Comprehensive Refresher
in EMDR Therapy

Trainer: Jasmine Alexander, PsyD (cand)

Day 3

Training Sessions 2 of 2

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What do you do when…??

1. You begin the desensitization phase. After the first set of BLS, you say _____.
2. After the first set of BLS, the client reports "Nothing. It was hard to hold the image in mind. I was just watching your hand going back and forth." You say _____.
3. After a set of BLS, the client reports feeling more disturbed. You say _____.

3

What do you do when…??

3. After a set of BLS, the client reports feeling more disturbed. You say _____.

4. The client reports the **same** disturbing images, feelings and thoughts as after the previous set of BLS. You say _____.

4

What do you do when…??

5. The client reports the same, unchanging and disturbing images, feelings and thoughts as after the **previous two sets BLS**. You say _____.

6. After the fourth set of BLS, the client reports feeling more disturbed and asks, "How can you stand to hear about these disgusting memories all day long?" You say _____.

5

What do you do when…??

7. After initially reporting significant disturbance for several sets of BLS, after two successive sets of BLS, the client reports only mild or positive associations. You say _____.

8. The client starts crying and reports re-experiencing sounds and images from the target incident. You say _____.

6

What do you do when…??

9. The client makes the stop signal.
   You say _____.

10. The target is a disturbing memory from eight years in the past. After several sets of BLS, the client reports having insights into a current life situation and feeling calm. After the next set of BLS, the client remains calm.
    You say _____.

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What do you do when…??

11. After asking the client to "Bring your attention back to the original experience," the client reports a SUD of 1.
    You say: _____.

12. The client reports the SUD is 0 and is not changing.
    You say _____.

8

What do you do when…??

13. During installation, the client reports a VoC of 7 for the first time. You say _____.

14. To start the body scan phase.
    You say _____.

9

What do you do when…??

15. During desensitization the SUD level has decreased and the emotion has changed from fear to anger. You realize you are running out of time.

How do you bring the session to a close?

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Questions?

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VII. **Selecting clients for initial clinical application of EMDR reprocessing**

- A. Clients selected for initial application of EMDR reprocessing need to be free from significant issues in the five areas covered in the "Assessing Stability and Readiness for Reprocessing" and "Confidential Patient Assessment" forms:

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VII. Selecting clients for initial clinical application of EMDR reprocessing

- 1. Medical concerns,
- 2. Social and economic stability,
- 3. Behavioral stability,
- 4. Mood stability, and
- 5. Comorbid personality disorder, structural dissociation, substance abuse and severe mental illness, such as bipolar and obsessive-compulsive disorder, and schizophrenia.

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B. Four classes of clients suggested for initial clinical use of EMDR Therapy

- 1. Clients without significant psychopathology whose history reflects a generally sound childhood can benefit with enhanced self-esteem, self-confidence and greater freedom to pursue their goals by working on mildly disturbing memories.
- 2. Clients with specific phobias –especially those of a traumatic origin, who do not suffer from another significant disorder (such as generalized anxiety disorder, social phobia, agoraphobia or another more serious disorder) and whose history shows a generally sound childhood can benefit from the phobia protocol (Leeds, 2009, 2016; Shapiro, 2001).

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B. Four classes of clients suggested for initial clinical use of EMDR Therapy

3. Clients with single episode, adult onset PTSD whose history shows a generally sound childhood and a good premorbid history are good candidates for initial experiences applying EMDR Therapy.

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B. Four classes of clients suggested for initial clinical use of EMDR Therapy

4. Clients with complex, early histories of neglect and/or abuse and who have experienced focal adult trauma experiences have been shown to respond well to EMDR reprocessing of the activated, adult traumatic experiences (van der Kolk, et al. 2007).

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B. Four classes of clients suggested for initial clinical use of EMDR Therapy

a) Make sure these clients meet readiness criteria.
b) Screen for degree of structural dissociation with MID
c) Practice and use the Container exercise as indicated.
d) Return to adult target if childhood material is activated.
e) Develop and install resources for adult target if sessions are repeatedly incomplete.

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B. Four classes of clients suggested for initial clinical use of EMDR Therapy

5. Review complete power point presentation with clinical examples by Andrew M. Leeds, Ph.D. "Getting Started with EMDR – Guidelines for clinicians in selecting clients for initial application of EMDR reprocessing during and immediately following basic training in EMDR" at:

https://www.sonomapti.com/emdr-research/#started

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VIII. Standards for scope of practice during and after basic training in EMDR Therapy

A. Professional standards such as the American Psychological Association Code of Ethics (2004, 2.01) state that:

"Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience."

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VIII. Standards for scope of practice during and after basic training in EMDR Therapy

B. During and after basic training in EMDR Therapy clinicians need to function at all times within the boundaries of the competence.

- While clinicians can apply EMDR Therapy to conditions other than PTSD, they should consider scope of practice criteria and provide informed consent based on options for and patient responses to empirically supported treatment methods they can personally offer or to which they can refer in their community.

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Questions?

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ii. Dual Attention and AIP

- Dual attention is the primary mediator of treatment effects during reprocessing
- Dual attention refers to the balance of attention of being able to shift continually between:

- the past (**M**emory) and
- the present (current **S**ensory perception – via BLS and clinician).

(Leeds, 2009, 2016; Shapiro, 1995, 2001)

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Maintain Dual Attention

- 1. Maintain a balance of dual attention between the associations that arise from the selected target and the bilateral stimulation.
  - a. Keep verbal interactions brief. There is no need to repeat or rephrase what the client said.

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Maintain Dual Attention

- Although verbal interactions may be brief, do not hesitate to probe and ask for additional information if what the client reports is:
  - i. vague
  - ii. unclear / ambiguous
  - iii. primarily focused on somatic / affect

We need information from the client to facilitate the reprocessing, especially if the client begins looping and we need to offer a Cog. Interweave

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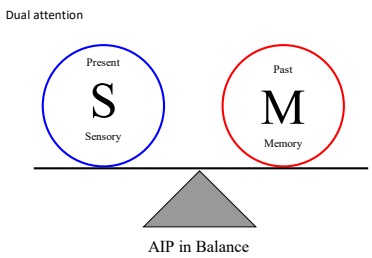
Dual Attention
The Teeter-Totter Model of Consciousness (Leeds)



AIP in Balance

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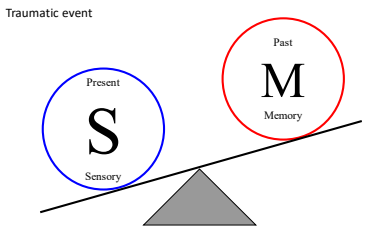
AIP during a traumatic event
The Teeter-Totter Model of Consciousness (Leeds)



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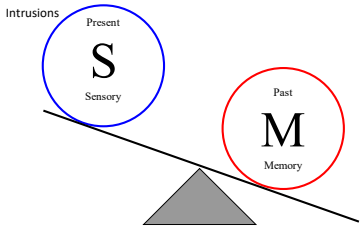
Intrusions after a traumatic event
The Teeter-Totter Model of Consciousness (Leeds)



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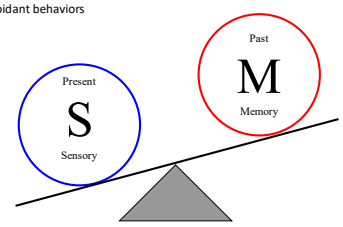
Avoidant behaviors after Trauma
The Teeter-Totter Model of Consciousness (Leeds)

Avoidant behaviors



Compulsive Work, Substance Use, Tension Reduction Behaviors

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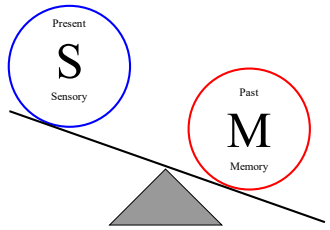
Prolonged Exposure

The Teeter-Totter Model of Consciousness (Leeds)

- PE



During PE attention is only on the memory

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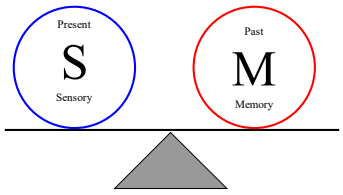
EMDR Reprocessing

The Teeter-Totter Model of Consciousness (Leeds)

- EMDR Reprocessing



AIP restores the balance with dual attention

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Any Questions - Comments?

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Assessing treatment effects

- As the client moves down channels of association, assess treatment effects from evidence of adaptive shifts in:
  - a. The client's brief verbal reports of changes in images, thoughts and sounds, emotions, sensations, beliefs and action urges or associations to other memories
  - b. Your observations of non-verbal indications of adaptive emotional and psychophysiological change.

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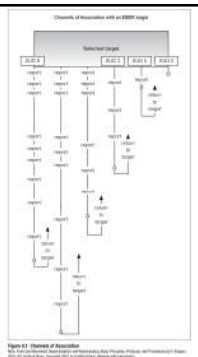

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When to return to target?

- There are four situations when we return to target:

1. After 6-14 sets (Approx. every 10 sets)
2. After 2-3 consecutive sets of positive / neutral info.
3. The client's reports are suggestive of ineffective reprocessing
4. The client got pulled out of their reprocessing

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How to return to target

- When returning to target, access current state of the target – therefore normally do not repeat the NC, details of the original image or original emotions or original location of physical sensations.
- "**When you bring your attention back to the original experience, what do you notice now**?"
- You do not need to check the SUD when you return to target if the memory is obviously still disturbing – but it's a good idea to do it anyway.
- After their report, ask: "**Where do you feel that in your body**?" Then say, "**Focus on that**."

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When to check the SUD

3. Check the SUD when the client reports ambiguous, neutral or positive material

If the client reports that the SUD rating is higher than 0, ask: "**What's the worst part of it now**?" _____.

After the client reports the worst part, say: "**Focus 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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How to return to target

- Why is it a good idea to check the SUD every 6-14 sets?

  AND, ask for the worst part?

- Even IF the report is STILL disturbing?

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When the SUD does not go to 0

- b. After returning to the target and first reprocessing any remaining material, if the SUD does not go down to 0, even after changing the direction or type of BLS, check for earlier ("feeder") memories or defensive material (fears and beliefs).
- i. Ask:
- **"What, if anything, keeps this memory from going to a 0?"**
- ii. Or, starting with the residual disturbing emotion, sensation, belief, or action urge, use an affect, sensation or defensive urge bridge to identify an earlier memory with the same or different theme.

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When the SUD is 0

- b. 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.
- c. When the client reports a SUD of 0 a second time, the Desensitization Phase is complete. Continue to the Installation phase.

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I. Case conceptualization and target sequencing in the Adaptive Information Processing model

The elements of treatment planning in EMDR Therapy

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X. The therapeutic relationship

- 1. More strongly associated with a positive outcome in psychotherapy than the method or years of experience of the clinician (Seligman, 1995).
- 2. As case complexity increases, the role of the therapeutic relationship becomes more central (Pearlman & Courtois, 2005; Spinhoven, Giesen–Bloo, van Dyck, Kooiman, & Arntz, 2007).
- 3. The time needed to establish a sufficient therapeutic relationship before beginning reprocessing can vary from a few minutes to months (where there is a history of chronic betrayal of trust).

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Case Conceptualization

Female combat veteran

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History female combat veteran with MVA and DV

- Clinician request for treatment planning consultation.
- Client presents as highly intelligent and has a top security clearance.
- Client presented for treatment with severe PTSD following a near fatal single vehicle crash involving her and her three children.
- Client had previous diagnosis of PTSD after several overseas deployments.
- She was married once before.
- She is experiencing domestic violence in her current marriage.

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History female combat veteran with MVA and DV

- For reasons that remain unclear, client went off the road and hit a concrete wall.
  - Two children suffered minor injuries.
  - Third child's skull was cracked open. Client held child's skull together pending arrival of emergency medical personnel. Initially she thought her child was dead, but the child has made a miraculous recovery over last three years and ran a cross country race a few weeks ago.
- Her husband's violence left her with cracked ribs a few years ago for which he went to jail for a short while.
  - He went off his bipolar Rx a few months ago, became verbally abusive and sexually assaulted her in her sleep. She is currently pressing charges against him.
  - She has had 9 miscarriages which she attributes to his violence.

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History female combat veteran with MVA and DV

- Clinician described this client as "highly dissociative".
- Client describes "walking up a trail in the mountains" in her mind when describing her trauma history.
- Client states she is "able to care for her children" but that when alone, dissociation is her preferred coping skill.
- Limited affect regulation.

- Clinician is seeking help with
  - Case formulation
  - Affect regulation suggestions
  - How to determine when it is "safe to proceed"…

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Peer guidance: Female combat veteran with MVA and DV

- Peer guidance:
  - Clarify degree of structural dissociation using
    - Multidimensional Inventory of Dissociation (MID) (Dell, 2006)
  - Is the client suicidal? Did the client attempt suicide?
  - Are there child protection reports needed?
  - Clarify safety and ability to maintain separation from husband.
  - Explore part(s) of personality involved with past return to living with violent husband.

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Peer guidance: Female combat veteran with MVA and DV

- Focus on functions of daily living and self-care.
- Develop skills for presentification, grounding, containment.
- Defer history taking or attempts to develop a targeting sequence for standard EMDR reprocessing.
- Seek consultation
- Seek advanced training

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Questions?

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III. Re-evaluation – Phase 8

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A. Re-evaluation: Continuing aspect of the EMDR approach to psychotherapy

1. Re-evaluation **<u>begins</u>** in History-Taking and Preparation Phases.
- Consider the impact of clients disclosing information, perceptions of the clinician's responses as well as the impact of skills building and stabilization exercises on patients' stability, symptoms, and functioning.

2. Once EMDR reprocessing has begun, **re-evaluation continues**:
- To assure stability of treatment effects from apparently complete reprocessing sessions; to confirm the appropriateness of continuing reprocessing on incomplete target memories or switching to an earlier target; and to monitor the effects of reprocessing.

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A. Re-evaluation: Continuing aspect of the EMDR approach to psychotherapy

Once EMDR reprocessing has begun…..

It's kind of like popcorn…
Things change.

Sometimes the memory is **MORE** disturbing.
Sometimes it's **LESS** disturbing.

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B. Re-evaluation takes place on two levels: a macro level and a micro level.

1. On the **macro level**, consider what you learn from re-evaluation for adjusting the overall treatment plan.

2. On the **micro level**, re-evaluate the specific impact of the previous session.

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The Big Picture - Macro Level

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The Big Picture - Macro Level

- C. Macro level of re-evaluation – monitoring client responses to treatment

1. How is the client doing overall?

2. Check feedback from the client's log:
   - a. Changes in dreams
   - b. Reactions to current stimuli that represent threat cues
   - c. Additional memories; new thoughts or insights.

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Phase 8 - Re-Evaluation
Macro Evaluation

Case conceptualization is dependent on what the client reports to confirm whether the hypothesis and proposed treatment plan are correct.

The information provided by the client sometimes leads the clinician to change or adjust the treatment plan and targeting sequence of memories.

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Phase 8 - Re-Evaluation
Macro Evaluation

Log report

1. **"What have you noticed since the last reprocessing session?"**
2. **"Have you had any new insights or new thoughts about the issue?"**
3. **"Have you noticed any dreams or new memories related to this issue?"**
4. **"What changes, if any, have you noticed in your behavior?"**
5. **Ask any other questions** that may be relevant to the client's presenting issues at intake, or issues discussed during the course of therapy to ascertain the client's progress and to adjust the treatment plan as necessary.

- Collect information and redirect to the Phase 8 tasks

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d. Actively inquire about changes in primary symptoms associated with the selected target memory from the previous session

- i. Intrusive re-experiencing,
- ii. Avoidant behaviors,
- iii. Agitation, hyperarousal,
- iv. Somatoform symptoms and states of anxiety,
- v. Depression,
- vi. Depersonalization and derealization,
- vii. Maladaptive, tension reduction urges and behaviors

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d. Actively inquire about changes in primary symptoms associated with the selected target memory from the previous session

- e. In cases where these issues were present at intake, monitor basic activities of daily living such as regular eating, sleeping, exercising, working and family life.

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When do we move on to the next target??

2. When clients' log reports indicate reprocessing has reduced current symptoms – continue with the treatment plan / targeting sequence of memories.

a. Move to the next target once phases 4-6 are fully completed. SUD 0, VoC 7

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Adjusting the treatment plan to return to stabilization

3. When reprocessing leads to:

- a. Additional disturbing memories, increased intrusions accompanied by less stable mood states, greater anxiety or increased urges for maladaptive or tension reduction behaviors
- b. You may need to consider adjustments to the treatment plan that focus on containment, stabilization, or increasing client access to external (social) or internal (self-capacities) resources.

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4. Some survivors of early neglect or abuse lack skills in self-monitoring

a. Sometimes further reprocessing will **improve** temporarily worsening symptoms.

b. Sometimes only further skills building and stabilizing interventions will avoid a decline into a regressed state that could slow down client progress or lead to a crisis.

c. Key elements to consider in making this determination are:

- clients' capacities to maintain normal self-care and
- daily activities that sustain their mental energy and their mental efficiency.

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D. The micro level of re-evaluation focuses on the target memory from the previous session.

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Checking details - Micro Level

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4. Micro Re-evaluation after a Incomplete Reprocessing Session

Did NOT finish phases 4-6

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A. Re-evaluation: Continuing aspect of the EMDR approach to psychotherapy

Once EMDR reprocessing has begun…..

It's kind of like popcorn…
Things change.

Sometimes the memory is **MORE** disturbing.
Sometimes it's **LESS** disturbing.

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Re-Evaluation – Phase 8
Micro Evaluation / INCOMPLETE TARGET
For a previously incomplete target

Unless additional, earlier material has emerged, just confirm the client is ready to continue reprocessing and then "return to target" to continue reprocessing.

Pick up where you left off in the previous reprocessing session.

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1. Resuming reprocessing for **Phase 4 - incomplete desensitization**

a. Confirm the client is ready to continue reprocessing
b. Then "return to target" to continue reprocessing.
c. It is not necessary to redo the entire Assessment phase.
d. It is not necessary to recheck the SUD level but it is good practice to do it anyway because the SUD can help us understand what, if anything, has changed since the last session and whether the client may be looping.

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1. Resuming reprocessing after Phase 4 - incomplete desensitization

e. Your primary aim should be to resume reprocessing.
f. Ask the client:
"When you bring your attention back to the experience we worked on in our last session, what do you notice now?"

g. If the client reports additional disturbing material say:
"Focus on that and notice what happens next."

i. When you return to target, if the client reports ambiguous, or apparently neutral or positive associations on the target, you will need to check the SUD rating.

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1. Resuming reprocessing after **Phase 4 - incomplete desensitization**

Micro-re-evaluation:

1. **"When you bring your attention back to the experience we worked on in our last session, what do you notice now?"**
2. **"On a scale from 0-10, where 0 is no disturbance or neutral, and 10 is the highest you can imagine, how disturbing does the incident seem to you now?"**
3. If the SUD is higher than 0, ask: "**What's the worst part of it now?"**
4. **"Where do you feel that in your body?"**

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1. Resuming reprocessing after incomplete target

Micro-re-evaluation:

If the client reports SUD 0, say:
"Notice how the incident seems to you now, and follow."

Offer one set of BLS, and after obtaining the report, check the SUD again.

If the SUD is reported as 0 for the second time, Phase 4 is complete. Advance to Phase 5, then Phase 6 so the memory can be regarded at "Complete."

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2. Resuming reprocessing after incomplete target - Phase 5 - Installation

- a. First verify the SUD remains a zero
- b. Check the VoC.
- c. Then resume Installation.

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3. Resuming reprocessing after incomplete target - Phase 6 - Body Scan

- a. Review the feedback from the log.
- b. Verify the SUD remains a zero and the VoC a seven.
- c. Then do the Body Scan again.

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4. Re-evaluation after a
Completed Reprocessing Session
(Completed Target)

SUD 0
Voc 7
Finished phases 3-6

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4. Re-evaluation after a
Completed reprocessing session

- a. Check the feedback from the client log (Macro Reevaluation)
- **THEN, BEGIN THE MICRO-REEVALUATION**
- b. Reassess the SUD and VoC on the selected target memory.
- c. If SUD=0 and VoC = 7, go on to next target in your treatment plan.
- d. **When the SUD or VoC have shifted**, consider whether this is due to additional material within that specific memory or whether it is due to an associated memory from within a cluster of similar experiences.

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Phase 8 - Re-Evaluation
Macro Evaluation

Log report

1. **"What have you noticed since the last reprocessing session?"**
2. **"Have you had any new insights or new thoughts about the issue?"**
3. **"Have you noticed any dreams or new memories related to this issue?"**
4. **"What changes, if any, have you noticed in your behavior?"**
5. **Ask any other questions** that may be relevant to the client's presenting issues at intake, or issues discussed during the course of therapy to ascertain the client's progress and to adjust the treatment plan as necessary.

- Collect information and redirect to the Phase 8 tasks

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4. Re-evaluation after a Completed reprocessing session

- **When the SUD or VoC have shifted…..**

a. Move back into Phase 4 or 5 and treat the memory as an **incomplete target.**

b. OR, if the information provided by the client in the Macro re-evaluation indicates you need to change the targeting sequence, open this new memory in Phase 3.

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- Re-Evaluation – Phase 8
  Micro Evaluation / COMPLETE TARGET

  For a previously complete target

Unless additional, earlier material has emerged, next access the previous target memory network. Then check the SUD on the previous target memory.

1A. "When you bring your attention back to the experience we worked on in our last session, what do you notice now?"

1B. You can also probe the target with questions that are more specific:

"When you focus on the experience we worked on in our last session, what images comes up? What thoughts do you notice about yourself and the incident?"

"**What emotions do you notice? What sensations?"**

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- Re-Evaluation – Phase 8
  Micro Evaluation / COMPLETE TARGET

  For a previously complete target

2. After listening to the client report, check the SUD level again:

"As you 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?"

2B. If the SUD increased above a zero, ask, **"What makes it a ____?"**
(State the SUD rating.)

Then ask, **"When you notice those disturbing _____ (images, thoughts, emotions, or sensations), do they feel more connected to that incident or to another related incident?"**

2C. Make a decision with what memory you will reprocess.

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3. In most cases, the SUD will remain a zero. If it has shifted, move back into Phase 4 for reprocessing the previous memory. If you need to open a new memory, move into Phase 3.

You can then check the VoC:

"Think about the original experience and those words _____"
(repeat the Positive Cognition that was installed 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?"

In most cases, the VoC will remain a seven. You can then go on to the next target in your treatment plan.

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4A. Unless you and the client conclude that residual disturbance relates to an associated memory, resume reprocessing the incomplete target as above for an incomplete target.

4B. If you and the client conclude that residual disturbance relates to an associated memory, then consider whether to make that associated memory the next target in your treatment plan.

5. If the SUD remains a zero, but the VoC has dropped below a seven, ask:

"What keeps it from being completely true?"

After the client's report, say **"Notice that and follow again."**

Resume reprocessing in Phase 5 and follow the standard procedural steps for the Installation Phase.

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Micro- Reevaluation

- It is good practice to indicate in your process notes that you conducted a re-evaluation on a target memory.
- For a completed memory, you may want to indicate:

Re-evaluation – Age 5: Being bullied by kids at school
SUD 0, VoC 7
COMPLETE

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Micro- Reevaluation

- A memory is regarded as fully reprocessed after at least one week since the last reprocessing session, and the memory is holding at SUD 0, VoC 7
- Keep in mind that things shift with EMDR reprocessing. Not only may NEW memories emerge that need to be added to Prong 1 and your targeting sequence, but sometimes the reprocessing within a memory shifts too

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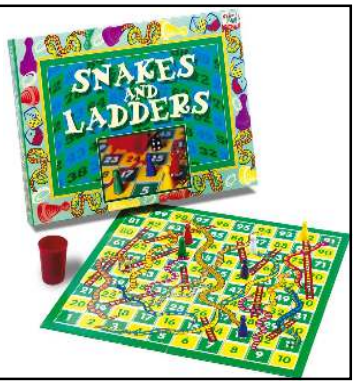
Micro- Reevaluation

- EMDR is like a game of snakes and ladders.
- We are trying to advance our way, but sometimes we slide back down and need to start things over in either Prong 1, or Phases 4, 5, or 6



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- Hence, the unpredictable nature of EMDR Therapy.
- We do not know what will emerge during the reprocessing, how the client will respond to the therapy, or what changes will need to be made to our treatment plan and targeting sequence of memories

"Wait! Stop! This isn't part of the script."

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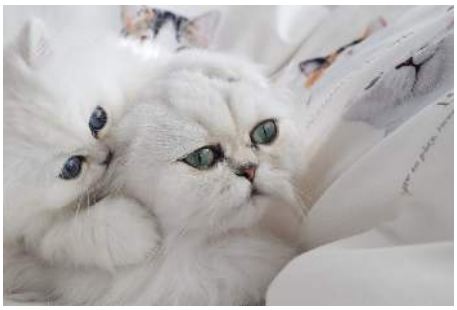
Any Questions - Comments?



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Group Exercise

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Scripted Vignette 1

Origins of violence:

The client is a 25-year-old bisexual Middle Eastern male who has voluntarily completed half of a court-approved program for men with problems with violence. His partner left him after an incident in which he grabbed them. The client was not arrested.

There had been many previous incidents in which the client yelled at them in an angry and controlling manner especially when he was having jealous feelings based on fears of infidelity. In fact, he has every reason to believe his partner has actually always been faithful. The client's father was often angry toward the client's drug-abusing mother and was violent toward the mother, the client, and the client's siblings on numerous occasions.

After his parents separated when he was 9 years old, the client's mother had a series of male friends and was frequently openly sexually affectionate with them. The young man is hard working and is pursuing his education at night school. He does not drink or use drugs.

87

Scripted Vignette 1

Case Conceptualization:

The client's anger and insecurities of his partner's infidelity stem from watching his father interact with his mother, and witnessing his mother have a series of lovers.

You begin reprocessing the **FIRST** memory which was an incident from when the client was 8 or 9 years old witnessing his father assaulting his mother while accusing her of infidelity. The client was too little and weak to stop the father.

Reprocessing on this memory was (supposedly) complete

Tasks:

Check the log. Re-assess the target memory and decide if it needs more work or to go on to the WORST target memory: witnessing his mother being sexually affectionate with a male companion.

88

Scripted Vignette 1 – Client and Therapist Role Play

89

Scripted Vignette 2

Avoiding her loving husband:

The client is a 32-year-old heterosexual Indian female now happily married to a loving man who has become an excellent step father to her daughter from her former marriage. Her former husband was physically threatening and sexually violent with her on several occasions, which led her to divorce him shortly after her daughter was born. She complains of not being able to tolerate making love with her current husband unless she has been drinking and experiences depersonalization and derealization when she does have sex with him.

90

Scripted Vignette 2

Case Conceptualization:

The client's fear, anxiety, disgust, and revulsion toward physical and sexual intimacy are rooted in the abuse the client experienced in her former marriage.

You begin reprocessing the FIRST memory which was the first reported incident of marital rape by the client's first husband.

Reprocessing on this memory was (supposedly) complete.

Tasks: Check the log. Re-assess the target memory and decide if it needs more work or to go on to the next target: the worst episode of rape in which she thought he might kill her and she experienced severe depersonalization

91

Scripted Vignette 2 – Client and Therapist Role Play

92

Scripted Vignette 3

Motor vehicle crash:

The client is a 45-year-old gay Indigenous male who developed driving phobia, nightmares and other symptoms of PTSD after his small car was struck on the passenger side door by a large white truck that failed to stop for a red light.

93

Scripted Vignette 3

Case Conceptualization:

The client reports no earlier accidents and the presenting symptoms are all connected to this reported car crash (there are no other reported crashes or accidents).

You begin reprocessing the FIRST memory moment of impact.

Reprocessing on this memory was incomplete.
The initial SUD rating was an 8. The last SUD rating before closure was a 3.

Tasks: Check the log. Re-assess the target memory and decide if it needs more work or to go on to the next target which is moving into Prong 2: intense fear when approaching intersections with a green light and drivers in cars or drivers approaching their red light at the intersection on the right.

94

Scripted Vignette 3 – Client and Therapist Role Play

95

Scripted Vignette 4

Threatened from within:

The client is a 34-year-old heterosexual White female who has been diagnosed with stage one breast cancer. Due to the early detection, type of cancer and available medical treatments, her prognosis is excellent. However, since her diagnosis she has begun having nightmares, panic attacks, and persistent, intrusive thoughts of her death. When she was 10 years old, her mother had finally died after years of illness and complications of stage four breast cancer that had been initially detected only after it had spread throughout her body.

96

Scripted Vignette 4

Case Conceptualization:

The client's panic, anxiety, nightmares, and persistent thoughts of dying are all rooted in how her own mother died due to breast cancer, and the mother trying to convince the client she was going to be "just fine."

You begin reprocessing the FIRST memory which was the scene from age seven when her mother first revealed her diagnosis to her and reassured her that, *"Everything is going to be just fine."*

Reprocessing on this memory was (supposedly) complete.

Tasks: Check the log. Re-assess the target memory and decide if it needs more work or to go on to the WORST memory: the sense of panic and dread, in spite of her good prognosis, when her physician given her diagnosis of her own cancer 8 months ago.

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Scripted Vignette 4 – Client and Therapist Role Play

98

Scripted Vignette 5

Survivor guilt:

The client is a 37 year old Black heterosexual combat veteran who served several tours in Iraq and who returned free of physical injuries unlike most of the soldiers in their unit who were maimed or killed by improvised explosive devices.

99

Scripted Vignette 5

Case Conceptualization:

The client's symptoms all seem to be connected to the reported incidents of deployment which were provided at intake. No other information was provided at intake.

You begin reprocessing on the FIRST memory (from a series of similar incidents) of the client witnessing the lead vehicle in their convoy being blown up killing or wounding all who were inside.

Reprocessing on this memory was incomplete.
The initial SUD rating was a 9. The last SUD rating before closure was a 5.

Tasks: Check the log. Re-assess the target memory and decide if it needs more work or to go to another target.

100

Scripted Vignette 5

Note:

The worst memory in the previously developed treatment plan was the death of the veteran's closest friend in an incident 2 months after the initial target.

New information has emerged from the log. The veteran reports having persistent, sleep disrupting nightmares about the worst incident. Strangely, the person who dies in these nightmares isn't the closest friend from their unit, but the veteran's older brother (then 18 years old) who had died tragically in a fiery car crash when the patient was 9 years old. The brother's death had not been reported during initial history taking.

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Scripted Vignette 5 – Client and Therapist Role Play

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Questions?

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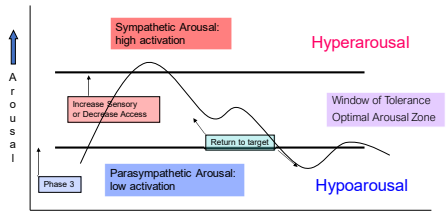
VI. Introduction to maintaining and restoring effective reprocessing

104

Maintain Arousal in the Window of Tolerance During Reprocessing



The Modulation Model

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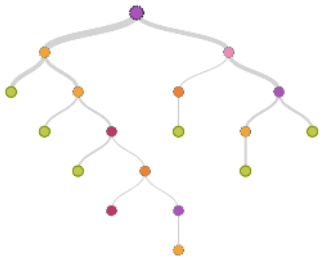
A. Standard sequences and decision trees during the desensitization phase



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A. Standard sequences and decision trees during the desensitization phase

1. When "nothing" changes early in reprocessing
2. Responding to transference material during reprocessing
3. Staying out of the way
4. When earlier memories are accessed
5. When more recent memories are accessed

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B. Responding to prolonged intense emotional responses

108

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Promoting synthesis not abreaction during intense emotional responses

- 1. Abreaction is a psychoanalytical term invented by Sigmund Freud after he abandoned hypnosis and Janet's theories.
- 2. As in the model of Structural Dissociation, in AIP, abreaction is not viewed as necessary or helpful. Synthesis between memory networks is the essential element in effective reprocessing.

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EMDR is not about abreaction

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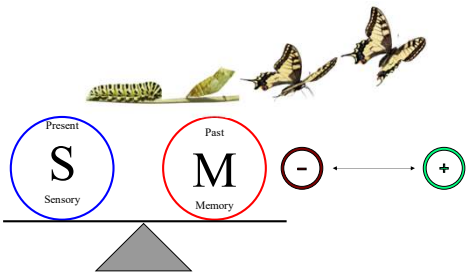
EMDR promotes dual attention leading to synthesis and transformation



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Promoting synthesis not abreaction during intense emotional responses

3. EMDR Therapy is more effective when reprocessing trauma in a detached manner compared with vivid reliving (Lee & Drummond, 2008; Lee, Taylor, & Drummond, 2006).

4. EMDR Therapy should not be viewed as an exposure extinction-based treatment but as a method of enhancing emotional information processing.

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The therapeutic stance: Mindfulness with compassion

5. During effective reprocessing, the appropriate stance with intense emotional responses should be one of mindfulness with compassion and support rather than trying to prolong, abbreviate, or distort patient's movement through material that is emerging.

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113

C. Good preparation is essential before dealing with high-charged material

1. Clients should know they are in control and can stop at any time by showing you the prearranged stop signal.

2. Clients should know that continuing sets of BLS is the best way:
   - a. To move through the emotional states that emerge
   - b. To ensure that maladaptive memory networks are reorganized and are no longer capable of producing future intrusive, painful re-experiencing.

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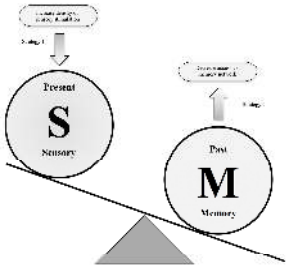

Two sets of strategies for maintaining dual attention during intense emotional and somatic responses

Reprinted with permission from Leeds, 2016, Figure 9.1 page 173.

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D. Increase the density of the sensory stimulation

1. Increase the number of movements per set of bilateral stimulation
2. Increase the frequency of verbal encouragement
3. Remain calmly supportive and mindful of options as you monitor evidence of effective reprocessing
4. Monitoring your own affect tolerance.

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E. Decrease the density of the bilateral stimulation

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1. Change the direction, speed, or number of repetitions of BLS or the mode or other characteristics of the BLS.

- a. Slow the speed of bilateral stimulation.
- b. Use the minimum number of repetitions per set—24.
- c. If eyes have been closed to help access the memory network with auditory or kinesthetic stimulation, instruct the client to keep eyes open during bilateral stimulation.
- d. Add a second or third mode of stimulation.

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2. Use interventions to decrease the degree to which the client is accessing the maladaptive memory network.

- a. Imagine disturbing images are farther away. Use an imaginary "remote control" to alter vividness, remove color, pause, or fast-forward.
- b. Imagine disturbing sounds are further away or decreasing volume with an imaginary "remote control."

119

119

2. Use interventions to decrease the degree to which the patient is accessing the maladaptive memory network.

- c. Focus on just one sensation.
- d. Focus on just one emotion.
- e. Focus on just one defensive action urge.

f. Offer a natural essential oil to help reorganize highly disturbing memories of taste or scent.

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Questions - Comments?

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I. Advanced topics in maintaining and restoring effective reprocessing:

The five causes of ineffective reprocessing

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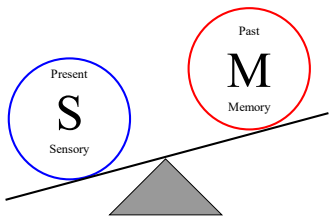
1 - Under Accessing the Maladaptive Memory Network

123

Under accessing maladaptive memory

The Teeter-Totter Model of Consciousness (Leeds)



Attention to bilateral stimulation is greater than the selected memory

124

A. Under accessing the maladaptive memory network

1. Increase access to the maladaptive memory network
2. Change the direction, speed, or number of repetitions of the bilateral eye movements or the mode or other characteristics of the bilateral stimulation.
3. Before each set of BLS, ask,

"Where do you feel it in your body?"

Then say, **"Focus on that,"** with the next set.

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A. Under accessing the maladaptive memory network

4. Return to target and remind the client of visual or other sensory threat cues from the memory.
5. Return to target and remind the client of the selected negative cognition to stimulate more of the disturbing emotion in the target memory.
6. Inquire about unspoken words: "With this next set of eye movements (taps or tones), notice any words that you wished you had said, or now wish to say, even if you would not actually say them out loud."

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A. Under accessing the maladaptive memory network

7. Inquire about unacted impulses:

"With this next set of eye movements (taps or tones), notice any impulses to act that had then, but didn't act on, or any impulses you have now, even if you would not actually act on them in real life."

8. Invite giving a voice to physical sensations:

"With this next set of eye movements (taps or tones), notice where you have that feeling in your body and imagine that part of your body could speak or express the feeling that is there."

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A. Under accessing the maladaptive memory network

9. Explore specific fears that may be interfering with accessing.

"What fears or concerns do you have now that might prevent this memory from being resolved?"

Resolve the identified fear with psychoeducation, RDI, or reprocessing the life experience associated with acquiring that fear.

10. Teach clients skills for decreasing depersonalization and derealization described in Leeds, 2016, Chapter 6 (and Week One) before resuming reprocessing.

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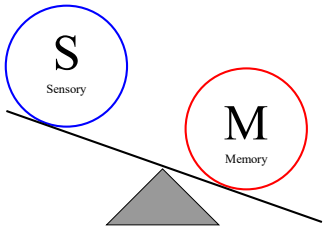
2 - Over Accessing the Maladaptive Memory Network

129

Over accessing maladaptive memory

The Teeter-Totter Model of Consciousness (Leeds)



Attention to the selected memory is greater than to BLS

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B. Over accessing the maladaptive memory network

1. Increase the number of passes to help pull the client through the abreaction.

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B. Over accessing the maladaptive memory network

•3. Abreactions typically last 60-90 seconds but in some cases may be a little longer. Continue with BLS until the client begins to calm as a result of the reprocessing.

•4. Should the abreaction not resolve after approximately three consecutive sets of BLS, stop the reprocessing. Use interventions to help increase distancing to the maladaptive memory network and to increase emotional regulation.

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3 – Need to shift to an earlier memory on the same theme

133

C. The need to shift focus to a different, earlier maladaptive memory network

- 1. Many clients spontaneously associate to earlier memories after you have started reprocessing on a selected target.
- 2. When this does not happen spontaneously, you may need to simulate what often occurs spontaneously with a simple one- or two-step intervention to redirect attention to the appropriate maladaptive memory network.

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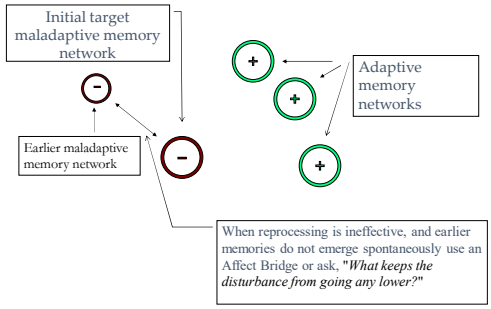
1 or 2 step inquiry for earlier memory



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Accessing an earlier maladaptive memory network **with the same theme**.
("Feeder" memories in Shapiro, 2018.)

3. After returning to target and determining that there has not been significant change

4. Or in the middle of a channel of associations with a persistent, disturbing, but unchanging response

5. Use the Affect, Somatic or Defensive Urge Bridge Technique.

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Accessing an earlier maladaptive memory network **with the same theme**.
("Feeder" memories in Shapiro, 2018.)

- 6. "**Let's do an experiment. Notice that thought** _____" — repeat the negative cognition in the first person — "**and where you are feeling it in your body.**

  Now just let your mind float back to the earliest time in your life when you had the same thought and with those same feelings in that part of your body. What memory comes up for you now?"

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Accessing an earlier maladaptive memory network **with the same theme**.
("Feeder" memories in Shapiro, 2018.)

7. Because the theme is the same, there is no need to do a full assessment on this maladaptive memory network.
8. Just continue reprocessing on the earlier memory until it is fully reprocessed—through desensitization, installation, and body scan phases—before returning to the originally selected target memory network to complete reprocessing.

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4 – Need to shift to an earlier memory on a different theme

139

D. Fourth Cause: The need to shift to accessing an earlier maladaptive memory network with a different theme

1. When you return to target and the SUD level has not gone any lower than the last one or two times you checked, you should consider exploring for an alternate maladaptive memory network linked to a different theme.

2. The earlier maladaptive memory network may be linked to a previously acquired defense (referred to as a "blocking belief" by Shapiro, 2018).

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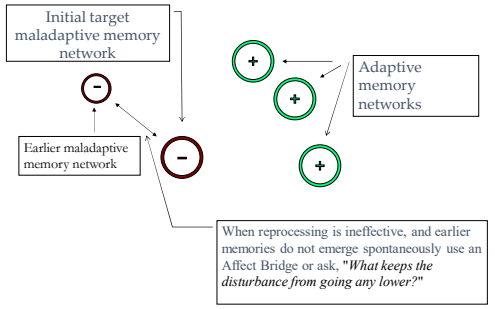
1 or 2 step inquiry for earlier memory



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How to access an earlier maladaptive memory network with a different theme

3. Ask **"*What keeps the disturbance from going any lower*?"**

4. Note: Sometimes, effective reprocessing can be restored by just saying, "Notice that" and continue reprocessing.

5. Alternately, if the client offers a new statement representing a different negative cognition, use that NC as the starting point for history taking or use an affect or somatic bridge to locate an earlier memory on the new theme.

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Questions - Comments?

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5 – Need a Cognitive Interweave

The maladaptive memory network is not linking into an adaptive memory network

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F. Using Interweaves to address lack of spontaneous synthesis between the maladaptive memory network and an appropriate adaptive memory network

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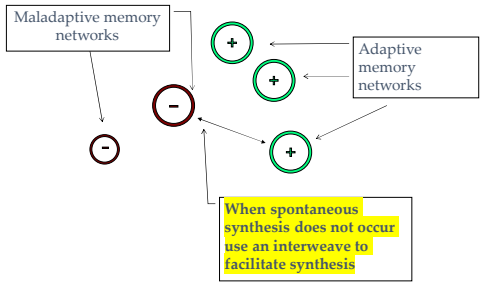
Using an Interweave to promote synthesis



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1. Cognitive Interweaves can be appropriate or essential in 4 types of situations

a. Responding to prolonged intense emotional responses
b. Bridging a lack of synthesis with adaptive memory networks
c. Assuring generalization of treatment effects
d. When limited progress has been made over the course of the session.

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Interweaves or "Cognitive Interweaves"

- 2. Shapiro (1995, 2001, 2018) refers to these interventions as "cognitive interweaves" because they involve making some kind of verbal interaction with the client.
- a. This terminology can be somewhat misleading, especially for those with previous training in cognitive behavioral therapy (CBT).

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3. Superficial similarities to interventions used in CBT,

- i. In CBT, the aim is to modify automatic (negative) thoughts.
- ii. These verbal interactions constitute the primary portion of treatment sessions and involve many back and forth exchanges.

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Differences between Interweaves and CBT interventions

- b. The aim of EMDR interweaves is to help the patient access an adaptive memory network.
  - i. Most interweaves merely stimulate already existing memory networks.
- c. The best interweaves are generally quite brief, lasting 15 to 30 seconds and often involve a single question.
- d. Another difference is EMDR clinicians can direct patients' attention to any aspect of adaptive memory networks, not only beliefs, but also include images, sounds, physical sensations, emotions, and action tendencies.

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Interweaves emulate spontaneous reprocessing

4. Deliberately stimulating an adaptive memory network should only be done in the service of supporting the client's own process and should stay as close as possible to spontaneous reprocessing.

5. After an interweave, do a standard length set of BLS, then verify effective reprocessing is restored.

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6. Three themes in EMDR and plateaus in reprocessing

- a. There is a relationship among:
  - i. The theme represented by the negative cognition selected in the assessment phase
  - ii. The issues that are emerging in the client's reports between sets of bilateral stimulation
  - iii. The three thematic domains from which interweaves are selected—responsibility, safety, or choices (Shapiro, 2018, pp. 256–282).

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Cognitive Interweaves

- Are offered in between sets of BLS and after finishing the RoT (Return to Target)
- They are only offered in Phase 4

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7. Recognizing which Interweave to use by theme

- Responsibility (can be used for terror with self-blame)
  - Defectiveness (Shame)
    - *I am unworthy. I am unlovable.*
  - Action (Guilt)
    - *I should (not) have done something. I should have known better.*
- Safety
  - Perception of danger
    - *I am not safe. I am going to die.*
- Choices
  - Perceived helplessness or lack of choice
    - *I am not in control. I cannot protect myself.*

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8. Responsibility

- a. Taking on of excessive responsibility for what happened.
  - i. For adult survivors this may be a protective mechanism to retain an image of their attachment figure as positive while developing a cause and effect explanation for why they are mistreated.
  - ii. Survivors of combat trauma use hindsight to second-guess what they should have done in the midst of chaotic situations.
  - iii. Rape survivors blame themselves, to preserve at least one element of their "assumptive world"—the idea that they have control (Janoff-Bulman, 1992).

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Foreseeing the need for "Responsibility" Interweaves

- b. We can anticipate the potential need to use a responsibility interweave when the NC identified in the assessment phase reflects shame or guilt.
  - i. Examples include: "I am worthless," "I am bad," "I am a failure," "I am not good enough," "I should have known better."

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c. Two types of responsibility interweaves

- i. Externalizing responsibility: the first type seeks a memory network with adaptive adult perspective that appropriately externalizes the responsibility for the other's bad behavior.
- ii. Compassionate interweaves: the second type of responsibility interweave seeks to access a memory network representing the capacity for a soothing, nurturing response to validate the intrinsic worth of the patient. This was often absent when needed at the time of the original experience.

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d. The Paradox of Terror Linked to Self-Blame

- i. Survivors of early abuse perceived the source of their vulnerability to danger in their own nature because they came to see themselves as defective.
- ii. You can only escape dangers that are external…
- iii. Rather than thinking first about a need for safety…
- iv. In clinical situations where there is persistent terror in a survivor of early childhood abuse, it may be more effective to ask: **"*Who was responsible for what he did to you that day, the little child or the adult*?"**

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Shifting locus of responsibility can lead to resentment or disgust

- e. Interweaves that shift the locus of responsibility can lead to the emergence of appropriate resentment of or disgust toward the other.
- i. **"*If the same thing happened to (your child, your best friend, or your sister), whom would you hold as responsible,* (your child, your best friend, or your sister) *or* (the perpetrator)*?*"**
- ii. **"*Is there a law against small children hitting (or sexually abusing) their caregivers or only a law to protect small children from being hit (or sexually abused) by their caregivers*?"**

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12. The most commonly used varieties of responsibility interweaves.

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a. Missing information

- i. Survivors of childhood sexual abuse blame themselves for the fact that the abuse happened but may never have considered how they came to hold such irrational beliefs.
- ii. There is evidence that sexual offenders induce cognitive distortions in their victims as a result of their own cognitive distortions (Salter, 1995).
- iii. Non-sadistic pedophiles work to stimulate sexual responses in their victims to create the illusion the child was interested in and wanted the sexual act. They then turn cause and effect around and say, "See, your body is saying you wanted this to happen."

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a. Missing information

- iv. During reprocessing a memory of childhood sexual abuse, patients may be stuck with feelings of shame and self-blame. You can offer the "missing information." **"*Did anyone ever tell you that with enough stimulation, any child is capable of becoming physically aroused even at a young age?*"** " No, I didn't know that." **"*Just notice that*."**
- v. Sometimes a brief question is all that is needed to make the connection to a healthy adult perspective.
- vi. Other times, patients will need more extensive psychoeducation or resource development to acquire missing knowledge and skills before they can resolve some adverse life experiences.

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b. "What if it happened to your child?"

- i. When clients are parents, they often will have an appropriate perspective when thinking about how their children deserve to be cared for while continuing to hold an excessive sense of responsibility for their own adverse early life events. In these cases, we can ask, **"What if it happened to your child? Who would you hold responsible, your child or the adult?"**
- ii. If they don't have children, perhaps we can ask about their adult perspective by asking about a favorite nephew or their neighbor's child.

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c. "I'm Confused."

- i. One of the most effective varieties of interweave starts with "I'm confused" and ends with a direct question.
- ii. Clients are often motivated to be helpful to their clinician when the clinician appears briefly unable to understand.
- iii. This creates a moment of receptivity where the patient wants to help resolve the clinician's "confusion."

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c. "I'm Confused."

- iv. When the patient keeps saying, "It's my fault I was beaten as a child," you can respond, ***"I'm confused. Are you saying that a 4-year-old child can do something and then deserves being beaten?"*** "Well, no?" ***"Notice that."***
- v. This interweave shifts from the autobiographical memory of the patient to the general fund of knowledge by referencing "a 4-year-old child."

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c. "I'm Confused."

- vi. Most adults know that no child deserves to be beaten. That's one of the reasons we have child protective service agencies and laws against child abuse.
- vii. You can use that fact as an interweave. ***"I'm confused. I'm wondering why there are laws in this country against child abuse?"*** "Because no child deserves to be physically abused." ***"Notice that."***

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f. Compassionate interweaves increase self-soothing

- i. When we think of a young child who has been maltreated, we readily imagine how a non-offending, supportive caregiver learning of the maltreatment would have impulses to reassure the child: ***"You're not to blame. It wasn't your fault. He shouldn't have done that to you. You are good person. What he did was wrong."***
- ii. When these adaptive memory networks for reassurance and support were not encoded in early childhood, it may be necessary to help patients during reprocessing by *deliberately accessing* other, later adaptive memory networks representing a "compassionate" interweave by *a soothing figure*.

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f. Compassionate interweaves increase self-soothing

- iii. In some cases, when survivors have become parents and can readily offer appropriate nurturing responses to a child, you can access a compassionate "internal parent."

"If this happened to your daughter, what would you say or do to let her know she is not to blame for what happened and that you still love her?"

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f. Compassionate interweaves increase self-soothing

- iv. In some cases, you will need to access a memory network holding the image of a compassionate other from the present or the past such as a member of the extended family, an adult friend, or a trusted figure such as a minister, teacher, or a member of a peer support group.
- **"*If your Aunt Rose knew of what happened to you, how would she respond to that little girl? Would she blame the little girl or would she offer reassurance?*"** "No, she wouldn't blame me. She'd hold me and tell me I deserved to be protected and treated with kindness." **"*Notice that.*"**

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d. Stimulating adaptive visual images

- i. You can deliberately stimulate adaptive memory networks with visual images. A common example is to ask the clients to imagine their adult self stepping into the memory with their child self and holding the hand of their child self or holding, comforting, or encouraging their child self. When clients cannot imagine their adult selves doing this, consider asking them to imagine a supportive family member, friend, or mentor to step into the memory to do this.

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e. Stimulating adaptive somatic responses

- i. When one defensive coping urge, such as submission, has been strongly conditioned from an early age, and alternate, adaptive coping responses are not readily accessible, you can consider inviting patients to practice an alternate response by changing their physical stance in the therapy office and engaging in a new somatic response. An example would be standing and pushing away with both arms while saying, "*Get away from me*!" or saying "*No! Leave me alone*," in a firm, strong voice.

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Questions - Comments?

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9. Safety

- a. The negative cognitions from the assessment phase that will alert you to the potential need for a safety interweave are those reflecting the external perception of danger: "I am in danger." "I will be hurt." "I am going to die."
- b. Safety interweaves can lead to the emergence of defensive action tendencies to flee, fight, maim, injure, or kill the perpetrator.
- c. Clinicians should not fear or suppress the emergence of these urges.
- d. Rather, see them as a way to work through the defensive impulses from the emotional brain that need to be resolved.

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e. Finding safety after a critical incident

- i. The moment of perceived threat to life in a motor vehicle crash, criminal or terrorist attack:
- ii. "I am going to die."
- iii. Ask, **"Where are you now?"**
- iv. The first response may be, "In the driver's seat."
- v. Then offer a second interweave, **"Where are you sitting today?"**
- vi. "In your therapy chair in your office." "Ok, notice that."
- vii. In this way the patient is accessing both the memory network with the threat cues from the traumatic memory active and at the same time is accessing evidence of current safety.
- viii. Another way to offer a safety interweave is just to ask the patient to "Notice what happened next."

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10. Choices

- a. You may be cued in the assessment phase for the potential need for choice interweaves by negative cognitions such as "I am not in control." "I am powerless." "I am helpless." "I am weak." "I cannot get what I want."
- b. These interweaves help the patient shift from an external locus of control—with external safety—to an internal locus of control—"I am in control now."
- c. Choice interweaves also represent the adaptive capacity to learn from the past and to make new choices.
- d. "I can protect myself." "I can stand up for myself." "I trust my judgment."

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e. Rehearsing alternate potential responses within the memory of the past event.

- i. The interventions for "unspoken words" and "unacted defensive action tendencies" — described previously — can both be considered forms of choice interweaves because they invite patients to imagine integrating new choices into the selected maladaptive memory network.

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e. Rehearsing alternate potential responses within the memory of the past event.

- ii. For survivors of childhood sexual abuse threatened with dire consequences if they ever revealed the nature of the abuse to anyone, being able to imagine disclosing the abuse to a sibling or a trusted authority figure represents the reclaiming of the truth, of learning to trust their own perceptions and judgments, and being able to act on what they know to be true.

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e. Rehearsing alternate potential responses within the memory of the past event.

- iii. For survivors of physical abuse where it was too dangerous to fight back, being able to imagine saying "stop," leaving, fighting back, or reporting the abuse to the authorities represents a new-found ability to access potentially more adaptive coping responses.

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11. Working with appropriate guilt and responsibility

- a. Sometimes clients have been violent with a spouse or a child, engaged in sexual assault or committed other violent crimes or unjustified acts of violence during war.
- b. During reprocessing, these clients may feel a tremendous sense of guilt and remorse.

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11. Working with appropriate guilt and responsibility

- c. Some clinicians believe that it is important for these clients to retain this guilt in order to maintain their motivation to avoid re-offending.
- d. In the EMDR model, we work from the hypothesis that reprocessing cannot "erase" or lessen appropriate negative emotions such as shame or guilt.
- e. Reprocessing can only modify maladaptive responses.

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11. Working with appropriate guilt and responsibility

- f. Treatment plans for patients who became involved with sexually abusing children after having been sexually abused as children normally begin with any pre-offending experiences of having been abused themselves (Ricci & Clayton, 2008; Ricci et al., 2006).
- g. Initial reprocessing sessions reorganize patients' awareness of the impact of the abuse on themselves and increase empathy for victims. After those earlier events have been resolved, reprocessing can be focused on the memories of patients' offenses. At this point, should the reprocessing become stalled and ineffective, you could invite patients to imagine what they would do if in those situations again.
- h. Thus it is always important to consider reprocessing antecedent experiences that may have contributed to deviant behaviors.

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Questions - Comments?

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f. Metaphors, stories, and fables

- i. Fables and fairy tales endure as important forms of literature because they represent succinct expressions of human wisdom in a form that the youngest child can understand and internalize.
- ii. This can be especially helpful when more straightforward interweaves have not worked to restore effective reprocessing.
- iii. It requires sensitivity, creativity, and cultural understanding to select a metaphor, story, or fable that is structured to fit what the patient needs at that moment.

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g. Two other times to consider deliberating stimulating adaptive memory networks

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Assuring generalization of treatment effects

- i. To assure generalization of treatment effects after using the standard question, "*When you bring your attention back to the original experience, what do you notice now*?" before beginning the next set of bilateral stimulation, probe with a brief version of the same type of interweave you used earlier.

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Assuring generalization of treatment effects

- ii. For responsibility you might ask:
  "And who was responsible for what happened that day?"
- iii. Or for choice you could ask,
  "And what would you do now if that happened again?"

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Assuring generalization of treatment effects

- iv. Because this theme had been chronically impaired, probing for the adaptive perspective again when the level of disturbance is low may either reveal

(a) that it has been fully addressed or
(b) that there is a need for further integration of the adaptive perspective.

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Ending on a different plateau

- v. To **support a shift to a new perspective** when time is running out and limited progress has been made over the course of the session.
- vi. If there is a clinical sense that appropriate anger at the perpetrator is close at hand but hidden, an interweave to externalize responsibility can help move the patient from shame and self-blame to an appropriate sense of anger at maltreatment.

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Ending on a different plateau

- vii. On the other hand, if the client seems over-whelmed by feelings of hurt or grief, offering a compassionate interweave before moving to closure can help end the session on a soothing note.
- **"*What would Aunt Rose say to reassure you*?"**
- "She'd hold me and tell me I deserved to be protected and treated with kindness."

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h. Use of previously installed resources as interweaves

- i. Resources installed during the preparation phase can be re-accessed as interweaves during ineffective reprocessing to assist patients in locating adaptive memory networks.
- ii. Previously installed supportive others can offer soothing encouragement or a healthy perspective.
- iii. Previously installed imaginal and symbolic resources, such as "the wise woman," "coyote," or "the hidden spring in the cave," can offer ways to access needed self-capacities contained in other memory networks that merely need a slight reminder to be accessed.

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Questions - Comments?

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Video illustrating use of interweaves

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