Comprehensive Refresher
in EMDR Therapy

Trainer: Jasmine Alexander, PsyD (cand)

Day 4

Training Sessions 2 of 2

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When Processing has Stalled

Blocked processing or "looping" occurs when clients are not "steadily progressing from one plateau to another." (Shapiro, 2018, p. 171)

Looping occurs when clients remain stuck with the same kind of emotions, sensations, images, and so forth for at least two consecutive sets.

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When Processing has Stalled: Strategies for Blocked Processing

- When clients begin looping, clinicians should do the following in this order:

1. Change the mechanics of BLS
2. Check for aspects that might be interfering with reprocessing
3. Check to ensure you are reprocessing the right memory (e.g., feeder)
4. Offer a Cognitive Interweave

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When Processing has Stalled: Strategies for Blocked Processing

1. Change the mechanics of BLS

Shapiro (2018) recommends changing the direction, length, speed, height, or width of the EM or the modality of BLS (e.g., from EM to KS).

"Combinations of changes may prove to have the greatest success" (Shapiro, 2018, p. 173)

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When Processing has Stalled: Strategies for Blocked Processing

2. Check for aspects that might be interfering with reprocessing

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When Processing has Stalled: Strategies for Blocked Processing

2. Check for aspects that might be interfering with reprocessing

i. Blocked defensive action urges (e.g., words, movements)
ii. Unaddressed fears (e.g., secondary gains)
iii. Blocked emotions

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When Processing has Stalled: Strategies for Blocked Processing

Shapiro (2018) states that clients should be encouraged to move their bodies, speak unspoken words during reprocessing, to let their emotions out etc.

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When Processing has Stalled: Strategies for Blocked Processing

If these strategies do not work, ask the client if they have any fears (blocking beliefs):

1. Fear of change
2. Fear of success or failure
3. Fear of the unknown
4. Fear of loss of control
5. Fear of getting better

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When Processing has Stalled: Strategies for Blocked Processing

If clients are blocking their emotions, they can be asked

"What's good about avoiding strong emotions?"

"What's the benefit you get from not feeling…?"

Then add BLS.

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Review - Cognitive Interweaves

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Review - Cognitive Interweaves

- 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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Review - Cognitive Interweaves

"The goal of EMDR treatment is a full integration of the adaptive material"

(Shapiro, 2018, p. 268)

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Review - Cognitive Interweaves

a. Cognitive Interweaves should only be used as a last resort - when needed – and be ***as brief as possible*** to promote staying out of the way (Shapiro, 2018)

b. Shapiro (2018) states that cognitive interweaves lay down "new tracks to link the appropriate neural networks. This linkage is accompanied by stimulating nodes that already exist or by infusing new information into the system" (p. 259)

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Review - Cognitive Interweaves

c. Cognitive interweaves should be utilized with topics of:

1. Responsibility
2. Safety
3. Choice

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Review - Cognitive Interweaves

d. Cognitive Interweaves should also be used "in that order" (Responsibility, Safety, Choice) to "vastly accelerate the treatment of early trauma" when case conceptualization of the use of interweaves suggests otherwise (Shapiro, 2018, p. 260)

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Review – Cognitive Interweaves Three themes in EMDR

e. 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 choice (Shapiro, 2018, p. 256–282).

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Review – Cognitive Interweaves Three themes in EMDR

f. There needs to be congruence with the:

- Theme of the NC
- Theme of the last report during reprocessing

This congruence will determine which Cognitive Interweave to use.

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Recognizing which Interweave to use by theme

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

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Recognizing which Interweave to use by theme

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  - Defectiveness (Shame)
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  - Action (Guilt)
    - ***NC:*** *I should (not) have done something. I should have known better*

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Responsibility Cognitive Interweave Examples

Responsibility (Externalizing)

- For defectiveness / shame

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Responsibility Cognitive Interweave Examples

Responsibility (Externalizing)

i. "Who was responsible for what happened to you that day, the little child or the adult?"

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Responsibility Cognitive Interweave Examples

Responsibility (Externalizing)

ii. "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)?"

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Responsibility Cognitive Interweave Examples

Responsibility (Externalizing)

iii. "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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Responsibility Cognitive Interweave Examples

Responsibility (Externalizing)

vi. "I'm confused. Are you saying that a 4-year-old child can do something and then deserves being beaten?"

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Responsibility Cognitive Interweave Examples

Responsibility (Externalizing)

- Action / guilt

v. "Did anyone ever tell you…..?"

vi. "And why did you do what you did at that time….?"

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Responsibility Cognitive Interweave Examples

Responsibility (Compassionate)

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Responsibility Cognitive Interweave Examples

Responsibility (Compassionate)

i. "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. "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?"

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Safety Cognitive Interweave Examples

Safety

- Perception of danger
  - *NC: I am not safe. I am going to die.*

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Safety Cognitive Interweave Examples

Safety

- i. "Where are you now?"
- ii. "Where are you sitting today?"
- iii. "What happened next?"
- iv. "It's over now. You survived, You're safe."

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Choice Cognitive Interweave Examples

Choices

- Perceived helplessness or lack of choice
  - *NC: I am not in control. I cannot protect myself.*

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Choice Cognitive Interweave Examples

Choices

i. “And what would you do now if that happened again?”

ii. “What was the truth in that situation?”

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Choice Cognitive Interweave Examples

Choices

iii. “When you think about that situation, what would you like to have done?”

iv. “If you could give a voice to the sensation in your _____, what would it say?”

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Recognizing which Interweave to use by theme

g. Once a cognitive interweave is offered, clinicians should include the exact interweave used in their process notes, as well as how the client responded.

h. The same interweave can be used again later in the reprocessing (e.g. after a RoT) to ensure the generalization of treatment effects.

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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.

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Scripted Vignette 1

- The target memory is an incident when the client was 8 or 9 years old witnessing his father assaulting his mother and accusing her of infidelity, while he was too little and weak to stop him.
- **NC**: I am weak. **PC**: I am strong.

Last report: I feel guilty that I couldn't protect my mother.
Interweaves:

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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.

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Scripted Vignette 2

The target memory was the worst episode of rape in which she thought he might kill her and she experienced severe depersonalization.

NC: I am disgusting. **PC**: I am lovable as I am.

Last report: Intense fear and dread, sensations of numbness and disorientation.

Interweaves:

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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.

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Scripted Vignette 3

The target memory is the moment of impact.

NC: I am going to die. **PC**: It's over. I survived.

Last report: High anxiety, with mild hyperventilation and tingling sensations in hands and face.

Interweaves:

_____
_____
_____

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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.

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Scripted Vignette 4

The target memory is a scene from age seven when her mother first revealed her diagnosis to her and reassured her that, "Everything is going to be just fine."

NC: I cannot trust. **PC**: I can trust myself.

Last report: I feel helpless and confused. Even then I knew she was not telling me the truth, but I felt I had to pretend I believed her.

Interweaves:

_____
_____
_____

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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.

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Scripted Vignette 5

The target memory is seeing the burned-out car in which the veteran's older brother (then 18 years old) had died tragically in a fiery car crash. The patient was then 9 years old.

NC: I can't cope. **PC**: I can cope.

Last report: Tears and anger at the older brother for abandoning him.

Interweaves:

_____
_____
_____

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Questions - Comments?

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Other Considerations for Reprocessing

During Phase 4, clients may report "NOTHING" after a set, especially when they are reprocessing for the first time.

The word "NOTHING" can mean a variety of things and clinicians should not take this word literally.

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Other Considerations for Reprocessing

The word NOTHING can mean 6 different things:

1. I don't think I'm doing this right
2. I've lost contact with the material
3. I got distracted

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Other Considerations for Reprocessing

The word NOTHING can mean 6 different things:

4. I don't feel anything in my body
5. I don't know how to put into words what's going on for me
6. My therapist doesn't want to hear what I have to say because it's stupid or insignificant

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Other Considerations for Reprocessing

Therefore, when clients say "NOTHING," clinicians should probe to see what clients ***actually*** mean.

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Other Considerations for Reprocessing

Additionally, there are three types of EMDR reprocessors:

1) Minimal Reprocessors
2) Optimal Reprocessors
3) EMDR All-Stars

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The Three-Pronged Approach

(Leeds, 2016, Shapiro, 2018)

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A. The Three-Pronged Approach

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

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Prong 2

Use the Standard Protocol to directly target:

i. Nightmares
ii. Flashbacks
iii. Triggers
iv. Avoidant behaviors

Should any of these continue to persist **AFTER** the successful reprocessing of the memories that were causing these symptoms in the first place.

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Targeting nightmares

1. Nightmares become targets in the second "prong" (present) of the standard EMDR Therapy–PTSD treatment plan only after identified traumatic experiences have been reprocessed to completion.

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Targeting nightmares – 2 Types

a. **Re-experiencing**: reliving a somewhat realistic narrative of elements of the patient's traumatic memory.

b. **Symbolic** of aspects of the traumatic experience, but with dramatically altered context or participants.

- i. When there is any evidence of ineffective reprocessing of symbolic nightmares, be alert to the need to scan for earlier material—using an affect, somatic, or defensive urge bridge.

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Monitoring intrusions

2. Emotional, somatic, and olfactory intrusions are as common as visual intrusions.

- a. Clinicians should actively solicit patient feedback about all forms of re-experiencing or should use standard assessment tools to reassess for intrusions as treatment progresses.
- b. Reprocess memories that are the source of intrusions.
- c. When explicit context is missing from intrusions, use an affect, somatic, or defensive urge bridge to identify the associated memory.

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Addressing avoidant behaviors

- 3. Avoidant behaviors – procedures for reprocessing recent occurrences of avoidant behaviors are essentially the same as for old memories.
  - a. "What image represents the worst part of the incident?"
  - b. Check whether associated memories have been reprocessed.
  - c. Continue with standard assessment and reprocessing.

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Questions?

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The Three-Pronged Approach

(Leeds, 2016, Shapiro, 2018)

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A. The Three-Pronged Approach

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iv. Most recent	Avoidant Behaviors	
v. Significant people		RDI for New Self-Concept

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The Standard Future Template

1. Standard Future Template:

Overcoming residual ***anticipatory anxiety*** and ***avoidance*** about a future situation that is directly connected to the SYMPTOM.

The "target" is of a situation that has NOT happened, but the client is AFRAID it will. It is an imaginary situation in the future.

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The Standard Future Template

1. Standard Future Template:

The "future situation" is generally very similar to something the client has already dealt with in the past or is currently dealing with.

Examples: Another car accident occurring
The cancer coming back
Another incident of infidelity with a new partner
My father continuing to be rude and disrespectful

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1. The Standard Future Template

a. Slight modifications of the Standard EMDR Protocol procedural steps

b. When the SUD is a 6 or above, consider using an Affect, Somatic, or Defensive Urge Bridge to identify unresolved memories or current stimuli **BEFORE** continuing with the standard future template.

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1. The Standard Future Template

SUD 6 or higher??

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A. The Three-Pronged Approach

1 Past	2 Present	3 Future
i. First	Flashbacks	The Standard Future Template *(overcoming residual anticipatory anxiety and impulses to avoid)*
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iv. Most recent	Avoidant Behaviors	
v. Significant people		RDI for New Self-Concept

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1. The Standard Future Template

c. During Phase 3 or Phase 4, when the SUD is reported as 0, you can invite the client to think of "optional scenarios" to deliberately bring the SUD rating higher (e.g., to increase and felt anxiety / fear about the future). This is done in service of helping the client so if they are ever in a situation like this, they will manage it!

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1. The Standard Future Template

d. Optional scenarios: When the SUD rating is 0, say:

- i. "*Now let's imagine something else happening that would make this situation more challenging*."
- ii. Either the clinician or the client can identify one or more cues that might increase anxiety or avoidance.
- iii. When the client again reports a SUD rating of 0 after optional scenarios have been desensitized, continue to the Installation phase.

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Questions?

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2. The Positive Template

2. The Positive Template: combines mental rehearsal of new skills and adaptive behaviors to potential challenges with bilateral stimulation to improve self-confidence and skills.

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A. The Three-Pronged Approach

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

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2. The Positive Template

- a. Positive Target: After known targets from the past and present have been reprocessed, and after offering any needed psychoeducation or skills building, ask the client to visualize a positive outcome in a **challenging future situation** while using a new or enhanced set of strategies or skills.
- b. For future situations that involve multiple steps these can be separated into a series of Positive Templates.

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2. The Positive Template

- i. During this exercise, negative or challenging aspects to a challenging future situation are meant to come up; however, the client should feel GOOD and POSITIVE about how they are handling the situation.
- ii. It is essential clinicians clarify with clients how they would handle this future situation and ensure that their manner of "handling" the situation is actually adaptive and healthy.

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The Positive Template
Procedures for Positive Visualization

- c. Note: there is no NC in the assessment phase.
- d. Positive Cognition: "When you imagine yourself in that future situation" (or "taking that step"), "what you would like to believe about yourself?"

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The Positive Template
Procedures for Positive Visualization

- e. Positive Visualization: "Imagine exactly the way you would like to think, act and feel in this situation" (or "when taking that step") "from start to finish with as much detail as possible. Let me know when you reach the finish."
- f. Positive Rehearsal: When the client reports a positive rehearsal from start to finish, PROBE to ensure the visualization is actually adaptive. Then, continue to Visualization with Installation of Positive Cognition.

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The Positive Template

Procedures for significant intrusions

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The Positive Template
Procedures for significant intrusions

- i. Negative Intrusions:

If the client reports significant disturbing thoughts, feelings, images or impulses during the first visualization, first consider if they are appropriate, OR, if there is a need for additional psychoeducation or skills building.

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The Positive Template
Procedures for significant intrusions

- ii. Take a SUD on the intrusions
- ii. If the SUD level is 4 or less, consider shifting to the Standard Future Template, and resolve these issues FIRST
- iii. Once the issues are resolved, return to the Positive Template and try again.

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The Positive Template
Procedures for significant intrusions

iv. If the SUD level on the intrusions are a 5 or above, use an Affect, Somatic, or Defensive Urge Bridge (or your case conceptualization) to identify the memories or cues FEEDING the SUD.

v. Reprocess these issues with the Standard EMDR Protocol before returning to the Positive Template.

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The Positive Template

Procedures for minor intrusions

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The Positive Template
Procedures for minor intrusions

- i. For minor disturbing thoughts, feelings, images, or impulses (SUD 1 or 2), welcome these as a "challenge."
- ii. Ask the client to identify one or more previously installed Resources. Access these by repeating their key descriptors.
- iii. Then ask the client to locate the disturbance in the body. Ask the client to notice what they feel while holding the Resource(s) in mind. Then add several shorts sets of BLS.

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The Positive Template
Procedures for minor intrusions

- iv. If the minor disturbance resolves, return to Positive Visualization with the Resource(s) and have the client start over the exercise again using the resources to help them work through the challenges of the situation.
- v. If the intrusions do not resolve, shift to the Standard Future Template.

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The Positive Template
Procedures for minor intrusions

- vi. If it still doesn't resolve, use an Affect, Somatic, or Defensive Urge Bridge to identify unresolved memories or cues. Then, reprocess the memory with the Standard EMDR Protocol before returning to the Positive Template.

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The Positive Template
Procedures for Installation

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The Positive Template
Procedures for Installation

- i. Positive Visualization with Installation of Positive Cognition:

  "In a moment, we will begin the eye movements, taps or tones). Think of those positive words _____" (repeat the PC as an "I" statement) "and again imagine exactly the way you would like to be and act in this situation" (or "when taking that step") "from start to finish with as much detail as possible. Let me know when you reach the finish."

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The Positive Template
Procedures for Installation

- ii. Offer an unlimited number of passes for BLS.
- Offer fast BLS
- iii. Instruct the client to tell you when to stop, or when they are finished.

  iv. Debrief with the client about how the visualization went. You may repeat the exercise a second time if the client wishes to do so.

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Questions?

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RDI to Foster a New Self-Concept

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A. The Three-Pronged Approach

1 Past	2 Present	3 Future
i. First	Flashbacks	The Standard Future Template *(overcoming residual anticipatory anxiety and impulses to avoid)*
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v. Significant people		RDI for New Self-Concept

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RDI to Foster a New Self-concept

1. The last and final step in Prong 3.

   b. RDI for New Self Concept helps clients acknowledge the ***positive and adaptive*** changes they have made and experienced as a result of receiving EMDR Therapy.

   c. This exercise helps clients acknowledge their ***new identity or self-concept*** where they are no longer defined by their "trauma identity."

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RDI to foster a new self-concept

1. Consolidating **a new sense of self**

2. Gather mastery memories **representing treatment gains**

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RDI to foster a new self-concept

3. Unlike RDI in Phase 2, **RDI for New Self-Concept** involves asking the client to think about gains they have experienced ***during their time receiving EMDR Therapy***. (Not anytime in their lifespan).

4. Only mastery memories that have occurred **during the time clients have received EMDR Therapy** should be installed.

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RDI to foster a new self-concept

3. **Only mastery memories that have occurred during the time clients have received EMDR Therapy should be installed.**

- a. Guide clients to identify the gains they have made.
  - i. Clients may have read them aloud from their log entries or personal journals.
  - ii. A written list, a collage, or verbal summary.

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RDI to foster a new self-concept

- b. Each adaptive gain can then be briefly targeted for installation with the image that represents it, a positive self-statement, and any emotions and sensations linked to this experience.

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RDI to foster a new self-concept

c. A few sets of bilateral stimulation can be offered to enhance the associations and access to each adaptive gain. This can be repeated for as many areas as indicated.

d. ***"Realize all installed resources are part of you now." "See and feel them merging into who you are."***

Install with BLS.

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RDI to foster a new self-concept

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Questions - Comments?

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IV. Cultural Humility, Cultural Competence, and Culturally Based Trauma

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A. The Cultural Challenge

•1. Culturally safe practice requires examining one's thoughts and controlling one's responses, especially in situations where biases are often activated (e.g., being stressed, multi-tasking, time constraints, need for closure) (Banaji, 2013)

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A. The Cultural Challenge

•1. "Ridley (2005) cites over 80 studies showing that psychotherapists engage in discrimination during their clinical practice.

•In his review of research on this topic, he discovered that the following clinical decision points were influenced by prejudicial stereotypes:

diagnoses and prognoses	medical therapy
referrals	reporting abuse or neglect
treatment planning	duty to warn
selection of interventions	involuntary commitment
frequency of treatment	importance of case history data
termination	interpreting test data

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A. The Cultural Challenge

•Ridley suggested other clinical behaviors might also be impacted, such as

- seeking consultation,
- developing empathy,
- expressing support,
- advocating for the client, and
- identifying with a client's issues."
- (Nickerson, 2016, pp. 4-5)

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Cultural Humility

•Tervalon and Murray-Garcia (1998) propose that Cultural Humility is a more suitable goal in multicultural medical education

•than traditional notions of "cultural competence" based on "a detached mastery of a theoretically finite body of knowledge."

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Cultural Humility

3. Tervalon and Murray-Garcia's notion of Cultural Humility incorporates

a. a lifelong commitment to self-evaluation and self-critique that includes qualities of humility

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Cultural Humility

3. Tervalon and Murray-Garcia's notion of Cultural Humility incorporates:

c. to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with people and groups who advocate for others.

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B. Building a strong cross-cultural therapeutic alliance can involve

- selective self-disclosures related to the clinician's cultural, linguistic, health, gender, or spiritual backgrounds and
- an exploration of the client's "Community Cultural Wealth Resources (CCWR) before attempting to gather sensitive history from the client." (Levis and Siniego, 2016, p. 82).

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"Community Cultural Wealth Resources" (CCWR)

1. Levis defines eight forms of CCWR (2016, p. 101) culturally attuned clinicians consider exploring in Phase 2 before Phase 1.
2. CCWR include aspirational, linguistic, familial, social, navigational, resistant capital, spiritual capital and cultural intuition.
3. Levis and Siniego (2016, p 81) offer examples of CCWR including Latino "familismo" "(loyalty, reciprocity, and feelings of community toward members of extended family—including close friends—that incorporates the notion of the family as an extension of self."

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"Community Cultural Wealth Resources" (CCWR)

4. Levis (2016, p. 101) explains:

"The acknowledgment and installation of the client's invisible and undervalued resources restores the client to a more empowered version of himself. This, in turn strengthens the therapeutic alliance, creating a healthy foundation for the desensitization and reprocessing of trauma."

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C. Acknowledgement & Installation of Spiritual Capital (Levis, 2016, p. 107)

•1. "From an existential perspective, [Spiritual Capital] is the ability to make meaning of our difficulties, pain, suffering, and trauma, which allows us to transform it into healing (Duran, 2006).

•Thus, spirituality and a connection to a reality greater than oneself serve as valuable resources for many culturally diverse individuals."

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C. Acknowledgement & Installation of Spiritual Capital (Levis, 2016, p. 107)

2. "A culturally attuned therapist can play an important role in validating a client's spiritual practice by installing it as a resource during the Preparation phase. This may provide the needed safety for the client to reveal important targets related to repeated instances of harassment, name-calling, racist, or discriminatory attacks on the client and others close to him or her."

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C. Acknowledgement & Installation of Spiritual Capital (Levis, 2016, p. 107)

3. "… acknowledgment of [and installation of] CCWR may serve to uncover targets that were invisible to either the clinician or the client, or both."

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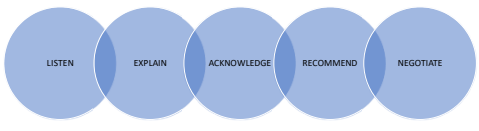
D. LEARN Model



•The LEARN Model is a strength based approach to battle the dominant narrative often inherent in Westernized treatment

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E. EMDR treatment of culturally-based trauma

•For an exploration of cultural and racial issues in the EMDR treatment of culturally based trauma Nickerson's 2016 edited book includes a range of helpful chapters including:

•1. Chang (2016). EMDR Therapy as Affirmative Care for Transgender and Gender Nonconforming Clients.

•2. Heber & Alter-Reid (2016). The Transgenerational Impact of Anti-Semitism.

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D. EMDR treatment of culturally-based trauma

•3. Levis (2016). Placing Culture at the Heart of EMDR Therapy.

•4. Levis & Siniego (2016). An Integrative Approach to EMDR Therapy as an Antioppression Endeavor.

•5. Nickerson (2016). Cultural Competence and EMDR Therapy.

•6. Nickerson (2016). Healing Culturally Based Trauma and Exploring Social Identities with EMDR Therapy.

•7. O'Brien (2016). EMDR Therapy with Lesbian/Gay/Bisexual Clients.

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E. Online Anti-Racism bibliographies and resources

•1. EMDRIA Antiracism Resources for adults, talking with children and teens and for mental health professionals.

- •a. https://www.emdria.org/publications-resources/practice-resources/antiracism-resources/

•2. EMDR & Racial Trauma special issue of *go with that* magazine Fall 2020 Vol 25 #3 "We Need a Change".

- •a. https://bit.ly/3ke6tGD

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E. Online Anti-Racism bibliographies and resources

- 3. From Ken Pope Anti-Racism & Racism Psychology: 57 Articles & Books—Cites + Summaries
  - a. https://kspope.com/ethics/anti-racism.php
- 4. Anti-Racism Resources compiled by Sarah Sophie Flicker and Alyssa Klein in May 2020. Articles, books, podcasts, videos, films and TV series, organizations to follow on Twitter and other lists of resources
  - a. bit.ly/ANTIRACISMRESOURCES

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Improving Cultural Competence from SAMHSA

- F. Free "Improving Cultural Competence" Substance Abuse and Mental Health Services Administration (US); 2014. Report No.: (SMA) 14-4849
- https://www.ncbi.nlm.nih.gov/books/NBK248428/

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G. A concise list of books on Anti-Racism and cultural competence

- 1. Brown, L. S. (2008). Cultural Competence in Trauma Therapy. Amer Psychological Association
- 2. DiAngelo, R. J. (2018). White Fragility. Beacon Press.
- 3. Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). Cultural Humility. American Psychological Association.
- 4. Kendi, I. X. (2016). Stamped from the Beginning. Bold Type Books.

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G. A concise list of books on Anti-Racism and cultural competence

•5. Saad, L. F. (2020). Me and White Supremacy. Sourcebooks, Inc.

•6. Singh, A. A. (2019). The Racial Healing Handbook. New Harbinger Publications

•7. Sue, D. W. (2010). Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation. Germany: Wiley.

•8. Sperry, L. (2011). Core competencies in counseling and psychotherapy: Becoming a highly competent and effective therapist. New York, NY: Routledge.

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H. Free Video Resources

•1. Smithsonian National Museum of African American History and Culture

- •a. https://nmaahc.si.edu/learn/talking-about-race
- •b. https://nmaahc.si.edu/learn/talking-about-race/resources

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Shapiro (2018) states:

EMDR Therapy cannot be effective in the absence of clinical skills.

EMDR dovetails the clinical skill set of the clinician.

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Questions - Comments?

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V. Ongoing continuing education in EMDR Therapy and Consultation

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V. Ongoing continuing education in EMDR Therapy and consultation

- A. Basic training in EMDR Therapy begins but does not complete your professional development in EMDR Therapy. Professional and ethical standards call for continuing education and consultation in areas of specialty practice.
- 1. Advanced workshops for working with specific populations.
- 2. Journal articles and books on evolving research on mechanisms and clinical applications.

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3. Consultation with EMDRIA Approved Consultants to refine understanding and skills.

- a. Consultation is essential

i. To reduce "continental drift" –gradual decreases in fidelity and misunderstandings about essential concepts and principles.

ii. To learn to safely and effectively meet the needs of clients with complex presentations that require specialized experience and training.

iii. To earn hours and advance toward EMDRIA Certification.

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VI. Systems issues

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A. Insurance reimbursement and acceptance by agency clinical directors.

- 1. EMDRIA can provide information and assistance in educating medical and clinical directors to obtain support for the use of EMDR Therapy in independent and organized clinical settings.

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B. Adjunctive use of EMDR Therapy

1. Referrals tend to work out better when you have a well-established relationship with the referring clinician.

2. There can be issues where your diagnosis and case formulation turn out to be substantially different than the referring clinician's.

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B. Adjunctive use of EMDR

- 3. Some cases are more suitable for brief adjunctive treatment such as a specific phobia that had a clear traumatic onset in a case otherwise free of complex trauma or structural dissociation.
- 4. Cases with a complex trauma history, long-term relational trauma, significant borderline personality disorder features, or structural dissociation are generally more appropriately addressed as a regular referral, rather than attempting adjunctive treatment.

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C. EMDRIA member code of conduct

- 1. Members are required to observe the professional and ethical standards of their respective clinical professions and to be in good standing with the professional organization with which they are affiliated and with their regulatory board.
- 2. To maintain the integrity of EMDR Therapy and assure patient welfare, only clinicians who meet EMDRIA standards (as an Approved Consultant) and have obtained EMDRIA approval should offer basic training in EMDR Therapy.
- 3. Only those who have completed an EMDRIA approved basic training in EMDR are eligible for full clinical membership in EMDRIA and to become EMDRIA Certified and Approved Consultant.

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D. The open door

1. Ideally treatment comes to an orderly close with discussion and review of the treatment process, gains, possible future issues, and scheduling of any follow-up visits or post-treatment assessment.

2. Other times, clients may abruptly decide they no longer need further treatment even when the clinician may think otherwise.

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D. The open door

a. Financial crises, a change in insurance coverage, or having to relocate or spend time away from home for an ill family member.

b. Clients may also feel significantly better after just a few sessions that they may prematurely terminate therapy.

3. I let my clients know my door will always be open to them. I want patients to know they can discontinue treatment and resume when indicated rather than to try to keep clients in long-term psychotherapy when that is not wanted, needed, or possible.

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Questions - Comments?

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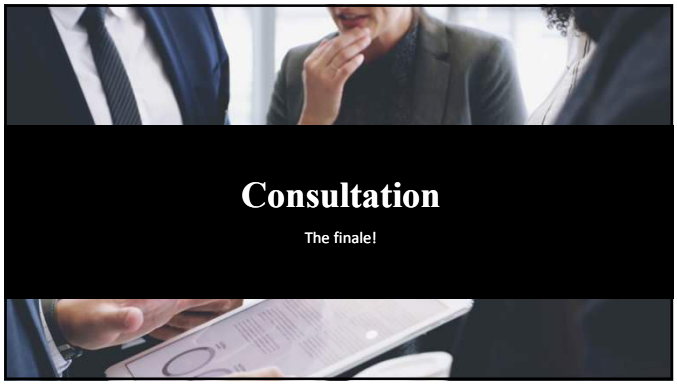

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