EMDR Basic Training Manual

An EMDRIA Approved 6-day Training Program

www.emdr-training.net

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Introduction: A Brief Explanation of EMDR

What is EMDR?

EMDR stands for Eye Movement Desensitization and Reprocessing Therapy.

It is a body-mind integrated therapy that has been proven to be highly effective for those who have experienced trauma.

EMDR was developed by Dr. Francine Shapiro in the late 1980s.

Since that time, it has become one of the most extensively researched approaches to psychotherapy, especially for resolving trauma-related experiences.

The Adaptive Information Processing (AIP) Model

EMDR is based on the Adaptive Information Processing Model, or AIP.

When an overwhelming event occurs, memories can become stored in a raw, fragmented manner.

These raw memory pieces—somatosensory information—remain in the brainstem and can create a flashback effect.

When something in the present activates this raw material, it can trigger an overreaction to the present.

The eight phases of EMDR therapy help clients access and integrate these raw remnants of the past, resulting in reduced reactivity.

A Comprehensive Approach to EMDR Therapy

There are many ways EMDR therapy has been modified for various populations and presentations.

This training will discuss some of those adaptations, while focusing on EMDR Therapy as a comprehensive approach.

- EMDR Therapy includes eight phases and three prongs.
- While there are steps and scripts, EMDR Therapy is intended for use by a qualified mental health professional.
- EMDR is a powerful, empirically supported psychotherapy approach.
- Appropriate training and clinical judgment are essential for successful EMDR treatment.

S.A.F.E. EMDR: Somatic and Attachment Focused EMDR

What Makes Personal Transformation Institute Different?

The Personal Transformation Institute (PTI) approaches EMDR from a trauma-informed perspective, with an expanded focus on somatic and attachment patterns.

- PTI expands Dr. Shapiro's AIP model to include how the body and attachment systems are affected by traumatic experiences.
- These adaptations often represent how clients maximized attachment and safety.

📝 **Clinician Note:** *This trauma-informed, somatic perspective helps create an atmosphere of safety and fosters appreciation for the protective patterns that clients developed to survive difficult experiences.*

By recognizing these adaptations:

- We can help soften shame and self-criticism that often block therapeutic progress.
- This approach can increase therapeutic trust and accelerate positive outcomes.

The Concept of "The Answer"

PTI's S.A.F.E. approach introduces a unique concept: "The Answer."

- Other therapies may refer to "protectors," "parts," or "defenses."
- The term "Answer" emphasizes the helpfulness of the client's adaptive response to stress and overwhelm.

These adaptations:

- Developed to protect the client
- Are reflected in the client's presenting issues
- Often become the client's greatest strength, but also a block to intimacy and freedom.

EMDR Basic Training Schedule

Weekend 1			Weekend 2		
Day 1	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**
Intro / Mindfulness					
Principles of Training Trauma The Answer EMDR Research & Overview Overview of 8 phases/3 prongs Model/Method /Mechanism Phases 1 & 2 History & Preparation Somatic Resources	Review Day 1 Completing Treatment Plan Phases 3-7 Children	Review Revaluation Completing Treatment Plan Present and Future Template Recent/ Restricted Processing Container Dissociation Other Specialty Area	Complex Trauma The Answer Review of Model Review Phases 1 & 2 Review of Resources Specialty Area	Review of Phases 3-7 Common Mistakes Cognitive Interweave Incomplete Action Somatic Processing	Review of Phase 8 Common Mistakes Review of Future Template Choice of Specialty Areas
Practice					
Questions & Consultations					

The 3 S's of this Training

SAFE

The basis of trauma treatment is safety; we want to do the same with you in the training.

SIMPLE

We will aim to take complex ideas and make them as simple and "user friendly" as possible. We are here to educate, not to intimidate!

SILLY

Only because Fun starts with F and not S. At times you will be invited to have some fun!

Fun can be an important resource. This can be a great way to balance the heaviness of trauma training.

This could also be framed as Social Engagement, which helps with emotional regulation.

It is a great way to stay present and know you are safe.

You Will Hear It, Experience It, and Practice It!

- We will be keeping in mind the Window of Tolerance as we teach.
- Our goal is to set the conditions for safety and stability as you learn this new paradigm.
- An important part of this training is the experiential aspect, in which you are working on your personal material.
- It is up to you to let us know what you need to make that safe and successful.

📝 **Clinician Note:** *Unlearning old habits is often the hardest part of learning this model of therapy.*

Key Reminders for Prioritizing Safety

In order to prioritize safety in this training, remember:

- Mistakes are required.
- Take care of yourself. Take a break when you need to.
- Let us know what you need during the training and at the end of the evaluation.
- Everything is optional, even being here!
- We are not trying to force anything. If you do not want to go deep, don't. (Practicing is required by EMDRIA; personal growth is optional.)
- If you do want to go deep, we are here to support you!
- Confidentiality is serious business. Please do not break this! You can be removed from the training for a violation of confidentiality. Talk about your own experience only in group discussions or at home.
- Stupid questions are welcome and encouraged!

PTI Mission & Philosophy

The mission of Personal Transformation Institute (PTI) is to offer the most cutting-edge, effective EMDR training with a foundation of attachment and somatic psychology. The trainings will not only teach the concepts but will also demonstrate the foundational principles of effective therapy:

- Nonviolence
- Mindfulness
- Compassionate Assumption
- Healthy Boundaries

Learn Through Experience

Applying these concepts to yourself, before you apply them to clients, gives you an opportunity to learn in an embodied, experiential way that invites deeper understanding and insight.

This training is:

- Powerful
- Potentially transformative
- Possibly challenging if something from your past is unresolved

Having this experience is essential to learn EMDR effectively, which is why it is required by EMDRIA, our professional organization.

We Support You

We offer support before, during, and after the training via access to various training videos online.

Please visit our website: www.emdr-training.net for further details.

PTI Email Group

This group is a great way to:

- Be a part of our community
- Ask clinical questions
- Exchange referrals with other graduates of PTI

Request access by going to Google Groups and searching emdrtraining or use this link:

https://groups.google.com/forum/#!forum/emdrtraining

A Path to More

This is a seamless opportunity to continue toward EMDRIA certification.

- After completing the 6-day training (including 10 hours of consultation), you are free to use EMDR with your clients.

EMDRIA Certification

- EMDRIA requires 20 additional hours of consultation and 12 hours of EMDR advanced training.
- Our Advanced Certification Packages fulfill these requirements.

Please visit our website: www.emdr-training.net for further details.

Personal Transformation Institute (PTI) Path

The Personal Transformation Institute (PTI) offers a seamless way to continue learning through the S.A.F.E. EMDR model beyond this training.

After completing basic training, our goal is to offer you the best after-training support possible.

We offer:

- A variety of training and demo videos on our website
- An email community for ongoing connection
- Access to member training videos for one full year

If you would like to become EMDRIA Certified, we offer an Advanced Certification Package that allows you to continue your certification process seamlessly with our unique training model.

Once you become EMDRIA Certified, you have the option to:

- Become a PTI Assistant
- Become an EMDRIA Approved Consultant
- Join the PTI team as a Trainer

Path to Certification and Growth

Step	Requirements	Notes
Step 1: Complete EMDR Training with PTI	40 hrs EMDRIA-Approved Training 10 hrs Consultation Join EMDRIA	You are now EMDR Trained" Access emdr-training.net for 1 year Stay connected: emdrtraining@googlegroups.com Begin planning for Advanced Training
Step 2: Become EMDRIA Certified	20 hrs Consultation 12 hrs Advanced Training (via PTI's Advanced Certification Package)	Deepen your clinical skill set Begin assisting others on their EMDR journey
Step 3: Become a PTI Assistant or EMDRIA-Approved Consultant	Mentor others Gain hands-on experience supporting trainings	Apply to become a PTI Assistant Begin Consultant-in-Training (CIT) pathway if pursuing EMDRIA Consultant status
Step 4: Become a PTI Trainer	Complete Trainer Application & Onboarding Process	Lead EMDR trainings Represent PTI in shaping the next generation of EMDR clinicians

Top Down vs Bottom Up Processing

There are two ways of learning and processing information: **Top Down and Bottom Up**.

We utilize both styles of learning in our training.

We also explore how these learning styles apply to how information is processed during trauma.

Top Down Teaching

- Cognitive
- Learning through information
- How most of us are taught in school
- Reading about learning to ride a bike

Bottom Up Teaching

- Learning through experience
- Information moves from the lower brain to the higher brain
- Learning by trying to ride a bike

Top Down Processing

- Can result in behavior changes and, over time, changes to emotional reactivity.
- Is not as effective in treating trauma.
- Traumatized clients have impaired capacity to integrate information from a Top-Down process.
- Higher cortical areas of the brain manage or override emotional and sensorimotor information.
  Example: We can choose to ignore the experience of being tired and decide to stay awake even while our body feels sluggish or our mood feels low.
- CBT uses Top Down Processing.

Bottom Up Processing

- Post traumatic symptoms are bottom up experiences
- It is emotional and sensorimotor processing
- Results in new, adaptive cognitions and meaning.
- Somatic Therapies rely on both Top-Down and Bottom-Up processing

Chart: Top Down vs Bottom Up Processing

Concept	Top Down	Bottom Up
Teaching Style	Cognitive, learning through information	Learning through experience
Example	Reading about learning to ride a bike	Learning by trying to ride a bike
Processing Impact	Behavior changes, less effective in trauma	Direct emotional and sensorimotor processing
Therapeutic Limits	Traumatized clients may struggle to integrate	Leads to adaptive meaning and cognition
Therapy Example	CBT	Somatic Therapies (often use both)

History & Evolution of EMDR

1987 — Shapiro's Discovery

Francine Shapiro notices that eye movements reduce the intensity of disturbing thoughts—sparking EMDR.

1989 — First Study Published

Shapiro publishes the first controlled study on Eye Movement Desensitization (EMD), showing its effect on trauma.

1990 — EMD Becomes EMDR

The method evolves into Eye Movement Desensitization and Reprocessing (EMDR), reflecting its broader therapeutic reach.

1997 — EMDRIA Founded

The EMDR International Association (EMDRIA) is formed to support training, research, and clinical standards.

2000s — Brain Imaging & Wider Use

Studies (e.g., Pagani, 2015) show brain changes during EMDR. It becomes widely used for PTSD, anxiety, pain, and more.

2014 — EMDR in Medicine & Beyond

Shapiro highlights EMDR's role in treating physical and emotional symptoms. New models like S.A.F.E. EMDR emerge.

References

Pagani, M. (2015, August). Imaging EMDR related neurobiological changes. Plenary presented at the 20th EMDR International Association Conference, Philadelphia, PA.

Shapiro, F. The Role of Eye Movement Desensitization and Reprocessing (EMDR) Therapy in Medicine: Addressing the Psychological and Physical Symptoms Stemming from Adverse

Life Experiences. The Permanente Journal. 2014;18(1):71-77. doi:10.7812/TPP/13-098.

Link to read this study- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3951033/

Link to EMDRIA website list of research: http://www.emdria.org/?page=emdrresearch

What is EMDR?

Definition of EMDR

EMDR stands for Eye Movement Desensitization and Reprocessing.

One component of EMDR is a technique called bilateral stimulation, where a therapist guides a client through eye movements, tones, or taps. However, EMDR is not just a technique—it is an entire integrated therapeutic approach that considers a person's somatic (physical) and emotional states.

History of EMDR

EMDR was founded in 1987 by Francine Shapiro and is now one of the most extensively researched methods of contemporary psychotherapy.

- EMDR has been empirically proven to be effective in treating:
    - Post-Traumatic Stress Disorder (PTSD)
    - Developmental trauma
- EMDR relieves the symptoms of trauma by changing the way traumatic memories are stored.
- Neurobiological imaging research has documented changes in the brain during EMDR sessions (Pagani, M. 2014).

The Adaptive Information Processing (AIP) Model

EMDR therapy is based on the Adaptive Information Processing (AIP) model, which proposes:

- Psychopathologies result from maladaptive encoding or incomplete processing of traumatic events.
- Both genetic predispositions and life experiences create memory networks stored in our minds and bodies.
- Memory networks shape how we experience the world, including our beliefs, attitudes, and perceptions.
- Memory networks can serve as:
    - Sources of dysfunction
    - Healthy resources to draw from

Traumatic Memory Storage and Processing

- Most memories are functionally stored in the brain.
- Traumatic events, however, are often stored without a coherent sense of time.
- This can lead clients to:
    - Feel that past traumatic events are happening again in the present.
    - Overreact to present stimuli with hyperarousal or somatic symptoms because of memory networks stored as trauma memories.

How EMDR Works

EMDR uses specific protocols to help:

- Access memories that are not integrated due to lack of safety
- Move them from emotional activation to a more logical, rational place

EMDR changes the way traumatic memories are stored so that:

- The human system can recognize that the traumatic event is in the past.
- Clients can feel safe in the present.
- Present-day triggers no longer have the same emotional charge.

The client can react to what is happening now instead of having an overreaction due to a past event.

Present-Focused Therapy

EMDR is a present-focused therapy.

- The focus is on how past events manifest in the present moment.
- Historical data is gathered only to access how the memory was stored.
- We do not ask how the client felt at the time of the event.
- Instead, we ask:

  💬 *How are these memories activating emotions in the present?*

📝 **Clinician Note:** *EMDR is a Therapeutic Approach, Not a Technique.*

Although EMDR brings together aspects of different theoretical orientations, EMDR is a comprehensive therapeutic treatment approach.

- It is based on the AIP model.
- If EMDR is used as a technique alone, it is less likely to be effective.

- EMDR is not just about eye movements or dual attention stimulation.
- The approach includes 8 phases and 3 prongs and is a fully integrated therapeutic orientation.

EMDR Incorporates Aspects of Other Orientations

Therapy Approach	Focus
Cognitive Therapy	Beliefs Addressed
Behavioral Therapy	Conditioned Responses Highlighted
Psychodynamic Therapy	Etiological Events Underscored
Experiential Therapy	Emotional Response Addressed
Systems Theory	Contextual Understanding
Hypnotic Therapies	Imagery Incorporated

PTSD and Research

What is Post-Traumatic Stress Disorder (PTSD)?

Post-Traumatic Stress Disorder (PTSD) is a mental health condition that can develop after a person is exposed to traumatic events. The DSM-5 outlines the following diagnostic criteria for PTSD:

Criterion A (One Required): Exposure to Trauma

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s)

- Direct Exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B (one required): Re-Experiencing the Trauma

The traumatic event is persistently re-experienced, in the following way(s):

- Intrusive Thoughts
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (One Required): Avoidance

Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related **reminders** (people, places, conversations, activities)

Criterion D (Two Required): Negative Thoughts or Feelings

Negative changes in mood or thinking that began or worsened after the trauma:

- Inability to recall key features of the trauma
- Overly negative beliefs or assumptions about oneself, others, or the world

- Exaggerated blame of self or others for causing the trauma
- Persistent negative emotional state
- Decreased interest in significant activities
- Feelings of detachment or isolation from others
- Difficulty experiencing positive emotions

Criterion E (Two Required): Arousal and Reactivity

Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F (Required)

- Symptoms last for more than one month.

Criterion G (Required)

- Symptoms cause distress or functional impairment (social, occupational).

Criterion H (Required)

- Symptoms are not due to medication, substance use, or other illness.

Reference

American Psychiatric Association. (2013) Diagnostic and Statistical Manual of Mental Disorders, (5th ed.). Washington, DC: Author.

Online resource: http://traumadissociation.com/des

Key Research Studies on EMDR's Effectiveness

Combat Vets and PTSD

Carlson et al. (1998)

- After 12 EMDR sessions, 77.7% of combat veterans no longer met PTSD criteria.
- There were no dropouts, and effects were maintained at 3- and 9-month follow-ups.

EMDR vs CBT (Cancer Patients)

Capezzani et al. (2013) Journal of EMDR Practice and Research, 5, 2-13.

- Comparative study of effects on PTSD, anxiety, and depression.
- This randomized pilot study compared EMDR to various CBT techniques in cancer patients.
- After 8 sessions, EMDR therapy was significantly more effective than CBT in reducing PTSD, anxiety, and depression.
- Almost all patients (95.2%) no longer had PTSD after EMDR treatment.

Developmental Trauma (Small "t" Trauma)

Cvetek, R. (2008) Journal of EMDR Practice and Research, 2, 2-14.

- Compared EMDR, active listening, and waitlist groups in addressing distressful life events that did not meet PTSD criteria.
- EMDR significantly lowered scores on the Impact of Event Scale (from "moderate" to "subclinical").
- EMDR also showed reduced emotional response after memory recall compared to control groups.

Pagani EEG Study (2012): Neurobiological Effects of EMDR

- EEG monitoring during EMDR sessions showed increased activation in the orbitofrontal, prefrontal, and anterior cingulate cortex.
- The limbic system was most active prior to EMDR processing, indicating initial emotional activation.
- Conclusion: EMDR eye movements are associated with significant relief from negative emotions.

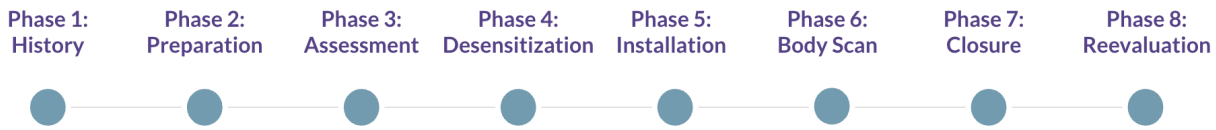
- This groundbreaking study was the first to image specific brain activations directly related to EMDR therapy.

Links to more research:

https://www.emdria.org/page/EMDRResearch

https://emdr-training.net/what-we-offer/additional-resources/emdr-training-faqs/
https://www.springerpub.com/journal-of-emdr-practice-and-research.html

Introduction to the 8 Phases of EMDR



EMDR therapy is organized into 8 phases, but it is not an 8-step therapy.

Therapists and clients will often weave in and out of the various phases depending on the needs of the client and the client's system.

The 3 Prongs of EMDR Treatment:

- The Past
- The Present
- The Future

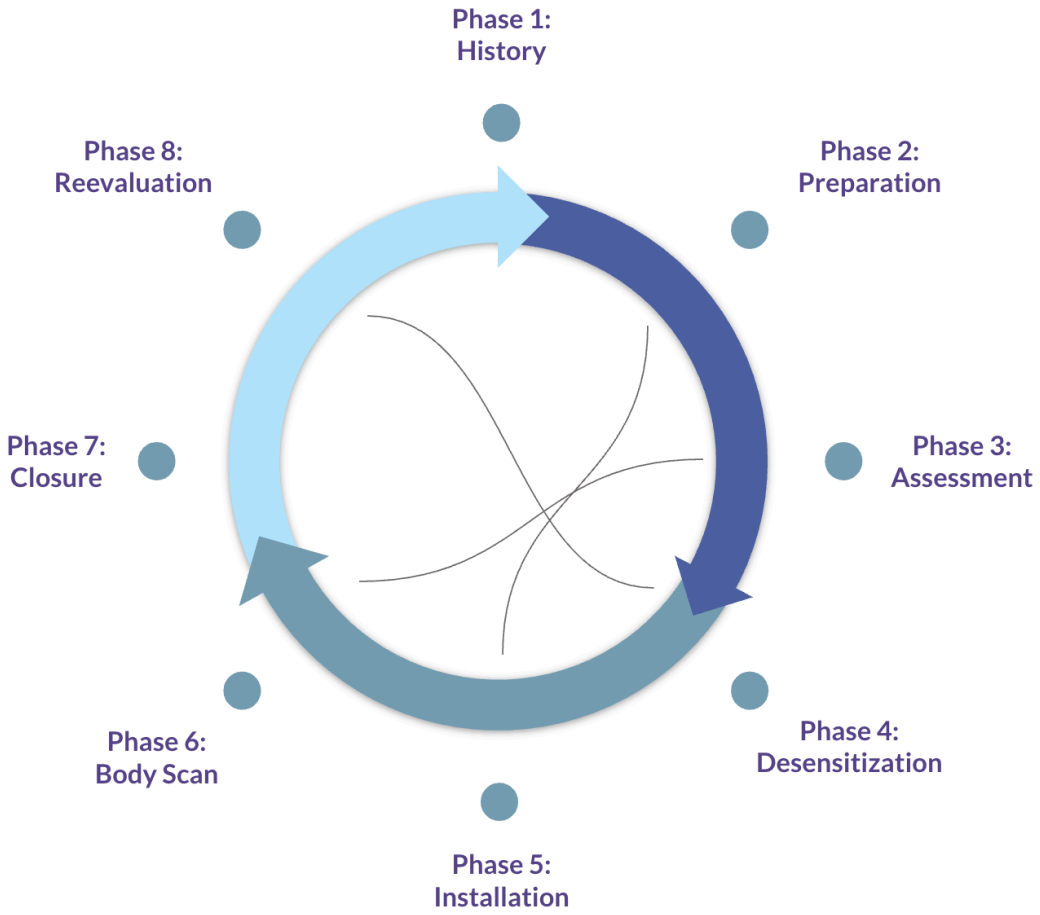
EMDR is a Therapeutic Approach, Not a Technique

It is essential to understand that EMDR is a therapeutic approach—it is not just a technique.

- Although scripts are provided in this training, they are designed to:
    - Assist you in learning and experiencing EMDR
    - Support the EMDR therapy process
- The scripts are helpful, but they do not capture the entire therapy process.

Since EMDR is a therapeutic approach and not a technique, using your clinical skills are important in all the phases.

Weaving In and Out of the 8 Phases of EMDR



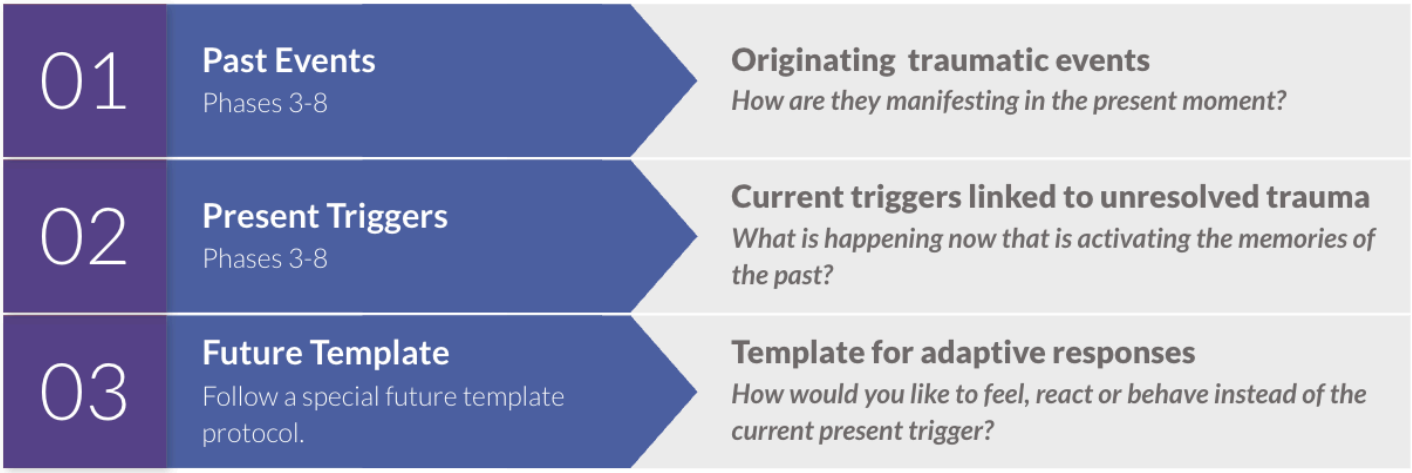
To guide your understanding, we've grouped the 8 phases into three overarching categories:

- Phases 1–2: Preparation & Safety
- Phases 3–8: Memory Processing
- Ongoing: Integration for the Future

Chart | Overview of the 8 Phases of EMDR Therapy

Phase	When & What	What Therapist Does
1. History	Beginning of Reprocessing Activation/Assessment of how memory is stored	Assessment of Resources Understand "The Answer" Client History DES II/ Other evaluation
2. Preparation	Resourcing, Education, Stabilization, Relationship, Treatment Planning	Development of resources, Safe Place, Container, Somatic Resources, others Targets Selected
3. Assessment	Accessing, Activation, Reprocessing Phase	Only do this if immediately followed by phase 4-7
4. Desensitization	Reprocessing Phase Cont. Accessing/Activating	Eye Movements long/fast, Noticing emotional regulation and using co-regulation.
5. Installation (of PC)	Reprocessing Phase, pairing Positive Cognition/target,	Eye movements long/fast
6. Body Scan	Reprocessing Phase, focus on body/target	Eye movements long/fast
7. Closure	For Complete or Incomplete Closing/ Stabilizing System	What do they need to leave feeling safe/contained?
8. Reevaluation	Subsequent sessions: 1. Target Memory 2. Current Symptoms 3. Current Issues 4. Treatment	This is continued throughout treatment.What effect is treatment having? What modifications or resources are needed?

3 Prongs of EMDR Treatment



Model, Method, & Mechanism

Model: The Adaptive Information Processing Model

The AIP model is the foundation of EMDR. It helps therapists:

- Informs Treatment
- Interprets Client Response
- Predicts Successful Application

Method: Protocols and Procedures

The EMDR method consists of:

- 8 Phases of Treatment
- 3 Prongs of EMDR Treatment: Past, Present, Future
- The Standard Protocol and Adaptations
- Fidelity to the Method predicts positive results

Mechanism: Why EMDR Works

Current research suggests that EMDR may work due to several interrelated mechanisms:

- Attention Bias
- Working Memory Effects
- Orienting Response Activation

- Somatic Perception Shifts
- Neurobiological Changes

📝 **Clinician Note:** *Brand new research is actively shaping the understanding of why EMDR works. See additional studies in the appendix.*

EMDR's Unique Contribution:

Unlike many therapies that focus solely on cognition, EMDR integrates the body, emotions, and memory networks through bilateral stimulation.

Reference

Pagani, M., Di Lorenzo, G., Monaco, L., Daverio, A., Giannoudas, I., La Porta, P., … Siracusano, A. (2015). Neurobiological response to EMDR therapy in clients with different psychological traumas. Frontiers in Psychology, 6, 1614. https://doi.org/10.3389/fpsyg.2015.01614

Section I: The Adaptive Information Processing Model (AIP)

In this section, we will cover the basic concepts and hypotheses of the Adaptive Information Processing (AIP) Model.

We will explore:

- Clinical implications
- How the AIP model differs from other models
- Applications of the AIP model in EMDR therapy

The AIP Model provides the theoretical basis of EMDR.

It proposes that much of psychopathology is caused by:

- Maladaptive encoding and/or
- Incomplete processing of traumatic or disturbing life experiences.

When this happens:

- Experiences are stored in the emotional part of the brain without a time or date stamp.
- When present-day experiences activate these stored memories, they feel like they are happening now, causing what may appear to be an "overreaction" to the present.

Key Clinical Questions Guided by the AIP Model

- What early experiences are stored in the system?
- How are those experiences organized in the present moment?
- How are past experiences manifesting now?

These questions help create the treatment map and predict potential blocks and outcomes.

Basic Hypotheses of the AIP Model

It is a Physical System

- The neurobiological information processing system is intrinsic, physical, and adaptive.
- The system integrates both internal and external experiences.

- Experiences are translated into physically stored memories.

Memory Networks

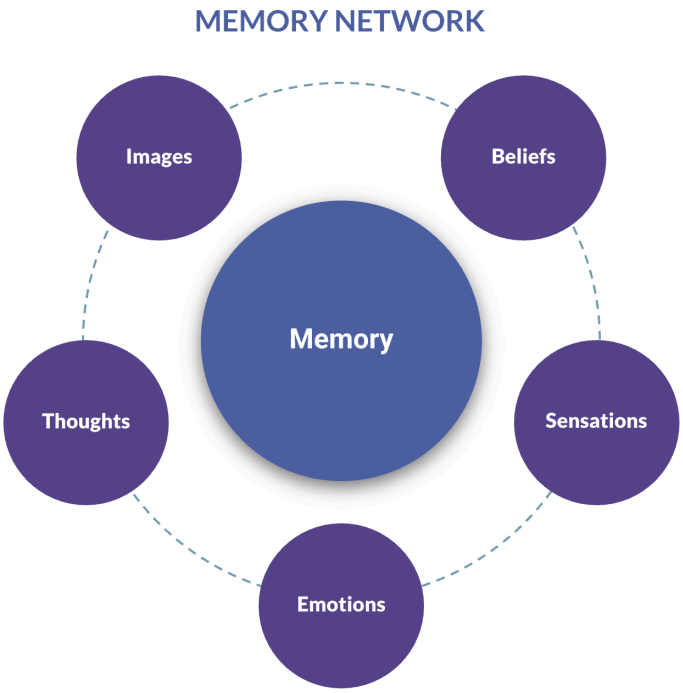
- Memories are stored in associative memory networks and are the basis of attitudes, beliefs, and perceptions.
- These stored memories contribute to both pathology and health.
- Trauma disrupts normal adaptive information processing, leaving unprocessed information dysfunctionally stored.
- New experiences link into previously stored memories, influencing interpretations, feelings, and behaviors.

How Memories Are Stored: The Memory Network

- Memories with similar components (sensory experiences, thoughts, emotions, body sensations, and beliefs about self) are linked together.
- **Adaptive memory networks** store positive beliefs, learning, and resources.
- **Maladaptive memory networks** (stored in a traumatic way) are often the source of pathology.

Chart | Adaptive vs. Maladaptive Networks

Adaptive Memory Networks	Maladaptive Memory Networks
Store positive beliefs and learning	Contain trauma-related content
Promote resilience and regulation	Drive current dysfunction
Facilitate integration of experience	Isolate and reinforce disturbance



Both **what happened** *and* **what didn't happen** contribute to how memories are stored.

Trauma can include DSM IV, V Criterion A events and/or the experiences of neglect or abuse that undermines an individual's sense of self-worth, safety, and ability to assume appropriate responsibility for self or other, or limits one's sense of control or choices.

Traumatic Events Are Often Stored in Isolation

- Traumatic memories may be stored in implicit, short-term memory systems when accompanied by high levels of disturbance.
- These memories:
    - Hold the perspectives, affects, and sensations of the disturbing event.
    - Are disconnected from adaptive memory networks.
- When triggered, they feel as if they are happening now.

Events in Life Trigger the Unprocessed Memory

- When similar experiences occur (internally or externally), they link into the unprocessed memory network.
- Negative perspectives, sensations, and affects resurface, reinforcing the memory.

"Ah… more proof that the lie is true."

Adaptive Memory Networks Are Also Present

- Adaptive information, resources, and memories are also stored.
- Direct processing through EMDR can:
    - Link unprocessed memories to adaptive networks
    - Transform how the memory is stored
    - Discard non-adaptive perceptions, sensations, and emotions

The Storage of Memories Changes Through Processing

- As processing occurs, there is a shift from implicit (non-declarative) memory to explicit (declarative) memory.
- Memories move from episodic to semantic memory systems. *(Stickgold, 2002)*

Transformation Occurs Through Processing

- Processing leads to an adaptive shift in all components of the memory:
    - Sense of time
    - Sense of age
    - Symptoms
    - Reactive behaviors
    - Sense of self
- There is a shift from an implicit understanding of a memory (a felt sense) to an explicit consideration of a memory (a narrativizing, meaning-making experience).
- This narrative understanding allows the client to feel that the memory is in the past and not have the somatic effects of the past interfering with the present. .

Summary of the AIP Model

- The EMDR Protocol, including dual attention stimuli (eye movements, taps, tones), helps process information and restore balance.
- Useful learning is kept; maladaptive material is let go.
- Positive memory networks are reinforced.

The Clinical Roadmap and the AIP

Presenting Complaints Are the Past Becoming Present

- Client complaints often stem from unprocessed memories that have not integrated into adaptive systems.
- These unprocessed memories make the system more vulnerable to overreacting to the present.

Access and Change How Memories Are Stored

- For the treatment plan roadmap, the focus is on the information processing system and the stored associative memories.
- EMDR targets maladaptively stored memories to help process them in an adaptive way.
- The information processing system and memory networks are key to effective clinical outcomes.

The Past Manifests in the Present Like a Window to the Past

- Memories are accessed as they are currently stored.
- This allows for proper associative connections to be made through the networks.

Unimpeded Processing Connects the Entire System

- Any interventions should be to assist the client's natural process and help them stay on their own track.
- Any interventions that distort the client's own networks and associations may keep them from accessing all of the associations that may need to be processed.
- Because of this, any intervention or distortion should be followed by accessing the client's natural system to help them process naturally.

📝 **Clinician Note:** *The basis of the AIP Model is that memories remain highly activated. EMDR helps the system naturally process these memories, creating adaptive connections and resolving the disturbance.*

The Principles of S.A.F.E. EMDR Trainings

Non-violence

> *"We keep moving forward, opening new doors, and doing new things, because we're curious and curiosity keeps leading us down new paths."*
>
> — Walt Disney

Being curious about the client may be the most important quality you bring to the therapy process.

Many therapists have heard the concepts of:

- Client-centered therapy
- Meeting the client where they are

However, some therapists mistakenly believe that being the expert in the room can feel like "violence" to the client. This is not the case.

Psychotherapy requires advanced education and clinical expertise—this is exactly what clients seek when they come to therapy.

Some clients may come in expecting either:

- A Dr. Phil-style therapist who tells them what to do
- A Bob Newhart-style therapist who sits silently and only listens

Neither extreme is an effective pathway for change.

The Principle of Nonviolence Recognizes Personal Choice and Freedom

- This is especially important because people who have experienced trauma have often also experienced violation, intrusion, and the loss of choice.
- Embodying nonviolence means being aware of:
    - Your words
    - Your intentions
    - Your actions
    - Your internal experiences
- These cues —whether spoken or unspoken— are communicated to the client through **neuroception**, the nervous system's unconscious scanning for safety and danger *(Porges, 2022)*.

Through subtle facial cues, body language, eye contact, and tone of voice, the therapist can model nonviolence as an embodied way of being.

Nonviolence Is the Recognition of Autonomy

- No one can *make* another person feel happy, angry, calm, or anything else.
- We are all ultimately responsible for our own reactions—a truth that can be both empowering and often difficult to grasp.

As clinicians:

- We help clients understand that unprocessed fragments of the past fuel present distress.
- We help clients see that adaptive patterns are often misguided attempts to connect and protect.
- This recognition is the beginning of healing, intimacy, and freedom.

Mindful Awareness

> *"Once we believe in ourselves, we can risk curiosity, wonder, spontaneous delight, or any experience that reveals the human spirit."*
>
> - E.E. Cummings

Mindful Awareness Starts with the Therapist

- Being aware of our own patterns is essential.
- It is an illusion that we can change another person's emotional state.
- We cannot "resource" a client or make them feel safe—we can only offer opportunities for empowerment, emotional regulation, and help them develop their own resources.

Be mindful of language—it is powerful.

Self-regulation is a key skill. We offer tools and suggestions for self-regulation—not the regulation itself.

> *"You don't have to know the answers for your patients. All you have to do is turn them inside themselves because they know the answers."*
>
> —Ron Kurtz

Mindfulness in EMDR

We can only be in the present moment.

- Francine Shapiro described mindfulness in EMDR as “dual awareness” – This is the ability to notice the present moment while activating a disturbing memory.

Mindfulness is not the same as meditation.

- Mindfulness: The ability to be present and notice what is happening.
- Meditation: A method that can help build mindfulness for some people.

We will offer mindfulness practices throughout the training and provide mindfulness scripts in the basic training portal for you to print and use with clients.

Why Mindfulness Matters in EMDR

- Mindfulness allows therapists to:
    - Be present with thoughts, feelings, sensations, and reactions.
    - Model mindful self-awareness for clients.
- Mindfulness supports other therapeutic principles like respect, compassion, healthy boundaries, and self-awareness.

Compassionate Assumption

We are always looking for how the client’s presenting issue makes sense.

- When we understand that symptoms are adaptations to pain or overwhelm, it is easier to offer compassionate assumptions.
- Compassionate assumption is the starting point for helping clients:
    - Develop self-compassion
    - Understand how their symptoms were created to maximize safety and connection.

Healthy Boundaries

> *“Understanding the connection between boundaries, accountability and compassion make me a kinder person.”*
>
> - Brene Brown

Healthy Boundaries Create Safety

- The principle of healthy boundaries is trauma-informed.
- Trauma is an invasion of boundaries and often results in difficulty recognizing or setting healthy boundaries.
- Clients who have experienced pervasive, complex trauma may:
    - Struggle to set boundaries
    - Rely on dissociation as a boundary of last resort
    - Have limited options outside of “completely open” or “completely shut” boundaries

Therapeutic Boundaries Build Safety

In therapy, clear boundaries can increase a client’s sense of safety.

The clinician can model healthy boundaries through:

- Session structure (time, payment)
- Being energetically in charge of the session
- Speaking the truth and embodying boundary clarity

Boundary Experiments Reveal Patterns

- Resourcing with clients using physical experiments of boundaries is a powerful way to see patterns of protection and connection in the present moment.
- Firm, rigid, or flexible boundary patterns are direct adaptations to the ways individuals have maximized safety and attachment.
- If a client has had many experiences of invasion of boundaries, they may struggle to see a full range of options for setting boundaries.

For example:

- Clients may only know boundaries that are completely open or completely shut.
- Clients with early caregiver role reversal may have blurred boundaries, struggling to know where they end and others begin.

The Opposite Pattern: Blurred Boundaries

Sometimes, clients develop blurred boundaries due to early caregiver dynamics:

- When a child’s caregiver depended on the child for emotional support, boundaries can become unclear.
- These clients may struggle to recognize:

    - Where they end and where another person begins
    - The difference between their emotions and someone else's needs

When children don't have adults who provide healthy boundaries and emotional safety, they often adapt by:

- Becoming highly attuned to the emotional climate
- Sensing and prioritizing what others need

This pattern may later present as:

- Controlling behaviors
- The need to please others

These are often the client's "Answers" that once served to maximize safety and connection.

Boundary Work in the SAFE Approach

Understanding the adaptive, historical value of a client's current boundaries is central to SAFE case conceptualization.

- Boundary experiments offer clients opportunities to explore new options.
- Clinicians must remain attuned to the client's emotional state during resourcing.
- If a client becomes activated, pause or consider moving to a different resource.

Boundary exploration in EMDR is not just a tool—it is often a profound relational experience that builds safety, trust, and self-awareness in real time.

Section II: Understanding The Answer

The Concept of "The Answer" in the SAFE Approach

In the SAFE approach, there is a unique and compassionate concept called "The Answer."

The Answer is:

- A nonviolent, strength-based lens for understanding client adaptations
- A way to view the automatic, habitual responses humans develop to maximize safety and connection
- A shared language for clinicians and clients to explore resources, strengths, and blocks to healing

The trauma-informed SAFE foundational principles offer the environment in which the Answer can be gently understood, appreciated, and applied.

The Answer provides a gentle, nonjudgmental, and practical invitation for clients to turn inward and notice how they may be participating in their own suffering.

The Power of Appreciation in the SAFE Approach

As the clinician gently and sincerely appreciates the helpfulness of the client's symptoms, they are making direct contact with the part of the client developed from a painful experience.

This adaptation—often called a defense—was made to maximize safety and connection.

These same foundational principles also offer a roadmap for couples to build deeper, more authentic connections.

📝 **Clinician Note:** *The way a client adapted to survive often now presents as the very thing keeping them stuck.*

The Answer Is How Attachment Patterns Show Up

The Answer includes:

- The things we do to stay attached
- Built-in survival defenses driven by the autonomic nervous system

The Answer is the attachment system's solution to staying safe and connected to caregivers.

What Shapes the Answer?

- The Family Culture: Early environment and modeled behaviors (“Boot Camp”)
- Genetic Tendencies: Our DNA – Traits and sensitivities we inherit
- Traumatic Experiences: The narrowing of the Window of Tolerance

The Problem Was Once An Answer

When listening to the client’s current symptoms:

- Consider how those symptoms were helpful to an overwhelmed system.
- Even if the symptoms are now distressing, they served a protective, adaptive purpose.

The symptom is “The Answer.” It was once adaptive, and is now the presenting issue. It represents our early childhood training—how we had to adapt to stay safe and stay connected.

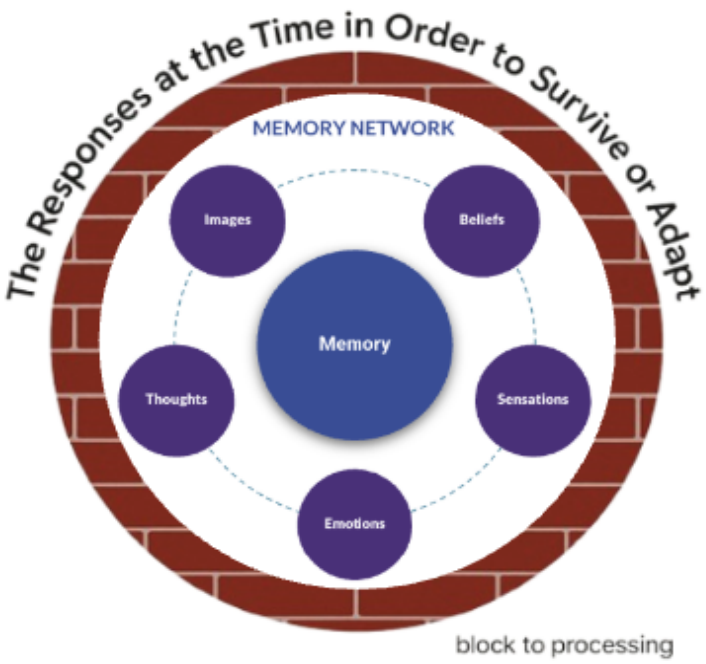
The Answer:

- Develops from repetitive survival strategies
- Becomes automatic
- Causes over-development of certain skills, traits, or defenses, which inevitably means other capacities are underdeveloped. The result is an imbalance in the system.

The Brick Wall: A Metaphor for the Answer

The Answer can be thought of as a brick wall surrounding the memory network.

It was built for protection but now blocks access to deeper healing.



Why The Answer Perpetuates the Problem

You cannot

- Figure out how to stop figuring it out.
- Work harder to stop working harder.
- Find the Answer outside yourself to learn how to trust your internal experience
- Cut off from others to try to connect

The Answer does not solve the problem—it perpetuates it.

We Are Always Trying to Fix the Problem With the Answer

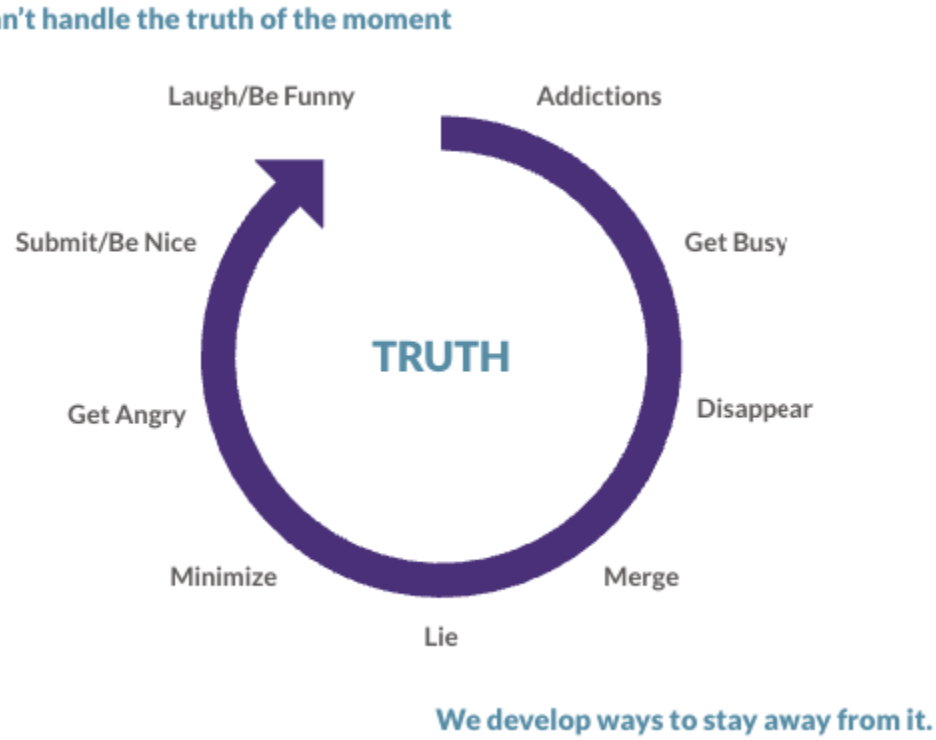
- The original painful experience is the root where the Answer began.
- We try to fix the problem by using the Answer, which often makes it worse.
- The trick is to:
    - See that the Answer is the water we swim in
    - Notice what the Answer is trying to make up for (the lie we believe about ourselves or the world)

What's Missing?

What's often missing is:

- The ability to sit with the sadness of what we didn't get
- The ability to process what we received that we didn't want

The Answer may have once been helpful to the client, but healing often begins when the client can grieve what was lost or never given.



Developed & Underdeveloped

The Nature of Balance in Human Adaptation

Since we are part of nature—and nature requires balance—when something is over-developed, another part of us is often under-developed.

Examples:

- A client who learned to cut off from emotions and developed strong logical, analytical skills because this was praised in their family of origin.
  → They became highly logical but struggle to connect to their own emotions and tolerate the emotions of others.
- A client who learned to regulate others by noticing how people feel and working to keep them calm and happy.
  → They became excellent at reading and managing others but struggle to tolerate other people's distress.

Even dissociation, cutting, substance abuse, and depression can be Answers.

We want to:

- Be aware of the client's history with these tendencies
- Recognize that the urge to return to these patterns may resurface when early memories are activated

Our Answers and Our Client's Answers: What They Do

- Were once very helpful for safety or attachment
- Became our strengths and go-to ways of managing
- Became so automatic they feel like the only option
- Often keep us from getting what we want most
- Can create what we don't want
- Manifest in our physical body
- Hold us back and keep us from knowing we are a shining star
- Will often be identified in the presenting problem

Nonviolence and The Answer

The client's Answer is both a defense and a strength.

We want to respect the adaptive purpose of the Answer and the client's reasons for developing it.

A nonviolent approach allows us to:

- Work with the Answer rather than against it
- Invite new opportunities to develop what is underdeveloped

This is especially important when working with what may look like resistance.

Nonviolence helps us:

- Gently move toward the Answer
- Appreciate the Answer instead of trying to make it go away
- Support the client in creating space for awareness and choice

When the client develops awareness, they can choose new options when they are ready.

The 5 C's of Working with The Answer

The 5 C's offer a gentle, respectful process for identifying and working with a client's Answer.

Catch it

- Silently notice when something is blocking forward progress.
- When a block appears, it likely signals that an Answer is present—whether from the client or the therapist.
- Watch for patterns and gently observe without intervening yet.

Curiosity

- Stay silent and become curious about the pattern you are noticing.
- Ask yourself:

  How does this fit in?

  How might this be a window into the past?

Celebrate & Collaborate

- Begin to see the client's pattern as adorable, understandable, and completely logical.
- The block makes sense—it's part of their adaptive story.
- Feel the connection:

  💬 *"I understand why you are doing this—it was helpful at one time."*

Contact

- This is the first time you name it out loud to the client.

- Example:
  - 💬 *"It seems like you are really good at…"*
  - 💬 *"It seems like this has been really helpful to you."*

Connect to the Past

- Gently invite the client to explore the origin of the Answer.
- Example:
  - 💬 *"I wonder how you learned to be so good at that?"*
  - 💬 *"I bet that was really helpful when…"*

The Background of "The Answer"

Wilhelm Reich/ Freud Defenses	Kurtz/Ogden Managing Experiences	Deb Kennard The Answer
Schizoid	Sensitive Withdrawn	Invisible One
Oral	Sensitive Emotional	Emotional One
Psychopathic	Dependent Endearing	Nice/Non-Threatening One
Masochistic	Self-Reliant	Independent One
Rigid	Tough/Generous	The Hero
	Burdened Enduring	The Rock
	Charming Manipulative	The Chameleon
	Industrious/Overfocused	The Doer
	Expressive Clinging	The Life of the Party

Questions to Find the Answer

The series of Answer questions will help you:

- Understand what your client is naturally good at
- Identify what may be underdeveloped
- Explore how your client responds to stressful situations

- Begin to uncover the client's unique Answer

The Character Types chart can also assist you in identifying:

- Patterns of relating to others
- Associated negative beliefs
- Overdeveloped and underdeveloped skills

Purpose of the Answer Questions

- Observe attachment patterns
- Notice client responses under stress
- Identify resources that may need to be developed

Questions to Find the Answer

- What are you most proud of?
- What is difficult for you to do?
- What do you do under stress?
- How do you handle extreme pressure?
- How are you with deadlines?
- How do you get your way or get what you want?
- Is it easy for you to say no?
- Do you cry easily?
- What do you do when you are upset?
- Do you cry in front of others?
- Would you call yourself a rule follower?
- How do you deal with conflict?
- In an emergency situation what are you likely to do?
- Is it easy for you to ask for help?
- Is it difficult for you to accept help?
- How convincing are you?
- What are you likely to do when someone tells you no?
- How do you handle feedback or criticism?

Using The Answer Questions in Session

Here is a brief example of how a clinician might reflect on a client's responses to the Answer Questions:

> 💬 *"So it sounds like you are really good at_____ and it is harder for you to _____."*
>
> (Pause to allow feedback—invite the client to agree or correct you.)
>
> 💬 *"I'm guessing that when we are processing and you get close to pain you might_____."*

(again allow space for feedback from the client)

💬 *"I wonder if it would be helpful to look at how you could develop _____."*

This is a very short example of what the clinician is listening for when using the Answer Questions.

What the Clinician is Looking For

In general, you are looking for patterns in how your client:

- Patterns of connection
- Patterns of protection
- How the client regulates emotion
- How the client deals with conflict
- How the client responds to stress

Consider revisiting the client's responses to these questions throughout treatment. As their system shifts, their answers may also change, offering valuable insights over time. The clinician is also noticing with curiosity as other answers arise in the therapy process.

📝 **Clinician Note:** *For an expanded understanding of how to use these questions, refer to the Answer practice sheets included in your training materials.*

Character Types

The Character Types chart is a tool to help clinicians understand the patterns that may surface as part of a client's Answer.

Note: The Character Types chart is not meant to label clients. It is a tool to support learning about the Answer.

What to Know About Character Types

- Each character type:
    - Manifests in the body
    - Is a go-to way of managing stress
    - Represents both a strength and a block to intimacy and treatment
- Most people are a combination of character types.

Character Types | Additional Notes

These are examples of possible adaptations that once helped a person stay safe or maintain connection with a caregiver. Over time, they can become patterns of relating to others. Most people have more than one character type, and each carries a strength within it.

The goal is to create balance and offer more choice—so the authentic self can be present.

The possible negative beliefs listed are just examples. There may be many variations based on the individual.

(Adapted from Ron Kurtz, 1990 and Pat Ogden, 2002)

📝 **Clinician Note:** These character types are not labels or diagnoses. They are adaptive strategies rooted in past experience. Most people relate to several types and various relationships create a need for different adaptations. As clinicians, we can use this framework to bring compassionate curiosity—supporting awareness without limiting or defining the client.

Chart | Character Types Overview

Character Type	Possible Negative Belief	Over-Developed	Under-Developed	Needed to Hear
The Invisible One	I'm in danger. I'm going to die.	Disappearing. Survival defenses. Sensitivity.	Safety, grounding, presence, feeling	"You are welcome here."
The Emotional One	I'm in danger. It's not safe to feel.	Merging into others. Over-identifying with others' emotions.	Boundaries. Ability to self-soothe.	"It's okay to feel safe when you are safe."
The Nice / Non-Threatening One	I'm helpless. I'm powerless.	Getting pity. Being a victim.	Personal power. Self-soothing.	"I'm here for you." "You can get your needs met."
The Independent One	I'm alone.	Competency. Ability to take control.	Asking for help. Trusting others.	"You can get support." "It's okay to ask for help."
The Rock	I don't matter. My needs don't matter.	Being dependable. Tolerating everything. Withstanding suffering.	Knowing what they want. Asking for it.	"What you want matters."
The Chameleon	I'm not enough.	Adaptation to survive. Ability to be ambivalent and fluid.	Knowing who they are. Being strategic.	"It's okay to just be you." "You matter."
The Hero	I'm not safe. I'm powerless.	Setting firm boundaries. Withstanding pain.	Being vulnerable. Receiving. Connection.	"It is safe to connect."
The Doer	I need to be perfect. I'm not enough.	Energy. Working hard. Taking action.	Play. Connection. Self-care.	"You don't have to work so hard." "It's okay to play."
The Life of the Party	I don't matter.	Energy. Fun. Action.	Rest. Being grounded. Authentic.	"You matter." "You don't have to be noticed to be needed."

Character Types (Written Out)

The Invisible One	Dissociates or disappears Body may be small, thin, pulled inward
The Emotional One	Feels intensely and senses how others feel A lot of emotional expression without clear direction or resolution
The Nice/Non-Threatening One	Pleases others, may seem helpless or overly "nice" Body often weak, limp, or collapsed
The Independent One	Struggles to trust that help is available Body often square, firm, and stable
The Rock	Endures pressure and does things they don't want to do Often procrastinates Body is thick, sturdy, low center of gravity
The Doer	Action-oriented, always thinking and doing Body is ready to move, leaning slightly forward
The Chameleon	Adapts to external expectations, convincing and flexible Movement side to side, struggles to be direct
The Hero	Tough, capable, takes charge, resists vulnerability Body may puff up, strong presence, "John Wayne" energy
The Life of the Party	Dramatic, energetic, needs to be seen Lots of movement in the upper body

Section III: Attachment

The Role of Attachment in EMDR

- **EMDR helps get to the root of the problem.**
- The power of EMDR often brings vulnerability to the surface.
- Vulnerability can trigger defenses or Answers.
- Creating safety, nonviolence, and a supportive environment is essential to the therapeutic process.

Why an Attachment Approach Matters in EMDR

This approach takes into consideration

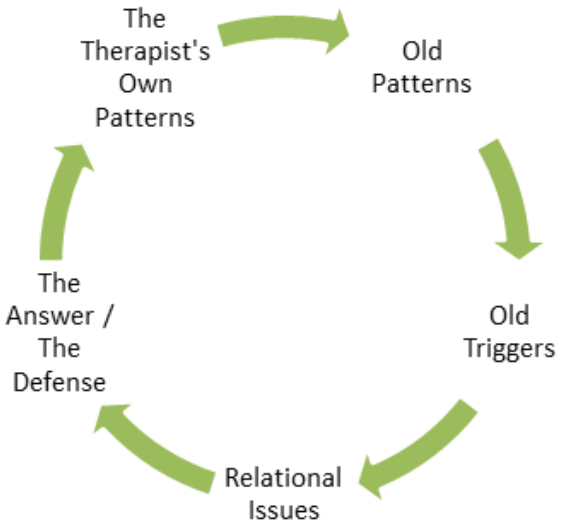
- Early attachment experiences and patterns shape how clients relate to themselves and others.
- Built-in trauma responses that also become patterns
- Both attachment patterns and trauma responses often become blocks to healing.

Attachment Patterns Are Predictable

- Whatever your client does in their life will eventually happen in your office.
- Attachment patterns are just that—patterns and they can repeat across relationships—they are the client's blueprint for connection.

The Blueprint Will Show Up in the Therapeutic Relationship

- You will eventually see the client's attachment blueprint in the room with you.
- When this happens, it is an opportunity—not a problem.
- Attachment patterns will surface:
    - Across all phases of the EMDR process
    - Within your relationship with the client



Attachment: Styles & Assessment

Understanding attachment styles helps us predict:

- How clients relate to others
- Their capacity for emotional regulation
- Their ability to develop resilience

Attachment Styles and Their Impact on Brain Development and Resiliency

Secure Attachment

Able to create meaningful relationships, be empathetic, and able to set appropriate boundaries

Dismissive/Avoidant Attachment

Avoids closeness or emotional connection, distant, critical, rigid, intolerant.

Insecure Attachment

Anxious and insecure, controlling, blaming, erratic, unpredictable and sometimes charming

Disorganized Attachment

Chaotic, insensitive, explosive, abusive, untrusting

Reactive Attachment

Cannot establish positive relationships

Reasons for Assessing Attachment before Trauma Processing

Assessing attachment patterns before processing trauma is essential because:

- Clients with complex trauma often have difficulty with:
    - Managing affect
    - Regulating emotions
    - Developing secure relationships
- Both somatic experiences and attachment patterns must be considered when creating a treatment plan in order to provide safe, effective treatment.
- Early attachment injuries can:
    - Become trauma response patterns
    - Make it harder for clients to remain within their Window of Tolerance

"Loss of ability to regulate the intensity of feelings is the most far-reaching effect of early trauma and neglect."

- Allan Schore

Section IV: A Somatic Focus

The Neurobiology of Trauma

When we are in a dangerous situation, our survival system takes over.

- Cortisol is released, which shuts down the hippocampus (the brain's information processing center).
- The experience is not processed in the usual, narrativized way, which is why **trauma leaves symptoms instead of memories.**

The Brain's Adaptive Design

- New research shows that the brain is more adaptive and interdependent than previously thought.
- Rather than three separate structures (as the triune brain model suggested), the brain areas work in concert.
- The brain's primary function is to:
    - Maximize survival
    - Maintain homeostasis and safety

This perspective:

- Supports the AIP model
- Informs EMDR Phase 2 preparation
- Helps clinicians determine appropriate resourcing strategies

We'll explore how this more integrated view of the brain supports the AIP model (Adaptive Information Processing) and how this understanding is useful in Phase 2 (Preparation) of EMDR therapy—especially when choosing resourcing strategies for each client.

Autonomic Nervous System and Trauma Responses

Trauma responses can be categorized through autonomic nervous system states:

- Parasympathetic System: Collapse, submit, feign death
- Sympathetic System: Fight, flight, freeze

The Hand Model of the Brain *(Siegel, 2012)*

We refer to "flipping the lid" when someone becomes dysregulated and moves outside their Window of Tolerance.

Window of Tolerance *(Siegel, 1999)*

- The Window of Tolerance is a framework for understanding autonomic and emotional arousal.
- When clients are within their Window of Tolerance, they can process and integrate information.
- When outside of this zone, clients:
    - Cannot process memories
    - May dissociate or become emotionally dysregulated

📝 **Clinician Note:** Awareness of where the client is in their Window of Tolerance is essential. If the client is not present and regulated, healing cannot happen.

Symptoms Instead of Memories

- Our neurobiology is built to prioritize survival. In dangerous situations, the survival system takes over. Cortisol is released, shutting down the hippocampus (our information processing center).
- This leaves emotional and physiological responses stuck in the system, unprocessed.
- These unprocessed experiences fuel the overreactions to present-day triggers.

The EMDR model—when applied correctly through all 8 phases—creates the conditions for this stuck experience to be processed, allowing the overreaction to resolve.

> **Trauma has symptoms instead of memories.**
> ***This is why talking about trauma doesn't help.***

The Brain-Body Disconnect Study (Kearney, 2022)

Recent research highlights that effective trauma therapy must center around: attunement and somatic sensory-affective experiences.

The study also highlighted the need for different approaches depending on the client.

- For some clients:
    - If easily overwhelmed by sensations and emotions → A top-down approach may be needed first to build tolerance.
- For other clients:
    - If emotionally shut down → A bottom-up approach may be more effective.

Considerations for Couples

In couples, it's common for one partner to become overwhelmed and the other to shut down.

This reinforces the need to assess individual affect tolerance patterns and tailor resourcing strategies for each client.

Individualizing Resourcing in Phase 2 of EMDR

Using the concept of the "Answer," we can individualize resourcing in Phase 2 of the EMDR therapy process.

Resource

Kearney, B. E., & Lanius, R. A. (2022). The brain–body disconnect: A somatic sensory basis for trauma-related disorders. Frontiers in Neuroscience, 16, 1015749. https://doi.org/10.3389/fnins.2022.1015749

The Window of Affect Tolerance

The Window of Tolerance is the optimal arousal zone where a client can safely process memories and integrate emotional experiences.

Trauma and Defensive Adaptations

When trauma occurs, the human system naturally turns to defensive strategies: fight, flight, freeze, collapse, or submit.

These are adaptive responses to danger, but they become problematic when they're triggered by non-threatening stimuli. The system reacts as if the danger is real, leading to a state of hyperarousal or hypoarousal.

Therapeutic Goal: Expanding the Window of Tolerance

We want to work at the edges of the client's Window of Tolerance.

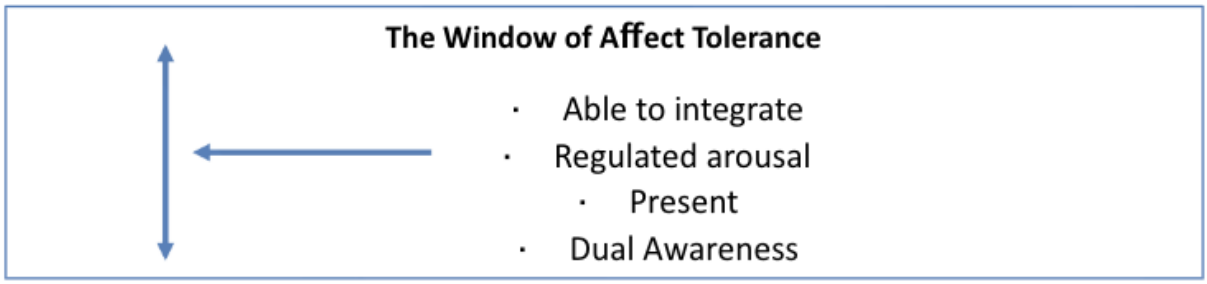
- Through safe resourcing and preparation, we can:
    - Help expand the Window of Affect Tolerance
    - Build the client's capacity to tolerate and process difficult emotions

When the window is expanded, clients develop a greater capacity to tolerate and process emotional experiences.

The Window of Affect Tolerance *(Visual Reference)*

Hyperarousal (Too much arousal, Unable to integrate, Fight, Flight, Freeze)

A R O U S A L



Hypoarousal (Too little arousal, Unable to integrate, Parasympathetic, Collapse, Submit)

Somatic and Attachment Focus (S.A.F.E.)

The S.A.F.E. Approach at Personal Transformation Institute

At Personal Transformation Institute (PTI), we look at the EMDR model (Adaptive Information Processing model) through the lens of somatic and attachment focus, informed by Sensorimotor Psychotherapy.

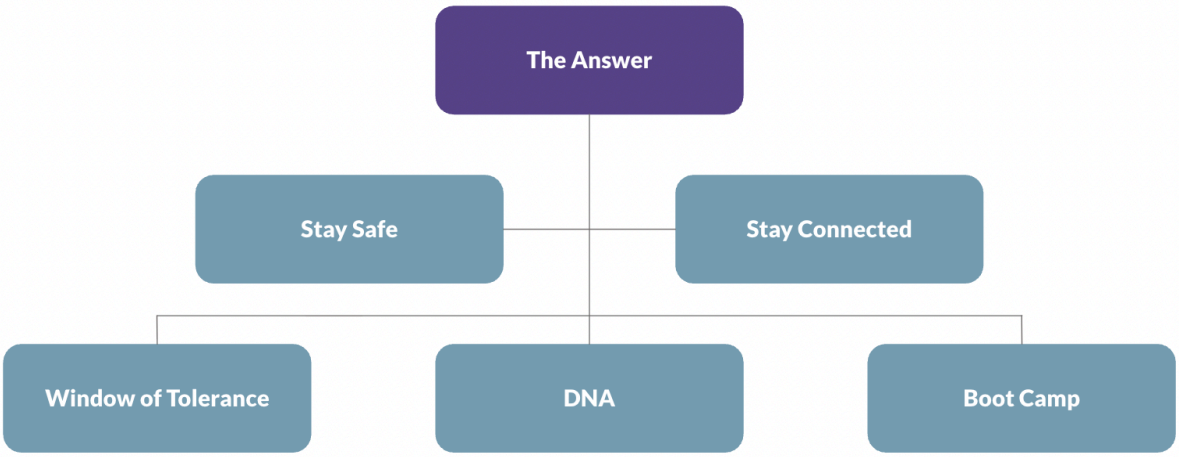
We combine somatic and attachment focuses because:

- Together, they create a safe and effective approach to EMDR therapy.
- This integrated method is the foundation of the S.A.F.E. approach (Somatic & Attachment Focused EMDR)

Why S.A.F.E. Matters

S.A.F.E. is the foundation of our treatment and training model. Without safety, there is no learning or therapeutic transformation. Emotional and physical safety are essential in both training and therapy.

- **Somatic focus:** We teach and use somatic resources—exercises to help clients manage affect and emotion.
- **Attachment focus:** We work with the positive and negative aspects of the client's "Answer" to help them remain within their Window of Tolerance.



PTI Additions to EMDR

The EMDR Approach	The S.A.F.E. Approach
AIP – Adaptive Information Processing Inadequately processed experiences are the root of clinical symptoms and distress.	**Somatic and Attachment Focused EMDR** The attachment and adaptive concept Somatic awareness: a distinction between developmental trauma and shock trauma—and how they interplay
Negative experiential contributors can be reprocessed and integrated when the nervous system is safe and regulated.	Adds depth to resourcing and treatment planning by accounting for nervous system capacity and attachment strategies.

The 8 Phases of EMDR and S.A.F.E. Additions

Phase	Purpose	Procedures	What S.A.F.E. Adds	Our Additional Procedures
Phase 1: Client History / Treatment Planning	• Client background information • Suitability for EMDR • Selecting targets	• History taking questionnaires and other diagnostics • Review resources • Find past events, present triggers and future needs	• History of Strengths and current resources • Concept of "The Answer" • Memories and Lies • Trauma and the body	• The Answer Questionnaire • The Arrows • Character Types Chart • Finding the "Root under the Answer"
Phase 2: Preparation	• Prepare appropriate clients for processing • Increase stability and access to positive	• Calm Safe Place • RDI • Psychoeducation • Metaphors • Preparation Checklist	• Somatic Resources • Predicting the blocks and strengths • Expanding WOT (Window of Tolerance)	• The 5 C's • Predicting the way the client's "Answer" may surface
Phase 3: Assessment	• Assessment of the target memory by activating various aspects of the memory	• The image, current negative belief, desired positive belief, current emotion, physical sensation and baseline measures	• An awareness of how the client's answer may surface as the memory is activated • Limbic Activation	• Present moment focus • Awareness of Attachment/Activation and WOT
Phase 4: Desensitization	• Process memories toward adaptive resolution (0 SUD) • Process all channels of association	• Standard protocols allowing spontaneous changes in emotion, insight, physical sensations and associated memories	• Awareness of Trauma symptoms • Differentiation of Developmental Attachment trauma and PTSD Trauma • WOT	• Somatic Processing • Somatic Cognitive Interweaves • The surfacing of The Answer
Phase 5: Installation	• Connect to positive networks • Increase generalization with associated memories	• Check for best positive cognition • Strengthen validity of positive belief	• How blocks may be The Answer • Awareness of missing attachment experience	• Awareness of The Answer • Missing experience
Phase 6: Body Scan	• Process of residual disturbance	• Concentrate on and processing of disturbing physical sensations	• Awareness of somatic processing	• A movement or gesture at the end of processing
Phase 7: Closure	• Ensure stability and completion	• Reminder of safe place, guided imagery, self-control techniques	• Memories and Lies • Somatic Resources	• Memory and Lie Chart • Somatic Resources
Phase 8: Reevaluation	• Evaluate treatment effects • Check for comprehensive processing	• Check on what has emerged • Activation of target memory • Integration with larger system	• Awareness of The Answer	• Balance with resources

Section V: Method – The 8 Phases

Phase 1: History Taking in the AIP Model

(Chapter 4, Shapiro 2001)

The Map of Treatment: Getting the Lay of the Land

In this phase we are looking for all of the usual psychosocial intake information as well as looking for the AIP aspects of the client's history. Continue to gather the information you currently gather but view it through the lens of the AIP.

Ask yourself:

- *How has the client adapted to stay safe and connected?*
- *How will they stay safe and connected during EMDR therapy?*

Assessing Safety and Stability

Begin by gathering information regarding:

- Current resources
- Current stability

You will practice at least one resource with all clients. Some clients who have complex trauma will require more resource development in phase 2.

(See Practicum Packet for full list)

Supplemental Questions to Ask

(In addition to questions from "The Answer" worksheet)

- 💬 *"How do you currently handle stress?"*
- 💬 *"Do you cry? If so, is it ever in the presence of others?"*
- 💬 *"On a scale of 0–10, how desperate are you to change?"*
- 💬 *"What are your greatest strengths?"*
- 💬 *"What support do you currently have?"*

When Working with Severe Trauma Histories

- Titrate information gathering.

- Start by exploring general or positive information using The Answer framework.
- Some clients may need more resourcing before discussing traumatic memories.

📝 **Clinician Note:** Trauma often presents as symptoms, not memories.

Additional Resources

- DES: Dissociative Experiences Scale (Eve Bernstein Carlson, Frank Putnam)
- SCID-D: Structured Clinical Interview for Dissociative Disorders
- MID: Multidimensional Inventory of Dissociation
- National Center for PTSD Resources: http://www.ptsd.va.gov/professional/assessment/all_measures.asp

The Problem Was Once an Answer

As clients explain current symptoms, listen for how those symptoms helped them survive. This insight sheds light on trauma impact and what may be underdeveloped.

Treatment Considerations

- Look for both big "T" traumas (those meeting PTSD criteria) and small "t" traumas (developmental and life events that caused disturbance).
- EMDR can effectively treat both trauma types.
- Don't overlook:
    - What didn't happen (neglect or absence of support)
    - Middle ground experiences, such as the internalized pressure of being the "Golden Child."

The **Golden Child** may:

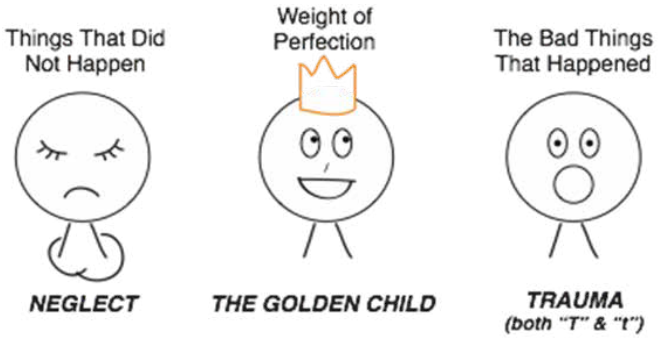
- Feel responsible for making parents proud
- Fear parental disapproval
- Miss the freedom to make their own life choices
- Carry these limitations into adulthood

Key Elements to Explore in History Taking

- Adverse Life Events
- Attachment Disruptions
- Internalized Pressure of Achievement

- What Didn't Happen

Approach each event with curiosity, asking yourself: *"How was the client's Answer helpful in each scenario?"*



📝**Clinician Note:** Although all clients are appropriate for the AIP model, not all are ready for the reprocessing of memories.

AIP Case Conceptualization: Key Questions

- How are the client's past experiences manifesting in the present?
- What are the memories that set the foundation for the present experience?
- What was the response to stress at the time?
- What is the client's "go-to" way of dealing with stress?

Client/Therapist Relationship: Readiness Check

The therapeutic connection is vital.

- Is there trust and safety in the therapeutic relationship?
- Can the client ask questions and express needs?
- Can the client provide honest feedback?
- Does the client have the ability to ask for help (including between sessions)?
- Are there any barriers to trust?
- Can the client maintain dual attention (staying present while recalling distressing material)?

Getting the Clinical Map

- Understanding Attachment Issues and Relationship Patterns
- Gender, Cultural, Ethnic Issues

- Secondary Gain
- Current stressors
- Timing
- Resources

Therapist Checklist

Has the Therapist Explored Each of the Following Areas?

- Dissociation (Screen for Dissociative Identity Disorder using DES or another assessment tool)
- Addictions — Even if far in the past. Predict urges and prepare for a different response.
- Suicide or Self Harm
- Harm to others
- Stabilization, Resources, and Support
- Medical Issues
- Legal Issues
- Timing considerations — Especially for the first reprocessing session

📝 **Clinician Note:** If the client screens positive for a Dissociative Disorder, reprocessing is not appropriate for weekend 1 trained clinicians.
(See Special Populations section for more detail.)

Dissociative Experiences Scale, DES: Screening for Safety

The DES should be used for all clients. Special preparation is needed for clients with Dissociative Identity Disorder in order to maintain safety and dual awareness (the ability to notice our experience in the present, even as we activate a disturbing memory) during reprocessing phases.

Special attention is required when clients present with:

- Years of unsuccessful psychotherapy
- Depersonalization and/or derealization
- Memory lapses
- Flashbacks and intrusive thoughts
- Somatic symptoms

- Chronic instability at home and/or work

Acute Presentations Requiring Caution or Case Consultation

- Suicide attempts
- Life-threatening substance abuse
- Self-mutilation
- Serious assaultive behavior
- Dissociative disorders

Stabilization Criteria

- Does the client have adequate stabilization and self-regulation strategies?
- Can the client return to calm between sessions?
- Does the client have adequate support systems (friends, family, community)?
- Have issues that could pose danger been addressed?
- Can the client call for help if needed?

Medical Considerations

- Assess general physical health—consider how stress may impact medical conditions.
- Pregnancy (high risk?)
- Medications
- Eye pain or conditions: If they have eye pain do not use EM until cleared by a physician.

Timing Considerations

- Timing of life events
- Assess therapist availability
- Determine the client's willingness to continue treatment (including the possibility of 90-minute sessions if needed)

Phase 2: Preparation

(Chapter 5, Shapiro 2001)

In Phase 2, we are:

- Predicting what the client will do when they begin to access painful memories
- Preparing for the worst
- Assessing the client's ability to regulate, stay safe, and connect
- Identifying resources to strengthen these abilities

Goal of Phase 2: we make sure the client has all the tools and resources needed to begin the reprocessing of memories.

We are looking for

- Dangerous issues
- Safety issues
- Patterns of safety and connection that will impede the healing process.

We want the client to:

- Move through processing as quickly and safely as possible.
- Feel that the therapeutic container is safe and strong (crucial to this process)
- Have all questions and concerns of the client answered

The therapist's task here is to understand what it is like to be the client as completely as possible.

Developing a Treatment Plan = Developing an AIP-Informed Resource Plan

In EMDR, treatment planning is different from traditional therapy.

In Phase 2, we are:

- Identifying what memories will be reprocessed
- Determining what resources are needed for the client to successfully access and reprocess memories.

We aren't just building a traditional treatment plan.

We are developing an Adaptive Information Processing (AIP) Informed Resource Plan.

The plan includes:

- **Information:** case conceptualization, the first traumatic memory, the negative cognition
- **Resources:** strategies that increase a client's Window of Tolerance

During Phases 1 and 2, we are also planning ahead to a certain degree: we understand that there are **Three Prongs to EMDR**, and that we are planning to move with our client from the past, through the present, and into the future.

The worksheet titled "Treatment Planning" (on the following page) can be a useful tool for the clinician to conceptualize the treatment plan.

In this section, we will explore:

- What needs to be established
- Goals of stabilization and resourcing
- How to conceptualize a case
- Examples of resources
- How to find the memories to target (and in what order)
- How negative cognitions relate to later phases

Understanding Resources

When we use the term resources, we are referring to any actions or automatic habit patterns that help a client regulate affect and connect with others. In other words, can the client stay present enough to successfully access and reprocess past upsetting memories.

This is one way the concept of "The Answer" is helpful. We are looking at the adaptations that helped the client maximize safety and connection. As we hear current symptoms, we stay curious about how those symptoms developed as part of the client's efforts to stay safe.

> These symptoms the client is now coming to "get rid of" were often helpful at one time.
>
> Through this lens, the client's current symptoms were once— and in many ways still are—resources.

In other words, clients come to us with their own resources. They may not always be healthy, but they still serve to help regulate their affect or connect with others.

Examples of Unhealthy Resources

- Substance use or abuse
- Using food in unhealthy ways
- Using angry outbursts to assist in boundaries

- Dissociation

How to Investigate Current Resources

We first investigate the client's current resources by listening to:

- The presenting issue
- The client's story (recommend keeping it brief and without trauma-related details)
- Responses from The Answer questionnaire and Arrows exercise

This early investigation takes place in an ordinary state of consciousness and mostly verbal.

We are looking for patterns and strengths as we listen, ask questions, and observe themes in the Arrows.

Once we become curious about a potential pattern,

- Invite the client into a short exercise or experiment to continue investigating
- Stay curious—not trying to fix or change anything, but to explore
- The goal here is mindful investigation, not immediate relief.

The Role of Mindfulness in Resourcing

We invite mindfulness.

The therapist will need the ability to be mindful and stay in an open state of curiosity. This, in turn, allows the client to stabilize themselves in mindfulness. The therapist can create the conditions for this stability by:

1. Slowing down
2. Being curious
3. Being mindful

> 📝 **Clinician Note:** Introduce Mindful Curiosity
> 💬 "Let's try a brief experiment—not to fix anything, but just to notice what comes up."

Mindfulness is the ability to notice experiences (sensations, thoughts, memories, emotions, beliefs) with curiosity and without trying to change them.

Stabilizing mindfulness is a skill that can be developed by the therapist, and like any other skill, it requires practice.

The Role of Resources and Imbalance

When working with resources:

- We are looking for areas of imbalance.
- We are *not* searching for the one Answer.
- We are looking for patterns the client developed to maximize safety and connection.

These patterns, while once useful, may now be keeping the client from the very thing they want most: connection and the ability to feel safe when they actually are safe.

Treatment Planning Worksheet

This worksheet helps organize key information for EMDR case conceptualization and target planning. Use it to map the client's current issue, triggers, history, and future goals.

---

1. Presenting Issue | What brings the client in now?

(Brief description of the main complaint, symptom, or struggle)

- **Presenting Problem** _____
- **Negative Cognition (NC)** _____

2. Present Triggers | What currently activates the issue?

- Trigger #1: _____
- Trigger #2: _____
- Trigger #3: _____

3. Past Events | What earlier experiences relate to this issue?

Memory/Event	Approx. Age	Notes
1.		
2.		
3.		

- **Touchstone (Earliest Memory): _____ (Age: __)**
- **Worst Memory: _____ (Age: __)**

4. Future Desired State | What does the client want to feel or believe instead?

Present Trigger	Desired Future State

Resources to Use | What resourcing skills or exercises will support this client?

What We Need to Establish in Phase 2 Before Reprocessing

Client Education

- Explain what EMDR is and what to expect:
    - Before, during, and after reprocessing
- Discuss the nature of trauma and memory
- Clarify what is expected of the client
    - Normalize the possibility of high levels of affect
    - Discuss the possibility of urges if addictions are present (or part of history)

Informed Consent

- May be formal, verbal, written, or all of the above.
- Ensure the client fully understands the EMDR process and gives informed consent

Resources and Adequate Stabilization

Establish a foundation of tools the client can use for regulation:

- Affect management
- Container / grounding
- Resource strategies
- Calm / Safe Place
- Alternative plans (e.g., for avoiding substance use)
- Relaxation and stress management tools

Strong Therapeutic Alliance

✨ A secure relationship between client and therapist is essential for safety and change.

The Mechanics of EMDR

Prepare the client for how EMDR will physically be conducted:

- “Ships in the night” seating
- Eye movements or alternative bilateral stimulation

Understanding “The Answer” to Predict Pitfalls

During history taking (Phase 1), we explored the client’s strengths, underdeveloped skills and the client’s Answer.

Now, we use The Answer to predict the client's ability to stay safe and connected during therapy and how the client is likely to respond during therapy.

Dangerous Things (Safety Risks):

- Suicidal tendencies
- Self-harm
- Harm to others
- Cutting
- Dangerous addictions
- Dissociative Identity Disorder (DID)
- Other serious safety concerns

Annoying Things (Connection Struggles):

- Overthinking
- Being overly critical
- "Nothing happens"
- Trying to please the therapist
- Perfectionism
- Helplessness
- Not telling the truth

Clinical Curiosity

Ask yourself:

"How were these behaviors adaptive in the client's history?"

"How did they help the client survive or stay safe?"

"What does the client need more or less of now?"

"What's underdeveloped or overdeveloped?"

The Goal of Resourcing & Stabilization

The goal of resourcing and stabilization is to assist the client in developing what is needed to tolerate the reprocessing phases of EMDR.

We are:

- Investigating what resources are already present
- Determining what is still needed
- Ensuring the client can:
    - Feel safe (affect regulation)
    - Feel connected (emotional closeness and vulnerability)

Why This Matters

Phases 3–7 focus on changing the way memories are being activated.

Everything we do prior to those phases should be done with the goal of reprocessing in mind and should support the client's ability to move safely into and through those phases

Key Priorities in Phase 2

- Remember that affect instability is often due to unprocessed memories
- Support the client in expanding their Window of Tolerance if needed.
- Help the client develop the ability to regulate affect and tolerate deep sadness.
- Assess their ability to return to calm in the session
- Stay aware of how "The Answer" may surface in reprocessing.
- Ensure the client can report present thoughts, images, and somatic experiences to some degree.

📝 **Clinician Note:** Often, an extended resource development phase is more about the clinician not being ready than about the client not being ready.

How do you know when the client is ready for reprocessing?

- You observe the client move from mild upset to calm within a session.
- The client uses resources outside of session.
- The client can track and report their internal experiences.
- There is a felt sense of emotional safety in the therapeutic relationship.
- The clinician and client have explored all:

- “Dangerous” things (safety concerns)
- “Annoying” things (connection patterns)
- They understand these behaviors were once adaptive, and they can predict how they might now interfere with the client’s desired change and healing.

Case Conceptualization: What Does the Client Need Prior to Processing Memories?

Visual | Case Conceptualization

	High in Resources	Low in Resources
Low Trauma	✅ *Ready for Processing* e.g., Athlete in a slump with strong support system	⚠️ *Needs Resourcing* e.g., Isolated trauma, little emotional support
High Trauma	⚠️ *Needs Stabilization* e.g., Multiple traumas but has access to coping tools	❌ *Extended Preparation Needed* e.g., Complex trauma, minimal support or skills

📝 **Clinician Note:** Some clients enter therapy with many internal and external resources, while others have limited support or coping skills. This matrix helps determine whether additional resourcing or stabilization is needed before reprocessing can begin.
See Section VI: Restricted Processing for more details on complex trauma.

Three Common Presentations in Case Conceptualization

1. Single Event Presentation (Rare for Comprehensive Treatment)

The client has the ability to change emotional states, can connect to others and presents with only one isolated event to work on.

Example: Athlete in a slump, a one-time traumatic event with no connected history

- In this case, the client has many resources and minimal life stressors

Clinical Approach:

- Spend less time in phases 1 & 2.

2. Multiple Issues Presentation (More Common)

The client has some resources, presents with many life stressors and symptoms are typically tied to **long-term patterns and events**

- Clients have many long-term issues to address and some resources.

Clinical Approach:

- Spend more time investigating resources and needs for stabilization and preparation.

3. No Positive Resources Presentation (Complex Trauma)

The client:

- Has extensive negative experiences
- Current resources are potentially dangerous or harmful
    - Client's current resources may include: dissociation, substance use and abuse, depression/avoidance, etc.
- Relies on trauma-based survival resources

Clinical Approach:

- Spend significant time in Phases 1 and 2
- Investigate the dangerous ways the client currently manages distress
- Prioritize extended preparation and resource development before beginning Phases 3 through 8

Resource | More of Less of

A Tool to Find What is Over/ Underdeveloped & Begin to Create Positive Cognitions

Client's Answer	More Of	Less Of
Overthinking	Connection with feelings	Thinking, Analyzing
Perfectionism	Ability to be with the truth of the moment	Trying to control self, outcomes or other's reactions
Obsessing (hyper)	Calming, Mindfulness	Thoughts
Substance Abuse (hyper trying to go hypo?)	Affect/Stress Management	Urges

This chart can be used along with the somatic resources in the resource section. The somatic resources serve to help the client widen the window of affect tolerance.

Resource | Arrows

Use the information gathered from The Answer to assess where the client falls on each continuum below. This will help you develop a customized resource plan to prepare the client for the reprocessing phases of EMDR.

Use the suggested resources based on client needs.

How to Use the Arrows Tool

- Evaluate the client's position on each continuum.
- Recognize the adaptive nature of the client's current strengths.
- Always frame observations in a positive, compassionate way.

Example:

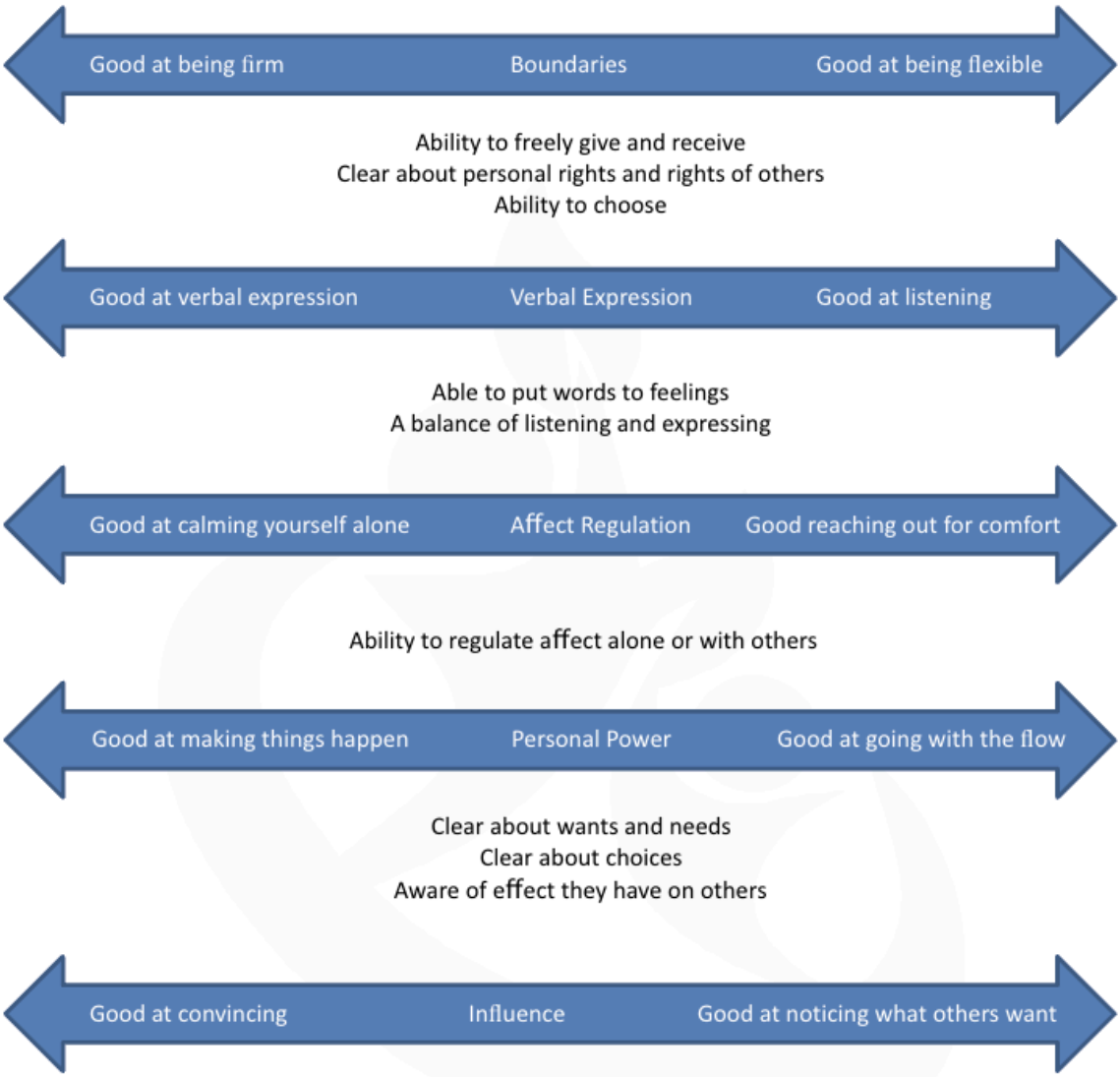
If a client is hypersensitive:

> 💬 *"You are really good at feeling the pain of others and trying to help them."*

If a client is insensitive:

> 💬 *"You are really good at setting boundaries and clearly separating your feelings/issues from the feelings/issues of others."*

The therapist can collaborate with the client by selecting a resource and practicing it together.



Resource | Boundaries

Approaching Boundary Work with Curiosity

When practicing boundary resources:

- We are investigating, not forcing.
- A curious, open attitude is essential.
- The goal is to invite, notice, and encourage the client to explore the experience.

⚠️ It is important to notice if activating is beginning to happen for the client. If so, stop and switch to a different resource or change the focus. This is not a time for processing emotional material.

Boundary Resource Exercises

Scarf Connection/Letting Go Exercise

Using a scarf, rope, necktie, or similar object, the client holds one end; the therapist holds the other.

💬 **Guiding Questions:**

"As you hold the other end of the scarf, what is just the right amount of tension in the scarf?"

"What tells you that?"

"What is a good distance between us as we hold the scarf?"

"What tells you that?"

"Would you like to try an experiment?"

"Notice how it feels as each of us holds on to an end. Whenever you are ready, I will drop my end. Let me know when you are ready."

(When the client indicates readiness, drop one end.)

"What do you notice as I drop my end?"

"Would you like to ask me to pick the scarf back up, or just have me pick it up?"

"Whenever you are ready, ask me to pick it back up." or "Okay, just let me know when you are ready to pick it back up."

"Now, I'd like you to notice what changes as I pick my end back up. What do you notice?"

"Now would you like to notice what happens as you drop your end, and I hold on to mine?"

(Allow an answer. When the client is ready, they drop their end.)

"What do you notice?"

"Now, would you prefer I ask you to pick up your end, or would you rather just pick it up when you're ready?" (Allow them to choose.)

"What do you notice?"

*"What did you notice was different when **I asked you** versus when **you decided**?"*

Mechanics to Consider in Boundary Exercises

- Sitting position
- Physical distance
- Maintaining dual awareness (being present in the room and noticing the resource exercise)

Dual Attention Stimulation (DAS) refers to the use of alternating, right-left tracking that may take the form of eye movements, tones or music delivered to each ear, or tactile stimulation, such as alternating hand taps.

Preferred method for dual attention: pass, set = one round trip, centerline to centerline

Consider:

- Range of motion
- Speed of the set
- Set length
- Direction of movement
- Glasses, contacts, bifocals (adjust eye movement range if needed)

Resource | Using Metaphors

Metaphors can support clients in just noticing their experiences without becoming overwhelmed.

Train Metaphor

*"In order to help you **just notice** the experience, imagine riding on a train and the feelings, thoughts, etc., like scenery going by."*

Movie Metaphor

"Imagine that you're going to see a movie—you know what the movie is about, but you don't know what is going to happen from one scene to the next, so let yourself be curious about it."

Experiments to Increase a Client's Window of Tolerance

- Always invite the client to participate.
- Always ask permission before using touch.
- Work with whatever is present—even if the client refuses the invitation.

Try Experimenting With:

- Boundaries
- Connection
- Proximity
- Saying No
- Choice
- Therapist turning around

Experiments for Bottom-Up Exploration:

- Physically or verbally set a boundary
- Move
- Be still
- Make an affirmative statement
- Talk or be silent
- Communicate without words

- Exaggerate a posture or movement and its opposite
- Say No
- Reach
- Physically connect with the therapist (e.g., holding ends of a scarf)

Suggested Props for Experiments:

- Beanie Babies
- Stand tray figures
- Balls
- Scarves or ties
- Sensory-stimulation objects (e.g., essential oils, cough drops, soft or textured objects, singing bowl)
- Marbles
- Pillows

📝**Clinician's Note:** Experimenting with connection issues is also a way to assess the client's Window of Tolerance.

- Somatic resources may activate unresolved attachment wounds or attachment trauma which can lead to hyperarousal or hypoarousal
- Be prepared to offer State Change / Safety Resources immediately after somatic exercises if needed.

Safety Resources to Offer:

- Breathe
- Center
- Align
- Safe / Calm Place
- Spiral
- Grounding
- Playing Catch
- Container
- Light Stream

Getting to the Root & Finding the Negative Cognition

A negative cognition is a negative belief about the self that feels true and helps access the root of the client's distress.

Key Terms

Presenting Issue / Present Triggers	A specific and current problem
Touchstone Memory	The earliest memory related to the presenting issue
Target Memory	The specific memory selected for reprocessing — often the Touchstone Memory
Negative Cognition (NC)	A belief about the self that helps identify the root of the issue
Root of the Issue / Problem	The earliest experience before the development of the client's Answer

⚠️ Do not confuse Negative Cognitions with CBT-style thought patterns. In EMDR, the NC is used to activate the limbic system and access memory networks. Finding the right NC is essential to locating the root of the presenting issue.

3 Prongs of Treatment

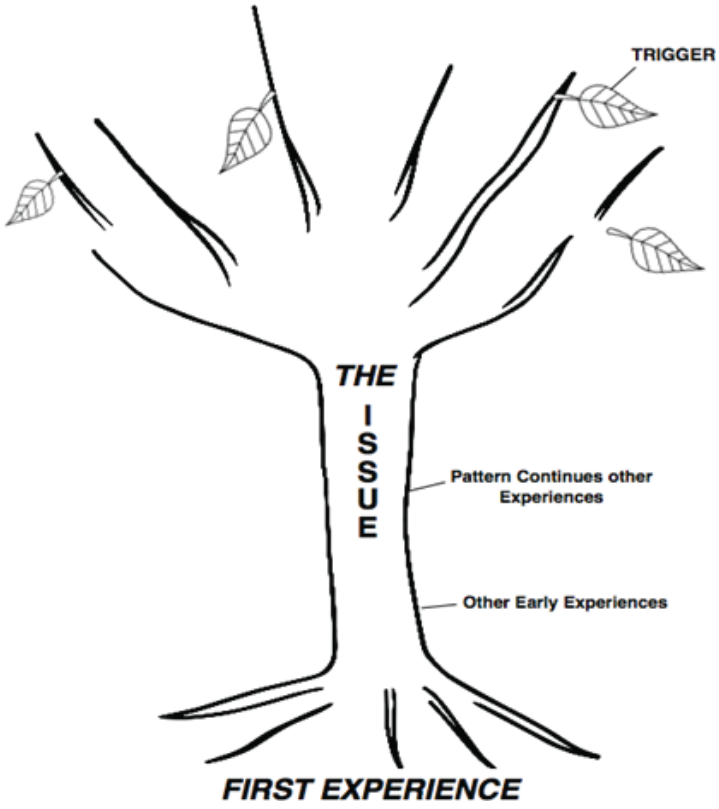
Past	Present	Future
• The first experience (earliest "Touchstone Memory") • The worst experience • Other times in chronological order if possible.	Explore where the presenting issue shows up now: • Work / School • Social situations • Intimate relationships	For each present situation: • Identify how the client would like to respond in the future • Explore new patterns of behavior and feeling • Identify missing experiences or underdeveloped skills and resources

The Bigger Picture: The EMDR Treatment Flow

- Focus on one presenting issue at a time.
- Ideally start with the earliest memory (Touchstone Memory) and work forward chronologically.
- After processing past memories:
    - Process the disturbance connected to present triggers.
    - Develop and install the client's preferred future responses.

Common Mistakes to Avoid

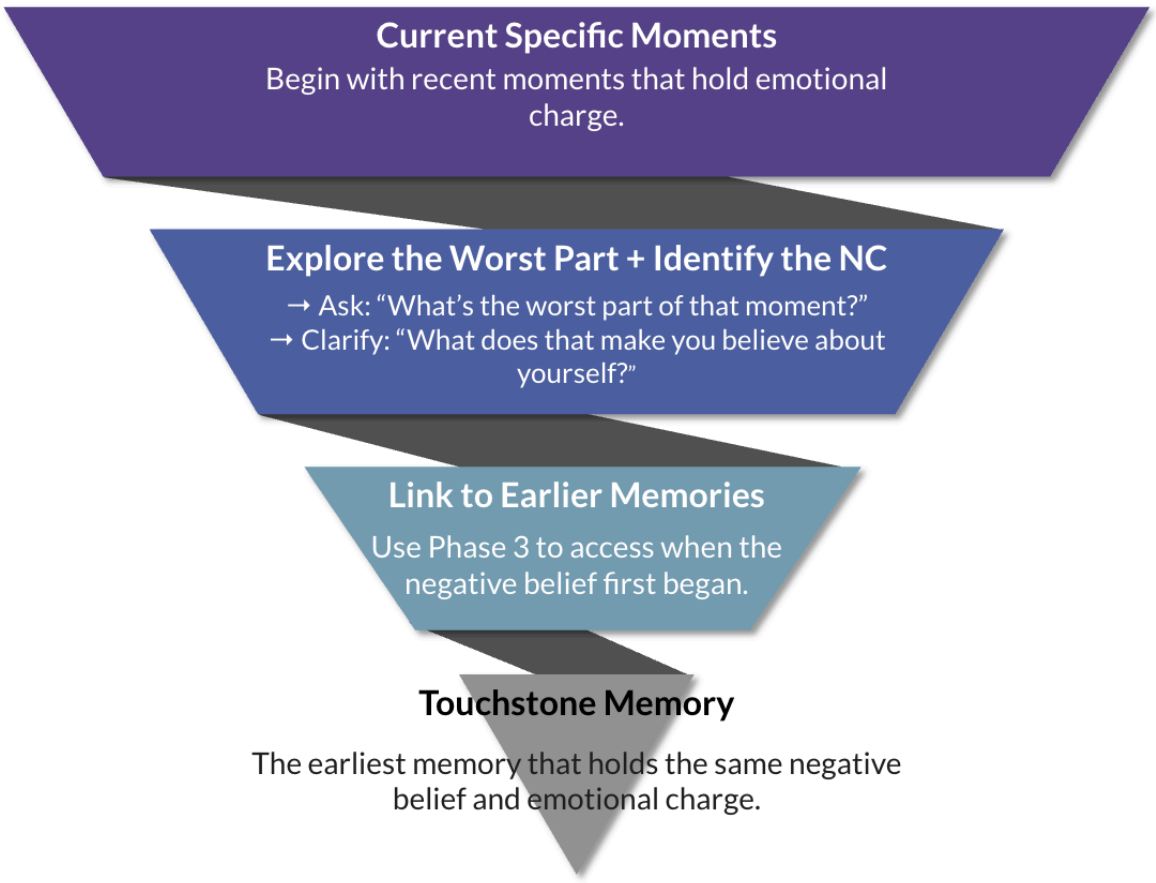
- Not realizing that EMDR is about what happens in the client's system now as we bring up past memories, present triggers, and future possibilities.
- Not identifying a specific moment in time for each memory.



The Map Maker: Accessing Early Memories

We are moving closer and closer toward earlier memories in Phase two:

Funneling Toward the Root



📝 **Clinician Note:** Although this is officially part of the History Phase, you will often be doing Preparation first — such as the Safe/Calm Place Exercise.

How to Begin

To find the earliest memories, ask the client to:

- Bring up a recent time when this issue was disturbing
- Bring up an example of the most upsetting time the issue occurred

It is important to gather this information in the least triggering way possible:

- Focus on headlines, not detailed descriptions
- It is recommended to collect this information just prior to reprocessing

---

Methods for Accessing Early Memories

1. Direct Questioning

(Part of Finding the Target's Script)

Ask:

> 💬 *"What is an earlier time that you can remember experiencing something similar?"*

No matter what earlier memory they report you will ask:

> 💬 *"And can you think of an earlier time?"*

Repeat this process several times until the client cannot think of any more events.

If Direct Questioning does not produce a childhood memory, continue to the next method.

> 📝 **Clinician Note:** Before moving forward, ensure your client is stable and not dissociative. These techniques can bypass defensive barriers and access deeper emotional material.

2. Float Back

(Shapiro, 2001, pp. 433-434)

Prompt:

> 💬 *"As you bring up the recent experience of _____, notice the image that comes to mind, the negative belief you are having about yourself, along with any emotions and sensations.*
>
> *Allow your mind to float back to an earlier time in your life when you may have felt this way before — and just notice what comes to mind."*

This method is similar to the hypnosis effect or somatic bridge. *(Watkins, 1971)*

3. Affect Scan

(Shapiro, 1995)

> 💬 *"Bring up that experience, the emotions and sensations you are having now, and allow yourself to scan back for the earliest time you experienced something similar."*

📝 **Clinician Note:** The Float Back and Affect Scan should only be used when the client is stable and there is time to continue into Phases 3–7 (Reprocessing Phases) within the same session

Finding the Targets: Getting to the Root of the Present Issue

In this section, the clinician is just gathering "the headlines" — not details about the events.

📝 **Clinician Note:** Gathering too many details can be too activating. For practicum purposes, you are also only gathering the headlines. Too many details can also result in the client talking a lot and getting in their head, neither are helpful for treatment planning.

As soon as it is clear that the client has a specific memory and it's a moment in time, the therapist should:

Confirm:

- 💬 *"What age were you?"*
- 💬 *"And what is an earlier time?"*

Continue asking for earlier memories until the client cannot think of any more.

Note that the recent examples of how the issue appears in the client's current life (Present Triggers) are used at the end of this form to identify the Future Desired Behavior/State — how the client wants to respond instead of repeating the Present Triggers.

Script:

"Please tell me some way you feel limited in your present life or a current symptom or issue you would like to focus on."	
"When you___ (the presenting problem), what is difficult for you to do, especially with people closest to you?" ***"Let's look at times in your life when you tried to do what is more difficult and it didn't go well."***	
"Please tell me a recent time that would be an example of this issue" - (Moment in time.)	Socially, Work, Intimate Relationships

"Can you give me an example of how this shows up in your life socially?" (*Moment* in time)	Present Trigger PT #1:
"Can you give me an example of how this show up in your intimate relationships?" (Moment in time)	Present Trigger PT #2:
"Can you give me an example of how this shows up in your life at work?" (Moment in time)	Present Trigger PT #3:
"As you bring up the worst part of this issue, what is the worst part of it now?	
"How disturbing is it now, on a scale of 0-10 with 0 being no disturbance and 10 being the highest disturbance you can imagine?"	SUD (Level of Disturbance) 0 1 2 3 4 5 6 7 8 9 10
"When you bring up this disturbance what is the negative belief you have now?"	NC:
"When you bring up the worst part of the present issue and the words _____(NC) What is an earlier time you can remember experiencing something similar?"	Earlier Memory: Age:
"And what is an earlier time?"	Earlier Memory: Age:
"How about an earlier time?"	Earlier Memory: Age:
"How about an earlier time?"	Earlier Memory: Age:
"How about an earlier time?"	Earlier Memory: Age:
"How about an earlier time?" The clinician keeps asking as long as the client keeps answering. Earliest is the "touchstone".	Earlier Memory: Age:

We recommend going straight to phase 3-7 after getting the earliest memory. The earliest memory is considered the Target or Touchstone Memory.

Red Flags Chart

Red Flag	Follow-Up Questions / Clinical Considerations
No family of origin memories	💬 *"What happened when you told your parents (caregivers)?"*
No affect with memories	Does the client seem to be thinking about what *should* be connected? How is the client's Answer showing up here? Are they skilled at analyzing or figuring things out?
Memories appear to go in a straight line without much or any affect	How is the client's Answer showing up here? Was the Negative Cognition too specific?
All memories are examples of the client's Answer—focused on staying safe or staying connected	💬 *"What happens when you don't or can't do that?"* *For example: "What happens when you are not perfect?"*
No affect or reported disturbance and the memories are focused on one caregiver	💬 *"What happened when you told the other parent (caregiver)?"*

The Negative Cognition

What is the Negative Cognition?

- **A core, negative belief about the self.**
- In EMDR, the NC is not the problem—it is a portal into the system to help access the root issue and associated early experiences.

Other portals besides NCs can include:

- Affect
- Behaviors
- Patterns
- Body sensations

As long as we access early memories tied to dysfunction or limitation, we are on the right track.

What Makes It the Correct NC?

The right NC typically:

- Has a negative emotional charge – the client can feel it.
- Feels true, even though the client knows it's not true.
- Reflects what the client has been trying not to believe or has been compensating for.
- Is about a core belief about the self.
- Applies broadly across life situations and relationships.
- Sounds like something a child would say, not adult language.
- Is irrational.
- Should feel as bad as possible to fully access the memory networks.

How to Find the Negative Cognition

Ask:

💬 *"When you bring up the worst part of that experience, what negative belief do you have about yourself right now?"*

or

💬 *"When you bring up that experience of _____, what does that tell you about yourself?"*

or

💬 *"When you focus on that [emotion], what's the negative belief you have about yourself, even though you may know better?"*

then

💬 *"If that [tightness/sensation] had words, what would it be telling you about yourself or the world?"*

Lighting the Limbic Lightbulb

The right NC activates the client's limbic system and opens access to the root of the issue (the early memories).

The therapist may notice a visible emotional shift (the "limbic lightbulb" lighting up) on the client's face.

Understanding the difference between the root of the problem and the Answer to the root of the problem is essential.

Sometimes clients respond with beliefs like:

"I have to be perfect"

"I have to be in control"

These are often part of the Answer — an adaptation — not the root. To explore deeper, ask:

💬 *"What does it mean if you're not perfect?"*

💬 *"What happens if you're not in control?"*

This helps guide the client toward the core belief underneath the Answer and helps reveal the actual NC, such as:

"I'm not good enough"

"I'm powerless"

Key Questions to Consider When Finding Targets

- Why did the Answer develop?
- What is the Answer an Answer to?
- How was it helpful?
- What is more difficult for them to do?

Therapist's Role:

- Understand what it's like to be the client.
- This helps differentiate whether the NC is part of the Answer or truly at the root.

Therapist's Self-Awareness

- Therapists should watch for their own Answers surfacing, especially if they notice distress, frustration or the urge to save, control, or calm the client.
- The purpose of the therapist understanding the client is to be able to set the conditions for the client to heal. It is not to fix the client or try to get them to do something.
- **We do not have the power to change or heal the client but we can set the conditions for the client's own system to do the changing and healing.**

How the Answer Connects to the NC

When the therapist understands how the client had to adapt (The Answer), they can better assess whether the NC is part of that Answer.

The correct NC activates the system and helps access the root experiences connected to the client's present issue.

The NC is most important when we are Finding the Targets to process and the PC, Positive Cognition, is most helpful in Phase 5, Installation.

After processing, always check:

💬*"Does the original PC still fit, or is there a better one now?"*

Accept whatever PC the client chooses.

What the Root NC Typically Looks Like

- Generalizes across life and relationships.
- Is NOT a behavior or about another person.
- Sounds like something a child would say.
- The client can feel it when stated.
- The limbic lightbulb lights up—it feels true, even though the client knows it's not.

When the NC Doesn't Come Naturally

The most powerful NCs come from within the client's system (in Finding the Targets).

They may not always be able to name it right away — and that's okay. Avoid automatically offering a menu unless the client is stuck. Instead, invite them inward:

💬 *"If you had to put that feeling into words, what would it say about you?"*

💬 *"What belief comes up about yourself when you bring that memory up now?"*

Family of Origin and Missing Experiences

The **root Negative Cognition (NC)** is often connected to a message the client received—directly or indirectly—from their **family of origin, especially their caregivers.**

It's important to remember:

- This does not necessarily mean the caregiver did something wrong or harmful.
- Sometimes the caregiver was trying to help (e.g., saying *"cheer up"* or *"move on"*), but in doing so, they may have unintentionally prevented the child from fully experiencing and processing their feelings.

📝**Clinician Note:** Exploring this dynamic can often be done through The Answer.

When the Core Issue is About What DID NOT Happen

- The root NC may be linked to what didn't happen rather than to a specific event.
- Finding what was missing (neglect, emotional absence, lack of attunement) can often be more difficult than finding what did happen.
- Busy or emotionally unavailable parents may not have provided the emotional response the child needed.

The root of the issue could be a missing experience rather than a direct experience.

The Role of The Answer-Extended

- The Answer-Extended helps therapists and clients explore family dynamics in depth.
- It brings awareness to how the client adapted to their environment.
- Often, the client's greatest strength is a direct adaptation to this missing experience.

⭐What the client became skilled at may provide a similar (but not fully satisfying) experience of what they needed but didn't receive.

This can later become a **block in relationships** if the client:

- Cannot trust receiving what they need from others
- Continues relying only on their adaptation for safety and connection

When Memories Feel Flat or Inaccessible

When doing the Finding the Targets section and the client seems to have trouble accessing memories or the memories seem flat with little charge, a good question to become curious about is

💬 *"I wonder if the root is something that did not happen."*

If the client shares memories that only involve people or events outside their family of origin and there is little or no affect with the recall of the memories, a good question to become curious about is:

💬 *"What was the response to your distress by your family of origin?"*

💬 *"What happened when you went home and told your caregivers about it?"*

If Activation Happens Before Identifying the NC

Sometimes, the client's system activates before you've found the 'perfect' NC.

This often means the client accessed the target through another pathway.

In this case continue with Direct Questioning:

💬 *"Was there an earlier time when you felt this way?"*

📝**Clinician Note:** The purpose of the NC is to activate the limbic system. Once it lights up—get the information and exit the target selection process.

Questions to Help Clients Access the Right NC

💬 *"Does 'I'm not good enough' seem to fit?"*

💬 *"Can you feel 'I'm stupid'?"*

💬 *"Which one of those feels the worst?"* (When the client says multiple NC's).

Variety of Access Points

There are multiple pathways to access early memories and develop the treatment plan.

Any of the following can be used to enter the system and track back to associated memories.

📝 **Clinician Note:** With each entry point, you can deepen the client's experience if needed to access the earliest memories (what the AIP model is based on)

Entry Points for Accessing Early Memories:

Negative Cognition	💬 *"When you say 'I'm not good enough,' what earlier times come to mind?"*
Behaviors	💬 *"When you feel the urge to yell, what earlier times come to mind?"*
Emotions	💬 *"Notice that anger and really allow it to be here and go back to an earlier time when you felt that similar anger."*

Body Sensations	💬 *"Focus on that tightness in your abdomen. What earlier times come to mind when you felt similar" or* 💬 *"If that tightness could speak in words, what would it be saying?"*
Senses	💬 *"As you notice that smell of cologne, what earlier time comes to mind?"*
People or Places	💬 *"When you bring up being with _____, what earlier memory comes to mind?"*

- The NC is often the easiest way to activate the system.
- It is a quick and direct route to accessing touchstone memories.

Negative Cognition Beliefs

The NC is:

- A conclusion the client made about themselves or the world during the early disturbing experience.
- It can be linked to what happened (e.g., abuse, neglect) or what didn't happen (e.g., lack of emotional support).

Important Characteristics of the NC:

- **It isn't true.** It's a lie, but it feels true.
- **It's irrational.** The client knows better but still feels it's true.
- **It's generalizable.** It's a global belief, not tied to one person or event.
- **It can be felt.** The client experiences it in their body and emotions.
- **It resonates with both the presenting issue and the early memory.**
- **It's usually an "I" statement.**

📝 **Clinician Note:** It's best to let the NC emerge organically from the client's system. Avoid offering options from the standard NC list unless the client is truly stuck.

Common Mistakes in Finding the NC and What to Do:

Mistake	Try This Instead
Client describes a behavior or situation e.g., "I yelled at my boss" or "I was abandoned"	💬 *"What does that mean about you?"* Encourage a shift from external events to internal beliefs about self.
Client shares a belief they had at the time of the event e.g., "I thought it was my fault back then."	💬 *"As you bring up that memory now, what do you believe about yourself — even though you may know better?"* Focus on the belief that is still active in the present moment while recognizing it is irrational.
Client gives a heady, intellectual answer e.g., "I am lacking secure attachment due to early environmental misattunement"	💬 *"What would a child say?"* Invite language that is emotionally raw, simple, and irrational.

Types of Negative Cognition (NC)

Category	Negative Cognition	Possible Positive Cognition
Defectiveness/Shame	"I'm permanently damaged"	"I can heal"
	"There is something wrong with me"	"I'm fine as I am"
	"I'm not good enough"	"I am good enough"
	"I'm a bad person or I'm bad"	"I am good or caring"
	"I'm incompetent (Ask if I'm stupid fits)"	"I can succeed"
	"I'm worthless/inadequate"	"I am worthy"
	"I am unlovable"	"I am lovable"
	"I am stupid"	"I am smart enough"
	"I am ugly"	"I am fine as I am"
	"I am a disappointment"	"I'm okay as I am"
	"I'm different"	"I'm okay as I am"
	"I'm invisible"	"I matter"
	"I'm a failure"	"I am worthy"
	"It's my fault"	"I did the best I could"
	"I should have done something"	"I did the best I could"
Responsibility/Guilt	"I should have known better"	"I did what I could"
	"I should not have"	"I can learn"
	"I'm going to die"	"I survived/ It's over"
	"I am in danger"	"I am safe now"
Safety	"It's not okay to be safe"	"I can feel safe when I am safe"
	"I am out of control"	"I can have control"
	"I am powerless"	"I have personal power"
Control/Choices	"I am helpless"	"I can make choices"
	"I am weak"	"I am strong"
	"I can't protect myself"	"I can protect myself"
	"I can't trust my judgment"	"I can trust my judgment"
	"I cannot get what I want"	"I can get what I want"
	"I have to be perfect"	"I can be human"

From The Answer to the Root NC

Possible Answer	Question to Ask	Possible Root NC
I have to be perfect	💬 *"What does it mean about you if you mess up or fail?"*	I'm worthless I'm unlovable I'm not good enough I'm a failure
I have to be in control	💬 *"What would happen if you are not in control"*	I'm powerless, I'm not good enough
I'm incompetent	💬 *"What would a kid say?"*	I'm stupid, I'm dumb
I'm a disappointment	💬 *"What does that mean about you?"*	I'm unlovable
I'm lazy	💬 *"What does that say about you as a person?"*	I'm a failure I don't matter I'm powerless
I have to please people	💬 *"What happens if you don't?"*	I don't matter, I'm worthless
I'm invisible	💬 *"Is it safe to be here?"*	I'm worthless I'm in danger I don't matter

Positive Cognition

The Positive Cognition (PC) reflects the client's desired way of seeing themselves. It represents hope, healing, and a shift away from the limiting beliefs (NCs) that emerged from past experiences.

Important aspects of the Positive Cognition:

- It is an expression of a new way of being: the hope of transformation.
- It reflects the client's desired direction of change.
- It is generalizable.
- There is a positive affect resonance, even if very small prior to processing

Common Mistakes When Finding the PC (And What to Do Instead)

Mistake	Try This Instead
Just negating the NC (does not reflect what they would like to believe) e.g., "I am not ugly"	💬 *"Would you like to believe, 'I'm fine as I am?'"*
Magical thinking e.g., "My mother loved me"	Invite a general self-focused truth: "I am lovable"
Too big / unbelievable e.g., "I am lovable."	Offer a bridge: "I'm learning to love myself"
Client believes PC must fit the time of trauma	Remind: 💬 *"It's what you want to believe **now**, not what was true then."*

Example: A memory of abuse may leave the client feeling powerless now, even though it has been 20 years and the client is no longer in the abusive situation

Phase 3: Assessment

(Chapter 5, Shapiro 2001)

The Full Range AIP EMDR Protocol

The Full Range AIP EMDR Protocol allows for a full range of associations to be made throughout memory and an integration across the entire system

What you're assessing in this phase: How the target memory is currently manifesting for the client — in the present moment.

> 📝 **Clinician Note:** A good way to think about this phase is **Activation**.
> You are lighting up the target memory and its components—like flipping on all the switches or starting the engine.

This is not about gathering new information – Your role is to activate the memory network and allow associated material to surface.

Before You Begin Phase 3

Confirm:

- The client is seated in the ready position for reprocessing
- All mechanics questions and testing are complete
- The client meets criteria for readiness to proceed to Phase 4
- You and the client have agreed on the target and the clinical map

> 📝 **Clinician Note:** The therapist determines the target, not the client.
> This is a clinical decision—similar to how a surgeon decides the surgical plan.
> Clinical judgment is essential here.

Common Mistakes in Phase 3 (and What to Watch For)

Common Mistake	Correction
Repeating what the client says or engaging in general conversation	→ Remember: The goal is to activate the memory as it is held now—flip the switch and move on.
Forgetting this phase is about the client's experience NOW — not how the client felt at the time of the event.	→ The client may naturally answer from the perspective of the past. It's the therapist's job to bring them back to the present experience.
Trying to explore or adjust the NC during Phase 3	→ The correct Negative Cognition should have been found in Phase 2. → If needed: 💬 *"Last time you said it was 'I'm not good enough', does that still fit?"*
Pausing between Phase 3 and Phase 4.	→ Ensure the client is fully ready to go straight from Phase 3 to Phase 4 without delay. Do not pause or introduce new steps in between.

Procedural Steps: Phase 3 – Assessment

1. **Target Memory**

   💬 *"When you bring up that memory, what picture represents the worst part?"*

   If client says there is not an image, ask:

   💬 *"When you think of the incident, what do you get?"*

2. **Negative Cognition (NC)**

   💬 *"What words go best with that picture (or incident) that express your negative belief about yourself now?"*

3. **Positive Cognition (PC)**

   💬 *"When you bring up that picture, what would you rather believe about yourself now?"*

4. **Validity of Cognition (VOC)**

   💬 *"When you think of that picture, how true do those words — [repeat PC] — feel to you now, on a scale of 1 to 7? Where 1 feels completely false and 7 feels completely true?"*

5. **Emotion**

   💬 *"When you bring up that picture and the words — [repeat NC] — what emotion do you feel now?"*

6. **Subjective Unit of Distress (SUD) Scale**

   💬 *"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?"*

7. **Physical Sensations**

   💬 *"Where do you feel it in your body?"*

📝 **Clinician Note:** As soon as you ask this question, you are in Phase 4.
Move directly into the first question of Phase 4 without pausing.

Transition to Phase 4 Example Script:

💬 *"I'd like to invite you to bring up that image, those negative words (example: 'I'm not good enough'), notice where you are feeling it in your body, and follow my fingers."*

Assessment Worksheet

Before you begin, ensure you and the client are in the correct seating position. Confirm you have practiced speed, distance, and type of Dual Attention Stimulation (DAS); and practiced the stop signal.

You should be fully prepared to start eye movements immediately after the final question in Assessment.

Assessment	
Target Memory	
💬 *"When you bring up that memory, what image represents the worst part?"*	
ONLY if no image: 💬 *"As you think of the experience, what is the worst part of it?"*	
Negative Cognition (NC)	
💬 *"What words go best with that picture that express your negative belief about yourself now?"*	
Positive Cognition (PC)	
💬 *"When you bring up that picture, what would you prefer to believe about yourself instead?"*	
Validity of Cognition (VOC)	
💬 *"When you think of that picture, how true do those words (PC above) 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
Emotion	
💬 *"When you bring up that picture and those words (repeat NC above), what emotion do you feel now?"*	
SUD (Subjective Units of Distress)	
💬 *"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 the memory feel to you now?"*	⬜ 0 ⬜ 1 ⬜ 2 ⬜ 3 ⬜ 4 ⬜ 5 ⬜ 6 ⬜ 7 ⬜ 8 ⬜ 9 ⬜ 10
Body Sensation	
💬 *"Where do you feel it in your body?"*	

Transition to Phase 4 Script:

> 💬 *"I'd like you to bring up that picture, those negative words (repeat NC), notice where you are feeling it in your body, and follow my fingers."*

Begin DAS immediately. (Typically 20 or more passes, customized to the client's needs)

📝 **Clinician Note:** As soon as you ask the SUD question, you are officially in Phase 4. Move directly into the first Phase 4 question without pausing.

Phase 4: Desensitization | A Reprocessing Phase

(Chapter 6, Shapiro 2001)

Reprocessing the Target

In this phase, we begin reprocessing the memory that is at the root of the current dysfunction.

The goal is to reduce the Subjective Units of Disturbance (SUD) to 0 for the target memory—and to do so twice for the treatment to be considered complete.

What's Happening in the AIP System

We are looking at how the memory is currently stored in the client's system. As the information arises, we allow it to move and process naturally, without interference.

- The client accesses the target memory and reprocesses the associated network.
- Learning occurs as the memory links into more adaptive networks.
- Processing continues until the disturbance decreases and the memory shifts.

After each set of Dual Attention Stimulation (DAS), the client gives brief feedback about their experience.

The clinician uses this feedback to track progress and determine when to return to the original memory.

> 📝 **Clinician Note:** We're not searching for new material here—we're allowing the memory to shift as the system processes. Stay attuned, stay out of the way, and follow the client's system.

Complete processing is confirmed when the client reports a SUD of 0 twice for the full memory.

Phase 4 is like a Three-Act Play

Act	What Happens
Act 1: Clearing the First Channel	💬 *"What do you notice now? Go with that."* → Repeat until responses become positive, neutral, or stop changing.
Act 2: Returning to the Target	💬 *"When you go back to the original memory now, what do you notice? Go with that."* → Continue until no new disturbance surfaces.
Act 3: SUD Check & Completion	💬 *"When you go back to the whole memory, how disturbing does it feel to you now on a scale of 0–10? Go with that. What do you notice now?"* → Repeat until you get **two zeros**.

Begin Desensitization Phase

> 💬 *"I'd like you to bring up that image, those negative words (repeat the negative cognition), notice where you are feeling it in your body, and follow my fingers."*

(or use an alternative form of Dual Attention Stimulation)

Dual Attention Stimulation (DAS)

- Sets of DAS (across and back) are typically done for 15–30 seconds.
- The length of each set may vary depending on the client's needs. It's okay to ask for feedback about whether they'd prefer more or fewer passes.
- You can begin with 24 passes (one pass = back and forth) during practice sessions.
- The rate and speed should be as fast as the client can comfortably tolerate, stopping in the midline.
- DAS may involve eye movements, tapping, or auditory tones.

📝 **Clinician Note:** The "24 passes" is a general starting point. You'll refine this with experience and as you attune to your client's needs. Some may require more, others fewer.

Feedback

After each set of DAS, the therapist checks in with the client.

Educate clients that they do not need to report everything they experienced during the set.

💬 *"What are you noticing now?"*

How to Recognize If Processing Is Happening

Memory Changes

- Images change or shift
- Emotions become more or less intense
- Sensations change in intensity or begin to move
- Thoughts change (either positively or negatively)
- Perspective shifts (more adult or adaptive perspective becomes possible)

Memory Network Changes

- Different people or times emerge
- Other memories surface
- Physical sensations are activated
- Emotional associations shift
- New or clearer beliefs arise

Types of Processing

Clients may process through one or more of the following:

- Visual (e.g., image changes)
- Emotional (e.g., grief or fear surfacing)
- Physical sensations (e.g., tightness releasing)
- Clusters or associated memories

Handling Unexpected or Emerging Memories

Therapist as a Container:

- During reprocessing, the therapist plays an essential role in containment:
- Stay connected and attuned while holding therapeutic boundaries
- Let the client lead—stay out of the way while keeping them grounded
- Use specific tools (like cadence, pacing, body cues) to support the client's process

When Processing Isn't Moving

If progress stalls, assess the following:

- Safety — is the client present?
- Dual Awareness — are they aware of both past and present?
- Window of Tolerance — are they within their emotional tolerance zone?
- Attunement — is the therapist emotionally present with the client?
    - Even asking: "Are you here with me?"

- Social Engagement — is the client socially engaged and connected?

If stuck:

- Return to the target memory.

Additional Notes on When to Return to Target Memory

- Responses are neutral or positive
- There's no movement
- The memory "feels different"
- The therapist feels lost or unclear
- It feels like the end of a channel

Return to Target Memory:

💬 *"When you bring up the original memory, what are you noticing now?"*

Client responds — continue another set.

💬 *"Go with that."*

Taking a SUD (0-10)

When you feel processing is nearing completion or to check progress:

💬 *"When bringing up the original incident, on a scale from 0 to 10, where 0 is no disturbance and 10 is the worst, how disturbing is it now?"*

📝 **Clinician Note:** A shift from 9 → 1 can be just as meaningful as 1 → 0. Both represent significant processing progress.

If SUD is stuck at 1 or 2:

💬 Explore:

"Where is the sensation in the body?"

"What keeps it at a 2 instead of a 0?"

"What's the disturbance now?

"Would you like this to become an awareness?

(Introduce Cognitive Interweaves—covered on Day 5)

"Is something fueling it?"

(Blocking Belief or Feeder Memory)

Feeder Memories

An earlier memory that was not uncovered or connected during the earlier phases can surface during reprocessing. This earlier memory may be fueling the disturbance and keeping the client from completing processing.

📝 **Clinician Note:** The emergence of a feeder memory can signal that earlier phases may not have been completed thoroughly enough.

Possible Reasons a Feeder Memory Appears:

This may indicate that earlier phases were not done correctly. A feeder memory may be a result of the following:

- The "Finding the Targets" process was done through symptoms only
    - e.g., Client reports repeated panic attacks but the root may lie in a much earlier experience.
- The process missed a younger memory—especially one before age 10

What to Do When a Feeder Memory Emerges:

1. Revisit "The Answer." Was the NC used in Finding the Targets actually something the client does well now?

    For example:

    - NC: "I'm out of control"

      → Likely their Answer—they are now very good at being in control.
    - NC: "I'm powerless"

      → Possibly the more accurate NC—the area they still struggle with.

    Note: This is especially likely if the target memory was an adult or older childhood memory.

2. Use Affect Scan or Float Back to Connect to Earlier Memory

    Affect Scan (Shapiro, 1995)

    - Developed by Shapiro, this technique supports the client in tracing current affect (emotions or body sensations) back to an earlier time when they felt something similar. It was inspired by the "Affect Bridge" (Watkins & Watkins, 1971), but does **not** involve hypnosis or reliving the memory.

💬 Prompt: *"Bring up that feeling in your body. Now allow yourself to scan back to an earlier time in your life when you felt this way before… just notice what comes up."*

Float Back (Shapiro, 2001, pp. 433–434)

- This technique guides the client to focus on the full experience of the target (image, negative belief, emotions, and sensations), and then "float back" to an earlier time when they felt the same way.

  💬 Example prompt:

  "As you bring up the recent experience of [insert], notice the image that comes to mind, the negative belief you're having about yourself, along with any emotions and sensations—and just let your mind float back to an earlier time in your life when you may have felt this way before… just notice what comes up."

Blocking Beliefs

A blocking belief is a limiting belief that interferes with reprocessing. It often shows up when a client cannot fully let go of a disturbance, even if other parts of the memory have cleared. Blocking beliefs are usually conclusions the client drew based on early experiences—often tied to the Answer, what they learned to do to stay safe or connected.

Examples:

- "It's not safe to be safe."
- "I need to feel anxious to achieve."
- "I will lose connection."
- "I don't deserve to be happy."
- "There will always be another disturbance."
- "There's always something to be worried about."

Ways to Process Blocking Beliefs

- Simply notice the belief and do a set of DAS. (Some may process through naturally.)
- If needed, help the client connect to when they learned this—this may become a new target.
- Revisit the client's Answer to determine if this belief is an extension of what kept them safe or connected.

📝 Blocking beliefs can emerge during **any reprocessing phase** — Phase 4, 5, or 6.

When the Client Appears Stuck or Blocked, Try:

- Change mechanics: Alter the direction, speed, or switch modalities (e.g., from eye movements to tapping).
- Change the client's focus of attention.
- Return to the original target memory.
- Check for a blocking belief or a feeder memory.
- Consider a Cognitive Interweave (covered on Day 5).

Intense Emotional Processing (Abreactions)

It is normal for clients to experience intense emotions during reprocessing. This may be the first time they've fully felt what they were once unable to feel.

Authentic emotional responses are:

- A sign that the system is releasing stored information.
- Different from patterned or defensive emotional responses.
- Often accompanied by relief or clarity once processed.

📝 **Clinician Note:** Your ability to tolerate emotion as a therapist is essential. The goal is not to calm it down—but to stay present and help the client stay in dual awareness. You must be able to tolerate deep emotion.

How to Support

- Check presence: *"Are you still with me?"*
- Attune to cadence: *"Yes, it's really sad…"*
- Encourage feeling the emotion (as long as the client is present and within the Window of Tolerance): *"Stay with that sadness. Let it be here."*
- Normalize: "*Just notice it.*" or *"This is old stuff."*

Use Metaphors

- Tunnel: *"Keep your foot on the gas—just drive through the tunnel."*
- Train: *"Watch the scenery go by—like a train ride."*

If the client signals STOP:

- Stop.
- 💬 Ask: *"What do you need right now?"* or *"What do you need to keep going?"*
- Client may need more preparation or additional resources.

- Return to EMDR reprocessing when the client is ready.

When "The Answer" is Active (Signs to Watch For)

These are patterns suggesting the client (or therapist) is operating from their Answer:

- Trying to control the process
- Having an agenda or being outcome-focused.
- Increased anxiety or frustration.
- Worry about failing or "doing it wrong."
- Checking the clock, impatience.
- Focusing on outcome instead of the moment.
- Resentful compliance: *"Well, you're the professional."*
- Difficulty responding or not knowing.
- Trying to please or rescue others.
- Getting distracted or going off-topic.
- Noticeable shifts in body movement or stillness.
- "I think" statements.
- Excessive storytelling or talking.
- Urges to explain every detail or be understood.

The Five C's of Working with the Answer

Step	Description
Catch it	Silently notice when a client (or therapist) is in a pattern that feels like the Answer.
Curiosity	Get quietly curious—*What is this behavior protecting? How might it be tied to the past?*
Celebrate & Collaborate	The client becomes adorable. We feel like we completely understand why the client is doing what they are doing (the block/answer).
Contact	Name it gently - first time you mention it to the client: 💬 *"It seems like you're really good at…"* or *"It seems like it can be helpful to…"*
Connect to the Past	Help them explore: 💬 *"I wonder how you learned to be so good at that?"* or *"I bet that was really helpful when…"*

Phase 5: Installation

A Reprocessing Phase

(Chapter 6, Shapiro 2001)

This phase begins after the client reaches a SUD of 0 (or an ecologically low disturbance) in Phase 4.

Purpose of This Phase:

- Strengthen the link to more adaptive memory networks.
- Allow what doesn't resonate with the Positive Cognition (PC) to surface and be reprocessed.
- DAS remains long and fast, unless the client needs otherwise.
- Generalization of learning can occur.

📝 **Clinician Note:** The PC may shift during Phase 4. Always ask if the original statement still fits or if there's a better one.

Check the Positive Cognition (PC):

💬 *"When you bring up the original incident, do the words (repeat the PC) still fit, or is there now a better statement?"*

➔ If the client has a more adaptive belief now, go with that.

Check the VOC (Validity of Cognition)

💬 *"Think about the original incident and those words (repeat the PC). On a scale from 1 (completely false) to 7 (completely true), how true do they feel now?"*

Link the Positive Cognition and the Target with DAS

💬*"Think about the original incident and those words (repeat the PC) and follow my fingers."*

- Use the same speed and length of DAS as in Phase 4.
- Continue sets and recheck VOC until PC is fully installed (VOC = 7).

If Client Gets Stuck (VOC < 7)

💬Ask:

"What would make it a 7?"

"What keeps it from being a 7?"

If still stuck:

- Check for a blocking belief.
- If identified, either process it as a blocking belief or treat it as a new target (as discussed in Phase 4).

⚠️ **Important: Do not confuse Phase 5 with the Future Template.**

If the client's system shows signs of activation or movement, continue reprocessing. You are still in a reprocessing phase.

Phase 6: Body Scan

A Reprocessing Phase

(Chapter 6, Shapiro 2001)

This phase begins after Phase 5 is complete, and the client reaches a VOC of 7 — or an ecological 5 or 6.

📝 **Clinician Note:** This is not just about numbers. Trust your clinical judgment to determine readiness to move forward.

Reprocessing Phase Continues

- DAS remains long and fast, unless there is a clear reason to adjust speed or length.
- The focus now is on processing any remaining physical sensations.

Body Scan Procedure

> 💬 *"Close your eyes and keep in mind the original memory and the words [repeat the Positive Cognition].*
>
> *Then bring your attention to the different parts of your body, starting with your head and working downward.*
>
> *Any place you find tension, tightness, or unusual sensation — tell me."*

Continue Dual Attention Stimulation (DAS) until the client reports a clear body scan (no unusual sensations).

Signs Processing May Be Occurring

- Change in intensity of the sensation
- Change in location
- Movement of sensation through the body

If Disturbance Increases:

- If intensity spikes or the client becomes more disturbed, check for new material.
- It may process out or it may indicate a new target memory that needs to be addressed in a future session.

⚠️ **Caution**

Only begin the body scan if you have sufficient time to complete it. If time is short, pause here and resume in the next session.

Phase 7: Closure

(Chapter 6, Shapiro, 2001)

Closure is the process of ending a reprocessing session—whether processing is complete or incomplete. Allow time to help the client shift states, savor progress, or re-stabilize before leaving.

AIP Perspective

In this phase, we are:

- Stabilizing or reinforcing positive/neutral states
- Limiting negative associations, if needed
- Redirecting attention toward more adaptive memory networks

If Session Was Complete

(SUD = 0, VOC = 7, clear Body Scan)

- Allow the client to express needs or reflections
- Offer encouragement and connection
- Invite the client to savor and integrate their progress

If Session Was Incomplete

(SUD > 0, VOC < 7, Body Scan not clear)

(This could happen in Phase 4, 5, or 6)

❗ Do not proceed to the next phase if the session is incomplete.

What to do: Leave plenty of time for stabilization and suggest stopping

What NOT to do:

- Recheck SUD
- Revisit PC or VOC
- Attempt the Body Scan

Supporting the Client

- Remind them of the experience of current safety
- Use previously established resourcing/stabilization tools (or collaboratively develop a new one for the moment)

Once the Client is Stabilized

- Validate their progress and hard work
- Help them reconnect to the present moment
  (e.g., *"What's your plan for the rest of the day?"*)
- Review safety plans or how to get support if needed
- Consider a check-in agreement, if helpful
- Suggest a way to reinforce gains between sessions:Journaling, Logging thoughts/emotions, or Resource practice

Instructions for Closing All Sessions

💬 *"The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams — that is normal.*

If so, just notice what you are experiencing.

If you wish, you can record it on the Memories and Lies chart.

Please continue to practice your resources and contact me if you need to."

Optional Closure Tools

Sometimes at the end of processing — whether complete or incomplete — it can be helpful to invite reflection. Two optional tools you can use are: Memories and Lies Framework and Understanding the Answer.

Concept	Why It Matters	When to Use	Watch Out For
Memories and Lies	Explains how limiting beliefs are formed — a lie based on earlier experiences.	After processing — to help clients understand insights and patterns.	Client may need more resources if they are unable to recognize their trigger is from the past.
The Answer	Reveals the client's survival strategy — how they stayed safe or connected.	When coping patterns show up — especially during closure or blocks.	May seem confusing if not introduced earlier (Phases 1–2).

Memories and Lies

EMDR is based on the belief that both dysfunction and health are rooted in earlier experiences.

- Traumatic experiences become stuck in the system and create patterns in how we view the world—our perceptions, attitudes, and beliefs.
- When something in the present activates that dysfunctionally stored memory, it feels as if the original event is happening again, and the reaction can seem like an overreaction.
- The limiting belief we hold about ourselves is often a lie—a conclusion we drew at the time of the original event, based on survival or attachment needs.

  ✨*"Anything that keeps you from being a shining star is either a lie or a memory."*

Memories and Lies Chart

Date/Time	What was your experience?	SUD 1-10	What was the memory or lie?	Savor what is New and True

The Answer: Adaptive Response & Pattern

- The Answer is the adaptive response the client developed to stay safe or maintain attachment.

- Over time, this becomes a patterned way of managing stress—a strength, but also a limitation.
- The Answer is often overdeveloped, which gives clues to what may be underdeveloped.
- Understanding the Answer helps us predict blocks and identify where processing may get stuck.

Phase 8: Reevaluation

(Chapter 8, Shapiro, 2001)

Reevaluation occurs throughout treatment—after each session, during reassessment of the treatment plan, and prior to completing treatment. The goal is to ensure that previous targets remain resolved and that progress continues toward transformation and integration.

Three Types of Reevaluation

Type	Focus
After Each Session	Was the target completed or incomplete? Assess client experience between sessions. Check for new insights, dreams, or changes in symptoms, behaviors, triggers.
Reevaluation of Targets / Plan	Review overall treatment plan. Are presenting issues or symptoms improving? Reassess previously identified targets and current functioning.
Reevaluation Prior to End of Treatment	Comprehensive evaluation of client's progress. Identify remaining disturbances, defenses, or maladaptive behaviors. Focus on future goals and adaptive functioning.

Reevaluating a Prior Session (Unfinished Reprocessing)

Ask generally about the following:

- Did the client experience any processing between sessions?
- Any new symptoms, behaviors, or shifts in reactivity?
- Were there any dreams, new insights, or spontaneous memories?
- Are previous triggers less or more active now?

📝 *Remember: A session can be incomplete in Phases 4, 5, or 6.*

Assess the Current State of the Previously Targeted Memory:

- Is the memory still disturbing?
- Have other associated memories surfaced?
- Have the presenting triggers decreased or changed?

Reevaluation Prior to Completion of Treatment

- Have the client's original issues or symptoms improved?
- Have past target memories remained clear and integrated?
- Have current patterns or relationships shifted?
- Are there any new or remaining present-day disturbances or limitations?
- Have any defenses, urges, or behaviors been activated during or before treatment?

Focus on the Future

- Explore and reprocess anything limiting the future for the client.
- Help the client implement new adaptive responses into daily life and relationships.

Complete vs. Incomplete Reprocessing

Status	What to Do
Completed	If the previous target was completed—meaning Phases 4, 5, and 6 are all fully processed—and the client reports no new disturbance in Phase 8: → Move to the next chronological target.
Incomplete	If the previous target was incomplete in Phase 4, 5, or 6: → Resume to a **Modified Phase 3** and continue reprocessing.

How to Restart Processing After an Incomplete Session: Modified Phase 3

Gently re-access the memory from the previous session using these questions:

Prompt the client:

💬 *"What is the image that is the worst part of that memory now?"*

💬 *"What emotions are you feeling now?"*

💬 *"On a scale of 0–10, how disturbing does it feel now?"*

💬 *"Where do you feel that in your body?"*

Then begin reprocessing:

💬 *"Bring up that memory, notice where you feel that disturbance in your body, and follow my fingers."*

Check other targets that may need reprocessing.

Once the target is fully reprocessed, check the rest of the Targeting Sequence Map:

- What still feels disturbing?
- What may have been resolved through the generalization effect?

💡 **Generalization Effect**

Sometimes, reprocessing one target leads to the spontaneous resolution of related memories. After completing a target, always review remaining targets for disturbance — some may have already been reprocessed without needing direct targeting.

Section VI: Completing the Treatment Plan

Each event in the treatment plan should be a moment in time — not a generalized period or theme.

Ideally, the treatment plan is completed in chronological order, beginning with the youngest memory and moving toward the most recent.

However, this isn't always linear. The therapist should use the Reevaluation Phase to determine which memories still hold emotional charge. These are processed using Phases 3–7, regardless of when they occurred.

- Memories are targeted from youngest to oldest when possible.
- More recent memories may be processed earlier if they are more intrusive.
- Each memory may take a full session—or even more—especially if the session is incomplete.

📝 **Clinician Note:** Don't rush through to "get to the next one."

Working with Present Triggers and Future Templates

Once all past events have been processed to a **SUD of 0** and **VOC of 7**, the present triggers are evaluated. Many times, these present-day triggers lose their emotional intensity after the past memories are resolved—but not always.

If a present trigger still holds charge, it is also processed using Phases 3–7.

For each present trigger, the therapist and client will have already developed a desired future state. These are addressed through the **Future Template Protocol**.

When the Earliest Memory Can't Be Processed First

There are times when the client cannot begin with the earliest memory. This might happen when:

- A more recent memory is intruding more strongly.
- The client is too overwhelmed to access earlier events due to the number or intensity of traumatic memories.

In these cases, the EMD protocol is recommended to help contain and restrict the processing.

Therapist as EMDR Expert

Although we ask for the touchstone memory and the worst memory to be listed on the same line of the treatment plan, this does not mean the client chooses which to target

first. This is like a patient going to the surgeon with appendicitis, and the surgeon asking, "Would you like me to remove your appendix or your spleen?"

The therapist is the expert in EMDR and is responsible for recommending the most efficient and effective path to healing.

📝 **Clinician Note:** Be collaborative with the client, but don't abdicate your clinical judgment. You guide the process.

Present Triggers

Once the past events (Part 1 of the 3-pronged approach) have been addressed, the present triggers are evaluated. These are any current people, situations, or experiences that continue to cause disturbance or dysfunction.

What to Look For:

- What in the present evokes disturbance or maladaptive behaviors?
- Are there people, situations, or events that still feel triggering?
- What targets were identified throughout the phases that still need attention?
- Which present-day triggers were once disturbing but have now been resolved through past memory reprocessing?

How to Process Present Triggers:

- Present triggers are processed using the same standard protocol as past events:
    - Start with Phase 3: Assessment and continue through Phases 4–8

📝 **Clinician Note:** The process is the same — but the client's felt experience may be different than when working with past events. Stay attuned.

Future Template for Each Present Trigger

For each present trigger identified, a Future Template is developed.

The client should have a vision and a map for how they want to respond in the future.

💬 *"How would you like to respond instead of how you're currently reacting?"*

📝 **Clinician Note:** This is where we help the client step into agency and choice — not just resolution of disturbance, but embodied new responses.

Section VII: Future Desired State

> *"If you don't know where you are going, you might not get there."*
>
> —Yogi Berra

Finding the Future Desired State during treatment planning begins the process of imagining a new, more adaptive future. What the client names as their desired response may shift after reprocessing, often becoming even more adaptive and aligned with healing.

📝 **Clinician Note:** The Future Desired State is a helpful starting point — not a fixed destination. Reprocessing may reveal more meaningful, integrated outcomes than the client could initially access.

Key Question

💬 *"How would you like to respond instead of the current trigger response?"*

What to Look For

- How the client would like to respond or feel
- What the client would like to be able to do
- How they would prefer to handle situations that once triggered urges, avoidance, or addictive behaviors
- New insights, behaviors, or patterns that are more adaptive
- What may be needed in terms of education, skills, or confidence
- Any remaining blocking beliefs or limiting patterns that emerge during this phase

📝 **Clinician Note:** This phase can surface what's still missing — or what's already changing — offering valuable material for closure or additional processing.

How to Create the Future Template

For each present-day trigger that has been reprocessed, invite the client to imagine their ideal response in the future.

💬 *"How would you like to be able to respond, feel, act, or believe instead?"*

💡 **Tip:** Keep the focus on a **specific**, **achievable** desired state — not a vague ideal.

Worksheet | Desired Future State

Instructions:

💬 *"Now we're going to look at each present trigger and decide how you would like to react, feel, or behave in that situation if it happens again in the future.*

(This should be something you can realistically imagine happening.)"

Present Trigger	Script	Desired Future State *(Write Client's Responses Here)*
Trigger 1:	*As you think about **[insert present trigger]**, how would you like to be able to react, feel, or behave if that — or something similar — were to happen in the near future?*	
Trigger 2:	*As you think about **[insert second present trigger]**, how would you like to be able to respond, feel, or show up in that kind of situation in the future?*	
Trigger 3:	*When you bring up the trigger of **[insert third present trigger]**, what would your ideal response look or feel like? How would you like to handle it moving forward?*	

Worksheet | Treatment Planning

This worksheet helps organize key information for EMDR case conceptualization and target planning. Use it to map the client's current issue, triggers, history, and future goals.

---

1. Presenting Issue | What brings the client in now?

(Brief description of the main complaint, symptom, or struggle)

- **Presenting Problem** _____
- **Negative Cognition (NC)** _____

2. Present Triggers | What currently activates the issue?

- Trigger #1: _____
- Trigger #2: _____
- Trigger #3: _____

3. Past Events | What earlier experiences relate to this issue?

Memory/Event	Approx. Age	Notes
4.		
5.		
6.		

- **Touchstone (Earliest Memory): _____ (Age: __)**
- **Worst Memory: _____ (Age: __)**

4. Future Desired State | What does the client want to feel or believe instead?

Present Trigger	Desired Future State

Resources to Use | What resourcing skills or exercises will support this client?

Future Template Protocol

Purpose

The Future Template helps clients imagine how they would like to respond, feel, or behave in situations that previously triggered distress.

- Uses its own protocol, different from the standard EMDR 8-phase protocol
- Processes Future Desired States identified on the Treatment Plan
- Usually completed after the related Present Trigger has been reprocesses
- Can be used as a standalone protocol when clinically appropriate
- Each Future Desired State should be based on a specific imagined moment in time

Introducing the Future Template to the Client

> 💬 *"We have addressed the past events, the root of the present disturbance, as well as the present triggers.*
>
> *Now we'll explore what you would like to be different in the future.*
>
> *We have a specific protocol to imagine your desired future, and to process blocks or enhance positive states."*

Future Template Protocol Steps

Step 1: Identify the Desired Response

> 💬 *"How would you like to respond in the future instead of your current reaction to this trigger?"*

Step 2: Run the Movie

Have the client link the Positive Cognition (PC) with their vision of the desired future

Ask them to run a mental movie of how they would like to respond — from beginning to end

> 💬 *"I'd like you to imagine a movie of you responding in that situation in the way you'd like to — and hold the words **(insert PC)** while you do.*
>
> *If anything negative, uncomfortable, or stuck comes up, let me know."*

Step 3: Ask: "What are you noticing?"

If the Client Says…	Therapist Response
Positive	Add DAS while the client runs the movie. Continue as long as the positive response holds.
Neutral	Explore what the client may need. Help them develop a desired response. Add DAS with the movie until it becomes positive.
Negative	Focus on body sensations. Add DAS until the response becomes neutral. Then assist in developing a desired response, and continue DAS with the movie until it becomes positive.

Step 4: Install the Positive Cognition (PC)

> 💬 *"Hold the PC with that situation. On a scale of 1–7, how true does it feel to you now?"*

Continue DAS until the client reports a VOC of 7

Step 5: Introduce a Challenge

Invite the client to imagine a challenge within the movie:

> 💬 *"I'd like you to think of something that could be challenging, and imagine that happening in the movie."*

If needed, offer a menu of possible challenges

Ask again:

> 💬 *"What are you noticing?"*

Use the same response flow:

- **If Positive:** Add DAS as long as the response remains positive.
- **If Negative:** Focus on body sensation with DAS until neutral. Then install the PC and continue until VOC = 7. (Repeat this step as needed.)

📝 **Clinician Note:** This protocol is often more imaginative and hopeful in tone, but can still bring up blocks or unexpected resistance. Let the client move at their own pace — and support them in building confidence in their new response.

📹*See the full demo video under the Basic Training Portal on the PTI website.*

Section VIII: Restricted Processing

Eye Movement Desensitization (EMD) *(Shapiro, 1987)*

Eye Movement Desensitization (EMD) was Francine Shapiro's original method. Initially, she believed it functioned like exposure therapy, desensitizing excess arousal.

Over time, however, Shapiro and others observed that clients spontaneously made new associations, leading to new learning and insight — a discovery that shaped the development of EMDR. EMDR allows for broader reprocessing and is considered more comprehensive than EMD.

📝 **Clinician Note:** If the client is able to tolerate full EMDR processing, EMDR is the preferred method.

What is EMD?

- EMD is a narrow-focused strategy.
- Only associations directly related to the selected target are allowed.
- If the client begins to drift into unrelated material, they are redirected back to the target.
- The therapist frequently checks the SUD (Subjective Units of Disturbance).
    - If there's any doubt about what to do next, it's appropriate to take a SUD after every set.

When to Use EMD?

- A recent event
- Intrusive triggers that may overwhelm the client

📝 **Clinician Note:** Even when using EMD, you still need to complete Phases 1 and 2 of the standard protocol. This remains a clinical decision based on client readiness and stability.

How to Use EMD

1. **Select the Target Memory**
    - Choose one image, sound, or intrusive part of the event.
2. **Select the image that represents the worst part**
    - *What words best match the image as a negative belief about yourself now?*
    - *What would you rather believe about yourself now (Positive Cognition)?*

- *How disturbing does the image feel now (SUD 0–10 scale)?*

EMD Script

Use this when applying the EMD protocol (after phase 1 and 2) — especially for recent events, intrusive triggers, or when full EMDR processing is not tolerated.

Target Setup

Step	Therapist Script	Client Response
Target Memory	💬 *"What image represents the worst part?"*	
Negative Cognition (NC)	💬 *"What words go best with that image that would be a negative belief about yourself now?"*	
Positive Cognition (PC)	💬 *"What would you rather believe about yourself now?"*	
SUD **(Subjective Units of Disturbance)**	💬 *"On a scale of 0–10, with 0 being no disturbance and 10 being the highest disturbance you can imagine, how disturbing does it feel to you now?"*	0 1 2 3 4 5 6 7 8 9 10

Begin Processing

💬 *"Bring up that image, the negative words (NC) _____, and follow my fingers."*

Begin eye movements (EM)

After each set, pause and check the SUD

Step	Therapist Script	Client Response
SUD **(Subjective Units of Disturbance)**	💬 *"On a scale of 0–10, with 0 being no disturbance and 10 being the highest disturbance you can imagine, how disturbing does it feel to you now?"*	0 1 2 3 4 5 6 7 8 9 10

Continue until the SUD is lowered

📝 **Note:** It may not reach 0 — this is expected with EMD.

Once the SUD Has Lowered

When the SUD is as low as possible, Install the Positive Cognition:

Step	Therapist Script	Client Response
Positive Cognition (PC)	💬 *"When you bring up that memory and the words — [repeat PC] — how true do those words feel to you now, on a scale of 1 to 7? Where 1 feels completely false and 7 feels completely true?"*	VOC Scale: 1 2 3 4 5 6 7

📝 **Clinician Notes:**

- Because this is just one piece of the memory, the VOC may not reach 7
- Do not move on to Phase 6: Body Scan

Afterwards

After EMD or other restricted/incomplete processing, consider using the **Creating a Container** exercise to support stabilization

Restricted Early or Recent Events Protocol

(Adapted from Shapiro, 2001)

Clinical Use of Restricted Protocol

Restricted processing protocols like EMD are appropriate when the client cannot tolerate full EMDR processing. They are not meant to replace the Standard EMDR Protocol, but are tools to use when clinical necessity requires a more limited approach.

EMD or the Restricted Protocol does not produce comprehensive reprocessing.

It is designed for symptom reduction only.

📝 **Clinician Notes:**

- Use restricted processing only when clinically necessary — not simply because it seems easier or more comfortable.
- When the client has the capacity and stability, the full EMDR protocol should be used, as it is empirically shown to result in more complete and lasting change.

The Role of the 8 Phases

Even when using restricted processing, all 8 phases of EMDR must still be used.

You still assess:

- The client's resources
- Their ability to change states safely
- Their history
- The targets and root causes of the presenting issue

📝 **Clinician Note:** This means completing a full intake, resourcing, and treatment planning — even if your reprocessing strategy is more contained.

Understanding the Window of Tolerance

A full understanding of the Window of Tolerance is essential when using restricted protocols.

📹 *A 2-hour training video on this concept will be available to all Basic Training members.*

How the Restricted Protocol Differs from Standard EMDR

Standard EMDR	Restricted Processing (EMD)
Longer DAS sets	Shorter sets of DAS (8–12 passes)
Free association allowed	Narrow focus on target only
"What do you notice now?" after DAS	Return to target after each set; do not ask open-ended question
SUD goal: 0 (twice)	SUD goal: proceed when SUD < 4
May include body scan (Phase 6)	Do not proceed to body scan
Comprehensive reprocessing	Symptom reduction only

What to Focus On

- You do not need all the details of the memory or event — **just the headlines**.
- Keep the focus narrow and contained to the selected target.
- Continue to check the SUD after each set to ensure the client is not outside their Window of Tolerance.

Restricted Protocol Flowchart

Procedure	Script	Therapist's Actions	Therapist's Notes
Step 1: Decide on Restricted Processing	*Choose the event for restricted processing.*	Clinical decision made in collaboration with the client.	
Step 2: Client tells entire event out loud with DAS	*"We have selected the target of [___] to process with the Restricted protocol. I'd like you to tell the story of the experience out loud, from just before the event to now, and follow my fingers. Let me know when you are finished."*	Begin DAS while client tells the story out loud from beginning to end. Stop when story is complete.	
Step 3: Identify first POD (Point of Disturbance)	*"Now I'd like you to review the event silently in your mind while I do DAS. Use your stop signal when the most disturbing part comes up, and we'll use that as our first target."*	Therapist begins DAS. Client uses stop signal. Use whatever they name (1–2 words) as the first target.	**Target 1 / POD 1**
Step 4: Phase 3 Setup – Access the POD	*"When you bring that up, what image is the worst part?"*	Accept any image or words that describe the worst part.	
4.a	*"What words go best with that picture that express your negative belief about yourself now?"*	Accept client's response and move to next question.	**NC:**
4.b	*"What would you rather* *believe about yourself now?"*		**PC:**
4.c	*"When you bring up that image/sound, on a scale of 0 to 10, how disturbing does it feel to you*	Note the SUD level.	**SUD:**

	now?"		
4.d	*"I'd like you to bring up that image, those words (NC), and follow my fingers."*	Begin DAS: short fast sets (about 10 passes).	
4.e	*"On a scale of 0 to 10, how disturbing is it now?"*	Ask SUD after each set. Repeat 4.d and 4.e until SUD is ≤ 4.	SUD may not reach 0.
Step 5: Identify Next POD (if needed)	*"Review the episode again and let me know what next part comes up as most disturbing. We'll use that as the next target."*	Repeat DAS while client mentally reviews the event and uses stop signal. Then return to Step 4 with next POD.	**Target 2, 3, etc.** Repeat until no new PODs surface.
Step 6: Install the Positive Cognition for Entire Episode			
6.a	*"Do the words (repeat PC) still fit, or is there another more suitable positive statement?"*	Allow client to adjust the PC if needed.	
6.b	*"Bring up that memory and those words — from 1 (completely false) to 7 (completely true), how true do they feel to you now?"*	Begin DAS — short fast sets of about 10 passes.	
6.c	*"On a scale of 1–7, how true do those words feel to you now?"*	Continue DAS sets until no change in VOC for 2 sets.	*Do not move to Body Scan (Phase 6). End here.*

Exercise | Creating a Container

This guided resource can be offered at the end of a session to help the client feel safe, complete, and grounded — especially after incomplete processing, restricted work, or emotionally intense moments.

Step 1: Notice and Offer Container

💬 *"We're nearing the end of our time, and I'd like to be sure you have everything you need to feel safe and complete as we wrap up.*

Would you be interested in a containing resource to help with this?"

Step 2: Specify What Needs to Be Contained

💬 *"First, let's decide what it is you feel the need to contain.*

Is it the strong feeling of _____ [sadness, anger, grief, etc.]?"

Step 3: Mindfully Invite a Container (Offer Menu)

💬 *"Okay. Just allow the perfect container to come to mind — something that's big enough and strong enough to hold your _____ [emotion].*

It could be as small as this coffee cup, as large as Mother Earth, or anything in between."

Step 4: Enhance and Deepen the Visualization

💬 *"Great. So imagine that _____ [name the container].*

How does the _____ [emotion] go in?"

Step 5: Mindfully Deepen

💬 *"Just allow the _____ [emotion] to enter the _____ [container] through the _____ [entry point].*

Let me know when you feel it's all inside."

Step 6: Seal the Container

💬 *"Would you like to _____ [close the door, put a lid on it, etc.], or have you already done that?"*

Step 7: Somatic Linking

💬 *"Now just sense the _____ [emotion] being contained in the _____ [container].*

What do you notice in your body now?"

Step 8: Extra Layers or Menu of Support

💬 *"Great. Now just see if there's anything else you need to feel that _____ [emotion] is safe and contained.*

You could put a lock on the door, have a special being guard it, or place it into a cave in the mountain."

Step 9: Deepen and Check for Completion

💬 *"Really sense the _____ [emotion] inside the _____ [container].*

What are you noticing in your body now?"

Step 10 (Optional): Invite Healing

💬 *"Would you like to invite healing energy, spiritual light, or supportive presence to penetrate the _____ [container] and help heal the _____ [emotion]?"*

Step 11: Complete the Process

💬 *"Just allow that _____ [energy/light/presence] to penetrate the _____ [emotion], and let me know when it feels complete."*

What is Complex Trauma?

Complex Trauma vs. Simple Trauma (PTSD)

Complex Trauma refers to trauma that happens repeatedly, cumulatively, and often becomes progressively worse over time.

- Examples: Ongoing physical or sexual abuse, war, human trafficking, chronic illness, or any prolonged exposure to extreme stress.

Post-Traumatic Stress Disorder (PTSD) typically results from a single traumatic event.

Examples: car accident, natural disaster, assault, etc.

📝 **Clinician Note:** Adult-onset trauma can reactivate earlier developmental trauma, especially if early experiences were unresolved.
This may trigger dormant memory networks and result in complex presentations in therapy.

Common Effects of Complex Trauma

- Difficulty regulating affect
- Poor self-esteem
- Struggles with interpersonal relationships

"I long for closeness, but it doesn't feel safe"

These internal conflicts often result in patterns that both seek connection and fear it.

Intrapersonal Trauma

When trauma is interpersonal, it creates conflicting internal states, particularly involving attachment figures.

- **Attachment is the source of danger** → Client may not trust others
- **"It's not safe to feel safe"** → Safety itself can be triggering
- Longing to connect while simultaneously fearing attachment
- Feeling trapped:
    - Wanting closeness, yet fearing it
    - Being uncomfortable in both intimacy and isolation

📝 **Clinician Note:** Complex trauma often includes layers of developmental trauma and PTSD — both must be considered in the case formulation.

Developmental Trauma

- Developmental trauma often appears through disrupted attachment patterns
- Identified by looking for overdeveloped human action systems through the concept of The Answer.

Hardwired Subcortical Systems

(From Panksepp's Research)

The following seven core emotional systems can become over- or under-developed due to trauma:

System	Function
SEEKING	Anticipation, curiosity, desire
RAGE	Frustration, restraint, indignation
FEAR	Pain, threat, foreboding
PANIC/LOSS	Separation distress, grief, loneliness
PLAY	Joy, carefree play
MATING	Sexual behavior, attraction
CARE	Nurturing, caregiving instincts

📝 **Clinician Note:** These systems are biologically wired and offer insight into how trauma shapes behavior, emotion, and relational dynamics.

A Somatic and Attachment Approach

In the S.A.F.E. EMDR model, we hold the lens that "the problem was once the answer." The client's current symptoms and adaptations — even if now limiting — were developed for a reason. At one time, they helped the client stay connected, stay safe, or survive.

Throughout training and practice, we will model how to:

- Attune to the client and build resourcing
- Help clients understand that their symptoms were once adaptive strategies
- Identify and work with strengths and blocks in the preparation phase
- Increase therapist awareness of their own strengths, blocks, and how these influence the process
- Recognize how attachment patterns re-emerge under stress
- Integrate body awareness and somatic cues into all phases of treatment
- Use somatic resources to support affect regulation and stabilization

📝 **Clinician Note:** This model invites both client and therapist to approach symptoms with curiosity, compassion, and context — understanding them as part of a system that has been doing its best to protect.

Section IX: Review of the Model and Method

A Brief Description of EMDR

When something disturbing happens, it can get stored in the brain in a way that makes the system feel like the event is either about to happen again — or is happening right now. This experience is stored physically in the brain.

Later, when something occurs that is similar or simply has an element that reminds the system of that earlier disturbing event, the brain reacts as if the original event is happening again.

EMDR helps move the memory to a more functional part of the brain — one that can recognize the event as being in the past. There is a **real, physical change** happening during EMDR.

The events that used to activate the brain into overreaction no longer have that effect. The person can now respond to the present without the past interfering.

Glossary of Core EMDR Terms

Term	Definition
Abreaction	The expression and consequent release of a previously repressed emotion, achieved through reliving the experience that caused it.
Adaptive Information Processing (AIP) Model	The theoretical model developed by Francine Shapiro (2001) to explain the observed effects and predict the treatment outcomes of EMDR therapy.
Affect Bridge	A hypnoanalytic technique first described by Watkins (1971, 1990) for identifying an earlier contributory experience by associating it from a current emotional disturbance.
Bilateral Stimulation (BLS)	Alternating back and forth — generally left to right — eye movements, kinesthetic, or auditory stimulation in EMDR treatment.
Blocked Processing	When processing does not move naturally toward adaptive resolution and additional clinical measures are required.

Cognitive Interweave	A deliberate accessing of memory networks by the clinician — either to activate a current association or introduce a missing one — with the goal of facilitating integration toward a positive outcome.
Completed Session	A session using the EMDR model in which the SUD is 0, the VOC is 7, and the Body Scan reveals either positive or neutral sensations.
Contributory Experience	Earlier experiences that laid the foundation for current dysfunction. These may have increased vulnerability or led to maladaptive responses.
Dual Attention Stimulation (DAS)	The use of alternating, right-left tracking — such as eye movements, tones, or tactile taps — to facilitate reprocessing in EMDR.
Emotional Processing	First described by Rachman (1980) as "a process whereby emotional disturbances are absorbed and decline to the extent that other experiences and behavior can proceed without disruption."
Etiological Experience	The earlier experiences that created memory networks contributing to the client's current level of distress.
Fear Structures *(First described by Lang in 1977*	Model for understanding anxiety. Includes three systems: physiological activity, overt behavior, and subjective report.
Future Template	The third prong of the EMDR standard protocol, focused on the client's desired future response to a present trigger.
Incomplete Session	A processing session where one or more of the following occurs: • SUD remains above 1 • VOC is less than 6 • Body Scan reveals residual negative sensations not present before the session
Inverted Protocol	An approach to complex trauma treatment (Hoffman, 2004) where the therapist targets the future first, then the present, and finally the early etiological experiences — after stabilization has been achieved.

Memory Networks	Part of Shapiro's AIP model (2001), describing how memories are stored across five aspects: image, thought/sound, physical sensation, emotion, and belief.
Phase-Oriented Approach	A general model for trauma treatment first proposed by Janet (1889), consisting of three phases: 1. Safety and Stabilization 2. Uncovering and modifying traumatic memories 3. Personality integration

Abbreviated Term Glossary

Abbreviation	Meaning
POD	Point of Disturbance
SUD	Subjective Units of Disturbance
PC	Positive Cognition
VoC	Validity of Cognition
DAS	Dual Attention Stimulation
BLS	Bilateral Stimulation

Somatic and Attachment Focused EMDR: Overview of Teaching Points

Memories and Lies: The Foundation of EMDR

- EMDR is based on the understanding that earlier experiences are the root of both dysfunction and health.
- Traumatic experiences become stuck in the system and form patterns that shape how we see the world:
  → Our perceptions, attitudes, and beliefs.
- When something in the present activates a dysfunctionally stored memory, the response may appear as an "overreaction."
  - In reality, it's the nervous system reacting as it did at the time of the original event.
- The limiting belief we hold about ourselves is often a "lie" — a conclusion we drew at the time of the event based on how we made meaning of what happened.
- The **Memories and Lies Chart** can help remind clients that triggers are often tied to both the memory and the lie associated with it.

The EMDR Model: More Than a Technique

EMDR is not a technique — **it is a complete psychotherapy model.**

It includes 8 phases of treatment, which can be grouped into 3 categories:

1. Preparation and Safety *(Phases 1 & 2)*
2. Processing Memories — Moving and Integrating *(Phases 3–8)*
3. Future Template Integration — *Assisting the client in bringing change into daily life*

Our Lens: Somatic and Attachment-Focused EMDR

At PTI, we teach EMDR through the **Adaptive Information Processing (AIP) model** with a somatic and attachment focus, informed by Sensorimotor Psychotherapy.

Going Deeper into The Answer

A key concept in this training is our simplified way of understanding attachment and trauma response.

"The Answer" is how the attachment pattern shows up —

the way we adapted to stay safe or connected to caregivers.

It includes:

- The things we learned to do in order to stay attached
- Built-in survival defenses (autonomic nervous system responses)
- Patterns that become both a strength and an imbalance

The Answer is influenced by:

- Family culture ("Boot Camp")
- Genetic tendencies (DNA)
- Traumatic experiences (impacting the Window of Tolerance)

📝 **Clinician Note:** The "Character Type Chart" is a support for learning about The Answer — not a way to label clients.

Character Types and The Answer

Each character type is a way of adapting. This model is not about labels, but about understanding survival strategies—both their gifts and limits.

Character Type	Presentation
The Invisible One	Dissociates or disappears; body may be small, thin, pulled in
The Emotional One	Feels a lot; senses others' emotions; overwhelmed by emotion without movement
The Nice One	Pleases others; may appear helpless; weak, limp body
The Independent One	Doesn't trust help is there; square, firm body
The Rock	Endures pressure; does what they don't want to do; sturdy, grounded body
The Doer	Thinking and action oriented; body slightly forward, ready for action

The Chameleon	Adapts to what others expect; difficulty being direct; side-to-side movement
The Hero	Takes charge; tough, capable; has difficulty being vulnerable; puffed-up posture
Life of the Party	Dramatic, needs to be seen; lots of movement in upper body

Each character type:

- Manifests in the body
- Becomes a go-to way of managing stress
- Represents both a strength and a block to intimacy or treatment

📝 **Clinician Note:** Most people are a blend of several character types.

Our job is to understand how these strengths were once adaptive — and how they might now be blocking connection or healing.

Working With "The Answer"

The 5 C's of Working with The Answer

Catch It

- Silently observe the pattern as it happens over and over again.

Curiosity

- Hold curiosity about what you're seeing.
- Notice tone, posture, rhythm, relational stance, or energy shifts.

Celebrate/Collaborate

- Acknowledge how The Answer helped the client adapt and survive.
- When we meet the Answer with understanding, the client "becomes adorable."

Contact

- The first time you name it, keep it gentle and observational:
  💬*"It seems like you're really good at _____."*

💬 *"It seems like it was helpful to _____."*

Connect to the Past

- Begin to gently link the pattern to earlier survival needs:

  💬*"I wonder how you learned to be so good at _____."*

  💬*"I bet that was really helpful when _____."*

📝 **Clinician Note:** The use of nonviolent communication is essential here.
The Answer is also the client's defense system .

Phase 1 & 2: History Taking and Preparation

These two phases go hand in hand. Often, preparation is needed before trauma history can be explored in depth.

Using The Answer in Early Phase Work

- The Answer exercise helps gather a history of resources and strengths.
- It also helps predict blocks that may come up during reprocessing.

  The expanded Answer asks more:

  - How it was helpful
  - How it gets in the way

Clinician should watch for:

- Somatic and attachment needs are revealed through tone, posture, movement patterns (pacing), and energetic cues
- Window of Tolerance: This is essential through all phases — especially at the beginning.
  - Notice signs of hyperarousal or hypoarousal
  - Stay curious about what dysregulates the client
  - Resource and slow down when needed
- Protective Patterns:
  - Dangerous: dissociation, harm to self/others, addiction
  - Annoying (but adaptive): overthinking, canceling, pleasing, lying, storytelling

Relationship Building

- Identify what's overdeveloped and what's underdeveloped.

- The presenting issue is often The Answer — a strength that also becomes a block.

Resources are developed based on what is underdeveloped, always with appreciation for The Answer and the use of nonviolent communication.

Treatment Planning & Finding the Targets

Reminders

- Do not begin "Finding the Targets" until you are ready to process.
- Going back through what's underdeveloped — the harder work for the client — will help you get to the root underneath The Answer.
- Stay connected to the Window of Tolerance and be mindful of what the client can tolerate.

Lighting the Limbic Lightbulb

When things feel blocked or "not working," become curious about The Answer.

Ask yourself:

- What survival strategy is showing up?
- What might this client be protecting?

Also check in with your own Answer:

- Are you talking too much?
- Trying to make the client feel better?
- Not following the script?

📝 **Clinician Note:** Your own Answer can show up when things get sticky. Pause and return to the model.

Phase 3: Assessment / Activation

- This phase activates the limbic system in the present moment.
- It is not about remembering — it's about lighting things up now.
- If a client says: "I felt…", redirect:

  💬 *"Right now in this moment, how does that feel to you?"*
- This phase should take 3–5 minutes
- Use the script. Keep things moving by asking the next question.
- Phases 3 and 4 always go together. Phase 3 is immediately followed by Phase 4.

Phase 4: Reprocessing

- Maintain awareness of the Window of Tolerance.
- Signs of activation or flooding may include:
    - Not answering or taking a long time to answer
    - Panic or fear of fear

Therapist should:

- Be present, boundaried, and grounded
- Remind the client you are here with them if needed
- Support deep emotional responses:

  💬 *"Yeah."*
  💬 *"That's a lot of sadness."*
  💬 *"Is it okay to let that sadness be here?"*

Cognitive Interweave & Attachment

- Use the missing experience as a framework for cognitive interweave.
- Stay aware of The Answer. If processing is blocked:

  💬 *"I wonder if that was what was missing at the time?"*

Somatic Processing

(Working with Intense Fear Response)

Goal: Uncouple the emotion from the body sensation

Therapist language:

💬 *"Would it be okay to let go of the emotion and just notice the body sensation?"*

💬 *"Is it okay to welcome the sensation?"*

Let the client:

- Name where the sensation is in the body
- Allow the movement to happen
  (e.g., shaking, trembling)
- Let the body complete the response naturally

Phase 5: Installation of Positive Cognition

Whatever doesn't match the new PC will come up here.

Therapist role:

- Connect with the positive
- Process anything that gets in the way

Always check at the start of this phase to see if a new, more adaptive PC has emerged.

Phase 6: Body Scan

This phase continues the reprocessing

Bring up the new positive belief

Whatever doesn't fit with that belief will "speak" through the body

Therapist watches for:

- Tension
- Tightness
- Discomfort

And stays curious:

💬 *"Just notice that."*

💬 *"Let's see what wants to happen."*

Phase 7: Closure

Closure resets the nervous system, regardless of whether reprocessing was complete or not – closes the Memory Network.

Check client's level of presence

Shift focus to the present moment and safety if needed

There are two types of closure:

Incomplete Session

- See what the client needs
- Suggest a resource to increase regulation and safety

Complete Session

- Invite the client to savor the transformation

Phase 8: Reevaluation

Reevaluation happens at the beginning of every session after the first.

Ask:

💬 *"What has changed?"*

Stay focused on:

- The presenting issues
- The shifts after processing

📝 **Clinician Note:** Many clients are used to focusing on what's not working. Bring attention to change — even subtle progress.

Review of the Adaptive Information Processing (AIP) Model

(Shapiro, 2001; Shapiro, 2006)

The Adaptive Information Processing (AIP) Model is based on the idea that uch of psychopathology results from:

- Maladaptive encoding of traumatic or disturbing events
- Incomplete processing of adverse life experiences

When experiences are not fully processed, they are stored in the emotional part of the brain without a "time and date stamp."

Later, when something in the present activates these memories, the nervous system responds as if it is happening now — what may appear as an "overreaction."

AIP Focus in EMDR

We are not just looking at the past — we are looking at how early experiences are stored and organized in the present moment.

We ask:

💬 *"What is the organization of that experience in the present?"*

💬 *"How are past experiences manifesting now?"*

This lens helps:

- Map the treatment
- Predict blocks
- Anticipate outcomes

Basic Hypotheses of the AIP Model: It is a Physical System

The neurobiological information processing system is:

- Intrinsic
- Physical
- Adaptive

This system:

- Integrates internal and external experiences
- Translates experiences into physically stored memories

📝 **Clinician Note:** EMDR taps into this built-in system, helping the brain do what it was designed to do — process and integrate experiences so the client can live in the present.

Memory Networks

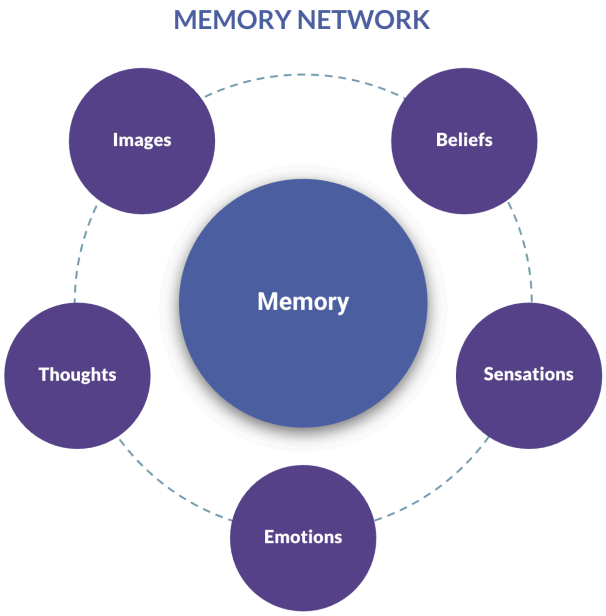
A foundational concept in EMDR and the Adaptive Information Processing (AIP) model

Memories are stored in associative memory networks, which are the foundation of our attitudes, beliefs, and perceptions

These networks contribute to both pathology and health.

Trauma disrupts normal adaptive information processing, leaving unprocessed material dysfunctionally stored in memory networks.

As new experiences occur, they link into previously stored memories — shaping how we interpret, feel, and behave in the present.



It's Both What Happened… and What Didn't Happen

Trauma includes more than just big "T" events. It's not just what happened—it's also what was missing.

Trauma can include:

- Criterion A events as defined by DSM-IV and DSM-5

and/or

- Neglect or abuse that undermines:
    - A person's sense of self-worth
    - Safety
    - Capacity to assume appropriate responsibility (for self or others)
    - Sense of control or agency
    - Perceived access to choice

📝 **Clinician Note:** The absence of safety, care, or attunement can be just as disruptive as overt trauma. Both shape the memory networks we work with in EMDR.

Memory Networks and How EMDR Facilitates Change

Understanding how trauma becomes stored—and how healing unfolds

Traumatic Events Get "Stuck" in the Brain

- When an experience is accompanied by high levels of disturbance, it may be stored in what functions like the implicit, short-term memory system.
- These memory networks contain the perspective, affect, and sensation of the disturbing event.
- These memories are stored in a way that does not allow connection with adaptive memory networks.
- When triggered, they feel like they are happening now.

Triggers Reactivate the Past in the Present

- Internal or external events can activate these unprocessed memory networks.
- When this happens, the negative affect, perspective, or body sensation rises to the surface — and again, it feels like it's happening now.

The Negative Is Reinforced

"Ah… more proof the lie is true."

- This builds out the dysfunctional memory network.
- Each reactivation can reinforce the earlier negative experience, making it stronger and more believable.

The Answer and Positive Information Are Also Stored

- It's not just trauma that's stored in memory networks.
- Adaptive information, resources, and strengths are also stored.
- EMDR facilitates direct processing of the unprocessed material, allowing it to:
    - Link into adaptive memory networks
    - Transform all components of the original memory
- Non-adaptive perceptions, affects, and sensations are discarded
- Useful learning and wisdom is retained.

How Memory Storage Changes With Processing

According to research (Stickgold, 2002), as processing occurs, EMDR facilitates a shift from:

- **Implicit (nondeclarative) → explicit (declarative) memory**
- **Episodic → semantic memory**

The client's experience of time, identity, and symptoms becomes more integrated and accurate.

The System Rebalances — and Transformation Happens

Processing causes an adaptive shift.

- Symptoms reduce
- Previously limiting beliefs are replaced by adaptive ones
- The brain integrates new, useful information and lets go of the old
- Emotional reactions become appropriate to the present
- Sense of self strengthens

When this shift happens, there is room for change.

Final Notes on How EMDR Supports Change

- The EMDR protocol, combined with dual attention stimuli (e.g., eye movements), supports this processing and helps rebalance the system.
- Adaptive learning is retained; maladaptive content is let go.
- New links are made to positive networks that were previously unavailable to the dysfunctionally stored memory.

Common Things a Therapist Has to Unlearn When Practicing EMDR Therapy

1. Thinking that the client needs to be completely stable in every way prior to starting EMDR processing.
    - Many clients will not be completely stable without doing the EMDR processing phases.
    - The client just needs to be stable enough to be safe during the processing.
2. Wanting the client to feel better.
    - With EMDR, we are accessing the root of the current issue, and when it is appropriately accessed there can be a high level of emotion.
    - Although we work to keep the client in the Window of Tolerance, the top of that Window is often where change can happen.
3. The therapist believing they are the healer with tools to give the client.
    - With EMDR therapy, we set the conditions for the client's own healing to happen.
4. Believing that the therapist is "making the client worse" when the client feels deep emotional pain.
    - The expression of deep emotional pain is common and a good sign — as long as the client is moving and changing in the process, is still in the Window of Tolerance, is present, and has dual attention.
5. Needing to know and understand exactly what the client is experiencing in Phases 3–6.
    - At times, the client may have an association that the therapist does not understand or does not feel is related.
    - The therapist should either keep going or have the client check in on the original memory if they feel lost.

What Can Happen When the Touchstone Memory Has Not Been Reached

- Client gets worse without relief
- "The Answer" shows up to block processing
- Flood of multiple memories
- Somatic symptoms, especially preverbal sensations with no clear narrative

These signs don't mean EMDR isn't working—they mean the system is pointing toward something deeper.

Reviewing 8 Phases of EMDR

Review Phase 1: History Taking in the AIP Model

(Based on Chapter 4, Shapiro, 2001)

Common Mistakes in Phase 1

Therapists often make the following mistakes when beginning EMDR work:

- Asking about trauma memories too early or taking a trauma narrative
- Not assessing current resources or emotional regulation ability first
- Skipping the Dissociative Experiences Scale (DES)
- Failing to identify the client's "Answer" before discussing trauma
- Not taking a full history because the client was referred "just for EMDR processing"
- Not exploring what it's like to be the client
- Not clarifying what the client hopes to gain from therapy

Safety and Stability First

During history taking, we are first assessing the client's strengths and ability to regulate emotion.

- We look for what is overdeveloped and underdeveloped in the client's patterns
- Use the **Client Readiness Checklist** to make sure you've considered all areas

  📝 *Note: You do not need to go through the checklist with the client — it's a tool for the clinician to ensure key areas are addressed before moving into Phases 3–7*
- Phases 1 and 2 go hand in hand — history taking and preparation happen together.

  As you gather information, you are also identifying what resources the client already has and what resources they need in order to move forward.

AIP Lens: What We're Really Asking

We are always holding the AIP lens and asking:

- How are past experiences manifesting in the present?
- What was the client's original response to those early experiences — and how might this emerge during therapy?
- Is the client able to be honest and give feedback about their experience in therapy?

- Do you understand the client's attachment patterns and relevant cultural factors?
- Are you aware of any maladaptive resources (e.g., addiction, suicidal thoughts) that may currently be helping the client cope?
- Do you have a clear clinical roadmap and treatment plan prior to starting processing?
- Do you know the early events that are likely driving the client's current stressors?

Review Phase 2: Preparation Phase

Common Mistakes in the Preparation Phase

- **Staying too long in this phase** because it's pleasant to work on resources — even when the client already demonstrates the ability to stay safe and manage affect
- **Rushing through this phase** based on the client's verbal assurance without observing them demonstrate regulation skills in session
- **Not fully understanding the client's strengths** — including how those strengths might block processing
- **Overlooking what is underdeveloped** in the client, which could create difficulty in later phases
- **Relying only on written informed consent without taking time to discuss**:
    - The nature of trauma
    - How EMDR works
    - The possibility of urges from past addictions resurfacing
    - The likelihood of deep emotional pain surfacing

📝 **Clinician Note:** Normalize these experiences as part of the healing process.

- **Failing to explain the AIP model** — particularly how current issues may be manifestations of past experiences stored in the brain in a way that causes overreactions in the present
- **Assuming a client cannot proceed to reprocessing if they cannot do the Calm Place Exercise**
- **Continuing the Calm Place Exercise even when it becomes distressing** — rather than pausing and switching to another resource

Preparing for Reprocessing (Phases 3–7)

In Phase 2, we are making sure the client:

- Understands the EMDR therapy model and the treatment plan
- Has enough trust in the clinician and therapy process
- Has demonstrated the ability to stay within the Window of Tolerance

📝 **Clinician Note:** Spend only as long as needed in this phase. We do not want to delay reprocessing longer than necessary, since reprocessing is what brings relief.

The Role of "The Answer" and Predicting Blocks

In this phase, we are observing the client's "Answer"—the protective pattern developed through attachment and trauma.

- We look for Dangerous and Annoying tendencies that might interrupt or block reprocessing.
- Understanding the "Answer" ahead of time helps the clinician plan how to work with it when it shows up in processing.

📝 **Clinician Note:** Taking time to understand these patterns makes reprocessing significantly more effective

Review Phase 3: Assessment Phase

Flipping on the Switches

In Phase 3, the therapist is activating the memory by asking a series of structured questions. Each question is designed to stimulate a different part of the brain and stored memory — lighting up the various ways the client may process.

Think of this phase as "flipping on the switches" — activating the memory networks so processing can begin in Phase 4.

The only "assessment" the therapist is doing is observing how the memory is currently held in the client's system — not evaluating the client's thoughts or behavior.

Key Reminders

- Negative Cognition (NC) is used to activate the affective circuits in the brain.
    - After Phase 3, the therapist should not bring up the original NC again during reprocessing for that specific target.
- We are not trying to change the client's cognition during this phase.
    - Our goal is to access the root of the disturbance so the presenting issue can resolve.

- Before asking the first question in Phase 3, the therapist should:
    - Confirm the client's seated position
    - Check the speed and distance for bilateral stimulation
    - Be ready to transition immediately into Phase 4

Once the memory is activated in Phase 3, **do not interrupt the process**. Transition straight into reprocessing.

Common Mistakes in Phase 3

- **Talking too much or repeating what the client says**
    - The therapist's role is to ask the scripted questions, light up the memory, and move on — not explore or process yet.
- **Not keeping the client in the present**
    - Clients may respond as if they're being asked how they felt at the time of the event.
    - 📝 **Clinician Tip:** *Gently redirect with:*

      💬 *"What about right now, in this moment?"*
- **Exploring or reworking the NC**
    - The correct NC should already be identified in Phase 2.
    - If needed, simply check:

      💬 *"Last time you said it was 'I'm not good enough' — does that still fit?"*
- Delaying Phase 4
    - The therapist must be fully prepared to move from activation to reprocessing without interruption.

Review Phase 4: Desensitization Phase – A Reprocessing Phase

Phase 4 Is Like a Three-Act Play

Act 1: Clearing the First Channel

💬 *"What do you notice now?"*

💬 *"Go with that."*

Repeat until the response becomes positive, neutral, or stops changing.

Act 2: Clearing Other Channels / Returning to Target

💬 *"When you go back to the original memory now, what do you notice?"*

💬 *"Go with that."*

Repeat until returning to the target yields no additional disturbing information.

Act 3: Completing Phase 4 / Checking SUD

💬 *"When you go back to the whole memory, how disturbing does it feel to you now on a scale of 0 to 10?"*

💬 *"Go with that."*

💬 *"What do you notice now?"*

💬 *"Go with that."*

Repeat until you get two 0s.

What You're Doing in This Phase: Key Concepts

Moving and Changing

In this phase, the therapist helps the client access how the memory is stored and move through the activation.

- Change (either more or less activation) is a sign that reprocessing is working.

Window of Tolerance

The therapist is tracking the client's presence and ensuring they stay within the Window of Tolerance.

- Feedback between sets helps the therapist assess if the client is too far in or out of the memory.
- Use tone and short phrases like: "Yeah, just notice that" to assist the client if affect is high.

Past Patterns Show Up

Everything that emerges during reprocessing should be seen through the AIP lens.

Ask:

💬 *"I wonder if that's what happened at the time?"*

💬 *"Do you think that's what you did back then?"*

These questions can help keep processing moving.

Welcoming Deep Emotional Pain

- Emotional release is normal and often a good sign.
- Many clients have never had space to express deep sadness or grief that often is present with attachment loss or trauma..
- A gentle reflection like *"Yeah, a lot of sadness, huh?"* helps normalize and allow the feeling.
- This kind of support can be the missing experience for many clients.

Body Sensations May Be Earlier or Preverbal Memories

Sometimes, clients get stuck in a disturbing body sensation. This may signal:

- A feeder memory surfacing spontaneously
- A later memory trying to enter the processing stream
- A preverbal memory showing up as sensation

If it's a new feeder memory:

- If there's enough time left, shift the focus to this new memory and reprocess.

If it's a different memory surfacing near end of session:

- Ask the client if the sensation feels like a new memory.
- If yes, acknowledge it and assure the client you'll return to it next session.
- Redirect back to the original memory.

For preverbal memories:

- Sometimes the client can just notice the sensation without attaching story or emotion (Ogden, 2002).
- Other times, the memory may need to be processed through Phases 3–7, even if it's just based on a story the client has heard.

📝 **Clinician Note:** If the memory has a charge, it can be processed using the standard protocol.

Returning to the Whole Memory

When checking on the original memory, use:

💬*"When you go back to the original memory, what do you notice now?"*

Don't pair it with the NC or ask how they feel, think, or believe.

Just ask about the memory as it is.

Checking the SUD Scale

- Only check SUD when you believe the client is near the end of processing.

📝 **Clinician Note:** Use the script as written. No paraphrasing—JUST READ IT.

Common Mistakes in Phase 4

- Starting with anything other than:

  💬 *"I'd like you to bring up the memory, those negative words (repeat the NC), notice where you are feeling it in your body, and follow my fingers."*
- Bringing up the NC again when checking back on the target.
- Not tracking the client's Window of Tolerance — especially if they are either too activated or too detached.
- Stopping the client's deep emotional response by asking, "Are you okay?" or "Do you want to stop?"
- Misunderstanding the goal: we are seeing how the memory is stored now, not how the client thinks about it.
- Missing the client's Answer when it surfaces.
- Avoiding or shutting down emotional release.
- Interrupting reprocessing to do resourcing when the client is actually in active, productive processing.
- Not reaching the touchstone memory, which can result in spinning or stuck processing.
- Not recognizing when a stuck body sensation is linked to:
  - a feeder memory
  - a later memory trying to surface
  - a preverbal memory
- Stopping at a 1 or only checking for a single 0 — both are incomplete sessions.
- Moving to Phase 5 without meeting the criteria for a complete session.
- Guiding the client to only one part of the memory when they are instructed to revisit the whole thing.
- Checking SUD too early.

    - It should only be checked when the therapist feels the client is near the end of processing.
- Not following protocol wording exactly. As Nike says, JUST READ IT.

Review Phase 5: Installation Phase

Phase 5 is still a reprocessing phase.

- By bringing up the desired Positive Cognition (PC) along with the original target memory, we are accessing any remaining disturbance that might be blocking full belief in the positive statement.
- Any part of the client that does not believe the PC will be activated, and dual attention stimulus (DAS) can help release any residual activation.

In addition to continued reprocessing:

- Pairing the PC with the memory strengthens the client's positive memory networks.
- Even though this is still reprocessing, Phase 5 is often shorter than Phase 4.
- The BLS/DAS remains long and fast in this phase.

Common Mistakes in Phase 5

- Believing we are trying to change the cognition or use cognitive restructuring
- Confusing this phase with the Future Template
- Not asking if there is a new, even better Positive Cognition than the original
- Not continuing with long and fast BLS/DAS
- Confusing this phase with the Calm Place exercise
- Moving on to Phase 6: Body Scan when the client has not yet reached a VOC of 7 (or a strong 6)

📝 **Clinician Note:** If the client does not reach a 7—or a clearly strong 6—the session is not yet complete. Stay in Phase 5 until the client reaches full belief in the Positive Cognition.

Review Phase 6: Body Scan

Residual Reprocessing

Phase 6 is still a reprocessing phase.

In Phase 6: Body Scan, the therapist pairs the Positive Cognition (PC) with the original memory and instructs the client to:

> 💬 *"Scan through your body, beginning at the top of your head and moving down. Let me know if you notice any tension, tightness, or unusual sensation."*

Whatever the client reports—even if they think it's unrelated or due to something external (e.g., "I think it's just the chair")—the therapist should still say:

> 💬*"Just notice that,"*
>
> and begin a set of dual attention stimulation (DAS).

If the sensation worsens or doesn't change, the therapist should consider:

- A feeder memory surfacing
- A later memory emerging and trying to get processed
- A preverbal memory appearing

Clients often have a sense if the sensation is connected to a different memory.

📝 **Clinician Note:** With clients who have complex trauma and many memories, this is common. Normalize it.
For example: *"Your system is trying to let go of everything at once. What's coming up is important. Let's make a plan to return to it next time."*
This helps the client **contain** the material until the next session.

If the Body Scan Feels Incomplete

While it's less common to have an incomplete session in Phase 6, it's possible.

If the client cannot get a clear body scan, the therapist should help the client return to a neutral or positive state:

- Use the incomplete session script
- Help the client access a calming resource like Calm Place or Container

📝 **Reminder:** Once the client has developed Calm Place using the full Calm Place Exercise script, the therapist does not need to read the script again or use DAS to access it.

The client should be able to access it independently and practice outside the office.

Simply prompt:

> 💬*"Can you bring up your Calm Place?"*

Common Mistakes in Phase 6

- Confusing this phase with relaxation-focused body scans
- Forgetting that this is still a reprocessing phase
- Overlooking the possibility of preverbal, feeder, or later memories surfacing
- Skipping DAS when the client reports a body sensation they think is unrelated (e.g., "It's just the chair")

Review Phase 7: Closure

Closing Down the Networks

Purpose of Closure

The goal of Phase 7: Closure is to ensure the client is in a safe, contained, and stable state before leaving the office.

- The therapist is assessing the client's current state and making sure they are:
    - Present
    - Grounded
    - Able to manage affect
- When doing Phases 3–7 for the first time with any client, the therapist should leave at least 15 minutes at the end of the session for this phase.

Supporting Containment

If the client is still emotionally activated, the therapist can gently shift the client's attention by:

- Asking about upcoming daily activities

  Example: *"What do you plan to do when you leave here today?"*
- Encouraging the client to plan or think ahead

This activates a different part of the brain and helps bring them back to the present moment.

📝 **Clinician Note:** Phase 7 is not optional or a quick wrap-up. It is a **critical safety step** that ensures the client is ready to leave the therapeutic space and engage in the rest of their day.

Common Mistakes in Phase 7: Closure

- Not confirming the client is present and able to regulate before the session ends

- Rushing the phase or not leaving enough time to help the client shift to a neutral state
- Not recognizing that there are two types of closure:
    1. **Complete Closure** — when processing feels complete and the client reaches a place of resolution
    2. **Incomplete Closure** — when processing is not yet finished and the client is helped to return to stability using resources (e.g., Calm Place, Container, Incomplete Session Script)

Review Phase 8: Reevaluation

Reviewing and Adjusting the Treatment Plan

Three Types of Reevaluation in Phase 8

1. Reevaluation of the target memory that was previously worked on
2. Reevaluation of the treatment plan to see what memories still need to be targeted and check each of them to see if there is still a "charge" to them

    📝 **Remember:** If you access and process the touchstone (earliest memory), other related memories could already have been processed.
3. Reevaluation of the client's complete treatment plan prior to termination

In the Reevaluation Phase, the therapist asks general questions about what the client has experienced between sessions.

Asking about present triggers is an important part of this process.

We are always looking at how the treatment is impacting the presenting symptoms.

Common Mistakes in Phase 8: Reevaluation

- Not asking about the presenting issue or original symptoms
- Assuming the client's system hasn't processed anything between sessions
- Chasing COWs (Crisis of the Week) instead of staying aligned with the treatment plan
- Failing to check back on the last target memory
- Overlooking that other related memories might also be resolved
- Not tracking overall progress or new information

Section X: Review of Treatment Planning

Review of Completing the Treatment Plan

Target Events in the Treatment Plan

Each event in the treatment plan should be a specific moment in time.

- Ideally processed in chronological order, from youngest to oldest.
- At times, more recent memories may also be processed when earlier ones are accessed and resolved.
- Note that each memory may require a full session or more, especially if the session becomes incomplete and must be resumed.

Re-accessing an Incomplete Target

If a target wasn't fully processed, restart in Phase 4 using these questions:

💬 *"What is the image that is the worst part of this memory now?"*

💬 *"What emotions are you feeling now?"*

💬 *"On a scale of 0–10, how disturbing does that feel to you now?"*

💬 *"Bring up that memory, notice where you feel that disturbance in your body, and follow my fingers."*

Reprocessing a New Target

Once a target memory is completely processed, move to the next chronological memory that still has a charge.

- Use Phases 3–7 to process the new target.
- The process is the same, but the **selection of the target is a clinical decision**, not the client's.

📝 **Clinician Note:** Letting the client choose the target would be like a patient with appendicitis choosing whether to have their appendix or spleen removed. The clinician is the expert and is responsible for selecting the appropriate target based on clinical judgment and the treatment plan.

Exceptions to Chronological Order

There are times when starting with the earliest memory is not possible:

- A more recent memory may intrude and need to be processed first.

- For clients overwhelmed by trauma, it may be clinically appropriate to begin with a more recent or manageable event.
- In these cases, use the EMD protocol to help contain and restrict processing as needed.

Review of Reprocessing Present Triggers

Present Triggers refer to how the presenting issue shows up in the client's current life.

- The Present Trigger should be a specific moment in time, not just a general issue.
- For example, instead of "anger with my son," the client should identify a specific moment when that anger was activated.

📝 **Clinician Note:** Identifying a specific moment helps create a clearer target and sets the stage for future-oriented work, where the client can begin to envision new patterns and responses.

Using Present Triggers in EMDR Processing

- Once the specific Present Trigger is identified, use it as the target memory in Phase 3.
- Then proceed with Phases 3–7 using the standard EMDR protocol.

Tracking Progress

- Evaluate Present Triggers in every session to assess treatment progress.
- During Phase 8: Reevaluation, revisit Present Triggers to see whether the client's activation to them has decreased.
- Always keep sight of why the client came into treatment and whether they are making the changes they desire.

📝 **Clinician Note:** Monitoring the client's goals and Present Triggers helps ensure EMDR therapy is making meaningful change in their daily life.

Review of the Future Template

The Future Template is a very important part of the EMDR protocol—and one of the most neglected by therapists.

The purpose of the Future Template is to help the client look at present problems and triggers and determine how they would like to respond, behave, or feel in the future for each one of them.

Getting a vision for the future is an important part of actually making that happen. This is not just a fun or optional activity—it is an essential step in ensuring that the brain's neural networks begin to create new, adaptive pathways.

A Different Protocol

The Future Template uses its own protocol, which is different from the basic EMDR protocol.

In this phase:

- The client is asked to run a mental movie of their desired future response while also holding the Positive Cognition (PC).
- The therapist instructs the client to notice any roadblocks, negative cognitions, or sensations that come up.
- If any disturbance arises, the therapist helps the client process it using Dual Attention Stimulation (DAS).

If the client does not run into any blocks and instead experiences positive responses while running the movie, the therapist will:

- Encourage the client to notice the positive, and
- Use DAS to help strengthen those new, adaptive pathways.

Supporting Clients Who Struggle with Visualization

Some clients may have difficulty connecting with a clear visualization of their future desired state. In that case:

- The therapist can assist by offering suggestions or narrating a specific scenario to help build the vision.
- If the client has a neutral or flat response, the therapist might offer an example like:

  💬 *"Would you like it if the next time your son leaves his dishes in the living room you could calmly ask him to come and get them without losing your temper?"*

- Then, help bring that scene to life:

  💬 *"So imagine walking into your house tomorrow after work and seeing the dishes in the living room…"*

Section XI: Special Considerations and Special Populations

This section will cover EMDR with the following considerations:

- Cognitive Interweaves
- Somatic Processing
- Incomplete Action
- EMDR for Chronic Pain
- Children
- Dissociation
- Phobias
- Substance Abuse
- Couples
- Military/First Responders
- Complicated Grief

Cognitive Interweave *(Shapiro, Ch. 10)*

The purpose of the Cognitive Interweave is to keep processing moving. It is called a Cognitive Interweave because it originates from the therapist. However, it may also be a movement or an experience.

A Cognitive Interweave is a brief statement or suggestion made by the therapist that may do one or more of the following:

- Provide missing information
- Activate currently held information
- Encourage generalization effects
- Assist the client in connecting to the present issue

This requires the therapist to be attuned and resonant with the client's system. The therapist is offering the next step in healing for the client.

📝 **Clinician Note:** Often, the client will arrive at this next step on their own. Unless the client appears to be out of the Window of Tolerance, allow a few additional DAS sets before offering a Cognitive Interweave—even if you've already thought of one. An attuned therapist may be one step ahead, but still allows the client space to get there first.

When to Use a Cognitive Interweave

- The client is looping
- Time is running out in the session
- The client appears to be out of the Window of Tolerance
- There is a lack of generalization

A Cognitive Interweave may also be the therapist offering a missing experience to the client. This should only be used when needed, and not as an attempt to prematurely bring the client into a more positive state.

📝 **Clinician Note:** This is not about cognitive restructuring or trying to make the client "think differently." It is simply about unblocking the process when the client cannot move forward on their own.

Example: A client who is processing early sexual abuse uses the stop signal. The therapist stops and then offers:

💬*"Can you notice that I stopped when you asked me to?"*

This provides the client with a new experience—having their boundary respected.

Types of Cognitive Interweaves

Cognitive interweaves offer support when processing stalls. They may:

- Offer new information through an experience, education, or new perspective
- Stimulate currently held information

These may take the form of:

- A direct question or statement
- Recognizing when "The Answer" is surfacing
- Activating the adult perspective
- Activating the perspective of a known resource
- Addressing common trauma-related misconceptions

Themes and Sample Uses

Responsibility

It is common for victims, especially children, to blame themselves. The therapist can:

- Offer a statement that differentiates age and responsibility (bring in the adult perspective)
- Help the client recognize the belief as "a lie"

Examples:

💬 *"How old were you?"*

💬 *"Do you know any 7-year-olds? Would you blame them if this happened?"*

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

Safety

Bringing the client into the present and helping them remain in the Window of Tolerance:

💬 *"How old are you now?"*

💬 *"Are you safe right here, right now?"*

Recognizing the current sense of not being safe as "a memory."

💬 *"Would you like that disturbance to be just an awareness?"*

💬 *"Where are you now?"*

💬 *"Are you here with me now?"*

💬 *"Where is [name of perpetrator] now?"*

Use orienting resources from the Somatic Resources section:

💬 *"Look around the room now — are you safe here?"*

💬 *"Yeah, it felt like you were going to die… but you made it, right?"*

Power / Control / Choices

- Statements regarding future choices
- Encouragement to learn from the past
- Accessing known resources for helping the child in the memory gain protection

📝 **Clinician Tip:** Your tone and timing matter more than your exact words. Stay attuned and use interweaves as gentle invitations—not corrections.

Other Examples of Cognitive Interweaves

"The Answer" Appears

Bring attention to what's already surfacing:

💬 *"Do you think that is what happened at the time?"*

💬 *"Yeah… that was really helpful at the time, huh?"*

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

Psychoeducation

Carefully used educational insights can validate the client's experience:

💬 *"Did you know it's normal in trauma to have symptoms instead of memories?"*

💬 *"Did you know that in pervasive abuse, it's common for the person being abused to initiate the abuse?"*

Deep Emotional Response

Support the client in staying present with sadness:

💬 *"Yeah… yeah… a lot of sadness."*

💬 *"Yeah… it's been here a long time."*

💬 *"You've had to hold that sadness in for a long time."*

💬 *"Yeah… is it okay to just stay with that sadness?"*

Somatic Processing *(Ogden, 2002)*

This is considered **an advanced technique**, and the EMDR Basic Training does not teach clinicians to use Somatic Processing independently. As with all specialty topics in this manual, this section is intended to introduce the concept for exposure — not for clinical application without further training.

Somatic Processing is often used for:

- Preverbal memories
- Traumatic memories involving intense fear or where fear is strongly associated with body sensations

The goal is to uncouple the fear or trauma story from the body sensation, which helps release excess arousal from the nervous system.

How to Recognize the Need for Somatic Processing

You may consider using Somatic Processing techniques when:

- The client is stuck in a fear response and appears to be out of their Window of Tolerance
- The client begins trembling, shaking, or experiencing intense somatic activation

What to Do

1. Let the client know what you're noticing

   💬 *"I'm noticing a high level of fear"* or *"I'm noticing you're shaking a bit."*

2. Invite the Client In & Offer Intervention

   💬 *"Would you like to try something that may help release the excess arousal from your nervous system?"*

3. Guide Their Attention to the Body

   💬 *"Would you be willing to focus on the [insert sensation — shaking, trembling, tingling, etc.]?"*

4. Set the Intention

   💬 *"Can you put the story aside for a moment and just follow the [body sensation]?"*

5. Encourage Release — Don't Stop It

   - Prompt the client to allow the sensation to happen without making it bigger or stopping it:

     💬 *"Good, just keep allowing the shaking to shake itself."*

     💬 *"Great, just keep following the shaking — allow it to be as big as it needs to be."*

💬 *"You're doing great. This is the normal release of excess arousal from your nervous system."*

What to Expect

- Somatic release often intensifies gradually, then drops off.
- The sensation may move through the body (e.g., arms → legs).
- Once the nervous system begins to release arousal, the client may access developmental or attachment trauma connected to the experience.
- If time allows, this may naturally lead into emotional processing, such as sadness or grief.

Incomplete Action

A Type of Somatic Processing

Another form of Somatic Processing involves **completing an incomplete action**. This occurs when a client was unable to complete a protective or defensive movement during a traumatic experience. Allowing that action to happen — within the safe environment of the therapy office — can offer profound relief and resolution.

📝 **Note:** This is considered an advanced technique, but elements of it may be useful within EMDR, particularly as a form of Cognitive Interweave.

What Is an Incomplete Action?

An incomplete action is a physical movement the client wanted or needed to take in a past situation but could not — such as running, pushing, or protecting themselves.

Trauma often freezes these actions in the nervous system. Allowing the client to complete the movement in the present can help discharge stored arousal and support healing.

When to Use This Technique

You may observe signs during processing, such as:

- The client's feet begin to move or shake, but they appear stuck
- Tension in the arms or legs that doesn't resolve with standard reprocessing
- The client appears immobilized or trapped in the memory

How to Introduce the Intervention

Use gentle language to reflect and invite:

> 💬 *"I'm noticing your feet are moving a little — would you like to try an experiment?"*

Example: Running or Kicking Motion

> 💬 *"Would you like to try allowing your feet to move in a running-in-place motion, as long as it feels good?"*

💡 The phrase *"as long as it feels good"* is essential — it keeps the client within the Window of Tolerance.

Let the client move naturally and observe what shifts.

Example: Pushing as a Protective Gesture

When working with a client stuck in anger or immobilization, you might say:

💬 *"Would you like to try something? I wonder what it would be like to push against the wall — only as much as feels good."*

💡 The therapist can gently model this by demonstrating a light push against the wall.

After the Movement: Continue Reprocessing

After completing the movement:

- Ask the client for a brief report on what they noticed

  💬 *"What do you notice now?"*

  💬 *"Let's go with that."*

- Resume reprocessing with DAS as appropriate

This technique often unlocks the next phase of processing and allows the client to move forward with greater ease.

EMDR for Chronic Pain

Core Concepts

- Persistent pain is a symptom, not the problem.
- Pain originates in the brain, not the body's tissues.
- The purpose of pain is to protect the body and facilitate healing.
- Pain is a matter of perception—how the nervous system interprets signals—and that perception is sometimes incorrect, causing pain to persist even when no tissue damage is present.
- Pain can be stored in maladaptive memory networks, along with related images, beliefs, emotions, and sensations.
- EMDR can help reprocess pain by accessing and resolving the root memory networks.

📝 **Clinician Note:** Adverse Childhood Experiences (ACEs) are often at the root of chronic pain. They shape the nervous system's sensitivity to stress, perception of safety, and development of over-adapted personality traits (often "The Answer").

Chronic Pain and the AIP Model

According to the AIP model, most symptoms stem from maladaptively stored earlier experiences.

EMDR clinicians use this model to anchor treatment, understanding that symptoms like panic attacks, depression, intrusive thoughts, and pain are indicators of deeper roots—not the root themselves.

💡 **Analogy:** A runny nose isn't the illness—it's a symptom of something deeper. Similarly, chronic pain is often a symptom of unprocessed trauma.

The Medical Model vs. EMDR Perspective

Traditional medicine often focuses on tissue damage, but many cases of chronic pain persist without physical explanation.

Lorimer Moseley, an Australian physiotherapist, defines pain as:

> "Pain is produced by the brain after a person's nervous system has been activated and concluded the body is in danger and action is required."

📝 **Clinician Note:** This highlights that pain is a brain-based perception, not always linked to actual injury.

How Pain Gets Wired into the System

- The brain creates a neural network between the body and brain, localizing the pain signal to an area needing "protection."
- This helps prevent further injury—but sometimes the brain gets it wrong.
- Pain may persist unnecessarily or exist without damage, particularly in individuals with early trauma or disrupted attachment.

Pain becomes another maladaptive symptom, much like anxiety or depression, which places it within the EMDR therapist's scope.

AIP + Pain = "The Answer"

- Maladaptive experiences form associative memory networks that encode thoughts, emotions, and sensations—often as part of "The Answer."
- If trauma is unprocessed, the nervous system may embed pain as part of its response pattern.
- Present-day triggers can reactivate the original pain network, reinforcing the pain loop.

Over time, this network becomes sensitized and wired in, even when no injury exists.

EMDR can reprocess these networks, releasing the pain stored alongside unprocessed memories.

Acute vs. Somatized Pain

- Acute pain from injury usually resolves with medical treatment.
- Somatized pain persists despite medical care and often lacks a physical cause.
- Clients may meet DSM-5 criteria for Somatic Symptom Disorder (SSD) when emotional/psychological distress manifests as chronic pain.

📝 **Clinician Note:** SSD = opportunity for healing. The client's pain may be real—but rooted in unresolved trauma rather than body tissue.

Summary

Believing all pain is from the body is like believing your nose is defective because it's running. Just like a runny nose is a symptom of a virus, chronic pain is often a symptom of adverse experiences.

EMDR can help reprocess the source of these experiences—just like with other trauma-related symptoms.

Finding the Targets: Getting to the Root of Chronic Pain (Script)

Presenting Issue

Explore the client's experience of pain—including sensation, thoughts, and emotions.

> 💬*"How would you describe the pain in terms of how it feels physically?"*

📝 **Clinician Note:** *Encourage the use of descriptive words like hot, sharp, jagged, etc., to connect the client directly to the sensation.*

Worst Part

> 💬*"When you notice the sensation of pain and you think about how it impacts your life, what's the worst part of it now?"*

📝 **Clinician Note:** Look for an emotional connection that goes beyond *"It hurts."* Example client response: *"I'm afraid I'll never get better."*

Present Triggers

Ask the client for examples of how the pain shows up in various areas of their life.

Trigger #1 – Recent Example

> 💬*"Please tell me a recent time that would be an example of this."*

Trigger #2 – Social Impact

> 💬*"Can you give me an example of how this shows up in your life socially?"*

Trigger #3 – Intimate Relationships

> 💬 *"Can you give me an example of how this shows up in your intimate relationships?"*

Trigger #4 – Work Impact

> 💬 *"Can you give me an example of how this shows up in your life at work?"*

SUD (Subjective Units of Disturbance)

> 💬 *"How disturbing is it right now, on a scale of 0–10, with 0 being no disturbance and 10 being the highest disturbance you can imagine?"*

📝 **Clinician Note:** "Disturbance" here refers to the client's full experience of pain, including mental and emotional upset—not just the physical sensation. It's different than asking, "What's your pain level out of 10?"

Negative Cognition (NC)

💬 *"When you bring up this disturbance, what is the negative belief you have about yourself now?"*

Example: "I'm powerless."

Earlier Memories

💬 *"When you bring up the worst part of the pain and the words '___' (insert NC), what is an earlier time you can remember experiencing something similar?"*

💬 *"How about an earlier time?"*

(Continue asking until you reach the earliest—this becomes the Touchstone.)

Future Desired State

Help the client envision a positive future response for each present trigger.

💬 *"Now I would like us to look at each present trigger and decide how you would like to react, behave, or feel in that situation when or if it happens in the future."*

💬*"As you think about the present trigger of ___, how would you like to be able to react, feel, or behave when that or something similar happens in the near future?"*

Pain and "The Answer"

Early Adversity and the Nervous System

Many studies show that adverse childhood experiences can lead to an overly sensitized nervous system, which increases the likelihood of chronic pain later in life. These early stressors shape how a person:

- Responds to stress
- Perceives safety and attachment
- Develops overadapted character traits in response to those stressors (also known as "The Answer")

Two Common Factors in Clients with Chronic Pain

1. Significant childhood abuse and/or neglect
2. Feelings of powerlessness, which may show up as:
    - Guilt
    - Self-criticism
    - Low self-esteem
    - High expectations of self
    - Extreme responsibility for others
    - Self-sacrifice
    - Hypervigilance

📝 **Clinician Note:** Even mild dysregulation rooted in childhood can lead to somatic symptoms. Regardless of severity, it's essential to explore how these experiences are being stored in the client's system and how their "Answer" is interfering with present functioning.

Common Traits in People with Chronic Pain

- Low self-esteem
- Perfectionism
- High expectations of self
- Wanting to be good or liked
- Guilt
- Dependence on others
- Conscientiousness
- Being hard on yourself
- Over-responsibility
- Taking responsibility for others
- Excessive worry
- Indecisiveness
- Powerlessness or helplessness
- Rule-following
- Difficulty letting go
- Cautiousness or shyness

- Repressed thoughts or feelings
- Lack of safety / hypervigilance
- Harboring rage or resentment
- Not standing up for oneself

Common "Answer" Character Types in Clients with Chronic Pain

- The Rock – always strong, never vulnerable
- The Invisible One – avoids attention, needs unmet
- The Emotional One – overwhelmed by emotional sensitivity
- The Nice/Non-Threatening One – prioritizes harmony, suppresses needs
- The Doer – overly productive, avoids stillness
- The Hero – rescues others, neglects self

Chronic Pain Syndromes

- Tension headaches
- Migraines
- Back or neck pain
- Foot pain
- Whiplash
- Fibromyalgia
- TMJ (jaw pain)
- Chronic pelvic or abdominal pain
- Chronic tendonitis
- Vulvodynia
- Sciatic pain
- Repetitive stress injury
- Myofascial pain syndrome

Autonomic Nervous System–Related Disorders

- Irritable Bowel Syndrome (IBS)
- Interstitial Cystitis (irritable bladder)
- Postural Orthostatic Tachycardia Syndrome (POTS)
- Inappropriate Sinus Tachycardia
- Chronic Regional Pain Syndrome (CRPS)
- GERD / Functional Dyspepsia

Other Related Syndromes

- Insomnia
- Chronic Fatigue Syndrome
- Paresthesias (numbness, tingling, burning)
- Tinnitus
- Dizziness
- Spasmodic dysphonia / globus hystericus
- Chronic hives

EMDR with Children

📝 **Note:** For more in-depth training on this topic, explore the 3-hour Advanced Webinar/Distance Learning Seminar at emdr-training.net.

General Considerations

- Children often process more quickly than adults
- They typically have fewer blocks or defenses to processing
- The Standard Protocol can be used with child-friendly adaptations
- It's encouraged to integrate music, art, movement, sand tray, and play across all phases

Phase 1: History Taking

- Gather information from parents/caregivers, school staff, legal professionals, previous evaluations, etc.
- Motivational questions for parents/caregivers:

  💬 *"From 0–10, how desperate are you for this to be better?"*

  💬 *"From 0–10, how much are you willing to be uncomfortable and involved?"*
- Collect information directly from the child (verbal, nonverbal, play themes)
- Use "what likely happened" when direct memory is unavailable
    - E.g., behavior in foreign orphanages or early neglect
- Explore the early years — the child's play themes and stories provide rich clinical insight
- Modify NC/PC into more child-friendly wording
- Use tools like photographs, art, sand tray, and storybooks
- Build a comprehensive Treatment Plan and Targeting Sequence Plan
    - What does the child need more or less of? (e.g., internal/external resources)
    - Identify their primary strategy for managing stress
    - Note favorite characters or toys to reference in later phases

Phase 2: Preparation

- Calm/Safe Place Exercise for kids
- Container Exercise adapted for children
- Work with parents to support stabilization and attachment

    - Weighted blankets or other concrete safety strategies
    - Normalize that behaviors may get worse before they get better
- Provide child-appropriate psychoeducation
    - Books, games, puppets, stuffed animals
    - Children may sit in parents' laps if helpful
- Offer simple brain-based explanations (e.g., how trauma affects the brain)

Phase 3: Assessment

- Use child-friendly language
- Introduce concrete SUD/VOC measurement tools such as:
    - Hand gestures (e.g., showing how big the feeling is)
    - Facial expression charts
    - Magnifying glass or other detecting tool for body sensations

Phases 4–6: Reprocessing

- Children often move around during processing — allow for flexibility
- Shorter sets may be needed due to faster processing
- Some children benefit from concrete SUD check-ins after each set
    - Ask: *"Better?"*, *"Worse?"*, or *"The Same?"*
- Link to positive memory networks using the parent's support or stories
- Incorporate "missing experience" or story-based interweaves to strengthen adaptive learning
- DAS (Dual Attention Stimulus) options for kids:
    - Finger puppets
    - Magic wands
    - Foam swords
    - Child's favorite toy or character
    - Drumming
    - Patty cake
    - Paintbrush strokes on hands or back

📝 **Clinician Note:** Watch for signs of dissociation

Phase 7: Closure

- Provide parents with specific tools to support their child
- Set expectations for post-session responses
- Offer attachment-building activities for the child and caregiver

Phase 8: Reevaluation

- Reassess the previous target
- Complete the Treatment Plan
- Complete the Future Template

Recommended Books on EMDR with Children

EMDR and the Art of Psychotherapy with Children: Treatment Manual
Robbie Adler-Tapia, PhD & Carolyn Settle, MSW, LCSW (2008)| 🔗 Link to Book

EMDR Therapy and Adjunct Approaches with Children: Complex Trauma, Attachment, and Dissociation
Ana Gomez, MC, LPC (2012) | 🔗 Link to Book

Dark, Bad…..Day Go Away: A Book for Children about Trauma and EMDR
Ana Gomez, MC, LPC (2007) | 🔗 Link to Book

The Thoughts Kit for Kids
Ana Gomez, MC, LPC | 🔗 Link to Kit

All the Colors of Me: My First Book about Dissociation
Ana Gomez & Sandra Paulsen | 🔗 Link to Book

Through the Eyes of a Child (Norton Professional Books)
Robert H. Tinker & Sandra A. Wilson (1999) | 🔗 Link 1 | 🔗 Link 2

Small Wonders: Healing Childhood Trauma with EMDR
Joan Lovett, MD (2007) | 🔗 Link to Book

Trauma-Attachment Tangle: Modifying EMDR to Help Children Resolve Trauma and Develop Loving Relationships
Deborah K. Wesselmann (2014) | 🔗 Link to Book

EMDR in the Treatment of Adults Abused as Children (Norton Professional Books)
Laurel Parnell, PhD (1999) | 🔗 Link to Book

Integrative Team Treatment for Attachment Trauma in Children: Family Therapy and EMDR
Debra Wesselmann, Cathy Schweitzer, & Stefanie Armstrong (2014) | 🔗 Link to Book

Eye Movement Desensitization and Reprocessing (EMDR) in Child and Adolescent Psychotherapy
Ricky Greenwald (1999) | 🔗 Link 1 | 🔗 Link 2

Treatment of Traumatized Adults and Children: Clinician's Guide to Evidence-Based Practice
Allen Rubin & David W. Springer (2009) | 🔗 Link to Book

The Whole-Brain Child
Daniel J. Siegel, MD & Tina Payne Bryson, PhD (2012) | 🔗 Link to Book

Parenting from the Inside Out
Daniel J. Siegel, MD & Mary Hartzell (2013) | 🔗 Link to Book

The “Answer” for Kids

Conversation Starters: What They Do Under Pressure or for Comfort

💬 *“When you have time to do anything you want, what do you like to do?”*

💬 *“What’s your favorite thing to do on a Saturday morning?”*

💬 *“What do you usually want to do after a long school day?”*

💬 *“What happens when someone tries to make you do something you don’t want to do?”*

💬 *“What do you usually do when you are really happy?”*

💬 *“How do people know when you’re unhappy?”*

💬 *“Do you like surprises?”*

💬 *“Do you like rules?”*

💬 *“Do you ever cry? Is it usually alone or in front of people?”*

💬 *“What is a recent time you had a lot of fun?”*

💬 *“What’s a recent time you were really frustrated?”*

💬 *“Do you ever get angry? How do people know?”*

💬 *“If you don’t want to do something, how do people know?”*

💬 *“Do you like to make up stories?”*

💬 *“If you want someone to do something for you, how do you get them to do it?”*

💬 *“If someone is doing something you don’t like, what are you likely to do?*

📝 **Clinician Note:** *These prompts are meant to be conversational, not clinical. Listen for how the child navigates pressure, control, emotions, and needs. These are the clues to their version of “The Answer.”*

Therapist Response Example

> 💬 *“So, it sounds like you’re really good at letting people know how you feel.”*
>
> 💬 *“And it sounds like it’s a little harder for you to let other people tell you what to do — like with teachers or parents asking you to do things?”*

You are looking for:

- **What is overdeveloped** (a strategy they’ve mastered or leaned on)?
- **What is underdeveloped** (a skill or trait that’s less accessible)?
- **When did they learn this strategy?** Why did they need to?

Alternative Approach: Superhero Exercise

Another way to explore a child's "Answer" is by creating a Superhero Version of themselves.

- What are your superpowers?
- When do you use them?
- What makes you want to hide them?
- Who are you protecting?
- What helps your superhero feel safe?

This allows the child to express their adaptive strategies through **imagination and play** — providing deeper insight in a non-threatening way.

Negative and Positive Cognition List for Children

Bad/Yucky Thoughts (NC)	Good Thoughts (PC)
I'm bad.	I'm good.
I'm stupid.	I'm smart.
I'm dumb.	I'm smart.
I'm going to explode.	I'm calm.
I'm unwanted.	I'm lovable.
I'm fat.	I'm just right.
I can't get it.	I can learn.
I'm uncomfortable.	I am comfortable.
I blew it.	I did the best I could.
I'm sick.	I'm all better.
I can't trust.	I can trust.
I'm not lovable.	I am lovable.
I'm not safe.	I'm safe now.
May Also Be About the Situation in a Critical Incident:	
I almost drowned.	I'm okay now.
I am scared.	I made it.

EMDR and Dissociative Disorders

Understanding dissociation is crucial for safe and effective EMDR treatment. Dissociation often develops in response to overwhelming trauma that could not be processed adaptively, and it exists on a continuum. Stabilization, assessment, and careful pacing are essential before moving into trauma processing.

Recognizing Dissociation

- Dissociation is a **protective response** when the system becomes overwhelmed.
- It is often seen **when clients move outside of their Window of Tolerance**.
- Dissociated states may hold:
    - Different aspects of the traumatic memory
    - Various animal defense responses (fight, flight, freeze, submit, attach)
    - Fragmented ego states, alters, or parts

The AIP Model supports that:

- The traumatic memory was not sufficiently processed.
- These unprocessed memory fragments can appear as ego states or personality states.
- The host/observer/self may not yet be established with a stable sense of presence.

The Continuum of Dissociation

Dissociation exists on a spectrum, ranging from:

- **Everyday** dissociation (zoning out, daydreaming)
- To **moderate** dissociation (losing time, detachment)
- To **severe** dissociation (amnesia, identity confusion, multiple self-states)

Therapists must consider:

- Symptoms
- How to manage dissociation within session
- Resourcing and stabilization strategies

Phase 1: History Taking

Assess for dissociation before beginning trauma processing.

Use tools such as:

- DES (Dissociative Experiences Scale)
- SDQ-20, MDI, SCID-D

Clinical signs may include spacing out, unexplained amnesia, fragmented narratives, and identity confusion or shifting

📝 **Clinician Note:** Don't expect a full trauma history up front.
Stabilization often comes first.

🔗 *Online resource: International Society for the Study of Trauma and Dissociation*

https://www.isst-d.org/

Phase 2: Preparation

- Focus on resourcing the client with what they need for stabilization.
- Develop a strong therapeutic relationship with consistent safety and boundaries.
- Spend time understanding the client's process.
- Phase 2 may take significantly longer for clients with dissociative disorders.
- Develop a Treatment Plan in collaboration with the client.

📝 **Note:** More advanced training is required to treat Dissociative Disorders.

Phases 3–7: Reprocessing

- Processing may need to move **very slowly.**
- In some cases, eye movements may not be used at all.
- The therapist must continuously monitor:
    - Window of Tolerance
    - Whether the client is present
    - The need to return to resourcing or containment

📝 **Special Consideration:** *For clients with **Dissociative Identity Disorder (DID)** or complex dissociative disorders, advanced training is necessary before beginning trauma reprocessing with EMDR.*

Recommended Books on EMDR & Dissociation

Looking Through the Eyes of Trauma and Dissociation
Sandra Paulsen, PhD | 🔗 Link to Book

Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy
Carol Forgash & Margaret Copeley | 🔗 Link to Book

EMDR Toolbox: Theory and Treatment of Complex PTSD and Dissociation
James Knipe, PhD | 🔗 Link to Book

EMDR and Dissociation: The Progressive Approach
Anabel Gonzalez & Dolores Mosquera | 🔗 Link to Book

EMDR Therapy and Adjunct Approaches with Children
Ana Gomez, MC, LPC | 🔗 Link to Book

Phobia Protocol

(Adapted from Chapter 9, Shapiro 2001)

Research shows that when all steps of the Phobia Protocol are followed, clients have a very high rate of symptom remission. Outcomes are less effective when only partial steps are used.

Phases 1 & 2: History Taking and Preparation

During these phases, focus on education, stabilization, and identifying the root of the phobia.

1. **Psychoeducation on Phobia Symptoms**
    - Explain phobia symptoms, including the concept of "fear of fear"
    - Help the client understand how avoidance and anticipatory fear perpetuate symptoms
2. **Address Secondary Gains**
    - Ask: 💬 *"What does this fear allow you to avoid?"*
    - Explore how "The Answer" may be showing up
3. **Identify the Phobic Target(s)**
    - What beliefs are associated with the phobia?
    - What events trigger the fear response?
    - What physical sensations accompany it?
4. **Teach Self-Control Procedures**

    To help clients manage anticipatory fear:
    - Container Exercise
    - Light Stream
    - Spiral Technique
    - Relaxation Cue / Safe Place

Phases 3–7: Reprocessing

Use EMDR standard reprocessing phases with specific focus on phobia-related targets.

Six Target Categories to Explore (in order):

Target Type	Description

1. Ancillary Events	Other experiences that may be reinforcing or related to the phobia
2. First Time	The earliest memory of feeling this fear
3. Most Disturbing Experience	The strongest or most traumatic memory related to the phobia
4. Most Recent Time	When the fear was last triggered
5. Associated Present Stimuli	Any current triggers (e.g., sounds, smells, images)
6. Physical Sensations or Signs of Fear	Include hyperventilation, heart racing, trembling, etc.

Additional Steps

Create a Future Template

- Develop a positive visualization of fear-free behavior and adaptive response

Action Plan / Behavioral Contract

- Work with the client to create a plan for exposure or real-world application
- Include practical tools and expectations

Visualization & Movie Technique

- Run a mental "movie" of the feared sequence from start to finish
- Reprocess any arising disturbance

Normalize Anxiety

- Prepare the client for some anxiety during real-world exposure
- Offer regulation tools and self-control techniques
- Encourage tracking/logging experiences
- Remind: "There is no failure—only information."

Address Emergent Targets

- Be prepared to reprocess new targets that arise between sessions

📝 **Clinician Note:** If the client becomes stuck or blocked, consider using a Cognitive Interweave to provide new perspective, stimulate adaptive processing, or reduce avoidance.

Addiction Protocol

ACE Score: Adverse Childhood Experiences Study

Online resource: *http://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract*

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

- The greater the exposure to childhood abuse and household dysfunction, the higher the risk for behaviors that lead to addiction and other health risks.
- A person with an ACE score of 4/10 has a 500% increased risk of developing addictions.
- A male with a score of 6/10 has a 4,600% increased risk of using intravenous drugs.

Addictions and the AIP Model

The Adaptive Information Processing (AIP) model guides therapists to look at the root of the current issue.

In addiction treatment, the focus is on identifying and reprocessing the early life memories that were maladaptively stored and now fuel the compulsion.

Addictions may include alcohol, drugs, pornography or sex, gambling, shopping, food, or any behavior that is used compulsively to manage emotional distress

Important: Treating addictions with EMDR requires training in both EMDR **and** addiction treatment to ensure safety and effectiveness.

Addictions as an "Answer"

- Addiction can be viewed as an adaptive response to trauma—it served a regulatory function for the client at some point.
- It is often a tool for **numbing pain** from unprocessed traumatic experiences.
- Even clients who are years into recovery may feel the **urge to use resurface** when they begin accessing the original trauma.

📝 **Clinician Note:** Normalize this response. It's not regression—it's a signal that the client is getting closer to the source of the pain.

Phase 1: History Taking

- Explore current resources, including the addiction itself as a former regulation strategy.

- Do **not** ask about traumatic memories unless the client has already demonstrated affect regulation without turning to their addiction.
- Use "The Answer" exercise to help uncover:
    - Current strengths
    - Overdeveloped traits
    - Underdeveloped coping skills

Phase 2: Preparation

- Assess readiness and stage of change (precontemplation, contemplation, etc.)
- Collaborate with the client where they currently are
- Prioritize:
    - Safety and stabilization
    - Predicting and preparing for risky or avoidant behaviors
- Understand that **complete sobriety may not occur** until trauma is addressed

📝 **Clinician Note:** Treatment planning must be flexible—emphasize stability over rushing reprocessing.

Phases 3–7: Reprocessing

- The **Targeting Sequence Plan** may require alternative protocols first to reduce urges and build stability.
- Once adequate preparation is complete, reprocess the **Touchstone event** that predates the onset of the addiction.

Alternative Protocols for Addiction	Creator	Focus
DeTUR (Desensitization of Triggers and Urge Reprocessing)	Arnold J. Popky, Ph.D.	Reduces urges and strengthens positive states
FSAP (Feeling State Addiction Protocol) Website: www.fsaprotocol.com	Robert Miller, Ph.D.	Identifies and reprocesses the link between positive feelings and addictive behavior

EMDR with Couples

(Adapted from Shapiro, Ch. 11)

For further training, attend the 3-hour Advanced Webinar/Distance Learning Seminar at emdr-training.net

Overview

In EMDR work with couples, we are looking at the specific patterns, behaviors, attitudes, and beliefs within the relationship that are rooted in each partner's past experiences. These old memory networks often inform how partners perceive each other and how they react in conflict.

Phases 1 & 2: History Taking and Preparation

Key areas to explore:

- Commitment Level of each partner
- Safety Issues (emotional and/or physical)
- Finding Targets — both relational and individual triggers
- Building a comprehensive treatment plan
- Exploring "The Answer" for each partner individually and as a couple

Getting Information Without Words

Invite each partner to respond *without words*:

💬 *"Without words, what is the current state of your relationship?"*

💬 *"Without words, demonstrate your greatest frustration in your relationship."*

💬 *"Without words, what do you want most from your partner?"*

💬 *"Without words, how would you like to see your relationship in the future?"*

💬 *"Without words, what do you appreciate about your partner?"*

📝 **Clinician Note:** These activities help bypass cognitive defenses and give insight into stored somatic and emotional responses.

Phases 3–8: Reprocessing and Reevaluation

Organize targets and processing around the couple's shared and individual experience of:

- Past:

    - Childhood events for each partner that impact how they relate
    - Significant past events in the relationship (e.g., betrayals, attachment wounds, breakdowns in communication)
- Present:
    - What do the partners do to trigger one another?
    - How do they cope/react in moments of disconnection?
- Future:
    - Co-create a shared vision for the relationship
    - Use EMDR to process blocks to emotional closeness and secure attachment
    - Use Future Templates to rehearse and reinforce healthier relational patterns

---

Navigating Joint vs. Individual Sessions

- Consider whether EMDR processing should occur in individual sessions or joint sessions based on:
    - Safety
    - Stability of the relationship
    - Level of emotional regulation in each partner
- Joint sessions may be used to strengthen attunement and process shared relationship wounds.
- Individual sessions are often necessary for deeper trauma work that impacts relational behavior.

“The Answer” Questions for Couples

- 💬 *“What is your favorite thing to do when you have a free day?”*
- 💬 *“What do you most dread?”*
- 💬 *“What is your favorite memory from early in your relationship?”*
- 💬 *“What did you like most about your partner when you first met?”*
- 💬 *“What are you most frustrated by in life now?”*
- 💬 *“What makes you happy?”*
- 💬 *“What does your partner do that drives you crazy?”*
- 💬 *“What is easy for you to do?”*
- 💬 *“What do you do if someone tells you no?”*
- 💬 *“How do you get your way?”*
- 💬 *“What is your favorite childhood memory?”*
- 💬 *“What do you admire most about your caregivers?”*
- 💬 *“What was frustrating about your caregivers?”*
- 💬 *“What is difficult for you to do?”*
- 💬 *“What was your favorite childhood activity?”*
- 💬 *“When you are upset how can people tell?”*
- 💬 *“When you need to recharge, what helps?”*
- 💬 *“If there is an emergency what are you likely to do?”*
- 💬 *“What makes you feel proud?”*
- 💬 *“How do you handle extreme pressure?”*
- 💬 *“What are you really good at doing?”*
- 💬 *“Does lots of connection make you feel better or worse?”*
- 💬 *“What is your first instinct when something bad happens?”*

EMDR With Military and First Responders

(Chapter 11, Shapiro, 2001)

Overview

Individuals in high-stress, high-risk professions—such as military personnel and first responders—are frequently exposed to potentially traumatic events. If they have a **history of trauma**, they may be **more vulnerable to PTSD**. Combat or other dangerous environments can trigger the **dysfunctional storage of memories**, which EMDR can help reprocess.

Phase 1: History Taking

- Develop a **treatment roadmap** according to the client's current needs.
- Explore resources (details may come later or not at all).
- Identify:
    - Current triggers
    - Other life stressors
    - Past traumatic experiences
    - Attachment and developmental history
    - Future goals and concerns
- **Consider military culture and values,** which may shape how the client presents.
- Clarify treatment goals:
    - Symptom reduction?
    - Comprehensive reprocessing?

Phase 2: Preparation

- **Safety may feel threatening**: For some clients, "feeling safe" may actually increase distress.
- Prioritize the therapeutic relationship and emotional containment.
- Identify and install alternative resources (beyond standard Calm Place).
- Maintain a collaborative tone—avoid a top-down or authoritarian stance.
- Provide psychoeducation to normalize trauma responses.
- Stay attuned to the client's Window of Tolerance.

Phase 3: Assessment

- Be aware that some clients may not share detailed content.
- **Low SUD scores** may be normal for this population due to emotional numbing or suppression.
- Emphasize use of a stop signal and check in often.
- Watch for:
    - **Blocks to processing**
    - **Avoidance or numbing**
    - **Hyperarousal or dissociation**
- Be ready to slow down processing as needed.
- Use **Cognitive Interweaves** if processing becomes stuck.

Phase 7: Closure

- Always plan to get a report post-processing (what came up, current state).
- Use grounding tools and presence-checks to ensure client is regulated.
- Reinforce resources and emphasize ongoing stabilization.

Unique Considerations for Military and First Responders

- Relationship stress and marriage concerns
- Reintegration challenges after deployment or fieldwork
- Guilt and survivor guilt
- Anger regulation
- Identity loss or shifts post-service

📝 **Clinician Note:** This population may present with high function on the outside and deep dysregulation underneath. Go slow, validate their strengths, and work collaboratively toward integration.

EMDR and Complicated Grief

(Chapter 8, Shapiro, 2001)

Overview

EMDR Therapy **does not remove or bypass the normal grief process**. Grieving is a natural, adaptive response to loss. However, in some cases, clients may become stuck in excessive or complicated grief. EMDR can help facilitate the natural grieving process and support movement toward integration and peace.

Possible EMDR Targets in Complicated Grief

- **The actual event:** The moment of death, hearing the news, witnessing suffering.
- **Intrusive images:** Replays of disturbing moments.
- **Nightmare imagery:** Recurring themes or trauma-linked dreams.
- **Present-day triggers:** Dates, places, smells, or sounds that reactivate distress.
- **Cognitive/emotional stuck points:**
    - Personal responsibility ("I should have done more.")
    - Mortality anxiety ("If it happened to them, it could happen to me.")
    - Previous unresolved losses that are reactivated by the current loss.

Common Blocks to Processing Grief with EMDR

Cognitive Block:

- *"If I let go of this pain, I'll lose my connection to them."*

Survivor Guilt:

- *"Why did I live and they didn't?"*

📘 *For structured EMDR interventions with grief and other special populations, see:*

Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations

by Dr. Marilyn Luber, PhD (Aug 17, 2009)

Section XII: Resources

1. Safe/Calm Place
2. Container
3. Somatic Resources
4. Spiral Technique
5. Light Stream
6. Mindful Scribble
7. Relational Mindfulness Exercises
8. Scripts for Morning Mindfulness
9. “The Answer” in Spanish

Important Note on Resource Use

If any resource begins to access disturbance, stop and switch to a different resource.

- Mild disturbance at the beginning can be normal.
- However, if the disturbance increases or the resource seems to activate the client further, discontinue and offer an alternative technique.

The Safe Calm Place Exercise

(Adapted from Shapiro, 2001, pp. 125–126)

This exercise is designed to help clients access a calming internal state that they can return to when needed during or outside of sessions. It can be used to build internal resources during the Preparation Phase of EMDR.

1. Image

> 💬 *"Bring up a place, either a real or imaginary place, that when you imagine being there you feel a sense of calm."*

2. Emotions and Sensations

> 💬 *"When you imagine being there, just notice the sounds and sights and how you feel right now… What do you notice?"*

(Let the client answer.)

3. Enhance the Experience

> 💬 *"Stay with those [repeat what the client named] and that feeling of [insert emotion], and follow my fingers."*

- Use a short, slow set of Dual Attention Stimulus (DAS) (e.g., slow eye movements or tapping) while the client is not talking—just noticing the positive sensations.
- Repeat for 3–4 short sets of DAS.

Then ask:

> 💬 *"What are you noticing now?"*

If the response is positive, continue.

If the response is negative, stop and use a different resource.

4. Cue Word

> 💬 *"When you bring up that calm place, what word or phrase best goes with that?"*

Then say:

> 💬 *"So notice those words and that calm place."*

(Then offer short, slow DAS sets to link the cue with the image.)

5. Self-Cue

> 💬 "Okay, now bring up that calm place on your own, along with the cue word, and notice the shift."

(Option to enhance with DAS or self-tapping.)

6. Cue with Disturbance

> 💬 *"Bring up a mildly irritating issue that may have happened today or yesterday and notice how you feel."* (pause)
>
> 💬 *"Now bring up the calm place and the cue word and see if you feel a positive shift."*

7. Self-Cue with Disturbance

> 💬 *"Now I'd like you to do that again. Think of another mildly irritating issue, bring up the calm place and cue word on your own, and let me know when you're finished."*

Optional Homework

Offer this as homework. Invite the client to practice using the cue word and calm place throughout the week and notice if it helps shift emotional states.

Important Reminder

- The client does not need to master this exercise before proceeding with EMDR. They simply need a resource that shifts their emotional state.
- In future sessions, you can simply remind them to access their Calm Place with the cue—no need to repeat the full protocol.

Creating a Container

Deborah Kennard, MS (©2015)

1. Notice and Offer Container

💬 *"We're nearing the end of our time, and I'd like to make sure you have what you need to feel grounded and complete before you leave.*

Would you be interested in a containing resource to help with this?"

2. Specify What Needs to Be Contained

💬*"Let's first decide what you feel the need to contain. Is it the strong feeling of _____ (e.g., sadness, anger, grief)?"*

3. Mindfully Invite and Offer Menu

💬 *"Okay, so just allow the perfect container to come to mind—something that's big enough and strong enough to hold your _____ (name the feeling)."*

"It could be something as small as a coffee cup or as large as Mother Earth, or anything in between."

4. Enhance/Deepen

💬 *"Great. So imagine that _____ (name the container).*

How does the _____ (emotion) go in?"

5. Mindfully Deepen

💬*"Just allow the _____ (name the emotion) to enter the _____ (name the container) through _____ (name the entry point—door, lid, light, etc.).*

Let me know when it feels like it's all inside."

6. Sealing the Container

💬 *"Would you like to _____ (close the door, put a lid on it, seal it shut), or have you already done that?"*

7. Somatic Linking

💬 *"Now just sense the _____ (emotion) being contained in the _____ (container).*

What do you notice in your body right now?"

8. Add Extra Layers of Protection (Optional)

💬 *"Great. Now just see if there's anything else you need to feel that _____ (emotion) is safe and contained.*

You could put a lock on the door, assign a guard or protector, or place it in a cave in a mountain.

You could even surround it with a protective light or energy."

9. Check for Completion

💬 *"So really sense the _____ (emotion) inside the _____ (container).*

What are you noticing now?"

10. Enhance / Deepen / Complete

💬 *"Just allow that _____ (energy/light/resource) to surround or penetrate the _____ (emotion) in the container. Let me know when it feels complete."*

Somatic Resources

(Adapted from Ogden, 2002)

These exercises can be offered to help clients regulate their nervous system during EMDR, especially in Phases 2 and 7, or during any point of dysregulation. Each can be demonstrated by the trainer, practiced in group pairs, and adapted for individual use in session.

Grounding

Use for Hyperarousal & Hypoarousal

Invite the client to connect with the support beneath them. Help them notice contact points and body sensations.

You might say:

> 💬 *"Begin by gently pressing your feet into the ground. Notice how the ground supports you."*
>
> *"Now bring your attention up through your body… to your seat on the chair, your back against the chair."*
>
> *"What do you notice in your breath, attention, or energy?"*

📝 **Clinician Note:** This is often a good starting place for clients who dissociate or feel disconnected from the body.

Alignment

Invite awareness of the spine to bring energy, presence, or calm.

For Hypoarousal:

You might say:

> 💬*"Notice what happens as you bring your attention to your spine and begin to lengthen it… from the bottom up, all the way to the top of your head."*

Eventually invite the client to stand and notice full-body alignment.

For Hyperarousal:

You might say:

> 💬*"Begin by noticing the current state of your spine. See if it wants to relax first… and then gently lengthen."*

📝 **Clinician Note:** Let the client's body lead. Some may respond more to softening first, while others benefit from upright activation.

Centering

Use for: Hyperarousal

Help the client create an energetic "container" for intense feelings or sensations.

You might say:

> 💬*"Open your arms and slowly form a circle with them — like you're creating a container that's just the right size to hold everything you're feeling."*
>
> *"Make the circle as large or as small as it needs to be, just for you."*

📝 **Clinician Note:** Centering can be especially helpful during emotionally overwhelming sessions when clients feel scattered or flooded.

Containment (Body Squeeze)

Use for: Hyperarousal or Hypoarousal

Demonstrate how to squeeze or apply light pressure to the body, moving from head to toe.

You might say:

> 💬*"Let's start at the top of the head. Gently press or squeeze here… now move to your shoulders… arms… torso… legs."*
>
> *"As you move, you can say: 'This is my body.' Just notice what happens."*

📝 **Clinician Note:** This can be grounding, but also activating for some clients. Always offer it with permission and monitor for signs of discomfort.

Orienting

Use for: Hyperarousal or Dissociation

Re-engage the client's awareness of the external world and present moment.

You might say:

> 💬*"Begin slowly turning your head side to side… notice what your eyes land on… allow your spine to gently follow."*
>
> *"Let's pause and name 3 things in the room that are red (or another color)."*

Ask:

> 💬*"How do you know you're here in this room right now?"*
>
> 💬*"What's your favorite object in this space?"*

📝 **Clinician Note:** Orienting supports dual awareness and can be a powerful in-the-moment reset for clients drifting too deep into memory or emotion.

Boundaries

Use for: Body-based boundary setting or exploration

Guide the client in exploring physical and energetic space. Use props or movement when helpful.

You might say:

> 💬*"Let's try a 'stop signal' — raise your arm in a way that says 'stop.' Notice what feels right — maybe out front, maybe off to the side."*

> 💬*"What distance feels comfortable between you and someone else?"*

You can use scarves, floor markings, or even chair spacing to help clients sense where boundaries feel safe and effective.

📝 **Clinician Note:** This can be empowering, but may also bring up trauma responses. Go slowly and stay attuned. Always get verbal consent before physical demonstrations or interactive partner work.

Optional Group Practice

Pair up and practice one of the somatic resources, such as Alignment or Grounding. One partner plays the role of therapist, guiding the exercise and noticing shifts.

Trainer or group leader can offer prompts like:

> 💬*"I notice you're breathing more deeply."*

> 💬*"You seem more settled — how does it feel?"*

Partners can then switch roles and either repeat the same exercise or try a new one.

Note: See Somatic Resources video in Basic Training Portal

Additional Somatic Resource Exercises

Playing Catch Conversation ("It's in Your Court")

Purpose: Builds social skills and awareness of the balance between listening and talking.

Instructions:

- Use a ball or soft object (i.e. beanie baby, etc)
- One person asks a question, then tosses the ball.
- The other catches, answers, and asks a question back while tossing the ball.

Which Do You Like Best?

Purpose: Builds awareness of personal preference and ability to express likes/dislikes.

Instructions:

- Hold up two objects (e.g., beanie babies).
- Ask:

  💬 *"Which one do you like more?"*

  💬 *"What tells you that?"*

  💬 *"What do you notice in your body that tells you that?"*

Scarf Connection / Letting Go Exercise

Purpose: Explore connection, letting go, and felt sense of choice.

Instructions:

- Therapist and Client hold opposite ends of a scarf (or rope, necktie, etc.).
- Explore tension, distance, and what feels "just right."
- Take turns dropping or requesting to pick up the scarf.
- Ask:

  💬 *"As you hold the other end of the scarf, what is just the right amount of tension?"*

  💬 *"What tells you that?"*

  💬 *"What is a good distance between us while holding the scarf?"*

- Let the client experiment with letting go:

💬 *"Notice how it feels as we each hold an end. When you're ready, I'll drop my end. Let me know when."*

💬 *"What do you notice now that I've dropped it?"*

💬 *"Would you like to ask me to pick it back up? Or just let me know when you're ready."*

- Then invite the client to drop their end:

  💬 *"Notice what happens as you drop your end. What do you notice?"*

  💬 *"Would you prefer I ask you to pick up your end or let you do it when ready?"*

  💬 *"What felt different when I asked versus when you decided?"*

Scarf Crossing Boundary Exercise

Purpose: Increase awareness of personal boundaries.

Instructions:

- The client may be sitting or standing.
- Use a scarf (or similar object) to mark a boundary.
- Experiment with putting objects in and out of the boundary.

  💬 *"Where would you like to place this object?"*
- Each time they do something, you can ask the following questions:

  💬 *"What tells you that's the right place?"*

  💬 *"What do you notice as you place it there?"*
- Invite the client to experiment and notice what happens when each object crosses into the boundary.

  💬 *"What changes when it crosses the boundary?"*

  💬 *"What do you notice somatically?"*

  💬 *"Are there words that go with that?"*
- If moving an object out of the boundary:

  💬 *"Are there words you'd like to say as you move it?"*

  💬 *"What are you noticing now?"*

Energetic Boundary Exercise

Purpose: Improve awareness and tolerance of external disturbance.

Instructions:

- Invite the client to think of a boundary-crossing person or situation.
  - 💬 *"What are you noticing in your body?"*
  - 💬 *"Where do you feel that?"*
  - 💬 *"How do you know it's there?"*
  - 💬 *"How far in does it go?"*
- Have the client place a hand on the area, then move it outward to where they want the energy to stop.
  - 💬 *"What's changing?"*

Somatic Mindfulness Exercise

Purpose: Develop mindful awareness and affect tolerance.

Instructions:

- Invite the client to bring up a mildly disturbing thought (e.g., starting EMDR).
  - 💬 *"What do you notice in your body?"*
  - 💬 *"How big is that sensation?"*
- If not a clear description, ask:
  - 💬 *"What's the quality of it—tightness, tingling, squeezing?"*
  - 💬 *"Where does it start and stop?"*
  - 💬 *"Is there any movement to it?"*
- If the client becomes overly activated, stop and switch to another resource.

Mindful Scribble | *By Alice Stricklin, LMFT (Adapted from Cathy Malchiodi's Bilateral Drawing)*

Purpose: Enhances self-regulation, mindfulness, and bilateral processing.

Instructions:

Invite the client to choose a color (from crayons, pencils, or markers) that represents calm or peace. Use non-dominant hand to freely draw on a large blank page. Avoid intentional shapes or figures - just let the color move freely on the paper. The therapist may model this parallel process. Guide the client through the process with the following mindful prompts:

> 💬 *"Just begin to notice how the color is finding its way on the paper, doing this without trying to analyze or understand what form is being made."*
>
> **(pause)**
>
> 💬 *"You may notice thoughts coming up, maybe thoughts like 'This is so weird and crazy—why am I doing this?' or 'What should I be making? Am I doing this right?' Just begin to notice whatever your thoughts are, and then gently bring your attention back to the tip of the _____ (marker/crayon/pencil)."*
>
> **(pause)**
>
> 💬 *"You may start noticing your mind wandering—maybe to what you're doing after the session, or something that happened earlier today or this week. Just notice what is calling your attention, and then gently bring your focus back to the tip of the _____ (marker/crayon/pencil)."*
>
> **(long pause)**
>
> 💬 *"As you continue, just notice what keeps calling your attention away. Is it more internal—like body sensations, thoughts, or feelings—or more external, like noises, smells, or awareness of me or others? Simply acknowledge what draws your attention, then gently return to the tip of the _____ (marker/crayon/pencil)."*
>
> **(longer pause)**
>
> 💬 *"Now I'm going to invite you to notice what is happening in your experience as you do this activity of noticing, catching, and returning to the present moment. What feels different in your body, mind, or emotions? Notice if nothing feels different—and bring in a little curiosity about that. Then gently bring your attention back to the tip of the _____ (marker/crayon/pencil)."*
>
> **(pause)**
>
> 💬 *"When you're ready, you can lay your pencil down and set the paper aside. Would you like to share what that experience was like for you?"*

Dreams Resources

Builds awareness of desires, internal resources, and personal possibilities.

This exercise helps clients explore what they would want in life if all limitations were removed. It can enhance motivation, hope, and future orientation — especially useful when clients feel stuck or disconnected from their goals.

Dreams List Activity

Instructions:

- Ask the client to imagine:

  💬 *"What would you do if you had absolutely no limits?"*

  (No limits of time, money, support, talent—or any kind.)
- Ask the client to reflect and journal or share:

  💬 *"What would you do?"*

  💬 *"Where would you go?"*

  💬 *"What would you own?"*

  💬 *"What would you create?"*

  💬 *"What would you experience?"*

  💬 *"What would you contribute?"*
- Encourage the client to create a list of 20 dreams (or more).
  - These can be big or small, serious or playful — there are no wrong answers.
  - The list can be revisited, refined, or used to identify positive targets, strengthen resources, or explore stuck points.

Additional Stress Management Strategies

(Shapiro, 2001)

Note: These resources can be used for incomplete sessions or additional stabilization.

Light Stream Technique

Purpose: Decrease distress through visualization and body awareness.

Use: For calming, when there is physical discomfort or unresolved body sensation.

1. Ask the client to concentrate on any disturbing or upsetting body sensations.
2. Identify the following by asking:
    - 💬*"If it had a _____, what would it be?"*
    - Choose from the following:
        - Shape, Size, Color, Temperature, Texture, Sound
3. Ask:

    💬 *"What is your favorite color you associate with healing?"*
4. Guide the client through visualization:

    💬 *"Imagine that this favorite colored light is coming in through the top of your head and directing itself at the shape in your body.*

    Let's pretend that the source of this light is the cosmos, so the more you use, the more you have available.

    The light directs itself at the shape and resonates, vibrates in, and around it. And as it does, what happens to the shape, size, or color?"
5. Continue to guide as long as the client reports change.This usually correlates with the disappearance of the upsetting feeling. Once the discomfort fades:
    - Invite the light to spread through the entire body.
    - Offer a calming statement (e.g., "Let the light bring peace and calm until next session.")
    - Bring the client to external awareness with a count of 5.

Spiral Technique

Purpose: Shift physical sensations connected to disturbance through imaginal movement.

Use: Body-based calming technique.

1. Ask the client to bring up a disturbing memory and focus on body sensations
    - **Note:** This is an imaginal exercise. There are no right or wrong responses.

    💬 *"When you bring up the memory, how does it feel from 0–10?"*

    💬 *"Where do you feel it in your body?"*
2. The clinician then asks the client to concentrate on the body sensations. Invite visualization.

    💬 *"Concentrate on the feeling in your body. Pretend the feelings are energy. If the sensation was going in a spiral, what direction would it be moving in—clockwise or counterclockwise?"*
3. Respond supportively, then guide:

    💬 *"Good. Now let's change direction. With your mind, move the spiral in the opposite direction. Just notice what happens."*
4. Ask:

    💬 *"What happens?"*

📝 **Clinician Note:**

- If the SUD decreases, the technique may be used for self-regulation at home.
- If the spiral doesn't move or change, try a different technique.

Breathing Shift

Purpose: Reduce disturbance by shifting breath and body awareness.

Use: Good for clients with low-level disturbance and somatic awareness.

1. Ask the client to bring up a good, happy, or positive memory.
2. Ask them to notice where they feel the breath in their body and place a hand there.
3. Then bring up a mildly disturbing memory and do the same:
    - Notice the breath.
    - Place hand on that location.
4. Finally, guide the client to move their hand back to the positive breath location and shift their breathing to match that style.

This change in breath often results in a shift in state. Teach as a self-regulation skill.

Diaphragmatic Breathing

Purpose: Support calming and full-body oxygenation.

Use: When a client is anxious, scattered, or needs grounding.

1. Ask the client to scoot slightly forward in their chair.
2. Instruct them to place one hand on their abdomen and one on their chest. Demonstrate this.
3. Guide the breath pattern:

   💬 *"Start by exhaling.*

   Then breathe in all the way with your abdomen for a count of 2,

   And then in with your chest for a count of 2.

   Hold your breath for a count of 7.

   Then exhale with your abdomen for a count of 4,

   And finally with your chest for a count of 4."
4. Repeat as needed to support regulation and relaxation.

Relational Mindfulness Exercises

Note: *1 bell = 1-minute remaining | 2 bells = please come to silence.*

These exercises cultivate present moment awareness in relationship with others. They build skills in curiosity, boundaries, listening, and being impacted by another.

Boundaries Game

Purpose: Build skill in setting and respecting boundaries.

Game 1: "No" Practice

- Pair up.
- **Round 1:** Person A makes an **unreasonable request**. Person B says no. Then switch roles.
- **Round 2:** Person A makes a **reasonable request**, using persuasion (e.g., cajoling, seduction, threats). Person B still says no. Switch roles again.

Game 2: Negotiation Practice

- Pair up.
- Person A makes a request.
- Person B gives a counter offer.
- Work together to **find a shared agreement.**

The Noticing Game

Purpose: Strengthen present moment awareness and connection.

- Pair up (ideally with someone new). If there is an uneven number, a training coach will join.
- Focus on present-moment awareness:
    - Notice sensations from all five senses.
    - Notice thoughts, emotions, and body sensations.
    - Surprise yourself!
- Trainer and assistant will demonstrate.

Instructions:

1. Decide who is A and who is B.
2. Begin the following call-and-response:
    - A: *"What I notice when I'm with you is _____."*
    - B: *"Hearing that, I'm noticing _____."*
    - A: *"Hearing that, I'm noticing _____."*
    - B: *"Hearing that, I'm noticing _____."*
    - Continue this flow for a few minutes.

Curiosity Game

Purpose: Cultivate genuine curiosity and presence in conversation.

- Trainer or coach will demonstrate.
- Find a partner (coach will fill in if odd number).
- The person with larger earlobes is Person A, smaller earlobes is Person B.
- Person A begins by asking any question they are genuinely curious about.
    - Avoid scripted or generic questions (*"Where are you from?"*) unless they spark real interest.
- Person B can answer, decline, or even lie—just like real life.

Round 1 – Ask with Curiosity:

- For ~2 minutes, Person A asks questions from a place of present-moment curiosity.

Round 2 – Feedback:

- Pause. Person B gives 30–60 seconds of feedback:

  💬 *"What did you like about the questions Person A asked?"*

  💬 *"Were there any questions you wish they'd asked?"*
- Switch roles. The trainer will ring the bell for time cues.

The trainer rings the bell once to signal 30 seconds remaining, and twice to come to silence.

Relational Mindfulness (Trainer Demonstration)

- The trainer or coach speaks aloud about their present moment experience.
- Trainees silently observe their own present moment experience.

- No dialogue—just noticing your body, mind, and emotions in response.

Relational Mindfulness Game

Purpose: Deepen vulnerability and attunement with others.

- Trainer selects 3 sentence stems.
- In pairs, take turns completing the stem.
- While one person shares, the other notices their own internal experience.
- Trainer will demonstrate first.

Examples of Sentence Stems:

- *"What I think you think about me is…"*
- *"A time I was disappointed in love is… the worst part about it was…"*
- *"A time I was elated in love is… the best part about it was…"*
- *"Something I'm afraid to share with you is…"*
- *"Something I don't want you to know about me is…"*
- *"Something I want to be seen/appreciated for is…"*
- *"Something most people don't know about me is…"*

Mindfulness Scripts

Who You Are Is Enough

I'll start with ringing a bell and end with ringing a bell, so you will know the beginning and the end.

Rings bell…

💬*"I would just like to invite you to notice being here."*

💬*"If possible, with a sense of curiosity, notice where your attention goes as you notice being here."*

(pause)

💬*"Does your attention go inside or outside? Maybe it's the sound of the heater, the sound of my voice, or other sounds around you that help you know you're here."*

💬*"Maybe it's seeing the light or the room."*

💬*"Just notice your first procedural way of sensing yourself being here."*

💬*"For others, you may feel your body resist being here as you notice it internally—perhaps your core, your heart, or your thoughts."*

💬*"Just notice how you know that you're here."*

(long pause)

💬*"Now bring your attention to the quality of being here. Is there a sense—maybe heaviness, tension, or an emotional quality like anxiety, relief, or happiness?"*

💬*"Bring your awareness to your system. What is here?"*

(long pause)

💬*"I'm going to say some words twice. Just notice what happens in your system as you hear them."*

'Who you are is enough.'

'Who you are is enough.'

💬*"Notice any part where those words landed and felt true."*

"Or any part of you that tensed up and said no, that isn't true."

"Or any way your answer showed up – or maybe you zoned out or thought of something else. Just bring a gentle awareness—whatever you're noticing is okay."

💬*"Now, notice that there's a root to that reaction—a memory or a lie that may still be here now."*

(long pause)

💬*"Now I'd like to invite you to bring up a resource—something that helps you."*

"It could be a resource of love or calmness. Maybe a person, a memory, music, art, something in nature, a pet, or a spiritual figure—whatever helps you."

💬*"In a moment, I'll ring the bell. You can take all the time you need."*

Rings bell…

Listen to Your Body

Rings bell…

💬*"Just begin to notice being here."*

💬*"If possible, bring a curiosity to your patterns of noticing."*

"Who you are is enough."

"Who you are is enough."

💬*"Notice any way those words landed and felt right. Or… notice any part of you that tensed up and said, "No, that isn't true."Or maybe your answer showed up in a different way — zoning out, thinking about something else."*

💬*"If possible, bring a gentle awareness to yourself: it's all okay."*

💬*"Whatever you're noticing in your system, I'd like you to notice that there is a root to that."*

💬*"There is an earlier experience."*

💬*"There is some memory… or some lie that is here right now."*

(long pause)

💬*"Now I'd like to invite you to bring up a resource — something that helps you."*

💬*"It could be a resource of love, calmness, or whatever state you like to be in."*

💬*"Maybe it's a person… a memory… a piece of music or art… something in nature… a pet… or a spiritual resource."*

💬*"Whatever helps you — allow it to be here."*

Rings bell…

(Pause and allow the client to take as long as needed.)

Rings bell again…

💬*"Just begin to notice being here."*

💬*"If possible, bring a curiosity to your patterns of noticing."*

💬*"Maybe it's an image of someone you're sure you love — no conflict — or a pet, or somewhere out in nature. Maybe even a piece of music or art, or a spiritual resource."*

💬*"As you bring that up, notice that there is a shift."*

💬*"If that is difficult for you, see if you can just bring a drop of love into your system."*

💬*"In a moment, I'll ring the bell. You can take all the time you need."*

Rings bell…

(Pause again, allowing full space for the experience.)

All Parts of You Are Welcome Here

(Five Minute Version)

💬*"Begin by getting comfortable in whatever way that is for you. With your feet on the floor, throwing your stuff on the floor, or just feeling yourself being here."*

💬*"I will start by ringing the bell and end by ringing the bell, so there is no question about when we are starting and ending."*

Rings bell…

💬*"Okay, so I would like to invite you to bring your attention to being here. With a sense of curiosity, notice what happens to you and your system."*

💬*"What calls your attention first?"*

💬*"What lets you know you're here?"*

💬*"Some of you might notice something inside—like your breath, your seat on the chair, an emotion, a thought, or even a body sensation."*

💬*"Others might notice something outside—like the sound of my voice, the fan, or the feeling of the air."*

💬*"Just notice—what calls your attention first? What tells you that you're here?"*

(Long pause)

💬*"I invite you to notice any way that you are not quite here."*

💬*"Maybe you're still feeling yourself on the highway driving here… or thinking about something that happened earlier… or someone at home… or something you're afraid you forgot."*

💬*"Maybe you're in the future—thinking about what will happen later or what you have to do…something that worries you, or excites you."*

💬*"Notice any way that you are not quite here. How do you know?"*

(Long pause)

💬*"Now I'm going to say some words. I'll say them twice. I'd like to invite you to notice what happens in your experience when you hear these words."*

"All parts of you are welcome here."

"All parts of you are welcome here."

💬*"Just begin to notice any way those words landed and felt right—or any part of you that tensed up and said, 'No, that doesn't feel right.'"*

💬*"Just allow whatever happens to be here."*

💬*"Become curious about it."*

(Long pause)

💬*"Take as long as you need to open your eyes."*

Rings bell…

💬*"Feel free to take notes on your experience if you want to."*

You Are a Shining Star

💬*"I'd like to invite whoever would like to join at whatever level feels best for you."*

💬*"We'll begin with a bell and end with a bell."*

Rings bell…

💬*"I'd like to invite you to notice being here."*

💬*"If you can, engage a sense of curiosity. What calls your attention first? Where does your attention go? Does it go inside or outside?"*

💬*"Does it go to a certain part of your body, or to a sense — something you hear, see, taste, or smell?"*

(long pause)

💬*"Now I'd like you to play a bit with your awareness — notice how you can direct it intentionally."*

💬*"First, notice directly outside of you."*

💬*"Maybe it's the sound of my voice or the humming of the projector."*

💬*"Maybe you sense the light in the room or the air on your skin."*

(pause)

💬*"Then, just notice how you can you direct your attention. With your eyes remaining closed, direct your attention to the projector in the middle of the room."*

💬*"Now direct your attention inside to your breath."*

💬*"Just notice if that was easy or difficult for you to do."*

(long pause)

💬*"Now I'd like to invite you to bring your attention to a part of your body that's calling to you."*

💬*"It might be a positive sensation—an openness—or tension or tightness. It could even be a lack of connection. Remember, your head is part of your body too."*

(long pause)

💬*"Wherever your attention goes, just notice it and invite that part to be there—as big as it needs to be."*

💬*"If that part of your body could speak in words, what would it be saying?"*

(long pause)

💬*"Whether you heard something or not, even the quiet could tell you something."*

💬*"Ask yourself gently: Is there any way that part is trying to help?"*

💬*"Could it be an answer? A memory? A lie?"*

💬*"Now ask yourself: What is new and true for me right now?"*

(long pause)

💬*"Now I'm going to say some words, and I'll say them twice. Just notice how those words land."*

"You are a shining star."

"You are a shining star."

💬*"Maybe they feel true. Or maybe a part of you feels irritated or tenses or says no. That's okay too."*

💬*"Whatever your response, see if you can bring in just a drop of love for yourself."*

💬*"In a moment, I'll ring the bell, but you can take as long as you need."*

Rings bell…

All Parts of You Are Welcome Here

(Ten Minute Version)

Rings bell…

💬*"I'd like to invite you to join at whatever level feels most comfortable for you."*

💬*"Just begin by feeling yourself being here."*

💬*"Notice the sounds, the environment."*

💬*"Sometimes the environment can bring us here very quickly — with a sound or something that captures our attention."*

💬*"Begin to notice — how do you know you're here?"*

(long pause)

💬*"If possible, bring in a sense of curiosity to that experience."*

💬*"What's calling your attention? What lets you know that you're here?"*

💬*"Does your attention go inside or outside?"*

(long pause)

💬*"Where does your attention go?"*

💬*"Maybe it's the sound in the room, something you see, smell, feel, or even taste."*

💬*"Perhaps it's a thought about being here — or how you got here."*

💬*"Maybe it's a sense of your body — relaxing into the chair, feet on the floor, or the pull of gravity."*

💬*"Maybe there's an emotion that tells you that you are here — an excitement or something else not tied to this room at all."*

💬*"Just notice… being here."*

(long pause)

💬*"Now I'd like to invite you to notice any way you are not quite here."*

💬*"Is there a sense of worry about something outside this room? Maybe something from yesterday, or someone on your mind? Even a joyful thought can pull us away from this moment."*

💬*"Maybe you're in the future — planning, worrying, or anticipating."*

💬*"Notice any way that you're not quite here. How do you know?"*

(long pause)

💬*"Now I'm going to say some words, and I'll say them twice."*

"All parts of you are welcome here."

"All parts of you are welcome here."

💬*"Just notice what happens in your system as you hear those words. Maybe they land and feel right. Maybe a part of you tenses up or disagrees — that's okay too."*

💬*"Whatever arises, simply notice it."*

(long pause)

💬*"Now I'd like to invite you to bring up a resource of love. Something or someone where there is no conflict — just the pure sense of love."*

💬*"It might be a person, a pet, something from nature, a piece of music, or a spiritual figure. Whatever it is for you, bring that into your awareness."*

💬*"And if that feels difficult, see if you can bring just one drop of love into your system."*

💬*"Remember: this is a resource you can connect with whenever you need it."*

(long pause)

💬*"In a moment, I'll ring the bell, but you can take as long as you need."*

Rings bell…

Section XIII: Furthering Your EMDR Training

After completing your EMDR Basic Training, you're considered a **PTI Member for 1 year!** As part of your membership, you'll receive:

- Access to training and demo videos
- Member discounts
- A supportive listserv: https://groups.google.com/forum/#!forum/emdrtraining
- Answers to your questions from our team!

Be sure to ask about:

Certification Groups, Online CEs, In-Person Retreats, and PTI Advanced Certification Program!

After completing the full training and your 10 consultation hours, you'll receive a **Certificate of Completion** (not Certification) for EMDR Basic Training.

What Is EMDRIA Certification?

PTI offers an Advanced Certification Program that meets the requirements of 20 hours of consultation and 12 hours of EMDRIA Approved Advanced Training.

EMDRIA Certification indicates a higher level of training and clinical experience in EMDR.

A clinician who becomes **EMDRIA Certified in EMDR** must meet the following criteria:

- Licensed or certified for independent practice in a mental health profession
- At least two years of professional experience
- Completion of an EMDRIA-Approved Basic Training
- A minimum of 50 EMDR clinical sessions with at least 25 different clients
- 20 hours of EMDR consultation with an Approved Consultant
- 12 hours of EMDRIA Credits (EMDR-focused Continuing Education) every two years

Learn more: www.emdria.org

Certification Period

- Certification is valid for 2 years from the date of acceptance.
- Please allow 3–5 weeks to receive your certificate after all required materials are submitted.
- All documents (including letters of recommendation) must be submitted in English.

- Do not submit incomplete applications to EMDRIA.

Certification Fees (as of this writing)

Category	Fee
EMDRIA Full Member	$150 USD
Non-EMDRIA Member	$350 USD

Note: To receive the member rate, you must maintain active EMDRIA Full Membership for the full 2-year certification period.

EMDRIA Certification Requirements

To apply, you must submit the following materials:

1. Basic Training Certificate

- Proof of completion from an EMDRIA-approved Basic Training program.

2. License or Certification

- A copy of your current professional license showing independent practice eligibility.

3. Notarized Experience Statement

Submit a single notarized document confirming both:

- "I have at least 2 years of experience in my licensed field."
- "I have conducted at least 50 EMDR therapy sessions with at least 25 clients."

4. Consultation Hours

- Must be with an Approved Consultant
- Documentation should indicate:
    - Total hours received
    - How many hours were individual (1:1 or focus on you in a group)
    - How many hours were group

Notes:

- At least 10 hours must be individual (this can be within a group if focused on you).
- The other 10 may be from small group consultation (max 8 participants).

- Consultants-in-Training may provide up to 15 hours; at least 5 hours must be with an Approved Consultant.
- Only hours received after Basic Training completion count toward certification.

5. Letters of Recommendation

- 1 letter from an Approved EMDR Consultant regarding your EMDR work
- 2 additional letters from colleagues or peers commenting on:
    - Your use of EMDR
    - Your professional ethics
    - Your overall character

6. 12 Hours of EMDRIA Credits

These must be completed after Basic Training and come from EMDRIA-approved programs.

Note: The Basic EMDR Training does not qualify for EMDRIA Credits.

Only courses completed after Basic Training and marked as “EMDRIA Credit” are eligible.

7. Code of Conduct

Read and agree to abide by EMDRIA’s Professional Code of Conduct (indicated on your application form).

Welcome to the PTI Community!

We offer support before, during, and after training. Here is the path to becoming a PTI trainer.

Step	Requirements	Notes
Step 1: Complete EMDR Training with PTI	40 hrs EMDRIA-Approved Training 10 hrs Consultation Join EMDRIA	You are now "EMDR Trained." Access emdr-training.net for 1 year Stay connected: emdrtraining@googlegroups.com Begin planning for Advanced Training
Step 2: Become EMDRIA Certified	20 hrs Consultation 12 hrs Advanced Training (via PTI's Advanced Certification Package*)	Deepen your clinical skill set Begin assisting others on their EMDR journey
Step 3: Become a PTI Assistant or EMDRIA-Approved Consultant	Mentor others Gain hands-on experience supporting trainings	Apply to become a PTI Assistant Begin Consultant-in-Training (CIT) pathway if pursuing EMDRIA Consultant status
Step 4: Become a PTI Trainer	Complete Trainer Application & Onboarding Process	Lead EMDR trainings Represent PTI in shaping the next generation of EMDR clinicians

At PTI, we offer an option for moving forward—but you're also welcome to find your own path. Certification is optional, but it's an important step toward becoming an expert.

*If you're pursuing EMDRIA Certification through PTI's Advanced Certification Package, the following Core Competencies outline what you'll learn and demonstrate throughout your consultation journey:

Core Competencies for PTI Advanced Certification Program

Certification is optional, but it can be an important next step in deepening your skills and becoming an EMDR expert.

PTI offers one path to certification, but you are welcome to pursue certification with any EMDRIA-approved consultant of your choosing.

I. Foundational Understanding

- Demonstrates conceptual understanding of the Adaptive Information Processing (AIP) model and PTI's additions to that view.
- Can clearly describe EMDR and apply it to a case presentation.
- Can explain the general neurobiology of trauma in simple terms.
- Understands and explains PTI's concept of "The Answer," including how it relates to attachment patterns and the body

II. Nonviolence and Therapist Role

- Demonstrates understanding of nonviolence as a therapeutic stance.
- Balances being a clinically sound expert with inviting the client into the therapy process.
- Understands the principle that the therapist does not "do" anything to the client.
- Demonstrates knowledge and practice of mindfulness, nonviolence, awareness, and compassion.

III. Therapist's Self-Awareness: Insight into the Clinician's Own "Answer"

- Can identify and articulate their own **"Answer."**
- Recognizes when their own Answer surfaces during therapy and understands its impact.
- Identifies patterns of overdeveloped and underdeveloped traits and takes steps to cultivate balance.
- Has body-based awareness of how their own Answer manifests somatically.

IV. Working with the Client's "Answer"

- Uses the **Answer Assessment Tool** to identify patterns and predict strengths and blocks.
- Recognizes when the client's Answer shows up during sessions.
- Applies the 5 C's to work with the client's Answer in a nonviolent, supportive way.
- Offers somatic resources to support underdeveloped traits and facilitate healing.

V. Window of Tolerance & Somatic Interventions

- Identifies when a client is **outside the Window of Tolerance.**
- Guides clients toward **somatic resources** to help expand their Window.
- Explains the concepts of the Window of Tolerance and dissociation clearly and effectively.

VI. Phases 1 & 2: History Taking & Preparation

- Combines history taking with preparation by assessing the client's Answer early.
- Uses the Answer to **predict needs and offer appropriate resources.**
- Demonstrates curiosity and welcomes the Answer throughout the process.
- Identifies overdeveloped vs. underdeveloped traits and develops resources to invite balance.

VII. Finding Target Memories

- Identifies when the client is not accessing the true root of their issue.
- Recognizes when the client is:
    - Going back through the Answer rather than a memory
    - Recalling rather than activating the memory ("lighting the limbic lightbulb")
    - Focused on symptoms rather than root material

VIII. Phase 3: Assessment / Activation

- Clearly explains and delivers Phase 3 questions as **activating prompts**, not data collection.
- Avoids interfering with the client's process through added words, gestures, or delays.

- Recognizes when a client is dysregulated and **modifies Phase 3 delivery accordingly.**
- **Transitions smoothly from Phase 3 to Phase 4.**

IX. Phase 4: Reprocessing

- Knows when to **stay out of the way** and let the client process.
- Maintains the stance of **nonviolent presence** while remaining the expert.
- Works with the client's Answer as it emerges.
- Tolerates deep sadness and supports the client without prematurely stopping.
- Identifies dysregulation and knows what to offer.
- Encourages continued reprocessing when appropriate.

Cognitive Interweaves:

- Uses interweaves skillfully to address:
    - Answer-related blocks
    - Missing experiences
    - Somatic integration
- Keeps interweaves **brief and focused**, avoiding talk therapy.

X. Phase 5: Installation

- Understands that Installation is still part of **Reprocessing**.
- Asks about and installs new, adaptive positive cognition (PC).
- Recognizes and works with the client's Answer as it appears here.

XI. Phase 6: Body Scan

- Understands that this is still part of Reprocessing.
- Recognizes new or earlier memories that may emerge, including pre-verbal memories.

XII. Phase 7: Closure

- Demonstrates ability to **close an incomplete session** skillfully.
- Offers appropriate resources or **state-shifting techniques** based on client need.

- Recognizes dysregulation and responds effectively.

XIII. Phase 8: Reevaluation

- Evaluates current symptoms and how EMDR is helping in present-day functioning.
- Adjusts the treatment plan when new information arises.

XIV. Completing the Treatment Plan

- Effectively evaluates and recommends next targets.
- Assesses whether memories should be targeted in chronological or priority-based order.

Coupon Codes

EMDR Lightbars

www.neurotekcorp.com

Use code **DKEMDR25** for $10 off
(Updated each year… **DKEMDR26**)

EMDR Tabs

Dharma Dr EMDR Tabs

Use code **PTIEMDR** for 10% off

Recommended Reading & References

Kurtz, R. (1991). *Hakomi: Body-centered psychotherapy*. LifeRhythm.
🔗 Link to Book

Levine, P. A. (1997). *Waking the tiger: Healing trauma*. North Atlantic Books.
🔗 Link to Book

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. W. W. Norton & Company.
🔗 Link to Book

Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. W. W. Norton & Company.
🔗 Link to Book

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). Guilford Press.
🔗 Link to Book

Shapiro, F. (2013). *Getting past your past: Take control of your life with self-help techniques from EMDR therapy*. Rodale Books.
🔗 Link to Book

Siegel, D. J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. W. W. Norton & Company.
🔗 Link to Book

van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.
🔗 Link to Book

🖥️ For more resources, visit: www.emdr-training.net

Thank You

Thank you for being part of this journey with us.

We're honored to support your training and growth as an EMDR clinician. Whether you're just beginning or continuing to deepen your practice, your work makes a meaningful difference in the lives of those you serve.

Remember:

You're not alone. You're part of a community. Mistakes are required.

Keep learning. Stay curious. Be kind to yourself.

With gratitude,

The PTI Team

www.emdr-training.net