Comprehensive Refresher
in EMDR Therapy

Trainer: Jasmine Alexander, PsyD (cand)

Day 2

Training Sessions 1 of 2

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Phase 2 – Preparation Phase

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C. There are 3 Primary Modalities of Bilateral Stimulation

1. Eye Movements
2. Kinesthetic Stimulation
3. Auditory Stimulation

When using BLS, only **ONE** modality should be utilized

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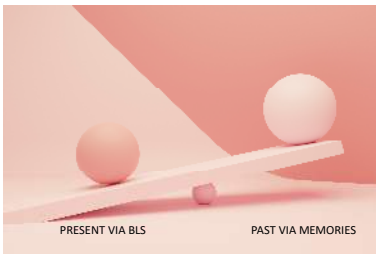
One foot in the present, one foot in the past



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Modes of stimulation

Only ONE modality of BLS should be utilized at any given time.

When using remote EMDR software, ensure the tones are turned OFF and not simultaneously running with the EM

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The Two Primary Effects of Bilateral Eye Movements

A. Compelled relaxation response (Wilson et al, 1996). Probably due on investigatory response in starting in the amygdala.

B. Increased episodic memory retrieval (Propper & Christman, 2008) and cognitive flexibility (Kuiken et al., 2001).

- Leading to new associations:
  1. If adaptive memory networks are available, synthesis between adaptive and maladaptive memory networks;
  2. Or if adaptive memory networks are not available, spreading activation with other maladaptive memory networks.

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Alternate modes of stimulation

When clients cannot tolerate eye movements due to dizziness, nausea, or any eye discomfort, alternate forms of bilateral stimulation should be used.

a. Consider client's cultural and religious factors when introducing bilateral stimulation. Eye movements may be considered 'witchcraft' or trance inducing.

b. Kinesthetic (tactile) stimulation

c. Auditory Tones

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2. Methods for generating bilateral stimulation

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a. Original method described by Shapiro (2018) for generating tracking eye movements

- i. Seated to the side – as close as comfortable
- ii. Avoid fingers pointing toward eyes
- iii. Straight movements – avoid "windshield wiper" arc
- iv. Start and stop at center of field of vision
- v. As fast as can be tolerated comfortably
- vi. Use good body mechanics to avoid self-injury

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a. Original method described by Shapiro (2018) for generating tracking eye movements

- vii. Use a wand if necessary
- viii. The two primary directions of EM to facilitate reprocessing are **horizontal and diagonal**.

Vertical EM are only to be used for a short period if the client reports dizziness or nausea.

Vertical EM are ***not*** considered an appropriate direction for reprocessing (Shapiro, 2018).

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a. Original method described by Shapiro (2018) for generating tracking eye movements

- vii. Standard number of 24-30 repetitions per set for all phases (4, 5 and 6) of reprocessing – **45-60 seconds of reprocessing**
- ix. Reduced speed and number of 6-12 repetitions per set used only in preparation phase (2) for calm place and RDI.
- x. Feedback and responses of the client should be considered in adjusting number of repetitions per set (more or fewer), speed, width and direction of eye movements.
- xi. Test variations: higher, lower, diagonal (vertical is not for reprocessing)
- xii. Use alternating hand signal if tracking is too difficult

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b. Original method for manual kinesthetic stimulation

i. Two handed touching on back of hands

- ii. One handed touching on back of hands avoids being face to face
- iii. Variations in speed, location and pressure

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c. Tones

i. Snap fingers
ii. Use clicker
iii. Tap bottom of paper or foam cup

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d. Advantages and disadvantages of technological aids

i. Neurotek Corporation: EyeScan, LapScan, Tac/AudioScan, and CATScan products provide bilateral visual, auditory, and kinesthetic stimulation for qualified EMDR-trained clinicians
   - www.neurotekcorp.com/

ii. EMDR Kit 1 and 2
   - www.emdrkit.com/

- visual, auditory and kinesthetic BLS

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Remote EMDR Therapy

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3. Remote EMDR Therapy

a. Clinicians should receive training in tele-health

b. Read EMDRIA's Guidelines for Virtual Delivery of EMDR Therapy, as well as additional resources on EMDRIA's website

c. Use a web-based platform such as RemotEMDR, ActiveEMDR, or CloudEMDR

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3. Remote EMDR Therapy

d. Facilitate EM manually

i. Client should have two objects **approximately one foot apart** on either side of their device

ii. Clinician should see client's eyes moving the full breadth of their visual field (sclera of the eyes should be observed)

iii. Clinician should be moving a wand / hand approximately 1 meter side to side

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3. Remote EMDR Therapy

d. Facilitate EM manually

- **Before practicing EM, ask:**
  - Do you wear contact lenses? If yes, the client should remove them
  - Do you have a history of eye problems? If yes, use clinical judgement whether to use EM or not

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3. Remote EMDR Therapy

d. Facilitate EM manually

- **Introduce EM:**
  - Test distance, height
  - Test horizontal and diagonal EM with your fingers / wand / internet application
  - Test EM for approximately 10 seconds. Start slow, then gradually increase the speed until the client can move their eyes as fast as they can tolerate. Make sure to instruct the client to not move their head, but only their eyes

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3. Remote EMDR Therapy

d. Facilitate EM manually

- **Introduce EM:**
  - Ask the client: Did the EM cause any pain, eye strain, discomfort or dizziness? If yes, do not proceed with EM. Use kinesthetic or auditory stimulation.
  - If the client can tolerate EM, ask: Which direction do you prefer? Then make note in the clinical file
  - For Virtual EMDR: Teach Post It Note Method

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3. Remote EMDR Therapy

e. Teach kinesthetic stimulation manually

This is necessary in the event the client abreacts during reprocessing

i. Variations of the Butterfly Hug

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3. Remote EMDR Therapy

Butterfly Hug

1.) Thumbs interlocked, middle fingers tapping
2.) Thumbs interlocked, entire hand tapping
3.) Thumbs unlocked, entire hand tapping
4.) Arms crossed, entire hand tapping on shoulders
5.) Arms crossed, entire hand tapping on biceps
6.) Arms crossed, entire hand tapping on abdomen
7.) Entire hand tapping on top of thighs
8.) Entire hand tapping on sides of thighs

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3. Remote EMDR Therapy

f. Discuss what to do in the event of an abreaction or technological failure

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Abreactions

- As with any interactive therapy where strong emotion can be triggered, clients with affect phobias, underdeveloped affect tolerance skills or limited resources may dissociate or abreact.
- Clinicians should consider making additional effort during Phases 1 and 2 to establish attunement, develop resources, and build affect tolerance skills in order to provide additional support and safety for the EMDR client.

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Abreactions con't

- Provide psycho-education and adequately frontload the client before beginning BLS and reprocessing
- Discuss what you and the client will do should an abreaction occur during EMDR Therapy.
- Make an agreement with the client to **not hang up or turn the laptop off.**

Jasmine Alexander Virtual EMDR Part III

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Abreactions

- Encourage the client to continue BLS
- Most likely need to switch to KS
- Therapist can come closer to the screen
- Increase communication

Jasmine Alexander Virtual EMDR Part III

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Questions - Comments?

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XIII. Issues and methods of informed consent to treatment with EMDR

1. Before testing any form of BLS, clinicians **must** provide psychoeducation and fully informed consent regarding EMDR therapy

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XIII. Issues and methods of informed consent to treatment with EMDR

2. Standards for informed consent vary by jurisdiction, type of licensure and professional codes of conduct.

a. Generally, specific written informed consent is **not** required for each method in independent practice. Some organized settings may require specific written informed consent.

b. When oral informed consent is sufficient, it is wise to **notate in the medical record / clinical chart** the nature of the information provided and the client's understanding and consent to the treatment options, risks and benefits reviewed.

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XIII. Issues and methods of informed consent to treatment with EMDR

3. Psychoeducation and Informed Consent for EMDR Reprocessing

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XIII. Issues and methods of informed consent to treatment with EMDR

3. Psychoeducation and Informed Consent for EMDR Reprocessing

"For many people, most memories tend to stored as just the story of what happened with a few vivid images. Memories for stressful and traumatic experiences can be stored in the brain with vivid pictures, sounds, thoughts, feelings, and body sensations. EMDR deliberately reactivates these different parts of disturbing memoires and allows the brain to reprocess the experience."

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XIII. Issues and methods of informed consent to treatment with EMDR

3. Psychoeducation and Informed Consent for EMDR Reprocessing

"That's why we wake up feeing differently about experiences from the day before that were still upsetting. The bilateral stimulation is what we use in EMDR to help the brain reprocess information stored in your brain."

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XIII. Issues and methods of informed consent to treatment with EMDR

3. Psychoeducation and Informed Consent for EMDR Reprocessing

"When we work with disturbing memoires, you may re-experience disturbing sensations, emotions, images, sounds, or smells from the event. These can sometimes be fairly vivid and intense. With EMDR, these tend to fade until they are no longer disturbing. After reprocessing is complete, they will be just like memories for most experiences – with just the story of what happened without disturbing images, sensations, or emotions."

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XIII. Issues and methods of informed consent to treatment with EMDR

3. Psychoeducation and Informed Consent for EMDR Reprocessing

"During reprocessing, people often make new connections and gain new insight. Occasionally, people remember experiences they had forgotten about or deliberately suppressed.

If you become tearful or upset and you can no longer follow the EM, I will encourage you to continue with BLS. Please stay out of the way and do not try to stop what is happening for you.

If at any point you feel the need to stop, just raise your hand like this."

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XIII. Issues and methods of informed consent to treatment with EMDR

3. Psychoeducation and Informed Consent for EMDR Reprocessing

"Do you have any questions?

Do you consent to the use of EMDR Therapy?"

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2. Re-experiencing aspects of the traumatic event

a. In EMDR reprocessing, clients must be fully prepared for the possible re-experiencing of a past traumatic event

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2. Re-experiencing aspects of the traumatic event

b. Re-experiencing is generally brief , lasting 60-90 seconds, and can consist of:

i. Disturbing thoughts, images, sounds, or smells
ii. Intense disturbing emotions
iii. Painful sensations from injuries
iv. Unwanted sexual arousal
v. Defensive action urges: fight, flight, nausea, etc.

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2. Re-experiencing aspects of the traumatic event

c. It is essential that clients be adequately prepared to face this possibility.

d. Failure to prepare patients for the possibility of re-experiencing exposes clients to being caught off guard and experiencing needless additional shame, distress, or fear. They may terminate therapy.

e. After successful reprocessing, such re-experiencing is unlikely to recur again.

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3. Remembering suppressed or dissociated material

a. More common in EMDR reprocessing (Lipke, 1995)

b. Importance of clinician neutrality

(Alpert, Brown, Ceci, Courtois, Loftus, & Ornstein, 1996; Roth & Friedman, 1997)

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4. Changes in how memories are experienced

a. Sensory aspects of memories for traumatic and adverse life experiences tend to fade after reprocessing

b. Scholars do not view standard EMDR reprocessing as a form of hypnosis (Nicosia, 1995).

c. In cases with forensic issues, **consideration of informed consent standards should not lead to a refusal to offer treatment with EMDR**. An orthopedic physician does not postpone setting broken bones until after the trial.

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4. Changes in how memories are experienced

d. When there are forensic issues, review these issues and educate the client, and if appropriate, the prosecuting or civil attorney.

- i. In high-profile legal cases, depositions can be given and videotaped before EMDR reprocessing
- ii. In high-profile legal cases, psychotherapy sessions can be video or audio recorded to document no hypnotic or other suggestive interventions were used.

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4. Changes in how memories are experienced

e. With recent traumatic loss of a family member or with combat veterans with the loss of a member of their unit, patients may fear losing their only memories for highly meaningful experiences.

i. Memories are not lost, erased or forgotten.

ii. With successful reprocessing, positive memories tend to resurface and to become more accessible.

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Questions - Comments?

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Calm Place & RDI

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Requisites:

1. Only SLOW BLS are utilized for these exercises

2. Only positive feelings, thoughts, and sensations should arise

3. If anything negative arises during the BLS, stop, and start over with a new resource

NOTE: Resources chosen for these exercises should **NOT** be simultaneously associated with trauma

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E. Calm place exercise

1. Originally known as the safe place exercise (Shapiro, 1995, 2001)
2. Leeds (2016) recommends referring to a "calm place" as some clients cannot identify a place of "safety".
3. Cultural factors: Terms such as calm, happy, peaceful, or special might be more appropriate. The location might be related to culturally significant elements, such as the client's religion or ancestry.

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E. Calm place exercise

4. Serves as both a stabilization exercise and an assessment tool.
   a. Clients who respond well to the calm place exercise are generally good candidates for EMDR reprocessing
      i. They show simple, positive shifts in state and an absence of any negative associations.

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Complex responses to the Calm Place suggest complex cases

b. Clients with complex or adverse responses may require more complex treatment plans and more sophisticated EMDR skills from clinicians.

i. Not being able to think of a calm place
ii. Images with both positive and negative associations
iii. Negative associations within that scene or to another disturbing scene
iv. Never slide from the calm place exercise into memory reprocessing due to negative associations
v. Instead, start over with another calm place, a tranquil place, a place of support from others, etc.

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The Calm Place essential points

5. **It is essential to screen clients for a dissociative disorder before offering any BLS procedures including the calm place exercise**.

6. Selecting memories and images for use in the calm place exercise:
   - a. If the patient has reported a history of chronic adverse childhood events ask for memories of **adult experiences.**
   - b. Patients can use purely imaginary scenes, but make sure that imaginary scenes were not originally the focus of a fantasy escape from inescapable fear and anxiety.

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The Calm Place

When clients cannot identify a calm place, suggest they focus on a place that is beautiful or peaceful or ***a place they have never been to before.***

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The Calm Place Script

1. Image: Say,

"Think of a place (real or imagined) you connect with feelings of being calm and peaceful."

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The Calm Place script 2

2. Emotions and sensations:

Say: **"*Notice the image that goes with your calm place. Notice what you hear, see and feel in this place.*"**

Ask, **"*What do you notice?*"**

Write down the descriptive words and phrases the client says.

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The Calm Place script 3

3. **Enhancement**:
Enhance the client's access to the memory network of the calm place by repeating the patient's key descriptive sensory words and phrases and emphasizing the positive feelings and sensations.

- Then ask: **"*What are you feeling and noticing now?*"**
- If the client continues to report pleasant feelings and images, go to the next step.

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The Calm Place script 4

4. **Bilateral stimulation**: Offer three to four sets of bilateral stimulation with 4-6 passes per set.

- Say, ***"Focus on your calm place and notice where you are feeling the pleasant sensations in your body."***
- Begin the first set of bilateral stimulation.
- Then ask, ***"What do you feel or notice now?"***
- If the client reports positive feelings and sensations, repeat two to three more times.
- Say, ***"Focus on that and follow again."***

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The Calm Place script 5

5. **Cue word**:

- Ask: ***"What word or phrase represents your calm place."***
- After the client identifies a cue word or phrase say, ***"Notice the positive feelings as you think of that word and follow again."***
- Offer 4-6 passes of bilateral stimulation.
- Then ask, ***"How do you feel now?"***
- Repeat this sequence with the cue word about three times.

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The Calm Place script 6

6. **Self-cuing**:

- Direct the client to access the calm place with the cue word. ***"Now I'd like you to say that word and notice how you feel."***
- After the client reports accessing the sensations of the calm place again, offer 4-6 passes of bilateral stimulation.

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The Calm Place script 7

7. **Cuing with disturbance**:

- Ask the client to, ***"Imagine a minor annoyance from the last few day and how it feels."***
- Pause and listen to the client's report.
- Then say, ***"Now focus on your calm place and your cue word _____ and notice what happens in your body."***

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The Calm Place script 7

7. **Cuing with disturbance**:

If the client is **ABLE** to access the positive emotions and sensations, offer 4-6 passes of bilateral stimulation. Repeat once or twice.

If the client is **UNABLE** to access positive emotions after a couple minutes, **DO NOT CONTINUE** WITH THE EXERCISE.

Assess if the reported disturbance was really "minor" or actually something more substantial. Put in the Container.

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The Calm Place script 8

8. **Self-cuing with disturbance**:

- Say to the client, ***"Now, I'd like you to think of another mildly annoying incident. Then shift back to focusing on your calm place by yourself. As you do this, notice the changes that happen in your body. Let me know when you have done this and are back to your calm place."***
- Homework: ***"I'd like you to practice using your calm place, between now and our next session at least once a day and any time you feel it would be helpful. We'll talk about it next time we meet."***

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The Calm Place Template

Step 1: Description of Image

Client Response: **On a beach, an atoll in the Indian ocean. See the blue water. It's calm. Beach. The sand is so soft and golden. Gentle breeze. Birds chirping in the palm trees behind me. I feel so at peace by myself.**

Step 2: Description of emotions and sensations

Client Response: I just feel so incredibly at peace. Relaxed. Very calm.

Step 3: Enhancement

Client Response: I feel so good. Like I'm actually there.

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The Calm Place Template

Step 4: Offer 3 sets of BLS

# of sets of BLS (EM, KS, AS)	Client Response:
4 EM	I just feel so relaxed
5 EM	I heard the water gently lapping. I'm laying in it, my feet are in the sand
6 EM	I am floating in the water. It feels so good

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The Calm Place Template

Step 5: Cue Word - Tranquility

# of sets of BLS (EM, KS, AS)	Client Response:
6 EM	It's so amazing here.
6 EM	I keep getting more and more relaxed.
6 EM	I am happy. This is what true tranquility is.

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The Calm Place Template

Step 6: Self Cuing (with cue word Tranquility)

# of sets of BLS (EM, KS, AS)	Client Response:
6 EM	Yes, this place is all mine.

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The Calm Place Template

Step # 7: Cuing with Disturbance **(Client thought of problems at the coin laundry)**

(If the client is able to shift back into the positive feelings of their calm place, then offer BLS)

# of sets of BLS (EM, KS, AS)	Client Response:
6 EM	Deep breathing. Feels so calming
6 EM	I love my calm place.

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The Calm Place Template

Step # 8: Self-cuing with disturbance

(No BLS offered)

Client Response: Yes, this exercise is soooooo amazing! I feel really good.

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Questions - Comments?

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F. Resource development and installation (RDI)

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5. RDI may be helpful for several kinds of clinical challenges:

i. Clients who do not meet readiness criteria for standard EMDR reprocessing for impulse control or affect regulation
ii. Clients with fears of starting EMDR reprocessing
iii. Clinician concerns over risks of premature termination if EMDR reprocessing were started
iv. Clients who experience episodic depersonalization

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5. RDI may be helpful for several kinds of clinical challenges:

v. Clients who lack any narrative capacity for describing recent stressful events
vi. Clients who become so flooded with affect, memories, or maladaptive urges after starting standard EMDR reprocessing that their day-to-day functioning is adversely impacted, and
vii. Clients who have chronically incomplete EMDR reprocessing sessions.

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6. Cautions with RDI

a. Clinicians should always screen for a dissociative disorder before offering RDI.

b. Clients with dismissing (Main, 1996) or fearful (Bartholomew & Horowitz, 1991) insecure attachment status may have limited or adverse responses to the RDI protocol and may need a modified RDI approach or a focus on developing positive affect tolerance (Leeds, 2006).

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7. Avoiding inappropriate or excessive use of RDI.

- a. Clinicians should not use RDI due to
  i. A vague sense that the patient is "unstable"
  ii. Anxiety about possible patient abreaction
  iii. Aversion to the content of patient memories
  iv. A preference for helping the patient to "feel good," or
  v. Fears of not being able to "complete" the session.
- b. Instead, these clinicians should obtain additional education, training, consultation, or EMDR to resolve their issues and make appropriate use of EMDR.

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What Resources Do Clients Need??

- RDI should be used to generate resources **SPECIFIC** to the client's presenting issues
- RDI should also be used to generate resources to assist in **SYNTHESIS** during reprocessing

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9. Resources can be drawn from three domains of experience

I. Resources can be drawn from three broad domains of experience:

1. Mastery memories
2. Relational resources, and
3. Symbols

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9. Resources can be drawn from three domains of experience

1. **Mastery memories**
   - experiences the client has actually engaged in and there was a positive outcome
2. **Relational resources**
   - people that the client knows or has never met
3. **Symbols**
   - animate or inanimate objects that are representative of the resource

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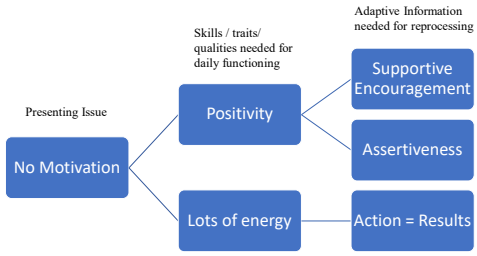
What Resources Do Clients Need?



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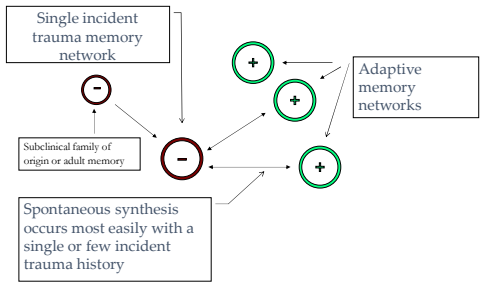
Reprocessing = Synthesis



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Without access to Adaptive memory networks, there will be lack of synthesis……

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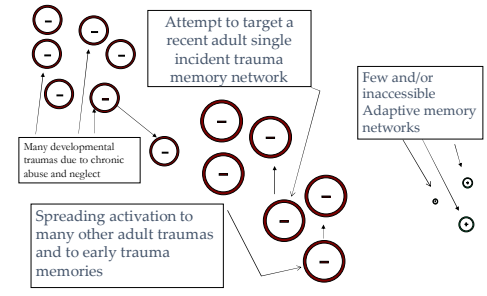

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RDI Scripted Protocol

Procedural script for Resource Development and Installation

1) Describe a recent incident or stressful situation _____

2) How disturbing does it feel to you right now, from 0 to 10, where 0 is no disturbance or neutral, and 10 is the highest disturbance you can imagine?

SUD: 0 1 2 3 4 5 6 7 8 9 10

3) What positive skill, strength or quality do you need that will help you with this stressful situation? (Identify up to three if possible.)

- *i)* _____
- *ii)* _____
- *iii)* _____

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Mastery Experience	Relational Resource	Symbol
Is there a time in your life where you were able to .....? *If NO, proceed to Relational Resource* *If YES, continue below*	*Is there someone in your life, from the past or present, or someone who you admire, who is able to.....?* If NO, proceed to Symbol If YES, continue below	*Is there an image or symbol (example: an animal, something in nature, a material item) that would help you be able to.....?* If NO, offer examples of what might help the client
What image best represents this situation where you were able to _____? _____	*What image best represents this situation where _____ was able to_____?*	*What image best represents this situation where _____ was able to_____?*
Where do you feel the positive feeling(s) in your body? _____ If there are no positive feelings, do not continue. Find a new resource.	*Where do you feel the positive feeling(s) in your body?* _____ If there are no positive feelings, do not continue. Find a new resource.	*Where do you feel the positive feeling(s) in your body?* _____ If there are no positive feelings, do not continue. Find a new resource.

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Mastery Experience	Relational Resource	Symbol
Now, focus on the image and notice where you feel the positive feeling(s) in your body and follow. (Add one set of 6-12 bilateral movements) *What do you notice in your body now?* _____ If the experience is positive or gets stronger, continue below. If there is a negative response, do not continue. Find a new resource.	*Now, focus on the image and notice where you feel the positive feeling(s) in your body and follow. (Add one set of 6-12 bilateral movements)* *What do you notice in your body now?* _____ If the experience is positive or gets stronger, continue below. If there is a negative response, do not continue. Find a new resource.	*Stay with that and follow again.* Do a second set of 6-12 bilateral movements. *What do you notice in your body now?* _____ If the experience is positive or gets stronger, continue below. If there is a negative response, do not continue. Find a new resource.
Stay with that and follow again. Do a second set of 6-12 bilateral movements. *What do you notice in your body now?* _____ If the experience is positive or gets stronger, continue below. If there is a negative response, do not continue. Find a new resource.	*Stay with that and follow again.* Do a second set of 6-12 bilateral movements. *What do you notice in your body now?* _____ If the experience is positive or gets stronger, continue below. If there is a negative response, do not continue. Find a new resource.	*Stay with that and follow again.* Do a second set of 6-12 bilateral movements. *What do you notice in your body now?* _____ If the experience is positive or gets stronger, continue below. If there is a negative response, do not continue. Find a new resource.

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Mastery Experience	Relational Resource	Symbol
Tell me a word or phrase that can help identify this resource. _____	*Tell me a word or phrase that can help identify this resource.* _____	*Tell me a word or phrase that can help identify this resource.* _____
Focus on where you notice the positive feelings in your body. Repeat that word or phrase and follow again. Do a third set of 6-12 bilateral movements. *What do you notice now?*	*Focus on where you notice the positive feelings in your body. Repeat that word or phrase and follow again.* Do a third set of 6-12 bilateral movements. *What do you notice now?*	*Focus on where you notice the positive feelings in your body. Repeat that word or phrase and follow again.* Do a third set of 6-12 bilateral movements. *What do you notice now?*

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What Resources Do Clients Need??

- When at least 3 resources have been installed, the client can be instructed to think about ALL the resources (including the cue word for each one) as the clinician provides another set of BLS
- The clinician then instructs the client to think of ALL the resources merging into who the client is

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RDI Template

Step 1: Describe a stressful situation

Client Response: I have difficulty standing up to my mother. She's overbearing and can be aggressive. I recently told her to stop parenting me and she told me she will parent me for the rest of my life. I didn't like that.

Step 2: How disturbing does it feel to you right now, from 0-10?

Client Response: Probably an 8.

Step 3: What positive strength, quality, or skills do you need to help you?

Client Response: Courage, confidence, and persistence.

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RDI Template

Step 4: Which one would you like to begin with? Is there a time in your life where you were able to be confident?

Client Response: I used to be in theatre. I was always confident on stage. I used to play the lead roles in plays.

What image best represents this situation?

Client Response: Me standing on stage, playing the lead in "Grease."

Where do you feel the positive feelings in your body?

Client Response: In my chest and heart.

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RDI Template

Step 4:

# of sets of BLS (EM, KS, AS)	Client Response:
6 EM	I was so good at acting. I was very confident.
6 EM	I believe in myself. I got this.
6 EM Cue Word: Confidence	I am a strong confident person

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Questions?

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Before proceeding to Phase 3….

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Phase three – Assessment of the target to be reprocessed

- **A.** Before proceeding to phase 3, you have achieved the following tasks:

1. Determined the client is a suitable candidate for the EMDR Standard Protocol – they meet readiness criteria
2. Establishing a good therapeutic relationship
3. Obtaining informed consent to treatment
4. Developed a written treatment plan with clearly identified memories and current stimuli that will be the primary targets for EMDR reprocessing
5. Assured the client has sufficient skills for managing anxiety, depressive and dissociative states, and maladaptive tension reduction urges.

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Pre-Requisite for the reprocessing of trauma memories:

Clients **MUST** be able to tolerate:

1) Emotions
2) Physical sensations
3) Memories
4) Therapeutic relationship

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What if clients CANNOT tolerate these aspects?

How can we move forward to help them?

In Phase 2, use the Progressive Approach (Gonzalez & Mosquera, 2012)

91

The Progressive Approach: Scripted Protocol for Targeting Phobias

A. The Progressive Approach (Gonzalez & Mosquera, 2012) was initially developed to be used with individuals who present with dissociative disorders; however, it can be used with ***any individual who presents with a phobia*** that would interfere with their ability to reprocess trauma memories

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The Progressive Approach: Scripted Protocol for Targeting Phobias

B. It can be used in the preparation phase for individuals who present with affect phobias or other phobias as a result of insecure attachment in childhood.

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The Progressive Approach: Scripted Protocol for Targeting Phobias

C. The purpose is to desensitize these phobias to help prepare clients for the eventual reprocessing of traumatic memories

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The Progressive Approach: Scripted Protocol for Targeting Phobias

D. This protocol should only be used if the clinician is relationally attuned to the client's needs.

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The Progressive Approach: Scripted Protocol for Targeting Phobias

E. The aim is to soften the phobia gradually over the course of a few sessions.

F. Clients whose phobias spontaneously resolve within several sets are generally very good candidates to proceed with the reprocessing of memories

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The Progressive Approach: Scripted Protocol for Targeting Phobias

G. Most steps from Phase 3 are omitted to avoid over activation of the memories associated with the phobia.

H. Approximately 6-12 passes at medium to fast speed should be offered.

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The Progressive Approach: Scripted Protocol for Targeting Phobias

I. Clinicians should return to target every set to reassess the SUD

J. Clinicians should be prepared to offer psychoeducation for phobias that are not softening

K. Offer six to eight sets maximum per session.

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The Progressive Approach: Scripted Protocol for Targeting Phobias

L. Caution:

• When the SUD is not going down after several sets of BLS, these responses are suggestive of a complex dissociative disorder or something else.

• Do not attempt to work through these challenging issues until you have adequate specialty education, training, and have received qualified consultation

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The Progressive Approach:
Scripted Protocol for Targeting Phobias

1. Ask the client, **"Do you have a fear to feel / show your emotions here with me?"**

2. Clarify if the client is fearful to feel their emotions, or to show their emotions.

These are two qualitatively different phobias and must be targeted separately.

3. Ask for the SUD:

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The Progressive Approach:
Scripted Protocol for Targeting Phobias

3. Ask for the SUD:

a. **"On a scale from 0 to 10, where zero is no fear or neutral, and ten is the highest fear you can imagine, how strong is the fear to ....?"**

b. **"What do you fear will happen if you.....?"**

c. **"Where do you feel the fear in your body?"**

d. **"Notice the fear, and follow."**

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The Progressive Approach:
Scripted Protocol for Targeting Phobias

4. The client should be instructed to not think about any specific memories, or thoughts, but rather to just notice the fear they are feeling in their body.

5. After each set, say:

a. **"Rest, take a deep breath in, let it go. What do you notice?"**

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The Progressive Approach: Scripted Protocol for Targeting Phobias

5b. After the report is given, the clinician should re-direct back to target by saying:

"I'm going to be quite repetitive and ask you the same question, but when you think about the fear of ....., on a scale from 0 to 10, where zero is no fear or neutral, and ten is the highest fear you can imagine, how strong is the fear to ....?"

c. **"And what do you fear will happen if you.....?"**

d. **"Where do you feel the fear in your body?"**

e. **"Notice the fear, and follow again."**

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The Progressive Approach: Scripted Protocol for Targeting Phobias

6. If the phobia spontaneously resolves after several sets, assess for additional phobias such as the fear to show emotions in front of the therapist, or the fear to work on their trauma memories.

a. If the SUD begins going down rapidly, more passes can be offered per set.

b. If the client presents with a phobia that would interfere with the client's ability to reprocess, this phobia must be targeted and desensitized first as part of the preparation phase (Phase 2).

c. The clinician should offer fast passes, perhaps 6-12 to see how the client responds.

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The Progressive Approach: Scripted Protocol for Targeting Phobias

7. Offer six to eight sets maximum per session. The goal is to ***soften the phobia*** which has been a psychological defense for many years.

8. If the SUD is not going down after several sets of BLS, and the presenting fear remains the same, the client may need psychoeducation or a cognitive interweave.

Otherwise, the client may present with more complex issues. Stop reprocessing and seek consultation. The lack of progress may also be suggestive of a complex dissociative disorder.

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Questions?

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I. Review:
Phase 1 - Balanced approach to history taking and targeting sequence

107

Approach history taking at a pace the client can tolerate

1. When there is a risk of overwhelming the client's current coping capacities, history taking must be deferred in favor of developing coping skills and self-capacities.

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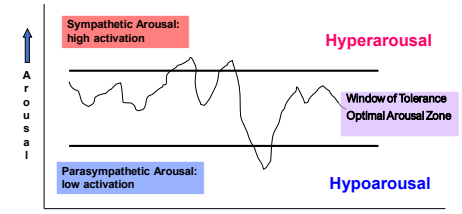
States of Organization Following Trauma Exposure



The Modulation Model

Ogden & Minton (2000); Siegel (1999)

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Zones of high and low emotional information processing

	Zone of high information processing	
Present Adaptive memory Networks	<=== Dual attention ====> Synthesis =======> AIP <======== Bilateral stimulation	Past Maladaptive memory networks
Past	Zone of low information processing	Past
Hyper-arousal	Orientation to past Central Switch <==========> Autonomic system	Hypo-arousal

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B. Keep the client's primary treatment goals and concerns central

1. Clinicians may propose additional issues to be addressed, but neither the clinician nor the method should dictate the course of treatment. EMDR reprocessing may not always be indicated.

2. Only clients who consent to the risk of uncovering additional material and to confronting traumatic material may be offered EMDR reprocessing.

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The primary aims of treatment:

3. The elimination of symptoms and the development of a new sense of self no longer uniquely defined by their traumatic experiences
4. A *symptom informed approach to selecting targets should guide treatment planning*.
5. Other approaches to treatment planning and target sequencing may be necessary for other diagnoses or where the patient has different treatment goals.

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a. Be aware of and sensitive to cultural or religious factors that might affect history taking.

i. Consider starting with inquiries only about clients' cultural wealth resources, rituals, objects, and symbols and using these for RDI procedures to strengthen the therapeutic alliance before exploring adverse and trauma experiences.

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Duration and origin of symptoms

6. For every significant symptom find out its origin:
   a. "When did that begin?"
   b. "What kinds of stressful events were going on in your life or with your family at about that time?"
   c. "How has the symptom change or evolve over time?"
   d. "What stressors were associated with these changes in the symptom?"

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II. A case example of history taking and targeting sequence

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Sexual Assault Survivor 24 year old single male

116

Presenting complaints - SYMPTOMS

- Fear of male authority figures
  - Current economic stress due to avoiding applying for better paying position with present employer for which client is eligible and likely to be hired due to fear of speaking and reporting to male work supervisor.
- Intense Panic Attacks
  - One or more attacks per day lasting 15 minutes
- Insomnia due to nightmares
  - Delays bed time due to fear of nightmares
  - Difficulty returning to sleep after nightmares
  - Restorative sleep limited to 4-5 hours per night
- Avoids dating
  - Fears proximity
  - Intimate touch triggers flashbacks

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Presenting complaints

- As an EMDR Therapist, what questions should we ask about the **symptoms** that will help us with case conceptualization?

- Nightmares
- Panic Attacks
- Anxiety
- Fear of males

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Current triggers

24 year old single male

- Avoids male authority figures.
- Declines opportunities for advancement that would involve working with male peers and male authority figures.
- Avoids enclosed places such as smaller bathrooms or small elevators for fear of having a panic attack.
- Delays bedtime due to fears of nightmares about sexual assault.
- Avoids men with romantic interest.
- Stopped dating as intimate physical contact triggers flashbacks of rape.
- Avoids being out alone at night especially in a park.

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Case Conceptualization

- As an EMDR Therapist, what questions should we ask about the **triggers** that will help us with case conceptualization?

- Being alone, in the dark
- Being alone, in the park
- Small spaces bring on anxiety and panic

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Trauma history of 24 year old single male

- Father: He experienced criticism and unrelenting standards with limited involvement from his often absent professional father until age 9 when father died of a heart attack.
  - Leading to fear of authority figures starting in elementary school.
- Step-brother: after his mother remarried, he was bullied verbally and physically by older step-brother from age 11 to 15 when step-brother left home.
  - He felt trapped, frightened and frozen during bullying.
  - He started having panic attacks at age 12.
- Raped: Age 23 by stranger while walking home at night through park.
  - Stopped dating
  - Started having nightmares about the rape and insomnia
  - Panic attacks worsened.

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Attachment organization of 24 year old single male

- Father: Dismissing.
- He describes his father as often absent due to long work hours.
- When present, father was critical with extreme standards he could never meet.
- Mother: Secure.
- Describes mother as always warm, affectionate and supportive.
- Remembers as a child playing with mother and laughing.
- As a young child, when upset always found comfort and understanding with mother.
- Stepfather: Dismissing.
- Describes stepfather as absent, cold and interested only in his son.
- Says he always sided with his son and dismissed his complaints of mistreatment.

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Presenting complaints

- As an EMDR Therapist, what questions should we ask about the **client's history** that will help us with case conceptualization?

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Resources
24 year old single male

- **Mastery memories**
- Excelled in sports. On winning soccer team in high school and college. Competed and often won at middle distances as a runner.
- Won an academic scholarship.
- Two female mentors in college: academic advisor and track coach.
- Graduated college with academic honors.

- **Supportive others**
- Close friendships.
- In regular contact with mother.
- Close to several members of running team and often runs in marathons.

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In what order should we address these targets?

- What guides our targeting sequence?
    - Chronology or Symptoms?
- Age 1-9: Father's unrelenting standards
- Age 11-15: Bullying by step-brother
- Age 22: Rape by stranger in park at night

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What is the WORST symptom?

- **Fear of male authority figures**
    - Current economic stress due to avoiding applying for better paying position with present employer for which client is eligible and likely to be hired due to fear of speaking and reporting to male work supervisor.
- **Intense Panic Attacks**
    - One or more attacks per day lasting 15 minutes
- **Insomnia due to nightmares**
    - Delays bed time due to fear of nightmares about rape by stranger in park
    - Difficulty returning to sleep after nightmares
    - Restorative sleep limited to 4-5 hours per night
- **Avoids dating**
    - Fears proximity
    - Intimate touch triggers flashbacks

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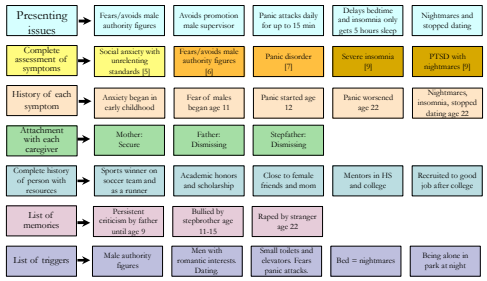
Case formulation



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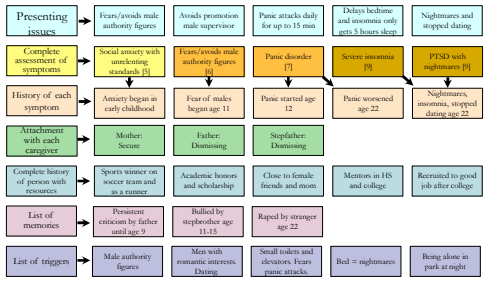
Case formulation



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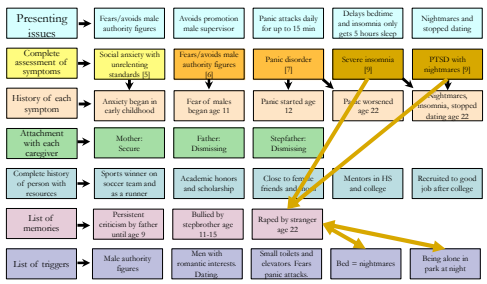
Case formulation



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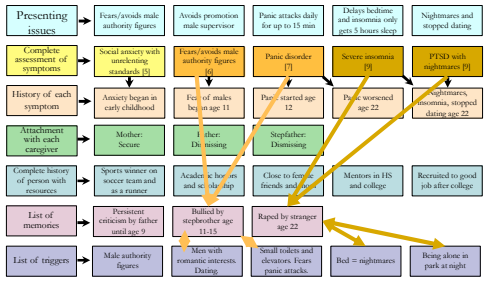
Case formulation



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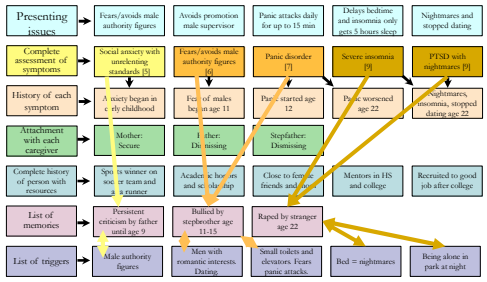
Case formulation



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Symptoms listed in order of onset then ranked by severity

Patient impact rating	Clinician Rank Order	Symptom

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Targeting Sequence in Order of Symptom Severity

Patient impact rating	Clinician Rank Order	Symptom

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Sample Treatment Plan

Time spent reprocessing memories varies from client to client

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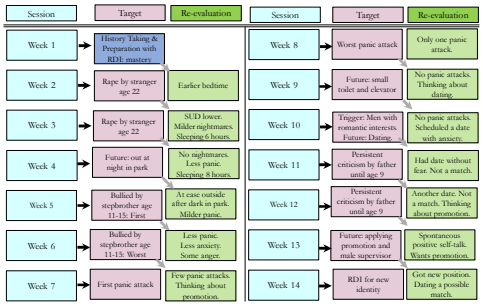
Case formulation leads to a target sequence that yields consistent symptom reductions



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Questions - Comments?

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III. Phase three - assessment of the target to be reprocessed

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Phase three - Assessment of the target to be reprocessed

A. Before proceeding to phase 3, you have achieved the following tasks:

1. Determined the client is a suitable candidate for the EMDR Standard Protocol – they meet readiness criteria
2. Established a good therapeutic relationship
3. Obtained informed consent to treatment
4. Developed a written treatment plan with clearly identified memories and current stimuli that will be the primary targets for EMDR reprocessing. You have CASE CONCEPTUALIZATION
5. Assured the client has sufficient skills for managing anxiety, depressive and dissociative states, and maladaptive tension reduction urges.

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B. Two main purposes of the assessment phase

1. Access key aspects of the maladaptive memory network
2. Establish **baseline** measures for the level of disturbance in the target memory, rated with the Subjective Units of Disturbance scale (SUD), and the felt confidence in a positive self-appraisal, rated with the Validity of Cognition scale (VoC).

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C. When learning EMDR, develop good habits to help you achieve fidelity

1. Follow the standard steps in order.
2. Use standard phrases from the script.
3. Read the script (if necessary) to maintain fidelity.
4. Make process notes:
   - a. To help you think about how to respond to client verbalizations
   - b. To provide a written record to present in consultation.
   - c. To track how the client responds to reprocessing from session to session

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D. Begin with the first target memory from your treatment plan

(Feeder Memory)

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VII. The Three-Pronged Protocol

What is the WORST symptom?

1 Past	2 Present	3 Future
i. First memory	Flashbacks	The Standard Future Template *(overcoming residual anticipatory anxiety and impulses to avoid)*
ii. Worst memory	Nightmares	
iii. Other past memories	Triggers	The Positive Template *(peak performance)*
iv. Most recent memory	Avoidant Behaviors	
v. Significant people		RDI for New Self-Concept

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Assessment Phase

- **Memory:**
- Image:
- NC:
- PC:
- VoC:
- Emotions:
- SUD:
- Body:

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EMDR STANDARD PROTOCOL TEMPLATE

MEMORY	**AGE 7 – Mom started being rude; telling me what to do**
IMAGE	**Her standing in front of me with a scowl look on her face**
NC	**I am shameful**
PC	**I am good**
VOC	**3**
EMOTIONS	**Shame, anger, anxiety**
SUD	**8.5**
BODY	**Head, face, chest, stomach**

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E. Identifying the Image - (Sensory Memory)

- 1. **"What image represents the worst part of the incident?"**
- 2. If the patient has no image, elicit another aspect of sensory memory: **"When you think of the incident, what part of the incident do you notice?"**
- 3. When patients offer an answer ("Fear" or "I am stupid") that is not a sensory memory, accept the response as helpful and use it to further the assessment of the image if possible.
- 4. "When you remember the 'fear' or the thought 'I am stupid,' which part of the memory is connected with that?"
- 5. The term "image" and its details are generally used only in the assessment phase.
- 6. A detailed image is not needed.

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F. Selecting the Negative Cognition

1. "**What words go best with that image**," (if there is no image, say, "with that incident") "**that express your negative belief about yourself now?"**

2. The NC in EMDR serves two primary purposes

   a. The first is to assist in accessing and activating the disturbing emotion(s) in the memory network.
   b. The second is to assist in identifying the PC.

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3. Selection Criteria for Negative Cognitions

a. A negative, irrational, self-referencing, self-assessment: an "I" statement.
b. A presently held self-appraisal when focusing on the picture or incident.
c. Accurately focuses the client's presenting issue.
d. Generalizable to related events or areas of concern.
   - i. Descriptive details can be omitted.
   - ii. "I am in danger from trucks," can be simplified to "I am in danger."
e. Resonates with the patient's associated disturbing emotion in the memory network.

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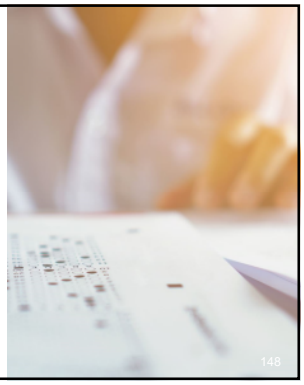
3. Selection Criteria for Negative Cognitions

f. The statement selected as the Negative Cognition must not be a possibly accurate description of disturbing circumstances, past events, negative attributes of others or the patient.

i. The NC cannot be "I am a liar" if the client actually lied



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3. Cultural factors with Negative Cognitions

g. NCs and PCs from group-oriented cultures may need to be more collectivistic and include family, group, and community, such as: "We are bad", or "We are not safe".

h. Consider cultural factors and the potential need to modify the language used in Assessment Phase 3 questions to reflect of the client's language and cultural perspective.

- For example, the term 'negative belief' might be better phrased as a **'bad thought'.**

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4. Four common responses can lead clinicians into difficulties when clients offer a statement that is:

a. An emotion, such as "terror".
- i. "What belief about yourself goes with that terror?"

b. A sensation, such as "tension" or "tightness in the chest."
- i. "What belief about yourself goes with "tightness in the chest?"

c. A possibly accurate or an actually accurate description.
- i. "When you think of _____ (repeat description), what do you believe about yourself?"
- ii. "What does that say about you as a person?"

d. Claims no negative belief or statement goes with the image.
- i. If necessary, inquire about disturbing emotion first and "work backwards" to the NC.

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Last options for selecting Negative Cognitions

5. "In your worst moments, when you are re-experiencing some aspect of this event, what negative thoughts or beliefs do you have about yourself?"

6. Apparent exceptions with "the frozen moment of time"
   - a. "It's horrible."
   - b. "I'm going to die."

7. The last option: ask the client to read the list of the most common NCs and PCs, select one statement from each column.

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G. Selecting the Positive Cognition

1. **"When you think of that image, what would you like to believe about yourself now?"**

2. Eliciting the PC serves two primary purposes

   - a. The first is to access adaptive memory networks in which the PC is encoded prior to starting the reprocessing.
   - b. The second is to assess the degree of ease or difficulty the patient experiences in locating an appropriate statement as an alternative to their NC statement.

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3. Selection Criteria for Positive Cognitions

- a. A positive self-referencing, self-assessment—an "I" statement
- b. Accurately focuses the patient's desired direction of change
- c. Is initially at least somewhat believable as a desirable, hoped-for goal
- d. Generalizable to related events or areas of concern
- e. Addresses the same issue or theme presented in the negative cognition

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4. The Positive Cognition is not:

a. The negation of the negative cognition such as: "I am not helpless."

b. An absolute statement. Avoid "always" or "never."

c. A magical thought about changing past events, negative attributes of others or the patient.

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There are 3 Themes for NCs and PCs:

- **RESPONSIBILITY**
- **SAFETY**
- **CHOICE**

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5. Need to have parallel themes with NC & PC

Initial NC:
I am worthless

Final PC:
I am worthy

Possible NC:
I am incompetent

Initial PC:
I am competent.

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H. Assessing the Validity of the Cognition (VoC)

1. "**When you think of that image**" (if there is no image, say "with that incident "), "**how true do those words**" _____ (repeat the positive cognition as an "I" statement) "**feel to you now, on a scale of 1 to 7, where 1 means they feel completely false and 7 means they feel completely true?**"

2. This initial VoC rating establishes a baseline rating prior to starting reprocessing of the target.

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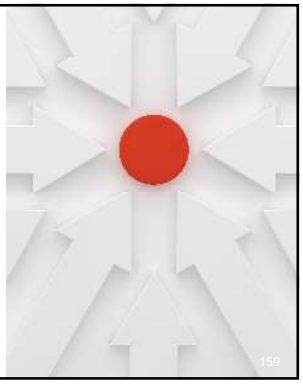
3. To obtain an accurate VoC rating, four separate conditions must be met

a. First, the client must be accessing and referencing the target memory network.

b. Second, the client must be thinking about the statement of the PC

c. Third, the client must understand the direction of the rating scale from 1, completely false, to 7, completely true.

d. Fourth, the rating must be a felt rating ("on a gut level"), not a cognitive rating of how true the client thinks the statement should be.



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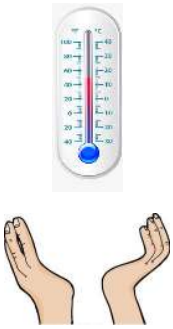
4. Cultural factors affecting obtaining VoC ratings.

- i. For some clients, a Likert scale may not be useful.
- ii. This can be changed to other measures, such as: hand movements, thermometer, colors, or faces.



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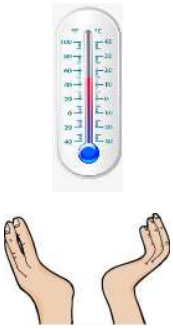
4. Cultural factors affecting obtaining VoC ratings.

Sometimes it is necessary to explain further: "Remember, sometimes we know something with our head, but it feels differently in our gut. In this case, what is the gut-level feeling of the truth of (PC) from 1 (completely false) to 7 (completely true)?

(Shapiro, 2018, p. 129)



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I. Accessing the Emotions

1. "**When you focus on that image**," (if there is no image, say " on that incident ") "and think of those words" _____ (repeat the negative cognition as an "I" statement), "**what emotions do you feel now?"**
2. Not necessarily what the person felt during the original incident.
3. Current state of the memory network.
4. More than one specific emotion is fine.
5. Only one emotion is also fine. No need to prompt for more emotions.

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6. Identifying the specific emotion(s) serves two purposes

a. First, it helps the client to access a central and crucial element of the maladaptive memory network.

- i. Specific patterns of emotional response are a central organizer of associated memory networks.
- ii. They help open channels for associations to any related maladaptive memory networks that needs to be addressed.

b. Second, the specific emotion establishes baseline information about how the maladaptive memory network is encoded and accessed before starting reprocessing.

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To obtain the **NC, PC, and VoC** the client must think about the image.

To obtain the **Emotions**, the client must think about the Image and NC **at the same time.**

(Make a cookie sandwich)

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J. Assessing the Subjective Units of Disturbance (SUD)

1. "On a scale from 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does the incident feel to you now?"

2. The SUD is not just a rating of the specific emotion, but is rather a rating of the overall sense of disturbance associated with the entire memory network.

3. The SUD is not a rating of how disturbing the event **was.**

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4. An initial low SUD rating can reflect

a. An accurate rating of an incident that is no longer significantly disturbing.

b. Limited accessing of the true level of disturbance in the memory network due to defenses ranging from intellectualization to structural dissociation.

c. Can lead to significant or even dramatic increases in the SUD in the middle of reprocessing.

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K. Identifying the Location

1. "Where do you feel it in your body?"

2. One location is enough. There is no need to prompt the patient for more locations.

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When the location is "Nowhere."

- "Close your eyes." "As I direct you to notice aspects of this incident, just notice where anything changes in your body. Notice where anything changes in your body as you focus on the image that represents the worst part of the incident. (Pause.) Notice where anything changes in your body, as you think of the words _____." (Repeat the statement of the negative cognition). (Pause.) "Now notice the _____." (Repeat the specific named emotion(s). (Pause.) "Where do you notice anything change?"

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Questions - Comments?

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Video demonstrating the Assessment Phase

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N. Rationale for order of steps in the assessment phase

1. Image – The image or *other sensory aspect of memory* requires clinician and client to identify *a specific target memory* or sensory experience rather than an abstract idea, belief or emotion. This facilitates the identification of the NC and PC before accessing more intense emotion or sensation.

2. Negative Cognition – Work on the cognitions immediately follows the identification of the image and before fully accessing the disturbing emotions and sensations, which might make it difficult to select negative and positive cognitions. The NC must be identified before the PC can be identified and rated.

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Rationale for order of steps in the assessment phase

3. Positive Cognition – The PC represents the possibility of a positive outcome to the reprocessing and helps confirm the theme being addressed. Asking for the PC begins to access adaptive memory networks (resources) even before reprocessing begins.

4. Validity of Cognition – The VoC provides the baseline rating for the PC. It provides a cognitive reference point for client and clinician to assess the degree of change between initial VoC in the Assessment phase and VoC at start of the Installation phase.

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Rationale for order of steps in the assessment phase

5. Emotion – The image and the NC are then used to access the affect. Accessing these three aspects of the maladaptive memory network then permits a valid baseline SUD rating.

6. SUD – The SUD provides a baseline measure of phenomenological and physiological arousal.

7. Location – Accessing the location of felt disturbance last verifies the person is truly feeling the disturbance (rather than having only mental images) and permits an immediate start to reprocessing.

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O. Defensive Action Urges

- a. Hypervigilance and scanning the environment
- b. The separation cry
- c. Flight
- d. Freeze with analgesia
- e. Fight
- f. Total submission with anesthesia
- g. Recuperative states of rest
- h. Isolation from the group.

Panksepp (1998) and van der Hart et al. (2006, pp. 37–38)

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Role of Defensive Action Urges in EMDR

2. The standard EMDR procedural steps do not call for the identification and accessing of defensive action urges that were most activated or most inhibited in the selected target memory.

3. Korn and Leeds (1998) noted that defensive action tendencies may contribute to ineffective reprocessing of memories of childhood abuse and neglect.

4. During the assessment phase (as well as history taking and "log reports"), be alert to references to defensive action urges that were overly reinforced or inhibited during the target memory to help you monitor whether they are appropriately resolved during reprocessing.

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Questions - Comments?

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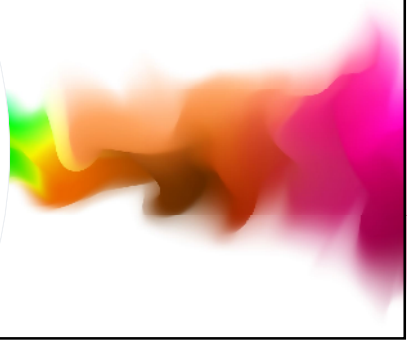
IV. Introduction to basic elements of phases four, five, six and seven



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B. Phase four: Desensitization

1. The goal of the desensitization phase is to foster spontaneous emotional information processing leading to synthesis between the maladaptive memory network of the selected target memory and other adaptive memory networks.

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2. Reprocessing begins with a brief orientation

- "We'll start reprocessing now. We will reprocess for 45-60 seconds. As we do sets of eye movements (taps or tones), sometimes things will change and sometimes they won't. You may notice other images, thoughts, emotions or body sensations. Other memories may come up. Other times you may not be aware of anything but the eye movements (taps or tones). Remember what we discussed with the metaphor of riding the train. There are no right or wrong responses. Just notice whatever happens. If you need to stop at any point, just show me the stop sign we rehearsed."

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2. Reprocessing begins with a brief orientation

- Shapiro (2018) states:

"Now remember, it is your own brain that is doing the healing and you are the one in control. I will ask you to mentally focus on the target and to follow my fingers with your eyes. Just let whatever happens, happen, and we will talk at the end of the set. Just tell me what comes up, and don't discard anything as unimportant. Any new information that comes to mind is connected in some way. If you want to stop, just raise your hand" (p. 137)

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3. Re-access the target before starting bilateral stimulation

I'd like you to focus on that image (if no image — 'on that incident')

and those negative words _____" (repeat the negative cognition – as an 'I' statement).

"**Notice where you are feeling it in your body, and follow my fingers.**

(or 'notice the lights,' 'the taps,' or 'the sounds')"

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3. Re-access the target before starting bilateral stimulation

Clients should not forcefully try to hold onto the image, NC, or emotions.

The purpose of these three elements are "merely to serve as an initial focal point for entering into the memory network"

(Shapiro, 2018, p. 137)

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Basic principles and procedures for Desensitization phase

- 4. Reprocessing the target experience continues to an adaptive resolution as indicated by a 0 SUD.
- 5. Provide discrete sets of bilateral stimulation and assess changes via brief patient reports.
- 6. Return to target periodically to assess gains and identify residual material.
- 7. Use additional interventions only when reprocessing is overtly blocked.

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Basic principles and procedures for Desensitization phase

- Approximately every 12 movements, or when you observe non-verbal changes in facial expression, breathing patterns, or eye movement, offer non-specific contingent encouragement to the client:

- **"That's it"**
- **"Just notice"**
- **"Good"**
- **"Follow"**

(Shapiro, 2018, p. 447)

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C. Phase five: Installation

1. Check for a better Positive Cognition (PC).
2. Check the VoC.
3. Continue reprocessing target with overt inclusion of PC.
4. Continue with **FAST** BLS
5. Check the VoC after each set of bilateral stimulation.
6. Fully integrate preferred belief into memory network as indicated by 7 VoC or "ecological" 6 VoC.

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D. Phase Six: Body Scan

1. Verify any residual (somatic) disturbance associated with the target is fully reprocessed, and,
2. Allow the client to reach higher levels of synthesis.
3. Provide discrete sets of FAST bilateral stimulation while the client focuses on reprocessing any residual physical sensations until there are only neutral or positive sensations.

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E. Phase Seven: Closure

1. Ensure client stability and current orientation at the close of each reprocessing session.

2. Use self-control techniques if needed to assure stability and current orientation.

3. Brief client about treatment effects.

4. Request the client to keep a log of self-observations between sessions.

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Questions - Comments?

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G. Use standard phrases after every set of bilateral stimulation in Phase Four

- 1. After a minimum of 24 to 30 complete movements, or 45-60 seconds of reprocessing you pause and say: ***"Rest. Take a deeper breath. Let it go. What do you notice now?"***
- 2. You should not say, "Relax" instead of "Rest." this would direct the patient to try deliberately to change their psychophysiological state perhaps at a moment of strong fear, shame, anger or grief.
- 3. ***"What do you notice now?"*** The form of this general inquiry permits the patient to make a report of whatever is most present in conscious awareness.

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Standard responses in Phase Four

4. **Do not inquire**: "*What do you feel now?*" or "*What do you notice about the picture now?*" or "*Did the fear change?*"

Such specific questions narrow and direct the patient's attention to material that may not be germane to the spontaneous and effective reprocessing of the maladaptive memory network.

5. Listen to the client's verbal report. Make sure to write down verbatim what the client says.

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Standard responses in Phase Four

6. There is no need to repeat or rephrase whatever the client said.

7. Unless the ckient's report indicates the need to make an intervention to deal with ineffective reprocessing, just give the standard instruction: "**Focus on that and notice what happens next**," or just, "**Go with that**."

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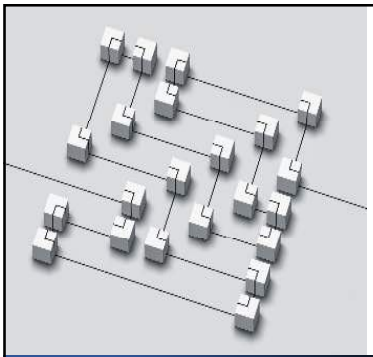

E. Channels of association

1. Generally, clients will experience some changes in their focus of attention from one set of bilateral stimulation to the next.

2. Clients may report changes in the intensity, characteristics and in specific aspects of the target memory or they may associate to another memory.

3. A channel of association can vary from a few sets of bilateral stimulation to more than 20 or 30 sets.

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4. Continue down a channel of association for between approximately 6-14 sets of bilateral stimulation until the patient begins to report neutral or positive material.

5. How often you need to return to target and identify another channel will also vary from a few to a great many.

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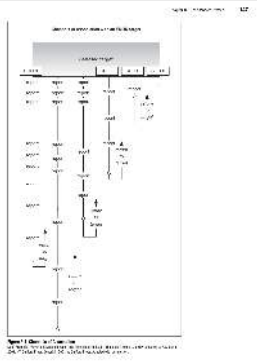

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F. Changing the bilateral stimulation

1. If the client reports the **same** disturbing content without change after two consecutive sets of bilateral stimulation, the first intervention is to change the direction, height, speed or width of the eye movements.

2. If you are using auditory stimulation, change the speed or type of sound.

3. If you are using kinesthetic stimulation, change the speed, intensity or location of the stimulation.

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Any Questions?

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H. Responses suggestive of effective reprocessing

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1. Changes in the perceptual memory

a. With increased accessing, the image may seem closer, more intense or a more disturbing image or series of images associated with the target incident may arise.

b. With effective reprocessing, the patient may report the image is further away, blurrier, less distinct, losing color, is smaller or is gone.

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2. Changes in emotion

a. With increased accessing of the maladaptive memory network, the patient may report increased intensity of fear, shame, anger or grief.

b. With effective reprocessing the patient may report a change from one emotion to another or a decrease in intensity of emotion.

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3. Changes in the sensation

a. With increased accessing of the maladaptive memory network, the client may report increased intensity of physical sensations or uncomfortable sensations in new locations.

b. With effective reprocessing the client may report a change from one sensation to another or a decrease in intensity of a sensation.

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4. Changes in the belief

a. With increased accessing of the maladaptive memory network, clients may report additional negative self-statements.

b. With effective reprocessing clients may report changes in their negative self-appraisals with more adaptive thoughts, insights or a new perspective on their experience.

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5. Changes in defensive action urges

a. With increased accessing of the maladaptive memory network, clients may report awareness of a new defensive action urge or increased awareness of a previously identified defensive action urge such as the urge to flee.

b. With effective reprocessing clients may report a decrease in a defensive action urge or a shift to a different defensive action urge such from the urge to flee to the urge to fight.

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6. Shifts to another memory

a. Many clients will report shifts to other memories within a cluster of similar events—such as other episodes of physical abuse by a stepsibling.

b. They may report earlier or more recent memories that may or may not initially appear to you, the clinician, to be related—such as a memory of a parent dismissing the patient's protest over maltreatment.

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When to return to target

There are 4 situations where we RoT

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I. When to return to target

1. When the client reports no further disturbing material and reports only neutral or positive material for **two to three consecutive sets of bilateral stimulation,** return to target.

2. Return to target after 6 – 14 sets of BLS, or after approximately 10 sets.

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I. When to return to target

3. Return to target if the client's associations become so remote from the original target that your clinical judgment suggests reprocessing of the selected target may no longer be occurring.

4. If the client gets "pulled out" of their reprocessing, RoT

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How to return to target

3. When you decide it is appropriate to return to the target, say: "***When you bring your attention back to the original experience, what do you notice now?"***

4. When returning to target, do not repeat the Negative Cognition, the details of the image, the original emotions or original location of physical sensations.

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J. When the client reports clearly disturbing additional material

1. You do not have to check the SUD.
2. After their report you can ask: "***Where do you feel that in your body?"***
3. Then after the client reports a location you can say, "***Focus on that.***"

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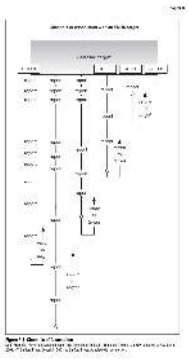

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K. Checking the SUD when the client reports ambiguous, neutral or positive material

1. The standard way to check the SUD scale is to say:

"***Focus on the original experience. On a scale from 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now?"***

2. If the patient reports that the SUD rating is a 1 or higher, ask:

"***What's the worst part of it now?"*** _____. After the patient reports the worst part, say: "***Focus on that, and notice what happens next."*** Or you can ask: "***Where do you feel that in your body?"*** _____. Then say, "***Focus that, and notice what happens next."***

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When the SUD is a 0

3. If the SUD rating is 0, say: "***Focus on how the incident seems to you now, and notice what happens next.***" If nothing clearly disturbing emerges after the next set of bilateral stimulation, check the SUD rating again.

4. When the patient reports a SUD rating of 0 a second time, you have completed the Desensitization Phase. Then continue to the Installation phase.

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6. When the SUD is a not 0

- a. Personal and cultural factors can be considered in electing to continue to the Installation Phase when the SUD is a 1 or 2.
- b. Shapiro (2018, p. 151) describes "ecological" factors such as "“I’m feeling sadness because my uncle died”. But these should be "tested" at least once with another SEM.
- c. Cultural factors may need to be considered including chronic or multigeneration trauma.

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Any Questions?

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III. Installation – Phase 5

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The aim of the Installation Phase

A. To extend reprocessing and assure generalization of treatment effects with a complete integration of a new perspective on the target memory network.

- 1. In all three reprocessing phases (Desensitization, Installation, Body Scan) use ***at least*** 24 complete movements in each set of bilateral stimulation at a similar speed.
- 2. After each set of bilateral stimulation, *instead of asking the client* "What do you notice now?" you instead check the VoC.

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The aim of the Installation Phase

3.

NOTE: Although Shapiro (2018) states we immediately check the VoC after each set of BLS, because Phase 5 is still considered a reprocessing phase, it is good practice to say after each set and before asking for the VoC, **"Rest, take a deeper breath, let it go, what do you notice now?"**

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B. Standard Installation phase procedural steps

1. Ask the patient, "**Do the words _____**" (repeat the positive cognition – as an "I" statement) "**still fit, or is there another positive statement that would be more suitable?**"

2. Then check the VoC on the selected Positive Cognition. "**Think about the original experience and those words _____**" (repeat the selected Positive Cognition in the first person). "**On a scale from 1 to 7, where 1 means they feel completely false and 7 means they feel completely true, how true do those words feel to you now?**"

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Before and after each set of BLS during Installation

3. Before each set in the Installation Phase say, "**Focus on the original experience and those words _____**" (repeat the selected Positive Cognition in the first person) "**and follow**."

4. Then offer another set of BLS.

5. After each set of bilateral stimulation check the VoC again.

6. Continuing to offer additional sets of BLS as long as the felt sense of validity improves even after the first VoC rating of a 7.

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C. When the VoC does not rise to a 7 after several sets of BLS

- 1. Check for a defensive or blocking belief or remaining issues by asking,

"**What thought or concern keeps these words from feeling completely true?**"

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C. When the VoC does not rise to a 7 after several sets of BLS

2. In some cases, the thought or concern the patient expresses can be directly targeted and resolved in a few more sets of BLS.

3. In other cases the thought or concern may come from another memory network that needs to be identified and targeted for reprocessing.

4. You may need to use an affect, somatic or action urge bridge to identify the target for an issue in the Installation Phase.

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D. When to accept a VoC less than a 7

1. Some clients will express a cultural or personal value rather than evidence of additional dysfunctionally stored material or a defense.

2. Shapiro (1995, 2001) refers to these statements as "ecological" meaning that they are an appropriate stopping place given the individual's values and the personal and social context.

3. Offer at least one additional set of BLS even when you hear a statement that seems to make a VoC of 6 seem acceptable.

4. When the VoC is a 7 and is no longer changing – or an "ecological" 6 – go on to the Body Scan phase.

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IV. Body Scan – Phase 6

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F. There are two purposes of Body Scan Phase.

1. To confirm that there is no residual material left unaddressed in the selected target memory.

2. To extend the gains that have been made in the Desensitization and Installation phases.

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Completing the Body Scan Phase

- 3. When the client reports only positive sensations, continue BLS to enhance the positive sensations until they are no longer getting more positive.
  - a. Focusing on such positive sensations and adding bilateral stimulation can lead to profound experiences of well-being and even to transpersonal states (Krystal, Prendergast, Krystal, Fenner, Shapiro & Shapiro, 2002).

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EMDR STANDARD PROTOCOL TEMPLATE

MEMORY	**AGE 7 – Mom started being rude; telling me what to do**
IMAGE	**Her standing in front of me with a scowl look on her face**
NC	**I am shameful**
PC	**I am good**
VOC	**3**
EMOTIONS	**Shame, anger, anxiety**
SUD	**8.5**
BODY	**Head, face, chest, stomach**

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EMDR STANDARD PROTOCOL TEMPLATE

# of passes and BLS (EM, KS, AS)	Client Response:
# 1 - 54 EM	Her standing in front of me with a scowl look on her face. I feel more anxiety
# 2 – 54 EM	Just feeling sick to my stomach.
# 3 – 50 EM	Other memories of times she shamed me. Always telling me what to do.
# 4 – 55 EM	Her yelling at me. I feel so small and stupid. Why did she always have to be like this with me?
# 5 – 64 EM	(Tears). I just feel so sad. She could be so intrusive.
# 6 – 60 EM	(Tears). More of the same stuff.
# 7 – 54 EM	I'm actually starting to feel angry. Remembered a time I yelled at her. Stood up to her. Dad would stand up to her for me.
# 8 – 60 EM	A few times Dad told her to "Back off" and she did.
# 9 - 54 EM	Just feeling sad again. Sad for her. But also feeling anger.
RETURN TO TARGET	I still feel distressed about it
SUD, Worst part, Body	6/10 – That she wasn't more reasonable. Treated me like I was dumb. Feel it in my stomach

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V. Closure – Phase 7

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A. Purposes of the Closure Phase

1. To provide a structured sense of completion to each EMDR reprocessing session.

2. To assure client stability before the client leaves the session.

3. To give the client guidance about observing and documenting emerging issues and changes that may occur following each EMDR reprocessing session.

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Completing the closure Phase 7

- Just because a session is incomplete does not mean that specific closure interventions are routinely needed.
- 3. Always give the client guidance about observing and documenting emerging issues and changes that may occur following each EMDR reprocessing session.

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B. Procedures for closing an incomplete session

1. An incomplete session is one where: the SUD rating is above a 1; the VoC rating is less than a 6; or there are residual negative sensations reported in the Body Scan that were not reported before the session began and that appear to be linked to the targeted material.

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B. Procedures for closing an incomplete session

2. Explain the need to stop the session

3. Offer acknowledgment and encouragement for the client's work in the session.

4. When stopping during the Desensitization phase, you should skip the Installation of Positive Cognition and the Body Scan Phase. Just move into Phase 7.

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B. Procedures for closing an incomplete session

5. You **should avoid returning to target** and asking for information about the selected target memory, as this would tend to increase disturbance. Therefore, you should not check the SUD or the VoC, as both of these require focusing on the target memory.

6. Explore the client's somatic, emotional and cognitive state.

7. Assess the patient's need for structured containment or stabilization procedures.

8. ***"We are almost out of time and we will need to stop soon. You have done good work today. I appreciate the effort you have made. How are you feeling?"***

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B. Procedures for closing an incomplete session

9. Preserve time for clients who need assistance with mentalization

10. Preserve time for clients who need structured containment:

- a. The calm place exercise may be enough.
- b. Other clients will need a series of stabilization, containment and sensory orienting exercises. Use those that were useful in the preparation phase.

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B. Procedures for closing an incomplete session

11. Just because a session is incomplete does not mean that such interventions are routinely needed.

12. When the client is in a stable state, debrief them about treatment effects.

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C. Procedures for closing a complete session

- 1. Some clients may benefit from or may need a brief discussion of the gains they experienced in the session.
- 2. Allow sufficient time for the closure phase based on the individual needs of each client.
- 3. In most cases, you can just brief the client about being alert to post session treatment effects and request a log report at the next session by reading the statement below.

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4. Brief the client and request a log report.

- 5. **"The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. You may notice changes in how you are functioning. To help us evaluate your responses to today's session, notice what you experience and make entries in your log. Remember to practice the _____ exercises we worked on to help you manage disturbances this week. We will review your log report and continue our work next time. If you have something urgent to report or need additional support before our next session, call me."**

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4. Brief the client and request a log report.

Why is it critically important to debrief clients about treatment effects and to request they keep a log following an EMDR session?

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Any Questions?

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VI. Video demonstrating Phases 3-7

"EMDR Reprocessing
Procedural Steps Script"

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