/or drugs (27%), lost a parent due to separation or divorce (23%); or witnessed their mother-treated violently (13%). Felitti and Anda’s important discovery was the more categories of trauma experienced in childhood, the greater the likelihood of experiencing high-risk factors in adulthood for alcoholism and alcohol abuse, chronic obstructive pulmonary disease (COPD), depression, fetal death, hallucinations, illicit drug use, ischemic heart disease (IHD), liver disease, risk of intimate partner violence, multiple sexual partners, obesity, poor health-related quality of life, posttraumatic stress disorder (PTSD), sexually transmitted diseases (STDs), smoking, suicide attempts, and/or unintended pregnancies. These are important findings that inform our work as EMDR practitioners.

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

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

Many of our most intractable public health problems are the result of compensatory behaviors like smoking, overeating, and alcohol and drug use which provide immediate partial relief from the emotional problems caused by traumatic childhood experiences. The chronic life stress of these developmental experiences is generally unrecognized and hence unappreciated as a second etiologic mechanism. These experiences are lost in time and concealed by shame, secrecy, and social taboo against the exploration of certain topics of human experience.

The findings of the Adverse Childhood Experiences (ACE) Study provide a credible basis for a new paradigm of medical, public health, and social service practice that would start with
comprehensive biopsychosocial evaluation of all patients at the outset of ongoing medical care.

Dr. Francine Shapiro’s Adaptive Information Processing (AIP) model is in keeping with the important findings of Felitti and Anda’s ACE Study (Shapiro, 2001, 2002, 2006, 2007). This model is used to guide our clinical practice and show EMDR Therapy’s clinical effects. The idea is that the direct reprocessing of the stored memories of the first and other events connected with the problem—as well as any other experiential contributors—has a positive effect on clients’ presenting problems. The results of case studies and open trials with various diagnostic categories support this prediction. In fact, many experts have taken the basic Standard EMDR Therapy Protocols reported by Dr. Shapiro in Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols and Procedures (1995, 2001) and adapted them to meet the particular needs of their clients while maintaining the integrity of EMDR Therapy.

The work on EMDR Therapy and clinical applications, as seen in the chapters in this book, are based on the AIP model. A number of EMDR Therapy clinical applications are mainly case studies or open trials that show promise; however, they are in need of further investigation. The following is a small sample of the types of conditions for which clinicians are using these clinical applications: addictions; anxiety; body dysmorphia; depression; dissociative disorders; excessive grief; family, marital, and sexual dysfunction; intellectual disabilities; pain; phobias; panic; and so on. For more information, visit the EMDR International Association website (www.emdria.org) or the EMDR Institute website (www.emdr.com).

The following are the randomized clinical trials reporting on the effectiveness of EMDR in conditions other than PTSD: adjustment disorder (Cvetek, 2008); bipolar disorder (Novo et al., 2014); fears and phobias (Doering, Ohlmeier, de Jongh, Hofmann, & Bisping, 2013; Muris & Merckelbach, 1997; Muris, Merckelbach, Holdrinet, & Sijsenaar, 1998; Muris, Merckelbach, van Haften, & Mayer, 1997; Triscari, Faraci, D’Angelo, Urso, & Catalisano, 2011); general symptoms of anxiety and distress (Abbasnejad, Mahani, & Zamyad, 2007; Arabia, Manca, & Solomon, 2011); obsessive-compulsive disorder (Nazari, Momeni, Jariani, & Tarrahi, 2011); and panic disorder (Feske & Goldstein, 1997; Goldstein, de Beurs, Chambless, & Wilson, 2001).

This is the fourth in a series of books dedicated to the better understanding of EMDR Therapy and how the Standard EMDR Therapy principles, protocols, and procedures form the basis for the work that we do as EMDR Therapy clinicians. To understand any subject matter deeply, the rule of thumb is to know the basics so that if a departure from the structure is needed, it is done in an informed manner. The purpose of Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations (Luber, 2009a) was to support the structure in Dr. Shapiro’s earlier texts (1995, 2001) by showing each step in detail. Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations (Luber, 2009b) built on that structure and showcased how many experts adapt the EMDR Therapy principles, protocols, and procedures for use with their specific populations, such as children; couples; and patients with dissociative disorders, complex PTSD, addictive behaviors, pain, and specific fears. The next book would have been: Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols and Summary Sheets: Anxiety, Depression, and Medical-Related Issues to continue to show how expert clinicians are working with EMDR Therapy for anxiety disorders, depression, and medical-related issues. However, in 2011, man-made and natural disasters were coming to the fore and impacting our colleagues experiencing the Tohoku earthquake and tsunami in Japan; floods in China, the Philippines, Thailand, Pakistan, Cambodia, India, and Brazil; earthquakes in Turkey and New Zealand; droughts and consecutive famines affecting Ethiopia, Kenya, and Somalia; storms in the United States, and so on. In consultation with Springer and EMDR colleagues in the EMDR Humanitarian Assistance Programs worldwide, the decision was made to move up the publication of Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters, in book, CD, and e-book formats. It was published in 2014 as an up-to-date collection of the current EMDR Therapy–related responses and protocols for recent trauma events.
In 2012, *Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols and Summary Sheets: Anxiety, Depression and Medical-Related Issues* was slated to appear and was originally conceptualized with *Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition (DSM-IV-R; American Psychiatric Association, 1994)* in mind; however, by the time publication grew near, *DSM-5* (5th ed.; American Psychiatric Association, 2013) had become the standard. This entailed some reorganization of the structure of the book. However, so much material was involved that it was decided to create three books instead of one. This is the first of a trio of books based on this material: *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Obsessive-Compulsive, and Mood-Related Conditions*, with the choice of book, CD, and/or e-book formats. Trauma- and stressor-related issues were separated from this current book and will appear as *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Trauma- and Stressor-Related Conditions* (Luber, in press) in late 2015 or early 2016. Medical-related issues, as well, were separated from this current book and will appear as *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Medical-Related Issues* (Luber, in press) in 2016.

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

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

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

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

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

In 2012, the CD-ROM versions of the original 2009 books were published in a different format (Luber, 2012a, 2012b). Included in the CD-ROM were just the protocols and summary...
This is sample from Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations (Luber, 2012a):

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

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

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

This text is divided into three parts with 10 chapters that cover working with anxiety disorders, including specific phobia, panic disorder, and the use of a specific procedure in the treatment of anxiety disorder; obsessive-compulsive and related disorders, including obsessive-compulsive disorder, body dysmorphic disorder, olfactory reference syndrome, and hoarding behaviors; and mood disorders, including bipolar disorder, major depression, and postpartum depression. To address the specific needs of their populations, authors were asked to include the types of questions relevant for history taking, helpful resources and explanations needed in the preparation phase, particular negative and positive cognitions that were frequent in the assessment phase and for cognitive interweaves, other concerns during phases 4 (desensitization) through 8 (reevaluation), a section on case conceptualization and treatment planning, and any pertinent research on their work.

In Part I, “EMDR Therapy and Anxiety Disorders,” the first chapter for “Specific Phobia” is by Ad de Jongh, on “EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol.” This is an updated version that originally appeared in Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations (de Jongh, 2009) and includes an important addition on the “Flashforward Procedure.” Under “Panic Disorder and Agoraphobia,” Ferdinand Horst and Ad de Jongh’s chapter, “EMDR Therapy Protocol for Panic Disorders With or Without Agoraphobia,” points to the connection of panic attacks with the patient’s perception of it as a life-threatening experience as the inspiration to work within the EMDR Therapy framework. In the section on “Use of Specialized

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Procedures in the Treatment of Anxiety Disorders,” Robin Logie and Ad de Jongh’s chapter, “The Flashforward Procedure,” introduces us to a very helpful way of addressing worst-case scenarios that have been resistant to resolution. This new procedure is included in a number of chapters in this book, because of its helpfulness in reframing and reprocessing difficult situations.


In Part III, “EMDR Therapy and Mood Disorders,” the first section on “bipolar disorder contains the chapter “The EMDR Therapy Protocol for Bipolar Disorder.” It is by the Barcelona EMDR Research Group under the tutelage of Benedikt L. Amann, and including Roser Batalla, Vicky Blanch, Dolors Capellades, Maria José Carvajal, Isabel Fernández, Francisca García, Walter Lupo, Marian Ponte, Maria José Sánchez, Jesús Sanfiz, Antonia Santed, and Marilyn Luber. It is based on the results of a controlled, randomized, single-blind pilot study with 20 bipolar I and II patients with subsyndromal symptoms, and a history of various traumatic events (Novo et al., 2014). The section “Major Depression” includes the chapter “DeprEnd©—EMDR Therapy Protocol for the Treatment for Depressive Disorders,” by Arne Hofmann, Michael Hase, Peter Liebermann, Luca Ostacoli, Maria Lehnung, Franz Ebner, Christine Rost, Marilyn Luber, and Visal Tumani. DeprEnd© is the result of a European network of depression researchers who created the EDEN Study—a multicenter randomized study in Germany, Italy, Spain, and Turkey—and offers an elegant and helpful way to address major depression. The last two chapters, in the section “Postpartum Depression,” by Anna Maria de Divitiis and Marilyn Luber, include “EMDR Therapy Protocol for the Prevention of Birth Trauma and Postpartum Depression for the Pregnant Woman,” and “EMDR Therapy Group Protocol for the Prevention of Birth Trauma and Postpartum Depression for Pregnant Women.” These chapters are helpful in primary prevention in an individual or group setting to reduce or avoid exposure to risk factors and to enhance clients’ defenses to prevent or minimize the effects of exposure to risk factors by encouraging their optimal participation in the process of childbirth and strengthening their resilience to reduce the negative effects of stressors experienced during childbirth.

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

Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Obsessive-Compulsive, and Mood-Related Conditions, in the manner of its predecessors, offers EMDR Therapy practitioners and researchers a window into the treatment rooms of experts in the fields of anxiety, obsessive-compulsive, and spectrum disorders, and mood-related conditions. It is designed to apply what we are learning through research and to support the increasing knowledge and capabilities of clinicians in the method of EMDR Therapy.
References


EMDR Institute website, www.emdr.com


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

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

By the time that *Implementing EMDR Early Mental Health Interventions for Man-Made and Natural Disasters: Models, Scripted Protocols, and Summary Sheets* was delivered in 2013 and published in 2014, the *DSM-IV* (American Psychiatric Association [APA], 1994) had transitioned to the *DSM-5* (APA, 2013), so I had to reorganize the current project. Sheri and I also decided to separate this book into three volumes: Treating Anxiety, Obsessive-Compulsive, and Mood-Related Conditions; Treating Trauma and Stressor-Related Conditions; and Treating Medical-Related Issues. I want to acknowledge the help of Ad de Jongh and Arne Hofmann in this process. These supportive and knowledgeable friends and colleagues assisted me in setting up a new structure for the project and suggested some of the content.

I want to recognize the joint efforts of the 31 authors of these 10 chapters from seven countries (Germany, Italy, The Netherlands, Spain, Turkey, United Kingdom, and United States) to complete *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols: Treating Anxiety, Obsessive-Compulsive, and Mood-Related Conditions*. I owe a great debt to each one of them for the time and energy that they devoted to this project. However, in many cases, our efforts went beyond that. The joy of interaction with my intelligent and creative colleagues is the essence of this effort and is one of the reasons that I continue to edit and work on these chapters. Experiencing their perspectives widened my own as I learned how they cope with the dilemmas of working with their particular population. I hope this text will inspire the clinicians who read it and help them to think about their clinical challenges within the context and structure of EMDR Therapy.

xxv
xxvi  Acknowledgments

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

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

I would like to thank and acknowledge the Western Massachusetts EMDR Regional Group for choosing me as their keynote speaker in May 2014. Their invitation was for me to speak about these four books (now six) on scripted protocols. I had not had the occasion to step back and review this body of work in which I had been engaged for nearly a decade, and they gave me a reason to do so. As I did, I looked at the basic statistics for the 6 books and found that there are approximately 135 authors, 126 chapters (including some updates of the same chapter), from 14 countries on 6 continents (although this may shift a bit before everything is submitted)! Thanks to Jim Helling, my keynote was titled, “EMDR Protocols and EMDR Practice: A Clinician’s Journey Toward Mastery.” It was a challenge to prepare an overview of this amount of work; however, I focused on recent trauma, the importance of self-care for practitioners, and an overview of the books themselves. I came up with eight important take-home messages about the process of my work that I shared with my Western Massachusetts audience:

• **Know the basics**: EMDR Therapy is a psychotherapy approach and how you conceptualize your client’s issue is critical. Know the AIP, the EMDR 3-Pronged Protocol, the EMDR 11-step procedure, and the eight EMDR Therapy phases.

• **Pay attention**: Make sure you are paying attention to all aspects of your clients’ presentation, such as their body language, facial expressions, tone of voice, how they interact with you, and how you feel in their presence.

• **Keep your eye on the ball**: Know the client’s goals, create the treatment plan together, and reevaluate at intervals.

• **Keep it simple**: The Standard EMDR Therapy Protocol is robust. Use it as your standard as well as the eight phases. Use other EMDR Therapy protocols when the Standard EMDR Protocol is not the best option, as in special situations and/or special populations, while keeping the Standard EMDR Therapy Protocol always in mind.

• **Consult to grow**: Work within your area of expertise, talk to your colleagues, check the *Journal of EMDR Practice and Research* and the Francine Shapiro Library to see what others are doing, get supervision to learn about a new area of expertise, and consult when you are triggered and it persists.

• **Remember where you come from**: You bring your unique self to the art and science of your therapeutic work, so learn EMDR Therapy and the basics. Always remember yourself and your own unique style. EMDR Therapy becomes yours when you integrate your style with the basic tenets of EMDR Therapy.

• **Take care of yourself**: Take a personal, professional, and spiritual life review at intervals. Notice what you do to take care of yourself and notice if you are not taking care of yourself so that you can ask for help. Keep a list of symptoms of vicarious trauma/burnout and check to see if you are showing signs or symptoms. Have a buddy and check in with each other at intervals.

• **Connect with the EMDR community**: EMDR Therapy is prevalent worldwide. Connect with your EMDR Association and your EMDR Therapy community group locally. Volunteer for Trauma Recovery: EMDR HAP and create a Trauma Recovery Network (TRN) in your region. WE NEED YOU!
I would like to add two more take-home messages in keeping with the importance of adding research into our clinical work:

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

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

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

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

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

I would like to acknowledge and thank the people who are involved in my daily life, helping me in so many invaluable ways that allow me both to have a “day” job and to indulge my interest in writing. They are Harry Cook, Rose Turner, and Dennis Wright. My overwhelming thanks to Lew Rossi, who has kept my computers working, even in the shadow of disasters and major catastrophes. I want to acknowledge my miniature schnauzer dog, Emmy Luber, who has been part of my writing from the beginning and always reminds me to take a break and connect with her. Thank you to Shirley Luber, my mother, who has been the primary audience for all I have written from kindergarten to my dissertation and into the present.

I would also like to acknowledge Bob Raymar, who has recently come back into my life after 45 years and changed it in so many ways. Thank you, Bob, for your caring and assistance: listening to my very long keynote, being infinitely patient, always finding time to comment on what I have written, lending me your insightful and discerning perspective and for showing me that the essence of someone can last over time.

I would like to recognize my friend and colleague, Ad de Jongh, by dedicating this book to him. I have known Ad from the early days of EMDR Therapy and he has been an extraordinary resource in the EMDR Therapy community. He has worked to uphold the standard of EMDR Therapy in the Netherlands and taught his colleagues and his students the importance of working within the scientific model by developing the Dutch EMDR Association (one of the largest), hosting continuing education, teaching university students, promoting EMDR Therapy, and helping put together the publication, “EMDR Nieuwsbrief.” He is responsible through his own work and his students for a great deal of research on a wide range of topics, especially with anxiety disorders, and with challenging populations, such as patients presenting with psychosis, intellectual disabilities, and so on. He has presented nationally and internationally and won many awards for his work. Most recently (2014), he was awarded the EMDR Research Award from EMDRIA. For me personally, he has been a friend, collaborator, and someone to whom I can turn to discuss ideas and get valuable feedback. Thank you, Ad, for all that you have done for the EMDR community and for me.
There are three chapters in Part I: EMDR Therapy and Anxiety Disorders; these chapters are Specific Phobia, Panic Disorder, and Use of Specific Procedures in the Treatment of Anxiety Disorders. Thus, this part is not to be considered a complete representation of anxiety disorders.

Alan Goldstein was one of the first psychologists to see the possibilities of Eye Movement Desensitization and Reprocessing (EMDR) Therapy for the treatment of anxiety disorders. He presented a paper titled *The Role of Eye Movement Desensitization and Reprocessing in the Treatment of Panic and Agoraphobia* at the Fourth World Congress on Behaviour Therapy in Queensland, Australia, in July 1992. Not long after this, Sanderson and Carpenter (1992) wrote the first article on phobias in the *Journal of Behavior Therapy and Experimental Psychiatry*, Kleinknecht (1993) reported on the rapid treatment of blood and injection phobias with EMDR, and Bauman and Melnyk (1994) published their study on eye movements and tapping in the treatment of test anxiety in the same journal. Goldstein and Feske (1994) published a series of case studies on EMDR and panic disorder in the *Journal of Anxiety Disorders*.

**Specific Phobia**

By 1993, Ad de Jongh and Erik ten Broeke began publishing their findings on specific phobias. Their coauthors included colleagues, namely de Roos, Renssen, van der Meer, Serra, Holmshaw, Doering, and van den Oord. Their first work appeared in the Dutch journal *Tijdschrift voor Directieve Therapy and Hypnose* and since then they have published the following:

- *Two articles in the EMDRIA Newsletter* (de Jongh & ten Broeke, 2000a, 2000b)
Part One: EMDR Therapy and Anxiety Disorders

In 2009, Ad de Jongh and Erik ten Broeke wrote, “EMDR and the Anxiety Disorders: Exploring the Current Status” for the Journal of EMDR Practice and Research’s Special Section on the 20th Anniversary of EMDR. Their article was based on Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition’s (DSM-4) criteria so their review of obsessive-compulsive disorder (OCD)—with the advent of DSM-5—would now be part of another category of disorders. They hypothesized that EMDR Therapy would be an excellent treatment for many of the anxiety disorders because these conditions often start as a result of adverse life events (for panic disorder and agoraphobia, see Kleiner & Marshall, 1987; for social phobia criteria, see American Psychiatric Association, 2000; for specific phobias, see de Jong, Fransen, Oosterink-Wubbe, & Aartman, 2006; Oosterink, de Jongh, & Aartman, 2009; for generalized anxiety disorder (GAD), see Roemer, Molina, Litz, & Borkovec, 1997), and/or these patients suffer from posttraumatic stress disorder (PTSD)-type symptoms (for panic attacks, see McNally & Lukach, 1992; for specific phobias, see de Jongh et al., 2006).

Although in vivo exposure has proven to be the treatment of choice for many specific phobias (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008), there is increasing support to show that EMDR is effective for fears and specific phobias in controlled case reports (e.g., de Jongh, 2012; de Jongh et al., 2002; Lohr, Tolin, & Kleinknecht, 1996) and case-controlled studies (de Jongh, Holmshaw, Carswell, & van Wijk, 2010); uncontrolled case reports as well are describing positive results (e.g., de Roos & de Jongh, 2008; de Jongh & ten Broeke, 1994, 1998; Kleinknecht, 1993; Marquis, 1991).

Despite the promise that EMDR Therapy holds for the treatment of a specific phobia, there are only three randomized controlled outcome studies concerning the treatment of spider phobia by the same group: Muris and Merckelbach (1997); Muris, Merckelbach, Holdrinet, and Sijsenaar (1998); and Muris, Merckelbach, van Haaften, and Mayer (1997). The early studies reported that EMDR Therapy showed some significant changes in the Subjective Units of Disturbance (SUD) scale; however, in vivo exposure showed superior results in participants’ approach behaviors and reducing avoidance behaviors. These studies did not follow the Standard EMDR Protocol in the following ways: lack of the future template; not preparing patients for the confrontation with anxiety-eliciting stimuli or situations, for example, not teaching self-regulatory skills; limited treatment spent on processing; and inadequate number of sessions. Therefore, these studies and their results are not accurate representations of EMDR Therapy.

Ad de Jongh’s “EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol” is an updated version of a chapter that appeared in Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations (Luber, 2009). De Jongh is thorough in his presentation of how to work with this population with a protocol that has been used in clinical practice and research projects (e.g., de Jongh et al., 2002; Doering, Ohlmeier, de Jongh, Hofmann, & Bisping, 2013). During Phase 1, he reviews the criteria for Specific Phobia, elicits what triggers the fear and helps identify the expected consequences, assesses the validity of the catastrophe, provides practical information about the fear or phobia, determines attainable treatment goal/goals, and identifies the touchstone event, the ancillary event/events, the most frightening events, and the most recent events related to the specific fear. In Phase 2, he explains EMDR Therapy and teaches distraction techniques for anxiety management between sessions. Phases 3 to 6 follow the Standard EMDR Protocol. He introduces the “Flashforward Procedure” (see Chapter 3) and addresses future concerns intensively through the installation of the future template, a video check, and in vivo confrontations. Closure is important and homework is in support of maintaining changes in between sessions. Reevaluation is a time to check the homework and the progress the client is making in between sessions.

### Panic Disorder and Agoraphobia

EMDR Therapy could be very helpful in treating panic disorder and agoraphobia. In the sparse research available, researchers found that most clients benefited from EMDR Therapy by showing a decrease in panic attacks, severity of anticipatory anxiety, and general signs of
distress (de Jongh & ten Broeke, 1996; Fernandez & Faretta, 2007; Feske & Goldstein, 1997; Goldstein, de Beurs, Chambless, & Wilson, 2001; Goldstein & Feske, 1994). Although further research by Feske and Goldstein (1997) with a randomized controlled study where EMDR was compared with a protocol without eye movements and a wait-list condition looked promising at first, the effects did not hold up after a 3-month follow-up. In 2001, Goldstein et al. investigated the efficacy of EMDR compared to association and relaxation therapy (ART): although EMDR Therapy was significantly better versus the wait-list group on the severity of panic and agoraphobic criteria, there was no difference on cognitive assessment and number of panic attacks.

Shapiro (1999) argued that more preparation is needed to get a positive outcome; this contention is supported by Fernandez and Faretta’s work (2007) with a woman with panic disorder where they increased the preparation phase to six sessions, resulting in remission of her symptoms and maintenance of her changes on a 1-year follow-up. In 2009, Leeds gave a critique of the difficulties with past research in order to come up with alternatives: his two models of treatment for panic disorder and panic disorder with agoraphobia. He asks for a treatment plan that addresses this population’s difficulty dealing with deep feelings, which includes “concrete anxiety management skills, resource development and installation for self-soothing and affect tolerance and then initially targets their panic attacks,” although these hypotheses must be investigated. According to Leeds, patients need a sense of mastery and confidence in the EMDR Therapy process, including a good enough sense of trust in the therapeutic relationship by reprocessing memories of the first, worst, and most recent panic attacks, before addressing “the core painful affects” that support the structure of the panic attacks and agoraphobia. An abbreviated version of this model can be found in his 2012 Journal of EMDR Practice and Research article “EMDR Treatment of Panic Disorder and Agoraphobia: Two Model Treatment Plans.” The question is whether this is true. A recent study on PTSD in patients with psychosis or schizophrenia showed that EMDR Therapy can be applied safely and effectively without any form of preparation prior to memory processing (even without the Safe Place exercise) and even with a vulnerable group like those with as severe a psychiatric condition as psychosis (van den Berg et al., in press). The same holds true for panic disorder with agoraphobia. Results of a randomized controlled trial comparing EMDR Therapy with cognitive behavioral therapy (CBT; introceptive exposure) for patients suffering with this condition showed that EMDR Therapy is efficacious even if the patients are treated without much preparation (van der Horst et al., in preparation). However, there are two studies and it is best to err on the side of caution if the client needs more preparation.

Ferdinand Horst and Ad de Jongh address the subject of EMDR and panic disorder in their chapter “EMDR Protocol for Panic Disorders With or Without Agoraphobia.” They point out the importance of determining the first and/or worst panic attack memory, the most recent memory, and other panic attack memories as appropriate targets for EMDR, as well as additional stressful life events that do not meet the criteria for PTSD but could be important for the development of panic disorder. In particular situations where processing has occurred and the client is still avoiding the situations where it would be difficult to escape (agoraphobic memories), they suggest the Flashforward Procedure.

**Use of Specific Procedures in the Treatment of Anxiety Disorders**

This last chapter in this section is “The Flashforward Procedure” by Logie and de Jongh (2014), which showcases the use of a specific procedure for the treatment of anxiety disorders. The Flashforward Procedure is considered the operationalization of anticipatory fear, which has its focus on the future and is considered to be the second prong of the 3-Pronged Protocol. Because many conditions specifically pertain to fear of future catastrophic events as being an important part of the condition, the Flashforward Procedure could be helpful in
addressing specific phobias, OCD, body dysmorphic disorder, hypochondriasis, psychosis and schizophrenia, PTSD, and anorexia nervosa.

The term “flashforwards” was first used by Holmes, Crane, Fennell, and Williams (2007) to explain the cognitive processes underlying suicidal thinking to improve treatment for patients who have suicidal imagery of a future suicide attempt. They posited that the current images appear like flashforwards to suicide, echoing flashbacks in PTSD by also possessing sensory qualities, feeling real and compelling, and being rich in detail. They suggested targeting several imagery features, such as changing the flashforward outcome to an alternative to suicide, reducing imagery reality and preoccupation, reducing comfort, or “imagery rescripting.”

As Engelhard, van den Hout, Janssen, and van der Beek (2010) reported in their article, “Eye movements reduce vividness and emotionality of ‘flashforwards,’” their goal was “to examine whether eye movements, indeed, reduce vividness and emotionality of visual images about feared future events compared to a no dual-task (exposure only) condition, in a non-clinical sample under controlled conditions.” They postulated that eye movements, in keeping with the working memory account (Andrade, Kavanagh, & Baddeley, 1997; Gunter & Bodner, 2008; van den Hout et al., 2001), would affect not only the vividness of past images but future-oriented ones as well; their findings upheld their hypothesis. In 2011, Engelhard et al. studied whether eye movement also affects recurrent, intrusive visual images about potential future catastrophes (flashforwards) in a sample of female undergraduates who reported such intrusions. The results were positive for less vividness of the intrusive images after recall with eye movement in comparison to just recall, with a comparable trend for emotionality.

De Jongh and ten Broeke (2009b) wrote that 20 years after EMDR’s introduction, there was little data to support the efficacy of EMDR Therapy for anxiety disorders other than PTSD. At that time, randomized outcome research was available only for panic disorder with agoraphobia and spider phobia. The outcome of this research reported that EMDR Therapy was less effective than exposure-based interventions (evidence-based interventions) but more effective than no-treatment control conditions or nonspecific interventions. De Jongh and ten Broeke concluded that even these results were flawed, as the studies used incomplete protocols or limited courses of treatment, so that the true success of EMDR Therapy with anxiety disorders remained a question.

In 2011, Triscari, Faraci, D’Angelo, Urso, and Catalisano improved their research and had two treatment conditions (CBT with systematic desensitization or EMDR Therapy) for patients with aerophobia. Patients were randomly assigned to these two experimental groups in a before- and after-treatment research design. The effectiveness of each group was evaluated comparing the pre- and post- levels of flying within subjects; comparison of the posttreatment scores between groups was done as well. Results showed the efficacy of each model with significant improvement in both conditions. In the best test of what EMDR Therapy could mean in treating specific phobias until now, Doering, Ohlmeier, de Jongh, Hofman, and Bisping (2013) compared 31 dental phobic patients randomly assigned to two conditions (EMDR or wait-list control). Results showed significant reduction in dental anxiety and avoidance behavior as well as symptoms of PTSD; at a 1-year follow-up, 83% of the patients were in regular dental treatment. Their findings suggested that processing memories of past adverse dental experiences can be helpful for patients with dental phobia.

De Jongh and ten Broeke (2009b) quoted from de Jongh, ten Broeke, and Renssen (1999):

The empirical support for EMDR with specific phobias is still meager; therefore, one should remain cautious. However, given that there is insufficient research to validate any method for complex or trauma related phobias, that EMDR is a time-limited procedure, and that it can be used in cases for which an exposure in vivo approach is difficult to administer, the application of EMDR with specific phobias merits further clinical and research attention (pp. 69–70). . . . Now, 10 years later, not much seems to have changed, and it has become even clearer that these conclusions pertain not only to specific phobia but also to the full spectrum of anxiety disorders, except PTSD. (p. 139)
Currently, 6 years later, there is not much change in the state of research with anxiety disorders from de Jongh and ten Broeke’s 2009 report. EMDR Therapy remains at the crossroads of acceptance; without gold-standard research on anxiety disorders, the future in this area will be severely limited.

To support the use of these protocols, summary sheets accompany each of these chapters to create a reminder of the salient points in the chapter and to provide a place to enter data for patients.

References


Part One: EMDR Therapy and Anxiety Disorders


EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol

Ad de Jongh

Introduction

When a person starts to demonstrate an excessive and unreasonable fear of certain objects or situations that in reality are not dangerous, it is likely that the person fulfills the criteria for specific phobia as stated in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*; American Psychiatric Association, 2013). The main features of a specific phobia are that the fear is elicited by a specific and limited set of stimuli (e.g., snakes, dogs, injections, etc.); that confrontation with these stimuli results in intense fear and avoidance behavior; and that the fear is “out of proportion” to the actual threat or danger the situation poses, after taking into account all the factors of the environment and situation. Symptoms must also now have been present for at least 6 months for a diagnosis to be made of specific phobia. The *DSM-5* distinguishes the following five main categories or subtypes of specific phobia:

- Animal type (phobias of spiders, insects, dogs, cats, rodents, snakes, birds, fish, etc.)
- Natural environment type (phobias of heights, water, storms, etc.)
- Situational type (phobias of enclosed spaces, driving, flying, elevators, bridges, etc.)
- Blood, injury, injection type (phobias of getting an injection, seeing blood, watching surgery, etc.)
- Other types (choking, vomiting, contracting an illness, etc.)

Research

Evidence suggests that with respect to the onset of phobias, particularly highly disruptive emotional reactions (i.e., helplessness) during an encounter with a threatening situation have the greatest potential risk of precipitating specific phobia (Oosterink, de Jongh, & Aartman, 2009). Regarding its symptomatology, some types of specific phobias (e.g., those involving fear of choking, road traffic accidents, and dental treatment) display remarkable commonalities with posttraumatic stress disorder (PTSD), including the reoccurrence of fearful memories of past distressing events, which are triggered by the phobic situation or object, but may also occur spontaneously (de Jongh, Fransen, Oosterink-Wubbe, & Aartman, 2006).

Although in vivo exposure has proven to be the treatment of choice for a variety of specific phobias (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008), results from uncontrolled (e.g., de Jongh & ten Broeke, 1994; de Jongh & ten Broeke, 1998; de Roos & de Jongh, 2008; Kleinknecht, 1993; Marquis, 1991) and controlled case reports (e.g., de Jongh, 2012;
de Jongh, van den Oord, & ten Broeke, 2002; Lohr, Tolin, & Kleinknecht, 1996), as well as case control studies (de Jongh, Holmshaw, Carswell, & van Wijk, 2011) show that eye movement desensitization and reprocessing (EMDR) can also be effective in clients suffering from fears and phobias. Significant improvements can be obtained within a limited number of sessions (see de Jongh, ten Broeke, & Renssen, 1999 for a review).

EMDR Therapy may be particularly useful for phobic conditions with high levels of anxiety, with a traumatic origin or with a clear beginning, and for which it is understandable that resolving the memories of the conditioning events would positively influence its severity (see de Jongh et al., 2002).

The aim of this chapter is to illustrate how EMDR Therapy can be applied in the treatment of specific fears and phobic conditions. The script has frequently been used in both clinical practice and research projects (e.g., de Jongh et al., 2002; Doering, Ohlmeier, de Jongh, Hofmann, & Bisping, 2013). For example, a series of single-case experiments to evaluate the effectiveness of EMDR for dental phobia showed that in two to three sessions of EMDR treatment, three of the four clients demonstrated a substantial decline in self-reported and observer-rated anxiety, reduced credibility of dysfunctional beliefs concerning dental treatment, and significant behavior changes (de Jongh et al., 2002). These gains were maintained at 6 weeks follow-up. In all four cases, clients actually underwent the dental treatment they feared, most within 3 weeks following EMDR Therapy treatment.

Similar results were found in a case control study investigating the comparative effects of EMDR Therapy and trauma-focused cognitive behavioral therapy (TF-CBT), among a sample of 184 people suffering from travel fear and travel phobia (de Jongh et al., 2011). TF-CBT consisted of imaginal exposure as well as elements of cognitive restructuring, relaxation, and anxiety management. In vivo exposure, during treatment sessions, was discouraged for safety and insurance reasons, but patients were expected to confront difficult situations without the therapist (e.g., returning to the scene of the accident, self-exposure to cars, or other anxiety-provoking cues). Patients were considered to have completed treatment when it was agreed that patients’ improvements had plateaued or they were unlikely to make significant further progress in treatment. The mean treatment course was 7.3 sessions. No differences were found between both treatments. Both treatment procedures were capable of producing equally large, clinically significant decreases on measures indexing symptoms of trauma, anxiety, and depression, as well as therapist ratings of treatment outcome.

The efficacy of EMDR Therapy was also tested in a randomized clinical trial among 30 dental clients who met the DSM-IV-TR criteria of dental phobia, and who had been avoiding the dentist for more than 4 years, on average (Doering et al., 2013). The participants were randomly assigned to either EMDR or a wait-list control condition. Clients in the EMDR Therapy condition showed significant reductions of dental anxiety and avoidance behavior as well as in symptoms of PTSD. These effects were still significant at 12 months follow-up. After 1 year, 83% of the clients were in regular dental treatment.

The Diagnostic Process

Treatment of a fear or a phobic condition cannot be started if the therapist is unaware of the factors that cause and maintain the anxiety response. Therefore, one of the first tasks of the therapist is to collect the necessary information. This is usually done by means of a standardized clinical interview, such as the Anxiety Disorder Interview Scale (ADIS-R), which is primarily aimed at the diagnosis of anxiety disorders (DiNardo et al., 1985). This clinical interview has two important aims:

- To gain insight into the interplay of factors on several possible problem areas, including the possibility of secondary gain issues; that is, the extent to which the client derives positive consequences by avoiding anxiety-provoking situations, such as losing a job or receiving extra attention and consideration from others.
- To establish the relative importance of the interrelated problems that many of these clients have and how they are related to the diagnosis-specific phobia. For example, it
may be that a client’s claustrophobia is not very specific and occurs in a variety of situations; in this instance, it may be wiser to consider (or to rule out) the possibility of the diagnosis panic disorder, as this condition generally requires more elaborate treatment.

To further enhance the reliability of the diagnostic process, it is often desirable to use valid and standardized diagnostic measures. These can be of help in getting a clear picture of the severity of the anxiety, in detecting other possible problem areas, and in making it possible to evaluate the course of treatment. Many examples of useful self-report questionnaires for fears and specific phobias can be found in Antony, Orsillo, and Roemer’s practice book (2001).

Another factor of significance is the motivation of the client. For example, it is important to find out why the client seeks treatment at this particular time. Different issues that affect motivation are as follows:

- **Self versus forced referral.** There may be a marked difference in effectiveness of the treatment depending on whether the client requested referral himself or was forced into it (e.g., “My wife said she would leave me if I did not get my teeth fixed”).
- **Past experience with therapy.** Also, clients’ experiences of therapy in the past may determine their attitudes toward treatment. If, for whatever reason, it did not work in the past, it is useful to find out why and to attempt to discriminate between genuinely fearful reluctance and lack of effort.
- **Comorbid psychiatric issues.** The therapist should remain aware that comorbid psychiatric illness, such as severe depression, might be a contributing factor toward a lack of motivation.
- **Low self-esteem.** If the phobic client suffers from feelings of low self-esteem, which, in the opinion of the therapist, contribute to a large extent to the client’s avoidance behavior, the self-esteem issue may be resolved first and becomes a primary target of processing.

### The Phobia Protocol Single Traumatic Event Script Notes

#### Phase 1: History Taking

During Phase 1, history taking, it is important to elicit certain types of information.

**Determine to What Extent the Client Fulfills the DSM-5 Criteria of Specific Phobia**

Identify the type and severity of the fear and to what extent the client fulfills all DSM-5 criteria for specific phobia.

**Identify the Stimulus Situation (Conditioned Stimulus, CS)**

An important goal of the assessment is to gather information about the current circumstances under which the symptoms manifest, about periods and situations in which the problems worsen or diminish, and about external and concrete (discriminative) anxiety-provoking cues or CS. The therapist should also be aware of other types of anxiety-producing stimuli, including critical internal cues, for example, particular body sensations (e.g., palpitations), images, and negative self-statements (e.g., “I can’t cope”).

**Identify the Expected Consequence or Catastrophe (Unconditioned Stimulus, UCS)**

To understand the dynamic of the client’s fears or phobia, it is necessary to determine not only the aspects of the phobic object or situation that evoke a fear response (the CS), but also what exactly the client expects to happen when confronted with the CS and then the UCS (for a more elaborate description, see de Jongh & ten Broeke, 2007). For example, a dog phobic may believe that if he gets too close to a dog (CS), it will attack him (UCS), whereas
an injection phobic may believe that if she has blood drawn (CS), she will faint or that the needle will break off in her arm (UCS).

The most commonly used method to elicit this type of information is to ask the client a series of open-ended questions that can be framed in the context of hypothetical situations (e.g., “What is the worst thing that might happen, if you were to drive a car?”) or actual episodes of anxiety (e.g., “During your recent appointment with the dentist, what did you think might happen?”). If the client remains unspecific about the catastrophe (e.g., “then something bad will happen”), it is useful to respond with more specific questions (e.g., “What exactly will happen?” or “What bad things do you mean?”) until more specific information is disclosed (“I will faint,” “I will die,” “I will suffocate,” etc.).

Please note that the UCS, being the mental representation of the catastrophe the client fears, should refer to an event that automatically evokes a negative emotional response. It is not always immediately clear where this information might have come from; that is, when and how the client ever learned that her catastrophe (e.g., fainting, pain, etc.) might happen. The therapist should be aware of the following possible events that may have laid the groundwork for the client’s fear or phobia:

1. A distressing event the client once experienced herself. For example, she might have fainted in relation to an injection (traumatic experience) at an early age.
2. A horrific event the client once witnessed (vicarious learning). For example, witnessing mother’s extremely fearful reaction to a needle.
3. An unpleasant or shocking event the client read or heard about that happened to someone or from learning otherwise that injections or anesthetic fluid can be dangerous (negative information).

Assess Validity of Catastrophe

The severity of a client’s fear or phobia is reflected in the strength of the relationship between the stimulus and the patient’s perceived probability that the expected negative consequence would actually occur. This relationship can simply be indexed using a validity of catastrophe rating (in this case, the validity of catastrophe that expresses the strength of the relationship between the CS and UCS in a percentage between 0% and 100%, using an IF-THEN formula. For example, IF (. . . “I get an injection,” CS), THEN (. . . “I will faint”). Such a rating could be obtained before and after each EMDR session. The general aim of the EMDR treatment of the phobic condition would then be to continue treatment until the client indicates a validity of catastrophe rating as low as possible.

Provide Information About the Fear or Phobia if Necessary

If adequate information about the dangerousness of the object, the animal, or the situation is lacking—and the client has irrational and faulty beliefs about it—it is of paramount importance that the practitioner provide appropriate and disconfirming information to the contrary. However, some clients need to be guided past the initial awkwardness or need for such education. For example, if the client’s lack of knowledge of the phobic objects (e.g., about airplanes and their safety) is likely to play a part, it may be wise to spend some time on this aspect first, and suitable reading material should be provided where appropriate.

Determine an Appropriate and Feasible Treatment Goal

There are a wide variety of treatment goals, from simple goals to more global or complex goals. An example of a limited goal for a needle-phobic individual might be pricking a finger, while a more global goal might be undergoing injections or blood draws, while remaining confident and relaxed. Generally speaking, treatment is aimed at reducing anxiety and avoidance behavior to an acceptable level and at learning how to cope. Goals can be formulated concerning both what the therapist would like the client to achieve during a single therapy session and what exactly the client should manage to do in natural situations.
when confronted with the phobic object. Clearly, the treatment aim is set in consultation with the client and will depend both on the client’s level of commitment and the therapist’s clinical judgment about what seems realistic or ecologically feasible. However, sometimes clients formulate a treatment goal that is not within their reach, unnecessarily difficult, or simply dangerous, such as a person with a dog phobia who set himself the target of acquiring the ability to spontaneously pet all sorts of dogs. A more appropriate aim of treatment, however, could be the ability to walk outside without having to change direction because of the appearance of a dog. The therapist should be clear about the objectives for each session but also be prepared to adapt to unexpected happenings.

**Identify the Conditioning Experience**

In general, with regard to the procedure, the memories of the meaningful and disturbing past events (i.e., the first, possible earlier ancillary experiences and other relevant events that had a worsening effect on client’s symptoms) are used as a focus for a series of subsequent EMDR Therapy (basic protocol) procedures that are applied separately, each involving a distinct target memory.

The first target that has to be identified is the origin; that is, the memory of the event that has caused (or in the patient’s perception clearly worsened) the fear (e.g., being bitten by a dog in case of a dog phobia, or having undergone a horrific medical or dental treatment that led to a medical phobia).

**Check for Possible Earlier (Ancillary) Experience**

Check whether this is indeed the first event. If not, identify the incident when the fear was felt for the first time.

**Identify Other Relevant Experiences**

The assessment should focus not only on the experiences pertinent to the development of the phobia per se, but also on all other, subsequent meaningful events that contributed to the fear. The therapist needs to check for related memories of events that could be considered as “collateral damage”; for example, being ridiculed by peers when the patient reacted with extreme fear when confronted with a small dog. These kinds of experiences are likely to have had an effect on an individual’s self-image and self-worth in general and therefore may also have to be addressed.

**Phase 2: Preparation**

The reprocessing work should not start until rapport and trust have been established and the client has been introduced to EMDR Therapy; that is, what EMDR Therapy is and what the client can expect to happen. A basic example (Shapiro, 2001) of what therapists can say is given in the script that follows. Clearly, the explanation could be changed, based on the current state of knowledge on trauma and trauma resolution, as well as certain personality characteristics, such as age and sophistication of the client.

Another well-established guideline, when using EMDR, is the preparation of the client for EMDR Therapy. To this end, it is important to make sure that the client is not afraid of her own fear reactions, since many phobias entail a fear of fear. If the client has never been able to deal with fear adequately, these things have to be worked out before targeting any traumatic memory. One helpful way to deal with it is to apply self-control procedures before a confrontational method such as EMDR Therapy is used. In particular, training a client in the use of distraction may be a way of challenging the client’s faulty beliefs (for example, the perception that she can exert no control over her anxiety). Later in therapy, distraction can be used as an immediate anxiety-management strategy. Examples of distraction techniques include mental exercises such as counting backward from 1000 in 7s, remembering a favorite walk in detail, and so on. In the case of a child, distraction can be applied, for instance, by thinking of animals beginning with each letter of the alphabet in turn. One of
the benefits of using distraction is that once the client feels confident with its use, these skills are helpful to direct his attention away from thoughts concerned with possible catastrophic happenings or with evaluating his own performance.

It is essential to explain how important it is to prepare oneself for possible discomfort and any between-session disturbance and to practice with what has been learned. This makes it more likely that the client will become proficient and confident in the utilization of such techniques.

There are indications that blood or injury phobics display an atypical symptom pattern in which an initial increase in heart rate and blood pressure is followed by a sudden drop and sometimes fainting. In such cases, it may be important to teach clients the Applied Tension Technique, as this procedure takes into account the diphasic response pattern that is considered to be characteristic of this type of phobia (Öst & Sterner, 1987). This tension technique teaches clients to tighten their muscles, which seems to counteract the drop in blood pressure. This tension–relaxation cycle should be repeated several times within each practice session. If the therapist has access to equipment for measuring blood pressure, it may be instructive to demonstrate the effect of the tension technique to the client. The client should be requested to start practicing the tension technique prior to the actual beginning of the EMDR treatment. Practicing should be done several times throughout the day. If the client has a medical condition that could be affected by the procedure, such as hypertension, she should consult a physician prior to practicing this technique. It is important to note that when the client has headaches during the practices, the strength of the tension should be decreased.

Phase 3: Assessment

Target Selection

Select a target image (stationary picture) of the memory. (See Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal for the series of targets that have to be processed.)

Obtaining Negative Cognition (NC) and Positive Cognition (PC)

The selection of cognitions within the EMDR Therapy treatment is an idiosyncratic process and will greatly depend on the client and the specific characteristics of the target event. For example, the clinician should be sure that cognitions meet the following criteria:

- Appropriate for the issue
- Formulated in the here and now
- Connected to the target image
- Convey the present state about the current belief in relation to the past event, such as “I am out of control,” not a statement of what was experienced in the past such as “I was out of control”
- Describe the actual experience in terms of a belief statement (e.g., NC: “I am prey”) and not the emotional state (e.g., NC: “I am desperate”)
- Are found in the control domain (e.g., “I am helpless,” “I am powerless,” “I am not in control”); in the majority of the cases, it is the NC of the memory of the conditioning experience

Therapists will discover in their work with clients suffering from phobic conditions that certain categories of cognitions pertain to specific types of fears, for example:
Chapter One: EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol

ANIMAL TYPE PHOBIAS

<table>
<thead>
<tr>
<th>I am powerless</th>
<th>I am in control</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am weak</td>
<td>I am strong</td>
</tr>
<tr>
<td>I am prey/in danger (e.g., dogs and insects)</td>
<td>I am safe</td>
</tr>
<tr>
<td>I am a coward</td>
<td>I am okay</td>
</tr>
</tbody>
</table>

SITUATIONAL TYPE AND NATURAL ENVIRONMENT TYPE PHOBIAS

<table>
<thead>
<tr>
<th>I am a coward</th>
<th>I am okay</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am powerless</td>
<td>I am in control</td>
</tr>
</tbody>
</table>

BLOOD-INJURY-INJECTION TYPE PHOBIAS

<table>
<thead>
<tr>
<th>I am a number, a piece of meat</th>
<th>I am okay</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am powerless</td>
<td>I am in control</td>
</tr>
</tbody>
</table>

The main criteria of the PC selection are the following:

- Level of meaning parallels (in the same cognitive domain) the NC
- Empowerment of the individual (e.g., “I can handle it”)
- Ecologically valid or feasible (e.g., PC: not “I have control over the spider”)

In case it appears necessary to address other relevant memories (see Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal), the therapist should take into account that the NC and PC of these targets may have different cognitive domains (e.g., within the self-worth domain rather than within the control domain).

Phase 4: Desensitization

Apply the Standard EMDR Protocol for All Targets

The Standard EMDR Protocol is used to process all targets. There is, however, one difference. To adequately tap into the memory network, it is most useful to have a somewhat different strategy for going back to target than is recommended for using the Standard EMDR procedure. More specifically, after having gone back to target, the client is asked to focus on the most salient detail of the target; that is, the aspect that (still) provokes the most disturbance. Therefore, the client may need time to connect emotionally with the disturbing material, but as soon as the client has decided what aspect is now perceived as most disturbing, bilateral stimulation (BLS) is introduced. Such a strategy of using a clear focus on the aspects of the target image by which the affect is triggered has proven to be an excellent way to facilitate a connecting of the nodes in the fear network that still have to be processed, often effectively activating a new flow of associations.

The work in Phase 4 follows the Standard EMDR Protocol. This procedure is to be repeated until the subjective units of disturbance (SUDs) = 0. Then the PC is installed. Each traumatic event associated with the problem that is not reprocessed during the normal course of the first target must be processed using the Standard EMDR Protocol until the SUDs reach an ecological 1 or 0 and the PC is installed.

1 Although this term is often used in relation to EMDR, support for bilaterality as a necessary condition for effectiveness in EMDR Therapy has a weak empirical base. It might be more appropriate to use the term “working memory taxation” in this respect (see de Jongh, Ernst, Marques, & Hornsveld, 2013).
Phase 5: Installation

The work in Phase 5 follows the Standard EMDR Protocol.

Phase 6: Body Scan

The work in Phase 6 follows the Standard EMDR Protocol.

Check the Other Targets

See Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal and decide whether it is still necessary to reprocess these experiences (SUDs when bringing up the memory > 0). If the SUD is > 0, continue with other memories that may still contribute to or “fuel” the client’s current phobic symptoms.

Check Whether the Client Has (Still) Any Disaster Image About the Future (Flashforward)

After all old memories—that currently “fuel” the fear—have been resolved, check whether the patient has an explicit disaster imagined about the future (called a flashforward). What does the patient think will happen to her, in the worst case or “doom scenario,” if what is feared cannot be avoided? If the client has a flashforward with a SUD > 0, continue with the Flashforward Procedure (Logie & de Jongh, 2014).

Check for Future Concerns

INSTALLING A FUTURE TEMPLATE

If all targets (Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal), including the flashforward, have been successfully processed, as well as current triggers, clients may still have to anticipate future situations in which the former stimuli are present (e.g., a dental treatment situation) and in which they need to interact with these stimuli. To check whether clients are fully capable of that, and to prepare for a future confrontation with the (former) anxiety-provoking object or situation, they are asked to mentally progress in time to identify a specific mental image of a typical future situation by which the fear prior to this session certainly would have been triggered. This may be a situation that clients usually avoid because of fear or a situation that they, until now, were not able to enter or to undergo without fear.

For the future template, it is useful to have clients select a picture of a situation in which they behave and feel in the way they really want it to happen. The goal of this procedure is merely to check that there are no future relapse triggers anymore and to prepare the client for future confrontations with the situation, thereby further increasing the feelings of self-confidence. From a practical point of view, clients are requested to hold in mind their picture and to visualize this scene as well as possible, while keeping in mind a standard PC (e.g., “I can cope,” or “I can handle it”). Next, the BLS is introduced. This is continued as long as clients report a strengthening of validity (until validity of cognition or VoC = 7). Thus, when this form of installation procedure has succeeded, clients fully believe that they are able to deal with their mental representation of the experience.

The therapist continues with this procedure (instruction and VoC rating), until the future template is sufficiently installed (VoC = 7).

If there is a block, meaning that even after 10 or more installations, the VoC is still below 7, there probably are more targets (probably a flashforward target) that have 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 clients need any new information, resources, or skills to be able to comfortably visualize the future coping scene. Introduce this needed information or skill.
**Video Check**

After the incorporation of a positive template for future action, the clinician asks the client to close his eyes, and to run a mental video. That is, the client imagines himself in the future and mentally runs a videotape of the time between the present session and a next possible (but successful) confrontation with the anxiety-provoking stimulus or situation (e.g., an upcoming dental treatment: waking, going to the dentist, taking a seat in the waiting room, etc.). The client is asked to identify any disturbing aspect in the mental video and is instructed that as soon as any disturbance arises during the running of the videotape, he should stop, open his eyes, and inform the therapist.

Next, these disturbing aspects are targeted with BLS, where appropriate. This is done by holding in mind the same PC as was used in the previous step (“I can handle it”), while a long set is administered.

The mental videotape is repeated until it can be viewed entirely without distress.

To provide the clinician with an indication regarding clients’ self-efficacy, have them rate their response on a VoC scale from 1 to 7. This procedural step may give the clinician feedback on the extent to which the goals have been met.

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, while BLS is introduced and the PC “I can handle it” is installed. In a sense, this movie is installed as a future template.

**In Vivo Confrontations**

**PREPARE THE CLIENT FOR IN VIVO CONFRONTATIONS**

It is likely that, through the application of the previous steps of the EMDR procedure, the meaning or severity of the initial event has been effectively reappraised. Yet, it could be that clients are not completely convinced of their ability to cope with a future encounter with the phobic stimulus. Sometimes, clients have avoided certain activities for so long that they no longer know how to behave and how to feel secure in their formerly phobic situation. If this is the case, it is important that the therapist identify and counter existing irrational beliefs that contribute to a sense of threat and anxiety, for instance, by the use of in vivo exposure assignments or behavioral experiments.

If clients are actually confronted with the stimuli that normally would evoke a fear response and clients gain an experience that the catastrophe they fear does not occur, this would help to demonstrate that their fears may be unfounded.

A behavioral experiment is an excellent opportunity to test if the treatment effects are generalized to all associated triggers or aspects of the situation. To this end, real-life exposure to the anxiety-provoking stimulus after successful reprocessing of the traumatic memories may further strengthen the believability of the PC, as the NC (and other still existing assumptions and beliefs) is contradicted by the consequences of acting in new ways.

As with any of the other steps in the phobia protocol, the in vivo exposure part should be a joint venture of client and therapist. Unforced willingness must be ensured. Some gentle persuasion is certainly permissible, but it must be clear to the client that nothing will happen against her will during the confrontation with the phobic stimuli or situation. Also, unexpected introduction of new fearful material is counterproductive, as this can both damage confidence and lead to a revision of estimates of the likelihood of threat and increased caution.

**IN VIVO EXPOSURE**

In vivo exposure is applied to reduce avoidance and promote the opportunity to evoke mastery through observing that no real danger exists. All varying stimulus elements within a situation should be explored. Therefore, the eliciting situation should hold the client’s attention. For instance, a person fearful of high places could be encouraged to be on the
roof of an apartment building that is not too distressful while paying attention to what is happening on the street or to certain objects such as trees, cars, and people.

It is essential that the therapist help the client pay attention to features of the phobic object or situation that are positive or interesting while being exposed to them.

It is important to anticipate various possibilities regarding elements that can be manipulated to ameliorate or to intensify the impact. It is this author’s experience that it is helpful to make variations with regard to the stimulus dimensions such as action, distance, and time. That is, in a real-life confrontation, for example with an animal, the animal can be induced to be more or less lively, close or more distant, to be positioned with its head to the client or not, and during a long or a more limited period of time. If necessary the therapist can demonstrate to the client how the therapist would handle the feared object (e.g., by petting a dog).

The therapist should make sure that confrontations are repeated so that the reduction in distress is fully consolidated before moving on. Thus, the overall aim is to foster confidence in a general ability to cope despite variations in circumstances.

The therapist should act in such a confident and relaxed manner that the client feels prepared for any eventuality. Check the results by assessing the validity of the catastrophe.

Phase 7: Closure

At the end of every session, consolidate the changes and improvement that has occurred by asking the client what has been learned during the session.

Planning Self-Managed Homework Assignments

After the therapy has been concluded, the therapist makes it clear that it is important to keep practicing during daily life in order to ensure that the changes are maintained.

Clients should be told to stop any current avoidance behavior as much as possible, and to consider each confrontation with the feared stimulus as an opportunity to put the newly acquired skills into practice. By using self-managed assignments, clients should be encouraged to incorporate as many critical situations in real life as possible. This allows clients to gain self-confidence through overcoming their fears on their own, learning of new and more independent and appropriate ways of coping, and perceiving further progress. Thus, dependence on the therapist should certainly be avoided. Clients are expected to confront situations regularly and alone on the basis of agreed homework tasks. These may include taking a holiday flight, visiting a dentist for a check-up, opening a window of the house on summer days when wasps are flying, using elevators, meeting people with dogs, climbing towers in cases of height phobia, or swallowing solid food in cases of choking phobia.

With regard to blood phobia, the procedure is different in that clients are instructed to practice the Applied Tension Technique (see Preparation Phase) in real-life situations, while exposing themselves to their anxiety-provoking stimulus as much as possible, such as watching violent films with bloodshed, paying visits to a blood bank, and talking about blood-related topics.

Phase 8: Reevaluation

The length of the interval between sessions will depend on several factors, including the nature of the problem, the frequency with which significant eliciting situations are encountered, and the availability of the therapist and the client. It is sometimes inevitable that clients experience a relapse. In many cases, this is due to the fact that clients now expose themselves to situations that they avoided for a long period of time. Also, a spontaneous return of fear should be expected to occur during the interval between sessions. This may lead to increased arousal, which in turn could render clients disappointed about the improvements that they expected, thus interpreting this as a signal that their problems will only worsen. It is therefore important to label their behavior in a positive sense and to redefine the relapse as a challenge to put into practice what is learned.
After application of the phobia protocol, there may still be a need for additional targeting and other strategies to ensure that the treatment goals are met. An evaluation of what still remains to be done should be made at the beginning of the next session. Clients are asked about their current symptoms and about their progress in terms of success in carrying out homework tasks. It is advisable to always evaluate in terms of clients’ SUDs level on the already processed material.

If the disturbance level has increased, these reverberations should be targeted or otherwise addressed. An extra test should be carried out by checking that the patient does not have any flashforward that is emotionally charged and thus has to be processed.

Further, the therapist should assess the necessity of teaching clients additional self-control and other relevant exercises that could further enhance their ability (e.g., the Applied Tension Technique) to confront the former anxiety-provoking situation in real life. Repeated rehearsal and reinforcement for success must be emphasized. To encourage hope and foster engagement in treatment, it is crucial that therapy sessions and homework assignments furnish experiences of success that clients can attribute to themselves. In this respect, these successes provide clients with direct experiential evidence that anxiety can, through their own effort, be controlled. Clinically, it is often observed that once clients manage to realize even a small achievement, the vicious circle of dependency, low self-esteem, avoidance, and further anxiety is broken. Therefore, it is important to work toward attainable and personally gratifying goals.

The Phobia Protocol Single Traumatic Event Script

Phase 1: History Taking

Determine the Type of Fear and Its Severity

Say, “What is the fear or concern that has brought you in today?”

Say, “Does this fear or concern seem excessive or unreasonable to you?”

If so, say, “Tell me about it.”

Identify the Stimulus Situation (CS)

An important goal of the assessment is to gather information about the current circumstances under which the symptoms manifest, about periods and situations in which the problems worsen or diminish, and about external and concrete (discriminative) anxiety-provoking cues or CS. The therapist should also be aware of other types of anxiety-producing stimuli, including critical internal cues, for example, particular body sensations (e.g., palpitations), images, and self-statements (e.g., “I can’t cope”).

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Say, “Describe the object or situation that you are afraid of.”

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Or say, “What exactly do you need to see, hear, or feel in order to get an immediate fear response?”

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Say, “What exactly about __________________ (state the object or situation) triggers your fear most?”

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Say, “Which incident caused your fear of ________________ (state the object or situation)?”

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Identify the Expected Consequence or Catastrophe (UCS)**

To understand the dynamic of the clients’ fears or phobia, it is necessary to determine not only the aspects of the phobic object or situation that evoke a fear response (the CS) but also what exactly clients expect to happen when confronted with the CS and then the UCS.

Say, “What are you afraid of that could happen when you are exposed to ________________ (state the object or situation: CS)?”

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Chapter One: EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol

Say, “Which incident caused your fear of ______________________ (state the catastrophe the client expects to happen)?”

Assess Validity of Catastrophe

Say, “Is it true you are saying that IF you would be exposed to ______________________ (state the phobic object or situation) THEN you would ______________________ (state the catastrophe the client fears will happen)?”

Say, “On a scale from 0% to 100% where 0% means it is completely false and 100% means it is completely true, how true does this feel that this will happen?”

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
(completely false) (completely true)

Provide Information About the Fear or Phobia if Necessary

If adequate information about the dangerousness of the object, the animal, or the situation is lacking—and clients have irrational and faulty beliefs about it—it is of paramount importance that the practitioner provide appropriate and disconfirming information to the contrary. However, some clients need to be guided past the initial awkwardness or need for such education.

Say, “What do you know about the relative dangerousness of ______________________ (therapist fills in the information specific to the phobic stimulus with which he or she is dealing)? Since there are other people that are not that fearful as you of ______________________ (state the phobic object or situation), wouldn’t it be wise to spend some time investigating whether it is really as dangerous as you think it is? Just to be sure that you don’t overestimate the probability of the danger or that something bad will happen to you. I mean, even if it appears to be more dangerous to be exposed to ______________________ (state the phobic object or situation) than you think it is now, it is important to find out, don’t you think? Thus, let’s look for the information we need. Where shall we start?”
**Determine an Appropriate and Feasible Treatment Goal**

Say, “Based on all that we have been talking about, let’s discuss our goal(s) for treatment. What is the goal and how will you know when you have reached your goal?”


**Identify the Conditioning Experience**

The first target that has to be identified is the origin; that is, the memory of the event that has caused the fear (e.g., being bitten by a dog in case of a dog phobia, or having undergone a horrific medical or dental treatment that led to a medical phobia).

Say, “What we have to figure out now is what memories are crucial to understand your fear. I assume that you were not born with this fear. So your fear started due to a certain event or series of events. Through these experiences you have learned to fear ______________ (state what learned to fear, for example, ‘a dog’). These experiences are, as memories, still active. One could say that every time you are exposed to a difficult situation such as ______________ (state client’s difficult situation, or, for example, ‘a walk in a park,’ or ‘being exposed to a dog’), memories of a former ‘damaging’ event, such as ______________ (state client’s former damaging event, for example, being bitten by a dog), are—consciously or unconsciously—triggered and reactivated. With EMDR, I will help you to resolve these memories, so that they lose their emotional charge. Once these memories become neutral, they will no longer stand in the way of your entering certain situations that might be related to your fear of ______________ (state the client’s fear) and thereby increase your confidence in doing so. To find the right memories, I’ll ask you to search in your mind through time, like a time machine, to determine which event on your timeline has started, or has aggravated, your fear.”

Say, “To begin with, which incident caused you to be afraid of ___________ (state the stimulus or CS)?” Or, in other words, “When did this fear begin?”


Or say, “When did you notice this fear for the first time?”


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Or say, “What incident causes you to be afraid of _______________ (state the feared consequence or UCS)?”

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Check for Possible Earlier (Ancillary) Experience

Check whether this is indeed the first event. If not, identify the incident when the fear was felt for the first time.

Say, “Is this indeed the first incident related to this fear? I mean, are you absolutely sure you did not have this fear or phobia prior to this incident?”

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Identify Other Relevant Experiences

Say, “What other past experiences might be important in relation to the acquisition or worsening of your fear or phobia?” For example, “After what event/s did the fear get worse?” or “Which other experiences gave rise to how fearful you are now?”

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Phase 2: Preparation

Explanation of EMDR Therapy

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.”

Teach distraction techniques for immediate anxiety management between sessions such as the following:

Say, “Please describe out loud, the content of the room, with as much detail as you can.”
Distraction techniques also include mental exercises such as counting backward from 1,000 in 7s, remembering a favorite walk in detail, and so on. For example, say the following:

Say, “Please count backward from 1,000 by 7s.”

Or say, “In detail, tell me about a favorite walk that you took.”

In the case of a child, distraction can be applied, for instance, by thinking of animals beginning with each letter of the alphabet in turn.

Say, “Think of an animal that begins with the letter A.”

Say, “Great, now let’s continue finding the names of animals using the rest of the alphabet. What would the name of an animal be for the letter B?”

Continue education about the process.

Say, “These exercises that we have been practicing may help you distract yourself when you are dealing with anxiety-provoking situations. It is really important for you to prepare yourself for possible discomfort, between sessions, by practicing these exercises. The more you practice, the better you will get at them.”

Teach the Applied Tension Technique for blood or injury phobics who often have an initial increase in heart rate and blood pressure that is followed by a sudden drop or fainting.
Chapter One: EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol

For clients with blood or injury phobias:

Say, “Please make yourself comfortable. Now, tense all of your muscles in your body, including those in your arms, torso, legs, and face. Please increase this tension. Now hold this tension (for about 15 seconds) until there is a warm feeling in your head. Okay? If so, release the tension and let your body return to its normal state (for about 30 seconds).”

This tension–relaxation cycle should be repeated five times within each practice session.

Say, “You can start practicing the tension technique this week, as we will begin our EMDR treatment next time. Practicing means doing the technique several times throughout the day. If you have hypertension, it is wise for you to check with your physician before practicing this technique. If you experience any headaches during the practices, decrease the strength of the tension.”

Phase 3: Assessment

Target Selection

Select a target image (stationary picture) of the memory. (See Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal for the series of targets that have to be processed.)

Say, “What picture represents the most disturbing part of this incident now?”

Obtaining the NC and PC

The following are examples of the types of NCs and PCs seen with specific phobia clients:

ANIMAL TYPE PHOBIAS

<table>
<thead>
<tr>
<th>I am powerless</th>
<th>I am in control</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am weak</td>
<td>I am strong</td>
</tr>
<tr>
<td>I am prey/in danger (e.g., dogs and insects)</td>
<td>I am safe</td>
</tr>
<tr>
<td>I am a coward</td>
<td>I am okay</td>
</tr>
</tbody>
</table>

SITUATIONAL TYPE AND NATURAL ENVIRONMENT TYPE PHOBIAS

<table>
<thead>
<tr>
<th>I am a coward</th>
<th>I am okay</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am powerless</td>
<td>I am in control</td>
</tr>
</tbody>
</table>
BLOOD–INJURY–INJECTION TYPE PHOBIAS

<table>
<thead>
<tr>
<th>I am a number, a piece of meat</th>
<th>I am okay</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am powerless</td>
<td>I am in control</td>
</tr>
</tbody>
</table>

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 the picture of the incident, what would you like to believe about yourself now?”

________________________

____________________________________

VALIDITY OF COGNITION

Say, “When you bring up the picture of the incident, how true do those words (repeat 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)

Identify Emotion, SUD Level, and Location of the Feeling

EMOTIONS

Say, “When you bring up the picture (or incident) and those words (state the negative cognition), 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?”

Phase 4: Desensitization

Apply the Standard EMDR Protocol for All Targets

Say, “I would like to ask you to be a spectator who is observing the things that are happening to you from the moment you start following my hand. Those things can be thoughts, feelings, images, emotions, physical reactions, or maybe other things. These can relate to the event itself, but also to other things that seem to have no relationship to the event itself. Just notice what comes up, without trying to influence it, and without asking yourself whether it’s going well or not. It’s important that you don’t try to keep the image that we will start with in mind all the time. The image is just the starting point of anything that can and may come up. Every once in a while, we will go back to this image to check how disturbing it still is to look at. Keep in mind that it is impossible to do anything wrong, as long as you just follow what’s there and what comes up. If you want to stop, just raise your hand.”

Then say, “Bring up the picture and the words _______________ (repeat the NC) and notice where you feel it in your body. Now follow _______________ (state BLS).”

This procedure is to be repeated until the SUDs = 0. Then the PC is installed. Each traumatic event associated with the problem, that is not reprocessed during the normal course of the first target, must be processed using the above protocol until the SUDs reach an ecological 1 or 0 and the PC is installed.

Note: This protocol uses a different strategy to go back to target than in the Standard EMDR procedure.

Say, “When you go back to the original incident, 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)

If the SUD is 1 or higher, options are as follows:

Say, “Look at the incident as it is now stored in your head. What aspect of it is most disturbing?”
Or say, “What is there in the picture that is causing the ____________ (state the SUD level)? What do you see?”

Then say, “Concentrate on that aspect. Okay, have you got it? Go with that.”

Do sets of eye movements or other BLS until SUD = 0.

**Phase 5: Installation**

*Install the PC*

Say, “As you think of the incident, how do the words feel from 1 being completely false to 7 being 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). Go with that.”

Continue this procedure until the VoC is 7.

**Phase 6: Body Scan**

Say, “Close your eyes and keep in mind the experience that you will have in the future. 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.”

If any sensation is reported, the therapist introduces BLS. If it is a positive or comfortable sensation, BLS is used to strengthen the positive feelings. If a sensation of discomfort is reported, this is reprocessed until the discomfort subsides. Finally, the VoC has to be checked.

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

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

**Check All Other Targets**

See Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal and decide whether it is still necessary to reprocess these experiences (SUD when bringing up the memory > 0).
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Say, “Okay, let’s check the next target that is in your list ________________________
(state the next target). 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)

If the SUD is > 0, continue the procedure and start at Phase 8: Reevaluation.

---

Check for any “Flashforward” Still Fueling Client’s Anticipatory Anxiety

THE FLASHFORWARD PROCEDURE

The Flashforward Procedure addresses clients’ irrational fears and anticipatory anxiety responses, which might persist after the core memories of past events have been fully processed. What does the patient think will happen to her, in the worst case or “doom scenario,” if what is feared cannot be avoided?

Say, “We have now dealt with all the events from your past that seem to have been feeding into your current problems and these are no longer distressing you. But, it could be that you are still left with some fear and dread of what might happen in the future, which has been left behind, even after all the past events have been dealt with. If so, we are going to focus on the future, and what it is that you are dreading, using the same procedure as we used for the past events.”

Determine the Flashforward

Step 1: Identify the Catastrophic Event

Say, “We need to figure out what kind of image is in your head that makes you scared about a future confrontation with what you fear. What is the worst thing you could imagine happening? Basically, we should look for your ultimate doom scenario.”

---

If necessary, the therapist asks additional questions, for example:

Say, “What do you imagine might go wrong if you ________________________ (state the concern, such as ‘come across a dog,’ ‘have a dental treatment,’ ‘climb a tower,’ etc.)?”

Say, “If you had a terrible nightmare about ________________________ (state the concern, such as ‘driving your car to work on a busy road’), what would the most disturbing picture look like?”

---

continued
Step 2: Follow the Event to Its Ultimate Conclusion

Say, “Why would this be so terrible for you?”

__________________________________________________________

__________________________________________________________

Say, “What would be the worst thing about that?”

__________________________________________________________

__________________________________________________________

Repeat as necessary until the client cannot identify anything worse.

Step 3: Make a Detailed Picture of Flashforward Image

The therapist might then ask the client to make a still picture of this scene. Ask that the picture be as detailed as possible.

Say, “Exactly what would ___________ (the flashforward identified above) look like?”

__________________________________________________________

__________________________________________________________

Or say, “What can you see in that?”

__________________________________________________________

__________________________________________________________

If clients still have more than one picture, they are asked to contrast these images, for example, by saying the following:

Say, “If you were forced to choose, what would be most disturbing for you now: the picture of ________________ (state the first example of what is disturbing, for example, your dying), or the picture that ________________ (state the other disturbing problem, such as the situation of being unable to care for your family)?”

__________________________________________________________

__________________________________________________________

Negative Cognition

Say, “What words go best with that picture ________________ (state the flashforward) that express your negative belief about yourself now?” or “When you think of ________________ (state the flashforward), what negative thought do you have about yourself now?”

Note: The therapist can suggest, “I am powerless.”

__________________________________________________________

__________________________________________________________

continued
Chapter One: EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol

Positive Cognition

Say, “When you bring up the __________________ (state the flashforward), what would you like to believe about yourself now?”

Or suggest, “I am in control/ I can deal with it/ I can handle it.”


Validity of Cognition

Say, “When you bring up the __________________ (state the flashforward), how true do those words __________________ (repeat 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)

Emotions

Say, “When you bring up __________________ (state the flashforward) and those words __________________ (state the negative cognition), 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 Phases 4 to 5 according to the Standard EMDR Protocol. For Phase 6, do the body scan and add the video check:

Say, “This time, I’d like you to imagine yourself stepping into the scene of a future confrontation with the object or a situation for which the future template was meant (e.g., making a trip on an airplane, meeting an unknown person, a dog, a dentist). 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.

continued
If you don’t hit any blocks, let me know when you have viewed the whole movie.

If clients encounter a block and open their eyes, this is a sign for the therapist to instruct clients to say the following:

Say, “Say to yourself ‘I can handle it’ and follow my fingers” (or other form of BLS).

If clients are able to play the movie from start to finish with a sense of confidence and satisfaction, clients are asked to play the movie once more from the beginning to the end, while eye movements are 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.”

Do this until the movie can be played without any blocks or significant disturbances. Continue Phases 7–8 according to the Standard EMDR Protocol.

Check for Future Concerns

INSTALLATION OF THE FUTURE TEMPLATE

If all targets (Phase 1: History Taking: Determine an Appropriate and Feasible Treatment Goal), including the flashforward, have been successfully processed, as well as current triggers, clients may still have to anticipate future situations in which the former phobic stimuli are present (e.g., a dental treatment situation) and in which they need to interact with these stimuli. To prepare for that, clients are asked to mentally progress in time to identify a specific mental image of a typical future situation by which the fear, prior to this session, certainly would have been triggered. This may be a situation that clients usually avoid because of fear or a situation that they, until now, were not able to enter or to undergo without fear.

Say, “Okay, we have reprocessed all of the targets that we needed to that were on your list. Now let’s anticipate what will happen when you are faced with ______ (state the anxiety-provoking object or situation).

Think of a time in the future and identify a mental image or photo of a typical situation that would have triggered your fear prior to our work together. What would that be?”

Say, “I would like you to imagine yourself coping effectively with ______ (state the fear trigger) in the future. Please focus on the image, say to yourself, ‘I can handle it,’ notice the sensations associated with this future scene, and follow my fingers (or any other BLS).”
Say, “To what extent do you believe you are able to actually handle this situation (VoC) 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)

The therapist continues with this procedure (instruction and VoC rating) until the future template is sufficiently installed (VoC = 7).

If there is a block, meaning that even after 10 or more installations the VoC is still below 7, there are more targets that have 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 the Appendix). Also, evaluate whether clients need 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 this situation?”

Video Check

After the incorporation of a positive template for future action, the clinician asks clients to close their eyes, and to run a mental video.

Say, “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 clients encounter a block and open their eyes, this is a sign for the therapist to instruct clients as follows:

Say, “Say to yourself ‘I can handle it’ and follow my fingers (or other form of BLS).”

The mental videotape is repeated until it can be viewed entirely without distress.

Say, “Please repeat the video until it can be viewed entirely without distress.”

To provide the clinician with an indication regarding clients’ self-efficacy, have them rate their response on a VoC scale from 1 to 7. This procedural step may give the clinician feedback on the extent to which the goals have been met.
Say, “As you think of the incident, how do the words feel from 1 being completely false to 7 being completely true?”

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

If clients are able to play the movie from start to finish with a sense of confidence and satisfaction, clients are asked to play the movie once more from the beginning to the end, while 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.”

---

**In Vivo Confrontations**

**PREPARE THE CLIENT FOR IN VIVO CONFRONTATIONS**

If clients are actually confronted with the stimuli that normally would evoke a fear response and clients gain an experience that the catastrophe they fear does not occur, this would help to demonstrate that their fears may be unfounded. A behavioral experiment is an excellent opportunity to test if the treatment effects are generalized to all associated triggers or aspects of the situation.

Say, “Many clients appear to avoid certain activities for so long that they no longer know how to behave and how to feel secure in this situation. To be able to help further alleviate your fears and concerns, it is important that you learn to counter the negative belief that contributes to this sense of threat and anxiety. Therefore, you need to actually test the catastrophic expectations you have that fuel your anxiety in real life. I would like to ask you to gradually confront the objects or situations that normally would provoke a fear response. It may seem odd, but if you have a positive experience and it appears that the catastrophe you fear does not occur, it helps you to further demonstrate—or to convince yourself—that your fear is unfounded.”

Say, “I want you to understand that nothing will happen against your will during the confrontation with the things that normally would evoke fear. The essence of this confrontation is that it is safe.”

**IN VIVO EXPOSURE**

This is done to reduce avoidance and evoke mastery while observing that no real danger exists. It is essential that the therapist help clients pay attention to features of the phobic object or situation that are positive or interesting while being exposed to it.

Say, “Please describe the most notable features of the situation. Are you noticing any interesting elements about ________________ (state the phobic object or situation)?”

---

It is our experience that it is helpful to make variations with regard to the stimulus dimensions such as action, distance, and time.

Say, “Isn’t it interesting to notice that now that you are confronted with this ________________ (state the object or situation) ________________

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(state the catastrophe the client normally would have feared to happen) does not occur?"

Say, “Do you notice that your anxiety is not as physically harmful as you might have expected?”

Say, “These emotional reactions will subside and fade over time. Therefore, it is important that you continue exposing yourself to the feared stimuli as long as you feel that you have achieved a certain degree of self-mastery. Please note that you are gradually learning to feel that you are capable of handling a certain level of anticipatory anxiety with confidence.”

The therapist should make sure that confrontations are repeated so that the reduction in distress is fully consolidated before moving on.

Check the results by assessing the validity of the catastrophe.

Say, “If you would encounter ________________ (state the phobic object or situation) again, on a scale from 0% to 100% where 0% means it is completely false and 100% means it is completely true, how true does this feel that this will happen?”

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (completely false) (completely true)

Phase 7: Closure

At the end of every session, consolidate the changes and improvement that has occurred.

Say, “What is the most positive thing you have learned about yourself in the last hour with regard to ________________ (state the incident or theme)?”

If the cognitions are not already on the identity level, say the following:

Say, “What does this say about yourself as a person?”

Say, “Go with that.”

Install with eye movements until there are no further positive changes.

Next, check the results by assessing the validity of the catastrophe.

Say, “If you would be exposed to ________________ (state the phobic object or situation), on a scale from 0% to 100% where 0% means it is completely false and 100% means it is completely true that this will happen, how true does this feel?”
Next, an explanation is provided about the coming three days concerning agreements, diary, and contact information.

Say, “Things may come up, or, they may not. If they do, great, write it down and it can be a target for next time. 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 next time.”

Planning Self-Managed Homework Assignments

After the therapy has been concluded, the therapist makes it clear that it is important to keep practicing during daily life in order to ensure that the changes are maintained.

Say, “It is very important to keep practicing with exposing yourself to difficult situations during your daily life in order to maintain the changes that you have experienced.”

Each time that you have a chance to see ______________ (state the feared stimulus), it is an opportunity for you to practice these new skills that you now know how to do. So, the more that you encounter ______________ (state the feared stimulus), the better you can get at ______________ (state the goal). Your brain learns to do new behaviors by practicing.”

By using self-managed assignments, the client should be encouraged to incorporate as many critical situations in real life as possible. This allows clients to gain self-confidence through overcoming their fears on their own, to learn new and more independent and appropriate ways of coping, and to perceive further progress.

Say, “Please make sure to put yourself in as many critical situations in real life as possible. The more that you do this, the more you will gain in self-confidence as you overcome your fears and learn more independent and appropriate ways of coping and see your own progress.”

Say, “Make sure to write down your responses when you are practicing your new skills. Sometimes, even with the skills, you might find that you re-experience your fear. I want to tell you that this can happen sometimes, and it is not unusual. What you can do at that time is to note what has led up to the feeling, what is going on around you, and what you did to help yourself handle the situation. Jot down some notes about what happened as soon as you can so that you won’t forget what happened and then bring them to the next session so that we can figure it out.”

For clients with blood phobia, say the following:

Say, “Please practice the Applied Tension Technique in real-life situations as much as possible, while exposing yourself to ______________ (state anxiety-provoking stimulus). That may, for example, be talking about blood-related topics with friends, watching a medical documentary, a violent film with bloodshed, or paying a visit to a blood bank.”

Phase 8: Reevaluation

Evaluate whatever is left to be done.
Chapter One: EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol

Say, “What have you been noticing since our last session?”

Say, “What are the current symptoms (if any) you have been noticing?”

Say, “What kind of progress have you noticed, especially in terms of the homework?”

Say, “As you think back on the target that we were working on last time, 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)

If the disturbance level has increased, these reverberations should be targeted or otherwise addressed.

If the client has relapsed, say the following:

Say, “As we spoke about before, it is not unusual to experience a relapse, as you expose yourself to situations that elicit your response. This is because you have exposed yourself to situations that you have been avoiding for a long period of time. You might have even noticed a return of some fear and become disappointed because you had expected improvements and now feel that your problems have only worsened. However, I see it really as a challenge that will allow you to put into practice what you have learned. What are your thoughts about what I am saying?”

The therapist should assess the necessity of teaching the client additional self-control techniques or other relevant exercises that could further enhance the client’s ability to confront the former anxiety-provoking situation in real life.

Say, “So what other resources do you think might be helpful in assisting you to deal with this situation?”

Repeated rehearsal and reinforcement for success has to be emphasized.

Say, “As we have discussed before, the more you practice putting yourself in these situations that have provoked your fear over a long time, and use all that we have worked on, the more you will be able to overcome your problem.”

To encourage hope and foster engagement in treatment, it is crucial that therapy sessions and homework assignments furnish experiences of success that clients can attribute to themselves.
Say, "I can see that through all of the work you did between sessions that you are really working hard [reinforce what the client has done that has been successful]."

Summary

This chapter illustrates how EMDR Therapy can be applied in the treatment of fears and specific phobias. These conditions are highly prevalent in the general population, and are characterized by an unreasonable and severe fear related to exposure to specific objects or situations, which tend to result in active avoidance of direct contact with these stimuli.

Clients with specific phobias display commonalities with PTSD in that they often experience vivid and disturbing memories of earlier events associated with the beginning of their fears. Activation of these mental representations plays an important role not only in the symptomatology of fears and phobias, but also in the process contributing to the maintenance and aggravation of clients’ symptoms. EMDR Therapy has been shown to be capable of resolving such memories, alleviating clients’ fears, and successfully reducing clients’ avoidance tendencies (de Jongh et al., 1999, 2011; Doering et al., 2013).

Like most other anxiety disorders, for specific phobia there are treatment approaches that have been found to be effective, particularly those with a cognitive behavioral signature. Although there always should be good reasons to deviate from such evidence-based treatment standards, EMDR has proven to fulfill a pivotal role in resolving memories of past events that started the fear or phobia, or those that still contribute to the severity of the client’s fear response (de Jongh, Ernst, Marques, & Hornsveld, 2013), particularly when these are likely to be activated when the clients are confronted with their phobic stimuli. Contrariwise, in many instances EMDR Therapy could profit from elements of CBT that add significant practical value and elevate the effectiveness of its use. That is the reason that in the present phobia protocol, EMDR is used for the processing of memories, while cognitive behavioral procedures (e.g., applied tension and in vivo exposure)—that are meant to teach clients to confront their feared stimuli until they feel they have achieved a degree of self-mastery that is needed to feel comfortable with handling these situations—are included as well.

References


SUMMARY SHEET:  
EMDR Therapy for Specific Fears and Phobias: The Phobia Protocol 

Ad de Jongh 
SUMMARY SHEET BY MARILYN LUBER

Name: ___________________________ Diagnosis: ______________

Medications: ________________________________________________

Test Results: ________________________________________________

☑ Check when task is completed, response has changed, or to indicate symptoms.

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

Purpose: To illustrate how EMDR Therapy can be applied in the treatment of specific fears and phobic conditions.

Phase 1: History Taking

Diagnostic Interview (e.g., Anxiety Disorder Interview Scale)

MOTIVATION ASSESSMENT

_____ Self-Referral    _____ Forced Referral

Failed Past Therapy:    ☐ Yes    ☐ No
If yes, what happened? __________________________________________

Comorbid Psychiatric Issues:   ☐ Yes    ☐ No
(Other comorbid issues may contribute to lack of motivation) ______________

Low Self-Esteem:    ☐ Yes    ☐ No
Low self-esteem can contribute to client’s avoidance behavior and may also have to be resolved, and to become a target of processing accordingly.
DETERMINE THE TYPE OF FEAR AND THE SEVERITY

Fear: ________________________________

________

Fear Excessive/Unreasonable: □ Yes □ No

Explain: ________________________________

IDENTIFY THE STIMULUS SITUATION (CONDITIONED STIMULUS, CS)

“Describe the object/situation that you are afraid of” ________________________________

____________________________________

“What do you need to see, hear, or feel in order to get an immediate fear response?” ________________________________

____________________________________

“What about _________ (the object/situation) triggers your fear the most?” ________________________________

____________________________________

“Which incident caused your fear?” ________________________________

____________________________________

IDENTIFY THE EXPECTED CONSEQUENCE/CATASTROPHE (UNCONDITIONED STIMULUS, UCS)

Expected consequence: ________________________________

____________________________________

Incident that caused your fear: ________________________________

____________________________________

ASSESS VALIDITY OF CATASTROPHE

“Is it true that you are saying that IF you would be exposed to _________ (state the phobic object or situation) THEN you would _________ (state the catastrophe the client fears would happen)?”

(0–100%) = __________

PROVIDE INFORMATION ABOUT THE FEAR OR PHOBIA IF NECESSARY

“What do you know about the relative dangerousness of _________ (fill in the information specific to the phobic stimulus with which the client is dealing)? Since there are also people on this planet that are not that fearful as you of _________ (state the phobic object or situation), wouldn’t it be wise to spend some more time in investigating whether it is really that
dangerous as you think it is? Just to be sure that you don’t overestimate the probability of the danger or that something bad will happen to you. I mean: even if it appears to be even more dangerous to be exposed to ________ (state the phobic object or situation) than you think it is now, it is important to find out, don’t you think? Thus, let’s look for the information we need.”

“Where shall we start?”

______________________________

DETERMINE AN APPROPRIATE AND FEASIBLE TREATMENT GOAL

Treatment goal: ____________________________

“How will you know when you reach your goal?” ____________________________

______________________________

IDENTIFY THE CONDITIONING EXPERIENCE

“Incident causing fear/incident when you noticed this fear for the first time”:

______________________________

CHECK FOR POSSIBLE EARLIER ANCILLARY EXPERIENCE

“Are you sure you did not have this fear/phobia prior to this incident?” ______

______________________________

IDENTIFY OTHER RELEVANT EXPERIENCES

Other relevant experiences. “After what event/s did the fear get worse?”/”Which other experiences led to how fearful you are now?”

______________________________

Phase 2: Preparation

Rapport and trust established in therapeutic relationship: □ Yes □ No

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

Teach Distraction Techniques

Describe content of room in detail: □ Yes □ No

Count backward from 1000 by 7s: □ Yes □ No

Describe favorite walk in detail: □ Yes □ No

For Children:

Animal names (A–Z) □ Yes □ No
For Blood/Injury Phobic Patients:

Applied Tension Technique: □ Yes □ No

“Please make it comfortable for yourself. Now, tense all of your muscles in your body, including those in your arms, torso, legs, and face. Please increase this tension. Now, hold this tension (for about 15 seconds), until there is a warm feeling in your head. Okay? If so, release the tension and let your body return to its normal state (for about 30 seconds).”

This tension–relaxation cycle should be repeated five times within each practice session.

“You can start practicing the tension technique this week, as we will begin our EMDR treatment next time. Practicing means doing the technique five times throughout the day, practicing five tension-relaxation cycles per time. If you have hypertension, it would be wise for you to check with your physician before practicing this technique. If you experience any headaches during the practices, decrease the strength of the tension.”

Client can handle own fear reactions: □ Yes □ No

Phase 3: Assessment

Target/Memory/Image: ________________________________

NC: ___________________________________________

PC: ___________________________________________

VoC: ________ /7

Emotions: ______________________________________

SUD: ________ /10

Sensation: ______________________________________

Phase 4: Desensitization

Apply the Standard EMDR Protocol for All Targets

Note: This protocol uses a different strategy to go back to target.

SUD: ________ /10; if the SUD is 1 or higher:

Options: “Look at the incident as it is now stored in your head.”

“What aspect of it is most disturbing?”

“What is there in the picture that is causing the SUD = ________ /10?”

“What do you see?”

“Concentrate on that aspect. OK, have you got it? Go with that.”

Do BLS until SUD = 0.

Phase 5: Installation

Install the PC.

Original PC: ______________________________________

Use original PC: ______________________________________

New PC: ______________________________________

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Use 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

Check the other targets to see if it is still necessary to reprocess these experiences.

<table>
<thead>
<tr>
<th>Other Targets</th>
<th>Age</th>
<th>SUD</th>
<th>SUD Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>___</td>
<td>___/10</td>
</tr>
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<td>5.</td>
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</tbody>
</table>

Check for any Flashforward Still Fuelling Client’s Anticipatory Anxiety

Check whether there is still anticipatory anxiety regarding the phobic object or situation. If so, ask the client to bring up a fantasy (image) of the most catastrophic outcome of a future confrontation with the phobic object or situation that would explain why the client is so anxious or terrified (see Expected Consequence/Catastrophe that was identified earlier).

Step 1: Identify the Catastrophic Event

“We need to figure out what kind of image is in your head that makes you still scared about a future confrontation with what you fear. What is the worst thing you could imagine happening? Basically we should look for your ultimate doom scenario.”

Step 2: Follow the Event to Its Ultimate Conclusion

“Worst thing about it?”

continued
Step 3: Make a Detailed Picture of Flashforward

Use this as a target for processing with the Standard EMDR Protocol (SUD = 0; VoC = 7).

Target/Memory/Image: ____________________________________________________________________________
NC: _______________________________________________________________________________________
PC: _______________________________________________________________________________________
VoC: __________ /7
Emotions: __________________________________________________________________________________
SUD: __________ /10
Sensation: __________________________________________________________________________________

**Video Check**

“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 blocks, say, “I can handle it,” and BLS. Repeat until whole movie can be viewed entirely without distress.

VoC: __________ /7

If client can play movie from beginning to end with confidence and satisfaction, play the movie one more time from beginning to end + BLS: □ Yes  □ No

**Check for Future Concerns**

**INSTALLATION OF THE FUTURE TEMPLATE**

Image of situation triggering your fear prior to our work together: __________________________________________________________________________

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

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.

Other new information, resources, or skills to comfortably visualize coping in the future:

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________

If blocks are not resolved, identify unprocessed material and process with Standard EMDR Protocol:

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________

Target/Memory/Image: __________________________________________

NC: __________________________________________________________
PC: __________________________________________________________
VoC: __________ /7
Emotions: ______________________________________________________
SUD: __________ /10
Sensation: _____________________________________________________

**Video Check**

“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 blocks, say “I can handle it,” and BLS. Repeat until whole movie can be viewed entirely without distress.

VoC: __________ /7

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

- [ ] Yes  - [ ] No

**In Vivo Confrontations**

**PREPARE THE CLIENT**

“Many clients appear to avoid certain activities for so long that they no longer know how to behave and how to feel secure in this situation. To be able to help you further alleviate your fears and concerns, it is important that you learn to counter the negative belief that contributes to this sense of threat and anxiety. Therefore, you need to actually test the catastrophic expectations that you have that fuel your anxiety in real life. I would like to ask you to gradually confront the objects or situations that normally would provoke a fear response. It may seem odd, but if you have a positive experience, and it appears that the catastrophe you fear does not occur, it helps you to further...
demonstrate—or to convince yourself—that your fear is unfounded. I want you to understand that nothing will happen against your will during the confrontation with the things that normally would evoke fear. The essence of this confrontation is that it is safe.”

Client agrees to in vivo exposure: ☐ Yes ☐ No

**IN VIVO EXPOSURE**

This is done to reduce avoidance and evoke mastery while observing that no real danger exists. Pay attention to features of the phobic object or situation that are positive or interesting while being exposed to it:

Description of most notable features of the situation: __________________________

_____________________________________________________________________

Thoughts during in vivo exposure: __________________________

_____________________________________________________________________

Thoughts someone who is not afraid would think in the situation: __________

_____________________________________________________________________

It is helpful to make variations with regard to the stimulus dimensions “action,” “distance,” and “time.”

“Isn’t it interesting to notice that now that you are confronted with this ________ (state the object or situation) ________ (state the catastrophe the client normally would have feared to happen) does not occur?”

☐ Yes ☐ No

“Do you notice that your anxiety is not as physically harmful as you might have expected?”

☐ Yes ☐ No

Importance of practice.

Check with VoC (0–100%): __________

**Phase 7: Closure**

Most positive thing learned: __________________________

_____________________________________________________________________

PC: __________________________

+ BLS

Check with VoC (0–100%): __________

Normal closure: ☐ Yes ☐ No

**Planning Self-Managed Homework Assignments**

Have clients expose themselves to difficult situations in daily life to maintain the changes.

“It is very important to keep practicing with exposing yourself to difficult situations during your daily life in order to maintain the changes that you have experienced. Each time you have a chance to see ________ (state the feared stimulus), it is an opportunity for you to practice these new skills that you
now know how to do. So, the more that you encounter __________ (state the feared stimulus), the better you can get at __________ (state the goal). Your brain learns best to do new behaviors by practicing.”

“Please make sure to put yourself in as many critical situations in real life as possible. The more that you do this, the more you will gain in self-confidence as you overcome your fears and learn more independent and appropriate ways of coping and see your own progress.”

For clients with blood phobia, say the following:

“Please practice the ‘applied tension technique’ in real-life situations as much as possible, while exposing yourself to __________ (state anxiety-provoking stimulus). That may, for example, be talking about blood-related topics with friends, watching a medical documentary, a violent film with bloodshed, or paying a visit to a blood bank.”

“Make sure to write down your responses when you are practicing your new skills. Sometimes, even with the skills, you might find that you reexperience your fear. I want to tell you that this can happen sometimes, and it is not unusual. What you can do at that time is to note what has led up to the feeling, what is going on around you, and what you did to help yourself handle the situation. Jot down some notes about what happened as soon as you can so that you won’t forget what happened and then bring them to the next session so that we can figure it out.”

Phase 8: Reevaluation

Noticed since last session: __________________________

________________________________________________

Current symptoms: ______________________________

New material: ___________________________________

SUD: __________ /10

If disturbance level increased, target it.

If relapse:

“As we spoke about before, it is not unusual to experience a relapse as you expose yourself to situations that elicit your response. This is because you have exposed yourself to situations that you have been avoiding for a long period of time. You might have even noticed a return of some fear and become disappointed because you had expected improvements and now feel that your problems have only worsened. However, I see it really as a challenge that will allow you to put into practice what you have learned.”

“What are your thoughts about what I am saying?” __________________________

New resources needed: ☐ Yes ☐ No

Give praise for accomplishments: ☐ Yes ☐ No