S.A.F.E. APPROACH TO EMDR THERAPY
Somatic and Attachment Focused EMDR

An EMDRIA Approved 6 Day EMDR Therapy Training
www.emdr-training.net
Deborah Kennard, MS, Founder and Author
2019
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Introduction

A Brief Explanation of 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 therapy is founded on the basis that trauma interferes with our brain’s processing. The theoretical basis for EMDR is called Adaptive Information Processing. Adaptive Information Processing, or AIP, posits that during trauma our brain processes and stores memories incorrectly.

This incorrect storage can lead to past memories feeling very present. Related or unrelated stimuli in the present can lead to clients reacting as they did at the time of trauma. The brain experiences the current, related event as if it were the past disturbing event.

It is important to understand that EMDR is not a technique. EMDR is a comprehensive psychotherapy, with 8 Phases and 3 Prongs and a variety of concepts we will explore, such as the Window of Tolerance and somatic resources. The technique utilized, called Bilateral Stimulation, is only one component of EMDR. Bilateral Stimulation involves the therapist guiding a client through a series of eye movements in order to access and disrupt disturbing memories. This disruption reprocesses the memory, leading to resolution and transformation.

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

At Personal Transformation Institute we approach EMDR from a somatic and attachment focus.

This attachment approach takes into consideration early attachment patterns and experiences, as well as the built-in trauma responses that themselves become patterns. In most therapies these patterns and trauma responses are considered blocks to the therapeutic process. However, at PTI we approach these blocks as strengths as well as challenges. We reconsider blocks as overdeveloped skills so that we can safely work within the client’s patterns, rather than against them.

This recasting of a block into what we call The Answer creates a space for the client to approach distressing memories with less resistance, as the therapist is working within their Window of Tolerance. This nonviolent approach emphasizes safety and allows the therapist and the client to do their work together more effectively.

At Personal Transformation Institute we also approach EMDR from a somatic focus. We believe the body and mind are deeply interconnected. That’s why trauma has symptoms, rather than memories. We teach a series of somatic resources, or body-based exercises, meant to manage the client’s affect and connection. We practice these same resources during the training to keep participants engaged and emotionally regulated.
# EMDR Basic Training Schedule

<table>
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The 3 S’s of this Training

(1) SAFE: The basis of trauma treatment is safety; we want to do the same with you in the training.

(2) 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!

(3) 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 a 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.

Unlearning old habits is often the hardest part of learning this model of therapy.
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 and Philosophy

The mission of Personal Transformation Institute (PTI) is to offer the most cutting-edge, effective EMDR trainings 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
• Respect
• Compassion
• Healthy Boundaries
• Self-Awareness

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, and 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 terrific way to be a part of our community, ask clinical questions, and 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 the completion of 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 as well as other criteria. Our Advanced Certification Packages fulfill these requirements. Find out more on our website.
Personal Transformation Institute (PTI) Path

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

After the completion of basic training, our goal is to offer you the best after-training-support possible. We offer a multitude of training and demo videos on our website, as well as an email community. You have access to member training videos for one full year.

If you would like to become EMDRIA Certified we offer an Advanced Certification Package which allows you to continue your certification process seamlessly with our unique training model. Once you become EMDRIA Certified you have the option to become both a PTI Assistant and an EMDRIA Approved Consultant. Then it is possible for you to join the PTI team as a Trainer!

Complete EMDRIA Approved EMDR Therapy Training with PTI.
40 hrs training & 10 hours consultation and you are "EMDR Trained"

- Join EMDRIA
- Utilize your 1 year membership access to emdr-training.net for training videos
- Stay connected to community by emailing emdrtc@googlegroups.com
- Plan to take Advanced Trainings as offered below

Become EMDRIA Certified
Complete Advanced Certification Package
20 hrs Consultation & 12 hours Advanced Training

Become PTI Assistant/ EMDRIA Approved Consultant

Become a PTI Trainer
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 go into detail on how these learning styles are applicable to our understanding of 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. We can decide to ignore the experience of being tired and choose to stay awake even while our emotional and sensorimotor experiences continue, e.g., feeling sluggish in the body or a lowered mood.
- 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
History and Overview of EMDR

References
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?

EMDR stands for Eye Movement Desensitization and Reprocessing. One component of EMDR is a technique called “bilateral stimulation” where a therapist will guide a client through eye movements, tones, or taps. However, EMDR is an entire integrated therapeutic approach that considers a person’s somatic (physical) and emotional states. EMDR was founded in 1987 by Francine Shapiro and is currently one of the most researched methods of contemporary psychotherapy. EMDR therapy has been empirically proven to be particularly effective in the treatment of Post Traumatic Stress Disorder (PTSD) as well as 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). EMDR therapy is based on a model called the Adaptive Information Processing model (AIP). This model posits that psychopathologies are a result of the maladaptive encoding or incomplete processing of traumatic events. A combination of our genetic predisposition and our experiences create memory networks that are stored in our minds and bodies. These memory networks dictate how we experience the world in the present. They are the basis of our beliefs, attitudes, and perceptions. Memory networks can be a source of dysfunction, as well as a healthy resource to draw from. Most memories are functionally stored in the brain but intense or traumatic events tend to be stored without a coherent sense of time. This incorrect storage can lead to a client to feeling like the past traumatic event is about to happen again at any moment or is currently happening in the present. They overreact to present stimuli with hyperarousal and/or somatic symptoms because of their dysfunctional memory network. Specific protocols in EMDR therapy help to access these memory networks in order to move them from a place of emotional activation to a more logical, rational place. EMDR changes the way traumatic memories are stored so that a client’s human system can know and feel that the traumatic event is in the past and they are safe in the present. Through EMDR therapy, the triggers of the present no longer have the same charge. The client can react to what is happening now instead of having an overreaction due to a past event.

EMDR is a present-focused therapy. In EMDR we are more interested in the ways past events manifest in a client’s system in the present moment than we are in gathering historical data. We do gather historical data, but it is mainly to access how that memory was stored. Therefore, we do not ask how the client felt at the time of the event. Rather, we ask how those memories activate emotions in the present.

Note: EMDR is a Therapeutic Approach not a Technique.

Although EMDR brings together various aspects of different theoretical orientations, EMDR is a therapeutic treatment approach. It is based on the Adaptive Information Processing (AIP) model. If a therapist uses EMDR as a technique, they are less likely to be effective. EMDR is not just the eye movement or dual attention stimulation. The approach includes 8 phases and 3 prongs and is a comprehensive therapeutic orientation.
EMDR Incorporates Aspects of Other Orientations

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What is Post Traumatic Stress Disorder (PTSD)?

**Criterion A (one required):** 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):** 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 of trauma-related stimuli after the trauma, in the following way(s):
- Trauma-related thoughts or feelings
- Trauma-related reminders

**Criterion D (two required):** Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):
- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

**Criterion E (two required):** Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):
What is Post Traumatic Stress Disorder (PTSD)?

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

**Criterion F (required):** Symptoms last for more than 1 month.

**Criterion G (required):** Symptoms create distress or functional impairment (e.g., social, occupational).

**Criterion H (required):** Symptoms are not due to medication, substance use, or other illness

**Reference:**

**Online resource:** [http://traumadissociation.com/des](http://traumadissociation.com/des)
**Combat Vets and PTSD**

Carlson et al. (1998) reported that after twelve EMDR treatment sessions, 77.7% of the combat veterans no longer met criteria for PTSD. There were no dropouts and effects were maintained at 3- and 9-month follow-up.

**EMDR vs CBT**

Capezzani et al. (2013). EMDR and CBT for cancer patients: Comparative study of effects on PTSD, anxiety, and depression. Journal of EMDR Practice and Research, 5, 2-13. This randomized pilot study reported that after eight sessions of treatment, EMDR therapy was superior to a variety of CBT techniques. "Almost all the patients (20 out of 21, 95.2%) did not have PTSD after the EMDR treatment."

**Developmental Trauma**

Cvetek, R. (2008). EMDR treatment of distressful experiences that fail to meet the criteria for PTSD. Journal of EMDR Practice and Research, 2, 2-14. EMDR treatment of disturbing life events (small "t" trauma) was compared to active listening, and wait list. EMDR produced significantly lower scores on the Impact of Event Scale (mean reduced from "moderate" to "subclinical") and a significantly smaller increase on the STAI after memory recall.

**Pagani Research: Neurobiological Aspects Correlated with EMDR Monitoring- An EEG Study (2012)**

During the Eye Movements of EMDR session EEG showed a significantly higher activation on the orbito-frontal, prefrontal, and anterior cingulate cortex in patients. (Movement to the frontal lobes.) Maximum activation of the limbic cortex of patients occurred prior to the EMDR processing. (Beginning activation in the emotional brain.)

Conclusion: relief from negative emotions. Ground-breaking methodology enabled this study to image for the first time the specific activations associated with the therapeutic actions typical of the EMDR protocol. The conclusion that the Eye Movements of EMDR are associated with a significant relief from negative emotions.

**Links to more research:**

https://www.emdria.org/page/EMDRResearch
https://emdr-training.net/what-we-offer/additional-resources/emdr-training-faqs/
**Research**

**Introduction to the 8 Phases of EMDR Treatment**

Phase One: History

Phase Two: Preparation

Phase Three: Assessment

Phase Four: Desensitization

Phase Five: Installation

Phase Six: Body Scan

Phase Seven: Closure

Phase Eight: Reevaluation

Although EMDR has 8 phases, it is not an 8-step therapy. In most cases it is required that the therapist and client weave in and out of the various phases depending upon the needs of the client and the client’s system. In addition, there are 3 Prongs of EMDR Treatment: the past, the present, and the future.

It is important to realize that EMDR is a therapeutic approach and not a technique. Although we have scripts, we cannot give you a scripted process for the whole therapy process. The scripts we give you here are to assist you in learning and experiencing EMDR. These scripts will also be an important part of the EMDR therapy process, but they are not all of it.

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

- Phases One through Two: Preparation and Safety
- Phases Three through Eight: Processing Memories
- Integrate changes for the future

Conceptualize the Phases by Grouping Them
# Overview of the 8 Phases: Chart

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

<table>
<thead>
<tr>
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<th>Phases 3-8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Events</strong></td>
<td>How are they manifesting in the present moment?</td>
<td></td>
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<tr>
<td><strong>Present Triggers</strong></td>
<td>What is happening now that is activating the memories of the past?</td>
<td>Phases 3-8</td>
</tr>
<tr>
<td><strong>Future Template</strong></td>
<td>How would you like to feel, react or behave instead of the current present trigger?</td>
<td>Follow a special Future Template protocol.</td>
</tr>
</tbody>
</table>


Model, Method, and Mechanism

A. Model: The Adaptive Information Processing Model

- Informs Treatment
- Interprets Client Response
- Predicts Successful Application

B. Method: Protocols and Procedures

- 8 Phases
- 3 Prongs (Past, Present, Future)
- The Standard Protocol and Adaptations
- Fidelity to These Methods Predicts Positive Results

C. Mechanism: Why EMDR Works*

- Attention Bias
- Working Memory
- Orienting Response
- Somatic Perceptions
- Neurobiological Aspects

*Brand new research on this is making therapy history! See research in appendix.

Reference
In this section we will cover the basic concepts and hypotheses of the Adaptive Information Processing (AIP) Model. We will explore clinical implications, how this model differs from other models, as well as the many applications of the AIP Model. We will come to understand the theoretical basis of EMDR. The Adaptive Information Processing (AIP) Model is based on the idea that much of psychopathology is a result of maladaptive encoding of, and/or incomplete processing of, traumatic or disturbing events or adverse life experiences. This prevents the adaptive integration of the material. The unprocessed experiences become stored in the emotional part of the brain without a time and date stamp. When something happens in the present to activate the stored experiences, they feel as if it is happening now, creating what appears to be an “over-reaction” to the present.

• We are looking at the early experiences and the way they are stored.
• We are asking: “What is the organization of that experience in the present moment? How are the past experiences manifesting now?”
• This helps create the treatment map and predict blocks as well as outcomes.

Basic Hypotheses of the AIP

It is a Physical System

• The neurobiological information processing system is intrinsic, physical and adaptive.
• The system integrates 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 attitude, beliefs, and perception.
• Those stored memories contribute to both pathology and to health.
• Trauma causes a disruption of normal adaptive information processing which results in unprocessed information being dysfunctionally held in memory networks.
• New experiences link into previously stored memories which are the basis of interpretations, feelings, and behaviors.

Memories and How They Are Stored: The Memory Network
Memories with similar components are linked in a network. Similar sensory experiences, thoughts, emotions, body sensations, and beliefs about self are linked to each other. Adaptive
Memory networks store positive beliefs, learning, and resources. The memory networks that are stored in a traumatic way are the source of the pathology. This includes the response at the time.

**It's Both What Happened and What Didn’t Happen**

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

**Traumatic Events Appear to Be Stored in Isolation**

- If experiences are accompanied by high levels of disturbance, they may be stored in what functions like the implicit, short-term memory system. These memory networks contain the perspectives, affects and sensations of the disturbing event and are stored in a way that does not allow them to connect with adaptive information networks. When triggered, the memories feel like they are happening now.

**Events in Life Trigger the Unprocessed Memory**

- When similar experiences occur (internally or externally), they link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise. It feels like it is happening now.

**The Negative is Reinforced: “Ah... more proof that the lie is true.”**

- This expanding network reinforces previous experiences.
The Adaptation and Positive Information Are Also Stored in Memory Networks

- Adaptive information, resources, and memories are also stored in memory networks.
- Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks and a transformation of all aspects of the memory.
- Non-adaptive perceptions, affects, and sensations are discarded.

The Way it is Stored Appears to Change

- As processing occurs, there is a posited shift from implicit/nondeclarative memory to explicit/declarative memory and from episodic to semantic memory systems (Stickgold, 2002).

A Transformation Occurs

- Processing of the memory causes an adaptive shift in all components of the memory, including sense of time and age, symptoms, reactive behaviors, and sense of self. This allows positive change to happen. 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).

In Summation:

- The EMDR Protocol along with dual attention stimuli, eye movements, or other methods, help to process the information and bring a balance back to the system.
- Useful learning is kept and the maladaptive information is let go.
- Links are made into the positive networks.

The Clinical Roadmap and the AIP

The Presenting Complaints and Issues are the Past Becoming Present

- The presenting complaints are a result of information that has not processed into the adaptive system.
- Unprocessed memories increase vulnerability to over-reacting to the present.

Access and Change the Way the Memories Are Stored

- For the treatment plan roadmap, the focus is on the information processing system and the stored associative memories.
- The EMDR procedures are intended to access maladaptively stored memories so they can be processed in an adaptive way.
- The intrinsic information processing system and the associated memories are the more efficient and effective means to get positive clinical results.
The Way the Past is Manifesting Now is Like a Window to the Past

- The memories are targeted and accessed as they are currently stored. This allows proper associative connections to be made through the networks.

Unimpeded Processing Allows for Connections to all Associated Material in the Targeted Memory, as Well as 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 association 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.

Note: The basis of the AIP model, is that memories are stored in such a way that they remain highly acti-
The Principles of S.A.F.E. EMDR Trainings

A. 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 can be the most important quality you can bring to the therapy process. Many therapists have heard of the concept of “client-centered” therapy. Another common concept is meeting the client where they are. This has left some therapists believing that the therapist is doing something wrong or bringing in a type of “violence” when they are the expert in the room. Psychotherapy requires advanced education and experience for licensing. That education is often continued throughout the person's professional career with extended advanced learning. If done well, this continued education provides the psychotherapist with expertise in some specific areas of mental health. That expertise is what most clients are seeking as they begin the therapy process. Walking into the first psychotherapy session, the client may only have the reference of Dr. Phil or the Bob Newhart show. They may walk in believing that the therapist will either tell them
exactly what they need to do to change or will only sit silently and listen to them talk. Those two ends of the spectrum are rarely an effective approach to change.

**How can we both be the expert and have a non-violent approach?** Embracing being the expert is like offering a method for chopping down a forest. We might not know what the trees contain, or even which type of trees that are being cut down, but we know the best way to do it is with an ax or a bulldozer. The psychotherapist may also recognize the need to create safety and do some things to prepare in advance of chopping down the trees.

**B. Awareness**

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

Having personal awareness of our patterns is important. It is an illusion that we have the ability to contain or change another person’s state. We cannot make someone safe or resource them. Be careful with language because it is powerful. We want to set the conditions and offer opportunities for our clients to become empowered, learn how to develop resources, and change emotional states. Self-regulation is an important skill and we want to be clear that we are offering tools and suggestions for that, rather than that we are resourcing them or we are changing the client’s state.

**C. Mindfulness**

“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.

**We can only be in the present moment.**

The EMDR model has an aspect of mindfulness that Francine Shapiro calls “dual awareness.” It is the ability to notice our experience in the present, even as we activate a disturbing memory. We will be offering mindfulness experiences each day of the training and we have scripts for mindfulness experiencing in the basic training portal of the website that you are welcome to print out and use with your clients. There is a difference between mindfulness and meditation. Meditation is one method that has been helpful for some people to increase the ability to be mindful. But mindfulness is just the ability to be present and to notice what is happening.

It is important for the EMDR therapist to have the skill of mindfulness so it can be modeled for the client. It is also very useful for the EMDR therapist to have the ability to be mindful of thoughts, feelings, sensations, and reactions to the client. This mindfulness helps with the other principles of respect, compassion, healthy boundaries, and self-awareness.
D. Compassion

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

You can’t make anyone happy or sad and you can’t make anyone heal.
The most compassionate thing you can do is allow the truth of the moment to be here without trying to change it or try to make it better.

Many clinicians have an illusion of control. This is likely one reason many are so afraid of hurting clients with EMDR. Making this boundary clear is important. Having clear boundaries is good therapy as well as good modeling. This illusion of control is actually a ripple of violence, a way of taking over the control of the client. Trying to “make” someone do something and control the process and the outcome. This can be very subtle, which actually may make it even more powerful and have adverse results on the healing and therapy process. The subtlest way of all is taking credit for the client’s healing in any way or the belief that we can make the client better.

We want to support you in making the switch from the illusion of control—of making someone do something, even in subtle or positive ways—to the concept of gaining awareness as the therapist. Always asking first before offering assistance, is vital. Would the client like to look more deeply into an issue? Would the client like to see if there is a way his old patterns are playing a role in keeping this undesirable dynamic alive?

Ask permission to assist.

At trainings, assistants can demonstrate this when a client appears stuck. Instead of jumping in with a way of helping the client to deepen or connect more deeply, stop to ask the client, “It appears you are blocked, would you like assistance in looking more deeply at this block?” Or, “Would you like assistance in connecting more deeply to this issue?” When it is presented as a question and if the client answers “yes,” in addition to having permission, the client’s system is also hearing them say “yes” to going deeper. They are making the choice. It is less likely that the “Answer” will get stronger if the client agrees to go deeper or look at the block.

Everything needs to be optional, even healing.

Instead of chasing the client around with logic when there is an emotional reason for the block, the client has the option of saying “no, I do not want to go deeper.” It is important that this is really an option and there is no pressure or investment on the clinician’s part for the client to have an affirmative answer. If that is the case, it could be that the client declines nonverbally or the client may say “Yes, but...” and offer a condition.
The Answer is a concept unique to Personal Transformation Institute. It is our way of conceptualizing attachment theory and trauma response in order to approach EMDR as safely as possible.

“The Answer” is how the attachment pattern shows up. It is the way we adapted to stay safe or stay connected to caregivers.

This includes:
- The things we do to stay attached
- Built-in survival defenses: Autonomic nervous system responses

“The Answer” is a result of three influences:
- The family culture: “Boot Camp”
- Genetic tendencies: Our DNA
- Traumatic experiences: The Window of Tolerance

Paradoxically, a client’s Answer is their greatest strength as well as their greatest block to happiness. It is a mechanism that keeps clients from getting what they most want and keeps clients from being free. It is an illusion that makes a map of the world and creates their reality. Our physical body actually becomes the manifestation of the Answer.

At the same time, however, a client’s Answer has also always been the means by which they have kept themselves safe and connected, and that cannot be disregarded. Since the Answer is basically a defense as well as strength, we want to work with it in a way that respects the reason it is here while inviting new opportunities to develop what is underdeveloped.

We do this by assisting the client in developing other options which include choices to act instead of react.

The client’s presenting issue is always also the client’s “Answer”

It is up to the clinician to help determine what is “underdeveloped” for the client to help find the real root of the issue. But first it is important for the clinician and the client to understand why the presenting issue is here and how it was once adaptive.

Understanding this may be the most important part of treatment planning.
As the client explains the current symptoms, begin to listen for how that symptom was helpful to an overwhelmed system.

Even though this symptom may be distressing to the client, the symptom is there for a reason. This symptom is “The Answer.”

The Answer was once adaptive and is now the presenting issue.

The Answer is basically our early childhood training and how we had to adapt to stay safe and to stay connected to our caregivers. It develops out of repetition and becomes automatic.

The "Answer" causes a client to over-develop certain skills, traits, or mechanisms.

There is an imbalance because if something is over-developed, something else must be under-developed.

One way to think about the problem of the Answer is like a brick wall surrounding the memory network:
The Answer Will Not Solve the Real Problem, It Actually Perpetuates It

- You can’t figure out how to stop figuring it out.
- You can’t work harder to try to stop working harder.
- You can’t find the Answer outside of you to learn how to trust your internal experience.
- You can’t figure out how to connect by cutting off

The Problem was Once the Answer

We are always trying to fix the problem with the Answer. The Answer then becomes a problem. The original experience is the root, where we began to first develop our Answer.

The trick is...

- To be able to see that the Answer is the water we swim in
- To be able to see what the Answer is trying to “make up for.” That is the lie. What experience gave us that view of ourselves or the world?

What is missing is the ability to be able to be with the sadness of what we didn’t get or what we got that we didn’t want.
Developed and Underdeveloped

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

Examples:
• A client learned to cut off from emotions and becomes very logical as that was encouraged and praised by his family of origin. He becomes very good at being logical and analytical but not so good at connecting to his emotions or being able to tolerate the emotions of others.
• Another client may learn to be really good at noticing how other people are feeling and taking steps to attempt to regulate others. They become really good at trying to keep others calm and happy but may have a more difficult time tolerating the distress of others.
• Even things like dissociation, cutting, substance abuse and depression can be an Answer. We want to be aware of a history of these tendencies because the urge may surface when the client activates the early memories.

Our Answers and Our Client’s Answers

• Were very helpful to keep us safe or attached at one time.
• Become our strength and go-to way of managing.
• Are now patterns that feel like the only option of reality.
• Keep us from getting the thing we want the most.
• 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 be identified in the presenting problem.

Non-violence and “The Answer”
The client’s Answer has served them as a defense as well as a strength and therefore we want to respect this seemingly contradictory nature of their Answer. We want to respect their reasons for having had to develop this Answer. We can do this by taking a non-violent approach to work with, rather than against, this adaptation. We can work with the Answer while inviting new opportunities to develop what is underdeveloped. This is especially important concerning working with what some consider resistance. Non-violence helps us gently go toward the Answer.

Instead of trying to make the Answer go away, we want to appreciate the Answer and offer support for the client to make space for awareness. The client is then able to have different choices when it is appropriate.
The 5 C’s of Working with “The Answer”

*A. Catch it:* Silently seeing it happen (anything that is blocking a forward progression indicates that an Answer is here, either the client’s or the therapist’s); noticing it as a pattern.

*B. Curiosity:* Still silent—become curious about the pattern, whatever you are seeing. How does it fit in? How is this a window into the past?

*C. Celebrate & Collaborate:* The client becomes adorable. We feel like we completely understand why the client is doing what they are doing (the block/answer).

*D. Contact:* This is the first time you mention it to the client, “It seems like you are really good at______” or “It seems like it can be helpful to ______.”

*E. Connect to the past:* “I wonder how you learned to be so good at that?” or “I bet that was really helpful when ______.”

---

**The Background of “The Answer”**

<table>
<thead>
<tr>
<th>Wilhelm Reich/Freud Defenses</th>
<th>Kurtz/Ogden Managing Experiences</th>
<th>Deb Kennard The Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizoid</td>
<td>Sensitive Withdrawn</td>
<td>Invisible One</td>
</tr>
<tr>
<td>Oral</td>
<td>Sensitive Emotional</td>
<td>Emotional One</td>
</tr>
<tr>
<td>Psychopathic</td>
<td>Dependent Endearing</td>
<td>Nice/Non-Threatening One</td>
</tr>
<tr>
<td>Masochistic</td>
<td>Self-Reliant</td>
<td>Independent One</td>
</tr>
<tr>
<td>Rigid</td>
<td>Tough/Generous</td>
<td>The Hero</td>
</tr>
<tr>
<td></td>
<td>Burdened Enduring</td>
<td>The Rock</td>
</tr>
<tr>
<td></td>
<td>Charming Manipulative</td>
<td>The Chameleon</td>
</tr>
<tr>
<td></td>
<td>Industrious/Over focused</td>
<td>The Doer</td>
</tr>
<tr>
<td></td>
<td>Expressive Clinging</td>
<td>The Life of the Party</td>
</tr>
</tbody>
</table>
Tools to Find a Client's Answer

The series of questions in The Answer: Questions to Find the Answer can help you understand what your client is good at, what they have yet to develop, and how they handle stressful situations, and of course, what their Answer is. The chart titled Character Types can help you understand the pattern your client has employed in relating to others, as well as the associated negative beliefs, and over/under-developed skills.

Questions to Find the Answer

This exercise will assist you in seeing the attachment patterns of your client. It will help you begin to see what the client does under stress and what resources may need to be developed.

- 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?

So it sounds like you are really good at____ and it is harder for you to ___.
(allow feedback from the client, correcting or agreeing with you)
I’m guessing that when we are processing and you get close to pain you might____.
(again getting feedback from the client)
I wonder if it would be helpful to look at how you could develop __________.
# Character Types

<table>
<thead>
<tr>
<th>Character Type</th>
<th>Possible Neg. Belief</th>
<th>Over-Developed</th>
<th>Under-Developed</th>
<th>Needed to hear</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Invisible One</td>
<td>I'm in danger. I'm going to die.</td>
<td>Disappearing, Survival Defenses, Sensitivity</td>
<td>Safety, grounding, staying present, feeling</td>
<td>&quot;You are welcome here.&quot; &quot;You are safe now.&quot;</td>
</tr>
<tr>
<td>The Emotional One</td>
<td>I'm in danger. It's not safe to feel safe.</td>
<td>Merging into other person. Knowing how others feel. Sensitivity.</td>
<td>Boundaries, ability to self-soothe.</td>
<td>&quot;It is okay to feel safe when you are safe.&quot;</td>
</tr>
<tr>
<td>The Nice/ Non-threatening One</td>
<td>I'm helpless. I'm powerless.</td>
<td>Getting pity. Being a victim.</td>
<td>Personal power. Self-soothing.</td>
<td>&quot;I'm here for you.&quot; &quot;You can get your needs met.&quot;</td>
</tr>
<tr>
<td>The Independent One</td>
<td>I'm alone.</td>
<td>Competency. Ability to take control.</td>
<td>Asking for help. Trusting others to help.</td>
<td>&quot;You can get support.&quot; &quot;It's okay to ask for help.&quot;</td>
</tr>
<tr>
<td>The Chameleon</td>
<td>I'm not enough.</td>
<td>Adaptation to environment. Ability to manipulate and adapt.</td>
<td>Being honest. Knowing who they are. Being straightforward.</td>
<td>&quot;It's okay to just be you.&quot; &quot;You matter.&quot;</td>
</tr>
<tr>
<td>The Hero</td>
<td>I'm not safe. I'm powerless.</td>
<td>Setting firm boundaries. Withstanding pain.</td>
<td>Being vulnerable. Connecting with authentic emotions.</td>
<td>&quot;It is safe to connect.&quot;</td>
</tr>
<tr>
<td>The Doer</td>
<td>I need to be perfect. I'm not enough.</td>
<td>Energy, working hard, taking action.</td>
<td>Play. Connection. Self care.</td>
<td>&quot;You don't have to work so hard.&quot; &quot;It's okay to play.&quot;</td>
</tr>
</tbody>
</table>

These are examples of possible answers. At one time these were needed adaptations for the person to either stay safe or keep connection to a caregiver. They then become a pattern of relating to others. Most people have multiple character types. Each character type has a strength in it. **The goal is to help create balance and more choices so the authentic self can be present.**

The possible negative belief is just an example and there may be many other options.

(Adapted from Ron Kurtz, 1990 and Pat Ogden, 2002) ©Deborah Kennard, MS 2015
Character Types (Written Out)

The character type chart is to support learning about the Answer, not to label clients
1. Each Character type:
   a. Manifests in the body
   b. Is a go to way of managing stress
   c. Is a strength and presents a block to intimacy and treatment for the client
   d. Most people are a combination of types

- **Invisible One**
  - Dissociate/disappear
  - Body may be small, thin, pulled in

- **Emotional One**
  - Feels a lot and senses how others are feeling
  - A lot of emotion without getting anywhere

- **The Nice/Non-threatening One**
  - Pleases others, may be nice, be helpless
  - Weak, limp body

- **The Independent One**
  - Unable to trust help is there
  - Square firm body

- **The Rock**
  - Endures pressure, good at doing what they don't want to do, procrastinates
  - Body thick, sturdy, low center of gravity

- **The Doer**
  - Action oriented, thinking and doing
  - Body ready to take action, slightly forward

- **The Chameleon**
  - Adapts to expectations of external environment, convincing
  - Movement side to side, difficulty being direct

- **The Hero**
  - Tough, capable, takes charge, difficulty being vulnerable
  - Body puffed up, John Wayne-like

- **Life of The Party**
  - Dramatic, larger than life, need to be seen
  - Lots of movement in upper body
EMDR gets to the root of the problem

• The power of the therapy brings more vulnerability
• Vulnerability often triggers "defenses" or "Answers"
• Safety matters, non-violence/environment

EMDR and Attachment

Why do we need an attachment approach? This approach takes into consideration early attachment experiences and patterns, as well as the built-in trauma responses that also become patterns. Both trauma responses and attachment patterns become blocks to healing in the therapy process.

Whatever your client “does” will eventually happen in your office. Attachment patterns are just that—patterns. They happen over and over again. So, the attachment pattern is the model of relationships the client follows—it is the "blueprint" by which they design their relationships.

You will eventually see that manifestation of that blueprint within your therapeutic relationship with that client. When you begin to see the manifestation of this, it is an opportunity. This will surface in all phases of the process.
A. Attachment Styles and 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

B. Reasons for Assessing Attachment before Trauma Processing

- Complex trauma results in difficulty managing affect, emotional regulation, and having secure relationships.
- These two factors, somatic experience and attachment, will need consideration for treatment planning in order to provide safe, effective treatment.
- Early attachment injuries become patterns of trauma responses that can make it difficult for clients to stay in the 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
The Neurobiology of Trauma
Trauma has symptoms instead of memories because: when we are in a dangerous situation our survival system takes over. Cortisol is released which shuts down the hippocampus, our information processing center and the experience cannot be processed through our usual, narrativizing ways.

The Triune Brain (Paul D. MacLean)
A. Reptilian – Brain stem (bodily functions)
B. Paleomammalian – Limbic System (emotions)
C. Neomammalian – Frontal Lobes (thinking)

Autonomic Nervous System and Trauma
A. Parasympathetic – Collapse, Submit, Feign Death
B. Sympathetic – Fight, Flight, Freeze

Hand Model of the Brain (Siegel, 2012)
“Flipping the Lid” when we go out of our Window of Tolerance.

Window of Tolerance (Siegel, 1999)
The Window of Tolerance is a way to conceptualize autonomic and emotional arousal. When a person is within the optimal arousal zone they are able to take in and integrate information. If they are outside of this zone they are not able to process memories. Awareness of where the client is in the Window of Tolerance is important because if the client is not present and regulated, healing cannot happen.

Symptoms Instead of Memories
Our neurobiology is built to help us survive. When we are in a dangerous situation our survival system takes over. Cortisol is released which shuts down the hippocampus: our information processing center. The person is then left with the emotional and physiological response to the experience stuck in their system, unprocessed. This becomes the overreaction to the present triggers. The EMDR model, when done correctly with all 8 phases, sets the conditions for this stuck experience to be processed and for the overreaction no longer happens.
Trauma has symptoms instead of memories. This is why talking about trauma doesn't help.

Memory systems shut down and the feelings or physical impulses take over. Language shuts down.

Frontal Lobes

Limbic System

Emotional Memory Center

Brainstem

Hippocampus: Where memories are stored

Amygdala: Sounds the alarm as if we are in danger

Physiology: Our instinctive reactions. Heart race increases, breathing stops, muscles tense in preparation of survival defenses.
The Window of Tolerance is the optimal arousal zone for processing memories.

When trauma occurs it is natural for the human system to go into defensive resources: fight, flight, freeze, collapse, or submit. These are natural adaptations to trauma and danger, but they become a problem when the trauma is triggered by something that is not life-threatening and yet the human system reacts to the trigger as if the trauma is life threatening. The client becomes stuck in hyperarousal or hypoarousal.

We want to work at the edges of a client’s tolerance where we can help to expand their Window of Affect Tolerance. If the Window is expanded the client has more tolerance for emotion.

**Hyperarousal**

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

<table>
<thead>
<tr>
<th>A R O U S A L</th>
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<tr>
<td>↓</td>
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<tr>
<td>The Window of Affect Tolerance</td>
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<tr>
<td>● Able to integrate</td>
</tr>
<tr>
<td>● Regulated arousal</td>
</tr>
<tr>
<td>● Present</td>
</tr>
<tr>
<td>● Dual Awareness</td>
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</tbody>
</table>

**Hypoarousal**

- Too little arousal
- Unable to integrate
- Parasympathetic
- Collapse, Submit
At Personal Transformation Institute we are looking at the EMDR model (Adaptive Information Processing model) through the lens of somatic and attachment focus, informed by sensorimotor psychotherapy.

We consider the Somatic and Attachment focuses together because they make for a safe and effective approach to EMDR Therapy. That’s why we call this Somatic and Attachment Focus by the acronym “S.A.F.E.”

S.A.F.E. is the basis of our style of treatment and training. Without safety there can be neither learning, nor therapeutic transformation. Emotional and physical safety are required in both training and in therapy.

• Our approach is safe because of our somatic focus: we teach and use somatic resources: exercises meant to manage affect and emotions.

• Our approach is safe because of our attachment focus: we use the positive and negative aspects of a client’s Answer in order to work within their Window of Tolerance.
The EMDR Approach

AIP
Adaptive Information Processing:

Inadequately processed experiences are the basis of clinical complaints.

Negative experiential contributors can be

The S.A.F.E. Approach

Somatic and Attachment Focused EMDR Adds:

The attachment and adaptive concept.

Somatic awareness

The distinction between developmental and trauma experiences.
# The 8 Phases of EMDR and S.A.F.E. Additions

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

1. Safety and Stability

First, you want to gather information regarding:

• Current resources
• Current stability

If you find that the client is not stable or does not have sufficient resources, you will essentially be starting in Phase 2, Preparation Phase. (See Practicum Packet for full list)

Questions to ask in addition to questions from “The Answer” worksheet:

• How do you currently handle stress?
• Do you cry and when you do 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 supports do you have?

If you have an idea that the client has a severe trauma history, you will want to titrate the information gathering. Gathering general or positive information first using the Answer concept.

• The client may need more resources prior to discussing traumatic memories.

Remember: Trauma often has symptoms instead of memories
• DES (Dissociative Experiences Scale); Eve Bernstein Carlson, Frank Putnam
  Other tools:
  • National Center for PTSD
  • http://www ptsd.va.gov/professional/assessment/all_measures.asp
  • SCID-D- Structured Clinical Interview for Dissociative Disorders
  • MID- Multidimensional Inventory of Dissociation

3. The Problem Was Once an Answer

• As the client explains current symptoms, begin to listen for how those symptoms were helpful to an
  overwhelmed system.
• This understanding can also explain the impact of trauma and what is underdeveloped.

Treatment Considerations

Although many of us are trained to look for big “T” traumas that meet the criteria for PTSD, it’s important
to also look for small “t” traumas and developmental and life events that cause disturbance. Both types
of experiences can be effectively treated with EMDR. Additionally, it’s crucial to identify what did not
happen or areas in which there was neglect.

There is also a middle ground between neglect and trauma, one that is often overlooked: it can be diffi-
cult to recognize the weight of responsibility of the “Golden Child.” For this client, there is often a sense
of needing to make parents proud by achieving or being good. When a client is afraid that a parent will
disapprove they miss the freedom to make life choices. This can create limitations in adult life.

During history taking, remember to look for:

• Adverse Life Events
• Attachment Disruptions
• Internalized Pressure of Achievement
• What Didn’t Happen

Approach each event with curiosity. How was the client’s Answer helpful in each scenario?
Important: Although all clients are appropriate for the AIP model, not all are ready for the reprocessing of memories.

AIP Case Conceptualization

- 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

The therapeutic connection is vital. Is there trust and safety in the relationship? Is the therapist confident the client is able to ask questions and state needs?

- Honest Feedback
- Ability to ask for help (call between sessions if needed)
- Are there any barriers to trust?
- Dual Attention?

Getting the Clinical Map

- Understanding Attachment Issues and Relationship Patterns
- Gender, Cultural, Ethnic Issues
- Secondary Gain
- Current stressors
- Timing
- Resources

Has the Therapist Explored Each of the Following Areas?

- Dissociation, Screened for DID (Use 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
Client Readiness for Processing Areas

Client Stability
Has client been screened for Dissociative Disorder? If client has Dissociative Disorder, this rules out processing phases for weekend 1 trained clinicians. (See Special Populations Section.)

The Mental Status Exam should be used for all clients. Special preparation is needed for clients with DD 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. Not limited to the following indicators:

- 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: The following require caution and possibly case consultation.

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

Stabilization

- Do they have adequate stabilization/ self-control strategies in place?
- Client must be able to go from disturbed to calm between sessions
- Client has adequate support system (friends, family etc.)
- Issues that may be a danger to client have been addressed
- Client is able to call for help if needed

Medical Considerations

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

Timing Considerations

- Timing of life events; Availability of Therapist
- Willingness to continue treatment, 90-minute sessions if necessary
Phase 2: Preparation

(Chapter 5, Shapiro 2001)

Introduction

In Phase 2 we are preparing for the worst. We are looking for the client’s ability to regulate, their ability to stay safe, and their ability to connect. We are planning what resources we can use to increase this ability.

In this Phase we are making sure the client has all of the tools and resources needed to begin the reprocessing of memories. We are looking for the dangerous issues and safety issues, as well as the annoying things and connection issues, that will impede the healing process.

We want the client to get through the processing as quickly and safely as possible. Making sure the therapeutic container is safe and strong is crucial to this process. We want to address all questions and concerns of the client. 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 Adaptive Information Processing Informed Resource Plan

Treatment planning in EMDR means something slightly different than it does in other therapies. In Phase Two we are preparing for reprocessing by not only figuring out what memories we will reprocess—we are determining what resources are needed so that we can discuss those memories in the first place.

We want to ‘develop a treatment plan’ that includes both information (case conceptualization, the first traumatic memory, the negative cognition—all concepts to be discussed in this section) and resources to increase a client’s Window of Tolerance.

We aren’t so much developing a treatment plan as we are developing an Adaptive Information Processing Informed Resource Plan.

During Phases 1 and 2 we are of course planning ahead to a certain degree: we understand that there are Three Prongs to EMDR and that we are planning on moving with our client from the past through 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 about Phase 2 we will learn more about what needs to be established, the goals of stabilization and resourcing, how to conceptualize a case, examples of resources, how to find the memories to target (and in what order), and learn about negative cognitions and their role in later phases.
Resources

When we use the term resources we are referring to any actions or automatic habit patterns that assist a client in affect regulation and connecting with others.

This is one way the concept of “The Answer” is helpful. We are looking at the adaptation that happened to help maximize safety and connection. So, as we hear the current symptoms we are curious about how those symptoms developed to help the client maximize safety and connection. These symptoms that the client is coming to you to “get rid of” were helpful at one time for the client. By looking through that lens, the client’s current symptoms were at one time, and in many ways still are, current resources.

In other words, clients come to us with their own resources. Of course, these current resources may not be healthy ones, but they still serve to assist in affect regulation or connecting to others. A good example of a potentially unhealthy resource is substance use or abuse. The client may be using substances to regulate affect and or connect with others.

Other unhealthy resources may be:
1. Using food in unhealthy ways
2. Using angry outbursts to assist in boundaries
3. Dissociation

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

1. The presenting issue.
2. The client’s story, (we recommend a brief version of the story without trauma related details).
3. Using The Answer questionnaire and looking at the various areas with the Arrows exercise (see page 65).

The first investigation of the client’s current resources is mostly verbal and in an ordinary state of consciousness. We are looking for patterns and strengths as we listen to the client’s story, ask the questions of the Answer exercise and then look at various areas with the Arrows.

Once we begin to get an idea or become curious about a pattern, we then invite the client to try an exercise or experiment where our intention is to continue to investigate with curiosity. We are not trying to make anything happen and we are not trying to get the client to feel better or make something happen.

We invite mindfulness. The therapist will need the ability to be mindful and stay in an open state of curiosity, which 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

Mindfulness is the ability to notice your experience while remaining curious and open about what arises. You can be mindful of:

1. Sensations
2. Thoughts
3. Memories
4. Emotions
5. Beliefs

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

With our concept of resources we are looking for areas of imbalance. We have many tools to use to help us deepen our understanding of the client. Remember we are not looking for THE ONE Answer. We are looking for patterns that the client has developed to maximize safety and connection and those patterns, while useful, are now keeping the client from the very thing they want most, connection and feeling safe when they actually are safe.
Treatment Planning

Desired Future State 1

Present Trigger #1

Presenting Problem

Past Event

Past Event

Past Event

Going Younger

Past Event

Past Event

Touch Stone (Earliest)

Worst

Resources to Use
We Need to Establish

Client Education
• Discuss EMDR and what to expect (before, during and after reprocessing)
• The nature of Trauma/Memory
• What is expected of the client
• Possibility of high level of affect
• Possibility of urges if addictions are in the present or past

Informed Consent
• May be formal/verbal/written, or all of the above.

Resources and Adequate Stabilization
• Affect management
• Container/Grounding
• Resources
• Calm/Safe Place
• Alternative plan instead of using/addiction
• Relaxation and stress management

Strong Therapeutic Alliance

The Mechanics of EMDR
• Ships in the night seating
• Eye movements and alternatives

Understanding the Answer to Predict the Pitfalls:
• In history taking we began to look at strengths and underdeveloped skills with the Answer and other information. Now we will look at how the Answer can predict or explain a client’s ability to stay safe and connected during therapy.

Dangerous Things (Safety): Suicidal tendencies, self-harm, harm to others, cutting, dangerous addictions, DID and others

Annoying Things (Connection): Over-thinking, becoming critical, nothing happens, trying to please you, being perfect, being helpless, not telling the truth and others

How were these adaptive in the client’s history? How did it help? What does the client need more of or less of? What is over and under developed for the client?
The Goal of Resourcing and Stabilization

We are assisting the client in developing what is needed in order to tolerate the reprocessing phases of EMDR.

We investigate what is here and determine what is needed. We want to ensure they have the ability to feel safe (affect regulation) and feel connected (toleration of connection).

Phases 3-7 are the phases in which we help the client to change the way the memories are being activated. Everything we do prior to those phases should be done with the goal of reprocessing in mind. During this phase it’s important to:

• Remember that affect instability is often due to memories that have not been processed
• Assist in helping the client increase the window of tolerance if needed
• Assist the client in increasing the ability to regulate affect and tolerate deep sadness
• Assess if the client is able to demonstrate the ability to change his/her emotional state from some degree of upset to relatively calm in the office
• Become aware as the clinician of the client’s Answers and predict how it may surface in reprocessing phases
• Ensure that the client can report his/her present thoughts, images and somatic experiences to some degree

*Often an extended resource development phase is due to the clinician not being ready more than it is the client not being ready.

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

• You are able to see the client change states, go from mild upset to calm in the office.
• The client reports the ability to use resources at home.
• The client shows some ability to track and report their experience.
• There is some sense of emotional safety in the therapeutic relationship.
• The therapist and client have explored all of the “Dangerous” and “Annoying” things, understands and appreciates that those behaviors were once adaptive and are still helpful, but is able to predict how they will now get in the way of the change and healing that the client desires.
What does the client need prior to processing memories? 

**Note:** Complex trauma may need a longer preparation and stabilization phase to develop resources. See Section VI: Restricted Processing for more on Complex Trauma.

**Single Event:** This presentation is rare. The client has ability to change emotional states and connect only one event to work on. (Example: Athlete in a slump, a one-time traumatic event with no hx connected)
- In this case they have many resources and only a few problems.
- Clinician need to spend less time in phases 1 & 2.

**Multiple Issues:** This presentation is more common, in which the client has some resources and many life stressors and symptoms that are a result of a lifetime of patterns and events.
- Client has many long-term issues to address and some resources.
- Clinician spends more time investigating resources and needs.

**No Positive Resources:** This presentation of complex trauma in which all of the client’s resources are potentially dangerous or harmful takes longer in the preparation phase to assist the client in building resources and safety prior to beginning phases 3 through 8.
- Client has had extensive negative experiences and the only resources are harmful or trauma-based survival resources.
- Client's current resources may include: dissociation, substance use and abuse, depression/avoidance, etc.
- Clinician spends a long time investigating the dangerous ways the client is currently managing and takes a longer time building resources in phases 1 & 2.
Resource: More of Less of

A “More of Less of” Chart:
A Tool to Find What is Over/ Underdeveloped & Begin to Create Positive Cognitions

<table>
<thead>
<tr>
<th>Client’s Answer</th>
<th>More Of</th>
<th>Less Of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over thinking</td>
<td>Connection with feelings</td>
<td>Thinking, Analyzing</td>
</tr>
<tr>
<td>Perfectionism</td>
<td>Ability to be with the truth of the moment</td>
<td>Trying to control self, outcomes or other’s reactions</td>
</tr>
<tr>
<td>Obsessing (hyper)</td>
<td>Calming, Mindfulness</td>
<td>Thoughts</td>
</tr>
<tr>
<td>Substance Abuse (hyper trying to go hypo?)</td>
<td>Affect/Stress Management</td>
<td>Urges</td>
</tr>
</tbody>
</table>

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.

Use the information from “The Answer” to look at each of the below areas for the client. Where are they on each continuum? You will then use this to suggest a plan for building resources and preparing for reprocessing phases. Use the suggested resources based on client need. The resource instructions are found in the resource section of the manual.

We are looking at each area and where the client falls on the continuum. Recognizing the adaptive nature of the current strengths, we will always frame the statements in a positive manner. For example, if someone is hypersensitive, we might say: “You are really good at feeling the pain of other people and trying to help them.” If someone is insensitive, we may say, “You are really good at setting boundaries and delineating your issues from the issues of others.”

The therapist can collaborate with the client by selecting a resource and practicing it together.
<table>
<thead>
<tr>
<th>Good at being firm</th>
<th>Boundaries</th>
<th>Good at being flexible</th>
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<tbody>
<tr>
<td>Ability to freely give and receive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear about personal rights and rights of others</td>
<td></td>
<td></td>
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<tr>
<td>Ability to choose</td>
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<tr>
<th>Good at verbal expression</th>
<th>Verbal Expression</th>
<th>Good at listening</th>
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<tbody>
<tr>
<td>Able to put words to feelings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A balance of listening and expressing</td>
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<table>
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<tr>
<th>Good at calming yourself alone</th>
<th>Affect Regulation</th>
<th>Good reaching out for comfort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to regulate affect alone or with others</td>
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<tr>
<th>Good at making things happen</th>
<th>Personal Power</th>
<th>Good at going with the flow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear about wants and needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear about choices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aware of effect they have on others</td>
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<table>
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<tr>
<th>Good at convincing</th>
<th>Influence</th>
<th>Good at noticing what others want</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to reach out for help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to ask for what you want/ Doesn’t take advantage or get taken advantage of</td>
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</table>
We are investigating when we practice resources. A curious attitude is useful as we invite the client to experiment in various ways. We are inviting, noticing and encouraging the client to be open to whatever happens in the resourcing. It is important to notice if activating is beginning to happen for the client and stop to switch to a different resource or change the focus. This is not a time for processing emotional.

**Boundary Resource Exercises**

**Scarf Connection/Letting Go Exercise**

Holding a scarf (rope, neck tie, or other object), have the client hold on to one end of the scarf and you hold on to the other. Investigate the following questions:

1. "As you hold the other end of the scarf, what is just the right amount of tension in the scarf?"
2. "What tells you that?"
3. "What is a good distance between us as we hold the scarf?"
   "What tells you that?"
1. "Would you like to try an experiment?"
2. "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 client indicates readiness, drop one end.)
3. What do you notice as I drop my end?"
4. "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."
5. "Now, I’d like you to notice what changes as I pick my end back up. What do you notice?"
6. "Now would you like to notice what happens as you drop your end and I hang on to my end? (Allow answer) Whenever you are ready drop your end. (When client drops it) What do you notice?"
7. "Now, would you prefer I ask you to pick up your end or would you rather just pick it up when you are ready?" (Allow answer and do what they choose.) "What do you notice?"
8. "What did you notice was different when I asked you versus when you decided?"
Sitting position
• Distance
• Dual awareness – Bilateral stimulation: moving the eyes

**Dual Attention Stimulation (DAS):** Dual Attention Stimulation 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
• Range
• Speed, length of set
• Direction
• Bifocals, glasses, contacts

**Resource: Metaphors**

Train: “In order to help you ‘just notice’ the experience, imagine riding on a train and the feelings, thoughts, etc., are just scenery going by.”

Movie: “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.
Work with whatever is present- even a refusal of the invitation.
Always ask permission before using touch.

**Try Experimenting with:**
Boundaries
Connection
Proximity
Saying No
Choice
Therapist Turning around

**Experiments that offer bottom up exploration of what is over and under-developed:**
Physically or verbally set a boundary
Move
Be Still
Make an affirmative statement
Talk
Be Silent
Communicate without words
Exaggerate a posture or movement and the opposite
Say No
Reach
Physically connect with Therapist, e.g., holding ends of a scarf

**Props:**
Beanie Babies
Stand Tray Figures
Balls
Scarves or Ties
Sensori-Stimulation objects, e.g., essential oils, cough drops or candy, soft or textured objects, singing bowl
Marbles
Pillows

**Note:**
Experimenting with Connection Issues is also a way to assess the client’s Window of Tolerance (WOT). Somatic resources may bring up unresolved Attachment Wounds and Attachment Trauma resulting in Hyper- or Hypo-Arousal.
Be prepared to offer State Change / Safety Resources following Somatic Resources.

**Safety Resources:**
Breathe
Center
Align
Safe / Calm Place
Spiral
Grounding
Playing Catch
Container
Light Stream
Getting to the Root & Finding the Negative Cognition

Key Words

• Presenting Issue/ Present Triggers: a specific and current problem
• Touchstone Memory: earliest experience related to the presenting issue
• Target Memory: the memory you are going to process. Will be the Touchstone Memory first.
• Negative Cognition: a negative belief about the self. Helpful in finding the Root of the Issue.
• Root of the Issue/ Problem: earliest experiential time prior to the Answer

Do not confuse the use of a negative cognition with CBT. The negative cognition (NC) is most important in helping us find the targets. Finding the right NC activates the limbic system allowing the client to have access to related memory networks. With the help of the therapist the client can find the root of the present issue.

Three Prongs of Treatment

1. Past
   • The first experience (earliest “Touchstone Memory”)
   • The worst experience
   • Other times in chronological order if possible.

2. Present
   This is the recent times that the presenting issue is a problem. Look at all areas of life:
   • Work/School
   • Social Situations
   • Intimate Relationships

3. Future
   • For each present situation identify how the client would rather respond in the future
   • Explore new patterns of behavior and feeling
   • Look for missing experiences or underdeveloped skills and resources

This is the larger view of the EMDR treatment. We target one presenting issue at a time.

Ideally, we start with the earliest memory first, the Touchstone Memory, and then process the later memories, past events, chronologically.
After all earlier memories are resolved, we process whatever disturbance is left in the present triggers. Then for each Present Trigger, the client and therapist together develop how the client would like to react in the future.

**Common Mistakes:**

1. Not understanding that we are looking at what happens in the client’s system NOW as we bring up past memories, present triggers and future possibilities.

2. Not getting a specific moment in time for each of the memories.
We are moving closer and closer toward earlier memories in Phase two:

**Note:** Although this is officially in the history phase, often you will be doing preparation first, as in doing the safe/calm place exercise.

To find the earliest memories ask the client to bring up a recent time that this issue was disturbing as well as an example of the most upsetting time that this was an issue.

It is important to get the information in the least triggering way possible. Just getting the headlines, not the details. **It is recommended that when possible you do this just prior to reprocessing.**

1. **Direct Questioning** (Part of Finding the Target’s Script)

   “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?”

---

**The Map Maker: Accessing Early Memories**

![Funneling toward the root diagram](image)
• You will ask this several times until they cannot think of any more events.

• If the Direct Questioning does not produce a childhood memory continue to the next level.

• Before proceeding be sure your client is stable and is not dissociative. These techniques can break through defensive barriers and access deeper emotion.

We recommend that the next methods of accessing memories are only used when you have time to continue to phases 3-7, reprocessing phases.

2. **Float Back** (Shapiro, 2001, pp. 433-434)

“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, and let your mind 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 affect or somatic bridge (Watkins, 1971).

3. **Affect Scan** (Shapiro, 1995)

“Bring up that experience, the emotions and the sensations that you are having now, and allow yourself to scan back for the earliest time you experienced something similar.”
Finding the Targets Getting to the Root of the Present Issue

In this section the clinician is just getting “the headlines” not details about the events. This is generally competed in a session prior to processing. Getting too many details can be too activating. For the practicum purpose you are also only getting the headlines. As soon as it is clear that the client has a specific memory and it is a “moment in time” the therapist should ask for the age and then ask, “and what is an earlier time?” Note that the recent examples of how the issue appears in the current life, Present Triggers, are then used at the end of the form for getting the Future desired behavior/state the client want instead of 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?”  Earlier Memory:  Age:

Clinician keeps asking as long as the client keeps answering. Earliest is the “touchstone”.

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

<table>
<thead>
<tr>
<th>Red Flags</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No family of origin memories</td>
<td>“What happened when you told your parents (caregivers)?”</td>
</tr>
<tr>
<td>No affect with memories</td>
<td>Does the client appear to be thinking about what “should” be connected? How is the client’s “Answer” here? Is he/she good at analyzing, figuring things out?</td>
</tr>
<tr>
<td>Memories appear to go in a straight line without much or any affect</td>
<td>How is the client’s “Answer” here? Was the NC too specific?</td>
</tr>
<tr>
<td>All memories are examples of the client’s “Answer”, staying safe of staying connected.</td>
<td>“What happens when you don’t/can’t do that?” i.e. “What happens when you are not perfect?”</td>
</tr>
<tr>
<td>Not any affect or reported disturbance and about one caregiver.</td>
<td>“What happened when you told the other parent (caregiver)?”</td>
</tr>
</tbody>
</table>
The Negative Cognition is a core, negative belief about self.
The Negative Cognition is not the problem from the EMDR Therapy view, it is a way to help access the core issue and associated early experience that laid the foundation for the current dysfunction.

The Negative Cognition is just a portal into the system. There are other portals, such as affect, behaviors, patterns, and body sensations that can also be used. As long as we get to the early memories that are being played out in dysfunctional or limiting ways, we are on the right path.

The correct Negative Cognition has the following characteristics:

• The client can feel it. There is a negative emotional charge when the client says the NC.
• The client “knows” it isn’t true, but it “feels” true, when they state the NC.
• It is likely the thing the client has been trying to not believe or make up for in life.
• It is about a core belief about self.
• It is generalizable across situations and relationships.
• It is usually words that a child would use and not adult language.
• It is irrational.
• We want it to be as bad as possible to help access the memory networks.

How to find the Negative Cognition:

“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 anger (or other emotion), what is the negative belief you have about yourself, even though you may know better.”

then

“If that______ (sadness, tightness, pain, squeezing) had words, what would it be telling you about yourself or the world?”

Lighting the Limbic Lightbulb:
The correct Negative Cognition helps to activate the client’s limbic system and opens the access to root of the issue, the early memories. The therapist is often able to see the limbic system light up by some change in the client's face.

**What is more difficult for the client to do?**

Understanding the difference between the root of the problem and the Answer to the root of the problem is essential. If the client reports an NC like, “I have to be perfect” or “I have to be in control,” it is likely they are at the Answer and not the root of the issue. A good question to ask here is, “What does it mean if you are not ________ (perfect or in control)?” This will help set the conditions for the client to access the true NC that will lead to the actual root of the present issue.

**Consider while finding the 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?

This is where the therapist’s other therapy skills are needed. You get an understanding of what it is like to be the client. The more you understand this the easier it will be for you to see if the negative cognition is part of the Answer or above the root of the problem.

It is useful for the therapist to see his/her own answer surface during the EMDR process in all phases by being aware of distress or frustration or trying to save, control, or keep the client calm. 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. (Both of these indicate the therapist’s Answer may be present.) 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.

**By understanding how the client HAD to adapt to stay safe or attached, the Answer,** we are able to see if the NC is actually a part of the Answer. This sets the conditions for the client’s system to activate and access the experiences connected with the root of the present problem.

**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.

**Note:** Always ask if the original PC still fits or if there is a better, even more adaptive one after processing Phase 4. The therapist accepts whatever PC the client says at that point.

**The root NC is generalizable to all areas of life and all relationships.** It is NOT a behavior or about someone else. The NC is something a child might say and is something the client can feel when it
is stated. The limbic light bulb lights up! The client can feel it even though they may, and likely do, know better. The client knows it's not true but it feels true.

**Ideally, the NC will come organically from the client’s system** (in Finding the Targets). This is not always possible, and the therapist may need to assist by offering some possibilities in the form of a question or a menu. It is important for the therapist to invite the client to go within to find the NC without automatically offering one. (See below for option for deepening the NC).

The root NC is often connected to a message we directly or indirectly received from our family of origin and often our caregivers. It does not mean that the caregiver or others “did something wrong or mean,” although that is a possibility. It is also possible that the person was attempting to help the child feel better by saying things like “cheer up and/or move on,” without allowing the child to feel whatever was needed at the time for as long as was needed. Exploring how this dynamic played out for the client can be explored during the Answer.

The NC could also be related to what DID NOT happen instead of something that happened. Finding what did not happen can be more difficult than finding what did happen. Neglect or just busy parents who were not tuned in to what the child needed can be found by asking about the reaction of the caregiver. The root of the issue could be a missing experience rather than a direct experience. The Answer-Extended can help the therapist and client understand the family dynamics of the family of origin and bring to awareness what the client learned to do to adapt to that environment. This will help bring to the surface, the client’s strength and how they became so good at doing that. What the client became good at somehow provides them with a similar (yet importantly different) experience of what they did not get but needed. This becomes the block to relationships when the client cannot trust the experience of receiving from another person the thing that they need the most.

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.”

Also, if the client reports all events outside of the 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” or “what happened when you went home and told your caregivers about it?”

**If the client’s system becomes activated prior to finding an appropriate NC, it is likely they have accessed it through another part of the system.** At that point the therapist proceeds with Direct Questioning, asking if there was an earlier time when they felt similarly. Remembering that the point of the NC is to activate the limbic lightbulb and if that happens, the therapist uses that opportunity to get the information and get out.

**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).

A. Variety of Access Points:

The treatment plan and early associated memories can be gathered from a variety of entry points into the client’s system. Any of the following can be used. Remember the AIP is based on earlier memories and that is what we are looking for here.

These are some examples. With each you can steep the client into the experience more if needed to get the earlier associated memories.

Negative Cognition - Irrational Belief About Self:

“When you say those words ‘I’m not good enough’ what earlier times come to mind when you had that belief?”

Behaviors:

“When you bring up this 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:

“As you bring up the experience of being ________ or being with _________, what earlier memory comes to mind?”

We are going to use the NC, Negative Cognition, to get to the early memory, touchstone, as it is often the easiest way to activate the system.
B. Negative Cognition Beliefs

This is the conclusion they drew about themselves or the world at the time of the early disturbing experience. This can be about what happened or what didn’t happen.

Important aspects of this Negative Cognition:

1. It isn’t true. This is a lie but it feels true.
2. It is irrational. The client will know better but still feel this is true.
3. It is what they believe now when they bring up the memory.
4. It is generalizable, a global type of statement and not related to one person or event only.
5. The client can feel it.
6. It resonates with the presenting issue as well as the earlier memory.
7. It is an “I” statement most of the time.

Note: It is best to get these from the client’s system, not from showing them the list!

<table>
<thead>
<tr>
<th>Types of Negative Cognition (NC)</th>
<th>Possible Positive Cognition (PC)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Defectiveness/Shame</strong></td>
<td></td>
</tr>
<tr>
<td>“I’m permanently damaged”</td>
<td>“I can heal”</td>
</tr>
<tr>
<td>“There is something wrong with me”</td>
<td>“I’m fine as I am”</td>
</tr>
<tr>
<td>“I’m not good enough”</td>
<td>“I am good enough”</td>
</tr>
<tr>
<td>“I’m a bad person or I’m bad”</td>
<td>“I am good or caring”</td>
</tr>
<tr>
<td>“I’m incompetent” (Ask if I’m stupid fits)</td>
<td>“I can succeed”</td>
</tr>
<tr>
<td>“I’m worthless/inadequate”</td>
<td>“I am worthy”</td>
</tr>
<tr>
<td>“I am unlovable”</td>
<td>“I am lovable”</td>
</tr>
<tr>
<td>“I am stupid”</td>
<td>“I am smart enough”</td>
</tr>
<tr>
<td>“I am ugly”</td>
<td>“I am fine as I am”</td>
</tr>
<tr>
<td>“I am a disappointment”</td>
<td>“I’m okay as I am”</td>
</tr>
<tr>
<td>“I’m different”</td>
<td>“I’m okay as I am”</td>
</tr>
<tr>
<td>“I’m invisible”</td>
<td>“I matter”</td>
</tr>
<tr>
<td>“I’m a failure”</td>
<td>“I am worthy”</td>
</tr>
<tr>
<td><strong>Responsibility/Guilt</strong></td>
<td></td>
</tr>
<tr>
<td>“It’s my fault”</td>
<td>“I did the best I could”</td>
</tr>
<tr>
<td>“I should have done something”</td>
<td>“I did the best I could”</td>
</tr>
<tr>
<td>“I should have known better”</td>
<td>“I did what I could”</td>
</tr>
<tr>
<td>“I should not have___”</td>
<td>“I can learn”</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
</tr>
<tr>
<td>“I’m going to die”</td>
<td>“I survived/ It’s over”</td>
</tr>
<tr>
<td>“I am in danger”</td>
<td>“I am safe now”</td>
</tr>
</tbody>
</table>
“It’s not okay to be safe”

Control/Choices
“I am out of control”
“I am powerless”
“I am helpless”
“I am weak”
“I can’t protect myself”
“I can’t trust my judgment”
“I cannot get what I want”
“I have to be perfect”

“I can feel safe when I am safe”

“I can have control”
“I have personal power”
“I can make choices”
“I am strong”
“I can protect myself”
“I can trust my judgment”
“I can get what I want”
“I can be human”
<table>
<thead>
<tr>
<th>Possible Answer</th>
<th>Question to Ask</th>
<th>Possible Root NC</th>
</tr>
</thead>
</table>
| I have to be perfect    | What does it mean about you if you mess up or fail? | I’m worthless  
I’m unlovable  
I’ 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       |
Common Mistakes in Finding the NC and What to Do:

1. It is a description of circumstances or behaviors.  “What does that mean about you?”

2. It is a past belief; what they believed at the time.  “As you bring up that memory in this moment, what do you believe about yourself now, even though you know better?”

3. Too heady or adult language.  “What would a child say?”

Positive Cognition

Important aspects of the Positive Cognition:

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

Common Mistakes When Finding the PC and What to Do:

1. Just negates the NC and does not reflect what they would like to believe. i.e. “I am not ugly.” “Would you like to believe ‘I’m fine as I am?’”

2. It is magical thinking. “My mother loved me.” “Would you like to believe ‘I am lovable?’”

4. The PC is too big or a leap for the client and not believable at all. “If I am lovable is too big of a step, would you like to believe ‘I’m learning to love myself?’”

5. The client will often think the positive belief needs to be believable at the time of the incident instead of what the client wants to believe now as he/she brings up the memory.

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

• Allows for a full range of associations to be made throughout memory as well as integration to be made into the full system.

What you are assessing in this phase: How the memory is currently manifesting for the client.

Note: A good way to think of this phase is Activation

You are likely not getting new information here. Instead you are activating the target memory and all of the components.

*LIKE FLIPPING ON ALL OF THE SWITCHES...STARTING THE ENGINE*

You are allowing for all of the associated material to surface in the network.

Before you start this phase you:
• Are in the ready seated position for reprocessing
• Have completed all of the mechanics questions/testing
• Know the client meets criteria to be ready for Phase 4 Reprocessing
• Have agreed on the target and understanding of the clinical map

The Client does not decide what target to reprocess. This would be like a surgeon asking a patient to decide the course of surgery. You must use your clinical judgement to decide what target to reprocess.

Common Mistakes in Phase 3:

1. Repeating what the client says or talking in general. The therapist is just lighting up the way the memory is presently held—like flipping a switch—and moving on.
2. Not remembering it is about NOW. The client will often think you are asking about how they felt or thought at the time of the memory. It is up to the therapist to constantly bring them back to NOW.
3. Thinking that this is a time to explore the NC. The therapist should already have found the correct NC in the Preparation Phase 2. If needed the therapist may say, “Last time you said it was I’m not good enough, does that still fit?”
4. Doing anything between Phase 3 and 4. The therapist should make sure that the client is ready to go directly from Phase 3 to 4 prior to asking the first question in Phase 3.
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?”

Negative Cognition (NC):
“What words go best with that picture (or incident) that express your negative belief about yourself now?”

Positive Cognition (PC):
“When you bring up that picture, what would you rather believe about yourself now?”

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?”

Emotion:
“When you bring up that picture and the words _______ (repeat NC), what emotion do you feel now?”

Subjective Unit of Distress (SUD) Scale:
“On a scale of 0-10, where 0 is no disturbance or neutral and 10 is the worst disturbance you can imagine, how disturbing does it feel to you now?”

0   1   2   3   4   5   6   7   8   9   10
Neutral/No disturbance   Highest Disturbance

Location of the Physical Sensations:
“Where do you feel it in your body?”

**AS SOON AS YOU ASK THIS QUESTION YOU ARE IN PHASE 4**
*Move right into the first question in phase 4*

“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.”

---

**Procedural Steps**

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Worksheet

Specific Instructions: Prior to starting, please make sure you are in the correct seating, have already practiced speed, distance and type of DAS, and practiced the stop signal. You should be ready to start eye movements after the final question in Assessment.

Target: (In training, earliest touchstone memory found. This should be a moment in time, not an issue.)

“When you bring up that memory, what image represents the worst part?: ________________

ONLY if no image (may be another perception of the five senses): “As you think of the experience, what is the worst part of it?” __________________________________________________________________________

Negative Cognition: “What words go best with that picture that express your negative belief about yourself now?” __________________________________________________________________________

Positive Cognition: “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 (repeat the positive cognition above) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”

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

Emotion: “When you bring up that picture and those words (negative cognition above), what emotion do you feel now?” __________________________________________________________________________

SUD: “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?”

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No disturbance/neutral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest disturbance</td>
</tr>
</tbody>
</table>

Location of Body Sensation: “Where do you feel it in your body?” __________________________________________________________________________

“I’d like you to bring up that picture, those negative words (repeat the negative cognition), and notice where you are feeling it in your body—and follow my fingers.” (DAS generally 20 or more passes/customized to need of client.)

Important!! After the following question, you immediately start DAS and are in PHASE 4. (Turn to next page.)
Reprocessing the Target:

Reprocessing memories that are at the root of the current dysfunction (The goal is for a SUD of 0 for each target memory).

What is happening in regard to the AIP:

- We are looking at the current manifestation of the memory as it is stored. As the information comes up we allow it to move and process unimpeded whenever possible.
- We are asking the client to bring up the target memory (accessing) and processing the memory network.
- SUD should be 0 twice for complete treatment.
- The information processing happens as the targeted memory becomes more adaptive. Learning occurs as it links into more adaptive networks.
- After each set of dual attention stimulation (DAS), the client gives feedback about the experience.
- All channels are accessed by returning to target and reprocessing what is still disturbing.
- Taking a SUD of the entire memory will tell you when processing is complete, or incomplete.

Phase 4 is like a Three-Act Play:

Act 1- Clearing the 1st channel.
What do you notice now? Go with that. Repeat until responses become positive, neutral or stop changing.

Act 2- Clearing subsequent channels / Going back to target.
When you go back to the original memory now, what do you notice? Go with that. What do you notice now? Go with that. Repeat until going back to target yields no additional disturbing information.

Act 3- Completing Phase 4 / Checking the SUDs.
When you go back to the whole memory, how disturbing does it feel to you now on a scale of zero to ten? Go with that. What do you notice now? Go with that. Repeat until you get 2 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 alternative Dual Attention Stimulation).

Dual Attention Stimulation:
In general, sets of DAS (across and back) are done for 15 to 30 seconds. However, it may be
longer or shorter depending on the needs of the client. It is fine to get feedback from clients about doing more or less for their processing. You can begin with 24 passes (one pass is back and forth) for the practice sessions.

• The rate and speed are as fast as they can comfortably tolerate. Stopping in the midline.
• Eye movements versus tapping/auditory

**Note:** The number of passes of 24 can be refined as the therapist is more comfortable and attuned to the client. Some clients will require more and some fewer.

**Feedback:**
• After a set of eye movements the therapist gets feedback.
• Educate clients that they do not need to tell you everything they experienced during the set of eye movements.
• Asking for feedback is general and open. “What are you noticing now?”

**How to Recognize If Processing Is Happening:**

**The Memory Changes:**

• Different Images/ Images Change  
• Emotions change/ More or less intense  
• Sensations change/ More or less intense and movement  
• Thoughts change/ Positively or negatively  
• Perspective changes/ More adult perspective possible

**Memory Network Changes: Channels**

• Different times and people associated  
• Different memories that are associated  
• Physical sensations associated  
• Associated emotionally  
• Associations to the beliefs

**Types of Processing:**

• Visual  
• Emotional  
• Physical Sensations  
• Clusters/Other memories

**How to Handle Various Memories That May Come Up Spontaneously:**

**Therapist as a Container:**
• The important aspects of an effective EMDR therapist
• Specific tools needed
• Staying connected while keeping boundary
• Staying out of the way

Information Not Moving:

• Assess for Safety
  • Are they present?
  • Dual Awareness?
  • Window of Tolerance?
• Attunement: Noticing if the client is here with you. Perhaps asking, “Are you here with me?”
• Social Engagement: Noticing if social engagement is online.
• Return to target

When to Return to Target Memory:
• Hearing neutral or positive responses
• No change
• It feels like a different memory
• The therapist feels lost
• Feeling like you are at the end of a channel

“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 the client is near the end of reprocessing or to check the progress.

“When bringing up the original incident (issue), on a scale from 0-10, where 0 is no disturbance and 10 is the highest disturbance you can imagine, how disturbing is the incident (issue) to you now?”

• At the end of a processing session there may be some blocks to completion. The difference from a client going from a 9 to a 1 and a client going from a 1 to a 0 can be the same amount of progress!

If SUD is stuck at 1 or 2:

• Body Sensation
• What makes it a 2? What is the disturbance?
• What keeps it from being a 0?
• Would you like this disturbance to be an awareness? (Using Cognitive Interweaves) (taught in Day 5)
• Look to see if something is 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.

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

• Doing the “Finding The Targets” through a symptom only. For example, all of the times the client had a panic attack. The root of that disturbance is likely prior to the beginning of the panic attacks.
• Not getting to a younger memory under age 10.

**What to do:**

• Go back through “The Answer.” Was the NC used in Finding the Targets something the client does well?
  For example, the NC “I’m out of control” is likely their Answer—what they do well now is being in control.
  “I’m powerless” is possibly the correct NC, the thing they do not do as well.

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

**Use Affect Scan or Float Back to Connect to Earlier Memory**


• Using the affect to find the earlier memory.
The blocking belief is a limiting belief that is keeping the client from fully processing and letting go of the disturbance of the past. This is the conclusion they drew or what they learned about themselves and the world in the past experiences. It is also often an “Answer.” It was helpful to stay safe or stay connected to caregivers.

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 is always something to be worried about, feared

Ways to Process Blocking Beliefs:

1. Just notice the belief and do a set. (Some will process out)
2. It may be necessary to connect to when they learned this. (Could be new target)

Note: A blocking belief can come up in any of the Reprocessing Phases: 4, 5 or 6.

When Client Appears Stuck/Blocked: What to Do If Things Aren’t Moving or Changing:

1. Change Mechanics: direction, speed, modality (*change to tapping*).
2. Change the focus of client’s attention.
3. Return to target.
4. Check for blocking belief or feeder memory
5. May need to use a Cognitive Interweave (which we will cover on Day 5)

Intense Emotional Processing (Abreactions)
- Intense Emotion is normal. This may be the first time they were free to feel authentic emotion.
- Having a therapist who is able to tolerate the client’s emotion is essential.
- Authentic emotion is different than a patterned emotional response.
- Information is being released
- Client is experiencing an underlying emotion or is having an appropriate response to a memory or a new understanding for the first time.
- An emotional response has a beginning, middle and an end.
- Check for presence. Ask: “Are you still with me?”
- Using cadence, a therapist may state, “Good, yeah it’s really sad.”
- If the client is present and within the Window of Tolerance, encouraging them to feel it.
- “Yeah; Stay with that sadness; Let it be here.”
- Statements to maintain dual awareness and attunement
• “Just notice it” or: “It’s old stuff”
• It’s crucial for the therapist to have the ability to tolerate deep emotional response.

Metaphors:

• Use the metaphor of a Tunnel: “Just keep your foot on the gas to get through.”
• Use the metaphor of a train: “Just watch the scenery go by.”
• If Client uses stop signal or asks to stop, stop! Ask:
  • What does client need right now?
  • What does client need to continue processing?
  • Client may need more preparation, or more resources.
Return to EMDR Reprocessing Model when client is ready

Some ways to recognize when The Answer is here- trying to help.

• Wanting to control
• Having a sense of an agenda
• Increased Anxiety or frustration
• Worry about failing or not doing it right
• Checking the clock / wanting something
to be over
• Focusing on the outcome instead of what’s happening in the moment
• Resentful compliance or “Well, you’re the professional.”
• Difficulty responding / not knowing
• Hoping to please or rescue someone else
• Getting off topic / being distracted
• Noticeable change in stillness or movement in the body
• Statements starting with “I think”
• Excessive talking or story-telling
• Urge to share every detail / worry about being heard or understood

The Five C’s of Working with the Answer

A. Catch it: Silently seeing it happen (anything that is blocking a forward progression indicates that an answer is here, either the client’s or the therapist’s); noticing it as a pattern.

B. Curiosity: Still silent—become curious about the pattern, whatever you are seeing. How does it fit in? How is this a window into the past?

C. Celebrate & Collaborate: The client becomes adorable. We feel like we completely understand why the client is doing what they are doing (the block/answer).

D. Contact: This is the first time you mention it to the client, “It seems like you are really good at______” or “It seems like it can be helpful to ______.”

E. Connect to the past: “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 starts after the client is at a 0 or ecological low disturbance in Phase 4.

• Strengthen a link into more adaptive networks. This is still a reprocessing phase. DAS is long and fast unless there is a reason for shorter and slower.
• Whatever does not resonate with the positive cognition has an opportunity to surface and be reprocessed.
• Generalization can occur.
• As the processing happens in Phase 4, the PC can become even more positive than it was in the History taking and Preparation phase. So always ask if the PC is the same or has changed.

Checking the Initial Positive Cognition:

“When you bring up that original incident, do the words (repeat the PC) still fit or is there now a better statement?” (It could be more adaptive.)

Check the VOC, Validity of Cognition:

“Think about the original incident and those words (repeat the PC). From 1, completely false, to 7, completely true, how true do they feel now?”

Link the PC and The Target and Add DAS:

“Think about the original incident and those words (repeat the PC) and follow my fingers.”

• DAS same speed and length as Phase 4.
• Check VOC after each set of DAS until the PC is fully installed (VOC=7)

If Client gets stuck at a number less than 7:
“What would make it a 7?”
“What keeps it from being a 7” (if they are stuck at 6)

If the client is still stuck, check for a blocking belief. The memory may process after the belief is brought to awareness and contacted as a blocking belief, or there may be a new target around the blocking belief as stated earlier.

*Please do not confuse phase 5 with Future Template*

• Continue reprocessing if there is an answer or movement.
Phase 6: Body Scan
A Reprocessing Phase
Chapter 6 (Shapiro, 2001)

This phase begins after a completion of Phase 5, a VOC of 7 or Ecological 5 or 6.

Note: This is not about numbers but more about your clinical judgement.

Reprocessing Phase Continues:

DAS is long and fast unless there is a good reason for another speed or length. What is left in terms of physical sensations can be processed.

Body Scan Procedures

“Close your eyes and keep in mind the original memory and the words (repeat the PC). 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 DAS until there is a clear body scan:
• Indicators that processing may be occurring include a change in intensity, location and movement.
• If intensity appears to get much worse and the client’s disturbance increases significantly, check for new material that may have been accessed in Body Scan. It may process out or may need to be a new Targeted Memory.
• This can also be an incomplete session if Body Scan is not completed.

Caution: Proceed with body scan only if sufficient time is available. If not, resume at following session.
Phase 7: Closure

(Closure is the process of ending the reprocessing session. It should be done for both Complete and Incomplete processing sessions. Allow enough time to help the client change states prior to leaving the office if necessary. Even if the client does not need to change states, it is good to allow client time to savor the positive results of processing.

AIP:
Stabilizing or focusing on positive or neutral. Limiting the negative associations if needed. Focus toward neutral or other positive associations (memory networks).

If session was complete:
(SUD = 0, VOC = 7, clear Body Scan)

Allow client time to express needs or wants
Encouragement and Connection
Savor the results

How to Close Down an Incomplete Session:
(SUD > 0, VOC < 7, no clear Body Scan)

Note: Incomplete can be in phase 4, 5 or 6. Do not move on to the next phase if it is incomplete.

- Leave plenty of time for stabilizing client and suggest stopping.
- DO NOT take SUD, check PC, take VOC or do Body Scan
- More stabilization may be needed for incomplete session
- Changing state: Experience of current safety.
- Make a plan for how client will deal with processing if it continues out of office.
- Use a stabilization strategy or resource that was useful in preparation phase or create new resource based on what is needed now.

Once the client is stabilized:

- Encourage the progress they have made and their hard work.
- Bring awareness to the present. Asking them about plans for the day or the week.
- Reminding them of any safety plans or how to access assistance if needed.
- Possibly make a contract for some check in.
- Suggest homework or some way for them to utilize gains and stabilize between sessions such as a memory log, journaling, or another activity.
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. It is normal. If so, just notice what you are experiencing and 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.”

Memories and Lies

- EMDR is based on earlier experiences as the root of both dysfunction and health.
- The traumatic experiences become stuck in the system and create patterns that become the way we see the world, perceptions, attitudes and beliefs.
- When something happens in the moment that activates the dysfunctionally stored memory it comes up as it was originally stored and appears to be an over-reaction.
- The limiting belief we have about ourselves is the lie and most likely the conclusion we drew about ourselves or the world at the time of the original event.

“Anything that keeps us from being a shining star is either a lie or a memory.”

The Answer:

- The adaptive response that was learned in order to keep attachment or to stay safe.
- That adaptive response becomes a pattern.
- The Answer, is the go-to way of managing stress.
- It also becomes a strength and a limitation.
- It is what is over-developed and from that we can assume what is underdeveloped.
- Knowing this helps predict pitfalls and blocks.
Memories and Lies Chart

<table>
<thead>
<tr>
<th>Date/time</th>
<th>What was your experience?</th>
<th>SUD 1-10</th>
<th>What was the memory or lie?</th>
<th>Savor what is New and True</th>
</tr>
</thead>
<tbody>
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Phase 8: Reevaluation
(Chapter 8 Shapiro, 2001)

Three types of Reevaluation:

1. After each session. Status of complete or incomplete target.
2. Reevaluation of Targets/Treatment Plan
3. Reevaluation prior to end of Treatment

Reevaluation of Prior Session

Unfinished Reprocessing Session

Ask generally about the following:
• Check for what client experienced between sessions.
• Assess if the client processed more between sessions.
• Changes in symptoms
• Changes in behaviors or patterns of relating
• Changes in reactivity or previous triggers.
• Dreams
• New thoughts or insights.

Assess the current state of the previous target:
• Is it still disturbing?
• Were other associated memories brought up?
• Were the present triggers more or less active?
• Remember incomplete session can be incomplete for phases 4, 5 or 6

Reevaluation Prior to Completion of Treatment
• Have client’s presenting issues or symptoms improved or changed?
• Evaluate how the client has transformed and integrated in a comprehensive way.
• Check targets that have been reported by client in history taking or other phases.
• Check patterns and relationships. Both past events and current functioning for disturbance or limitations.
• Explore any present disturbances, distress or maladaptive behaviors.
• Address any defenses, urges or behaviors that may have been activated during treatment or prior to treatment.
• Focus on the Future response and goals of the client. Target and reprocess anything limiting the future for client.
• Assist client in implementing new adaptive responses into life.
Complete and Incomplete Reprocessing

Completed: If your previous target was completed, (phases 4-6 ALL completed) AND no new disturbance related to this target is reported in phase 8, move on to the next chronological target on the treatment plan that still holds a charge.

Incomplete: If your previous target was incomplete in phase 4, 5 or 6, proceed to a modified phase 3 to continue reprocessing the same target through completion of phases 4, 5 and 6.

How to Start Up Processing Again After an Incomplete Session: Modified Phase 3

1. Instruct client to bring attention to the memory from previous session.
   “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 that feel to you now?”
   “Where do you feel that in your body?”
   “Bring up that memory, notice where you feel that disturbance in your body, and follow my fingers.

2. Check other targets that may need reprocessing

3. When fully processed check the rest of the targeting sequence map to see what still feels disturbing and what has been reprocessed due to generalization effect.
Section VI: Completing the Treatment Plan

Each event in the treatment plan should be a moment in time.

Completing the treatment plan ideally goes in chronological order from youngest age for the memory to the oldest age. At times, more recent memories are processed along with the older memories, so the therapist is always checking in the Reevaluation Phase to see which memory still has an emotional charge. Going from the youngest age to the older ages in chronological order, the memories that still have a charge are processed in Phases 3-7. Note that each memory could possibly be a whole session or more than one session in the case of an incomplete session. After all of the past events have been processed to a SUD of 0 and VOC of 7, the present triggers are then evaluated to see if those too need to be processed using Phases 3-7. Many times the present triggers lose the affective charge after the older events are processed but at times this is not the case.

For each present trigger the client and therapist have developed the desired future state for the client and those are addressed with the Future Template Protocol.

There are times when the client cannot process the earliest memory first and must start with a more recent memory due to the intrusion of the more recent memory. This may also be the case for clients who cannot handle going to the earlier memories due to being overwhelmed with too many traumatic memories. In that case the EMD protocol is recommended to help restrict the processing. Even though we ask for the touchstone memory and the worst on the same line of the targeted treatment plan, this does not mean the client chooses which one to work on. This is like a patient who goes to the surgeon with appendicitis and the surgeon asks if they would like him to remove the appendix or the spleen.

The therapist is always the expert on EMDR and makes recommendations to the client about the most efficient and effective way to provide that treatment.
Present Triggers

Once the past events (Part 1 of 3 prongs) have been addressed, target and process anything in the present that continues to cause disturbance or dysfunction.

What to look for:

- What in the present time evokes disturbance or maladaptive behaviors?
- People, situations and events that still trigger a disturbance.
- Targets that were identified throughout the process and phases should be evaluated.
- Identify the present triggers that were previously disturbing that have been resolved by the reprocessing of the past events.

How to do it:

- Reprocessing of the present triggers is the same protocol as reprocessing the past. Starting with Phase 3: Assessment and continuing through Phases 4-8.

Note: FOR EACH PRESENT TRIGGER IDENTIFIED, A FUTURE TEMPLATE IS DEVELOPED.

We want the client to have a vision and a map of where they would like to go. How would they like to respond instead of the current present trigger response?
Section VII: Desired Future State

“If you don’t know where you are going you might not get there.” - Yogi Berra

The future template is an important part of the EMDR protocol. After working through the past and the current triggers, it is a way of giving the client a vision and a way of seeing what may be needed or missing in order to have the desired future.

How would they like to respond instead of the current present 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 the client would like to handle situations that previously triggered urges or addictive behaviors
• Strengthen the new insights, behaviors and patterns that are more adaptive
• Reveal what is needed in terms of education, skill or confidence
• May also reveal blocking or limiting beliefs in this treatment phase

How to do it:

• For each Present Trigger, ask the client:
• “How would you like to be able to respond,” or “feel,” “act,” or “believe?”
**Desired Future State Worksheet**

<table>
<thead>
<tr>
<th>Present trigger 1:</th>
<th>Future Desired State:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“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.”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present trigger 2:</th>
<th>Future Desired State:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“As you think about_______(name second present trigger), how would you like to be able to react, feel, or behave in the future?”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present trigger 3:</th>
<th>Future desired state:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“As you think about_______(name third present trigger), how would you like to be able to react, feel, or behave in the future?”</td>
<td></td>
</tr>
</tbody>
</table>
Future Template Protocol

Purpose: to help the client look at the present problems and triggers and determine how they would like to react, behave, or feel in the future for each one of them.

- Has its own protocol different from basic EMDR Protocol
- Used to process “Future Desired States” on the Treatment Plan
- Usually completed after the corresponding Present Target has been reprocessed
- Can be used as a stand-alone protocol if clinically appropriate
- Each Future Desired State needs to be an imagined moment in time

Describing Future Template to Client:
“We have addressed the past events, the root of the present disturbance, as well as the present triggers and now we will look at what you would like to be different in the future. We have a specific protocol to imagine your desired future and process blocks and enhance and deepen the positive states.”

Future Template Protocol:
1. Identify how the client would like to respond in the future, instead of the current response to a present trigger.
2. Run a movie.
   - Have the client link the positive belief PC with the vision for the future and run a movie of how they would like to respond from beginning to end. When they hit a roadblock, discomfort or a challenge, let the therapist know.
   - “I would like you to run a movie of the desired state and the words (PC) ________. If you get to anything negative or a roadblock, stop and tell me.”
3. Ask client “What are you noticing?”
   - If POSITIVE: Add DAS sets while client runs the movie. Keep going as long as positive continues to get more positive.
   - If NEUTRAL: Explore what the client needs. Assist them in developing a desired response. Add DAS with running movie until response is positive.
   - If NEGATIVE: Have client focus on body sensations: add DAS until response is Neutral. Then help client develop desired response and add DAS with running movie until response is positive.
4. Install the Positive Cognition until VOC is 7.
   - “Hold the PC with that situation. On a scale of 1-7, how true does it feel to you now?” (Keep doing sets until VOC is 7.)
5. Create a Challenge
• “I’d like you to think of a something that could be challenging and imagine that happening in the movie” (You may need to offer a menu of options.)
• “What are you noticing?”

• If POSITIVE: Add DAS as long as it continues to be positive.
• If NEGATIVE: Focus on body sensation with DAS until neutral. Install PC to VOC of 7 if possible. (Repeat step 4 until it is 7)

(See video on the PTI website under Basic Training Portal)
Eye Movement Desensitization (EMD)  
(Shapiro, 1987)

EMD was Francine Shapiro’s original method which she thought was desensitization of excess arousal, similar to exposure therapy. After using EMD with multiple individuals it was found that they spontaneously made new associations and there was a new learning aspect to the therapy, leading to the development of EMDR. EMDR allows the client’s system to reprocess in a way that is more comprehensive than EMD. For this reason, if the client is able to tolerate the full processing of EMDR, that is the method of choice.

EMD is a narrow-focused strategy that allows only associations related to the selected target. If the association is not directly related to the selected target the client is asked to re-focus by going back to target and checking the SUD frequently. The SUD can be taken after every set if there is any question about what to do.

When to use EMD:
• With a Recent Event or Intrusive Triggers. There is still a need to do phases 1 & 2! This is a clinical decision.

How to use EMD:
1. Choose a target memory. (May be one image, sound or another intrusive part)
2. Select the image that represents the worst part
3. What words best go with that image that would be a Negative belief about yourself now?
4. What would you rather believe about yourself now?
5. When you bring up the Image and the NC, how disturbing does it feel now from 0-10?
1. After each set of EM a SUD is taken:
Target Memory: ________________________________________________________________
“What image represents the worst part?”_________________________________________
“What words best go with that image that would be a negative belief you have about yourself now?”_________________________________________
“What would you rather believe about yourself now?”________________________________
“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
“Bring up that image, the negative words ______________________ and follow my fingers.”
2. Begin eye movements. After each set of EM, check SUD until it is lower; it will likely not get to 0.

“Take a breath. On a scale from 0-10, how disturbing is that memory now?” (Once the client gets to a 0, or as low as possible, move on to VOC.)

“When you bring up that memory and the words ______ (PC), how true do those words feel to you now on a scale of 1-7, with 1 feeling completely false and 7 feeling completely true?”

Note: Due to being one piece of the memory, it is unlikely the client will process to a VOC of 7.
Note: Do not move to body scan, phase 6.

After doing the Restricted/Recent Protocol, EMD, or an incomplete session, the client may benefit from the Creating a Container Exercise.
Understanding the Window of Tolerance is necessary for all trauma processing. We will have a 2-hour video on understanding the Window of Tolerance that will be available for all Basic training members.

**PLEASE NOTE:** EMD or Restricted Protocol should not replace the EMDR protocol. It does not produce comprehensive reprocessing but only symptom reduction.

Restricted processing should be done for clinical reasons such as because the client cannot tolerate the full EMDR processing protocol. If the client is able to process with the full protocol, that protocol should be used as it has been empirically shown to be effective in reducing disturbance and changing the way the client’s system reacts.

We do not want you to use this protocol in place of the full protocol just because you feel it is easier for the client or for you.

No matter what type of processing you are doing with EMDR, it is necessary to do all 8 phases. We need to have some idea of the client’s current resources, the ability to change states in a way that is not dangerous. We want to know the client’s history. We still find the targets and identify the root of the present issue.

**Protocol for restricted reprocessing. We do not need to get all of the details; just the headlines.**

**Note:** These are the specific differences from the Standard Protocol:
1. Shorter sets of DAS (8-12 passes)
2. Return to Target after each set of DAS to assess the SUD instead of asking “What do you notice now?”
3. The next step of the process starts once the SUD is lower than 4 instead of getting to 0 twice.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Script</th>
<th>Therapists’ Actions</th>
<th>Therapists’ Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1:</strong> Decide with Client that Restricted Processing is necessary.</td>
<td>Choose the event for restricted processing.</td>
<td>This is a clinical decision made in collaboration with client.</td>
<td></td>
</tr>
<tr>
<td><strong>Step 2:</strong> Entire event out loud with DAS.</td>
<td>&quot;We have selected the target of ____ to process with the Restricted protocol. I would like to invite you to tell the story of the experience out loud, from just before the event to the current moment and follow my fingers. Please let me know when you are finished.&quot;</td>
<td>Therapist begins DAS while the client tells the entire story out loud from beginning to end. Stopping at the end of the story.</td>
<td></td>
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<tr>
<td><strong>Step 3:</strong> Selection of first POD (Point of Disturbance)</td>
<td>&quot;Now I would like you to review the event again, silently in your mind, while I do DAS and allow the most disturbing part to show up. When it does, use your stop signal and we will use that as the first target.”</td>
<td>Therapist does DAS. Client uses stop signal. When they use the stop signal that piece of the event will be used as the first target.</td>
<td>Target: 1st POD 1:_______________ (Just in 1 or 2 words not the whole story.)</td>
</tr>
<tr>
<td><strong>Step 4:</strong> Accessing POD Phase 3</td>
<td>&quot;When you bring that up, what image is the worst part?&quot;</td>
<td>Take whatever they say as the worst part, even if not an image.</td>
<td></td>
</tr>
</tbody>
</table>
| 4.a | "What words go best with that picture that express your negative belief about yourself now?” | Take whatever they say here and ask the 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, where 0 is no disturbance and 10 is the highest disturbance, how disturbing does the memory feel to you now?” | | SUD:
<table>
<thead>
<tr>
<th>4.d</th>
<th>“I’d like you to bring up that image, those words (NC) and follow my fingers.”</th>
<th>Begin DAS: Short fast sets @ 10 passes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.e</td>
<td>“When you bring up that image/sound on a scale of 0 to 10 how disturbing does it feel to you now?”</td>
<td>Stay with this POD until SUD reduced to 4 or less. Ask SUD, by repeating words to left, at the end of every set. Once SUD has lowered as far as it can on this SUD then move on to step 5. The SUD may only get to a 4.</td>
</tr>
<tr>
<td>5. Moving to next POD target. (After getting next POD, keep going back to step 4 until they run the whole video and no more POD's.)</td>
<td>“Now I’d like you to review the episode again silently and tell me whatever comes up as the next worst part, we will use that as the next target” ** go back to 4******</td>
<td>Therapist does DAS while client reviews the episode and uses stop signal at the next part. <strong>Go back to 4.</strong> Repeat until no worst parts surface. Target 2:__________ Target 3:__________ Target 4:__________ There may be several PODs or just 1 or 2</td>
</tr>
<tr>
<td>6. Install the PC for ENTIRE EPISODE</td>
<td>“Do the words (repeat PC 4.b) still fit or is there another positive statement that feels more suitable?”</td>
<td>Allow client to agree or change PC.</td>
</tr>
<tr>
<td>6.a</td>
<td>“Bring up that memory and those words (repeat PC), from 1, completely false to 7, completely true, how true do they feel to you now?”</td>
<td>Allow client to answer.</td>
</tr>
<tr>
<td>6.b</td>
<td>“Hold those together, those words and that memory.”</td>
<td>Do short, fast sets of DAS, about 10 passes.</td>
</tr>
<tr>
<td>6.c</td>
<td>“On a scale of 1-7, how true do those words feel to you now?”</td>
<td>Do short, fast sets of DAS, repeating that phrase until there is no change in the VOC for 2 consecutive sets. The client may not get to a 7. End with this. Do not do phase 6 body scan.</td>
</tr>
</tbody>
</table>
1. Notice and Offer Container
“So we are nearing the end of our time and I would like to be sure you have all of the time you need to feel complete and safe when you leave the office today. Would you be interested in a containing resource to help with this?”

2. Specify What Needs To Be Contained
“First, let us decide what it is you feel the need to contain. Is it the strong feeling of _______ (sadness, anger, grief)?”

3. Mindfully Invite and Offer Menu
“Okay, so just allow the perfect container to come to mind that will be big enough and strong enough to hold your _____ (emotion). It could be as small as this coffee cup or as large as Mother Earth, or anything in between.”

4. Enhance/Deepen
“Great. So imagine that __________ (name container) and how does the ____ (emotion) go in?”

5. Mindfully Deepen
“So just allow the _______ (name emotion) to enter the _______ (name container) from that _________ (name entry point) and let me know when you feel it is all inside.”

6. Sealing Container
“Would you like to_________ (close the door, put a lid on it...), or have you already done that?”

7. Somatic Linking
“So just sense the _______ (emotion) being contained in the _______ (name container), and what do you notice in your body now?”

8. Extra Layers/Menu
“Great. Now just see if there is anything else you need to feel that _______ (emotion) is safe and contained. You could put a lock on the door, have a special being as the guard, you could put it into a cave in mountain.”
9. Deepen/Check for Completion
“Great. So really sense the____(emotion) inside the_____ (describe container). And what are you noticing in your body now?”

10. Spiritual/Energy Resource
“Would you like to invite healing or spiritual energy or light to penetrate the ____ (container) to help heal the ___ (emotion)?

11. Enhance/Deepen/Complete
“Just allow that ______(energy/light) to penetrate that______(emotion) and let me know when it feels complete.

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What is Complex Trauma?

Complex Trauma vs. Simple Trauma or PTSD:
• Complex trauma is trauma that happens repeatedly, cumulatively and often is progressively worse over time. This could be ongoing abuse (physical or sexual) in a family. It can also be a result of war, human trafficking, chronic illness or any situation of extreme stress over time.
• Post-Traumatic Stress Disorder (PTSD) is the result of a single traumatic event.
• Adult-onset traumatic experiences can activate the cumulative effect of developmental trauma and activate the dormant memory networks.

Complex Trauma often results in:
• Difficulty regulating affect
• Poor self-esteem
• Difficulty in relationships
• Considerations in therapy and the attachment focus: Trauma that happens and is interpersonal. There is an attachment aspect to the trauma
• When the trauma is perpetrated by an attachment figure, the client can become stuck in not trusting or feeling trapped
• It’s not safe to feel safe
• Longing to attach, not be alone, fear of attaching
• Conflict. Not comfortable in relationships
• Complex trauma may have layers that are both developmental and PTSD trauma
• Developmental trauma shows up in attachment patterns
• Looking for over developed human action system by using The Answer

From Panksepp Research on Hardwired Subcortical Human Structures:
• SEEKING (anticipation, desire)
• RAGE (frustration, body surface irritation, restraint, indignation)
• FEAR (pain, threat, foreboding)
• PANIC/LOSS (separation distress, social loss, grief, loneliness
• PLAY (rough-and-tumble carefree play, joy)
• MATING (copulation—who and when)
• CARE (maternal nurturance)

These are also the things that get overdeveloped and underdeveloped due to trauma.

A Somatic and Attachment Approach
• Attunement and resources for clients will be modeled at the training
• Understanding how the problem was once adaptive
• A clear way to predict and work with strengths/blocks in the preparation phase
• An understanding of the therapist’s own strengths and blocks and how they play a role in the therapy process
• Understanding attachment patterns and how they show up when the client is under stress
• Bringing the body into all phases of treatment
• Using Somatic resources as a way to help the client learn how to regulate affect
A Brief Description of EMDR

When something disturbing happens, it gets stored in the brain in a way that our human system feels like that event is either going to happen again at any moment or is happening now. This is stored physically in the brain.

When some event happens that may be similar or just has an element that reminds the system of that disturbing event, the brain reacts as if the original disturbing event is happening.

EMDR helps to move the storage of that memory to a more functional part of the brain that can experience the event as actually being in the past. It is important to know that there is a real physical change happening with EMDR. The events that previously activated the brain into over-reaction no longer have that effect. The person can now react to the present without the past interfering.

Glossary of Terms

**Abreaction:** The expression and consequent release of a previously repressed emotion, achieved through reliving the experience that caused it.

**Adaptive Information Processing Model:** The theoretical model developed by Francine Shapiro (2001) to explain the observed effects and predict the treatment outcomes of the 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:** Alternating back and forth, generally left to right, eye movements, kinesthetic or auditory stimulation in EMDR treatment.

**BLS:** Bilateral Stimulation

**Blocked processing:** When processing does not move toward an adaptive resolution naturally in the therapy process and the clinician needs to take additional measures beyond the standard EMDR protocol.

**Cognitive Interweave:** A deliberative accessing of the memory networks by the clinician, to either access a currently held association or to add in a missing association, with the purpose of facilitating the effective integration of memory networks toward a positive outcome.

**Completed Session:** A session using the EMDR model in which the SUD is 0, The VoC is 7 and there is a clear Body Scan, or positive or neutral sensations.
**Contributory Experiences:** Earlier experiences that laid the foundation for the current dysfunction. These experiences may have increased vulnerability or maladaptive responses.

**Dual Attention Stimulation (DAS):** Dual Attention Stimulation 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.

**Emotional Processing:** First described by Rachman (1980) “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 laid the foundations, memory networks, that contribute to the current level of distress in the present.

**Fear Structures:** First described by Lang (1977), this is a model for understanding anxiety and the three systems: physiological activity, overt behavior and subjective report.

**Future Template:** The 3rd prong of the EMDR Standard Protocol that focuses on the future desired response to the Present Trigger.

**Incomplete Session:** In a processing session the SUD ends at a rating above a 1, the VOC ends as less than a 6 or the Body Scan ends with residual negative sensations that were not present prior to the reprocessing of a target.

**Inverted Protocol:** An approach to complex trauma treatment, first described by Hoffman (2004) in which the treatment target the future first, the present and then the early etiological experiences after significant stabilization has been achieved.

**Memory Networks:** An aspect of Francine Shapiro’s EMDR Model (2001) AIP, describing how memories are stored in 5 different aspects: image, thought and sound, physical sensation, emotion and belief.

**Phase Oriented Approach:** A general model for the treatment of PTSD, first proposed by Janet (1889), in which there are 3 Phases: 1) Safety and Stabilization, 2) Uncovering and modifying traumatic memories, 3) Personality integration.

### Abbreviated Term Glossary

**POD:** Point of Disturbance

**SUD:** Subjective Unit of Disturbance
Somatic and Attachment Focused EMDR Overview of Teaching Points

1. Memories and Lies: EMDR is based on earlier experiences as the root of both dysfunction and health.
   a. The traumatic experiences become stuck in the system and create patterns that become the way we see the world: our perceptions, attitudes, and beliefs.
   b. When something happens in the moment that activates the dysfunctionally stored memory it comes up as it was originally stored and appears to be an “over-reaction.”
   c. The limiting belief we have about ourselves is the “lie” and most likely the conclusion we drew about ourselves or the world at the time of the original event.
   d. The Memories and Lies Chart is a way to remind clients that triggers are the memories and lies which precipitate particular dysfunctional responses

2. EMDR is a complete approach to psychotherapy, not a technique.
   a. EMDR has 8 phases of treatment
   b. The 8 phases can fit into 3 categories
      • Preparation and Safety (Phases 1 & 2)
      • Processing Memories – Moving and Integrating (Phases 3-8)
      • Assisting in integrating changes into lives by integrating a Future Template.

3. We are looking at the EMDR model (Adaptive Information Processing model) through the lens of somatic and attachment focus, informed by sensorimotor psychotherapy

4. Going Deeper into The Answer: A unique aspect of this training is our simplified way of conceptualizing attachment theory and trauma response. “The Answer” is how the attachment pattern shows up, the way we adapted to stay safe or stay connected to caregivers. This includes:
   a. The things we do to stay attached
   b. Built in survival defenses: Autonomic nervous system responses
   c. These become our strength as well as an imbalance.
   d. “The Answer” is a result of three influences
      • The family culture: “Boot Camp”
      • Genetic tendencies: DNA
• Traumatic experiences: The Window of Tolerance

5. Character type chart is to support learning about the Answer, not to label clients
   a. Invisible One
      • Dissociate/disappear
      • Body may be small, thin, pulled in
   b. Emotional One
      • Feels a lot and senses how others are feeling
      • A lot of emotion without getting anywhere
   c. The Nice/Non-threatening One
      • Pleases others, may be nice, be helpless
      • Weak, limp body
   d. The Independent One
      • Unable to trust help is there
      • Square firm body
   e. The Rock
      • Endures pressure, good at doing what they don’t want to do, procrastinates
      • Body thick, sturdy, low center of gravity
   f. The Doer
      • Action oriented, thinking and doing
      • Body ready to take action, slightly forward
   g. The Chameleon
      • Adapts to expectations of external environment, convincing
      • Movement side to side, difficulty being direct
   h. The Hero
      • Tough, capable, takes charge, difficulty being vulnerable
      • Body puffed up, John Wayne-like
   i. Life of The Party
      • Dramatic, larger than life, need to be seen
      • Lots of movement in upper body

6. Each Character type:
   a. Manifests in the body
   b. Is a go to way of managing stress
   c. Is a strength and presents a block to intimacy and treatment for the client
   d. Most people are a combination of types

7. Working with “The Answer”
   a. The 5 C’s of working with the answer

      • **Catch It:** Silently observe it happening over and over again
      • **Curiosity:** Be curious about the pattern you are seeing
      • **Celebrate/Collaborate:** We understand and appreciate the Answer and the client “Becomes Adorable”
      • **Contact:** The first time you mention it, “It seems like you are really good at_____.” or “It seems like it was helpful to_____.”
      • **Connect to the past:** “I wonder how you learned to be so good at______.” Or “I bet it was really helpful when______.”
   b. The use of nonviolent communication is necessary because the answer is also the defense.
8. Phases 1 and 2: History Taking and Preparation Phase  
   a. These phases go together and preparation is often needed prior to getting trauma history  
   b. “The Answer” exercise is used to get a history of resources and strengths as well as to predict blocks  
   c. The expanded “Answer” asks more detail about how it was helpful and how it gets in the way  
   d. Somatic and attachment needs are revealed in the way the client answers the questions as well as the words used. Notice the tone of voice, patterns, behavioral and energetic indicators  
   e. Awareness of the Window of Tolerance is crucial through all phases, especially in the first phases  
   f. Predicting the worst  
      • Dangerous  
         1. Harm to self and others, dissociation, addiction  
      • Annoying  
         1. Overthinking, canceling session, pleasing therapist, blaming others, lying and much more  
   g. Relationship building  
   h. Identifying what is overdeveloped and underdeveloped. The presenting issue is always also “The Answer”, the strength and the block  
      i. Resources are developed based on what is underdeveloped to assist in positive treatment outcomes, with a constant appreciation of “The Answer” and nonviolent communication  
9. Treatment Planning and Finding the Targets  
   a. Do not do “Finding the Targets” until you are ready to process.  
   b. Going back through the thing that is more difficult for the client to do, the underdeveloped, will get you to the root under the answer.  
   c. Lighting the Limbic Lightbulb  
   d. Become curious about “The Answer” if the client feels blocked or like it is not working  
   e. Be aware of your “Answer” in the process, talking too much, trying to make the client “feel better,” not following script  
10. Phase 3: Assessment/Activation Phase  
    a. The questions are activating the limbic system, lighting things up in the present moment.  
    b. This is not remembering but activating  
    c. If the client uses past tense, “I felt…”, the therapist brings back to this moment, “Right now in this moment….”  
    d. This phase should take 3 to 5 minutes. This is where the script is important and keeping the client moving by asking the next questions is important.  
    e. Phases 3 and 4 are always together. Phase 3 is immediately followed by phase 4, Reprocessing Phase  
11. Phase 4: Reprocessing  
    a. Keep an awareness of the Window of Tolerance  
       • Not answering when getting feedback or taking a long time to answer  
       • Panic or fear of fear  
    b. Therapist should aware, present and boundaried  
    c. Reminding client they are here if needed  
    d. Supporting deep emotional responses  
       • “Yeah”, “A lot of sadness”, “Is it okay to let that sadness be here?”  
    e. Attachment  
       • Missing experience is the framework for cognitive interweave  
       • Keeping awareness of the client’s “Answer” and curiosity if a block to processing appears, “I wonder if that is what happened at the time”
f. Somatic Processing: Intense Fear Response
   • Uncoupling the fear from the body sensation, “Would it be okay to let go of the emotion and just notice the body sensation?” “Is it okay to welcome the sensation?”
   • Becoming curious about the body sensation, where is it in the body, allowing the movement to happen
   • Allowing the (shaking, trembling etc.) to move itself.

12. Phase 5: Installation of Positive Cognition
   a. Whatever doesn’t fit with new positive belief is going to come up
   b. Connecting with positive
   c. Processing what is in the way
   d. Always checking for new more adaptive positive belief at beginning of this phase

13. Phase 6: Body Scan
   a. Continuing reprocessing and bringing up the new positive, whatever doesn’t fit with that will speak somatically
   b. Processing noticing tension, tightness or discomfort

14. Phase 7: Closure
   a. Closing down the networks
   b. Awareness of the Window of Tolerance, level of presence
   c. Shifting focus to present moment safety if needed
   d. Two ways of doing closure, one for incomplete and one for complete session.
   e. Incomplete: see what client needs and suggest a resource to increase safety and presence
   f. Complete: savor the transformation

15. Phase 8: Reevaluation
   a. Beginning every session after the first
   b. What has changed? Keeping an eye on the presenting issues and the changes after processing
   c. Many clients are used to focusing on the negative and it is helpful for therapist to ask about presenting issues and symptoms to bring awareness to progress.
Review of the Adaptive Information Processing Model (AIP)
(Shapiro, 2001 and Shapiro, 2006)

The Adaptive Information Processing (AIP) Model is based on the idea that much of psychopathology is a result of maladaptive encoding of, and/or incomplete processing of, traumatic or disturbing events or adverse life experiences. This prevents the adaptive integration of the material. The unprocessed experiences become stored in the emotional part of the brain without a time and date stamp. When something happens in the present to activate the stored experiences, they feel as if it is happening now, creating what appears to be an "over-reaction" to the present.

• We are looking at the early experiences and the way they are stored.
• We are asking: “What is the organization of that experience in the present moment? How are the past experiences manifesting now?”
• This helps create the treatment map and predict blocks as well as outcomes.

Basic Hypotheses of the AIP:

It is a Physical System

• The neurobiological information processing system is intrinsic, physical and adaptive.
• The system integrates 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 attitude, beliefs and perception.
- Those stored memories are the contributors to pathology and to health.
- Trauma causes a disruption of normal adaptive information processing which results in unprocessed information being dysfunctionally held in memory networks.
- New experiences link into previously stored memories which are the basis of interpretations, feelings and behaviors.

It’s Both What Happened and What Didn’t Happen

- 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, ability to assume appropriate responsibility for self or other, or limits one sense of control or choices.
Traumatic Events Appear To Be Stored In Isolation

• If experiences are accompanied by high levels of disturbance, they may be stored in what functions like the implicit, short-term memory system. These memory networks contain the perspectives, affects and sensations of the disturbing event and are stored in a way that does not allow them to connect with adaptive information networks. They feel like they are happening now when triggered.

Events In Life Trigger The Unprocessed Memory

• When similar experiences occur (internally or externally), they link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise. It feels like it is happening now.

The Negative Is Reinforced: “Ah...more proof that the lie is true.”

• This expanding network reinforces the previous experiences.

The Answer and Positive Information Are Also Stored in Memory Networks

• Adaptive information, resources, and memories are also stored in memory networks.
• Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks and a transformation of all aspects of the memory.
• Non-adaptive perceptions, affects, and sensations are discarded.

The Way It Is Stored Appears to Change

• As processing occurs, there is a posited shift from implicit/nondeclarative memory to explicit/declarative memory and from episodic to semantic memory systems (Stickgold, 2002).

There Is A Transformation That Occurs

• Processing of the memory causes an adaptive shift in all components of the memory, including sense of time and age, symptoms, reactive behaviors, and sense of self. There is room for change to happen.

Further Notes

• The EMDR Protocol along with dual attention stimuli, eye movements or other methods, help to process the information and bring a balance back to the system.
• Useful learning is kept, and the maladaptive information is let go
• Links are made into the positive networks that were not available to the dysfunctionally stored memory.
Common things a therapist has to unlearn when learning the EMDR therapy model

• 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.
• 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 of Tolerance is often where change can happen.
• The therapist believing they are the healer with tools to give the client.
• Believing that the therapist is “making the client worse” when 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 and is still in the Window of Tolerance, present and having dual attention.
• 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 related. The therapist should either keep going or have the client check in on the original memory if they feel lost.

With EMDR therapy we set the conditions for the client’s own healing to happen

• What can happen when you have not gotten to the touchstone memory:
  • Getting worse without relief
  • “Answers” coming up to stop the process
  • Flooding of many memories
  • Somatic symptoms: Earlier memories or preverbal memories show up as sensations.
Common Mistakes in History Taking

- Asking about the trauma memories too soon or taking a trauma narrative
- Not asking about current resources and ability to regulate emotion first
- Not taking a DES
- Not knowing what the client’s “Answer” is prior to talking about trauma or pain
- Not taking a history because the client says they have been referred just to do EMDR processing
- Not understanding what it is like to be the client
- Not knowing what the client wants as a result of therapy

Safety and Stability

In history taking we are finding out first about the client’s strengths and ability to regulate emotionally. We are looking for what is overdeveloped and underdeveloped for the client.
Use the Client Readiness Checklist to make sure you have looked at all of these areas. Remember that you are not necessarily going through this checklist with the client. It is a tool for you to remember to address all of those areas prior to moving into Phases 3 - 7.
Phases 1: History Taking, and Phase 2: Preparation Phase, are done in conjunction with each other. We are always looking at what the client’s current resources and needed resources are as we gather information and develop the treatment plan.

We Take the AIP View

- How are the past experiencing manifesting in the present?
- What was the client’s response at the time of the earlier events that will likely surface during therapy?
- Is the client able to be honest and give honest feedback?
- Do you understand the client’s patterns of attachment and cultural issues?
- Understanding current resources even if they are potentially harmful like addiction or suicidal thoughts? How are these helpful to the client?
- Do you understand the clinical roadmap and treatment plan prior to processing?
- Do you know the early events that are likely fueling the current life stressors?
Review Phase 2: Preparation Phase

Common Mistakes in Preparation Phase

- Taking too long in this phase because it is pleasant to work on developing positive resources, when the client already has sufficient ability to be safe and manage affect.
- Not taking long enough in this phase because the client verbally reports an ability to stay safe and manage affect, taking the client’s word for it and not actually seeing the client demonstrate the resource in the office.
- Not fully understanding the client’s strengths and how they may be a block to processing.
- Not understanding what is “under-developed” for the client prior to processing.
- Just using a written informed consent and not taking the time to discuss the nature of trauma, how EMDR works, the possibility of urges from past addictions and the possibility of deep emotional pain surfacing. Not normalizing all of that.
- Not explaining to the client with the use of the AIP model, how the current issues are likely a manifestation of past experiences that are stored in the brain in a way that causes an overreaction to the present.
- Thinking that if the client cannot do the Calm Place Exercise, they are not able to move on to Phase 3-7.
- Not stopping and switching to another resource if the Calm Place Exercise becomes negative.

Preparing for Reprocessing Phases:

In Phase 2, Preparation, we are making sure the client understands the EMDR approach to therapy and how the treatment plan is developed. Using the client’s own information is the best way to describe how the past is manifesting in the present.

The clinician is taking only as long as needed to make sure the client has everything that is needed, including enough trust in the clinician and therapy process, to begin reprocessing the earlier experiences that are the root of the current distress. We do not want to delay this any longer than necessary because this is what helps the client process the memories, so they are no longer manifesting in the present.

We are looking for the Dangerous and Annoying tendencies that may block the process. In this phase we are looking at the client’s “Answer”, so we can predict how it may come up as a block to processing.

The clinician can then make a plan for what to do when it surfaces. Taking the time to understand this makes the processing much more effective.
Flipping on the Switches:

In Phase 3, Assessment Phase, the therapist is activating the memory by asking the questions in that phase. Each question is intended to activate a different part of the brain and stored memory, thus lighting up all of the ways the client can possibly process. It is important to remember that the only “Assessment” the therapist is doing here is the assessment of how the memory is currently held in the client’s system. The Negative Cognition is used here to light up the affective circuits of the brain. After Phase 3, the original NC is never brought up again by the therapist in regard to that specific target memory. We are NOT trying to change the client’s cognition. We are looking to help the client find the root of the current disturbance, so the presenting issues are resolved.

Prior to starting the first question in phase 3, the clinician has already checked the seated position, the speed and distance and is ready to immediately move into phase 4, Reprocessing. After lighting up the memory networks in phase 3, doing anything other than beginning phase 4 will likely interrupt the process.

Common Mistakes in Phase 3

• Repeating what the client says or in general talking. The therapist is just lighting up the way the memory is presently held and moving on. Flipping on the switches.
• Not remembering it is about NOW. The client will often think you are asking about how they felt or thought at the time of the memory. It is up to the therapist to constantly bring them back to NOW.
• Thinking that this is a time to explore the NC. The therapist should already have found the correct NC in the Preparation Phase 2. If needed the therapist may say, “Last time you said it was I’m not good enough, does that still fit?”
• Doing anything between phase 3 and 4. The therapist should make sure that the client is ready to go directly from phase 3 to 4 prior to asking the first question in phase 3.
Phase 4 is like a Three-Act Play:

Act 1- Clearing the 1st channel.
What do you notice now? Go with that. Repeat until responses become positive, neutral or stop changing.

Act 2- Clearing subsequent channels / Going back to target.
When you go back to the original memory now, what do you notice? Go with that. What do you notice now? Go with that. Repeat until going back to target yields no additional disturbing information.

Act 3- Completing Phase 4 / Checking the SUDs.
When you go back to the whole memory, how disturbing does it feel to you now on a scale of zero to ten? Go with that. What do you notice now? Go with that. Repeat until you get 2 zeros.

Moving and Changing

In Phase 4: Reprocessing, the therapist is helping the client access and move the way the memory is activated in the brain. As long as there is change—which can look like either more or less activation—we know the reprocessing is working.

Window of Tolerance

During this phase the therapist is keeping the client’s Window of Tolerance in mind. The purpose of the feedback between sets is to help the therapist know that the client is still present and not too far in the memory or too far out of the memory. The therapist can use their voice in a calming way to help assist the client in staying present and in the Window of Tolerance. That can sound like “Yeah, just notice it” while the client is doing the DAS, if the client is in a high level of affect.

Past Patterns Show Up

The therapist should view everything that happens in phase 4 through the AIP lens. How is the past manifesting in this moment? The question, “I wonder if that is what happened at the time?” or “Do you think that is what you did at the time?” can keep the processing moving.

Welcoming Deep Emotional Pain

Often the client will experience a deep emotional release with the EMDR processing. This is normal and often a good sign. Some clients have never had the opportunity to express the deep sadness or grief that often is present with attachment loss or trauma. When the therapist notices sadness beginning to surface, a statement such as “Yeah, a lot of sadness, huh?” can be very effective. It is often a relief for clients to have someone who is encouraging feelings to be here as that is often the missing experience for them.
Body Sensations May Be Earlier or Preverbal Memories

If the client gets stuck in a disturbing body sensation it may be a Feeder Memory that has not surfaced previously. This can come up spontaneously for the client and they can have access to the memory. If it is clear that the feeder memory is the actual root of the disturbance, and there is adequate time left in the session, the therapist can recommend that the memory focus be switched to this new memory that has appeared.

Other times the client may be stuck with a disturbing body sensation due to the next memory, in which they were older, coming to the surface and attempting to be processed. If this is late in the session and there is not enough time to process the memory, just asking the client if they feel like this sensation may be a different memory surfacing, is the best way to deal with it. The client often has awareness that it is a new memory. The therapist can then assure the client that they will get to that memory in the next session and redirect the client to the original memory.

Preverbal memories also often surface as a disturbing body sensation. At times they can be processed by just noticing the sensation and putting aside the story or the emotional response (Ogden, 2002). Other times, the preverbal memories may need to be set up with Phases 3 - 7 and the target may just be a story that the client has heard. As long as when the client accesses the memory there is a charge to it, it can be processed with the basic EMDR protocol.

Going Back to the Whole Memory To See How It Is Stored In This Moment

When going back to check on the original memory it is important to just say the words “When you go back to the original memory, what do you notice now?” You are not pairing the NC with it or asking the client how they feel now, what they think now or any other aspect of the memory.

Check the SUD Only When We Think Client is Near End of Reprocessing

The SUD should only be taken when it seems the client is near the end of processing and should be read exactly as stated. JUST READ IT.

Common Mistakes in Phase 4

- Doing anything but starting immediately with the statement: “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 when checking back on the target.
- Not having an awareness of the client’s Window of Tolerance and knowing if the client is present but accessing the memory.
- Stopping the client if there is a deep emotional response and asking if they need to stop or if they are okay.
- Not understanding that what we are looking for in this phase is how the memory is currently stored in the system instead of the client thinking about the memory and reporting that.
- Not recognizing the client’s answer when it surfaces.
• Not encouraging deep emotional release such as deep sadness.
• Not trusting the EMDR process and stopping to do resourcing when the client is adequately accessing and reprocessing a memory.
• Not being at the touchstone memory or even knowing what the earliest memory is, thus the client’s processing appears to spin or get stuck.
• Not knowing that when the client gets stuck with a disturbing body sensation that does not appear to process it is often due to a feeder memory, a later memory that is trying to get in line to be processed or a preverbal memory appearing.
• Not getting a 0 twice or stopping at a 1 and thinking that is good enough.
• Not understanding that if the client does not get to a 0 or a 1, in which the therapist has worked to help the client get to a 0, it is an incomplete session and the therapist should not move on to phase 5, but to the incomplete session statement.
• Guiding the client to one aspect of the memory when the client is instructed to go back to the earlier memory. Not understanding that we are always going back to the whole memory when checking on the original memory and pairing nothing else with that.
• Checking a SUD too soon. It should only be checked when the therapist feels the client is near the end of processing.
• Not saying the words exactly as stated in protocol! As Nike says, JUST READ IT.
Linking and Reprocessing
Phase 5: Installation Phase, is still a reprocessing phase. By bringing up the desired positive statement along with the original target memory, we are looking for any disturbance that is keeping the client from believing the positive statement. Any part of the client that does not believe the statement will be accessed and the DAS can assist the client in releasing any residual activation.
In addition to the continued reprocessing, pairing the PC with the target memory helps the client to strengthen the positive networks.
Although this phase is still reprocessing, and the BLS/DAS is still long and fast, this phase is often shorter than phase 4.

Common Mistakes in Phase 5
• Thinking we are trying to change the cognition or do cognitive restructuring
• Confusing this phase with the Future Template
• Not asking if there is a new, even better statement than the original PC
• Not continuing with long and fast eye movements
• Confusing this phase with the Calm Place
• Not understanding that if the client does not get to a 7 or a strong 6, there can be an incomplete session in this phase and the therapist should not move on to Phase 6: Body Scan
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Residual Reprocessing
In Phase 6: Body Scan, the therapist pairs the positive cognition with the original memory and instructs the client to scan through the body, beginning with the top of the head, going down and reporting any tension, tightness or unusual sensation. Whatever the client reports, even if the client thinks there is an external reason for the body sensation, the therapist should suggest the client notice that and offer DAS. If the body sensation gets much worse or doesn’t change, the therapist should investigate the possibility of a feeder memory, a later memory surfacing and trying to get processed or a preverbal memory coming up. The client will often have a sense if the sensation that is stuck is about a different memory. When you are working with a client with complex trauma and many memories, it is common for this to happen. The therapist should normalize it by saying the client’s system is trying to let go of everything at once and let the client know that what is coming up is important. Making a plan to look at the new material the next time can help the client contain it until the next session. In Phase 6 there can be an incomplete session but it is unlikely. If the client does not get a clear body scan the therapist may need to help the client change to a neutral or positive state by reading the incomplete session script and then helping the client access a calming resource such as Calm Place or Container. Remember that once the therapist has helped the client develop the Calm Place with the Calm Place Exercise Script, the only thing the therapist needs to do is remind the client to access the Calm Place. The therapist never again needs to read the Calm Place script or do DAS with the client to help access. The client should be able to access the Calm place by themselves and be able to practice outside of the office.

Common Mistakes in Phase 6

• Confusing this phase with the body scan relaxation.
• Not understanding that we are still reprocessing in this phase.
• Not seeing that preverbal, feeder or next older memories can surface in this phase.
• Not doing DAS with the client because they report a reason for the body sensation such as, “I think it is just the chair.”
Review Phase 7: Closure

Closing Down the Networks
The purpose of Phase 7: Closure, is to assure that the client is in a good place to leave the office in a safe contained way. 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. The therapist is assessing the current state of the client and looking to make sure the client is present and in a contained enough state to leave the office. Some common ways to help the client move from an activated emotional state to a neutral state are to ask about current daily activities, such as, "What do you plan to do when you leave here today?" Shifting to thoughts about routine activities or planning help the client become present and shift to a different part of the brain.

Common Mistakes with Phase 7: Closure

- Not making sure the client is present and able to manage affect prior to leaving session.
- Not taking enough time to assure the client can leave the office in a contained, safe manner.
- Not understanding the two types of closure
Three Types of Reevaluation in Phase 8

- Reevaluation of the target memory that was previously worked on.
- 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 that if you access and process the touch stone (earliest memory), other related memories could already have been processed.
- 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 Reevaluation: Phase 8

- Not asking about the presenting issue or symptoms that brought them to treatment.
- Assuming the client’s system has not processed anything since they left last time.
- Chasing COWs: Crisis of the Week.
- Not going back to check the target memory from the last session.
- Not checking to see if other memories have also lost the activation.
- Not checking on progress and new information.
Section X: Review of Treatment Planning

Presenting Problem
________________________________________________________
NC___________________________________________

Past Event
_____________________________________________________
_______________________ Age_____

Past Event
_____________________________________________________
_______________________ Age_____

Past Event
_____________________________________________________
_______________________ Age_____

Resources to Use

Going Younger

Past Event
_____________________________________________________
_______________________ Age_____

Past Event
_____________________________________________________
_______________________ Age_____

Past Event
_____________________________________________________
_______________________ Age_____

Touch Stone (Earliest)                                Worst
__________________________________________________ Age __________________________ Age _____
Each event in the treatment plan should be a moment in time.

- Ideally processed in chronological order from youngest to oldest age.
- At times more recent memories are also processed when the early ones are processed.
- Note that each memory could possibly be a whole session or more than one session in the case of an incomplete session.

Re-Accessing an Incomplete Target
If the target is incomplete you’re restarting the session in Phase 4:
“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: Steps to begin reprocessing a new target after the previous target is completed
Once the target memory is completely processed, move on to the next chronological memory that still has a change. Process that memory with Phases 3-7.

Selecting the Target is a clinical decision
The client does not choose which target to work on. Letting the client chose would be like a patient who goes to the surgeon with appendicitis and the surgeon asks if they would like him to remove the appendix or the spleen. You are the expert.

Of course, there are exceptions to all rules. For example: A more recent memory intrudes and the client must start there. This may also be the case for clients who cannot handle going to the earlier memories due to being overwhelmed with too many traumatic memories. In that case the EMD protocol is recommended to help restrict the processing.

Review of Reprocessing Present Triggers
The Present Triggers are the examples of how the presenting issue is showing up in the client’s life in the present. It is important for the therapist to help the client come up with a specific moment in time for the present triggers and not have them just be an issue. For example, the client might have the issue of anger with her son and the therapist should ask for the client to give her a recent example of when this was a problem.
Having the Present Trigger be a specific moment in time is important in the next phase of the treatment, the future desired state, where the client gets a vision for the future and how they would like to experience life in a different, more positive way.

To process the Present Triggers, the specific moment in time is put in Phase 3 as the target memory. Then the basic EMDR protocol is used for Phases 3-7.

The Present Triggers should be evaluated every session to see if the client is making progress in the treatment. Every time processing is done with Phases 3-7, the reevaluation will include checking on the Present Triggers and the client’s current activation to them in life.

Always keep an eye on why the client came into treatment and if the client is making the changes they would like to make. This is an important part of the EMDR Therapy model.

Review of Future Template

The Future Template is a very important part of the EMDR protocol that is most neglected by therapists.

The purpose of the Future Template is to help the client look at the present problems and triggers and determine how they would like to react, 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 activity, but an important way to make sure the brain’s neural networks have started creating these important new pathways.

The Future Template has its own protocol which is different than the basic EMDR protocol. The Future Template protocol asks that the client run a movie of the future desired state along with the desired Positive Cognition and then let the therapist know if they run into any roadblocks or difficulty.

The therapist then assists the client in processing any negative cognition or sensation that appears as the client runs the movie of the desired state by doing DAS.

If the client does not run into any roadblocks and only has positive experiences with running the future desired movie, the therapist instructs the client to notice the positive and does DAS to help strengthen those pathways.

Some clients may have difficulty connecting with the future desired state as a visualization and the therapist should then assist them by making some suggestions. If the client has neutral or a flat response, the therapist may say something 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 the therapist can help the client fill in the vision by saying) “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 the EMDR with the following considerations:

1. Cognitive Interweaves
2. Somatic Processing
3. Incomplete Action
4. EMDR for Chronic Pain
5. Children
6. Dissociation
7. Phobias
8. Substance Abuse
9. Couples
10. Military/First Responders
11. Complicated Grief
Cognitive Interweave

(Shapiro, Ch. 10)

The purpose of the Cognitive Interweave is to keep processing moving. It is only called a Cognitive Interweave because the therapist thinks of it. It may be a movement or experiences.

What is a Cognitive Interweave?

It is a brief statement or suggestion made by the therapist that does the following:
- Provides missing information.
- Activates currently held information.
- Encourages generalization effects.
- Assists client in connecting to present issue.

This requires that the therapist resonates and is attuned to the client's system. The therapist is offering the next step in healing for the client. Often the client will arrive at this next step on their own, so unless the client appears to be out of the Window of Tolerance, allow a few sets of DAS to go after you have thought of a possible Cognitive Interweave. Sometimes the attuned therapist is one step ahead of the client throughout the reprocessing phases.

When to Use a Cognitive Interweave

- Client is looping.
- Time is running out in session.
- Client appears to be out of the Window of Tolerance.
- Lack of generalization.

A Cognitive Interweave may also be the therapist offering the missing experience to the client. This should only be used when needed and not as an attempt to prematurely take the client to a more positive state.

Example: A client who is processing early sexual abuse uses stop signal and therapist offers for the client to notice the experience of therapist stopping when the client asks her to stop.
A. Offering new information through an experience, education or new perspective
B. Stimulating currently held information

**Examples**
- Direct Question or Statement
- Recognizing “The Answer” appearing
- Activating the adult perspective
- Activating the perspective of a known resource
- Addressing misconceptions that are common in trauma memories

1. **Responsibility:** It is common for the victim to blame themselves, especially children. Offer a statement differentiating age and responsibility.
   - Recognizing the belief as “a lie.”
2. **Safety:** Bringing client into the present and keeping the client in the Window of Tolerance.
   - “How old are you now?”
   - “Are you safe right here right now?”
   - Use resources to bring them back into the Window of Tolerance and out of survival resources.
   - Recognizing the current sense of not being safe as “a memory.”
   - Using an orienting resource from Somatic Resources section.
3. **Power/Control:** Choices
   - Statements regarding future choices
   - Learning from the past
   - Accessing known resources for helping the child in the memory have protection

**Examples of Cognitive Interweaves:**

The Answer
- Bring the client’s awareness to the answer surfacing in processing.

“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?”
Safety

- When the client gets out of the Window of Tolerance:

“Would you like that disturbance to be an awareness?”
“Are you safe now?”
“Where are you now?”
“Are you here with me now?”
“Where is ______ (the perpetrator) now?”

Use the Orienting Response
“Look around the room now, are you safe here?”
“Yeah, it felt like you were going to die, but you made it, right?”

Bring in the Adult Perspective/Stuck on Responsibility
“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?”

Psycho-Education
“Did you know that is normal in trauma to have symptoms instead of memories?”
“Did you know that it is a common response in pervasive abuse for the person being abused to initiate the abuse?”

Deep Emotional Response
“Yeah.. yeah.. a lot of sadness” - Therapist’s voice helps connect and stay here. “Yeah, it’s been here a long time.”
“Yeah, you have had to hold that sadness in for a long time.”
“Yeah, is it okay to just stay with that sadness?”
Somatic Processing

(Ogden, 2002)

**Note:** There are two 12-hour Advanced Trainings on our website on this topic. This is an advanced technique and this training does not teach you to use Somatic Processing. As with all of the specialty areas in the basic training, it is just to give you exposure to the many areas of specialty use. Somatic Processing is used for preverbal memories as well as traumatic memories with a lot of fear where the client has associated the fear response to the body sensation. For Somatic Processing the therapist helps the client uncouple the fear and story from the body sensation, allowing the excess arousal to be released from the nervous system.

**How to recognize the need for Somatic Processing**

- The client is stuck in a fear response and appears to be out of the Window of Tolerance.
- The client begins trembling or shaking.

**What to do**

- Tell the client you are noticing either a high level of fear or shaking.
- Ask them if they would like to try something that may help release the excess arousal from the nervous system.
- Ask the client if they would be willing to focus on the (name the body sensation) “shaking,” “trembling,” “tingling,” or whatever the client is reporting.
- Ask the client if they could put the story aside for a moment and just follow the “shaking” or whatever body sensation they have reported.
- Instruct the client to just follow the sensation and allow it to happen without stopping it.
- Continue to encourage the client by saying things like: “Good, just keep allowing the shaking to shake itself.”
- “Great, just keep following the shaking, allowing it to be as big as it needs to be without making bigger or stopping it.”
- “You’re doing great, it’s just the normal release of the excess arousal stuck in your nervous system.”

The Somatic Processing usually gets gradually stronger and then drops off. It also often moves to different parts of the body as in first arms then legs.

Often at the end of the Somatic Processing of the excess arousal, the client will begin to access the developmental attachment trauma associated with the memory. If time permits the processing can continue and may include deep sadness.
Another type of Somatic Processing is Completing the Incomplete Action. When a client is unable to complete an action that would have provided protection or safety, it can be a relief for the client to allow that action to happen in a safe environment of the therapy office. This is also an advanced technique but parts of it may be useful in the EMDR process.

**Examples**

- The client’s feet are moving or shaking during the processing and they appear stuck.
- Completing the incomplete action can be used as a “Cognitive Interweave.”
- The therapist can report to the client what they are noticing. Then ask the client if they would like to try an experiment.

  “Would you like to try allowing your feet to move in a running in place motion, as long as it feels good?” (The words ‘as long as it feels good’ are important to keep the client in the Window of Tolerance.)

- The therapist then instructs the client to allow their feet to move.
- This can also be done with pushing against a wall. The client is stuck with anger and the therapist notices tension in the client’s arms and they appear stuck.

  “Would you like to try something? I wonder what it would be like for you to push against the wall, only as much as feels good.” (The therapist demonstrates a gentle pushing against the wall.)

After any and all of these, the therapist gets a report from the client and continues with the reprocessing
Persistent pain is a symptom, not the problem.
- Pain comes from the brain, not the tissue of the body.
- Pain's purpose is to protect the body and facilitate healing.
- Pain is a matter of perception—how a person's nervous system perceives what is happening—and sometimes the perception can be incorrect, causing pain to persist where no tissue damage is present.
- Pain can be stored in maladaptive memory networks along with other images, beliefs, thoughts, emotions, and sensations, which can result in somatic symptoms.
- Pain can be reprocessed just like other images, beliefs, thoughts, emotions, and sensations that are stored in maladaptive memory networks—by getting to the root.
- Adverse childhood experiences are frequently at the root of persistent pain.
- Adverse childhood experiences strongly influence and prime how a person's system responds to stressors, how he or she perceives safety and attachment, and the character traits that become over-developed as “The Answer” to the stressors.

Chronic Pain and the AIP Model
- The AIP model states that most pathologies are derived from earlier life experiences that are maladaptively stored in the nervous system.
- The model is used to anchor the therapist as he/she works with clients.
- Panic attacks, depression, intrusive thoughts, and PAIN are thought of as symptoms—not the problem.

Example: If you catch a cold, it’s likely you won’t mistake your runny nose as the source of your ailment. Rather, you understand that the runny nose is a symptom and indicator of something deeper that is going on in your system.

- The current medical model holds firmly that pain is the result of tissue damage in the body, but this is often not the case.
- Most medical professionals are hesitant to look for a deeper cause of pain because the medical paradigm for understanding pain, as well as that of our culture at large, is incomplete.
- Lorimer Moseley, an Australian physiotherapist, recently improved upon older definitions of pain by stating, “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.”

Note: Moseley’s description states that pain does not come from the body. It comes from the brain.
• Pain's purpose is to protect the body and facilitate the repairing of tissue.
• When the brain detects that an area of the body needs special attention, a neural network is activated between the brain and body where the pain message is brought to awareness and localized to the pertinent part of the body.
• This uncomfortable sensation motivates actions that prevent further damage and encourage healing.

• However, sometimes the brain gets it wrong and can mistakenly localize pain to areas that need no special attention.
• According to Moseley’s definition, all pain is a matter of perception—how the person’s nervous system perceives what is happening—and sometimes the perception can be incorrect, causing pain to persist beyond the necessary time for damaged tissue to heal, and/or exist even in the absence of detectable damage.
• Those with unresolved trauma and early attachment disruptions are especially susceptible to this type of pain.
• When this happens, pain manifests similarly to other maladaptive emotional or behavioral symptoms like depression and hypervigilance, which puts pain within the EMDR therapists’ scope of practice.

• The AIP model also states that memories are stored in associative memory networks, which are the bases of our attitudes, beliefs, behaviors, and perceptions (aka “The Answer”).
• If a client is unable to adaptively process an earlier life experience that was disturbing, a network of neural pathways from the brain to the body is formed that contains the perspectives, emotions, and sensations of the traumatic event. Just like symptoms such as anxiety or depression can become associated with a memory network, so can pain.
• Once these neural pathways are formed, they may be stimulated by present-day events that are similar to the previous event.
• Over time the neural network that contains the pain pathway can be strengthened, sensitized, and wired into the circuitry of the client’s nervous system.
• Pain then becomes part of the client’s “Answer.” This is how the nervous system learns to create pain even if there is no medical condition in the body to warrant it.
• EMDR can be used to directly process the unprocessed information at the source of these memory networks so that maladaptive beliefs, thoughts, emotions, and sensations—including pain—can be released.

• Oftentimes, pain is in fact the direct result of injury or tissue breakdown.
• People who experience this type of acute pain typically seek out medical care, and with the right
• However, clients who seek out mental health professionals typically do so because doctors have found no medical reason for their pain, and the numerous treatments that the client sought did not help even though they should have.

• Instead, they may be experiencing somatized pain that is caused, increased, or prolonged by mental, emotional, or behavioral factors. Clients with this condition often meet the DSM-5 criteria for Somatic Symptom Disorder (SSD).

• If you have a client who presents with SSD, it's good news for both therapist and client. It means there is hope for pain reduction because, for example, the client's back pain may not be rooted in the tissue of his or her back after all. Rather, it may be rooted in earlier experiences in the client's life that are presently stored in his or her system.

Summary: Theorizing that pain is always due to damage in the body is like saying that your nose must be defective if it is running. Just like a runny nose is a symptom of a virus in the system, chronic pain is often a symptom of adverse life experiences that were maladaptively or incompletely processed. The good news is you can use EMDR to treat chronic pain just like you would anything else you work
Presenting Issue
• The client’s experience of pain, including sensation, thoughts, and emotions.

“How would you describe the pain in terms of how it feels physically?”
• Use descriptive words like hot, sharp, jagged, etc. to directly connect the client 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?”

• Look for an emotional connection that goes beyond “It hurts.”
• Example: “I’m afraid I’ll never get better.”

Present Trigger #1

“Please tell me a recent time that would be an example of this.”

Present Trigger #2

“Can you give me an example of how this shows up in your life socially?”

Present Trigger #3

“Can you give me an example of how this shows up in your intimate relationships?”

Present Trigger #4

“Can you give me an example of how this shows up in your life at work?”

SUD

“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?”

• “Disturbance” here is different than the typical “What’s your pain level out of 10?”
• The SUD is a way of gauging the client’s full experience of pain—mental and emotional upset surrounding the pain in addition to the level of pain that is experienced in the body.
Finding the Targets: Getting to the Root of Chronic Pain (Script)

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 ______(NC) what is an earlier time you can remember experiencing something similar?”

“How about an earlier time?”

• Clinician keeps asking as long as the client keeps answering. The earliest is the “Touchstone.”

Future Desired State

“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”

Many studies show that adverse childhood experiences can lead to an overly sensitized nervous system, which can lead to chronic pain later in life. These childhood stressors strongly influence and prime how a person’s system responds to stress, how he or she perceives safety and attachment, and the character traits that become overdeveloped as “The Answer” to these stressors. In general, you will likely see two common factors in those with chronic pain:

- Significant childhood abuse and/or neglect.
- Feelings of powerlessness. This shows up in a client through overdeveloped traits of guilt, self-criticism, low self-esteem, high expectations for self, extreme responsibility for others, self-sacrifice and hypervigilance.

It is important to mention that those with less obvious childhood stressors can still develop somatic symptoms. Even mild degrees of dysregulation rooted in childhood experiences can be enough to trigger symptoms. Regardless of the level of childhood stress, it’s important to explore how these previous experiences are currently being stored in the client’s system, how “The Answer” to these previous stressors are getting in the client’s way, and which past experiences are at the root of the client’s pain.

**Common Character 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
- Being overly responsible
- Taking on responsibility of others
- Excessive worry
- Indecisiveness
- Powerlessness/helplessness
- Rule following
- Difficulty letting go
- Being cautious, shy, or reserved
- Repressed thoughts and feelings
- Lack of safety/hypervigilance
- Harboring rage or resentment
- Not standing up for yourself
Common “Answer” Character Types in People with Chronic Pain

• The Rock
• The Invisible One
• The Emotional One
• The Nice/Non-threatening One
• The Doer
• The Hero

Chronic Pain Syndromes

• Tension headaches
• Migraines
• Back pain
• Neck pain
• Foot pain
• Whiplash
• Fibromyalgia
• Temporomandibular joint (TMJ) syndrome
• Chronic abdominal and pelvic pain
• Chronic tendonitis
• Vulvodynia
• Sciatic pain syndrome
• Repetitive stress injury
• Myofascial pain syndrome

Autonomic Nervous System Related Disorders

• Irritable Bowel Syndrome (IBS)
• Interstitial Cystitis (irritable bladder syndrome)
• Postural Orthostatic Tachycardia Syndrome (POTS)
• Inappropriate Sinus Tachycardia
• Chronic Regional Pain Syndrome (CRPS)
• Functional Dyspepsia or Gastroesophageal Reflux Disease (GERD)

Other Syndromes

• Insomnia
• Chronic Fatigue Syndrome
• Paresthesias (numbness, tingling, burning)
• Tinnitus
• Dizziness
• Spasmodic dysphonia and/or globus hystericus
• Chronic hives
EMDR with Children

**Note:** For further training, please attend our 3-hour Advanced Webinar/Distance Learning Seminar found at [www.emdrtherapybasictraining.com](http://www.emdrtherapybasictraining.com)

- Children process more quickly
- Children have fewer blocks or defenses to processing
- The standard protocol can be used and made to be “kid friendly”
- It’s possible and encouraged to use music, art, movement, sand tray and play in all phases

**Phase 1: History Taking**

- Information from parents, school, legal workers, and past evaluations
- 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?
- Information directly from child
- Information can also be gathered from what likely happened, as in the usual behavior/response
- Circumstances in foreign orphanages
- Targets may be arrived at through present triggers and what likely happened
- Explore the early years. The child’s play themes and stories provide valuable information
- Modifying NC and PC to more child friendly words
- Use of photographs, art, sand tray and other concrete tools
- Developing a comprehensive treatment plan
- Targeting Sequence Plan
- What does the child need more of or less of? (i.e., Resources)
- Identify the child’s main strategy for managing stress
- Identify a child’s favorite toys, characters, etc. for usage later in the process

**Phase 2: Preparation**

- Calm/Safe Place for Kids
- Container Exercise
- Working with parents for stabilization and to maximize attachment
- Weighted blanket/ concrete safety
- Informed Consent and Education
- Practice with parents and targeting ways child triggers
- Parents to expect behaviors will get worse before they get better can assist them in being patient and
- more supportive
• Simplified explanation of EMDR
• Use of books, games, puppets, stuffed animals
• Younger children could be worked with while sitting on parents lap
• Provide education about how the brain works and how trauma affects it

**Phase 3: Assessment**

• Child friendly terms
• Use of concrete measurement tools
• Hand showing how big disturbance (SUD/VOC)
• Faces showing disturbance (SUD/VOC)
• Magnifying glass for body sensation or another detecting device

**Phases 4-6: Reprocessing**

• Children often move about during processing
• Processing can be much faster — shorter sets
• Some children will need concrete feedback
• Use of SUD every time for some
• “Better,” “Worse,” or “The Same”
• Linking into positive networks can be assisted by parents
• Use of story or missing experience can help positive links
• Recognizing dissociation in children
• DAS can be provided via finger puppets, magic wands, foam swords, the child’s favorite toy or character in the office (using eye movements), drumming, patty cake, etc.
• Paint brushes on the back or palms of child’s hands for DAS

**Phase 7: Closure**

• Offering specific tools for parents to assist children
• Set expectations and offer specific attachment activities

**Phase 8: Reevaluation**

• Assessing the previous target
• Completing the Treatment Plan
• Completing the Future Template
Books on EMDR with Children

EMDR and the Art of Psychotherapy with Children: Treatment Manual Jun 2, 2008 by Robbie Adler-Tapia PhD and Carolyn Settle MSW LCSW

EMDR Therapy and Adjunct Approaches with Children: Complex Trauma, Attachment, And Dissociation Jul 27, 2012 by Ana Gomez MC LPC

Dark, Bad.....Day go away: A Book for Children about Trauma and EMDR by Ana Gomez MC LPC (2007)

The Thoughts Kit for Kids by Ana Gomez MC LPC

The Different Colors of Me: My First Book about Dissociation Ana Gomez and Paulsen, S.

Through the Eyes of a Child (Norton Professional Books) Feb 17, 1999 by Robert H. Tinker and Sandra A. Wilson

Small Wonders: Healing Childhood Trauma with EMDR Oct 26, 2007 by Joan Lovett

Trauma-Attachment Tangle: Modifying EMDR to Help Children Resolve Trauma and Develop Loving Relationships Dec 17, 2014

EMDR in the Treatment of Adults Abused as Children (Norton Professional Books) June 17, 1999 by Laurel Parnell

Integrative Team Treatment for Attachment Trauma in Children: Family Therapy and EMDR Mar 31, 2014 by Debra Wesselmann and Cathy Schweitzer

Eye Movement Desensitization Reprocessing (EMDR) in Child and Adolescent Psychotherapy May 1, 1999 by Ricky Greenwald

Treatment of Traumatized Adults and Children: Clinician’s Guide to Evidence-Based Practicing 17, 2009 by Allen Rubin and David W. Springer

The Whole Brain Child by Daniel Siegel and Tina Payne Bryson 2012 Bantam books

Parenting from the Inside Out by Daniel Siegel, MD and Mary Hartzell 2013 Penguin Publisher
The “Answer” for Kids

1. When you have time to do anything you want, what do you like to do?
2. What is your favorite thing to do on a Saturday morning?
3. What do you usually want to do after a long day at school?
4. When someone tries to make you do something you don't want to do, what usually happens?
5. What do you usually do when you are really happy?
6. How do people know if you are unhappy?
7. Do you like rules?
8. Do you like surprises?
9. Do you ever cry? Is it usually alone or in front of people?
10. What is a recent time you had a lot of fun?
11. What is a recent time you were frustrated?
12. Do you ever get angry? How do people know you are angry?
13. If you don't want to do something, how do people know?
14. Do you like to make up stories?
15. If you want someone to do something for you, how do you get them to do it?
16. If someone is doing something you don't like, what are you likely to do?

Therapist

• Begin to listen for what they do under pressure, what is overdeveloped and underdeveloped.

“So, it sounds like you are really good at ________________ (letting people know how you feel). And it sounds like it is harder for you to ________________ (let other people tell you what to do, like with teachers or parents asking you to do things).”

• Therapist is looking for how this was once an answer for the client. How did they learn how to do that so well? Why did they need to learn how to do that?
• Another way to do the “Answer” for kids is to create a superhero with special super powers.
Negative and Positive Cognition List for Children

<table>
<thead>
<tr>
<th>Bad/Yucky Thoughts (NC)</th>
<th>Good Thoughts (PC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m bad.</td>
<td>I’m good.</td>
</tr>
<tr>
<td>I’m stupid.</td>
<td>I’m smart.</td>
</tr>
<tr>
<td>I’m dumb.</td>
<td>I’m smart.</td>
</tr>
<tr>
<td>I’m going to explode.</td>
<td>I’m calm.</td>
</tr>
<tr>
<td>I’m unwanted.</td>
<td>I’m lovable.</td>
</tr>
<tr>
<td>I’m fat.</td>
<td>I’m just right.</td>
</tr>
<tr>
<td>I can’t get it.</td>
<td>I can learn.</td>
</tr>
<tr>
<td>I’m uncomfortable.</td>
<td>I am comfortable.</td>
</tr>
<tr>
<td>I blew it.</td>
<td>I did the best I could.</td>
</tr>
<tr>
<td>I’m sick.</td>
<td>I’m all better.</td>
</tr>
<tr>
<td>I can’t trust.</td>
<td>I can trust.</td>
</tr>
<tr>
<td>I’m not lovable.</td>
<td>I am loveable.</td>
</tr>
<tr>
<td>I’m not safe.</td>
<td>I’m safe now.</td>
</tr>
</tbody>
</table>

May also be about the situation in a critical incident:

<table>
<thead>
<tr>
<th>I almost drowned.</th>
<th>I’m okay now.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am scared.</td>
<td>I made it.</td>
</tr>
</tbody>
</table>
How to Recognize Dissociation

- Dissociation and Trauma/Window of Tolerance
- Review of trauma models: Ego State Theory, BASK, EMDR

AIP
- The overwhelmed system was unable to sufficiently process the experience (i.e., memories).
- Dissociated states will hold different aspects of the traumatic memory as well as different animal defenses or trauma reactions.
- The configuration of memory networks can look like ego states, alters, personality states.
- The host/observer/self is not established with a sense of presence.

The Continuum of Dissociation
- Symptoms
- Management in session
- Resourcing

Phase 1: History Taking
- First, assess for dissociation. DES-Dissociative Experiences Scale
- Therapist may not get a detailed history right away as stabilization may be needed first
- DES, SDQ-20, MDI, SCID-D
- Online Resources- [https://www.isst-d.org/](https://www.isst-d.org/)
- Clinical signs

Phase 2: Preparation
- Resourcing the client based on their needs
- Developing a therapeutic relationship
- Getting an understanding of the client’s process
  - Phase 2 can take a long time
- Treatment Plan (More training is needed to treat Dissociative Disorders)
  - Trauma processing is an important part when the client is ready
EMDR as a framework for treatment

Phases 3-7: Reprocessing
- The therapist may need to slow down processing and possibly not use eye movements at all.
- There should be a constant evaluation of the Window of Tolerance and if the client is present in the processing.
- For DID more training is needed prior to reprocessing trauma with that population.
Books on EMDR and Dissociation

Looking Through the Eyes of Trauma and Dissociation: An illustrated guide for EMDR Therapists and Clients 
Feb 23, 2009 by Sandra Paulsen Ph.D
Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy Dec 17, 2007 by Carol Forgash and Margaret Copeley
EMDR Toolbox: Theory and Treatment of Complex PTSD and Dissociation Sep 5, 2014 by James PhD Knipe
EMDR and Dissociation: The Progressive Approach Jun 10, 2012 by Anabel Gonzalez and Dolores Mosquera
EMDR Therapy and Adjunct Approaches with Children: Complex Trauma, Attachment, and Dissociation Jul 27, 2012 by Ana Gomez MC LPC
The research has indicated that when all of the steps of this Phobia Protocol are followed there is a very high rate of remission of symptoms. When fewer steps are used, the results are less positive.

Phases 1 & 2: History Taking and Preparation Phase

- Education about Phobia Symptoms: Fear of Fear, how symptoms perpetuate
- Address Secondary Gains: What are they able to avoid? Use “The Answer”
- Explain what is happening and identify Targets to be addressed
- What beliefs are associated with the Phobia?
- What events trigger the Phobia?
- What physical sensations go along with it?
- Teach Self-control Procedures to handle fear of fear
- Container
- Light Stream
- Spiral Technique
- Relaxation Cue/Safe Place

Phases 3-7

Six Aspects for Finding the Targets for Reprocessing (in this order):
1. Any Ancillary Events—Other things that may be supporting the phobia
2. The first time the fear was experienced
3. The most disturbing experiences
4. The most recent time it was experienced
5. Any associated present stimuli
6. The physical sensations or other signs of fear, including hyperventilation

Other Steps

1. Create a positive template for fear-free future action.
2. Create a contract for Action Plan.
3. Run a visualization, mental movie, of the full sequence of events over time and space and reprocess any disturbance
4. Prepare the client to expect some anxiety during actual exposure and offer tools to help the client manage (e.g., log experiences and use self-control techniques). Inform that there is no failure, only information.
5. Complete reprocessing of targets that may emerge between sessions.

Note: If they continue to be blocked a Cognitive Interweave intervention may be necessary.
ACE Score: Adverse Childhood Experiences Study


- The more extensive exposure to abuse and household dysfunction the higher the probability of behaviors that lead to health risk.
- The person with a score of 4 out of 10 has a 500 percent increase in likelihood of the development of addictions
- A score of 6 in males shows a 4,600% increased likelihood of using intravenous drugs

Addictions and the AIP Model

The EMDR therapy model, AIP, looks at the root of the current issue. What earlier events are linked and currently stored in a dysfunctional way. With addictions we will, ultimately, discover the early memories and allow the client to reprocess those memories to lessen the impact they have in the present which may be fueling the need for addictions.

Addictions may include alcohol, drugs, pornography, sex, gambling, shopping, food or anything that is used compulsively to manage underlying issues.

Careful treatment planning, including developing resources and a safety plan, are necessary. Working with addictions requires training in both EMDR and addictions in order to provide a safe, effective treatment.

Addictions as an “Answer”

It is important for the therapist to see the adaptive nature of the addiction. The addiction serves or did serve at one time to help the client regulate. It is useful in numbing the pain of past traumatic events that are stored in the client’s system.

Even if the client has been clean and sober for many years, it is important to predict that the urge to use may surface as the client gets close to the source of pain, the reason for the addiction.

Phase 1: History Taking

- History of current resources include the discussion of the addiction as a past resource
- Do not ask about traumatic memories unless the client has demonstrated the ability to have affect management without using
- The use of “The Answer” exercise and concept will assist in identifying the current strengths and resources as well as the underdeveloped skills
Phase 2: Preparation

- Address readiness and stages of change
  - Collaborating with the client at the current stage
- Safety and stability
  - Predicting, normalizing and preparing for the dangerous and annoying tendencies of the client
- Timing of treatment
  - Complete sobriety may not be possible without addressing the underlying cause, therefore, treatment planning needs to consider this aspect

Phases 3-7: Reprocessing

- Targeting sequence plan may include an alternative protocol first, such as those listed below
- Once there is adequate stability and enough preparation, the Touchstone should be reprocessed prior to the start of the addictive behavior

Possible alternative protocols:
- DeTUR (Desensitization of Triggers and Urge Reprocessing) Arnold J. Popky, Ph.D.
- FSAP (Feeling State Protocol) Robert Miller, Ph.D. http://www.fsaprotocol.com
Note: For further training, please attend our 3-hour Advanced Webinar/Distance Learning Seminar found at www.emdrtherapybasictraining.com

- We are looking at the specific patterns, behaviors, attitudes and beliefs in the relationship that are based on past experiences with each partner.

Phases 1 & 2: History Taking and Preparation Phase

- Commitment Level
- Safety Issue
- Finding Targets
- The complete treatment plan
- The Answer for Couples, both together and separately

Getting information 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?”

Phases 3-8: Reprocessing and Reevaluation

- Past, present and desired future as a couple
  - Past: Explore both childhood and past events in the relationship.
  - Present: What do the partners do to trigger each other?
  - Future: A vision for the relationship and steps to get there.

- Navigating joint vs. individual sessions
1. What is your favorite thing to do when you have a free day?
2. What do you most dread?
3. What is your favorite memory from early in your relationship?
4. What did you like most about your partner when you first met?
5. What are you most frustrated by in life now?
6. What makes you happy?
7. What does your partner do that drives you crazy?
8. What is easy for you to do?
9. What do you do if someone tells you no?
10. How do you get your way?
11. What is your favorite childhood memory?
12. What do you admire most about your caregivers?
13. What was frustrating about your caregivers?
14. What is difficult for you to do?
15. What was your favorite childhood activity?
16. When you are upset how can people tell?
17. When you need to re-charge, what helps?
18. If there is an emergency what are you likely to do?
19. What makes you feel proud?
20. How do you handle extreme pressure?
21. What are you really good at doing?
22. Does lots of connection make you feel better or worse?
23. What is your first instinct when something bad happens?
When someone has a history of trauma they are more vulnerable to getting PTSD. The combat or high stress environment that is physically dangerous can trigger the creation of dysfunctionally stored memories.

**Phase 1: History**
- Getting a road map according to client’s needs
- Resources (May need to get details later or not at all)
- Current triggers
- Other life stressors
- Past experiences
- Attachment and Developmental History
- Future
- Various military culture issues
- Setting the goals for treatment
- Symptom Reduction vs. Comprehensive

**Phase 2: Preparation**
- It may not be safe to feel safe
- Therapeutic Container/Relationship
- Need for alternative resources
- Collaborative
- Education/Normalize symptoms of trauma
- Important to recognize client’s Window of Tolerance

**Phase 3: Assessment**
- May not share details
- Low SUD may be normal
- Practice stop signal and remind
- Recognize blocks to processing
- May need to slow down processing
- Possible blocks/ Cognitive Interweaves

**Phase 7: Closure**
- Plan to get a report
- Specific ways to check if client is present

**Various Military Issues**
- Marriage
- Reintegration with society
- Guilt/Survivor Guilt
- Anger
- Identity issues
EMDR And Complicated Grief

(Chapter 8, Shapiro, 2001)

EMDR Therapy does not take away the normal grief process. However, there can be ways that the client is stuck with excessive or complicated grief. EMDR Therapy can help those clients go through the grief process with a greater sense of peace.

Possible areas to target:
- Actual Events — The actual death or suffering
- Intrusive Images
- Nightmare Images
- Present Triggers
- Issues of personal responsibility, mortality, or previous unresolved losses.
- Possible Blocks:
  - The belief that they will lose connection with loved one if they process excessive grief
  - Survivor Guilt

Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Special Populations Aug 17, 2009 by Luber PhD, Dr. Marilyn
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 of the morning mindfulness
9. The Answer in Spanish

Important note regarding resources: If any resource begins to access disturbance stop and switch to a different resource. Mild disturbance in the beginning is normal but if the resource seems to activate the client and the disturbance getting more intense the resource should be stopped and a different one offered.
The Safe Calm Place Exercise

(Adapted from Shapiro 2001, pp. 125-126)

Image
“Bring up a place, either a real or imaginary place, that when you imagine being there you feel a sense of calm.”

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)

Enhance
“Stay with those __________ (describe what client said) and that feeling of __________ and follow my fingers. (do a short/slow set of DAS while the client is not talking, just noticing the positive.) And what do you notice now?” Offer 3 to 4 short, slow sets of DAS. “What are you noticing now?” (If positive, go on.)

Note: If it’s positive go on, if it’s negative stop and use a different resource.

Cue Word
“When you bring up that calm place, what word or phrase best goes with that?” _____ “So notice those words and that calm place” (Link that with some slow, short sets of DAS.)

Self-Cue
“Okay now bring up that calm place on your own and the cue word and notice the shift.” (After they report you can offer some DAS or they can do tapping on their own to enhance it.)

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.”

Self-Cue with Disturbance
“Now I’d like you to do that again. Think of another mildly irritating issue and bring up the calm place and word on your own and let me know when you are finished.”

Note: Offer this as an option for homework for them to notice if the Cue Word and the Calm Place are helpful throughout the week.

Important: They do not need to be able to do the Calm Place Exercise prior to proceeding. They just need to have a resource that helps them change their emotional state.

• Once the therapist has helped the client develop the Calm Place with the Calm Place exercise, the only thing the therapist does in future sessions is remind the client to access the Calm Place with the cue.
Creating a Container

Deborah Kennard, MS

1. Notice and Offer Container
   “So we are nearing the end of our time and I would like to be sure you have all of the time you need to feel complete and safe when you leave the office today. Would you be interested in a containing resource to help with this?”

2. Specify What Needs to be Contained
   “First, let us decide what it is you feel the need to contain. Is it the strong feeling of _______ (sadness, anger, grief)?”

3. Mindfully Invite and Offer Menu
   “Okay, so just allow the perfect container to come to mind that will be big enough and strong enough to hold your _____ (emotion). It could be as small as this coffee cup or as large as Mother Earth, or anything in between.”

4. Enhance/Deepen
   “Great. So imagine that ______ (name container) and how does the ____ (emotion) go in?”

5. Mindfully Deepen
   “So just allow the _____ (name emotion) to enter the ______ (name container) from that ______ (name entry point) and let me know when you feel it is all inside.”

6. Sealing Container
   “Would you like to _______ (close the door, put a lid on it...), or have you already done that?”

7. Somatic Linking
   “So just sense the ______ (emotion) being contained in the ______ (name container), and what do you notice in your body now?”

8. Extra Layers/Menu
   “Great. Now just see if there is anything else you need to feel that ______ (emotion) is safe and contained. You could put a lock on the door, have a special being as the guard, you could put it into a cave in mountain..”

9. Deepen/ Check for Completion
   “Great. So really sense the____ (emotion) inside the____ (describe container). And what are you noticing in your body now?”
11. Enhance/Deepen/Complete

“Just allow that ______(energy/light) to penetrate that_____(emotion) and let me know when it feels complete.

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Grounding: Hyperarousal and Hypoarousal
In a seated position, gently push both feet into the ground. Gradually begin to notice how the body feels as this grounding takes place. Going up the body, notice the seat on the chair, the back against the chair, etc. Notice what changes in energy, attention, breath, etc.

Alignment: Hyperarousal and Hypoarousal
For Hypoarousal: “Notice what happens as you bring your attention to your spine and begin to lengthen it. What do you notice? You can continue bringing your attention from the bottom to the top of your head, gradually noticing the alignment. Eventually, standing to notice the complete alignment.”

For Hyperarousal: “Begin by noticing the current state of the spine.” Relaxing the spine may be helpful first. Followed by lengthening. Followed by what feels best for the client.

Centering: Hyperarousal
“Begin by opening your arms and slowly spread them out to form a circle. With your arms, form a container big enough to hold all of the feelings, sensations or parts. Or make it small enough to feel contained.”

Containment (Body Squeeze): Hyperarousal and Hypoarousal
Have the client begin at the top of the head, feeling and slightly squeezing the head. Demonstrate for them how to move down the body squeezing, from head to shoulder to arms, to legs. While they are squeezing they may say “this is my body.”
Note: This may be activating for some clients.

Orienting: Hyperarousal and Hypoarousal
When a client appears to be dissociating or going too far into a memory, orienting can bring them back to dual awareness and their attention back into the room. Have them slowly turn their head from side to side, leading up to 360 degree turning movements through the head, neck and spine. Having them notice what happens in their body as they do this.
Ask the client to notice 3 things in the room that are red (or any color). Have them tell you how they know they are here in the room. Ask them to focus on their favorite item in the room.

**Boundaries**

Practicing the "stop signal" is one example of a boundary. Experiment with how it feels in the body as they practice the stop signal. Instructing them to do what feels "good." Maybe the stop signal is to the side, or perhaps it is out in front of their body. Holding an arm out straight feels better for some. Be aware that this can be triggering for some clients.

You can experiment with boundaries by using a scarf, or a tie on the floor. Where does the boundary feel good to them? How far away? How close? You can also experiment with distance in chairs and check in with them on what feels like a good distance apart. This can be done while standing and walking closer or farther apart. Invite them to be aware of internal cues that tell them it is a good distance. Use caution that this can be activating for some clients.

**Group Practice**

Groups of 2 can practice the Alignment exercise together. The therapist guides and demonstrates awareness as the client goes up the spine from the feet, to the head, ending with standing and total alignment, getting reports from the client and noticing and reporting shifts such as,

“**Oh, I see you are breathing more deeply**” or “**It seems like you are making more eye contact now**” or whatever you are seeing.

The person who is the therapist next can do the same exercise or choose a different somatic resource to practice.

**Note:** See Somatic Resources video in basic training portal
**Additional Somatic Resource Exercises**

1. **Playing Catch Conversation (“It’s in Your Court”)**
   This resource builds social skill and awareness of a balance between listening and talking.
   
   - Using a ball or a beanie baby, have a conversation.
   - When you ask a question throw the ball to the other person.
   - The other person catches the ball, answers the question and asks you a question, throwing the ball back.

2. **Which Do You Like Best?**
   This resource builds awareness of knowing what you like or knowing and expressing what you want.
   
   Using 2 beanie babies or other objects, hold them both up and ask:
   - “Which one do you like more?”
   - “What tells you that?”
   - “What do you notice in your body that tells you that?”

3. **Scarf Connection/Letting Go Exercise**
   Holding a scarf (rope, neck tie or other object), have the client hold on to one end of the scarf and you hold on to the other. Investigate the following questions:
   
   1. “As you hold the other end of the scarf, what is just the right amount of tension in the scarf?”
   2. “What tells you that?”
   3. “What is a good distance between us as we hold the scarf?”
   4. “What tells you that?”
   5. “Would you like to try an experiment?”
   6. “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 client indicates readiness, drop one end.)
   7. “What do you notice as I drop my end?”
   8. “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.”
   9. “Now, I’d like you to notice what changes as I pick my end back up. What do you notice?”
10. “Now would you like to notice what happens as you drop your end and I hang on to my end? (Allow answer) Whenever you are ready drop your end. (When client drops it) What do you notice?”

11. “Now, would you prefer I ask you to pick up your end or would you rather just pick it up when you are ready?” (Allow answer and do what they choose.) “What do you notice?”

12. “What did you notice was different when I asked you versus when you decided?”

4. **Scarf Crossing Boundary Exercise**

This resource increases awareness of boundaries and personal space and power.

The client may be sitting in a chair or standing. Invite the client to use the scarf or similar object to create a boundary in front of them. It may be straight across or in a semi-circle, allowing the client to decide. Experiment with putting objects in and out of the boundary.

1. Have client select objects to represent people or issues.
2. Ask the client where they would like to place that object. Each time they do something, you can ask the following questions:
   - “What tells you that is the right place?”
   - “What do you notice as you place that object there?”

3. Invite the client to experiment and notice what happens when each object crosses into the boundary.
   - “What changes?”
   - “What does you notice somatically?”
   - “Are there words that go with that?”

4. If the client would like to remove an object from inside the boundary, ask if there are words they would like to say as they move it out.

5. After each movement, ask the client:
   - “What changes?”
   - “What are you noticing now?”

5. **Energetic Boundary Exercise**

This resource increases the client’s ability to tolerate external disturbances.
Invite the client to bring to mind someone or something that represent boundary crossing. Allow time for the client to respond. Then ask various questions about this, allowing the client to deepen the experience.
- “What are you noticing in your body?”
- “Where are you feeling that in your body?”
- “How do you know you’re where you are feeling it in your body?”
- “How far in does it go?”

Invite the client to place a hand on that part of the body. Then move the hand out from the body to the place they would like it to stop.
- “What are you noticing?”
- “What is changing?”

6. Somatic Mindfulness Exercise
This resource increases affect tolerance, mindful awareness and somatic awareness.

Invite the client to notice what happens in the body when they bring up the thought of ____ (any mildly disturbing thought or anxiety, possibly the thought of beginning the process of finding the targets) Experiment with the following questions allowing time for the client to answer:

Invite the client to drop the story and just notice the physical sensations. *If the client becomes activated stop and switch to a different resource.
- “What do you notice in your body?”
- “As you notice that ______ (tightness, etc.) how big is it?”
- If not a clear description ask: “What is the quality of it? Is it a squeezing, contraction, tightness, tingling?”
- “Where does it start and stop?”
- “Is there any movement to it?”
7. Mindful Scribble

By: Alice Stricklin, LMFT
Adapted from Cathy Malchiodi’s Bilateral Drawing

Invite the client to choose a color (from crayons, pencils, or markers) that represents calm/peace. Ask them to sit with a large piece off blank paper either in their lap, on the floor, or at a table (whichever is most comfortable). Then invite them to place the writing utensil in their non-dominant hand, and let the color find its way to the paper any way that it wants too. Without trying to draw anything in particular, just let the color move around the way it seems to want to go on the paper. (the therapist can be paralleling this with them by doing the same thing on your own paper as a way to demonstrate). Then the therapist will gently guide the client into mindful drawing with the following prompts:

- Just begin 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 it’s thoughts like “this is so weird and crazy, why am I doing this”, or thoughts like “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 wondering to what you are doing after the session, or evaluating events from earlier today or this week. Just notice what calls your attention and then gently bring your attention back to the tip of the ___________ (marker/crayon/pencil). (long pause)

- As you are noticing what keeps calling your attention away, just notice if it is more internal distractions like body sensations, thoughts, feeling, or more external distractions like noises, smells, awareness of me or others. As you begin to notice what draws your attention just acknowledge it then gently bring your attention back to the tip of the _______ (marker/crayon/pencil) (longer pause)

- I’m going to invite you to notice what is happening now in your experience as you are doing this activity of noticing, catching, returning to the present moment. Notice what feels different in your body, mind, emotions. Notice if nothing feels different. Bring in a little curiosity about that for a moment, then gently bring your attention back to the tip of the ___________ (marker/crayon/pencil) (pause)

- When you are 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

Dreams List
This activity builds resources of choices and awareness of dreams and desires.

What would you do if you had absolutely no limits?
* No limits of time
* No limits of money
* No limits of support from others
* No limits of talent
* No limits of any kind

* What would you do?
* Where would you go?
* What would you own?
* What would you create?
* What would you experience?
* What would you contribute?

Make a list of 20 dreams (or more).
Note: These resources can be used for incomplete sessions or additional stabilization

A. Light Stream Technique
1. Ask client to concentrate on any disturbing or upsetting body sensations.

2. Identify the following by asking:
   • “If it had a ________, what would it be?”

   A. Shape          B. Size           C. Color           D. Temperature          E. Texture           F. Sound

3. Ask the client:
   "What is your favorite color you associate with healing?"

4. Say to the client:
   • “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. If client gives feedback that it is changing in any way, continue repeating a version of the above and ask for feedback until the shape is completely gone. This usually correlates with the disappearance of the upsetting feeling. After it feels better, bring the light into every portion of the person's body, and give her a positive statement for peace and calm until the next session. Ask client to become externally aware at count of five.

B. Spiral Technique
1. Client is asked to bring up a disturbing memory and to concentrate on the body sensations that accompany the disturbance. Client is told this is an imaginal exercise and 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. Clinician then asks the client to concentrate on body sensations.
   • “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. Whatever the client answers, respond with, “Good,” and instruct him/her to move the spiral in the opposite direction.

   • “Now with your mind, let’s change direction and move the spiral.” (state clockwise or counterclockwise to indicate the opposite direction). “Just notice what happens as it moves in the opposite direction.”

4. Ask the client:
   • “What happens?”

If the technique works, the client will report that moving in the opposite direction will cause the feelings to dissipate and the SUD to drop. Teach it to the client for self-use. If the client says the spiral doesn’t change, doesn’t move, nothing happens, then choose another technique.

C. Breathing Shift
1. Ask the client to bring up a good, happy, or positive memory. Try to use whatever affect is most useful.
2. Ask him to notice where his breath is starting and to put his hand over that location in his body. Let him breathe a moment or two and instruct him to notice how it feels.
3. Now ask him to bring up a memory with a low level of disturbance and notice how his breath changes.
4. Ask him to put his hand over that location in his body.
5. Now ask him to change his hand to the previous location and deliberately change his breathing pattern accordingly.

This should cause the disturbance to dissipate. Teach it to the client for self-use.

D. Diaphragmatic Breathing
1. Ask the client to take a deep breath and fill lungs completely so they get the most out of breathing. You may suggest that they scoot forward in their chair and place one hand over their abdomen and the other hand over their chest (demonstrate for client).

   • “Start by exhaling and then breathe in all the way with your abdomen for a count of two and then breathe in all the way with your chest for a count of two. Hold that for a count of seven and then breathe out all the way with your abdomen for a count of four and breathe out with your chest for a count of four.”
Relational Mindfulness Exercises

Note: One bell means 1-minute remaining. 2 bells mean please come to silence.

A. Boundaries Game

Game 1: Pair up – A makes an unreasonable request, B says no (switch) A makes a reasonable request, and try to convince, seduce, cajole, threaten, B says no (switch)

Game 2: Pair up – A makes a request, B counter offers, you collectively agree upon something.

B. The Noticing Game

• Split into pairs, preferably with someone you don’t know. If there is an uneven number a training coach will join.
• Things to notice: 5 senses, thoughts, emotions, body sensations. All should be in the present moment. Surprise yourself!
• Trainer and Assistant will demonstrate how to do this first.
• One person is A and one person is B.
• A goes first.
  • 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 ____________.

C. Curiosity Game

• The Trainer and/or the Training Coaches will demonstrate how to play.
• Everyone finds a partner. If there is not an even number a training coach will help.
• The person with the larger ear lobes is A and the person with smaller ear lobes is B.
• Person A goes first and asks any question of Person B they wish.
• The only rule is: You have to be genuinely curious about their answer. So, no sleepwalking through this by asking “Where are you from?” unless you are genuinely curious about that answer.
• Person B is allowing themselves to be impacted however they naturally are by their questions. They may, like in everyday life, either answer, refuse to answer, or lie.

Round 1

• Person A continuously asks Person B questions they are genuinely curious about for about 2 minutes. Let any prepared questions go and try to allow present moment curiosity to be here and guide the questions.

Round 2

• Pause for 2 minutes and have Person B give Person A 30 to 60 seconds of feedback.
• “Person B, share what you liked about Person A’s questions so far and any questions you wish A would have asked.”
• After about 60 seconds of feedback, the partners switch.
• Trainer will ring bell, 1 ring means 30 seconds left and 2 rings means please come to silence.

D. Relational Mindfulness Exercise

As the Trainer or Training Coach describes his/her present moment experience, notice what happens in your present moment experience.

E. Relational Mindfulness Game

• Trainer chooses 3 sentence stems. In pairs, each person takes a turn sharing something while the other person notices their own present moment experience.
• Demonstrate first. 1 ring is a warning, 2 rings means please come to silence.

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.

Does it go inside or outside? Maybe it’s the sound of the heater, the sound of my voice or sounds outside of you that tell you that you are here.

Maybe seeing the light or seeing the room.

Just notice what is your first procedural way you sense yourself being here.

For others, you may feel your body suddenly resist being here as you notice it internally.

Maybe your attention goes to your core or your heart or your thoughts.

Just notice how you know that you’re here.

Long pause…………………………………………………………………………………………

I would like to invite you to bring your attention to the quality of being here.

Is there a sense, maybe a sense of heaviness, or a sense of tension

Maybe an emotional quality of being here – like anxiety or relief or happiness.

Bring your awareness to your system.

What is here?

Long pause…………………………………………………………………………………………

Now I am going to say some words, and I’ll say them twice.

I would just like to invite you to notice in your system what happens in your system as you hear these words.
Who you are is enough.

Notice any way those words landed and felt right.

Or any part of you that tensed up and said no, that isn't true.

Or any way your answer showed up. Maybe zoning out or thinking about something else.

If possible, bring a gentle awareness to yourself: it's all okay.

Whatever you’re noticing in your system, I would 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 would like to invite you to bring up a resource.

Something that helps you.

It could be a resource of love or calmness or whatever state you like to be in.

Maybe it's a person or a memory of a piece of music or art, something in nature, a pet.

Maybe it’s a spiritual resource.

Whatever helps you.

In a moment, I will ring the bell, and 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.

Notice any way those words landed and felt right.

Or any part of you that tensed up and said no, that isn't true.

Or any way your answer showed up. Maybe zoning out or thinking about something else.

If possible, bring a gentle awareness to yourself: it's all okay.

Whatever you’re noticing in your system, I would 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 would like to invite you to bring up a resource.

Something that helps you.

It could be a resource of love or calmness or whatever state you like to be in.

Maybe it's a person or a memory of a piece of music or art, something in nature, a pet.

Maybe it’s a spiritual resource.

Whatever helps you.

In a moment, I will ring the bell, and 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.
Maybe it is an image of someone you are sure you love – no conflict – or a pet, somewhere out in nature, or 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 as long as you need.

Rings bell…………………………………………………………………………………………

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, or feeling your seat on the chair, or maybe even an emotion or a calming, or a thought, or even a body sensation that tells you that you are here.

For some of you, the first thing you might notice is something outside of you.

Maybe the sound of my voice, or the fan coming on, or even people talking in the room next door, or the feeling of the air outside of you.

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 are still feeling yourself on the highway driving, or something that happened to you on the way here, or a conversation that you had, or somebody at home, something you’re afraid you forgot.

Or maybe there is some way you’re in the future, thinking about what will happen today, what you have to do when you leave here, or something in the future that worries you or excites you.

Notice any way that you are not quite here.

How do you know?

Long pause. ……………………………………………………………………………………

Now I am going to say some words. I am going to say them twice and I would 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.

In a moment, I will ring the bell. Take as long as you need and open your eyes.

Rings bell…………………………………………………………………………………………

Feel free to take notes on your experience if you want to.
You Are a Shining Star

I would like to invite whoever would like to join at whatever level feels best for you. I will start with a bell and end with a bell.

Rings bell……………………………………………………………………………………………..

I would 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 certain five sense perception? Maybe something you hear, something you see, something you taste or smell.

What happens for you?

Long pause……………………………………………………………………………………………..

Then I would like you to kind of play with this – your awareness, and your attention. 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 can get a sense of the light in the room or the feeling of the air on your body, outside of you.

Long pause……………………………………………………………………………………………..

Then just notice how you can you direct your attention – if your eyes are closed, 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 for you to do or difficult.

**Long pause** ........................................................................................................................................

Now I would like to invite you to bring your attention to some part of your body that calls your attention.

Maybe it’s a positive sensation, an openness in some part of your body or maybe it is tension or tightness.

Whatever it is. Whatever calls your attention, just notice it.

Or it could just be lack of being able to connect with a part of your body. Remember that your head is a part of your body.

**Long pause** ........................................................................................................................................

Wherever your attention goes just notice it and invite that part to be there as big as it needs to be. Whatever is there.

As you invite it to be as big as it needs to be, I would like to invite you to notice: If that part of your body could speak in words what would it be saying?

**Long pause** ........................................................................................................................................

Whether you heard something from that part of your body or not maybe even the being quiet could tell you something.

As you hear those words or the quiet just asking is there is any way that is trying to help?

Is there any way that could possibly be an answer?

Just notice with curiosity as you ask, what is that an answer to?

How is that what’s helpful?
How is that a memory?

How is that a lie?

What is new and true for you right now?

**Long pause**

Now I am going to say some words, and I’ll say them twice. I would like you to notice what happens in your system as you hear these words.

You are a shining star.

You are a shining star.

Just notice whatever part of you heard that, however it landed, or maybe there is a part of you that got irritated or tightened up. That’s okay too.

Whatever happened for you, notice if you can bring in 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)

I would like to invite you to join at whatever level you are comfortable.

Just feel yourself being here.

Hear the sound and the environment.

Sometimes the environment can bring us here very quickly – with a sharp sound or something that calls our attention.
Begin to notice, for you, how do you know you’re here?

**Long pause**

If possible, bring in curiosity to that experience.

Notice what calls your attention. What tells you that you are here?

Does your attention go inside or outside?

**Long pause**

What part of your experience does your attention go?

For some of you it might be hearing the sounds in the room. Or seeing something. Or smelling something or feeling a sensation. Like the air on your skin.

It could even be a taste – maybe a five-sense perception.

For some of you the first thing you might notice is a thought. The thought of being here or the thought of how you got here.

Some of you might notice a sense of being here physically like relaxing of your body or the seat or gravity holding you to the chair or your feet on the floor.

Maybe there is an emotion that tells you that you are here. An excitement about being here. Maybe an emotion about something else that’s not here at all.

Just notice being here.

**Long pause**

I would like to invite you to notice any way you are not quite here.

Maybe there is some sense of worry about something that is happening outside of here. Or something that happened yesterday. Or someone. Or even a positive feeling or thought about something that happened – that calls your attention.
Maybe some way you’re in the future. Thinking and worrying or excited about something that’s happening in the future.

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. I would just like to invite you to notice whatever happens in your experience as you hear these words.

All parts of you are welcome here.

All parts of you are welcome here.

Just notice any way those words landed and felt great.

Or any part of you that may have tensed up or said no, that isn’t true.

Whatever it is, just notice it.

Long pause

I would like to invite you to bring up a resource of love.

Some way or something where there is no conflict but just the pure sense of love. Maybe it’s a person, a pet, something out in nature, a spiritual figure. Whatever it is for you.

If that is difficult for you, I would like to invite you to see if you can bring one drop of love into your system.

You know that this is a resource you can connect with any time you need to.

In a moment, I will ring the bell, and you can take all the time you need.

Rings bell
We won’t forget you! After your basic training you are a “member” of the PTI for 1 year! With your membership you receive:

Access to training and demo videos
An email list serve: https://groups.google.com/forum/#!forum/emdrtraining
Members Discounts
Answers to your questions!

Ask about Certification Groups, Phone/technology, In-person retreats, and Advanced Trainings!

After this complete training and completion of your 10 hours of consultation you receive a certificate of completion (not certification) of the EMDR BASIC TRAINING. Certification requirements are below.

What is Certification?

A clinician who is EMDRIA Certified in EMDR has been licensed or certified in their profession for independent practice and has had a minimum of two years of experience in their field. They have completed an EMDRIA approved training program in EMDR therapy, have conducted a minimum of fifty clinical sessions in which EMDR was utilized, and have received twenty hours of consultation in EMDR by an Approved Consultant. In addition, they must complete twelve hours of continuing education in EMDR every two years. For more information visit www.emdria.org.

Certification Period:

If approved, Certification status will be granted for 2 years from the date of acceptance.

Please allow 3-5 weeks to receive your certificate after ALL materials are submitted for administrative processing. EMDRIA asks that you do not submit incomplete applications. All application materials, including Letters of Recommendation, must be submitted in English.

Certification Fees:

Full Member of EMDRIA  |  $150.00 US Dollars (As if this writing)
Non-EMDRIA Member  |  $350.00 US Dollars
Note: In order to receive the Member rate for Certification, you must maintain current EMDRIA Full Membership status during the 2 year Certification period.

Certification Criteria:

The applicant for the designation of EMDRIA Certified Therapist must meet the following criteria:

1. EMDRIA Approved Training: Submit evidence of having completed an EMDRIA approved Basic EMDR Training program. A copy of your certificate of completion is required.

2. License/Certification: Show evidence of a license/certification/registration as a mental health professional. A photocopy of your license/certification/registration to practice independently is required.

3. Attach notarized documentation supporting the following statements:
   • Do you have at least two years of experience in your field of license/certification/registration?
   • Have you conducted at least 50 EMDR sessions with at least 25 clients?
   • Both statements can be included on one single notarized document. Applicants can simply state, "I have at least 2 years of experience in my field of license and I have conducted at least 50 EMDR therapy sessions with at least 25 clients" or similar wording and have it notarized.

4. Have you received 20 hours of consultation by an Approved Consultant in EMDR?*
   • Answer yes or no on the application form.
   • Then you will need to obtain documentation from the Approved Consultant(s) you received your consultation from, verifying the number of hours you have received from him/her and how many of those hours were individual consultation (focus on you in group) and how many were group consultation.
   • If you have received consultation from more than one Approved Consultant, you will need documentation from each. At least 10 of these hours must be obtained through individual, EMDR-focused consultation, which you can obtain in a group.
   • The remaining 10 hours may be obtained through small group consultation.
   • Consultation groups cannot exceed more than 8 participants at a time.
   • Consultants-in-Training can provide up to 15 hours of consultation; the remaining 5 hours must be with an Approved Consultant.

   Note: Only consultation hours received AFTER completion of an EMDRIA Approved Basic Training program can be applied towards this requirement.

5. Attach letter(s) of recommendation from one or more Approved Consultant(s) in EMDR, regarding your utilization of EMDR with clients.
6. Attach two letters of recommendation regarding your professional utilization of EMDR (if possible), ethics in practice, and professional character. These can be obtained from colleagues or peers.

7. Attach certificates of completion of 12 hours of EMDRIA Credits (continuing education in EMDR).
   • The Basic EMDR Training is not awarded EMDRIA Credits - only EMDRIA Approved
   • Credit Programs in EMDR that are completed after the entire Basic Training program can receive
   • EMDRIA Credits and be used towards this application requirement.

   • Applicants must read and verify on the application form that they agree to adhere to EMDRIA's
     Professional Code of Conduct

Welcome to the PTI Community!

We offer support before, during and after training

Complete EMDRIA Approved EMDR Therapy Training with PTI.
40 hrs training & 10 hours consultation and you are "EMDR Trained"

Become EMDRIA Certified: Complete Advanced Certification Package
20 hrs Consultation & 12 hours Advanced Training

Become PTI Assistant/EMDRIA Approved Consultant

Become PTI Trainer
Ours is one option for moving forward. You may also find someone on your own and create your own Certification path. Certification is optional but an important step toward becoming an expert.

Core Competencies for PTI Advanced Certification Program

I. Conceptual understanding of Adaptive Information Processing (AIP) model and the PTI additions to that view.
   A. Able to clearly describe EMDR, and how it applies to a case presentation.
   B. Able to articulate a general neurobiology of trauma in simple terms.
   C. Able to articulate how the PTI concept of “The Answer” is important in the EMDR model and how it applies to the attachment patterns as well as to the body.

II. Conceptual understanding and effective demonstration of the concept of nonviolence.
   A. Demonstrates an understanding of the balance between being an expert with clinically sound recommendations and inviting the client into the therapy process.
   B. Understands and demonstrates the understanding that the therapist cannot “do” anything to the client.
   C. Understanding concepts of mindfulness, nonviolence, awareness and compassion

III. Clinician is able to understand and effectively identify their own “Answer.”
   A. Is able to articulate and identify when their own “Answer” surfaces in the therapy process, and the effect that has on the process.
   B. Is able to identify what is overdeveloped and underdeveloped and what steps may be needed to begin to develop the under developed.
   C. Has some insight of how their own “Answer” manifests in their body.

IV. Clinician is able to understand and effectively work with the client’s “Answer.”
   A. Is able to use the answer assessment tool and identify patterns and predict strengths as well as potential blocks.
   B. Is able to identify when the client’s “Answer” surfaces in various points in the therapy process.
   C. Is able to effectively use the “5 C’s” to work with the client’s answer in a nonviolent manner.
   D. Is able to identify somatic resources that will be useful to offer to assist the client in developing what is underdeveloped.
B. The clinician is able to effectively identify when a client is out of the Window of Tolerance.
C. The clinician is able to identify and guide the client toward a somatic resource to help the client expand the Window of Tolerance.
D. Effectively explain the Window of Tolerance and dissociation.

VI. Understanding and demonstrating competency in Phases 1 and 2.
   A. Understanding and demonstration of combining history taking and preparation by getting the history of the client’s “Answer” first.
   B. Accurate and appropriate use of “The Answer” to predict and offer what may be useful in the preparation phase.
   C. Offering appropriate resource development based on the client’s needs (Answers).
   D. Understanding and demonstrating curiosity and welcoming of “The Answer” throughout the EMDR process and moving forward at times by guiding and inviting the client toward more resource development.
   E. Able to identify what is overdeveloped, the Answer, and what it underdeveloped and how to work with resources to invite more balance.

VII. Understanding and demonstrating competency in finding the memories to target.
   A. Demonstrates the ability to identify when a client is not accessing the actual “root” of the present issue.
      1. Identify when the client is going back through “The Answer.”
      2. Identify when the client is thinking about and remembering the past instead of activating and funneling, “Lighting the limbic lightbulb.”
      3. Identify when the client is going back through a symptom and not activating the actual “root”.

VIII. Understanding and demonstrating competency in Phase 3: Assessment/Activation
   A. Ability to clearly explain and demonstrate Phase 3 questions and how those questions are activating and not information gathering.
   B. Demonstrating the ability to ask the questions in Phase 3 without adding in extra words or body language or delays that may interfere.
   C. Able to identify when the client is out of the Window of Tolerance in Phase 3.
   D. Able to identify appropriate times to not ask all of the Phase 3 questions when a client is highly activated.
   E. Seamlessly moves from Phase 3 to Phase 4.

IX. Understanding and demonstrating competency in Phase 4: Reprocessing.
   A. Demonstrates the ability to stay out of the way of the client’s processing when it is moving and the client is appropriately accessing the memory.
   B. Demonstrates ability to be “the expert” and “non-violence”.
   C. Works with and recognizes “The Answer” as it surfaces in this phase.
   D. Demonstrates the ability to tolerate deep emotional sadness without moving toward stopping
E. Demonstrates the ability to identify when a client is out of the Window of Tolerance and what steps to offer in that case.

F. Demonstrates the ability to encourage the client to keep going in the deep pain or to continue the reprocessing as soon as it is possible.

G. Demonstrates the ability to use appropriate cognitive interweaves, especially concerning the following:
   1. Working with the client's answer if there is a block
   2. Offering the missing experience
   3. Somatic cognitive interweaves
   4. The interweaves are brief and not moving into “Talk therapy”

X. Understanding and demonstrating competency in Phase 5: Installation.
   A. Understands and demonstrates the understanding that this is still reprocessing phase.
   B. Asks about new, more adaptive PC.
   C. Works with and recognizes “The Answer” as it surfaces in this phase.

XI. Understanding and demonstrating competency in Phase 6: Body Scan.
   A. Understands and demonstrates the understanding that this is still a Reprocessing Phase.
   B. Awareness of the possibility of the next later memory surfacing or an earlier, possibly pre-verbal memory surfacing in this phase.

XII. Understanding and demonstrating competency in Phase 7: Closure.
   A. Understands and demonstrates competency in closing down an incomplete session.
      1. Recognizes the need for and offers a resource based on client need.
      2. Recognizes and is able to suggest a state changing exercise for the client.
      3. Able to recognize when the client is out of the Window of Tolerance.

XIII. Understanding and demonstrating competency in Phase 8: Reevaluation.
   A. Understands and demonstrates competency in looking at the present day effect of treatment and how the treatment is improving the client’s current symptoms.
   B. Is able to alter the treatment plan when new information arises between session.

XIV. Understands and demonstrates competency in completing the treatment plan.
   A. Is able to effectively evaluate and recommend the next memory to target.
   B. Is able to evaluate memories in chronological order and determine which memory is appropriate
Recommended Reading/References
Ogden, Minton, Pain (2006) Trauma and the Body: A Sensorimotor Approach to Psychotherapy
See the resources section on our website: www.emdr-training.net
These sheets can be used with clients, but they are designed to use at the training. Clients may need a longer preparation phase as well as assessment of dissociative symptoms.

Day 1:
- The Answer
- Resource Development/Practice
- Practice Mechanics/Preparation Sheet

Day 2:
- Finding the Targets
- Phases 3-7 on Touchstone Memory

Day 3:
- Recent/Restricted Processing: Focusing on either an unfinished target from day 2 or a recent event

Day 4:
- The Answer
- Resource Development/Practice
- Practice Mechanics/Preparation Sheet

Day 5
- Finding the Targets
- Phases 3-7 on Touchstone Memory

Day 6
- Finish incomplete session or reprocess next memory
- Future Template

IMPORTANT! Although we give you scripts for some phases of EMDR therapy, it is not a “manualized therapy.” Since all clients have different needs, you will be doing various things in the 8 phases of the EMDR therapy process. Do not take these scripts and think they are adequate for starting in the first session with a client. You will need all of your clinical skills combined with that we teach you in this training for comprehensive EMDR therapy.
**Weekend 1 Practice Sheets**

**“The Answer”**

“The first information we want to get is regarding your strengths and what you do under stress. This information will help us in the preparation phase for you. We will see what you are really good at doing and also what is less developed for you. This information will be useful as we continue the EMDR treatment process.”

“As you answer the following questions, there is no need to read into them too much. Whatever comes to mind first will be fine.”

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are you most proud of?</td>
<td></td>
</tr>
<tr>
<td>What is difficult for you to do?</td>
<td></td>
</tr>
<tr>
<td>What do you do when under stress?</td>
<td></td>
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<tr>
<td>How do you handle extreme pressure?</td>
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<tr>
<td>How are you with deadlines?</td>
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<tr>
<td>How do you get your “way”?</td>
<td></td>
</tr>
<tr>
<td>Is it easy for you to say “no”?</td>
<td></td>
</tr>
<tr>
<td>Do you cry easily?</td>
<td></td>
</tr>
<tr>
<td>What do you do when you are upset?</td>
<td></td>
</tr>
<tr>
<td>Do you cry in front of others?</td>
<td></td>
</tr>
<tr>
<td>Would you call yourself a “rule follower”?</td>
<td></td>
</tr>
<tr>
<td>How do you deal with conflict?</td>
<td></td>
</tr>
<tr>
<td>In an emergency situation what are you likely to do?</td>
<td></td>
</tr>
<tr>
<td>Is it easy for you to ask for help?</td>
<td></td>
</tr>
<tr>
<td>Is it difficult for you to accept help?</td>
<td></td>
</tr>
<tr>
<td>How convincing are you?</td>
<td></td>
</tr>
<tr>
<td>What are you likely to do when someone tells you “no”?</td>
<td></td>
</tr>
<tr>
<td>How do you handle negative feedback or criticism?</td>
<td></td>
</tr>
</tbody>
</table>

Therapist may take a moment to look for patterns, then take a guess: “So it sounds like you are good at _____, and it is harder for you to ____. When you get close to pain I wonder if you will _____. (Looking for what is over and under developed for the client)
“In next section we are looking at various areas of strengths. I will be taking a guess about where you are in each of these areas. My guess will be based on the answers to The Answer questions. It is very helpful to have you correct me after I guess. We will then decide on a resource to practice.”

- Good at being firm
- Boundaries
- Good at being flexible

- Ability to freely give and receive
- Clear about personal rights and rights of others
- Ability to choose

- Good at verbal expression
- Verbal Expression
- Good at listening

- Able to put words to feelings
- A balance of listening and expressing

- Good at calming yourself alone
- Affect Regulation
- Good reaching out for comfort

- Ability to regulate affect alone or with others

- Good at making things happen
- Personal Power
- Good at going with the flow

- Clear about wants and needs
- Clear about choices
- Aware of effect they have on others

- Good at convincing
- Influence
- Good at noticing what others want

- Ability to reach out for help
- Ability to ask for what you want/ Doesn’t take advantage or get taken advantage of
Boundary Exercises

We are investigating when we practice resources. A curious attitude is useful as we invite the client to experiment in various ways.

We are inviting, noticing and encouraging the client to be open to whatever happens in the resourcing.

It is important to notice if activating is beginning to happen for the client and stop to 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
(See other resources to practice in the “Resources” tab of the manual)

Holding a scarf (rope, neck tie or other object), have the client hold on to one end of the scarf and you hold on to the other. Investigate the following questions:

1. “As you hold the other end of the scarf, what is just the right amount of tension in the scarf?”
2. “What tells you that?”
3. “What is a good distance between us as we hold the scarf?”
4. “What tells you that?”
5. “Would you like to try an experiment?”
6. “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 client indicates readiness, drop one end.)
7. What do you notice as I drop my end?”
8. “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.”
9. “Now, I’d like you to notice what changes as I pick my end back up. What do you notice?”
10. “Now would you like to notice what happens as you drop your end and I hang on to my end?” (Allow answer) Whenever you are ready drop your end. (When client drops it) What do you notice?”
11. “Now, would you prefer I ask you to pick up your end or would you rather just pick it up when you are ready?” (Allow answer and do what they choose.) “What do you notice?”
12. “What did you notice was different when I asked you versus when you decided?”
Practicing the Mechanics: This is preparing for doing Phases 3 and 4. It is not to be done on the first day with clients.

The seated position should be close for eye movements, with the knees in the “ships passing in the night” position.

Eye Movements Distance:
“We are going to practice the eye movements. I am going to start close and you can let me know when it is a tolerable distance.” Therapist starts about 8 inches from the clients face and slowly moves out asking the client if that is a good distance.

Speed:
“I will start out fast and slow down if needed. We want it to be as fast as you can tolerate. You do not need to try hard to focus on the fingers, it is just a way to help you move your eyes back and forth.” The therapist starts with fast movements and only slows down if the client says they need slower.

Directions:
“There are times when a change in direction can be useful so would it be okay to practice diagonal movements?” The therapist does diagonal movements starting from top left first, then the other way, from top right.

Tapping:
“There are times when it can be useful to switch from eye movements to tapping. Would it be okay to practice tapping on your knees? I can tap directly on your knees, on the back of your hands or on your palms, which of those would you like?” The therapist can also use a pet or another object to do the tapping if there is an ethical issue or preference to not touch the client.

Reminder Instructions:
“The EMDR process is intended to bring balance to your system. I will be asking you some questions with the intention of helping you to find the root of your presenting issue. As we have discussed, some disturbing experiences become stored in your system with the original images, sounds, thoughts, emotions and body sensations. When these memories are activated in the present it may feel like an over-reaction but it is just the inadequately processed memories that are being activated. As we go through this process the best thing you can do is notice your experience and give honest feedback. You do not need to try to do anything. I will do the eye movements for a while and then stop and ask you what you are noticing. At that time you can just give me a snapshot of what you are experiencing. I do not need to know everything that you experience. Whatever you experience is okay.”

Dual Awareness/Noticing the experience/The Train/Video metaphor.

“Some people like to use the metaphor of watching the experience go by like looking out of the window of a train or watching a video on a screen. Would one of those feel useful to you?”
Stop Signal:

“If you would like to stop at any time, it is okay. Would you like to raise your hand or do a time-out signal?” Therapist demonstrates the 2 methods and asks the client to practice doing the signal.
Finding the Targets Getting to the Root of the Present Issue

In this section the clinician is just getting “the headlines”, not details about the events. This is generally competed in a session prior to processing and getting too many details can be too activating. For the practicum purpose you are also only getting the headlines. As soon as it is clear that the client has a specific memory and it is a “moment in time” the therapist should ask for the age and then ask, “and what is an earlier time”. Note that the recent examples of how the issue appears in the current life, Present Triggers, are then used at the end of the form for getting the Future desired behavior/state the client want instead of 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?"

<table>
<thead>
<tr>
<th>Earlier Memory:</th>
<th>Age:</th>
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</table>

"How about an earlier time?"

<table>
<thead>
<tr>
<th>Earlier Memory:</th>
<th>Age:</th>
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"How about an earlier time?"

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"How about an earlier time?"

<table>
<thead>
<tr>
<th>Earlier Memory:</th>
<th>Age:</th>
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</table>

"How about an earlier time?"

Clinician keeps asking as long as the client keeps answering. Earliest is the “touchstone”.

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

<table>
<thead>
<tr>
<th>Red Flags</th>
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</table>

- No family of origin memories
- No affect with memories
- Memories appear to go in a straight line without much or any affect
- All memories are examples of the client’s “Answer”, staying safe of staying connected.
- Not any affect or reported disturbance and about one caregiver.

<table>
<thead>
<tr>
<th>&quot;What happened when you told your parents (caregivers)?&quot;</th>
</tr>
</thead>
</table>

Does the client appear to be thinking about what “should” be connected? How is the client’s “Answer” here? Is he/she good at analyzing, figuring things out?

<table>
<thead>
<tr>
<th>How is the client’s “Answer” here? Was the NC too specific?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>&quot;What happens when you don’t/can’t do that?”</th>
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</thead>
</table>

i.e. “What happens when you are not perfect?”

<table>
<thead>
<tr>
<th>&quot;What happened when you told the other parent (caregiver)?&quot;</th>
</tr>
</thead>
</table>
Phase 3: Assessment Full Protocol

**Specific Instructions:** Prior to starting, please make sure you are in the correct seating, have already practiced speed, distance and type of DAS, and practiced the stop signal. You should be ready to start eye movements after the final question in Assessment.

**Target:** (In training, earliest touchstone memory found. This should be a moment in time, not an issue.)

“When you bring up that memory, what image represents the worst part?: ________________

**ONLY if no image** (may be another perception of the five senses): “As you think of the experience, what is the worst part of it?”

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

Positive Cognition: “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 (repeat the positive cognition above) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?”

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

Emotion: “When you bring up that picture and those negative words (negative cognition above), what emotion do you feel now?”

**SUD:** “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?”

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No disturbance/neutral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest disturbance</td>
</tr>
</tbody>
</table>

Location of Body Sensation: “Where do you feel it in your body?”

“I’d like you to bring up that picture, those negative words (repeat the negative cognition), and notice where you are feeling it in your body—and follow my fingers.” (DAS generally 20 or more passes/customized to need of client.)

**Important!! After the following question, you immediately start DAS and are in PHASE 4.** (Turn to next page.)
A. DESENSITIZATION: After the DAS of 20-30 back and forth, “What are you noticing now?” Allow them to answer, and no matter what they say, you say: “Go with that.” Then do another set of DAS, generally 20 or more passes that are customized to the needs of the client.

Repeat: “What are you noticing now? Go with that.” Continue DAS as long as the client reports change or new information (as many sets of DAS as necessary) until the client stops reporting change for two consecutive sets of DAS, then ask (B).

B. BACK TO TARGET: “When you go back to the original memory, what are you noticing now? (Pause for a response). “Go with that.” (DAS, 20 or more passes customized to the client).

Repeat: “What are you noticing now?” (Pause for a response). “Go with that.” (Sets of DAS). Continue with sets of DAS as long as client reports change or new information (as many sets of DAS as necessary).

When the client goes back to the original target after two consecutive sets of DAS and still reports no change check SUD (see C below).

C. CHECK SUD: When you believe they are at or near end of processing, say “When you bring up the original memory, on a scale of 0 to 10, where 0 is no disturbance and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now? Go with that.” (Sets of DAS.)

If SUD is stuck at 1 or 2, ask, “Where do you feel it in your body? ___Go with that.” Set(s) of DAS or, “What is the most disturbing part of that memory now?”

REPEAT Steps A, B, and C until SUD is 0 twice (or ecologically sound).

Phase 5: Installation
Installation links the desired Positive Cognition with the original memory/experience:

1. “Do the words (repeat the PC) still fit, or is there another positive statement you feel would be more suitable?”
2. “Think about the memory and those words (repeat the selected PC). From 1, completely false, to 7, completely true, how true do they feel?”
3. “Hold them together. Those words _______ and that memory. ” Do DAS.
4. “On a scale of 1 to 7, how true do the words (PC) ______ feel to you now?” (After each set)
5. Continue installation as long as the material is becoming more adaptive. Continue sets of DAS until the VOC no longer strengthens. Once the VOC=7 (or ecological), go to Phase 6: Body Scan.
6. If client reports a 6 or less, check appropriateness and address blocking belief (if necessary) with additional sets of DAS. (Note: If running out of time, set aside the blocking belief to be addressed at a later time and proceed to closure for incomplete session.)
Phase 6: Body Scan

“Close your eyes and keep in mind the original memory and the words (repeat the selected Positive Cognition). Then bring your attention to the different parts of your body, starting with your head, and working downward. Any place you find any tension, tightness or unusual sensation, tell me.” If any sensation is reported, do DAS. If there is a positive/comfortable sensation, do DAS to strengthen the positive feeling. If a sensation of discomfort is reported, reprocess until discomfort subsides. After a clear Body Scan: “Is there a gesture or movement that would help you connect with that feeling of ____________ (name the PC or new positive feeling)?”

Phase 7: Closure

An unfinished session is one in which a client’s material is still unresolved (i.e., s/he is still obviously upset; the SUD has not gone down to 0; the VOC has not gone up to 7; you have not had time to complete the Body Scan). The following is a procedure for closing down an unfinished session. The purpose is to acknowledge clients for what they have accomplished and assist them in being present and as stable as possible prior to leaving.

*** Procedure for closing unfinished sessions*** If complete go directly to #3.
1. Give the client the reason for stopping. “We are almost out of time and we will need to stop soon.” Give encouragement and support for the effort made. “You have done some very good work and I appreciate the effort you have made. What feels like the most important thing you have learned about yourself or for yourself today?”

2. Do a containment exercise: “I suggest we do a relaxation (or a container) exercise before we stop. I suggest we _____.” Suggest either a relaxation exercise or a container exercise. Examples include: Container imagery (put it away in a container until the next session); Safe/Calm Place; Light Stream; etc.

3. Read the “Debrief the Experience” section to the client, as scripted below:

Closure for 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. If so, just notice what you are experiencing and if you wish you can record it on the Memories & Lies log. Use the resources we have worked on to help manage any disturbance. We can work on this material next time. If necessary, you can call me.”
<table>
<thead>
<tr>
<th>Present trigger 1:</th>
<th>Present trigger 2:</th>
<th>Present trigger 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“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.”</td>
<td>“As you think about _______(name second present trigger), how would you like to be able to react, feel, or behave in the future?”</td>
<td>“As you think about _______(name third present trigger), how would you like to be able to react, feel, or behave in the future?”</td>
</tr>
</tbody>
</table>

Future Desired State:

Future Desired State:

Future desired state:
Phase 8: Reevaluation

Check for what the client experienced between sessions:

- Assess if the client processed more between sessions.
- Changes in symptoms
- Changes in behaviors or patterns of relating
- Changes in reactivity or previous triggers
- Dreams
- New thoughts or insights

Reevaluate the Target from last session. “Do you remember what we worked on last time?”

Assess the current state of the previous target:

- Is it still disturbing?
- Were other associated memories brought up?
- Were the present triggers more or less active?
- Remember, incomplete session can be incomplete for phases 4, 5, 6.

If INCOMPLETE, Restart Phase 4 Reprocessing by asking:

“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.”

Continue sets of DAS, as if you are starting in top of Phase 4, until you get to a 0, then move on to Phases 5-7.

If COMPLETE: Go to the next memory in chronological order that still has a charge, by taking a SUD, and process Phases 3-7.
Restricted Early Events or Recent Events Protocol

(Adapted from Shapiro, 2001)

Understanding the Window of Tolerance is necessary for all trauma processing. We will have a 2 hour video on understanding the Window of Tolerance that will be available for all Basic training members.

**PLEASE NOTE:** EMD or Restricted Protocol should not replace the EMDR protocol. It does not produce comprehensive reprocessing but only symptoms reduction.

Restricted processing should be done for clinical reasons such as because the client cannot tolerate the full EMDR processing protocol. If the client is able to process with the full protocol, that protocol should be used as it has been empirically shown to be effective in reducing disturbance and changing the way the client’s system reacts.

We do not want you to use this protocol in place of the full protocol just because you feel it is easier for the client or for you.

No matter what type of processing you are doing with EMDR, it is necessary to do all 8 phases. We need to have some idea of the client’s current resources, the ability to change states in a way that is not dangerous. We want to know the client’s history. We still find the targets and identify the root of the present issue.

**Protocol for restricted reprocessing. We do not need to get all of the details; just the headlines**

**Note:** These are the specific differences from the Standard Protocol:

1. Shorter sets of DAS (8-12 passes)
2. Return to Target after each set of DAS to assess the SUD instead of asking “What do you notice now?”
3. The next step of the process starts once the SUD is lower than 4 instead of getting to 0 twice.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Script</th>
<th>Therapists’ Actions</th>
<th>Therapists’ Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1:</strong> Decide with Client that Restricted Processing is necessary.</td>
<td>Choose the event for restricted processing.</td>
<td>This is a clinical decision made in collaboration with client.</td>
<td></td>
</tr>
<tr>
<td><strong>Step 2:</strong> Entire event out loud with DAS.</td>
<td>&quot;We have selected the target of ____ to process with the Restricted protocol. I would like to invite you to tell the story of the experience out loud, from just before the event to the current moment and follow my fingers. Please let me know when you are finished.&quot;</td>
<td>Therapist begins DAS while the client tells the entire story out loud from beginning to end. Stopping at the end of the story.</td>
<td></td>
</tr>
<tr>
<td><strong>Step 3:</strong> Selection of first POD (Point of Disturbance)</td>
<td>“Now I would like you to review the event again, silently in your mind, while I do DAS and allow the most disturbing part to show up. When it does, use your stop signal and we will use that as the first target.”</td>
<td>Therapist does DAS. Client uses stop signal when they use the stop signal that piece of the event will be used as the first target.</td>
<td>Target: 1&lt;sup&gt;st&lt;/sup&gt; POD 1: ___________ (Just in 1 or 2 words not the whole story.)</td>
</tr>
<tr>
<td><strong>Step 4:</strong> Accessing POD Phase 3</td>
<td>“When you bring that up, what image is the worst part?”</td>
<td>Take whatever they say as the worst part, even if not an image.</td>
<td></td>
</tr>
<tr>
<td>4.a</td>
<td>“What words go best with that picture that express your negative belief about yourself now?”</td>
<td>Take whatever they say here and ask the next question.</td>
<td>NC:</td>
</tr>
<tr>
<td>4.b</td>
<td>“What would you rather believe about yourself now?”</td>
<td></td>
<td>PC:</td>
</tr>
<tr>
<td>4.c</td>
<td>“When you bring up that image/sound on a scale of 0 to 10, where 0 is no disturbance and 10 is the highest disturbance, how”</td>
<td></td>
<td>SUD:</td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4.c</td>
<td>“When you bring up that image/sound on a scale of 0 to 10, where 0 is no disturbance and 10 is the highest disturbance, how disturbing does the memory feel to you now?”</td>
<td>SUD:</td>
<td></td>
</tr>
<tr>
<td>4.d</td>
<td>“I'd like you to bring up that image, those words (NC) and follow my fingers.”</td>
<td>Begin DAS: Short fast sets @ 10 passes</td>
<td></td>
</tr>
<tr>
<td>4.e</td>
<td>“When you bring up that image/sound on a scale of 0 to 10 how disturbing does it feel to you now?”</td>
<td>Stay with this POD until SUD reduced to 4 or less. Ask SUD, by repeating words to left, at the end of every set. Once SUD has lowered as far as it can on this SUD then move on to step 5. The SUD may only get to a 4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Moving to next POD target. (After getting next POD, keep going back to step 4 until they run the whole video and no more POD’s.)</td>
<td>“Now I’d like you to review the episode again silently and tell me whatever comes up as the next worst part, we will use that as the next target” <strong>Go back to 4</strong>****</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Install the PC for ENTIRE EPISODE</td>
<td>Therapist does DAS while client reviews the episode and uses stop signal at the next part. Go back to 4. Repeat until no worst parts surface.</td>
<td></td>
</tr>
<tr>
<td>6.a</td>
<td>“Do the words (repeat PC 4.b) still fit or is there another positive statement that feels more suitable?”</td>
<td>Allow client to agree or change PC.</td>
<td></td>
</tr>
<tr>
<td>6.b</td>
<td>“Bring up that memory and those words (repeat PC), from 1, completely false to 7, completely true, how true do they feel to you now?”</td>
<td>Allow client to answer.</td>
<td></td>
</tr>
<tr>
<td>6.c</td>
<td>“Hold those together, those words and that memory.”</td>
<td>Do short, fast sets of DAS, about 10 passes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“On a scale of 1-7, how true do those words feel to you now?”</td>
<td>Do short, fast sets of DAS, repeating that phrase until there is no change in End with this. Do not do phase 6 body scan.</td>
<td></td>
</tr>
</tbody>
</table>
Weekend 2 Practice Sheets

“The Answer”

“The first information we want to get is regarding your strengths and what you do under stress. This information will help us in the preparation phase for you. We will see what you are really good at doing and also what is less developed for you. This information will be useful as we continue the EMDR treatment process.”

“As you answer the following questions, there is no need to read into them too much. Whatever comes to mind first will be fine.”

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are you most proud of?</td>
<td></td>
</tr>
<tr>
<td>What is difficult for you to do?</td>
<td></td>
</tr>
<tr>
<td>What do you do when under stress?</td>
<td></td>
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<tr>
<td>How do you handle extreme pressure?</td>
<td></td>
</tr>
<tr>
<td>How are you with deadlines?</td>
<td></td>
</tr>
<tr>
<td>How do you get your “way”?</td>
<td></td>
</tr>
<tr>
<td>Is it easy for you to say “no”?</td>
<td></td>
</tr>
<tr>
<td>Do you cry easily?</td>
<td></td>
</tr>
<tr>
<td>What do you do when you are upset?</td>
<td></td>
</tr>
<tr>
<td>Do you cry in front of others?</td>
<td></td>
</tr>
<tr>
<td>Would you call yourself a “rule follower”?</td>
<td></td>
</tr>
<tr>
<td>How do you deal with conflict?</td>
<td></td>
</tr>
<tr>
<td>In an emergency situation what are you likely to do?</td>
<td></td>
</tr>
<tr>
<td>Is it easy for you to ask for help?</td>
<td></td>
</tr>
<tr>
<td>Is it difficult for you to accept help?</td>
<td></td>
</tr>
<tr>
<td>How convincing are you?</td>
<td></td>
</tr>
<tr>
<td>What are you likely to do when someone tells you “no”?</td>
<td></td>
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<tr>
<td>How do you handle negative feedback or criticism?</td>
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</table>

Therapist may take a moment to look for patterns, then take a guess: “So it sounds like you are good at _____, and it is harder for you to ____. When you get close to pain I wonder if you will _____.__. (Looking for what is over and under developed for the client)
“In next section we are looking at various areas of strengths. I will be taking a guess about where you are in each of these areas. My guess will be based on the answers to The Answer questions. It is very helpful to have you correct me after I guess. We will then decide on a resource to practice.”

- Good at being firm
- Boundaries
- Good at being flexible

- Ability to freely give and receive
- Clear about personal rights and rights of others
- Ability to choose

- Good at verbal expression
- Verbal Expression
- Good at listening

- Able to put words to feelings
- A balance of listening and expressing

- Good at calming yourself alone
- Affect Regulation
- Good reaching out for comfort

- Ability to regulate affect alone or with others

- Good at making things happen
- Personal Power
- Good at going with the flow

- Clear about wants and needs
- Clear about choices
- Aware of effect they have on others

- Good at convincing
- Influence
- Good at noticing what others want

- Ability to reach out for help
- Ability to ask for what you want/ Doesn’t take advantage or get taken advantage of
Boundaries Exercises

We are investigating when we practice resources. A curious attitude is useful as we invite the client to experiment in various ways.

We are inviting, noticing and encouraging the client to be open to whatever happens in the resourcing.

It is important to notice if activating is beginning to happen for the client and stop to 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

(See other resources to practice in the “Resources” tab of the manual)

Holding a scarf (rope, neck tie or other object), have the client hold on to one end of the scarf and you hold on to the other. Investigate the following questions:

1. “As you hold the other end of the scarf, what is just the right amount of tension in the scarf?”
2. “What tells you that?”
3. “What is a good distance between us as we hold the scarf?”
4. “What tells you that?”
5. “Would you like to try an experiment?”
6. “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 client indicates readiness, drop one end.)
7. What do you notice as I drop my end?”
8. “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.”
9. “Now, I’d like you to notice what changes as I pick my end back up. What do you notice?”
10. “Now would you like to notice what happens as you drop your end and I hang on to my end? (Allow answer) Whenever you are ready drop your end.” (When client drops it) What do you notice?”
11. “Now, would you prefer I ask you to pick up your end or would you rather just pick it up when you are ready?” (Allow answer and do what they choose.) “What do you notice?”
12. “What did you notice was different when I asked you versus when you decided?”
Practicing the Mechanics: This is preparing for doing Phases 3 and 4. It is not to be done on the first day with clients.

The seated position should be close for eye movements, with the knees in the "ships passing in the night" position.

Eye Movements Distance:
“We are going to practice the eye movements. I am going to start close and you can let me know when it is a tolerable distance.” Therapist starts about 8 inches from the clients face and slowly moves out asking the client if that is a good distance.

Speed:
“I will start out fast and slow down if needed. We want it to be as fast as you can tolerate. You do not need to try hard to focus on the fingers, it is just a way to help you move your eyes back and forth.”
The therapist starts with fast movements and only slows down if the client says they need slower.

Directions:
“There are times when a change in direction can be useful so would it be okay to practice diagonal movements?” The therapist does diagonal movements starting from top left first, then the other way, from top right.

Tapping:
“There are times when it can be useful to switch from eye movements to tapping. Would it be okay to practice tapping on your knees? I can tap directly on your knees, on the back of your hands or on your palms, which of those would you like?” The therapist can also use a pet or another object to do the tapping if there is an ethical issue or preference to not touch the client.

Reminder Instructions:
“The EMDR process is intended to bring balance to your system. I will be asking you some questions with the intention of helping you to find the root of your presenting issue. As we have discussed, some disturbing experiences become stored in your system with the original images, sounds, thoughts, emotions and body sensations. When these memories are activated in the present it may feel like an over-reaction but it is just the inadequately processed memories that are being activated. As we go through this process the best thing you can do is notice your experience and give honest feedback. You do not need to try to do anything. I will do the eye movements for a while and then stop and ask you what you are noticing. At that time you can just give me a snapshot of what you are experiencing. I do not need to know everything that you experience. Whatever you experience is okay.”

Dual Awareness/Noticing the experience/The Train/Video metaphor.

“Some people like to use the metaphor of watching the experience go by like looking out of the window of a train or watching a video on a screen. Would one of those feel useful to you?”
Stop Signal:

“If you would like to stop at any time, it is okay. Would you like to raise your hand or do a time-out signal?” Therapist demonstrates the 2 methods and asks the client to practice doing the signal.
Finding the Targets- Getting to the Root of the Present Issue

In this section the clinician is just getting “the headlines”, not details about the events. This is generally competed in a session prior to processing and getting too many details can be too activating. For the practicum purpose you are also only getting the headlines. As soon as it is clear that the client has a specific memory and it is a “moment in time” the therapist should ask for the age and then ask, “and what is an earlier time”. Note that the recent examples of how the issue appears in the current life, Present Triggers, are then used at the end of the form for getting the Future desired behavior/state the client want instead of 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:
"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?"

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<tr>
<th>Earlier Memory:</th>
<th>Age:</th>
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“And what is an earlier time?”

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“How about an earlier time?”

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</table>

Clinician keeps asking as long as the client keeps answering. Earliest is the “touchstone”.

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

<table>
<thead>
<tr>
<th>No family of origin memories</th>
<th>“What happened when you told your parents (caregivers)?”</th>
</tr>
</thead>
<tbody>
<tr>
<td>No affect with memories</td>
<td>Does the client appear to be thinking about what “should” be connected? How is the client’s “Answer” here? Is he/she good at analyzing, figuring things out?</td>
</tr>
<tr>
<td>Memories appear to go in a straight line without much or any affect</td>
<td>How is the client’s “Answer” here? Was the NC too specific?</td>
</tr>
<tr>
<td>All memories are examples of the client’s “Answer”, staying safe of staying connected.</td>
<td>“What happens when you don’t/can’t do that?” i.e. “What happens when you are not perfect?”</td>
</tr>
<tr>
<td>Not any affect or reported disturbance and about one caregiver.</td>
<td>“What happened when you told the other parent (caregiver)?”</td>
</tr>
</tbody>
</table>
Phase 3: Assessment Full Protocol

Specific Instructions: Prior to starting, please make sure you are in the correct seating, have already practiced speed, distance and type of DAS, and practiced the stop signal. You should be ready to start eye movements after the final question in Assessment.

Target: (In training, earliest touchstone memory found. This should be a moment in time, not an issue.)

“When you bring up that memory, what image represents the worst part?: _____________

ONLY if no image (may be another perception of the five senses): “As you think of the experience, what is the worst part of it?” ________________________________

Negative Cognition: “What words go best with that picture that express your negative belief about yourself now?” ________________________________

Positive Cognition: “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 (repeat the positive cognition 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
Completely false     Completely true

Emotion: “When you bring up that picture and those words (negative cognition above), what emotion do you feel now?” ________________________________

SUD: “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
No disturbance/neutral     Highest disturbance

Location of Body Sensation: “Where do you feel it in your body?” ________________________________

“I’d like you to bring up that picture, those negative words (repeat the negative cognition), and notice where you are feeling it in your body—and follow my fingers.” (DAS generally 20 or more passes/customized to need of client.)

Important!! After the following question, you immediately start DAS and are in PHASE 4. (Turn to next page.)
Phase 4: Reprocessing

A. DESENSITIZATION: After the DAS of 20-30 back and forth, “What are you noticing now?” Allow them to answer, and no matter what they say, you say: “Go with that.” Then do another set of DAS, generally 20 or more passes that are customized to the needs of the client. Repeat: “What are you noticing now? Go with that.” Continue DAS as long as the client reports change or new information (as many sets of DAS as necessary) until the client stops reporting change for two consecutive sets of DAS, then ask (B).

B. BACK TO TARGET: “When you go back to the original memory, what are you noticing now?” (Pause for a response). “Go with that.” (DAS, 20 or more passes customized to the client). Repeat: “What are you noticing now?” (Pause for a response). “Go with that.” (Sets of DAS). Continue with sets of DAS as long as client reports change or new information (as many sets of DAS as necessary).

When the client goes back to the original target after two consecutive sets of DAS and still reports no change check SUD (see C below).

C. CHECK SUD: When you believe they are at or near end of processing, say “When you bring up the original memory, on a scale of 0 to 10, where 0 is no disturbance and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now? Go with that.” (Sets of DAS.) If SUD is stuck at 1 or 2, ask, “Where do you feel it in your body? _____. Go with that.” Set(s) of DAS or, “What is the most disturbing part of that memory now?” REPEAT Steps A, B, and C until SUD is 0 twice (or ecologically sound).

Phase 5: Installation

Installation links the desired Positive Cognition with the original memory/experience:

7. “Do the words (repeat the PC) still fit, or is there another positive statement you feel would be more suitable?”
8. “Think about the memory and those words (repeat the selected PC). From 1, completely false, to 7, completely true, how true do they feel?”
9. “Hold them together. Those words _______ and that memory. ” Do DAS.
10. “On a scale of 1 to 7, how true do the words (PC) _______ feel to you now?” (After each set)
11. Continue installation as long as the material is becoming more adaptive. Continue sets of DAS until the VOC no longer strengthens. Once the VOC=7 (or ecological), go to Phase 6: Body Scan.
12. If client reports a 6 or less, check appropriateness and address blocking belief (if necessary) with additional sets of DAS. (Note: If running out of time, set aside the blocking belief to be addressed at a later time and proceed to closure for incomplete session.)
Phase 6: Body Scan

“Close your eyes and keep in mind the original memory and the words (repeat the selected Positive Cognition). Then bring your attention to the different parts of your body, starting with your head, and working downward. Any place you find any tension, tightness or unusual sensation, tell me.” If any sensation is reported, do DAS. If there is a positive/comfortable sensation, do DAS to strengthen the positive feeling. If a sensation of discomfort is reported, reprocess until discomfort subsides.

After a clear Body Scan: “Is there a gesture or movement that would help you connect with that feeling of _____________. (name the PC or new positive feeling)?”

Phase 7: Closure

An unfinished session is one in which a client’s material is still unresolved (i.e., s/he is still obviously upset; the SUD has not gone down to 0; the VOC has not gone up to 7; you have not had time to complete the Body Scan). The following is a procedure for closing down an unfinished session. The purpose is to acknowledge clients for what they have accomplished and assist them in being present and as stable as possible prior to leaving.

*** Procedure for closing unfinished sessions*** If complete go directly to #3.

1. Give the client the reason for stopping. “We are almost out of time and we will need to stop soon.”
   Give encouragement and support for the effort made. “You have done some very good work and I appreciate the effort you have made. What feels like the most important thing you have learned about yourself or for yourself today?”

2. Do a containment exercise: “I suggest we do a relaxation (or a container) exercise before we stop. I suggest we _____.” Suggest either a relaxation exercise or a container exercise. Examples include: Container imagery (put it away in a container until the next session); Safe/Calm Place; Light Stream; etc.

3. Read the “Debrief the Experience” section to the client, as scripted below:

   Closure for 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. If so, just notice what you are experiencing and if you wish you can record it on the Memories & Lies log. Use the resources we have worked on to help manage any disturbance. We can work on this material next time. If necessary, you can call me.”
Completing the Treatment Plan

<table>
<thead>
<tr>
<th>“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.” (This needs to be something you can imagine happening.)</th>
<th>Future Desired State:</th>
</tr>
</thead>
<tbody>
<tr>
<td>One for each present trigger listed above. Present trigger 1: “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.”</td>
<td>Future Desired State:</td>
</tr>
<tr>
<td>Present trigger 2: “As you think about________(name second present trigger), how would you like to be able to react, feel, or behave in the future?”</td>
<td>Future Desired State:</td>
</tr>
<tr>
<td>Present trigger 3: “As you think about________(name third present trigger), how would you like to be able to react, feel, or behave in the future?”</td>
<td>Future desired state:</td>
</tr>
</tbody>
</table>

There may be more or less than 3 of each

Transfer the information to the one page sheet on the following page
Treatment Planning

Presenting Problem

NC

Past Event

Age

Past Event

Age

Past Event

Age

Resources to Use

Going Younger

Desired Future State 1

Present Trigger #1

Desired Future State 2

Present Trigger #2

Desired Future State 3

Present Trigger #3

Present Trigger #1

Present Trigger #2

Present Trigger #3

Past Event

Desired Future State 1

Desired Future State 2

Desired Future State 3
Phase 8: Reevaluation

Check for what the client experienced between sessions:

• Assess if the client processed more between sessions.
• Changes in symptoms
• Changes in behaviors or patterns of relating
• Changes in reactivity or previous triggers
• Dreams
• New thoughts or insights

Reevaluate the Target from last session. “Do you remember what we worked on last time?”

Assess the current state of the previous target:

• Is it still disturbing?
• Were other associated memories brought up?
• Were the present triggers more or less active?
Remember, incomplete session can be incomplete for phases 4, 5, 6.

If INCOMPLETE, Restart Phase 4 Reprocessing by asking:

“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.”
Continue sets of DAS, as if you are starting in top of Phase 4, until you get to a 0, then move on to Phases 5-7.
If COMPLETE: Go to the next memory in chronological order that still has a charge, by taking a SUD, and process Phases 3-7.
<table>
<thead>
<tr>
<th>Date/time</th>
<th>What was your experience?</th>
<th>SUD 1-10</th>
<th>What was the memory or lie?</th>
<th>Savor what is New and True</th>
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