

Welcome to Day 5!



Day 5 Overview

Finding the Root

Review of practice sheets & root identification

Phases 3-7

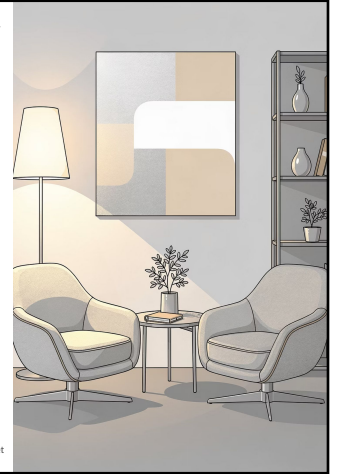
Deep review of assessment through closure

Cognitive Interweave

Tools to keep processing moving

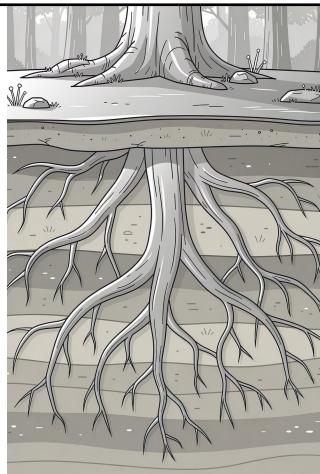
Pain & Illness

Somatic and preverbal dimensions



Finding the Root

Trainer: please share screen and review practice sheets on Finding the Root.



Relational Longing

We look for the relational longing to find the attachment wound.

"Someone there to protect me"


"Someone who loves me unconditionally"

"Someone who accepts me just as I am"





"Someone I can trust to handle things"

Common mistake: Making it about the self rather than a relational longing for another person.





Finding the Root with

- 
Gather information
 Collect history from caregivers and other adults in the child's life
- 
Play & story
 Children reveal what happened through play; therapist tells story in 3rd person and child identifies the worst parts
- 
Rate the memories
 Order memories from least to most "yucky" using child-friendly language
- 
Build the timeline
 Create a visual timeline collaboratively with the child

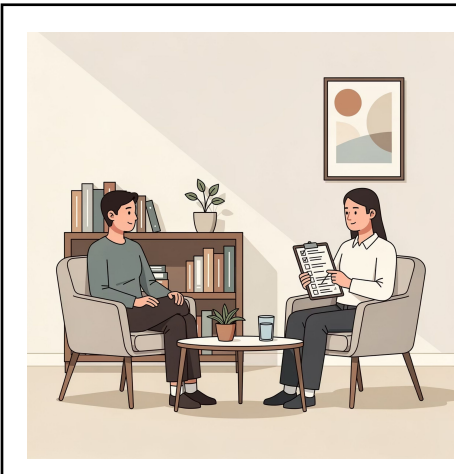
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Phases 3-7 Review

A deep dive into the core reprocessing phases – from activation to closure.

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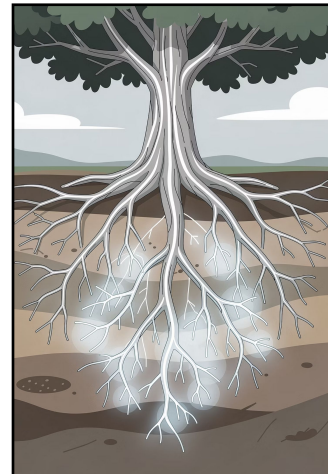


PHASES 3-7 REVIEW

Be Ready Before Starting the Engine

Phases 1 & 2 must be complete before entering Phase 3.

- Stabilization done
- History complete
- Resources in place



PHASES 3-7 REVIEW

Start with the Earliest Event

- **Touchstone Memory**
The earliest memory on the target plan – the root of present distress
- **Hidden, Early Fuel Source**
Often not obvious – the therapist must help the client locate it
- **Earliest Memory**
May predate conscious recall – body sensations are key indicators

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PHASE 3: ASSESSMENT

Flipping On the Switches

Phase 3 is about **activation** – not gathering new information.

Light up all parts of the brain

Cognitive, emotional, somatic – all activated simultaneously

Activate the reactivity of the memory

We want the system to feel it, not just think about it



PHASES 3-7 REVIEW

Just Ask the Questions

Do not repeat, clarify, or get into conversation.

- ☐ **Why it matters:** Conversation pulls the client into their head – out of felt experience and into analysis.



PHASES 3-7 REVIEW

We Are Always Looking at NOW

How does the client's system *react* to that memory now?

- ☐ We are not revisiting the past – we are observing the present-moment response to it.

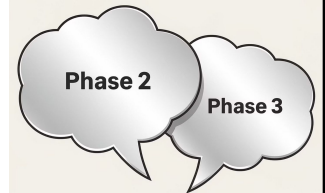



PHASES 3-7 REVIEW

The NC Carries Over from Phase 2

The **Negative Cognition** gathered in Phase 2 will likely be similar when re-asked in Phase 3 – this is expected and correct.

- ☐ No need to search for a new NC. Trust the process – the work done in Phase 2 is already informing Phase 3.





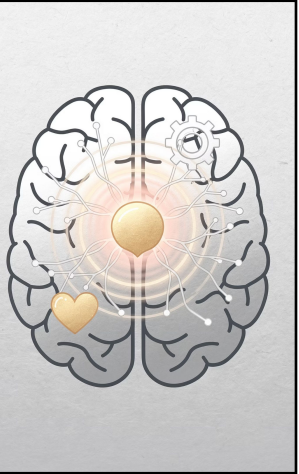
PHASES 3-7 REVIEW

Go Immediately from Phase 3 to Phase 4

Once activation is complete, move directly into desensitization – do not pause, summarize, or debrief between phases.

Any delay risks disrupting the activated state you just carefully established.

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PHASES 3-7 REVIEW

Remember – It's Not CBT

The NC is for activation
We are lighting up the memory network – not correcting or changing the thought

Go for Feeling, not Thinking
We want somatic, emotional activation – not cognitive analysis or insight

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PHASE 4: DESENSITIZATION

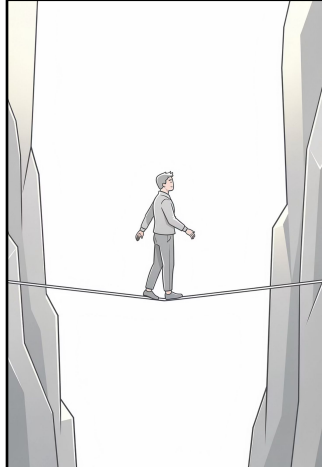
Moving the Train Down the Tracks

We are looking for moving and changing – as long as there is change, the process is happening.

Change = progress
The train is moving, even if the destination isn't yet visible

Dual awareness matters
The client just needs a gentle awareness that they are here, now, safe

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PHASES 3-7 REVIEW

Regulation: Is the Client Present Enough?

Continuously assess: Is the client within the Window of Tolerance?

Signs of hyperarousal
Overwhelm, flooding, dissociation – client may be above the window

Signs of hypoarousal
Numbing, shutdown, disconnection – client may be below the window

In the window
Activated but present – processing can continue effectively

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PHASES 3-7 REVIEW

Window of Tolerance

The optimal zone where the client is activated enough to process, but regulated enough to stay present.

Hyperarousal

- Too much arousal
- Unable to integrate
- Fight, Flight, Freeze

Window of Affect Tolerance

- Able to integrate
- Regulated arousal
- Present
- Dual Awareness

← AROUSAL →

Hypoarousal

- Too little arousal
- Unable to integrate
- Parasympathetic
- Collapse, Submit

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PHASES 3-7 REVIEW

The Past Patterns Show Up

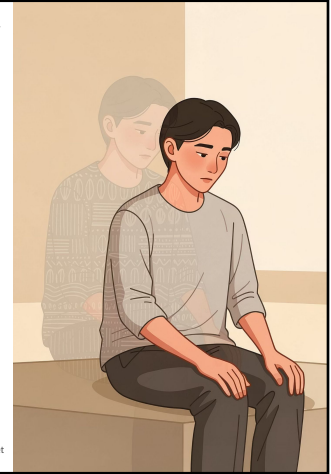
Watch for the old patterns emerging *in this moment*:

How is the past manifesting right now?

The client's reactions, posture, emotional tone – all carry history

See it through AIP

Past unprocessed memory is driving present-moment disturbance



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PHASES 3-7 REVIEW

Welcoming the Deep Emotional Pain

Do not shy away from or try to soothe deep distress. The pain is the path – encourage the client to move through it, not around it.

- ☐ The therapist's comfort with grief and pain directly impacts the client's ability to fully process.



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PHASES 3-7 REVIEW

Body Sensations May Be Earlier or Preverbal Memories

Feeder Memory

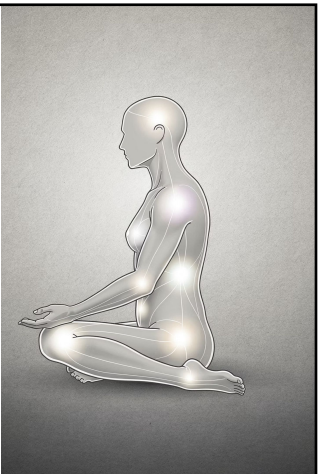
A disturbing body sensation may signal a feeder memory blocking progress

Next Memory

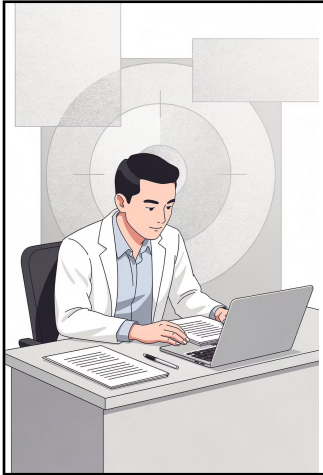
The sensation could be the leading edge of the next memory in the chain

Preverbal Memory

No image or narrative – only sensation. May predate language development entirely



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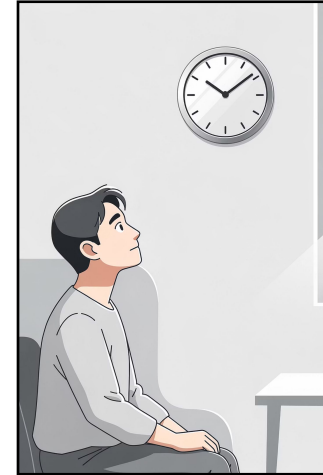
PHASES 3-7 REVIEW

Always Return to the Whole Memory

Common mistake: Not going back to the original memory to check how it's currently stored.

- When returning to the target, simply say the original words — bring up the *whole memory*, not just the NC. Let the system show you what remains.

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PHASES 3-7 REVIEW


Only Check the SUD at the End of Processing

Taking the SUD too early can interrupt the flow. Ask yourself: "Do I think they are at the end?"

When to check
When the client appears calm, processing has slowed, and change seems complete

When NOT to check
Mid-process — it pulls the client out of the felt experience into evaluation

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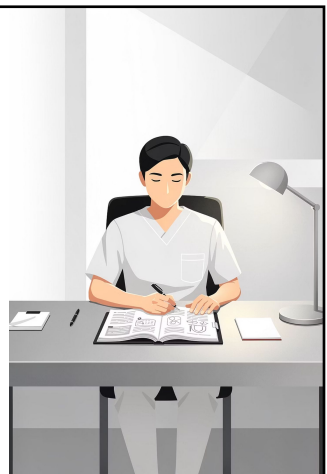
PHASES 3-7 REVIEW

Checking on the Target Memory

Bring up the *whole memory* — not the NC — when returning to target.

- Return to the original image, sensations, and feelings together. Pairing anything else with the return check disrupts the process.

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PHASES 3-7 REVIEW

Follow the Script for Going Back to Target

We are always returning to the *whole memory* — pairing nothing else with that check.

- Trust the protocol. The script exists for a reason — deviating introduces cognitive interference at a critical moment.


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PHASES 3-7 REVIEW

Encourage the Client to Keep Going

When deep emotional pain surfaces, **encourage the client to stay with it and move through it** — this is where the healing happens.

"Notice that" and "Go with that" are your most powerful tools. Stay present and let the process unfold.



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PHASES 3-7 REVIEW

The Client's Answer Will Likely Surface


The therapist is always watching through the AIP lens:

"I wonder if this is what happened at the time..."

Trust that the client's system is moving toward resolution. The answer is already in there.



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PHASES 3-7 REVIEW

Do Not Resource Instead of Reprocess

(Unless absolutely necessary)

The therapist must be able to sit with pain
 Resourcing to avoid distress is the therapist's discomfort, not the client's need

Resourcing interrupts healing
 Processing the pain IS the treatment — diverting away delays resolution

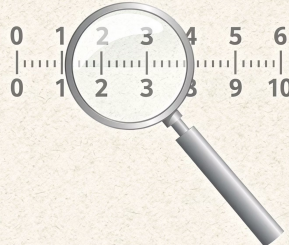
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PHASES 3-7 REVIEW

SUD: The Big Difference Between 1 and 0

The gap from 9 → 0 can be *smaller* than the gap from 1 → 0.

A SUD of 1 is not "close enough." The move from 1 to 0 often requires its own complete processing — don't rush it or assume it will resolve on its own.



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Incomplete Sessions: Go Straight to Phase 7

Sessions can be incomplete in Phases 4, 5, or 6. Do not continue to the next phase – go directly to closure.

Correct: Go to Phase 7

Mistake: Continue to Phase 5

Mistake: Then Phase 6

Skipping to Phase 5 or 6 with an incomplete session leaves the client in an activated, vulnerable state.



Working with Children in

Phases 3-7

- **Kids process quickly**
Expect faster movement through memories – follow their pace
- **Movement & play breaks**
Normal and necessary – build them into the session structure
- **BLS alternatives**
Adapt bilateral stimulation delivery to be age-appropriate and engaging
- **Concrete SUD/VOC measures**
Use hands, blocks, or visual scales instead of abstract numbers



In Phases 3-7: Don't Change the Words

Follow the protocol script exactly – with the exception of age-appropriate adaptations for children.

Just Read It!

- Improvising the language introduces therapist interpretation at precisely the moment the client needs unfiltered protocol.



Still Clearing Out & Linking to the Positive

Phase 5 continues reprocessing while beginning to install the Positive Cognition.

Not just reinforcement

Whatever doesn't resonate with the PC will surface for further reprocessing




PHASE 5: INSTALLATION

The PC Surfaces What Doesn't Fit

As we pair the **Positive Cognition** with the memory, anything that doesn't yet resonate will come up — and that's the next material to process.

- ☐ This is a feature, not a problem. Trust the system to surface what remains unresolved.



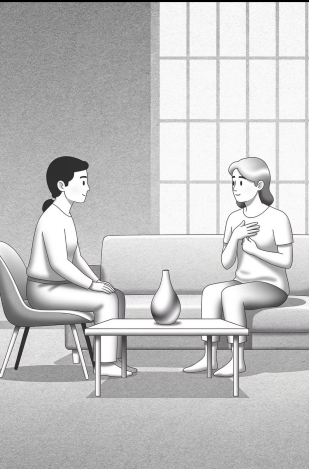
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PHASE 5: INSTALLATION

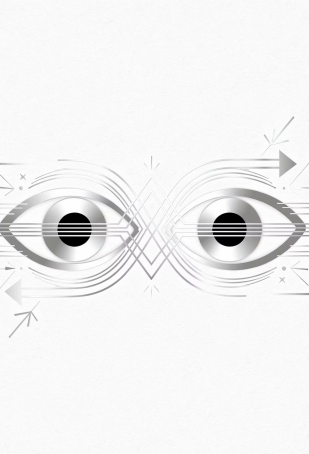
Always Check: Has the PC Changed?

Reprocessing in Phase 4 often improves the PC spontaneously. **Before starting Phase 5, always ask if it has shifted.**

- ☐ Things move and change — the PC that was a 3 on the VOC may now feel like a 6. Honor that progress before installing.



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PHASE 5: INSTALLATION

Eye Movements in Phase 5: Long and Fast

BLS in Phase 5 mirrors Phase 4 — **long sets, fast speed**. It is still an active reprocessing phase.

- ☐ Do not slow down or shorten the sets just because you've moved into Phase 5. Full reprocessing speed is maintained throughout.


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PHASE 5: INSTALLATION

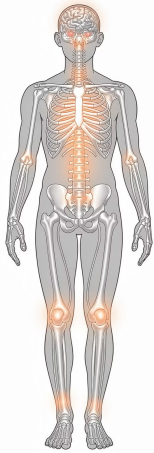
Incomplete Phase 5: Go Straight to Phase 7

If Phase 5 is incomplete, skip directly to closure — **do not continue to Phase 6.**

- ☐ It is rare for Phase 5 to be incomplete — but when it is, the same rule applies as in Phase 4: protect the client by closing safely.



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Phase 6: Body Scan

Activating the Lowest Part of the Brain

Phase 6 brings the reprocessing down into the body — targeting residual disturbance stored below conscious awareness.

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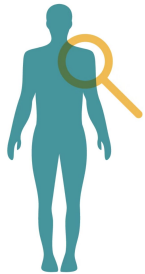
PHASE 6: BODY SCAN

Looking for Residual Disturbance

The body often holds what the mind has already let go of. Phase 6 searches for lingering disturbance connected to the memory.

- Even if the SUD is 0, the body scan may reveal remaining activation that needs to be processed before closure.

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PHASE 6: PROCEDURE

Residual Reprocessing

Whatever body sensation the client reports — even if they think there's an external reason — notice it and offer DAS.

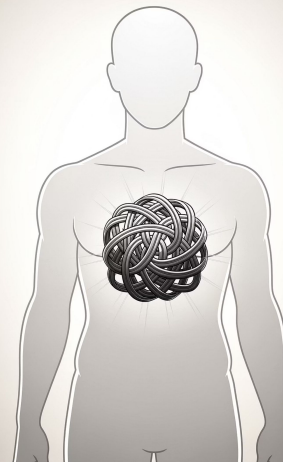
Always offer bilateral stimulation

The body's report is valid data, regardless of the client's explanation for it

Watch for feeder or preverbal memories

Unresolved body sensations may signal deeper, earlier material

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PHASE 6: PROCEDURE

Un-Resolving Body Sensations

When a body sensation persists despite processing, ask:

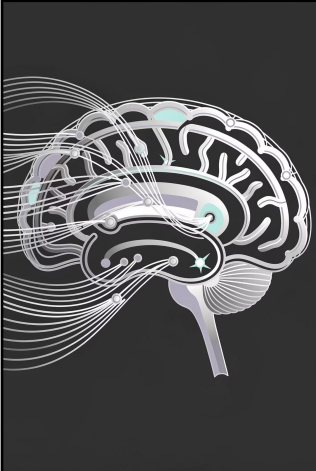
Is there a feeder memory?

An earlier, unprocessed memory may be fueling continued activation

Is this preverbal?

Body-only memories with no narrative require different handling — work with pure sensation

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PHASE 6: BODY SCAN

Phase 6 Is Reprocessing – Not Relaxation

Phases 4, 5, and 6 are all **reprocessing** phases. Phase 6 is not a wind-down – it is active and therapeutic.

- Do not introduce relaxation techniques or shift tone in Phase 6. Maintain full reprocessing attention until disturbance is fully clear.

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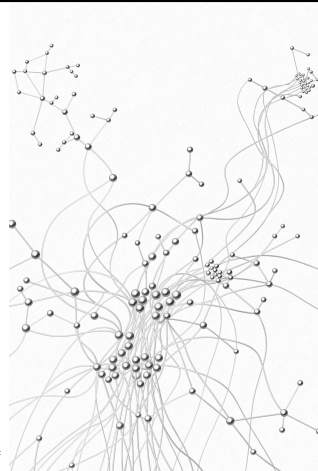
PHASE 6: BODY SCAN

Everything Is Related

Offer bilateral stimulation even if the client thinks a sensation is unrelated to the memory.

"We should always notice what is there – whatever it is."

- The client's explanation for a sensation doesn't determine its relevance. Trust the system – process what shows up.



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PHASE 6: BODY SCAN

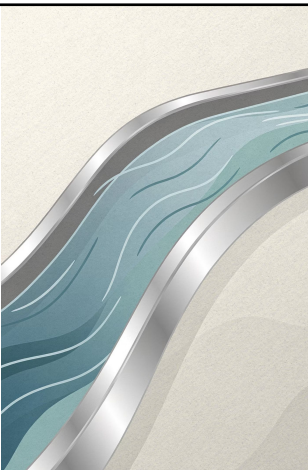
Maintain the Flow

Phases 4, 5, and 6 are all about following the flow and processing memory networks as they arise.

"What do you notice?"

"Go with that."


These two phrases are your anchors throughout Phases 4–6. Simple, consistent, and effective.



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PHASE 6 KIDS ALTERNATIVES

Body Scan Adaptations for Children



- **Magnifying glass**
Use a prop to have the child "scan" their body – makes it concrete and engaging
- **Body map**
Point to or draw on an outline of a body where they feel something
- **Doll or figurine**
Child identifies sensations on a physical object to reduce self-consciousness


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Phase 7: Closure
Closing Down the Activation, Changing the State

Phase 7 brings the client safely back to the present — whatever the outcome of the session.

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PHASE 7: CLOSURE

Closing Down the Networks

The purpose of Phase 7: ensure the client is in a safe, contained state before leaving the office.

- Deactivate open networks**
Memory networks activated during processing need to be gently closed
- Restore safety and containment**
The client must be grounded and present before the session ends

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PHASE 7: CLOSURE

From Activated to Neutral

The goal of closure is to help the client move from an emotionally activated state to a calm, present, neutral state.

- This is not about processing more — it's about safely returning the client to functional baseline so they can re-enter their day.

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PHASE 7: CLOSURE

Goal: Present Enough to Drive Home Safely

Always leave time at the end of the session to bring the client to a calm, present state.

- This is a clinical and ethical responsibility — not optional. A client who leaves flooded is a safety concern.

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Two Types of Closure – Know the Difference

Complete Session

Processing finished, SUD = 0, Phase 6 clear

→ Read the Closure Statement

Incomplete Session

Time ran out or SUD above 0 at end of Phase 4, 5, or 6

→ Read the Script for State Change

- ❑ Common mistake: treating both types the same. The incomplete session script is specifically designed to contain an open, activated memory network.



Cognitive Interweaves

Tools to keep the processing moving when it gets stuck.



What a Cognitive Interweave Does

- **Provide missing information**
Introduce what the system needs but doesn't yet have access to
- **Access what they already know**
Stimulate information that is held but not yet linked to the traumatic memory
- **Generalization**
Help the client connect insight from one memory to broader patterns
- **Connect to the present**
Bridge the past memory to the client's current life and resources



Using a Cognitive Interweave

Be attuned with the client

The interweave must arise from deep attunement – reading what the system needs in this moment

Anticipate the next natural step

A good interweave nudges the process in the direction it was already heading



COGNITIVE INTERWEAVES

Wait a Few Sets First

Waiting is best. Don't step in too soon.

Give the client's system room to find its own way. The interweave is a tool of last resort, not first response.

- ❑ Intervening prematurely can short-circuit organic processing. Trust the natural AIP movement before introducing a cognitive interweave.

COGNITIVE INTERWEAVES: TIMING

When to Use a Cognitive Interweave



Client is looping

Cycling through the same content without movement or change



Time is running out

Session must end soon and processing is not yet complete



Out of window of tolerance

Client appears flooded or shut down and needs gentle redirection



Lack of generalization

Processing is stuck on a single incident and not connecting to broader patterns

COGNITIVE INTERWEAVES

The Missing Experience

A cognitive interweave can also be the therapist offering the missing relational experience directly.

The Answer concept

When the therapist embodies the response the client's childhood self needed, this IS the interweave

Attachment focus maintained

Always keep the relational lens — the missing experience is relational, not cognitive



COGNITIVE INTERWEAVES: TYPES

Two Types of Cognitive Interweave

Type 1: New Information

Introducing information through an experience, education, or new perspective the client doesn't yet have access to

Type 2: Stimulate Held Information

Activating knowledge, wisdom, or perspective the client already holds but cannot currently access from within the traumatic memory

Examples of Cognitive Interweaves

- **Direct question or statement**
A simple, well-timed question that opens new processing pathways
- **Recognizing "The Answer" appearing**
Naming it when the client's system begins to offer its own resolution
- **Activating the adult perspective**
Inviting the client's adult self to offer wisdom to their younger self
- **Activating a known resource**
Bringing in a trusted figure from the client's life or imagination
- **Addressing trauma misconceptions**
Gently correcting distorted beliefs common in trauma memories (e.g., "It was my fault")

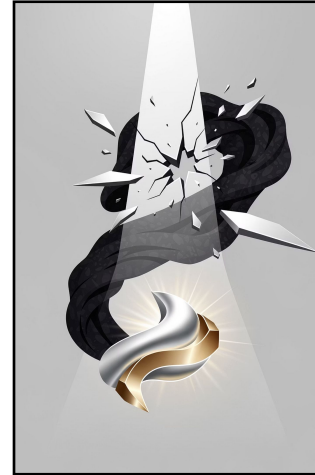


Responsibility Interweave

When a client carries misplaced guilt or shame from trauma:

Help them recognize the belief as "a lie" — it was never true, even if it felt real.

- ☐ This is one of the most powerful interweaves. Trauma creates a logic of self-blame — the responsibility interweave gently dismantles it.

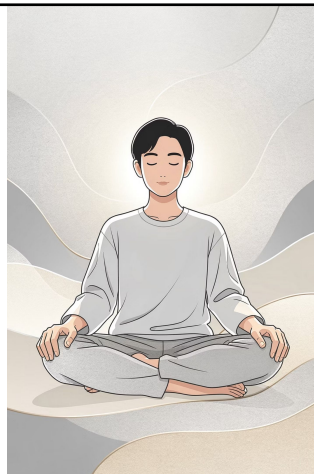


Safety Interweave

Used to bring the client into the present and keep them within the Window of Tolerance.

"Are you safe right here, right now?"

- ☐ This simple question anchors the client in present reality and re-establishes dual awareness when they are flooded by the past.



When the Client Is Out of the Window

Use these grounding prompts to restore present-moment safety:

"Would you like that disturbance to be an awareness?"

"Are you safe now?"

"Where are you now?"

"Are you here with me now?"

"Where is [the perpetrator] now?"



Use the Orienting Response

Techniques to restart stalled processing and reconnect clients with present-moment awareness during EMDR.

Grounding

Reconnecting with physical surroundings.

Sensory awareness

Focusing on external stimuli to anchor the nervous system.

Present-moment check-in

Identifying current physical and emotional state.



Empowerment

Helping clients access agency, growth, and external resources through carefully framed questions.

Future Choices

"Has anything changed since then?"

Learning from the Past

"Is there anything you have learned from that experience?"

Accessing Resources

"If your grandmother was here, what would she say?"



The Answer

Bring the client's awareness to **The Answer** already surfacing in their own processing – reflect it back gently.

"Yeah, that's what kept you safe, huh?"

The therapist mirrors what the client's adaptive system is already discovering – validating without leading.



Bringing in the Adult Perspective

For clients stuck on self-blame or responsibility for childhood events.

Age Awareness

"How old were you?"

Perspective Shift

"Do you know any 7-year-olds? Would you blame them?"

Reframe Responsibility

"Can a 5-year-old make an adult abuse her?"



Psycho-Education

Providing **normalizing information** to reduce shame and reframe the client's understanding of their responses.



"Do you know that it is normal in trauma to have symptoms instead of memories?"

"Did you know that it is a common response in pervasive abuse for the person being abused to initiate the abuse?"

Deep Emotional Response

The therapist's voice holds the client present – reflecting emotion back without rushing to resolve it.



Tone and pacing matter as much as words – the therapist's resonance helps the client stay connected and regulated.

Keep It Simple – Try These First

Before introducing a cognitive interweave, exhaust these simpler interventions to restart processing.



Return to Target

Redirect attention back to the original memory or body sensation.



Change Mode of BLS

Switch bilateral stimulation type – tapping, auditory, or eye movements.



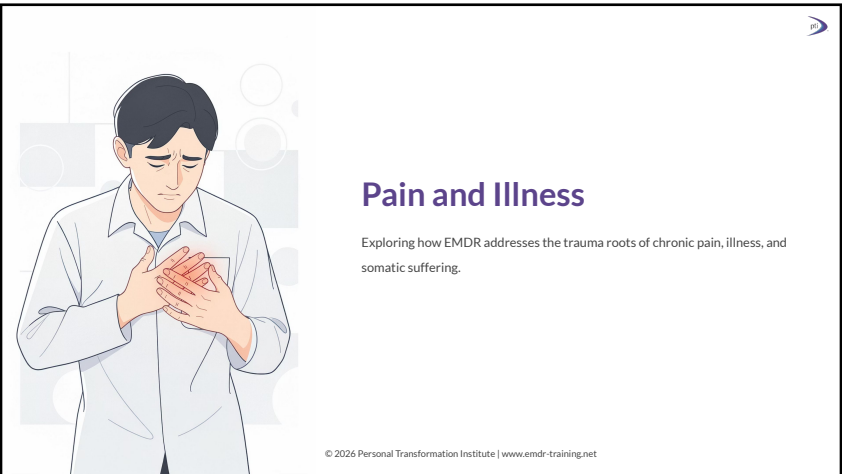
Focus on the Body

Direct client's awareness to physical sensation or location.



Slow Down / Speed Up

Adjust the pace of BLS to shift the processing state.



Pain and Illness

Exploring how EMDR addresses the trauma roots of chronic pain, illness, and somatic suffering.

EMDR Is Effective for Pain & Illness

Research supports EMDR as a **powerful intervention** across a range of physical conditions rooted in or worsened by trauma.



Chronic Pain

Targeting trauma that sensitizes the nervous system to persistent pain signals.



Cancer

Addressing trauma of diagnosis, treatment, and body betrayal.



Phantom Limb Pain

Processing grief, trauma of loss, and somatic memory of the missing limb.

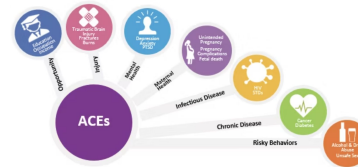


Chronic Illness

Reducing nervous system dysregulation that amplifies illness symptoms.

The ACEs Connection

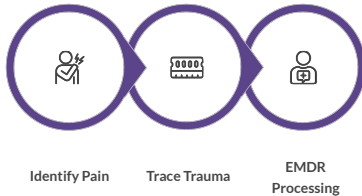
High ACE scores significantly increase likelihood of developing chronic pain or illness later in life.



- **Nervous System**
Results in an overly sensitized, hyperreactive nervous system.
- **Stress Response**
Influences how the body responds to ongoing stress and threat.
- **Somatic & Attachment**
Shapes somatic experience and capacity for secure relationships.

The Root of Pain

Chronic pain often has **unprocessed trauma at its core**. EMDR targets the memories and experiences sustaining the pain cycle.



Identifying what to target is the critical first step — pain is often an answer, not just a symptom.

Phantom Limb Pain

What happens just before a painful flare may reveal the present trigger — and point back to the root memory.

Possible Targets Include

Finding Out

The moment of learning about the loss of the limb.

The Traumatic Event

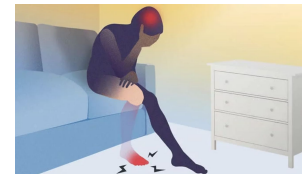
The incident that led to the loss itself.

Grief & Loss

The ongoing mourning process for the body part.

Present Triggers

Current stimuli preceding painful flares.



EMDR with Cancer

Cancer brings **layered trauma** – from diagnosis shock to existential threat. EMDR addresses each layer systematically.

Trauma of Finding Out

The moment of diagnosis and its emotional impact.

Treatment Targets

Painful, frightening, or dehumanizing treatment experiences.

Body Betrayal

Grief and anger at one's own body for becoming ill.

End-of-Life Issues

Fear, unfinished business, and legacy concerns.



Pain as an Answer

When a client's adaptive strategy requires **overriding the body's signals**, chronic pain can itself be the "Answer" – a survival role.



Common Answer Roles

- The Invisible One
- The Rock
- The Nice / Non-Threatening One
- The Doer
- The Hero
- Combinations of the above

ANS Disorders & Trauma

Autonomic Nervous System dysregulation from unresolved trauma manifests as **recognized medical syndromes**.



IBS

Irritable Bowel Syndrome

Interstitial Cystitis

Irritable Bladder Syndrome

POTS

Postural Orthostatic Tachycardia Syndrome

GERD

Gastroesophageal Reflux Disease

Overwhelmed ANS: Other Syndromes

An overtaxed autonomic nervous system also drives these commonly **misunderstood conditions** – all potential EMDR targets.

Insomnia

Hyperarousal preventing restorative sleep.

Chronic Fatigue

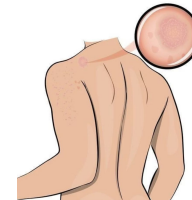
Exhaustion from a perpetually activated stress response.

Paresthesias

Numbing, tingling, and burning sensations.

Chronic Hives

Skin hypersensitivity linked to nervous system dysregulation.





PAIN AND ILLNESS: TODAY'S PRACTICUM

Time to Practice

Please turn your attention to the Trainer's shared screen for today's practice sheets.

- Use the practicum to apply cognitive interweave concepts and pain/illness targeting in a supported, supervised setting.



Thank You