

# COMPASSIONWORKS EMDR THERAPIST TRAINING

**EMDRIA Approved EMDR Therapy Training**

Developed by  
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Rev. 01/2018

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**WELCOME**

Trainer and Consultant

Training Support

Housekeeping

- 6-Day Training Structure: 40/10/10
- Cameras must be turned on
- Lunch, Day 3—working lunch
- Training Manual—Handouts; [CompassionWorks.com](http://CompassionWorks.com)

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**ADDITIONAL  
SUPPORT**

- Facebook group:
- CompassionWorks EMDR Therapists
- Private group to ask questions, share resources, referrals
- Geomap of CompassionWorks EMDR Therapists

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**TRAINING  
GUIDELINES**

Use the "parking lot (zoom chat box)" for questions that may be off the current topic being discussed

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Questions about clients are best when they're general in nature

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Make sure you are in a private setting during the demo and practicum

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For issues related to training, including practicum, contact Jordan or the trainer directly

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**EMDR THERAPY  
TRAINING  
REQUIREMENT**

- Attend and participate the 6 days of training
- Complete the entire training within 12 months
- Participate in 2-hour group consultations
- Practice after weekend 1 with actual clients
- Complete assigned reading
- Pass the exam with a score of 70 or above
- EMDR Trained at the end of the training

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**EMDR THERAPY  
TRAINING  
REQUIREMENT**

**Text Recommended Reading Schedule:**

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Day 1                      Chapters 1&2

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Day 2                      Chapter 3

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Between Day 3 & 4    Chapters 4-8

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Day 4                      Chapter 9

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Day 5                      Chapter 10

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Day 6                      Chapter 11&12

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Required reading

1. Shapiro, F. (2018). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols and Procedures* (3rd ed.). New York, NY: The Guilford Press
2. [See Sarah Thores-McIntyre's EMDR 2020 Webinar Series 3: EMDR's 8 Essential Elements](#)
3. [Guidelines for Virtual EMDR Therapy \(Spring 2020\)](#)

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**INTRODUCTION**

- Consider being a volunteer for the demos
- Remember we're working in emotional space
- Find something to work on in practicum:
  - Pick an issue/event of a 7 or less, from 0-10
  - If you have a childhood trauma history, let us know if you need assistance with selecting an issue/event to process
  - Review target selection for practicum
- You may become teary, tired or even exhausted for up to 72 hours after processing or after the training
- Honor confidentiality and maintain cultural awareness

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**INTRODUCTION**

All the trainers at CompassionWorks strive to be DEI conscious.

- We want to provide a safe and professional environment.
- We acknowledge that as humans we cannot fully understand or appreciate others' experiences from different backgrounds.
- We are open to talking about these topics and welcome the opportunity to grow and collaborate in this area.
- Feedback and discussion on these topics is welcome throughout the training.

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**GOALS FOR THIS WEEKEND**

- To summarize overview of traumatology and neurobiology of trauma
- To integrate and apply EMDR therapy to psychotherapy
- To practice the basic EMDR standard protocol to feel competent
- To apply EMDR therapy with appropriate existing and new clients

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**DAY ONE GOALS**

- Review the development of EMDR therapy
- Describe the current inclusion of EMDR therapy in treatment guidelines
- Identify and explain the concepts of the AIP model
- Compare and contrast EMDR therapy from other psychotherapy approaches
- Observe EMDR demo/video

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**DAY TWO GOALS**

The standard of EMDR therapy:

- Eight phase treatment procedure
- 3-pronged approach
- Safeguards to client readiness

Supervised practicum

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**DAY THREE GOALS**

Review the AIP model, 8-phases of EMDR therapy, and the 3-pronged approach

Supervised practicum

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**INTRODUCTIONS**

Name and practice setting/  
experience

What's **One Thing** you  
would most like to gain  
from this training?

One minor  
frustration/annoyance

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**EMDR: HOW IT ALL BEGAN**

- Francine Shapiro developed EMDR therapy
- A walk in the park in 1987
- From noticing to teaching
- Shapiro's 1989 pilot study, *Efficacy of the Eye Movement Desensitization Procedure in the Treatment of Traumatic Memories*, was the first randomized controlled study published in the *Journal of Traumatic Stress*. She examined one-session effects with 22 traumatized individuals.

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**FROM EMD (1987) TO EMDR (1990)**

- EMD – Behavioral model of desensitization
- From desensitization model to Adaptive Information Processing (AIP) model
- Cognitive restructuring of the perceptions regarding the traumatic event
- Changes in anxiety and fear is a *byproduct* of comprehensively reprocessing the pathogenic memory (adaptive processing)
- The AIP model explains generalization of treatment effects to other memories

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**CURRENT INCLUSION IN TREATMENT GUIDELINES**

- The American Psychiatric Association Practice Guidelines (2004) for treatment of patients with Acute Stress Disorder and PTSD includes EMDR therapy as an effective treatment
- The World Health Organization (WHO; 2013) included EMDR therapy as recommended for children, adolescents and adults with PTSD
- The American Psychology Association (2017) has approved EMDR therapy for treating civilian trauma
- The International Society for Traumatic Stress Studies (ITSS; 2018) designated EMDR therapy as an effective treatment for PTSD
- The UK's National Institute for Clinical Excellence (2018) now requires clinics that provide PTSD services to offer clients both trauma focused CBT and EMDR therapy

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**EMDR THERAPY RESEARCH**

- More than 30 randomized controlled studies have been conducted on EMDR therapy (de Jongh et al., 2019).
- Some of the studies show that 84%-90% of single-trauma victims no longer have post-traumatic stress disorder after only three 90-minute sessions.
- 100% of the single-trauma victims and 80% of multiple trauma victims no longer were diagnosed with PTSD after only six 50-minute sessions (Marcus et al., 1997).

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**EMDR THERAPY RESEARCH**

- 77% of combat veterans were free of PTSD in 12 sessions, and effects for all were maintained at follow-up (Carlson et al., 1998).
- Both EMDR therapy and CBT produced significant reduction in PTSD and behavior problems.
- EMDR therapy was significantly more efficient, using approximately half the number of sessions to achieve results (Jabaghaderi et al., 2004; Mavrouzi et al., 2020; Starbuck et al., 2020).
- EMDR therapy is effective with children and individuals with NDD (Beron et al., 2019; Beer, 2018; Karatzis et al., 2018; Sopina et al., 2020).
- Preliminary findings indicate that virtual EMDR therapy is effective (Farrell et al., 2023; Fisher, 2021; Liou et al., 2022; Rosser et al., 2023).

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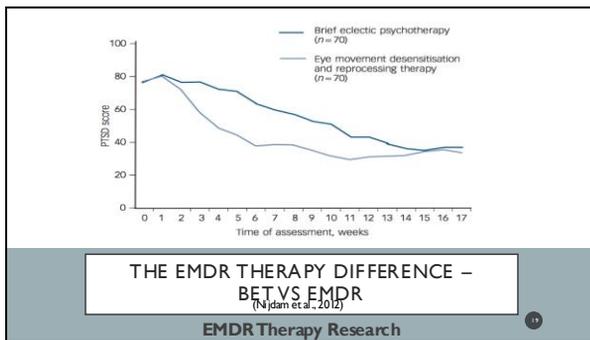
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**CURRENT EMDR THERAPY-RELATED RESEARCH AND TRAUMA**

- EMDR Publications & Resources • <https://www.emdrria.org/publications-resources/>
- Journal of EMDR Practice and Research • <https://connect.springerpub.com/content/sgremdr>
- International Society for the Study of Trauma and Dissociation • <https://www.istd.org/resources/dissociation-faq/>
- Trauma • [www.trauma-pages.com](http://www.trauma-pages.com)
- EMDR Foundation • <https://emdrfoundation.org/resources/lookit/>

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**ADAPTIVE INFORMATION PROCESSING (AIP) MODEL CONCEPTS**

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### TRAUMA EVENTS

- “Big T” trauma—A traumatic event that precipitates PTSD, e.g.,:
  - The person experienced, witnessed, or was confronted with a life-threatening event
  - The person’s response involved intense fear, helplessness or horror
  - Event examples: hurricane, rape, sexual molestation, car accident, combat experience, etc.

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### TRAUMA EVENTS

- A “small t” trauma—Ubiquitous events that are rampant throughout childhood, for example:
  - Repeated violations such as neglect, verbal abuse, emotional abuse
  - Regular intrusion and violation such as bullying, stalking, harassment
  - Vicarious trauma (from news [especially if work related], witnessing abuse or listening to client’s abuse as a therapist)
  - General life events such as relationship problems, work/school issues
- In either case, there is a long-lasting negative effect upon self and psyche

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### SYMPTOMS OF TRAUMATIC STRESS

- Traumatic stress symptoms impair social, occupational, health, relational, and other areas of functioning. Examples of symptoms:
  - Hyper-vigilance or hypo-vigilance
  - Exaggerated startle response
  - Flashbacks
  - Nightmares; Night terrors
  - Sleep disturbance
  - Irritability
  - Agitated behavior
  - Anxiety and/or depression

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**MANIFESTATIONS OF PTSD**

- The point is:

Many life experiences, both big T and little t, manifest the symptoms of traumatic stress and the symptoms are intrusive, recurrent, and involuntary.

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**TRAUMA Elements**



**T** = TRIGGERS ARE A THREAT  
**R** = REACTIVE RESPONSES  
**A** = ALIENATION ≠ ISOLATION  
**U** = UNSAFE ≠ UNCERTAIN  
**M** = MEMORY DISTORTION, FRAGMENTED PIECES  
**A** = AUTONOMIC NERVOUS SYSTEM DYSREGULATION

**TRAUMATIC STRESS RESPONSE: SUMMARY**

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**THE ADAPTIVE INFORMATION PROCESSING (AIP) MODEL**

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**ADAPTIVE  
INFORMATION  
PROCESSING  
(AIP) MODEL:  
MEMORY  
CONCEPTS**

- Memories are in two forms (Tulving, 2002).
- **Implicit** (non declarative) Memory System:
  - Link somatic, perceptual and behavioral elements
  - Memories that surprise us with their emotional charge when triggered
  - Highly rigid and tightly connected to the original stimulus
  - Relies on brain structures present from birth



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**ADAPTIVE INFORMATION PROCESSING  
(AIP) MODEL: MEMORY CONCEPTS**

Memories are in two forms (Tulving, 2002) cont'd.

- **Explicit** (declarative) Memory System:
  - Links factual (semantic) or autobiographical (episodic) elements of memory
  - Memories that have sensation, emotion, and association to time or place
  - These memories are highly flexible and associative
  - Relies on brain structures developed around age 3, for example, based on the development of the medial temporal lobe and orbitofrontal cortex



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**ADAPTIVE  
INFORMATION  
PROCESSING  
(AIP) MODEL:  
MEMORY  
CONCEPTS**

- **Memory and Trauma** (Siegel, 2010 & 2018):
  - Adrenaline increases implicit memory encoding
  - While excessive cortisol levels decrease memory consolidation to explicit memory
  - That is, associations between events, episodic memories, have not been extracted, generalized, to the semantic memory networks (explicit memory system);
  - And dissociation blocks memory consolidation



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**ADAPTIVE INFORMATION PROCESSING (AIP) MODEL: MEMORY CONCEPTS**

In General:

Memories are linked in networks that link related thoughts, images, emotions, and sensations.

Memories are linked in **associative memory networks** and are the basis of perception, attitude and behavior.

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**ADAPTIVE INFORMATION PROCESSING (AIP) MODEL**

As time passes, these neural networks start to generalize to other parts of the person's life, and new experiences are influenced by the past experiences, linked to the appropriate emotions and accessible for the person to utilize in the future.

Under normal circumstances, this information processing may occur during thinking, talking, expressive/artistic activities, and/or dreaming.

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**ADAPTIVE INFORMATION PROCESSING (AIP) MODEL**

- The brain's information processing system naturally moves toward mental health. That is, the neurobiological information processing system is intrinsic, physical, and adaptive:
- Learning occurs when new associations are forged with material already linked in memory—Generalized to all associated structures
- Geared to integrate internal and external experiences
- Experiences translate into biophysically linked memories



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ADAPTIVE  
INFORMATION  
PROCESSING  
(AIP) MODEL

Therefore, linked memory experiences contribute to pathology and health.

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However, trauma causes disruption of normal adaptive information processing, that is, inadequately processed information is linked in memory networks, and trauma memories become **associative and accumulative over time**.

For example, if the memory has high levels of disturbance, the information is linked in the implicit memory system, where it links the perspectives, affects, and sensations of the event. In this disturbed form, the high charge does not allow the memory system to connect with the adaptive memory network because the amygdala is overriding the prefrontal cortex.

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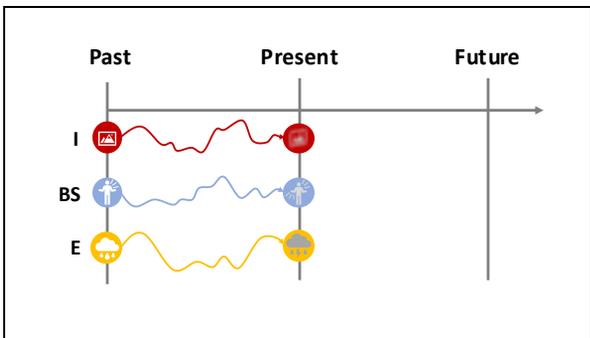
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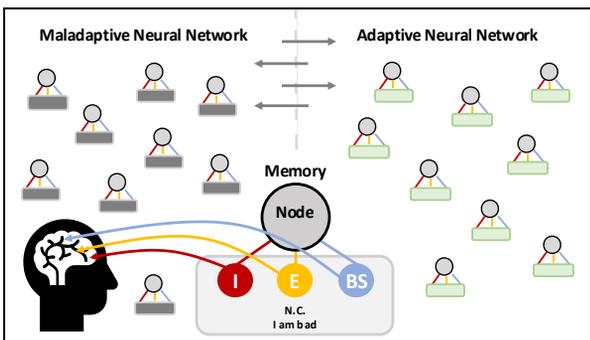
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**ADAPTIVE INFORMATION PROCESSING (AIP) MODEL**

**In conclusion:**

Maladaptive memory networks link perspectives, affects, and sensations of the disturbing event and are linked in such a way that does not allow connection with the adaptive information networks

Similar experiences occur and link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise

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**ADAPTIVE INFORMATION PROCESSING (AIP) MODEL**

- However, as information processing occurs while using dual attention bilateral stimulation, it facilitates linkage to the adaptive memory networks and it transforms all the aspects of the memory, integrating the previous isolated memory network to the entire memory system, resulting in memory reconsolidation.
- The expanding network reinforce adaptive (positive) information, and resources, as memories become accessible to the individual.

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**ADAPTIVE INFORMATION PROCESSING (AIP) MODEL**

**In summary:**

- During information processing the non-adaptive perceptions, affects, and sensations lose charge (neuronal activation)
- As processing occurs, a shift from implicit or nondeclarative memory to explicit or declarative memory occurs
- Processing causes an adaptive shift in all components of the memory, including sense of time and space, age, symptoms, reactive behaviors, and sense of self

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**CLINICAL IMPLICATIONS OF THE AIP MODEL**

Thus, based on the AIP model, clients seek counseling for one of three reasons:

1. Organically based—they have brain dysfunction, hip joint problems, etc.,
2. Inadequate information—they need education, for example, about the effects of trauma, parenting, any lack of information, etc.,
3. Maladaptive neural networks—they have unprocessed memories

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**CLINICAL IMPLICATIONS OF THE AIP MODEL**

Therefore, clients with non-PTSD issues can be treated with EMDR therapy. However, different situations/diagnoses might require specialized EMDR protocols. All protocols incorporate the 3-pronged approach, past-present-future.

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**TOUCHSTONE  
EVENT**

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**TOUCHSTONE  
EVENT**

Memories are composed of linked information: Images, thoughts, sensations

This information may be "frozen" - Dysfunctionally linked and unchanged in the memory system

This information is the encoded experience of earlier *T* or *t* traumas linked to the presenting problem

The earliest event is termed a "touchstone" memory or event

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**AFFECT SCAN**

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**CONTAINER EXERCISE**

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**CONTAINER EXERCISE**

- Containment
  - Image of container
  - Gather disturbing images, thoughts, emotions, body sensations
  - Put in the container
  - Close container and put it away

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**LUNCH**

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**CLINICAL IMPLICATIONS OF THE AIP MODEL: MEDICATION**

The AIP model posits that pathologies are represented by dysfunctional information physiologically linked and that can be accessed and transformed directly, without the use of medication.

Therefore, EMDR therapy focuses on the *pathogenic memory* itself.

However, if medication was in use while a target was reprocessed and medication was later reduced or stopped, then reprocess the memory to make sure it is fully cleared.

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**EMDR  
THERAPY**

EMDR therapy is used to address the experiences that contribute to clinical problems and health

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The difference in EMDR therapy is that the bilateral dual attention stimulus method (e.g., EMs, taps or tones) activates the information processing system—that's how the maladaptive information is processed, and the block is removed

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Another perspective in understanding the process is by the adage that, "Neurons that fire together, wire together" (Hebb, 1949).

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**THREE-  
PRONGED  
PROTOCOL**

The goal of treatment is to process maladaptive memories and incorporate new adaptive ones.

**Past:** What memories set the foundation for the pathology? These memories are reprocessed.

**Present:** What situations trigger or stimulate the disturbance? These triggers are desensitized.

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**THREE-  
PRONGED  
PROTOCOL**

- **Future:** What skills, behaviors (actions), information are necessary for optimal functioning in the future?
- Once memories are reprocessed and triggers are desensitized, future adaptive outcomes are explored for related challenges
- Timing, client stability, and readiness predicates the focus of the prong, for example, the focus might be on stabilizing the client or setting future positive templates—Clinical judgement precedes which prong to address first

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**EMDR STANDARD PROTOCOL DEMO/VIDEO**

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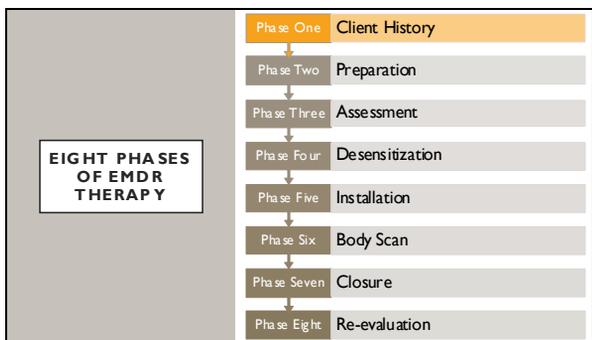
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**PHASE ONE: HISTORY TAKING**

**Broadening Statement:**

- "I want to start off by acknowledging that I am a [name identities.....] therapist."
- "I want you to know the trauma work we are starting and will be doing together is going to bring up possible concerns, fears, challenges, and a need for validation/recognition of your lived experiences."
- "I recognize that because of the differences in our social location (name specifically your identities, intersectionality, power/privilege) discomfort, ignorance, my implicit biases or lack of understanding will come up in our work together."
- "As such, I would like for you to know I am able and willing to discuss/explore these barriers with you during therapy."
- "Please know I will not take it personally if you at any time feel uncomfortable and would like to address how I am showing up in the space where I may be activating you based on who I am."

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**PHASE ONE: HISTORY TAKING**

- Client Readiness
- Level of rapport with therapist
- Affect tolerance and regulation
- Life stability
- Suicidal/homicidal assessment
- Support system
- General physical health
- Medications, drugs, alcohol

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**PHASE ONE: HISTORY TAKING**

- Client Readiness
- Systems issues, secondary gains
- Timing considerations
- Legal requirements
- Dissociation (Dissociative Experiences Scale)
- Divide the total by 28
  - If less than 30, do phase 4 (desensitization)
  - If more than 30, not EMDR ready for phase 4—Work on stabilization (phase 2-Preparation)

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**PHASE ONE: HISTORY TAKING**

- Client Intake:
  - Use standard intake process
- Focus on trauma history
  - Genograms and trauma timelines
- Presenting problem and symptoms
  - Listen for images, negative cognitions (trauma created core beliefs), body sensations

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**PHASE ONE: TREATMENT PLANNING  
THREE-PRONGED APPROACH**

Maladaptive life experiences get carried forward

A horizontal timeline with three vertical tick marks labeled 'Past', 'Present', and 'Future'. The 'Past' tick mark has three horizontal lines extending to the left, representing past events.

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**PHASE ONE:  
TREATMENT  
PLANNING**

Use clinical judgment in choosing a comprehensive treatment plan

Psycho-education	Problem-solving	Stress management tools
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Some clients need strengthening of internal and external resources before processing a traumatic event.

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**PHASE ONE:  
TREATMENT PLANNING  
THREE-PRONGED  
APPROACH**

Three-Pronged Approach to Identify Targets:

- Past: First stage
- Touchstone event
- Present: Second stage
- Current symptoms or triggers
- Future: Final stage
- Adaptive alternatives for the future

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**PHASE ONE:  
TREATMENT PLANNING-  
IDENTIFYING  
EMDR TARGETS**

**Past traumatic issues:**

- Top ten list (10 worst incidents)
- Sequences of abuse or mistreatment

**Touchstone Event**

**Single Incidents**

**Identify: first, worst, and most recent**

- If possible, always start with first or worst

**Repetitive similar incidents (clusters)**

- Find an event that represents the cluster

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**PHASE ONE:  
TREATMENT PLANNING-  
IDENTIFYING  
EMDR TARGETS**

- Targets with no clear memory of a trauma or disturbing life event:
  - Target the dysfunction (reaction, behavior, etc.)
  - Target the negative cognitions or beliefs
  - Target emotions
  - Target body sensations

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**PHASE ONE: CASE  
CONCEPTUALIZATION  
AND  
CLIENT READINESS**

- Screen for dissociation, including DID
- Assess etiology of psychosis or organic issues
- Consult M.D. for organic issues based on loss of consciousness during event or other physical issues
- Assess danger to self or others
- Assess any current crisis or situation needing an action plan
- Check on the client's ability to use some method to change states
- Check on the client's ability to maintain contact with therapist and sensation during bilateral stimulation sets
- "Truth-telling" agreement or ability

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**PHASE ONE:  
TARGET SEQUENCE PLAN**

- Group breakout session
- Select a client from your own practice
- Then, develop a target sequence plan for this client (use the worksheet provided)

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**PHASE ONE:  
TARGET SEQUENCE PLAN FOR  
COMPLEX CASES**

- **Themes** are formed based on childhood events or the adverse childhood experience questionnaire (ACE)
- **Cluster** different kinds of traumatic incidents (similar events)
- Components of memory, for example, negative affect, negative cognition, etc.
- Preparation phase: Begin with training on affect regulation, which includes resource development and installation, as well as positive affect tolerance

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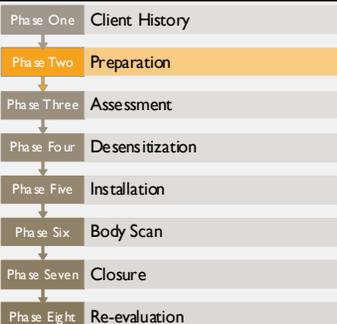
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**EIGHT PHASES  
OF EMDR  
THERAPY**




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**PHASE TWO: PREPARATION**

- Consider psychological first aid
- Appropriate therapeutic relationship
  - Client-centered approach; client empowerment
  - Therapist attunement to facilitate bonding
- Sufficient trust for client honesty about his/her experience
- Address client's fears or concerns about EMDR

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**PHASE TWO: PREPARATION**

- Introduce EMDR therapy to clients
  - EMDR background
  - Research supporting EMDR
- Cautions for clients with strong emotions—remind them is like going through the tunnel
- BLS setup—EMS, taps, or tones, and speed
- Metaphor for EMDR processing (train)
- Set EMDR therapy expectations

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**PHASE TWO: PREPARATION**

- Emotional Regulation
  - Dual Attention Awareness
    - One foot in the present, one in the past
  - The "Stop Sign"
    - "Remember to raise your hand anytime you want to stop"
- Safety: Suicidal ideation, psychotic features, bipolar; getting more dysregulated
- Stabilization: Stress management, grounding strategies
- Symptom reduction: Anxiety management, blocking strategies

(Cloitre, et al, 2011; Ford et al, 2016)

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**MANAGE  
EMOTIONAL REGULATION**

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Imaginary line from the back of the head to 12-14 inches in front of the face

- The back of the head symbolizes being in the memory (dissociated)
- The hand 12-14 inches from the face symbolizes being fully present

**NOTE:** In processing, it's important for the client to remain within the space between the nose and the fingers for dual attention.

**BACK OF HEAD SCALE**



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**Window of Tolerance** (Ogden et al., 2006)

Hyperarousal Zone	Increased sensation Emotional reactivity Hypervigilance Intrusive imagery Disorganized cognitive processing
	
Hypoarousal Zone	Relative absence of sensation Numbing of emotions Disabled cognitive processing Reduced physical movement

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**PHASE TWO:  
PREPARATION**

- Stabilization Strategies:
  - Containment
  - Reverse Spiral Technique
  - Light Stream Technique
  - Safe/Calm Place Exercise
  - Resource Development and Installation
  - Positive Affect Tolerance

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**PHASE TWO: PREPARATION**

- BLS/DAS Setup Demo:
  - Distance from client, 12-14 inches in front of client's eyes and sitting side by side
  - EMs, side-to-side or diagonally across
  - Taps
  - Tones
  - Speed/duration:
    - Safe/Calm Place, slow 4-8 passes; Processing phases (4-6), fast 24-36 passes
  - Jim Krnje (2015) Back of the Head Scale: How present are you?

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**PHASE TWO: PREPARATION**



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**VIRTUAL  
EMDR  
THERAPY**

**Attunement**

- Resourcing
- Affect regulation
- Verify client's local emergency information

**Dual Attention Stimulus**

- EMs - eyes move side to side across midline
- Tapping - butterfly hug or side of the knees

**Desensitization**

- Start with Target with the lowest SUD level
- Go back to Original Incident more often, approximately after 5 sets

**Platforms**

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**PHASE TWO:  
PREPARATION**

**Safe/Calm Place Exercise**

- Is a state change exercise
- Is administered prior to using EMDR standard protocol
- It helps calm the system
- It gives a place to go, if client becomes dysregulated or abreacts
- Sets are slow and short, **4-8 passes.**
- Choose minor annoyance (SUD 1-2).

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**PHASE TWO:  
PREPARATION**

**Safe/Calm Place Exercise**

**Instructions:**

- "Close your eyes and imagine a scene that is very calm and safe. It may be a beach, a country scene, or any place that you feel safe or comfortable."
- "Describe for me this place and what you're experiencing. Please include what you see, smell, hear, and how your body feels."
- "Now notice where you feel those pleasant sensations in your body and follow my fingers."
- "What do you notice now?" If pleasant, say, "continue noticing that." Repeat until there is no more positive change.

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**PHASE TWO: PREPARATION**

**Safe/Calm Place Exercise**

**Instructions:**

- "What word goes best with your experience right now?"
- "Now repeat that word in your mind as you imagine your safe/calm place and follow my fingers."
- "Now, I want you to bring up that image and say your word to yourself and notice what you feel without eye movement."
- "What do you notice now?" If negative, return to strengthening the safe/calm place.

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**PHASE TWO: PREPARATION**

**Safe/Calm Place Exercise**

**Instructions:**

- If positive, continue with:
- "Think of a minor annoyance and notice how you feel."
- "Now think of the word and imagine your safe/calm place."
- "What do you notice now?"

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**LIGHT STREAM**

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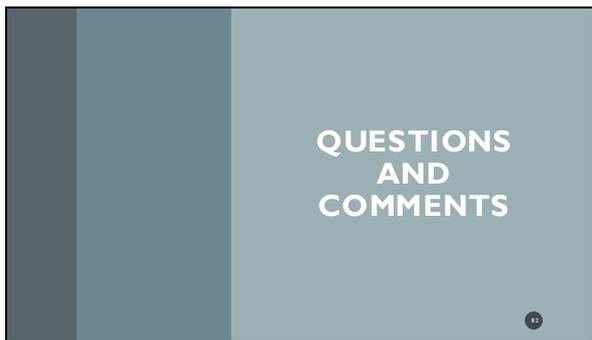
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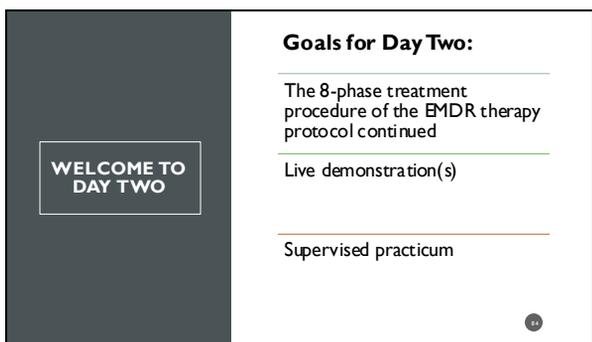
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**PHASE TWO: PREPARATION**

**DEMO**

- Reminder: Make sure you are in a private setting during the demo and practicum
- Safe/Calm Place

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**PHASE TWO: PREPARATION**

**Safe/Calm Place Practicum**

Break into pairs and practice the Safe/calm place exercise

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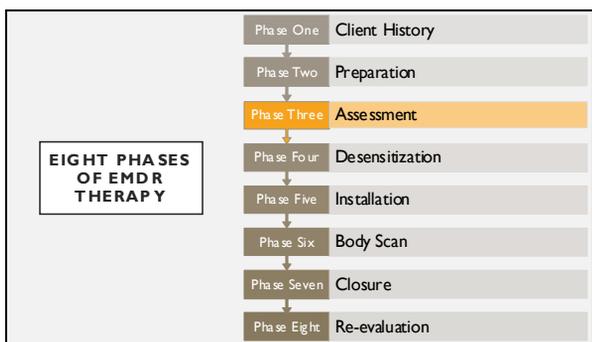
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PHASE THREE: ASSESSMENT  
(AKA - TARGET FORMATION)

- Original Incident
- Referred to as: Incident, Target or Memory
- “The issue we have agreed to work on today is...”
- “What happens when you think of the incident?” or “When you think of the incident, what do you get?”

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PHASE THREE: ASSESSMENT  
(AKA - TARGET FORMATION)

- Image
- “What picture represents the worst part of the experience as you think about it now?”
- Or
- “What picture best represents the experience to you?”
- Or
- “When you think of the incident, what comes to mind?”

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PHASE THREE:  
ASSESSMENT  
(AKA - TARGET  
FORMATION)

- Negative Cognition (NC)
- It must be an “I” statement
  - A negative self-referencing belief
  - It’s about the self that was true then and true even now when the memory is triggered.
  - Stated in the present, for example, “I’m worthless”
  - EMDR will not change/ remove an actual negative cognition, only the one the trauma created. Start with:
    - “What words go best with that picture that expresses your negative belief about yourself **now?**”
    - “What thoughts do you have about yourself?”

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**PHASE THREE:  
ASSESSMENT  
(AKA - TARGET  
FORMATION)**

- Negative Cognition (NC) Cont'd
- "What does that make you believe about yourself **now**?"
- Drill down by asking, "If that were true, what does that say to you about you?"
- For example, "I was not in control" is not a good NC.
  - The NC has to be a belief rather than a description of the event. "I was not in control" is a description of the event.
- Continue to hone by asking, "If that were true, what does that say about you?"

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**PHASE  
THREE:  
ASSESSMENT  
(AKA - TARGET  
FORMATION)**

- Positive Cognition (PC):
- Self-referenced, generalizable belief
- Positive language – avoid the word "not"
- Appropriate and relevant, same issue as Neg Cog
- Avoid "always" and "never"
- Identified by what feels right to the client
- "When you bring up that picture, what would you prefer to believe about yourself instead?" Or
- "How would you like to define yourself?"

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**PHASE THREE: ASSESSMENT  
(AKA - TARGET FORMATION)**

- Validity of Cognition (VoC)
- "When you think of the memory, how true do the words (repeat PC) feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?"
- "What is the gut-level feeling of the truth of (repeat PC), from 1 (completely false) to 7 (completely true)"

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• Emotions

• “When you think of the memory and the words (repeat NC), what emotions do you feel now?”

**PHASE THREE: ASSESSMENT (AKA - TARGET FORMATION)**

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**PHASE THREE: ASSESSMENT (AKA - TARGET FORMATION)**

• SUD (Subjective Units of Disturbance)

• “On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?”

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**PHASE THREE: ASSESSMENT (AKA - TARGET FORMATION)**

• Body Sensations

• “Where do you feel it (the disturbance) in your body?”

• If client has difficulty accessing body sensations try...

• “Close your eyes and notice how your body feels. I will ask you to think of something and when I do, just notice what changes in your body. Notice your body. Now, bring up the picture of the memory. Tell me what changes. Now add the words (repeat NC). Tell me what changes.”

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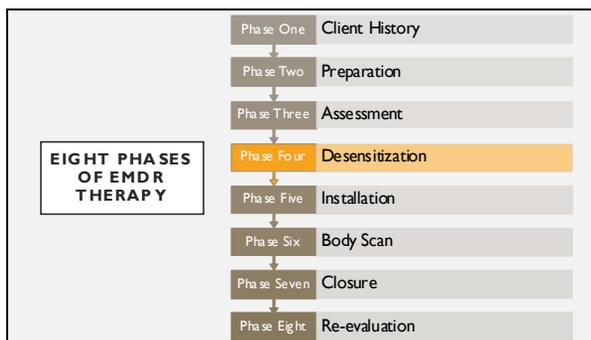
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**PHASE FOUR: DESENSITIZATION**

**Note:**

- Before you start this phase, you should have prepared the client with which dual attention stimulus you will provide, for example, EMs, Taps, or Tones and speed
- Remember, the goal of reprocessing disturbing material is to reduce the disturbance to a SUD of 0
- Also, cognitive restructuring is occurring during this phase of EMDR

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**PHASE FOUR: DESENSITIZATION**

Remind the client:

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

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**PHASE FOUR: DESENSITIZATION**

- **Begin Desensitization**
- "I'd like for you to bring up the picture and the words (repeat NC) and notice where you feel it in your body. Now, follow my fingers with your eyes."
- Observe and stay connected
- Maintain empathic connectedness without intruding
- Start with 24 passes during processing and adjust as necessary, for example, add more passes

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**PHASE FOUR: DESENSITIZATION**



A diagram showing a central node with several vertical channels extending downwards from it, representing the connection between nodes and channels in the desensitization process.

**Note:**

- Node - key experiences
- Targets contain the image, emotions, body sensations and erroneous beliefs associated with traumatic memories.
- Channels are smells, sounds, cognitions, body sensations, emotions that make up the strands of connections to the nodes
- Channels radiate from the nodes like fingers on a hand
- Channels can include associated thoughts, images, etc.
- You can tell you're at the end of a channel when the client reports nothing is happening or repeated neutral/positive responses.

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**PHASE FOUR: DESENSITIZATION**



A diagram showing a central node with several vertical channels extending downwards from it, representing the connection between nodes and channels in the desensitization process.

**Check-in Point:**

You may need to educate/re-educate the client, for example:

- "no need to report everything, only what's happening now."
- "Be honest."
- Important to report changes in images, emotions, body sensations

You're listening for the end of a channel, at which time you'll return the client to the Original Incident or Memory (Target)

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**PHASE FOUR:  
DESENSITIZATION**

**During Check-in Point:**

- If Negative material: "Go with that"
- If mixed neg/neutral/pos material: "Go with that"
- If neutral material, do two more sets. Then: "Go back to the original incident, and what do you get?" Then "Go with that"
- If positive material, do two more sets. Then: "Go back to the original incident, and what do you get?" Then, "Go with that". If still positive or no new material, check the SUD.

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**PHASE FOUR:  
DESENSITIZATION**

- Returning to the Original Incident
- Ask, "Think of the original incident and what do you get?"
  - If **positive material or if no new associations, emotions, sensations, or images reported, do another set, and then check SUD.**
- If SUD=1 or 2 ask, "what prevents it from being a zero?" "Go with that." (The SUD is typically checked at the beginning and at the end of the session.)
- When the SUD = 0, the Original Incident is considered desensitized
- Note:** You are desensitizing the Original Incident and not the end of the channel

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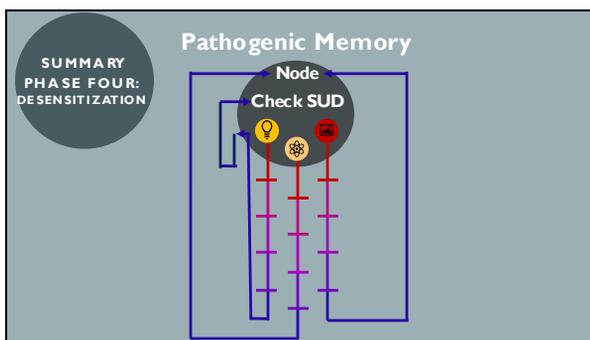
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**Summary**

- If no processing occurs for two consecutive sets, change eye movements, DAS, or focus on physical sensations.
- Once all associated channels have been processed, returning to the original incident will result in no disturbing emotions, thoughts, or body sensations, that is, **there is no charge or activation.**
- SUD = 0 the target is considered desensitized
- SUD=1, ecologically valid or appropriate to the individual, given present circumstances, for example, present safety concerns

**PHASE FOUR:  
DESENSITIZATION**

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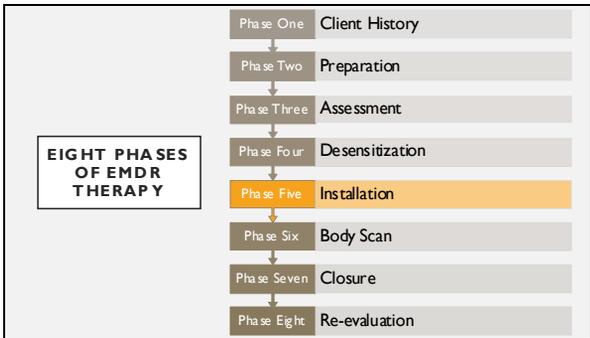
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**PHASE FIVE: INSTALLATION**

- Check the Positive Cognition, **only after a SUD=0 or ecological 1.**
- "Do the words (repeat PC) still fit, or is there another positive statement that fits better?"

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**PHASE FIVE:  
INSTALLATION**

- Check the VOC
- “As you think of the original incident, how true do the words (repeat PC) feel now, from 1 (completely false) to 7 (completely true)?”

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**PHASE FIVE:  
INSTALLATION**

Install the PC with fast 24-36 passes

- “Now think of the original incident and hold it together with the words (repeat PC). Keep repeating the words (PC) in your mind and notice your experience.”

Keep doing sets until the VOC=6 or 7

- If the client continues reporting a 6 or less, evaluate for any emerging associations that need to be addressed.
- Ask, “What prevents it from being a 7?”
- If dysfunctional blocking beliefs do not remit after successive sets, a full EMDR standard protocol is necessary—target the associated pathogenic memory with the negative self-assessment (use affect scan or flo atback technique to determine associated memory).

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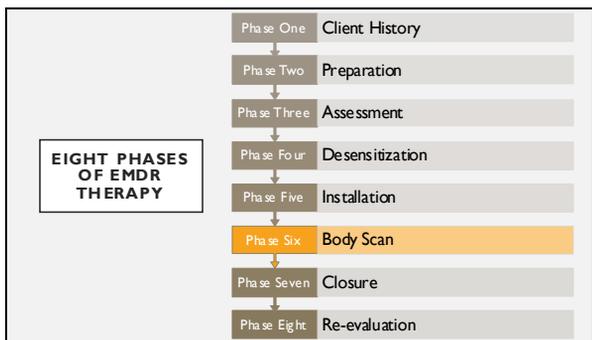
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**PHASE SIX:  
BODY SCAN**

- Do body scan after VOC=7 or 6, if ecologically appropriate:
- “Close your eyes and keep in mind the original incident and the PC.”
- “Notice your body, starting with your head and working downward. Any place you find any tension, tightness, or unusual sensation, tell me.”

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**PHASE SIX:  
BODY SCAN**

If any tension or disturbance, target with BLS/DAS sets.

The body scan phase is complete when the client is able to hold the target incident and PC and there is no residual tension after mentally scanning the body.

Positive sensations can be targeted with fast BLS/DAS sets (24-36 passes) to strengthen it.

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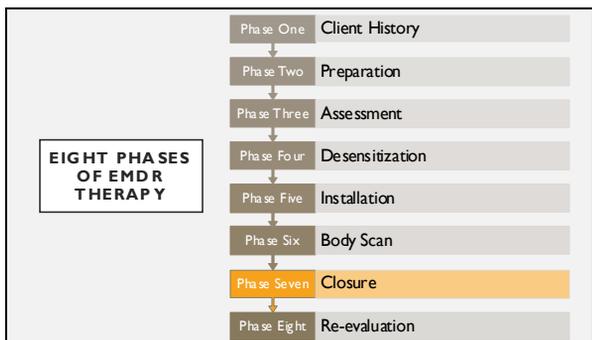
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**PHASE SEVEN:  
CLOSURE**

- **Complete Session**
  - “Remember that following an EMDR session you may experience continued processing in the next few days, including dreams, insights, new memories, emotional vulnerability, and body sensations.”
  - “This is normal.”

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**PHASE SEVEN: CLOSURE**

- **Complete Session**
  - “Keep a log of things that arise, especially potential future targets”
  - “If something disturbing arises, write it down and do the Containment exercise, Safe/Calm Place &/or Spiral technique”
  - “If you feel it necessary, you can contact me.”

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**PHASE SEVEN:  
CLOSURE**

- **Incomplete Session**
  - Inform the Client:
    - “We are almost out of time and it is clear that there is more processing to be done on this issue. Is this a good place to stop for today?”
  - Acknowledge the client’s work:
    - “You have done some very good work today, moving through this issue.”

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**Incomplete Session**

- Go back to target and check the SUD
- Skip the Installation of PC and Body Scan
- Do Containment, Safe Place, or any other state change exercise
- Same closing statement as for a complete session

**PHASE SEVEN: CLOSURE**

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**LUNCH**

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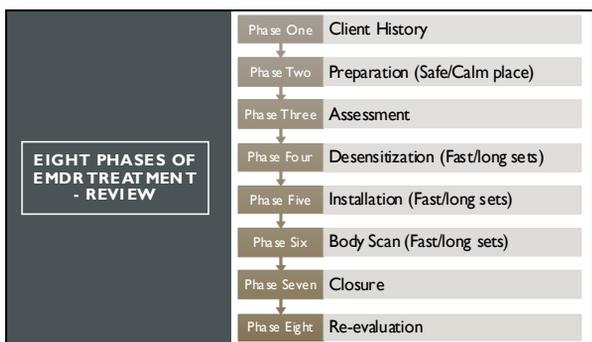
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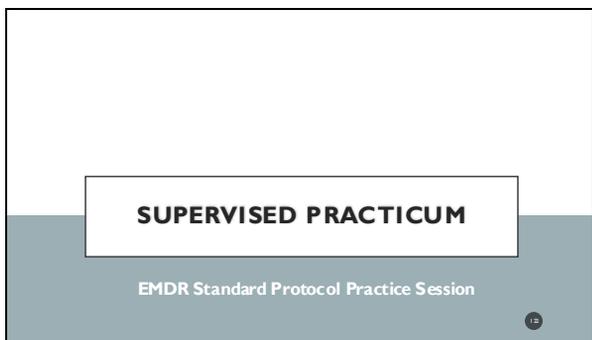
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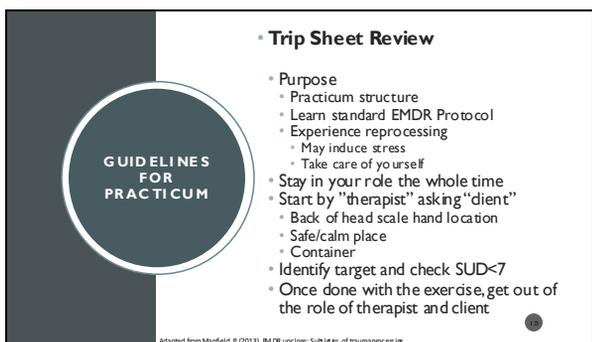
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**GUIDELINES FOR PRACTICUM**

- Allow yourself to experience EMDR through your own process and make it safe
- Follow the EMDR standard protocol; **don't improvise**
- Use your personal self-awareness skills.
- Monitor your own affect tolerance and use self-soothing techniques as needed

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**GUIDELINES FOR PRACTICUM**

Some of your basic therapy skills are very useful in EMDR, including presence, witnessing, and holding boundaries.

Other skills such as reflecting, asking for elaboration, and interpreting can inhibit EMDR.

Be open to feedback.

Make sure you are in a private setting during the demo and practicum

A practicum supervisor will be available to help with any questions or concerns.

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**EMDR STANDARD PROTOCOL PRACTICE SESSION**

Pair off in two's (or three's if assigned)

The therapist is the therapist for the whole time

Honor confidentiality and maintain cultural awareness

If any problems/concerns arise during practicum

- Immediately contact Trainer or Administrator

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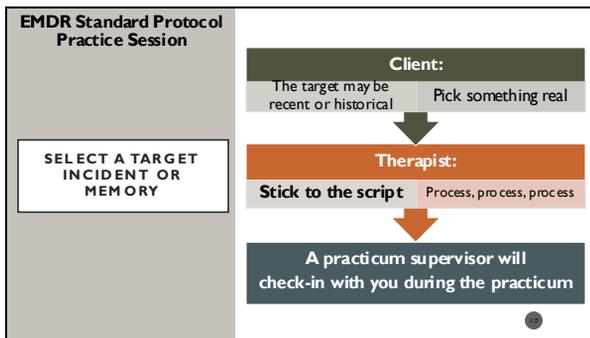
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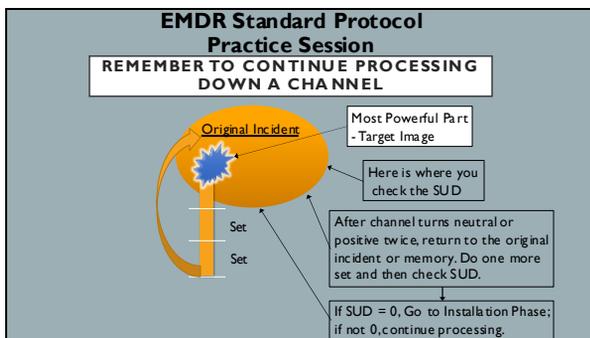
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**QUESTIONS?**

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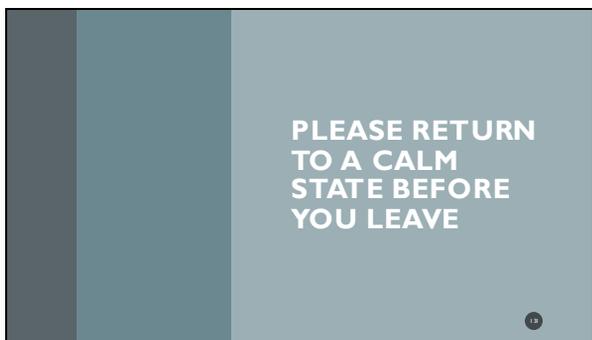
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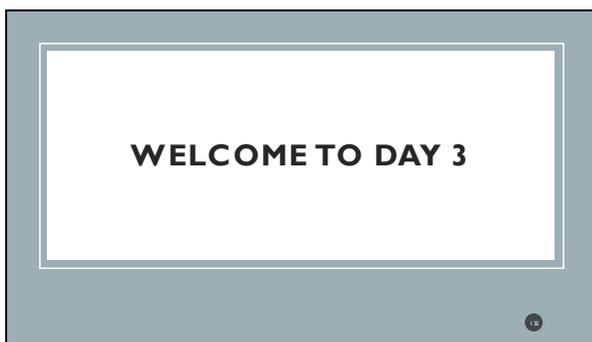
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**WELCOME  
TO DAY  
THREE**

- Day 1 was the foundation
- Day 2 was the EMDR therapy standard protocol and some practice
- Today, it all comes together
- Goals for Today
  - Consultation Calls
  - EMDR Mechanisms of Action
  - Review the 8-phase treatment procedures of the basic EMDR therapy protocol
  - Finish 8-phase treatment procedure
  - Supervised Practicum

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**CONSULTATION CALLS**

- Review Schedule
- Keep track of calls
  
- Calls will be as scheduled via zoom
  - You need 10 hours to complete the training
  - Announce yourself when you arrive to get credit.

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**CONSULTATION  
CALLS**

- Use the case presentation form, and be prepared to give:
  - Image:
  - NC:
  - PC:
  - VOC:
  - Emotion:
  - SUD:
  - Ending SUD:
  - New PC:
  - Ending VOC:
- During the case presentation, discuss how the session progressed.

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# MECHANISMS OF ACTION

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- MECHANISMS OF ACTION
- Orienting Response
  - Working Memory Hypothesis
  - REM and NREM Sleep
  - Prefrontal Attentional Flexibility (Mindfulness and Metacognitive Awareness)
  - Inter/Intra Hemispheric Activation

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- MECHANISMS OF ACTION
- Orienting Response**
- A natural response of interest and attention that is elicited when attention is drawn to a new stimulus, activating the sympathetic system
  - First, there is an **alerting reaction** in response to a new stimulus in the environment, then an **investigatory response** to the repeated stimulus presentations
  - Habituation/relaxation occurs in the face of no danger or threat, activating the parasympathetic system
  - The dual attention stimulus, e.g., EM disrupts the traumatic associative network so that learning can occur
  - During EMDR, the dual attention process facilitates access and desensitization of the traumatic memory since there is no actual present danger or threat

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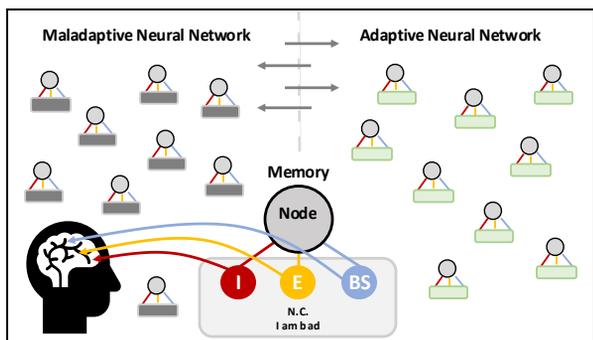
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**MECHANISMS OF ACTION**

**Working Memory Hypothesis**

- Recalling an emotionally charged memory and making eye movements both require the working memory visuospatial sketchpad, so moving your eyes from side to side while recalling a memory leaves less capacity for the working memory.
- And fast EMs disrupt the working memory system, decreasing vividness, which results in decreased emotionality.

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**MECHANISMS OF ACTION**

**REM Sleep**

- EMDR eye movements are similar to that of Rapid Eye Movements during REM sleep
- EM produces similar effects from REM/dream state while sleeping—the integration of traumatic memories into general semantic networks

**NREM Sleep**

- Integrates acquired information from short-term memory to long-term memory system
- EMDR eye movements are similar to slow-wave effects, that is, new formed memories are reactivated and consolidated to the long-term memory system

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**MECHANISMS OF ACTION**

**Prefrontal Attentional Flexibility (Mindfulness and Metacognitive Awareness)**

- Awareness is focused attention, a prefrontal cortex function
- Focus attention activates and links different regions of the brain together
- EMDR standard protocol has similar effects to focus attention, that is, implicit memories are linked to explicit memory systems, the flexible and adaptive system

**Inter/Intra Hemispheric Activation**

- EMDR standard protocol activates both hemispheres, horizontally and vertically, whereby integration occurs and there's no longer memory system isolation, that is, there is no fragmented memory due to trauma and all the components of the memory are integrated.

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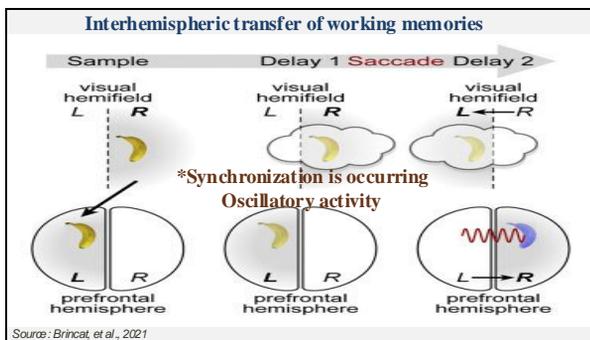
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**MECHANISMS OF ACTION**

- Orienting Response
- Working Memory Hypothesis
- REM and NREM Sleep
- Prefrontal Attentional Flexibility (Mindfulness and Metacognitive Awareness)
- Inter/Intra Hemispheric Activation

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MECHANISMS  
OF ACTION

- There are many hypotheses for how EMDR works—some are very similar
- There is a plethora of research testing these hypotheses, but none have been proven, that is, determined cause and effect
- Some propose a multiplex approach
- Please visit [EMDRIA.org](http://EMDRIA.org) for the latest research

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**EIGHT PHASES  
OF EMDR -  
REVIEW**

Phase One	Client History
↓	
Phase Two	Preparation (safe/calm place)
↓	
Phase Three	Assessment
↓	
Phase Four	Desensitization (fast/long sets)
↓	
Phase Five	Installation (fast/long sets)
↓	
Phase Six	Body Scan (fast/long sets)
↓	
Phase Seven	Closure
↓	
Phase Eight	Re-evaluation

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**PHASE TWO: PREPARATION**

- BLS/DAS Setup:
  - Distance from client, 12-14 inches in front of client's eyes and side by side
  - EMs, side-to-side or diagonally across
  - Taps, knees
  - Tones
  - Speed/duration
- **Virtual vs. in-person EMDR therapy**

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VIRTUAL  
EMDR  
THERAPY

Attunement

- Resourcing
- Affect regulation
- Verify client's local emergency information

Dual Attention Stimulus

- EMs - eyes move side to side across midline
- Tapping - butterfly hug or side of the knees

Desensitization

- Start with Target with the lowest SUD level
- Go back to Original Incident more often, approximately after 5 sets

Platforms

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REVIEW: PTSD  
AND BRAIN  
ACTIVITY

Traumatic experiences inhibit the brain's natural ability to process memories

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Traumatic material is linked dysfunctionally in the implicit memory system in **an excitatory form**

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Present day events activate the original material resulting in PTSD symptoms

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Good history and assessment of client, including ego strength, affect regulation, boundaries is crucial to treatment outcome

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**REVIEW: PTSD  
AND BRAIN  
ACTIVITY**

Keep in mind the:

- Importance of relationship and attunement with the client (transference)
- Importance of therapist having "done own work" (countertransference)

Return to stabilization as needed, e.g., safe/calm place

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**CASE  
CONCEPTUALIZATION  
AND  
CLIENT READINESS  
REVIEW**

- Screen for dissociation, including DID
- Assess etiology of psychosis or organic issues
- Consult M.D. for organic issues based on loss of consciousness during event or other physical issues
- Assess danger to self or others
- Assess any current crisis or situation needing an action plan
- Check on client's ability to use some method to change states
- Check on client's ability to maintain contact with therapist and sensation during bilateral stimulation sets
- "Truth-telling" agreement or ability ●

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**REVIEW:  
COMPONENTS OF  
EMDR STANDARD  
PROTOCOL**

- Incident/Pathogenic Memory
- Picture (sensory level: images, sounds, smells, touch, taste)
- Cognitions (Neg & Pos Cogs)
- Emotions
- Body sensations
- Measurement scales (SUD & VOC)
- Bilateral dual attention stimulation

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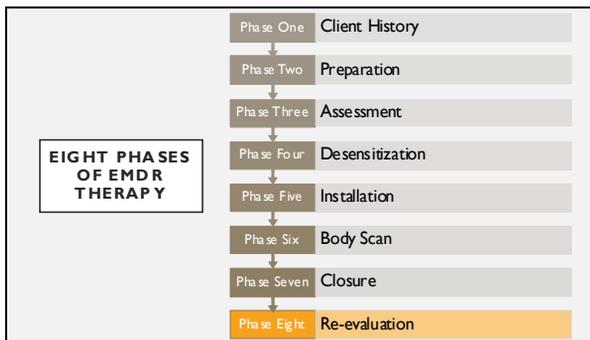
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**PHASE EIGHT: RE-EVALUATION**

- Re-evaluation occurs after every EMDR processing session.
- If target is not a 0 or ecological 1, continue processing target
- Focus on:
  - Has the target been resolved?
  - Has associated material been addressed?
  - Have all necessary targets been reprocessed?
  - Have the anticipated future difficulties been addressed?
- For long-term trauma and multiple events, reevaluation may involve targeting and reassessing

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**DEMO**

**EMDR STANDARD PROTOCOL**

**WITH RE-EVALUATION PHASE**

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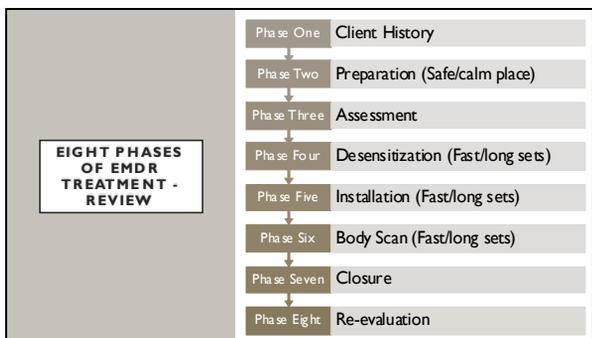
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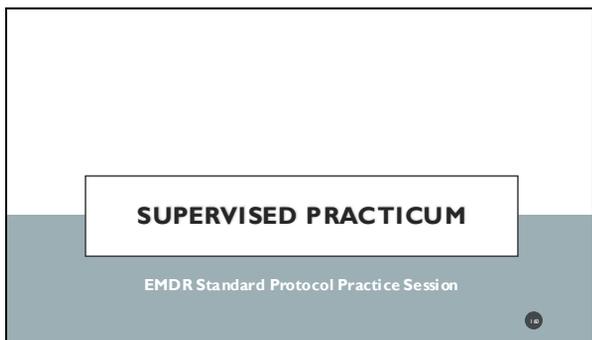
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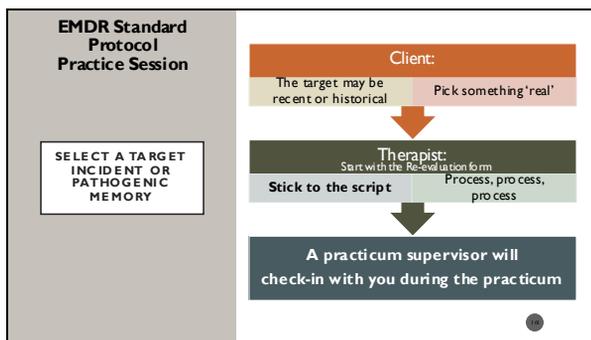
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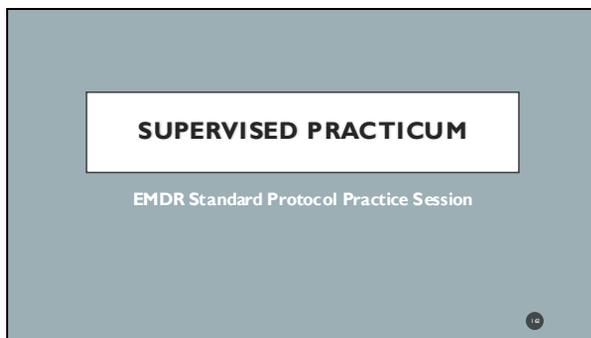
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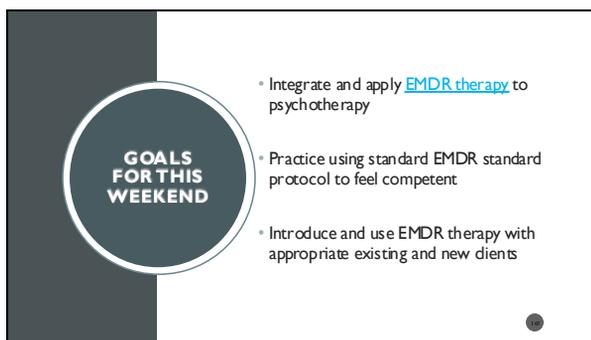
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**GOAL FOR WEEKEND 2**

- Resource Development & Installation
- More Clinical Implications
  - How to handle Abreactions
  - Strategies for Blocked Processing
  - The appropriate application of Cognitive Interweaves
- Advanced Methodology: Additional protocols and specific populations
- Professional and Legal Issues
- The Future Template

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**QUESTIONS AND EVALUATIONS**

**MINDFUL BODY SCAN**

**CHECK-OUT: ONE TAKE AWAY**

**LET US KNOW IF YOU NEED HELP RETURNING TO A CALM STATE**

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**WELCOME TO DAY 4**

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**WELCOME**

Trainer and Consultant

Training Support

Housekeeping

- Restrooms
- 6-Day Training structure: 40/10/10
- Cameras must be turned on
- Lunch, Day 6—working lunch



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**INTRODUCTIONS**

All the trainers at CompassionWorks strive to be culturally and linguistically competent.

We want to provide a safe and professional environment.

We acknowledge that as humans we cannot fully understand or appreciate others' experiences from different racial/ethnic backgrounds.

We are open to talking about these topics and welcome the opportunity to grow and collaborate in this area.

Feedback and discussion on these topics are welcome throughout the training.

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**WELCOME**

- EMDR Therapist Training Weekend I
- Adaptive Information Processing Model
- 8 Phases of EMDR Therapy
- Touchstone Event
- 3-Pronged Protocol
- BLS/DAS
- Practice



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**GOALS FOR THIS WEEKEND**

- Identify and summarize the 8-Phases
- Apply Resource Development & Installation
- Integrate More Clinical Implications
  - Strategies for blocked processing
  - How to handle abreactions
  - Apply appropriate application of cognitive interweaves
- Integrate Advanced Methodology: Additional protocols and specific populations
- Evaluate Professional and Legal Issues
- Practice and Apply the Future Template

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**GOALS FOR TODAY DAY FOUR**

- EMDR 8-phases of EMDR Therapy
- More Clinical Implications
  - Strategies for Blocked Processing
  - Cognitive Interweaves
  - Abreactions
- Recent Event Protocol
- Self-Use (Self-Soothing)
- EMDR with Couples
- EMDR with Children and Adolescents
- EMDR with Neurodiverse Clients

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**AIP MODEL**

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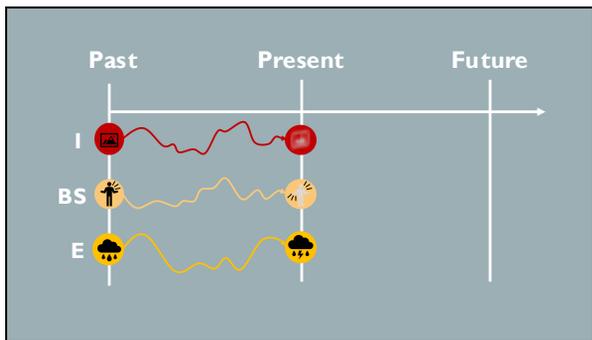
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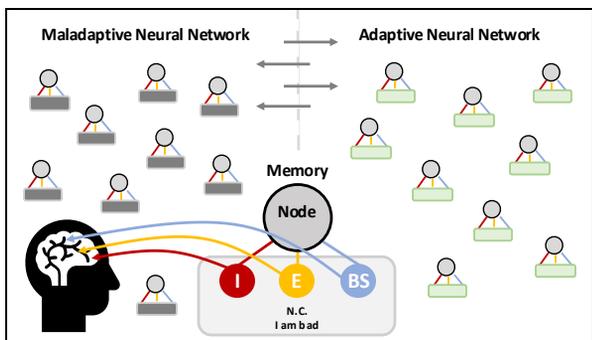
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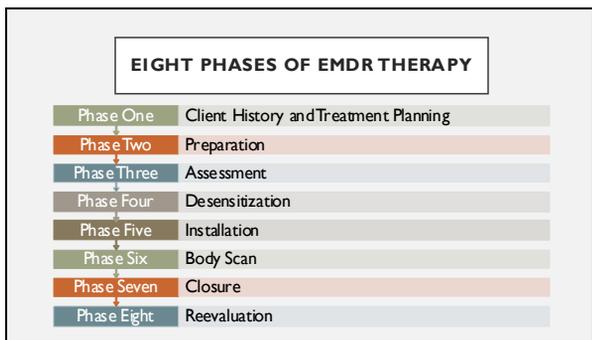
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PHASE ONE:  
HISTORY TAKING  
REVIEW

- History
  - We want to do EMDR in the context of the person's life experiences
  - Administer the DES
  - Use floatback technique or affect scan to identify long-standing patterns of client dysfunction and the original events that set them in motion
- Listening for Targets
  - Trauma Timeline
  - Top Ten List
  - Life Themes
  - ACE (Adverse Childhood Experiences Questionnaire)
  - Micro-aggressions

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PHASE TWO:  
PREPARATION  
REVIEW

- Preparation
  - Give an adequate explanation
  - EMDR may trigger memories and bring up additional targets
  - EMDR processing may trigger irritability and anger

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PHASE TWO:  
PREPARATION  
REVIEW

- Preparation
  - Begin with Stabilization Strategies (SUDs > 8 or dissociation)
  - Containment
  - Calm/Safe Place
  - Light Stream
  - Reverse Spiral
- Additional Stabilization Strategies
  - \*Resource Development and Installation (RDI)
  - \*Body Awareness or EMD (image and NC)
  - \*Flash Technique or EMDR 2.0

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**PHASE THREE:  
ASSESSMENT  
REVIEW**

- Assessment
  - Image
  - Negative Cognition (NC)
  - Positive Cognition (PC)
  - Validity of Cognition (VOC), Scale of 1-7
    - Reassess a PC with a VOC of 1 or 2, as it could potentially indicate a flaw in logic, applicability, or ecological appropriateness. It's possible the client is not reporting at the "gut" feeling level.
  - Emotion
  - Subjective Units of Disturbance (SUDS) Level, Scale of 0-10
  - Body Sensations/Location

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**PHASE FOUR:  
DESENSITIZATION  
REVIEW**

- Desensitization (Fast EMs, 24-36)
  - Knowing when to return to original incident:
    - After two reports of a positive or neutral
    - Memory chaining
    - To refocus processing
  - When negative and positive material is reported, ask the client to focus on the negative material.
  - Attunement with the client during processing
    - Seeing the processing in the client's face
    - Providing the parasympathetic calming response
    - Take a deep breath with the client

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**PHASE FIVE:  
INSTALLATION  
REVIEW**

- Installation (Fast EMs, 24-36)
  - Checking the PC
  - Checking the VOC
  - VOC Should be a 6 or 7
    - 5 or less consider:
      - Original incident not cleared out
      - Feeder memories
      - Blocking belief not cleared, will need to target it and possibly use RDI
      - Wrong PC
  - If negative material emerges, an associated channel, continue processing
  - Install the PC with resolved incident

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**PHASE SIX: BODY SCAN REVIEW**

- Body Scan (Fast EMs, 24-36)
- To assess lingering tension being held in the body
- If negative material emerges, continue processing
- Do not do the body scan if you do not have enough time to reprocess a channel

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**PHASE SEVEN:  
CLOSURE REVIEW**

- Closure
  - “The processing we have done will continue...”
  - “Keep a log” (TICES)
  - Make sure the client always returns to a calm state before leaving the office. Use:
    - Calm/Safe Place
    - Reverse Spiral
    - Containment
    - Light Stream
    - Body Awareness—only deep breathing

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**PHASE EIGHT:  
REEVALUATION  
REVIEW**

- Reevaluation
  - Reassess Target Memory
  - Check SUDs
  - Continue processing, if needed
  - Continue processing the previous incomplete session by asking the client to:
    - “Think about the incident/target.”
    - “What’s the worst part?”
    - “What’s the SUDs level?”
    - “What emotions do you feel now?”
    - “Where do you feel the sensations in your body?”

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**EIGHT PHASES OF EMDR THERAPY REVIEW**

- Phase One: Client History
- Phase Two: Preparation
- Phase Three: Assessment
- Phase Four: Desensitization
- Phase Five: Installation
- Phase Six: Body Scan
- Phase Seven: Closure
- Phase Eight: Reevaluation

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**GROUP DISCUSSION**

Name \_\_\_\_\_

Briefly: Insights or Questions about EMDR \_\_\_\_\_

Identify a client that has been triggering for you?

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**MORE CLINICAL IMPLICATIONS:**

**BLOCKED PROCESSING**

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**BLOCKED PROCESSING**

- Processing Stops When:
  - Nothing is reported several times, usually after two consecutive sets
  - Same thing is reported twice or more
  - Original incident or image remains fixed
  - SUD stays above a "0" or ecological "1"

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**BLOCKED PROCESSING**

- Forms of blocked processing:
  - Looping
  - Ancillary trauma nodes
  - Blocking beliefs

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**BLOCKED PROCESSING**

- Looping
  - Client cycling around the same plateau of information
  - Same emotions, sensations, images are recurring in two successive sets
  - Relief of distress is followed by the same round of negative thoughts

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**BLOCKED  
PROCESSING:  
LOOPING**

- Strategies to Unblock Looping
  - Alter the Eye Movements
  - Focus on Body Sensations
    - All sensations
    - Localized sensations
  - Ask for "Unspoken" words
  - Using movement
    - Act out a desired movement
  - Scanning for most disturbing material
  - Scanning for visual cues, sound, dialogue
  - Alter the image
    - Make it further away

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**BLOCKED  
PROCESSING:  
LOOPING**

- Strategies to Unblock Looping
  - Redirect to negative cognition
    - "Hone" the negative cognition
  - Reinroduce the original negative cognition with the last image of the disturbing event
  - Add a positive statement:
    - Say, "It's over..." during the set.
  - If the block is during *Installation*, recheck positive cognition
  - Return to the original incident

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**BLOCKED  
PROCESSING:  
ANCILLARY  
TRAUMA**

- Ancillary Trauma Nodes
  - Feeder Memories
    - Untapped earlier memories
  - Fear

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**BLOCKED  
PROCESSING:  
ANCILLARY  
TRAUMA**

- Strategies to Unblock Ancillary Targets
  - Feeder memories
    - Subtle float back can be used
      - Float back to the earliest time when NC could have applied
      - Say, "Let your mind trace back to when or how this could have started!"
    - If feeder memory emerges, set as a new target, reprocess it fully, and then return to the previous target and reprocess.

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**BLOCKED  
PROCESSING:  
ANCILLARY  
TARGETS**

- Strategies to Unblock Ancillary Targets
  - Fear
    - Fear of going crazy
    - Fear of change
    - Fear of feeling the feeling
    - Fear of taking days to get back to normal

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**BLOCKED  
PROCESSING:  
BLOCKING  
BELIEFS**

- Blocking Beliefs
  - Examples of blocking beliefs:
    - "I will never get over this problem."
    - "If I go on with my life, it means I didn't love my child and her memory will be forgotten."
    - "I've had this problem for so long, I could never completely solve it."
    - "I don't deserve to get over this problem."
    - "If I hate my job enough, it'll help me get another one."
    - "Feeling triggered in a car helps keep me safe, for example, by getting my partner to drive better."

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**ADDITIONAL STRATEGIES FOR BLOCKED PROCESSING**

- Change bilateral DAS speed, strength or method
- Have the client focus on body sensation(s)
- Have the client scan for the most upsetting visual aspect of the incident
- Return to Target Incident
- Bring in an already developed RDI
- Use emotional distancing techniques
- Target blocking beliefs

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**MORE CLINICAL IMPLICATIONS:  
COGNITIVE INTERWEAVES**

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**COGNITIVE INTERWEAVES**

A proactive strategy used in the *Desensitization* phase (4) for blocked processing by duplicating as much as possible a spontaneous response

Therapeutically weave together appropriate neural networks and associations, for example, from maladaptive to the adaptive network

Use when necessary but not as the first intervention

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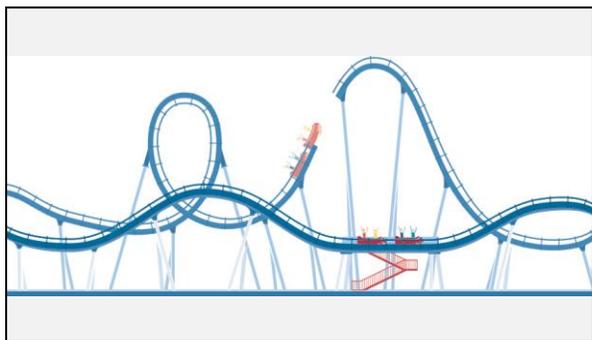
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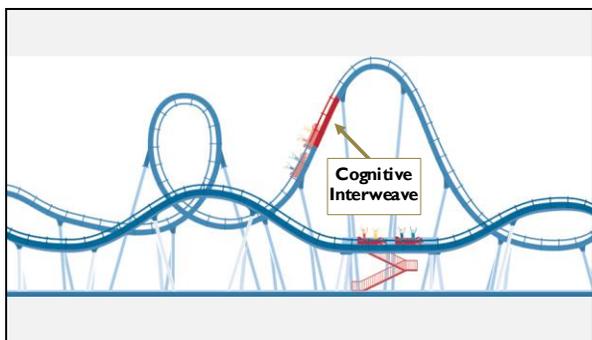
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**COGNITIVE  
INTERWEAVES**

- Guidelines for using cognitive interweaves:
  - Use when processing is blocked, and the clinician is comfortable with the EMDR standard protocol
  - Use to assist a child
  - Use in question form with adults
  - Don't interpret, inquire or instruct to elicit thoughts, actions, affects, and/or imagery
  - Offer the interweave in the order of *Responsibility, Safety, and Choice*
  - Note, cognitive interweaves do not solve the problem but instead it gets the process going again

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**COGNITIVE INTERWEAVES**

- When to use it?
  - Looping
    - Even after successive sets, the client remains at a high level of disturbance with repetitive negative thoughts, affect and imagery
  - Insufficient information
    - Client lacks knowledge and experience to progress cognitively, affectively, or behaviorally
  - Lack of generalization
    - Generalization to ancillary targets does not occur
  - Time pressure
    - Client needs more time to reach stability for example, disturbance is too high before ending a session

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**COGNITIVE INTERWEAVE THREE ASPECTS**

- Most cognitive interweaves relate to one of three aspects of a client's traumatic experience
  1. **Responsibility**
    - Survivors tend to believe they are responsible for their mistreatment
      - The shift is away from, "It was my fault" to "I was innocent"
  2. **Safety**
    - Clients realize that their perceived lack of safety is from the past
      - This is a *felt-sense* memory of *not-feeling safe*
    - The shift is from, "I'm in danger" to "I'm safe now."

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**COGNITIVE INTERWEAVE THREE ASPECTS**

- Most cognitive interweaves relate to one of three aspects of a client's traumatic experience (continued):
  3. **Choice**
    - The child as a victim had no choices.
    - The shift is from, "I have no control" to "As an adult, I can now choose"; "I am now in control", or if a child, "I have adults who can protect me now."

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**COGNITIVE  
INTERWEAVE  
CHOICES**

Education

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Reality check

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Metaphor/analogy

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Let's pretend

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What if it were your child?

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Socratic method

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Verbalizations and actions

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**COGNITIVE  
INTERWEAVE  
CHOICES**

• **Education**

- Explain the effects of modeling and natural physiological responses, for example, say:
  - "Did you know . . . ."
  - "There is a need for children to have negative attention over no attention?"
  - "The abuser is often the one who shows the most caring?"
  - "Male sexual abuse by a female abuser is often not viewed as abuse?"
  - "Physical stimulation can cause sexual arousal and be pleasant, even if you don't want to?"

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• **Reality Check**

- This is used to elicit an adult, more adaptive perspective, for example, say:
  - "I'm confused. You..."
  - "What if it were your child?"
  - "I'm confused. If it were your child, it would be her fault"
- For a child, for example, say:
  - "As a child, adults are supposed to protect you."

**COGNITIVE  
INTERWEAVE  
CHOICES**

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**COGNITIVE INTERWEAVE CHOICES**

**• Metaphor/Analogy**

- Fables, fantasies, history or therapist's own story, can draw parallels.
- Use to jumpstart blocked processing.
- After introducing a metaphor, go back to target to continue standard processing.

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**COGNITIVE INTERWEAVE CHOICES**

**• Let's Pretend**

- Invite the client to imagine a new action, for example, say:
  - "Let's pretend you could say something to him, what would it be?"
  - "If the perpetrator tried it now, what would you do?"
  - "What resource could help you?"
- Invite the *adult self* to hold and comfort the *child self*.
- If a child, invite a protective figure to provide comfort to the injured child.

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**COGNITIVE INTERWEAVE CHOICES**

**• Socratic Method**

- For example, say:
  - "How did you come to believe that?"
  - "What evidence do you have?"
  - "Is there another possible interpretation?"
  - "What exactly are you taking for granted here?"
  - "Is there another possible view you should consider?"
  - "Go with that"

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**COGNITIVE INTERWEAVE CHOICES**

- **Verbalization and Actions**
  - Ask the client to verbalize the anger or abuse to the perpetrator
  - Ask the client to act out what is felt needed in the moment

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**COGNITIVE INTERWEAVES**

- **Common Errors**
  - Intervening too quickly
  - Talking too much
  - Waiting too long for a verbal response
  - Bringing in a resource too quickly
  - Not using interweaves when needed

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**COGNITIVE INTERWEAVES**  
**CASE CONCEPTUALIZATION**

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**COGNITIVE INTERWEAVE CHOICES**

- Education
- Reality check
- Metaphor/analogy
- Let's pretend
- I'm confused
- What if it were your child?
- Socratic method
- Verbalizations and actions

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**LUNCH**

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**MORE CLINICAL IMPLICATIONS:  
ABREACTIONS**

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**ABREACTIONS**

- Abreaction is when a “high level of disturbance” occurs.
- Unmetabolized perceptions/memories are being brought to the surface.
- EMDR is not causing the distress, it is releasing it. Remind the client,
  - “It’s like going through a tunnel, keep your foot on the gas.”
  - About the *Train Metaphor* – “looking out the window watching the scenery go by”
- Provide a sense of current safety to the client. For example, say:
  - “You are safe now.”
- Clinician maintains a position of *detached compassion*
  - Stay grounded
  - Go to your own safe/calm place

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**ABREACTIONS**

- An abreaction has a beginning, middle, and end.
- In most instances, the abreaction is occurring as the information is being processed.
- **Strategies for handling abreactions**
  - Bring client’s attention to the dual focus of awareness.
  - Consider shifting attention to:
    - Issues of secondary gain, blocking beliefs, or feeder memories

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**ABREACTIONS**

- **Strategies for handling abreactions Cont’d**
  - Monitor dissociation and differentiate
    - Old feeling of dissociation related to the event
    - Dissociation that is triggered because the client is out of the window of tolerance
  - Decrease disturbance through visual manipulations
    - Change memory to a still photo
    - Change memory to a black and white video
    - Imagine *Adult self/Nurturing Figure* entering the picture or any other already developed RDI
    - Place a protective glass wall between the self and the event or perpetrator

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**VIDEOS:**

GET INTO ROLE OF  
THERAPIST AND MANAGE  
AFFECT DYSREGULATION

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**RECENT EVENT  
PROTOCOL**

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**RECENT EVENT  
PROTOCOL**



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**RECENT EVENT  
PROTOCOL**

- **Phase 1—History**
  - Obtain brief description of what happened
- **Phase 2—Preparation**
  - Educate client about EMDR and trauma
  - Stabilize client - do Safe/Calm place
  - Determine if client is appropriate for EMDR processing
- **Phase 3—Assessment: Mental Video Replay**
  - Have the client tell the narrative from the beginning to the end and record each disturbing part of the event
  - Do not take a SUD while recording the disturbances
  - Do a "Google search" for disturbances
- **Phase 4—Desensitization**
  - Start with the worst part, do the assessment and desensitization

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**RECENT  
EVENT  
PROTOCOL**

- **Phase 4—Desensitization Cont'd**
  - After the worst part of the memory is desensitized, go back and process each disturbance in chronological order.
  - For each point of disturbance:
    - Do Assessment, Desensitization, and Install on each disturbance. Do not do a Body Scan yet.
  - Once all parts of the memory are processed, have client visualize the entire sequence of event from beginning to end. Identify any disturbances and process.
- **Phase 5—Installation**
  - Once visualization is clear with no disturbance, find one overarching Positive Cognition for the entire memory and install

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**RECENT TRAUMATIC  
EPISODE PROTOCOL  
(R-TEP)**  
  
 24-72 hours  
  
Source: Ben Shapiro & Brurit Laub (revised Sept. 2014)

**Phase 3—Assessment:**

- Target (point of disturbance=PoD): "Describe what is disturbing to you"
- Image: "Is there a picture that goes with this PoD?"
- NC: "What negative words go with that PoD...or about yourself now?"
- PC: "When you bring that PoD, how would you like to think about it or about yourself now?"
- VOC: "From 1 to 7, how true do these words feel to you now?"
- Emotions: "When you bring up that PoD and those words (NC), what emotion(s) do you feel now?"
- SUD: "From 0 to 10, how disturbing does the PoD feel to you now?"
- Location of Body Sensation: "Where do you feel it in your body?"
- **Start Desensitization phase**

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**RECENT EVENT  
PROTOCOL  
&  
R-TEP**

**Summary**

- Phase 1: Obtain brief description
- Phase 2: Educate and stabilize client
- Phase 3: Assess targets (points of disturbance)
- Phase 4: Desensitize the target (Original incident)
- Phase 5: Install PC
- Phase 6: Do Body Scan
- Phase 7: Do Closure
- Phase 8: Do Reevaluation as appropriate

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## SELF-USE

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**SELF-USE**

**For Client Self-Soothing**

- As stress reduction
- It is not for processing trauma, as it can retraumatize the client

**For Therapist Self-Use**

- To minimize effects of vicarious traumatization
- The sooner sets are done, the sooner vicarious trauma will be processed, assimilated, and resolved
- If an associated unprocessed dysfunctional material emerges, get help – don't do it alone

**Butterfly Hug**

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# EMDR WITH COUPLES

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## EMDR WITH COUPLES

- Consider joint couple sessions and individual EMDR processing sessions
- Preferable to do processing in the absence of the partner
- Full processing may be inhibited
- Controlling partner may use the information later
- Disdosure may lead to difficulties
- Partner may become emotional or disruptive during the processing

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## EMDR WITH COUPLES

- Potential Targets are:
  - Attachment injuries (e.g., family of origin)
  - Times of lack of support
  - Mistakes made in childrearing
  - Anything that causes recriminations
  - Any present triggers that cause disturbances, for example:
    - Sound of the partner's voice
    - Habits
    - Smells
    - Look on the face
    - Specific situations, such as a partner staying out late
    - Cap on toothpaste

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**EMDR  
WITH  
COUPLES**

- Regarding issues of Infidelity
- Evaluate and determine
  - Betrayal of trust on the partner
    - Sense of safety in the relationship
    - Ability to trust their own perceptions
- Potential Targets
  - Scene of behavior
  - Imagined scenes of partner
  - Intrusive imagery is targeted ASAP

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**EMDR WITH CHILDREN AND ADOLESCENTS**

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**EMDR WITH CHILDREN AND ADOLESCENTS**

- Eight Phases of Treatment
  - 1 *Client History and Treatment Planning*—Get a thorough history of events and symptoms; build trust relationship with child and ask parents for support during treatment.
  - 2 *Preparation (Psycho-education)*—Use play to introduce EMDR and explain to parents EMDR therapy and what to expect during treatment. Make sure the child can tolerate affect. Children 4 or older can do eye movements.
  - 3 *Assessment (target is formulated)*—Select target based on parent's report or child's report—target symptoms, e.g., nightmares, feeling lonely, etc.; use child Likert scales, e.g., happy-sad, bad-great; use list of Kids Cognitions
  - 4 *Desensitization*—follow the child's lead; use simple language, e.g., good or bad.

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**EMDR WITH CHILDREN AND ADOLESCENTS**

Eight Phases of Treatment Cont'd

- **1. Installation**—pair the target with PC, e.g., feeling good, I'm good.
- **2. Body Scan**—simply ask how the child's body feels. Or suggest to think about the thing that makes the child feel good so you can do eye movements (**always return the child to a calm state**)
- **3. Closure**—ask the child to pay attention to any changes, and if any disturbing material emerges, to focus on the thing that makes the child feel good. Also, practice with child deep breathing to self-regulate.
- **4. Re-evaluation**—review changes from last session. This is better done with the parent. Inquire about symptom changes.
- **Three Pronged EMDR Protocol**—ask the child to think about what makes them feel bad now, or about something that might make them feel bad later (future template).

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**MODIFIED EMDR STANDARD PROTOCOL WITH CHILDREN**

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**EMDR with Children and Adolescents**

**PRESENTING ISSUE OR MEMORY:** "YOUR MOM TOLD ME ABOUT WHAT HAPPENED TO YOU. COULD YOU TELL ME ABOUT IT?"

**PICTURE:** "WHAT IS THE WORST PART OF WHAT HAPPENED?" OR "WHAT IS THE YUCKIEST PART?"

**NEGATIVE COGNITION (NC):** "HOW DOES IT MAKE YOU FEEL NOW?" (KI PI F NECESSARY OR GIVE NC, E.G, I'M BAD OR FEEL BAD).

**POSITIVE COGNITION (PC):** "HOW WOULD YOU LIKE TO FEEL NOW?" (KI PI F NECESSARY OR GIVE PC, E.G, I'M GOOD OR FEEL GOOD)

**VALIDITY OF COGNITION (VoC):** "AS YOU THINK ABOUT WHAT HAPPENED HOW DO YOU (Rate, as written above) FEEL IT, FROM 1 to 7, 1 MEANS YOU DO NOT FEEL IT AND 7 MEANS YOU COMPLETELY FEEL IT?"

1 2 3 4 5 6 7  
 (Feels Completely False) (Feels Completely True)

**EMOTIONS/FEELINGS:** "WHEN YOU THINK ABOUT WHAT HAPPENED, AND \_\_\_\_\_ (Repeat the NC) WHAT EMOTIONS/DO YOU FEEL NOW?"

**SUBJECTIVE UNITS OF DISTURBANCE (SUDS):** "FROM 0 TO 10, WHERE 0 IS NOT BAD OR NEUTRAL AND 10 IS THE HIGHEST YOU CAN IMAGINE HOW BAD DOES THE INCIDENT/INJURY/FEEL TO YOU NOW?" (USE OTHER SCALES, E.G., FACE LIKERT SCALE)

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

**LOCATION OF BODY SENSATION(S):** "WHERE DO YOU FEEL IT IN YOUR BODY?" (USE BODY DRAWING, IF NECESSARY)

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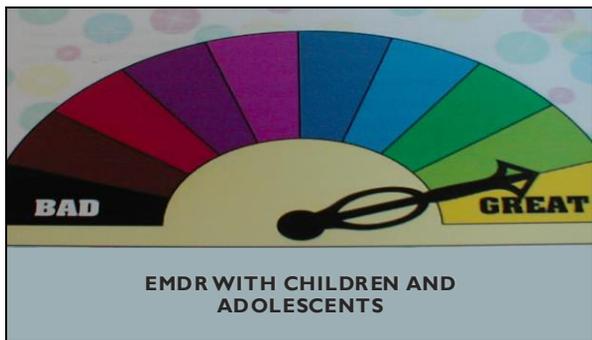
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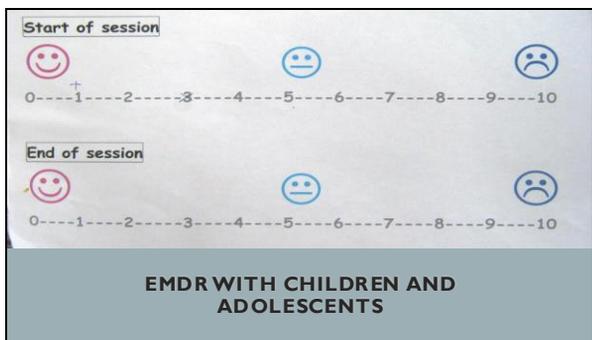
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EMDR WITH CHILDREN AND ADOLESCENTS	
List of Kids Cognitions - Adler-Tapia and Settle (2017)	
<b>Good Thoughts (PC)</b>	<b>Bad Thoughts (NC)</b>
I'm good	I'm bad
I'm in a clear place/sunshine	I'm in fog
I'm calm	I'm going to explode
I'm cool (as a cucumber)	I'm hot
I do belong	I don't belong
I'm clever	I'm stupid
I can do it	I can't do it
I do understand	I don't understand
I can get help	I can't get help
I'm lovable	I am not lovable
I fit in my skin	I am uncomfortable in my skin
I'm just right	I am fat
I did the best I could	I messed up

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**EMDR WITH CHILDREN AND ADOLESCENTS**

**Summary**

- Use child's words/thoughts when possible
- Change to alternative stimulation, e.g., tapping
- For younger children less than 10-yo, **do not complete the worksheet, do it later, not during the session.**
- Use short sets, about 12 passes
- Use more cognitive interweaves to assist children with making appropriate associations
- Note:
  - Children have fewer associative neural networks
  - *Don't expect linear progression but rather cyclical with growth spurts or healing moments*

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**EMDR WITH NEURODIVERSE CLIENTS**

**Neurodiversity**

- Neurodivergence is having a type of brain functioning that is not neurotypical, for example, Autism, ADHD, or Tourette syndrome, etc.
- EMDR standard protocol modification
  - Use fewer passes (12) and adjust speed as needed
  - If having difficulty with EMs, use tapping/butterfly hug and/or parent/caregiver applies DAS
  - Do not focus on cognitions
  - Focus on affect and/or body sensations
  - Closely monitor the window of tolerance and return to target more often, if client experiences multiple associative memories
  - Use simple language, for example, good or bad and verify terms used are mutually understood

Adapted from: Carbaugh & Provenius, 2020; Bruzen et al., 2015; van Driel et al., 2022; and Paulson, 2012.

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**QUESTIONS AND COMMENTS**

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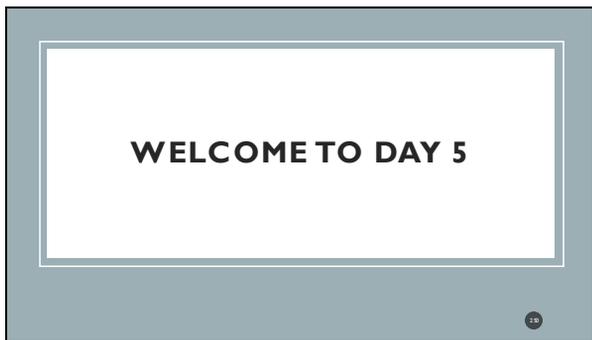
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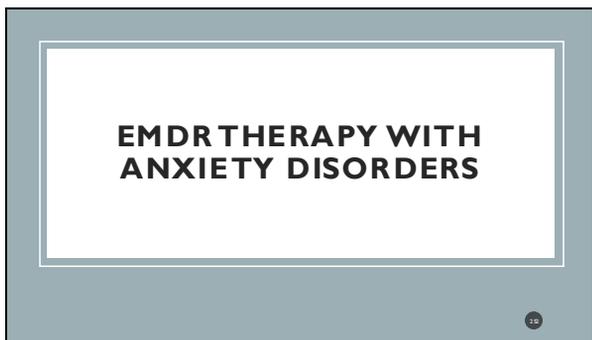
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EMDR  
THERAPY  
WITH  
ANXIETY  
DISORDERS

- History and Treatment Planning
- Current symptoms
- All Triggers
- Earliest event, etiology
- Coping strategies
- Trauma related anxiety
- Early childhood neglect
- Generational trauma
- Family history of anxiety disorders
- Eating and sleeping patterns
- Substance use – include caffeine and nicotine

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**EMDR THERAPY WITH ANXIETY DISORDERS**

- Target Order (For Phases 4-6)
  - First, Worst, and Most recent
  - Assess for dissimilar (unexpected) situations triggering anxiety
  - Future template: Desired emotional and behavioral responses
- **OCD:** Target current triggers (compulsion and/or obsession-behaviors and thoughts), followed by a future template for each trigger, then past-related disturbing memories. Once all targets have been desensitized, develop and install PC. (Marr; 2012).

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EMDR THERAPY  
WITH PHOBIAS

Get a thorough history

Remember, the client is likely to encounter the phobia trigger in the future

Preparation – teach self-control strategies to handle “fear of fear,” for example, state change strategies, etc.

Break down fearful elements into small and manageable pieces, and then systematically target and desensitize them

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**EMDR THERAPY WITH PHOBIAS**

- Target Order (For Phases 4-6)
  - Antecedent/ancillary events that contribute to the phobia
  - First memory of the phobia
  - Worst frightening incident and other related experiences to the fear
  - Most recent memory of the phobia
  - Any associated present stimuli
  - Physical sensations
  - Mental video playback of full sequence—Use Adapted Protocol with Video Playback—only include image, emotion, and bodily sensation—cognitive processing is left until the end of treatment, once you target the past memory and install future template

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**EMDR THERAPY WITH PHOBIAS**

Incorporate a positive template for fear-free future action, including all aspects of experience

Contract for action

TICES grid – reprocessing of all triggers and targets

**NOTE:** In anxiety and OCD, every trigger (obsession and compulsion) is considered a separate recent "traumatic event," which is reinforced and perpetuated multidimensionally, and they need to be reprocessed separately.

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**EMDR THERAPY WITH ADDICTIONS**

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EMDR  
THERAPY  
WITH  
ADDICTIONS

- Phase One: *History and Treatment Planning*
- Complete addiction history
  - Substance, behaviors, emotional addiction
- Trauma history
  - Attachment issues
- Dual diagnoses
  - Assess treatment priorities
- Assess ego states
  - How old does the "user" feel to the client, the ego state that is using?
  - What has happened in the past?
    - AA, family support, alternative behaviors
- Assess the client's motivation for change
  - Motivational Interviewing (Miller, 2002)

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EMDR  
THERAPY  
WITH  
ADDICTIONS

- Phase Two: *Preparation*
- Affect Tolerance
  - Increase skills needed to reduce stress overload and increase affect tolerance
- Ego Strength
  - Determine self-efficacy and self-esteem levels
  - Develop resources to increase strength and confidence or connection to previous mastery
  - Develop internal resources (RDI) on alternative behaviors and have the client practice using these resources. This helps with developing a new normal.

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EMDR  
THERAPY  
WITH  
ADDICTIONS

Phases Three-Eight:

- Choose less intense targets
- Target dysfunctionally linked information
  - reward system vs. consequence of addiction—via EMDR a person can gain insights to the cost of addiction
- Potential targets
  - The most intense feeling associated with the addiction
  - Urge to use or engage in behavior
  - Relief after use or behavior
  - Secondary gain
  - Symptom associated with function of survival (basic instinct)
- Protocols for Addiction
  - EMDR Standard Protocol
  - Popky's DeTur Protocol
  - Robert Miller's FSAP – Feeling State Addiction Protocol
  - Addiction Focused-EMDR

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ADDICTION FOCUSED-EMDR		
MAIN INDICATION (S)	AIMS	INTERVENTION MODULE
<ul style="list-style-type: none"> <li>Need for preparation, enhancing skills, and resources to handle future difficult situations</li> <li>PTSD symptoms, achievable, personal goal</li> <li>Self medication</li> </ul>	<b>Resourcing:</b> Increasing safety, strength, and accessibility of resources	1. Safe place and RDI 2. Install positive treatment goal
	<b>Trauma-Focused (TF) EMDR:</b> Reducing the impact of the past	3. Target memory associated with PTSD (T-traumas) 4. Target memory fueling negative affect and affect intolerance (ACE, t-traumas)
<ul style="list-style-type: none"> <li>Low self-efficacy/low self-esteem</li> <li>Fear of sobriety</li> <li>Fear of relapse</li> <li>Feeling of powerlessness in the face of the addiction</li> </ul>	<b>Addiction Focused (AF) EMDR:</b> Reducing the impact of change-blocking fears	5. Target memories fueling negative core beliefs (ACE, t-traumas) 6. Target negative flash-forwards of prolonged abstinence 7. Target negative flash-forwards of relapse 8. Target memories of relapse

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ADDICTION FOCUSED-EMDR		
MAIN INDICATION (S)	AIMS	INTERVENTION MODULE
<ul style="list-style-type: none"> <li>High levels of craving and corresponding relapses</li> <li>Client wants to reach an unrealistic or dysfunction goal</li> <li>The addictive behavior is linked to the healthy need</li> <li>Desire thinking, craving</li> <li>The substance or the behavior itself is attractive</li> </ul>	<b>AF-EMDR:</b> Reducing the attractiveness of addictive behavior	9. Target memories of craving 10. Target positive memories 11. Target memories linking substance or behavior underlying healthy needs 12. Target positive flash-forwards about "dry use" 13. Target positive flash-forwards about desired goal
	<b>AF-EMDR:</b> Increasing stability of treatment effects	14. Desensitization of trigger situations 15. Future templates and mental videos

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### EMDR THERAPY WITH GRIEF

- EMDR therapy
  - Does not eliminate the normal grief process
  - Reprocesses the emotional shock from the pain of the loss
  - Helps the person accept and mourn the loss
- Focuses on:
  - When the person realized/learned about the loss
  - The actual event, the death of the person
  - Intrusive images, nightmares, and present triggers
  - Previous unresolved losses

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CULTURAL  
AWARENESS/  
HUMILITY  
AND EMDR  
THERAPY

- Military personnel and families
- First responders (LEOs, Fire fighters, and EMTs)
- Gender Spectrum and LGBTQIA+
- Marginalized/minoritized individuals
- Intergenerational trauma
  - Consider institutional/systematic injuries (e.g., racism, discrimination, etc.)
- EMDR therapy language usage and cultural understanding
  - Words do not have the same semantic meaning across cultures
  - Use appropriate language/terms based on cultural norm
  - Consider the AIP model the information processing system is intrinsic and adaptive with minimal clinician intrusion.

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## RESOURCE DEVELOPMENT AND INSTALLATION (RDI)

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**RESOURCE DEVELOPMENT AND INSTALLATION  
(RDI-DURING PHASE 2; KORN & LEEDS, 2002)**

- Do RDI during *Preparation* phase (especially when a client's issue is complex, and DES score is above 30) and use during *Desensitization* phase when processing is blocked.
- Can use to develop positive introjects, increase affect regulation and adaptive responses
- Enhances positive resources and memory networks
- **Note:**
  - enhancing positive states while using RDI does not change underlying traits linked to traumatic material, EMDR processing is still needed.

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**RESOURCE DEVELOPMENT**

- **Preparation phase—Resource Development: Protocol Overview**
- Client imagines adaptive behavior/response and identifies empowering positive cognition, emotion and physical sensation.
- Reinforce the positive associations with slow BLS.
- Run a movie from start to finish with effectively handling a future situation. If negative material emerges, contain it, put it aside and redirect to focus on positive feelings and sensations.
- At the end, the client should feel emotionally, physically, and cognitively comfortable with the anticipated event.

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**RESOURCE DEVELOPMENT AND INSTALLATION (RDI)**

**Mastery**

- Client's experiences of positive attributes or positive responses to challenging situations
- A physical stance or movement related to a positive state or capacity

**Relational Resources**

- Positive role models
- Memories of supportive others
- Allies (adult self, imaginary ally)

**Symbolic Resources**

- Figures or symbols from dreams or artwork
- Images from cultural, religious, or spiritual sources
- Image of a positive goal state or future self

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**RDI  
PROTOCOL**

- Identify challenging situation or target
- Identify the resource needed
- Check the resource
- Develop the resource
  - Enhance sensory information (sight, sound, smell, taste, body sensations)
- Install with **slow/short** sets (8-10 EMs) of BLS
- If disturbance occurs, tell the client to set aside and return to pos. image & feelings (may need fewer sets)
- Link Resource with verbal and/or sensory cues
- Future rehearsal using positive resource
- Close with a reminder to practice

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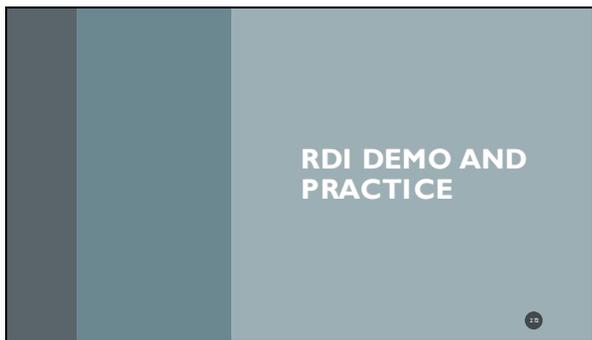
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**TRIGGERING CLIENT EXERCISE**

Start with "Most Triggering Client"

Float back to the Touchstone event

- If SUD < 7, process Touchstone
- Otherwise, process "Most Triggering Client"

If Touchstone is completed, process "Most Triggering Client"

- If SUD = 0, Install, Body Scan, Closure
- If SUD > 1, go to Closure for Incomplete Session

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**DEMO  
TRIGGERING CLIENT**

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**SUPERVISED PRACTICUM**

EMDR Standard Protocol with Floatback  
Practice Session

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**TRIGGERING  
CLIENT  
EXERCISE**

- Honor confidentiality and maintain cultural awareness
- The Therapist is the Therapist the Whole Time
- Start with "Most Triggering Client"
- Float back to the Touchstone event
  - If SUD < 7, process Touchstone
  - Otherwise, process "Most Triggering Client"
- If Touchstone is completed, process "Most Triggering Client"
  - If SUD = 0, Install, Body Scan, Closure
  - If SUD > 1, go to Closure for Incomplete Session
- If any problems/concerns arise during practicum
  - Immediately contact Trainer or Administrator

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**TRIGGERING  
CLIENT TRAINING  
PRACTICE EXERCISE**

- Get started right away
- Read the script – you don't need to put it in your own words
- Write down the Image, NC, PC, VOC, SUDs
- Begin processing on touchstone event or triggering client
  
- **Practicum supervisor will check in periodically**

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**COMMENTS  
AND  
QUESTIONS**

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**WELCOME TO DAY 6**

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**GOALS FOR TODAY DAY SIX**

Legal and ethical issues, virtual EMDR

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EMDR therapy with complex PTSD

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Future template, **the third prong**

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Demonstration

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Practice

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Evaluations and certificate of completion

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**PROFESSIONAL LEGAL AND ETHICAL ISSUES**

**Informed consent**

- Court Issues
- Memory: true vs. false
- Memory might change
- Intense emotions

**Use good clinical judgment**

- Client stability
- Affect tolerance
- Dissociation

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**PROFESSIONAL LEGAL AND ETHICAL ISSUES**

**EMDR therapy standards**

- EMDR therapy is an 8-phase and 3-prongs therapy
- Not just eye movements
- Not a technique
- Know that Safe/Calm place is a state change exercise
- RDI and Cognitive Interweave are specific interventions used judiciously
- Progress Notes (see Leeds, A.M. [2016] *A guide to the standard of EMDR therapy protocols for clinicians, supervisors, and consultants.*)

**Practice within your area of competence**

**Seek consultation and further training**

- [EMDR Certification, EMDRIA Membership](#)
- [EMDR Specialty Trainings](#), for example, [@CompassionWorks](#)
- EMDRIA Annual Conference

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**VIRTUAL EMDR THERAPY**

**Attunement**

- Resourcing
- Affect regulation
- Verify client's local emergency information

**Dual Attention Stimulus**

- EMs - eyes move side to side across midline
- Tapping - butterfly hug or side of the knees

**Desensitization**

- Start with Target with the lowest SUD level
- Go back to Original Incident more often, approximately after 5 sets

**Platforms**

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**EMDR THERAPY WITH SEXUAL ABUSE SURVIVORS**

- Have adequate supervision and consultation
- Use RDI to assist in stabilization
- Use the Positive Affect Tolerance protocol if there is an extensive history of early emotional neglect, insecure attachment, personality disorder, and positive affect phobia (Leeds, 2022).
- Be sensitivity to boundaries, touch, words, jokes
- Set appropriate goals
  - Not memory retrieval, not to determine if it happened or not; it is acceptable to alleviate symptoms w/o knowing the cause.
- Determine client readiness
  - Emotional containment, current life stressors/stability
- Structure your targets based on
  - Older memories first – already part of the historical past, not current danger

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**EMDR THERAPY WITH SEXUAL ABUSE SURVIVORS**

- Integration
  - May need time between targets for verbal processing, integration, or adjustments to new schemas
- Information Plateaus
  - May need Cognitive Interweaves (starting with responsibility, safety, and choice)

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**EMDR  
WITH  
COMPLEX  
PTSD**

**Phase One: History and Treatment Planning**

Complex PTSD is usually defined as a person experiencing chronic and repeated traumas (e.g., childhood/interpersonal traumas), which affects the person's self-organization such as emotion regulation, self-concept, relational difficulties, and changes in attention and consciousness (dissociation); Complex PTSD is in addition to the core PTSD symptoms (Cloitre et al., 2014; Herman, 1992).

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**EMDR WITH COMPLEX PTSD**

**Phase One: History and Treatment Planning**

<ul style="list-style-type: none"> <li>• Thorough Abuse History</li> <li>• Dissociation Screening</li> <li>• Identify Client Resources – possible RDI material</li> </ul>	<ul style="list-style-type: none"> <li>• Signs and Symptoms:               <ul style="list-style-type: none"> <li>• Boundary Issues, Interpersonal Relationships</li> <li>• Distortions of Body Awareness, Sexuality</li> <li>• Flashbacks, Nightmares, Body Reactions</li> <li>• Panic/Anxiety</li> <li>• Depression</li> <li>• Addictions</li> </ul> </li> </ul>
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**EMDR WITH COMPLEX PTSD**

**Phase One: History and Treatment Planning**

- Signs of Dissociation
- History of child abuse
- Attachment problems
- History of failed prior treatment
- Three plus prior diagnoses
- Amnesia for periods of time during childhood/adulthood
- Somatic symptoms
- Uneven functioning
- Existence of parts who seem to have a separate existence, for example, age, function, body sensation, name, etc.

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**ADAPTIVE INFORMATION PROCESSING (AIP) MODEL**

- Memory and Trauma (Siegel, 2010 & 2018):
  - Adrenaline increases implicit memory encoding
  - However, excessive cortisol levels decrease memory consolidation to explicit memory
  - That is, associations between events (episodic memories) are not connected with the semantic memory networks (explicit memory system)
  - Dissociation blocks memory consolidation

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**EMDR with Complex PTSD**  
Phase One: History and Treatment Planning

**CONTINUUM OF DISSOCIATION**

The diagram features a large, dark grey arrow pointing from the bottom-left to the top-right. Three orange dots are placed along the arrow's path, each with a label and a brief description below it:

- **Being in the Zone**  
(Focused on task, Highway Hypnosis, Medication)
- **Derealization**  
(Anxiety is high enough that the situation appears as though it is not real, like a dream)
- **Depersonalization**  
(Not feeling as though you are in your own body, watching as if the events are happening to someone else)

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**EMDR with Complex PTSD**  
Phase One: History and Treatment Planning

**CONTINUUM OF DISSOCIATION**

The diagram features a large, dark grey arrow pointing from the bottom-left to the top-right. Three orange dots are placed along the arrow's path, each with a label and a brief description below it:

- **Complex Post-Traumatic Stress**  
(Reliving Trauma)
- **Unspecified Dissociative Disorder**  
(Ego states exist but all contained by the personality)
- **Dissociative Identity Disorder**  
(Ego states are distinctive, separate, and share the body)

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EMDR  
WITH  
COMPLEX  
PTSD

**Phase Two: Preparation**

- Build a strong therapeutic relationship
- Educate client about long-term therapy (no miracle cure)
- Educate client about the focus on symptom relief rather than memory retrieval
- Determine stabilization needs and increase affect tolerance (via EMD protocol)
- Develop positive internal resource images for ego strengthening, for example,
  - Child self/adult self-relationship, inner advisor, nurturing figures, spiritual resources, etc.

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EMDR WITH  
COMPLEX PTSD

**Phases Three to Eight**

- Reprocessing Traumatic Memories
  - Do a “trial run” of EMDR with a low-level target (SUDS=5) or target a trigger
- Assess affect tolerance
- Be prepared for:
  - Strong abreactions
  - Body memories
  - Dissociation – Clarify if experience is part of memory; If yes, keep processing. If a defense against experience, use tools
  - Blocking beliefs

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EMDR  
WITH  
COMPLEX  
PTSD

**Phases Three to Eight**

- Reprocessing traumatic memories
- Be prepared for:
  - Memory Chaining (one target links with others—overwhelming the system)
- Contain and target only one “channel” at a time
- Looping and blocked processing
- Pace treatment—conduct EMDR processing every other session with an integration session in between

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EMDR WITH COMPLEX PTSD

**Phases Three to Eight**

- Reevaluation and Ending
- Three-Pronged Approach
  - Past traumas
  - Current life triggers
  - Install future templates
- Therapy related to skill building may be needed, for example, things the client never learned as a child, e.g., social skills, education, adult responsibility, safety, etc.

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**BACK OF THE HEAD SCALE**

Additional Strategies for Complex Trauma

Based on Jim Knipe (2015), EMDR Toolbox.

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Imaginary line from the back of the head to 12-14 inches in front of the face

- The back of the head symbolizes being in the memory (dissociated)
- The hand 12-14 inches from the face symbolizes being fully present

NOTE: In processing, it's important for the client to remain within the space between the nose and the fingers for dual attention.

**BACK OF HEAD SCALE**



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### TARGETING DEFENSES

- Traumatic experiences may negatively influence personality structure in three different ways.
  1. Dysfunctionally linked memories in the maladaptive neural network
  2. Psychological defenses:
    - i. Avoidance,
    - ii. Idealization, and
    - iii. Shame
  3. Ego states that are separate self states or parts that are not integrated in the whole self

Adapted from Jim Knipe (2015), EMDR Toolbox.

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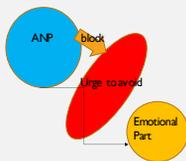
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### TARGETING AVOIDANCE

- Target avoidance defense by having the client notice:
  - Level of urge to avoid (LOUA)
  - Image
  - Emotions
  - Body sensations
- BLS until the LOUA goes down and adaptive response is reached



Adapted from Jim Knipe (2015), EMDR Toolbox.

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### TARGETING IDEALIZATION DEFENSE

- Idealization defenses are distortions in perceptions to maintain a positive affect with self and push negative feelings from conscious awareness.
- Target the idealization defense:
  - Image - from a memory of the most positive moment or feeling
  - Level of positive affect (LOPA) on a 0-10 scale
  - Body sensations
- Do sets of BLS until the person is able to get past the defense.

Adapted from Jim Knipe (2015), EMDR Toolbox.

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## EMDR, EMDr AND EMD

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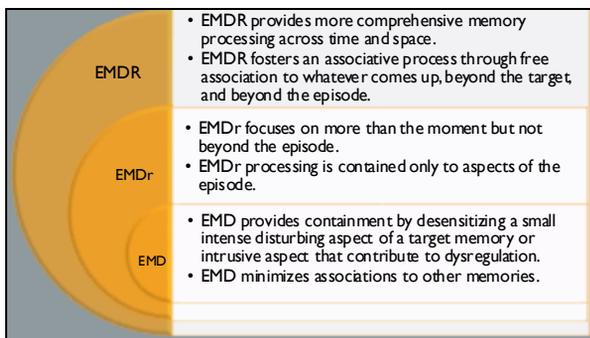
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### EMD

- **Assessment Phase:** Complete EMDR standard protocol
- **Desensitization Phase:** Use the Target Image and NC, get a SUD; instruct client to focus on it as you do fast BLS, 12-20 passes
- After each set:
  - Instruct client to blank it out and take a deep breath
  - You may ask, "what do you get now?" If the client reports associative channels or high levels of disturbance, do less passes.
  - Go back to Target Image and NC to obtain SUD
- Continue until Target Image and NC SUD reduces to 0
- If NC no longer matches image, drop belief and focus on image and emotion
- If the charge is still high (7-10) but there is no image, scan for any other disturbances, e.g., sound, smell, or body sensation. Or change EMD protocol to Recent Traumatic Event Protocol.
- **Note:** Returning to the image and NC is to desensitize, not to reprocess.

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**SUDS 9 or higher, consider other protocols:**

- **FLASH TECHNIQUE** (Manfield et al., 2021).
- **EMD** (Shapiro, 2018)
- **EMDR 2.0** (Matthijssen et al., 2021).
- **RDI (develop and install several resources)**
- **Positive Affect Tolerance protocol** (Leeds, 2022)

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LUNCH

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**FUTURE TEMPLATE**

- Expanded version of the *Installation* phase
- Purpose
  - Sets adaptive skill, behavior, emotional/sensory responses within the memory system and real-world experiences
  - Primes individual for an adaptive response in life as it shows up
  - Reveals hidden fears and negative cognitions
  - Reveals inappropriate responses
- Utilizes behavioral rehearsal (teach, model, visualize and feel), that is, rehearsing future situations strengthens confidence related to a present issue, and incorporate to positive memory networks

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**FUTURE  
TEMPLATE**

Goals

- Develop skills and strengthen confidence
- Address anticipatory anxieties and explore adaptive patterns

Protocol

- Once past and present templates are resolved
- Explore client's future desired perception, feeling, behavior and belief

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**FUTURE  
TEMPLATE**

- Protocol
  - Client imagines adaptive future responses and runs a movie for future encounters of previously disturbing person, place or situation.
  - Determine necessary skills training
  - If Negative belief, sensation, or trigger emerges:
    - More reprocessing is needed, for example,
      - Feeder memories
      - Blocking beliefs
      - Additional traumas

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**FUTURE  
TEMPLATE**

- Protocol
  - If Negative belief, sensation, or trigger emerge:
    - Teach relevant skills
  - Consider the standard protocol on whatever came up, that is, address current disturbance with standard NC ("I will lose control") and PC, emotion, physical sensation—**target directly these disturbances**
  - After a full validity of PC ("I can succeed/I can hold my own") is achieved, proceed with future template protocol

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FUTURE  
TEMPLATE

• Protocol

According to Shapiro (2018):

The incorporation of a detailed positive future template should not generally be attempted until both the earlier memories that caused the dysfunctional reactions and the present stimuli are successfully reprocessed (p. 206).

And,

Triggers should be appropriately reprocessed before attempting to incorporate any positive template for the future (p. 211).

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FUTURE TEMPLATE

- Protocol Overview as *Expansion of Installation Phase*
- Evaluate any emerging negative associations or distortions.
- Client imagines adaptive behavior/response and identifies empowering positive cognition, emotion and physical sensation.
- Reprocess any negative material and reinforce the positive associations with **fast BLS**.
- Run a movie from start to finish with effectively handling a future situation/challenge.
- At the end, the client should feel emotionally, physically, and cognitively comfortable with the anticipated event.

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FUTURE TEMPLATE

DEMO AND PRACTICE

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**REMINDER AND REVIEW**

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### EIGHT PHASES OF EMDR - REVIEW

- Phase One: Client History and Treatment Planning
- Phase Two: Preparation (Safe/calm place, RDI, Slow and short sets)
- Phase Three: Assessment
- Phase Four: Desensitization
- Phase Five: Installation
- Phase Six: Body Scan
- Phase Seven: Closure
- Phase Eight: Reevaluation
- Future Template

(Fast and long sets)

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### EMDR AND THE 3 PRONGS: REVIEW

- **Past Prong:** Fast and long BLS. Sequence:
  - Touchstone: 5-year-old, "writing alphabet" (phases 3-8)
  - Worst: 4<sup>th</sup> grade science fair (phases 3-8)
  - Most Recent: Last year, "missing friend's party" (phases 3-8)
- **Present Prong/Triggers:** Fast and long BLS
  - Invitation to social gathering
  - Perceived failure/corrected at work (phases 3-8)
  - Paying bills (phases 3-8)
  - Any other triggers (phases 3-8)
- **Future Prong (Future Template—3<sup>rd</sup> Prong):** Fast and long BLS
  - Mental Video Replay: Ask for a raise but fear rejection

Once this target sequence is complete, move on to talk therapy to discuss insights, or move on to the second target sequence.

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**EMDR AND THE 3 PRONGS: REVIEW**

- **Future Template** (3<sup>rd</sup> Prong): Fast and long BLS
  - The future template links past and present templates by “targeting a positive ‘future template’ that incorporates behaviors appropriate for the future” (Shapiro, 2018, p. 203). The future templates should reflect the likelihood of a client’s real-world experience.
  - Future resourcing, for example, for OCD, anxiety, upcoming events, etc.
    - By addressing each possible encounter that may arise
    - By addressing any feared object or anticipatory fear, sensation, hyperventilation, etc.

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**GOALS FOR THIS WEEKEND**

- Reviewed the basics of EMDR therapy
- Practiced conceptualizing cases
- Conducted resource development and installation
- Acquired strategies for blocked processing
- Practiced and witnessed cognitive interweaves
- Acquired additional tools for affect tolerance
- Reviewed complex PTSD, dissociation
- Reviewed anxiety disorders, addictions, etc.
- Practiced, Practiced, Practiced!

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**CHECK-OUT: ONE TAKE AWAY**  
**DO EVALUATION**  
**DO POST-TEST NO LATER THAN BY END OF CONSULTATION**  
**MINDFUL BODY SCAN**

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